Investigation into the circumstances surrounding the death of a man in February 2007 at Queen's Medical Centre, Nottingham, whilst in the custody of HMP Glen Parva

Report by the Prisons and Probation Ombudsman for England and Wales

February 2010

This is the report of an investigation into the circumstances surrounding the death of a man in February 2007 at the Queen's Medical Centre in Nottingham. At the time, the man – who was originally from Somalia – was a prisoner in the custody of HMYOI Glen Parva. He had transferred from HMYOI Feltham to Glen Parva three days earlier.

The man had complained of headaches and eye pain for several weeks and was in severe pain when he collapsed in the holding room on unit 15 at Glen Parva in February. He was taken to Leicester Royal Infirmary, and was subsequently transferred to the Queen's Medical Centre where he underwent surgery on the same day. After a series of post operative tests, he was diagnosed with brain stem death. He died at 11.10am. He was only 19 years old. The cause of death was determined to be bleeding in the right side of his brain, caused by a ruptured 'Berry aneurysm'. The underlying cause of this type of aneurysm was most likely a congenital weakness. In other words, he would have been born with an abnormal set of blood vessels at the base of his brain.
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I would like to extend my sincere condolences to the man's family. To lose a family member when they are as young as he was is difficult enough. That he died whilst he was being held in custody only compounds the grieving process.

I must also apologise for the long, and frankly inexcusable, delay in issuing my report. The investigation was originally led by one of my investigators. At the request of the Coroner, work was suspended whilst expert neurological reports were completed and a separate police investigation was conducted. Another of my investigators then reopened the investigation in November 2007. She subsequently left my office, having been unable to complete her inquiries. I am therefore grateful to a third investigator who resumed the investigation in November 2008.

At the beginning of the process, I asked one of my family liaison officers to contact the man's family. She has remained in touch with the family's solicitor and has twice met the man's relatives, alongside the first and third investigators, in March 2007 and January 2009 respectively. I trust that, within this report, I have responded to all the questions that the family have raised.

Also at the start of my investigation, I asked the local Primary Care Trust to commission a clinical review of the treatment that the man received in custody. (The principal purpose of the clinical review was to assess whether the care he received was equivalent to that he could have expected in the community.) I am grateful to the clinical reviewer for completing his review, which is annexed to my report. He judges that, on the balance of probabilities, the man's death could not have been prevented. However, he expresses concern at some failures by healthcare staff at both Feltham and Glen Parva.

I would like to thank the Governor of Glen Parva for appointing a liaison officer to assist with my investigation. I am similarly grateful to the staff and management at Glen Parva and Feltham for their co-operation.

My report includes six recommendations. I endorse a further six recommendations made by the clinical reviewer. I am disappointed that two of these repeat those I

have made in previous reports on deaths at Glen Parva. I draw this matter to the attention of the Director of Offender Health as well as to the Chief Executive of the Primary Care Trust.

My investigations into deaths from natural causes frequently raise as many issues as those I conduct into self-inflicted deaths. This is certainly true here.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2010**

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SUMMARY

The man was born in Somalia in 1988. He came to the UK in 2002. In October 2006, he was remanded into custody by the Magistrates Court following his arrest for two offences against the person. He was transferred to HMYOI Feltham after his court appearance.

A fortnight later, the man transferred to HMYOI Glen Parva due to overcrowding at Feltham. In October he received an Incentives and Earned Privileges (IEP) warning because he had kicked his cell door. He was involved in a fight with another prisoner in November. He sustained a fracture to his thumb during this fight, for which he received treatment at the Leicester Royal Infirmary. He was subject to an adjudication (prison disciplinary hearing) as a result of his behaviour.

The man assaulted an officer in December 2006 and was restrained by staff. He was again subject to the adjudication process as a result. A nurse confirmed that he had not been injured during the control and restraint procedure. In December and January 2007, he reported suffering from headaches and was prescribed paracetamol.

The man appeared at Crown Court in London in January 2007. He had been reluctant to attend court, and received another IEP warning because of his refusal earlier that morning. After his court appearance, he returned to Feltham. He then returned to Crown Court for another hearing in January.

In January, the man was treated for a sore throat and neck ache. Four days later he was prescribed paracetamol after complaining of a headache. The same month, he felt faint and vomited in the prison gym. He was assessed by a doctor, and a nurse checked on him later that day. During the course of January he reported a series of headaches and was prescribed paracetamol on each occasion by three different members of nursing staff.

It was thought that the man was experiencing a migraine at the end of January and he was prescribed ibuprofen. In the early hours of in February, he told a nurse that he had a severe headache and eye pain. He was referred to the doctor. During the doctor's examination later that day, the eye pain was not recorded or treated. It is unclear whether he told the doctor about it.

The man was due to be transferred back to Glen Parva for a second time in February, once again as a result of overcrowding at Feltham. However, he initially refused to transfer and had stripped his clothes off. Officers used control and restraint procedures to move him to the reception area. Once in reception he began to co-operate. A nurse assessed him following the use of restraint and reported that he had no injuries. She went on to authorise his transfer to Glen Parva. The nurse claimed that she had spoken to a doctor to agree the transfer, but a subsequent investigation revealed that she had not done so.

The man settled into unit 15 at Glen Parva after he arrived and shared a cell with the young man with whom he had transferred from Feltham. He felt increasingly unwell

overnight, and in the morning told an officer that he was experiencing a headache and a pain behind his right eye.

The officer became increasingly concerned about the man and made two telephone calls to staff in the healthcare centre in February. Despite the officer describing his symptoms accurately, nursing staff did not come to the unit to assess him that day as they were asked to do.

One morning in February 2007, the officer's concern for the man escalated because he was visibly suffering and in greater pain. She made two further phone calls to the healthcare centre in an attempt to have him examined. At 10.30am, a senior nurse performed a brief assessment of him in the entrance to his cell and gave him some painkillers. She considered that he could wait to be examined by a doctor that afternoon.

The man was unlocked after lunch and asked to wait in the unit's holding room en route to being taken to his appointment with the doctor. He collapsed in this room at 1.50pm. Healthcare staff arrived within five minutes, and an ambulance was called at about 2.00pm. He was taken to Leicester Royal Infirmary where he underwent a scan.

It was decided that the man needed surgery, and he was transferred to the Queen's Medical Centre in Nottingham later that afternoon. Surgery to remove a haematoma (large blood clot) was performed shortly after his arrival. He was moved to the Intensive Care Unit (ICU) and his family arrived during the night. However, he did not recover, and he was pronounced dead at 11.10am. The cause of death was a bleed in his brain as a result of a ruptured aneurysm.

My investigation has identified failings by healthcare staff at both Feltham and Glen Parva. Whilst the clinical reviewer judges in his clinical review that, on the balance of probabilities, the man's death was not preventable, it is clear that certain staff failed to carry out their duties as they should have done. The man's family have raised a number of other concerns about his time in custody which I address in my report.

I make six recommendations, including one asking that consideration be given to a disciplinary investigation into the actions of the senior nurse. I also endorse six recommendations made by the clinical reviewer.

THE INVESTIGATION PROCESS

1. The investigation was initially opened by an investigator in February 2007. Notices were issued to both staff and prisoners at Glen Parva informing them of the investigation process. They were given the opportunity to contact my investigator if they felt that they could assist in providing any relevant information.

2. In February, the investigator was asked to suspend his investigation by the Leicestershire Constabulary whilst neurological reports were completed at the Coroner's request. The police completed their enquiries, and in November 2007 I appointed another investigator to continue the work. Unfortunately, she was unable to see the investigation through to its conclusion before she left my office in September 2008. Another of my investigators resumed the investigation in November 2008. I must repeat what I have said in my foreword: I sincerely regret the very long delay in issuing this report.

3. The original investigator wrote to the local Coroner's office in February 2007 to inform them of the nature and scope of my investigation, and to request a copy of the post mortem report. HM Coroner will receive a copy of my report.

4. The clinical reviewer was appointed by the local Primary Care Trust to carry out a review of the medical treatment which the man received at both Feltham and Glen Parva. His review was somewhat delayed by the police investigation conducted in 2007. He conducted interviews with staff at both Glen Parva and Feltham in the spring of 2008. His report was received by my office in September 2008.

5. One of my family liaison officers contacted the man's family shortly after I opened the investigation. She explained her role and that of my office and provided information about the investigation process. She also gave the man's family the opportunity to meet and discuss their concerns. Both the family liaison officer and the original investigator met his family in March 2007.

6. The family liaison officer subsequently wrote to the family to provide further information and to acknowledge the concerns which had been highlighted during their initial meeting. I trust I have answered these concerns within my report. I also hope that my investigation gives the family a better understanding of the events leading up to his death.

7. The family liaison officer met the man's family again in January 2009, alongside the third investigator and one of my Assistant Ombudsmen. They explained to the family the reasons for the delay in issuing my report.

HMYOI FELTHAM

8. Feltham is a young offenders institution (YOI), located in west London. It has a maximum operational capacity of 764 remand and sentenced prisoners.

9. The YOI accommodates young people aged from 15 to 17 years who cannot be held in secure local authority accommodation, and young adults aged between 18 and 21 years. They generally come from either London or the south east of England. The majority of the accommodation at Feltham is in single cells.

10. Locked complaint boxes are located on each unit to allow prisoners to make complaints. There are also two race relations managers in post at Feltham, as well as an equal opportunities manager. Like all Prison Service establishments, Feltham has implemented an anti-bullying policy.

11. My office has been responsible for the investigation of all deaths in prison custody since April 2004. Since that time, no prisoners have died at Feltham.

12. The provision of healthcare at Feltham is the responsibility of Hounslow Primary Care Trust. They commissioned Serco, a privately run company, to deliver primary healthcare and the arrangement has been in place for the last three years. There is a member of nursing staff on site at Feltham who can deliver healthcare 24 hours a day. During the period when the man was at Feltham, a doctor attended between 9.00am and 5.00pm from Monday to Friday, and between 9.00am and midday at weekends. At other times, an out of hours service was available, just as it would be in the community.

13. HM Chief Inspector of Prisons completed her most recent inspection of Feltham between 4 and 8 June 2007. She found that:

    'Feltham has benefited from strong management, considerable investment and protection from some of the more damaging effects of overcrowding. Overall, staff have responded well, and it is a long way from the establishment described … in the Mubarek inquiry.'

    (The Mubarek inquiry refers to the death of a young man who was killed by his cell mate. The tragedy exposed significant failings at Feltham.).

14. I have reviewed the report issued by the Independent Monitoring Board (IMB) at Feltham relating to 1 November 2006 to 31 October 2007 and covering the period when the man was there. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The IMB report indicates that the percentage of prisoners from a black and minority ethnic background during this 12 month period was consistently above 60 per cent. The Board recognises the progress made at Feltham, but also expresses concern that the pressures experienced by the prison estate as a whole may impact on those improvements:

‘Given the recent rises reported in the number of deaths in custody nationally, we take the opportunity of our annual report to [refer to] … the significant, additional risks faced by Feltham given its high proportion of Foreign Nationals, the number of prisoners on remand, their mental health needs, and age profile …’

15. As regards the provision of healthcare at Feltham, the IMB says:

‘… bringing the NHS into Feltham five years ago has led, and is leading, to considerable improvements in the healthcare being offered … overall we feel the health services are generally improving, and many of the facilities being offered to the prisoners are at least equal to those usually available from the NHS outside prison.’

HMYOI GLEN PARVA

16. Glen Parva is a young offenders' institution located near Leicester. It has a maximum operational capacity of 808 young men aged between 18 and 21 years. The establishment opened in 1974 and has always held young offenders. All prisoners who arrive at Glen Parva spend their first six nights in a dedicated induction unit. In total there are 12 residential units.

17. HM Chief Inspector of Prisons completed an inspection of Glen Parva between 25 and 27 June 2007. She made the following observations in the introduction to her report of that inspection:

> ' … we were pleased to find that Glen Parva had progressed and was now performing reasonably well across all the main areas that constitute a healthy prison ... Reception, first night and induction were all satisfactory … staff-prisoner relationships were much improved … Despite a challenging and volatile population, Glen Parva remained an essentially safe place … Considerable progress had been made in the management of … race equality … however, there was still more to do to address bullying adequately …'

18. Since 2004, I have investigated three deaths at Glen Parva, all of which were self inflicted. The clinical reviewer, who conducted the clinical review of the man's medical care, completed clinical reviews of two of the three previous deaths. In relation to all three of the cases he has now reviewed at Glen Parva, he has made the same recommendation relating to a failure to obtain a prisoner's records from their community doctor once they enter custody. There is another recommendation, regarding poor record keeping by healthcare staff, which was also raised in one of his previous clinical reviews.

19. Healthcare at Glen Parva is commissioned by the local Primary Care Trust. The nursing staff are employed through the Prison Service. There is a combination of registered general nurses (RGNs), mental health nurses (RMNs) and nurses which specialise in learning disabilities, and a member of nursing staff is on site 24 hours a day. From Monday to Friday, there is full nursing cover from 7.15am until 8.00pm. During nights and at weekends, both a qualified nurse (either an RGN or RMN) and a clinical support worker are present. Both members of staff are trained to deal with basic emergency situations.

20. A full time doctor's surgery operates at Glen Parva on weekdays. There is a lead doctor, supported by colleagues, all of whom are employed by the same local provider. At the time that the man died, there was a locum doctor who regularly provided this service. On weekends, a doctor runs a surgery in the afternoons only. After 6.00pm on weekdays and at weekends, Primecare run an out of hours service which staff can call if they need advice regarding a prisoner's health. There are ten in-patient beds in the healthcare centre.

21. The most recent annual report issued by the Independent Monitoring Board at Glen Parva relates to the two year period from December 2006 to November 2008. The Board believes that Glen Parva is a prison that has continued to

improve. However, they express concern that the Measuring the Quality of Prison Life survey conducted in February 2008 produced results which the Board considered to be 'unpalatable'. They are also critical of the standard of accommodation, some of which is uninhabitable.

22. The IMB considers that the issue of race equality is prioritised at Glen Parva. New members of staff receive appropriate training, and meetings attended by both staff and prisoners are held each month. A full-time race equality officer has been appointed. The IMB believes that complaints procedures are well publicised if any individual feels unfairly treated. Complaints forms and a locked complaints box are located on each unit, and the instructions are clear.

23. If a prisoner wishes to make an application (or complaint) to the IMB, they must put the relevant form in an envelope, which is then placed in the requests and complaints box on the unit. Members of the IMB place blank forms in these boxes occasionally to check that they are being delivered by prison staff.

24. Unit 15 functions as the induction unit when prisoners arrive at Glen Parva. The unit is staffed by six officers and one senior officer. Prisoners are interviewed before being located in a cell.

KEY FINDINGS

Events at Feltham in October 2006

25. The man was remanded into custody at Magistrates Court in October 2006, having been charged with committing two offences. His case was committed to be dealt with at Crown Court in January 2007, and he was transferred to HMYOI Feltham.

26. When the man arrived at Feltham shortly after 7.00pm, a nurse assessed him in the reception area and completed a routine first reception health screening. (This is a basic assessment of prisoners' health issues which takes place every time a person enters custody as a new reception.) He told the nurse he had not experienced any prior episodes of ill health and he reported no current health concerns. He told the nurse that, to the best of his knowledge, there was no history of any recurring illness within his family.

27. The man said that he was a cannabis user and the nurse referred him to the Counselling, Assessment, Referral, Advice and Throughcare Service (CARATS) at the prison. (The CARATS team works with those offenders who misuse drugs.) He was considered fit for normal location but, due to the nature of his alleged offences, he was assessed as representing a high risk of harm to other prisoners and was located in a single cell.

28. In October, the man's Cell Sharing Risk Assessment was reviewed by a senior officer. Following the review, the risk he represented to other young offenders was reduced to the medium level, and he was moved to Swallow Unit. The man spoke with his personal officer and told him that he had no concerns.

Events at Glen Parva from October 2006 to January 2007

29. The man was transferred to Glen Parva in October. His medical record indicates that he was fit for transfer and that he was not taking any medication. According to the investigation completed by the Leicestershire Constabulary, he was transferred out as a result of overcrowding at Feltham. He left Feltham at 11.10am and arrived at Glen Parva at 2.05pm. Unfortunately, my investigator has not seen the reception health screening form which was completed upon his arrival. He should have gone through a similar reception process to the one he had experienced at Feltham. He was located onto Unit 15 at Glen Parva, an induction wing.

30. The man did not appear to settle well at Glen Parva. In October, he was given an Incentives and Earned Privileges (IEP) Scheme warning by an officer after he repeatedly kicked his cell door. (The IEP scheme is intended to encourage and reward good behaviour. Additional entitlements, such as more visits, can be gained in return for good behaviour. However, those entitlements can be lost if behaviour deteriorates.) The officer made an entry in the man's wing history record describing him as a '… young man who needs help to understand rules and regulations'. The man was moved to Unit 12 in November.

31. At about 3.00pm in November, the man was involved in a fight with another prisoner after interrupting a game of pool in the Unit 12 association area. The man had insisted that he should be allowed to play with the others. He sustained a fracture to his right thumb during the subsequent fight. As a result of this incident, he was subject to an adjudication (a disciplinary hearing) as was the other prisoner involved. After being found guilty of fighting, 50 per cent of his earnings were withheld for 14 days. He was also stopped from associating with other prisoners for five days and was not allowed to buy items such as sweets and cigarettes for a week.

32. The man's fractured thumb was examined by a doctor and he was referred to Leicestershire Royal Infirmary (LRI) for treatment. His thumb was put in plaster and he was discharged back to Glen Parva. He returned to the LRI in December to complete the treatment for his injury.

33. At about 10.30pm in December, the man was being escorted back to his cell by an officer after again disrupting a game of pool during the association period. As they walked back to the cell, he tried to return to the association area. He spun around and assaulted the officer, pushing into him with his shoulder, causing the officer to stumble. He was restrained by the officer, placed in ratchet handcuffs and relocated onto Unit 7 (the segregation unit).

34. The man was examined by a nurse as part of the safety algorithm process which has to take place before a prisoner is placed in segregation. The aim of this process, outlined within Prison Service Order 1700, is to see whether there are any medical reasons for not placing the prisoner in segregation. The nurse confirmed that he had not sustained any injuries as a result of the control and restraint procedure which had been used.

35. In December, the man was subject to another adjudication as a result of his behaviour two days earlier. After being found guilty, his earnings were reduced by 50 per cent for two weeks, he was prevented from buying items such as sweets and cigarettes for two weeks and he was not allowed to take part in association periods for one week.

36. The man did not come to the attention of healthcare staff again until 21 December. At 11.30pm, he was examined by a nurse and complained of a headache. He was prescribed paracetamol. He also reported a headache in January 2007 and paracetamol was prescribed once more.

Events at Feltham from January to February 2007

37. The man received an IEP warning at Glen Parva regarding his behaviour early on 9 January as he did not initially cooperate with being taken to a court appearance in London. His warning sheet, completed by an officer, recorded that the man was 'in bed on court release'.

38. The man's family told my investigator that on the day that he went to Crown Court a member of the prison staff had thrown his copy of the Qur'an across his cell.

39. The man eventually left Glen Parva at 8.10am in January to appear at Crown Court. He arrived at court at 11.40am. After his appearance, instead of returning to Glen Parva, he was transferred to Feltham and arrived there at 5.15pm. He was screened by a nurse upon arrival and no new health concerns were identified. Upon arriving at Feltham that evening, he spoke with his mother on the telephone. The following day, he attended his offender management reception interview.

40. The man appeared at Crown Court again in January. He underwent a routine healthcheck before he left and was considered fit to appear at court. He arrived at court at 8.40am. After his hearing, he was transferred back to Feltham.

41. A prison doctor assessed the man in January after he complained of a sore throat and neck ache. The doctor found that he had a mild throat infection. He was advised to take in more fluid. There is no record of him complaining of a headache at the time.

42. A Cell Sharing Risk Assessment was completed in January 2007 in which it was noted that the man did not wish to share a cell at the time because he wanted first to address his quick temper. He reported having a headache on the same day and was prescribed paracetamol. The next day he was located on Partridge Unit.

43. During the daytime in January, the man vomited three times and fainted whilst exercising in the gym. He was taken to the healthcare centre where he was assessed by the prison doctor. The doctor instructed him to drink more fluids because he was dehydrated, and to eat more. His blood pressure was taken and he was prescribed prochlorperazine, a drug used to treat nausea. The doctor also started him on a course of paracetamol. Both medications were prescribed until 27 January.

44. The man returned to his residential unit after his examination. A nurse subsequently checked on him in the evening and told officers on Partridge Unit to let her know if he developed a rash, as he had complained to her that the light was hurting his eyes.

45. In January, the man met his personal officer. Three days later he was still feeling unwell so his personal officer completed a sickness application form for him. He was assessed by healthcare staff later that day and was prescribed paracetamol after complaining of a headache.

46. The man was again prescribed paracetamol by nursing staff at the end of January after complaining of headaches each day. He was examined by three different nurses.

47. The man was prescribed ibuprofen for pain relief as it was thought that he was experiencing a migraine. On this occasion, he was assessed by the same member of nursing staff who examined him previously.

48. The man's headaches continued. At 2.25am in February he rang his cell bell after he had woken up with a severe headache and a pain behind his right eye. At 3.00am, a nurse came to assess him. He reported his symptoms and the nurse prescribed soluble paracetamol. An appointment was made for him to see the doctor later that day.

49. The prison doctor carried out that consultation. In a written statement, he recalled that the man had presented with a headache but with no other significant symptoms or complaints. The doctor did not record in the medical record (nor did he recall in his statement) that the man reported any eye pain during the examination. An entry concerning the consultation was made in the man's medical record for the doctor by a nurse. The nurse recorded that the man had denied having a migraine. The doctor wrote in his statement that the man had not been in any apparent distress. He recalled that he had taken a full and appropriate history from him. On the basis of the symptoms with which he presented, the doctor prescribed pain relief medication and referred him to have his ears syringed.

50. Later that day the man was told he would be transferring back to Glen Parva. Once again, the investigation conducted by the Leicestershire Constabulary indicates that overcrowding at Feltham necessitated the move.

51. In February, the man refused to be transferred to Glen Parva, claiming that he had previously been subjected to racist bullying by its staff. Following his refusal to comply with the transfer, officers went to his cell. He was standing naked near the window in his cell when officers arrived to escort him to reception area 'B'. He had stripped himself and doused both himself and the floor of his cell on Partridge Unit with water and what was probably shower gel. He thought that this would prevent officers from moving him as the floor was very slippery.

52. A Principal Officer (PO) recorded in the 'Use of Force' form that the man did not behave aggressively, but that he did not comply with staff. A Senior Officer (SO) wrote in his form that the PO had spoken at length with the man to persuade him to get dressed and complete the transfer, but without success.

53. In the event, the man was restrained at about 10.30am on the instructions of the PO, with the permission of the Governor who was also present. The SO took hold of his head; an officer took his left arm and another officer his right arm. The officers ended up slipping on the floor because it was wet but managed to restrain the man as he lay prone on the floor. Despite several requests to get dressed, he refused to comply. The officers then stood him up under restraint. Contrary to the instructions issued in Prison Service Order 1600 relating to the planned use of control and restraint, a member of healthcare staff was not present when the man was restrained and moved out of his cell.

54. A blanket was sought to cover the man. In the meanwhile, he said he was experiencing difficulties breathing whilst being held in the restraint position so the SO released his head and he stood upright. The other two officers

maintained their locks on his arms. The man continued to refuse to comply with the transfer from his cell. A blanket was brought and he was covered up. His shoes were put on his feet by one of the officers.

55. The man was placed in ratchet cuffs and moved from Partridge Unit downstairs to the search room. He walked to the search room under the restraint of the officers. Once he arrived, there was some prolonged negotiation before he eventually agreed to comply. The cuffs were then removed, the officers' hold was released, and he agreed to dress himself. The PO wrote in his statement that the correct control and restraint procedures were used when the officers moved the man and that the minimum force required was used throughout. The appropriate use of force forms were completed by the PO, the SO and both officers.

56. The man complained of dizziness after the use of the control and restraint procedure when he was assessed by the nurse. He told the nurse that he felt unwell. She consulted his clinical records and noticed that he had been assessed by both a nurse and the doctor the previous day. She recorded that he had sustained no visible injuries, assessed him as being fit to transfer out of Feltham, and told him to report sick to a nurse upon his arrival at Glen Parva if he still felt unwell.

57. This nurse later claimed that she had consulted the doctor by telephone when she was deciding whether the man was fit to transfer. She stated that the doctor had told her on the telephone that he had examined the man on the previous day, and that he could be transferred. The doctor was attending to other prisoners on Albatross Unit at the time. The nurse claimed that she had assessed the man as fit to transfer on the basis of her conversation with the doctor. (This situation is addressed in the 'Issues' section of this report, as it has since emerged that the nurse had not consulted the doctor as she claimed to have done.)

58. After the nurse had assessed him, the man was escorted from reception area 'B' to the van for transfer. He was no longer protesting and seems to have made his way peaceably to the van. The prisoner escort record (PER) was completed to indicate that he had not sustained any visible injuries as a result of the control and restraint procedures which had been used. The van left Feltham at 11.05am.

59. The Prisoner Escort Record (PER) completed prior to the van's departure makes no mention of the man having to be handcuffed during the journey to Glen Parva. A governor has been the Deputy Head of First Days in Custody at Feltham since April 2006, dealing with the reception and induction process. He told my investigator that prisoners are not normally cuffed when they are transferred between prisons. He said that such an event would be exceptional, and that he cannot remember it ever happening during the time that he has worked in the reception and induction group. He has worked at Feltham for 12 years.

60. The governor said that because nothing was marked on the PER to indicate that the man was handcuffed for the journey, it can be presumed that this did not happen. Such an unusual course of action would warrant an explanation on the PER.

61. The governor said that prisoners who are being transferred out of Feltham are walked to the van without cuffs. They are then each locked in a separate cellular compartment in the body of the van. Some vans have six compartments, but those used for the journey to Glen Parva usually have ten. There is, on average, one transfer each week from Feltham to Glen Parva.

62. One of the man's fellow prisoners travelled in the same van to Glen Parva in February. He said in his police statement that the man claimed to have been 'jumped' by staff at Feltham when he had refused to transfer out. (The prisoner has since been released from custody and, unfortunately, it has not been possible for my investigators to either locate or interview him.)

Events at Glen Parva from 2 February

63. The man was transferred to Glen Parva and arrived at 1.35pm. The prisoner said in his statement to the police that, when they got off the van, the man told him that he was getting a headache. He recalled that the man's left eye was starting to close up at this point (it was in fact his right eye that was causing him pain).

64. An officer who was working in the reception area that afternoon, recorded in the Cell Sharing Risk Assessment document that the man wanted to share a cell with the prisoner and that both men had seemed pleased to do so. He also noted that he did not report any problems or concerns to him when this assessment was completed. During the reception process, the officer informed the man of the first night procedure for prisoners. Four days after the man died, the officer made a statement recalling that he had been 'in a good mood, quiet and polite' when he entered Glen Parva.

65. Whilst in reception, the man complained of 'dizziness' to the nurse during the routine health screening. She prescribed paracetamol. He was then placed on Unit 15, which is an induction unit. None of the staff involved in his reception process recorded that there was anything unusual about his eye.

66. An officer collected the man from the telephone room on Unit 15 and took him to his cell. During interview, she told my investigator that he had neither complained to her of feeling unwell in February, nor had seemed unwell to her on that evening. She observed nothing in his appearance or behaviour at this stage which caused her concern. As part of the process of settling him into the unit, the officer asked him if he was okay. She did not recall observing that he was still upset or agitated after the use of control and restraint procedures at Feltham earlier that day, although she was not aware that force had been used at the time. Nonetheless, whilst she would subsequently become concerned about him, she indicated that there was nothing remarkable about his presentation on the day of his arrival at Glen Parva.

67. The prisoner said in his police statement that, during a night in February, the man had asked for the light to be turned down because his eye was overly sensitive. The prisoner also told the police that the man's left eye began pointing outwards at this point, away from his nose. He said that the man had made a patch for his eye out of material.

68. The prisoner said that he rang the cell bell several times during the night because he was worried about the man. He recalled that the night patrol staff had said that they would contact the healthcare centre. However, he told the police that the man was not seen by healthcare staff during the night. Unfortunately, there is no record of the events described by the prisoner. My investigator requested the relevant cell bell records, but staff at Glen Parva have been unable to retrieve this information from their computer.

69. The entries made in the observation book kept on Unit 15 do not include any mention of either the man or the prisoner until the man collapsed. (Any areas of concern or significant incidents are supposed to be recorded in this book.) An officer wrote that it had been a 'quiet evening' on 2 February. During the handover to the day staff a member of staff noted in the book that it had been a 'quiet night' and that there was nothing to report.

70. During morning unlock the man spoke to the officer. He told her that he had a pain behind his right eye. He said that he wanted to be examined by a doctor, and she showed him where to fill in the appropriate application form. A little later, she spoke with him again. He told her that his eye was sore and that his head hurt. She observed that his eye was visibly swollen or 'puffed up', as if he might have had an eye infection.

71. The officer was worried about the man because he was evidently in pain and discomfort at this point. She was not unduly alarmed, but could see that he was unwell. From her personal experience, she considered that he might be suffering with a migraine.

72. Out of concern, the officer telephoned the healthcare unit at about 9.00am to ask if the man could see a doctor. She hoped to speed up the appointment process. However, she was told that he could not be assessed that day by a doctor as there were no more appointments available. The officer told my investigator that she spoke with a female member of the healthcare team at this stage, although she could not recall exactly who it was.

73. Later that day, the man pressed his cell bell. The officer went to see him and he complained again of eye pain and a worsening headache. The officer telephoned the healthcare centre for a second time at about 2.30pm, but was told that a doctor was no longer on site and that nobody else was available to come to Unit 15 to assess him that day. The officer was told that an appointment would be made for him to be examined by a doctor the next morning. When my investigator spoke with the officer, she said that, to the best of her recollection, she believed that she had spoken with the senior nurse on

this occasion. The senior nurse has confirmed that she did speak to the officer when she rang the healthcare centre for the second time that day.

74. The officer advised the man that healthcare staff would not assess him until the next morning. She advised him to place a cold flannel on his head to help relieve the pain in the meantime. He said that he would lie down on his bed to try and relieve the pain.

75. The man was assessed by a substance misuse worker. It would appear he did not discuss any health problems with him.

76. The prisoner told the police that, the man complained of blurred vision, had not eaten and had slept a lot. He said that they continued to ring the cell bell. He indicated that no healthcare staff were brought to assess him until Sunday, by which time the prisoner said that the man was in a great deal of pain, rolling around and clutching his eye.

77. The observation book kept on Unit 15 is similarly unable to confirm the prisoner's recollection of the night in February. During the handover to the night staff, the comment that it had been a 'quiet' evening is recorded in the observation book. When the night staff went off duty the next morning, they again noted that it had been a 'quiet night'. An incident involving other prisoners during the course of the night is fully detailed, but there is no mention of the man until he collapsed later that day.

78. Shortly after morning unlock, the officer spoke with the man. He complained of both a headache and experiencing eye pain overnight. He was holding his right eye and was visibly suffering. The officer described in interview how his eye had been both red and swollen, as if it was infected. When the officer spoke with the clinical reviewer she could not recall whether on that Sunday morning the eye was pointing in its normal direction.

79. The officer checked the appointment list and found that the man had been given a doctor's appointment in the afternoon. Having been under the impression that he was going to be assessed in the morning, and feeling increasingly concerned about his wellbeing, she was not satisfied that the examination would be further delayed. She telephoned the healthcare centre and was told by the senior nurse that no doctor's appointments were available until the afternoon. In interview, the officer said that she continued to press for a nurse to examine the ma in the interim and was told that nursing staff were due to visit Unit 15 later that morning. The senior nurse has confirmed that she spoke to the officer on the telephone that morning.

80. The officer told my investigator that, as the weekend progressed, she became increasingly frustrated by the failure of healthcare staff to come to Unit 15 and examine the man. She described how her concern for his welfare grew from Saturday to the Sunday. As time went on, she said that he was evidently in more pain. She thought that she had accurately described the distress that the man was in when she spoke with the healthcare team on the telephone. The

senior nurse has denied that the officer was 'quite insistent' when asking for him to be assessed.

81. A little later that morning, the man pressed his cell bell again. The officer went to see him and observed that he was in more pain than the previous day. His eye was still puffy and swollen; he was in a heightened state of physical distress and was complaining loudly. She told him that a nurse was on the way, and she then telephoned the healthcare centre for the second time that morning to ensure that a nurse was shortly due on Unit 15. The man's cell mate also spoke with the officer at this stage. She recalled that he had told her that the man was 'really struggling'. The officer tried to reassure him that a nurse would arrive imminently.

82. The senior nurse arrived on Unit 15 shortly after the officer's second telephone call to the healthcare centre. The officer escorted her up to the man's cell at about 10.30am. He was lying down on the bed with a towel over his eyes to shield them from the light. During interview, the officer told my investigator that she and the senior nurse had stepped just inside the cell, but that the nurse had not examined him either standing by his bed or sitting down next to him. The man had got up off his bed and met them just inside the entrance to his cell. The senior nurse handed him some pain relief medication, which he swallowed. She told him that he would be examined by a doctor that afternoon.

83. The officer had reported the man's symptoms of eye pain and a headache to the nurse over the telephone. She recalled during interview that he had also described his symptoms himself when the nurse visited his cell. The officer said that his eye pain and distress were readily apparent to her, especially because he had placed a towel over his eyes.

84. The officer told my investigator that the senior nurse had not examined the man's eye when she visited his cell, nor had she asked to do so, and she did not remember him refusing to let the nurse look at his eye. The officer said that the nurse spent approximately two minutes with him and she did not consider that the nurse had conducted a thorough examination.

85. The senior nurse said in interview that the man told her of both his eye pain and the fact that he had had a headache since the previous day. She said that she had asked him a number of questions to determine what was wrong. She also said that she had asked him to get up, walk to the sink and drink some water, in order to observe his brain function and co-ordination. She said that these had appeared to be normal.

86. Contrary to the officer's recollection of events, the senior nurse said that she had tried to examine the man's eye, but that he had been reluctant to let her do so. She indicated that she had therefore not done so, because she was concerned that she might be accused of assaulting him if she went against his wishes. She observed that his right eye was 'tightly closed'. The nurse assessed that his eye pain was the main problem, and that his headache was not as severe. In her assessment, he did not present with any other symptoms at that time.

87. There was no doctor in the prison on the Sunday morning. At weekends, a doctor will attend Glen Parva in the afternoons to assess emergency cases that healthcare staff have referred to them. The senior nurse said that she had been concerned that the man should see a doctor later that day because his headache had lasted more than 24 hours, and because she said that he would not let her examine his eye.

88. Again contrary to the officer's recollection, the senior nurse did not consider that the man had been 'unduly distressed' at the time she examined him, and she therefore judged that he could wait until the doctor arrived in the afternoon to perform a full assessment.

89. The man's cellmate collected lunch for them both at about 11.30am and returned to the cell. A second officer later said in his statement that he remembered the man seeming too unwell to get his own lunch. At 1.10pm, a further officer responded after the man rang his cell bell. He observed that he appeared unwell, and that his eye had 'puffed up'. He assured him that arrangements had been made for him to be examined by the doctor that afternoon.

90. At around 1.35pm, the second officer went to the man's cell and told him to get ready for his doctor's appointment. The officer found him lying in bed with 'a towel wrapped round his head'. He observed that he was visibly unwell at this stage. The man got dressed and made his way downstairs from the third landing to the 'holding room', or 'phone room', on the ground floor. (This is a room containing telephones and a television where prisoners wait for officers to escort them off the wing to the healthcare unit.)

91. Whilst the second officer finished his unlocking duties, the man made his own way down to the holding room. The first officer told my investigator that other prisoners were present in the holding room when he collapsed. A third officer confirmed that he had been the first member of staff to reach him after his collapse. He said that, at about 1.50pm, he had been half way up the stairs near the holding room when one of the other prisoners had come out and shouted, 'He's been sick.'

92. The third officer went into the holding room and saw the man sitting with his back to the wall. He described how his eyes had glazed over and said that he seemed unresponsive. Although the prisoner who raised the alarm had referred to him having been sick, he did not seem to have actually vomited at this point. He was seated but very unsteady, and the third officer caught hold of him when he began to roll to one side and lose his balance. It seemed to this officer that the man was going to keel over. He lowered him to the floor and placed him in the recovery position to keep him safe.

93. The first officer had been in the unit office when the third officer raised the alarm over the radio. She arrived in the holding room to find the man unconscious and supported in the officer's arms. She recalled that, amongst other staff, two other officers were present.

94. An SO, who was acting up as a temporary principal officer at the time, was in the control room. He answered a telephone call which said that the man had been found collapsed in the holding room. He was instructed that the unit's senior officer should be informed. The SO asked the communications officer in the control room to put a call out for the unit's senior officer.

95. At this point, the call came over the radio from the holding room requesting medical assistance, indicating that a 'code blue' emergency was underway on Unit 15. (A 'code blue' emergency indicates that a prisoner is experiencing breathing difficulties.) The SO went to the holding room to assist. En route, he held open the gates to allow healthcare staff to make their way through.

96. A PO, who was the duty manager, subsequently arrived in the holding room to find officers in attendance, along with the SO and two governors. One was the duty governor on the day.

97. During interview, the first officer recalled that the other prisoners present in the holding room when the man collapsed were quickly relocated by staff. This ensured him more privacy, and allowed him to be treated without interruption. She also said that, once healthcare staff were asked to attend, their response was very quick and efficient. She estimated that the senior nurse arrived within at most five minutes, shortly followed by other members of the healthcare team.

98. The senior nurse received the emergency call at just after 1.50pm and went straight from Unit 14 to Unit 15. She was the first member of healthcare staff to arrive. She recalled that the man had been placed on his left side in the recovery position. Once the third officer was relieved by her, he resumed his task of taking prisoners to the visitors centre.

99. The nurse checked the man's pupils, and found them to be unequal and unreactive. She recalled in interview that he was unresponsive at this stage. She noticed that he was salivating from the right side of his mouth and that his breathing was laboured and shallow. He had also now vomited.

100. Two staff nurses then arrived bringing oxygen equipment with them. The senior nurse administered oxygen to the man and inserted an airway into his throat. She also checked his pulse and blood pressure, and found them to be within normal limits.

101. After assessing the man, the senior nurse asked the first officer to organise for an ambulance to be called as a matter of urgency and requested that the paramedics be told that he was unconscious. The officer contacted the control room and asked that an ambulance be called. Both the prison's records and the East Midland Ambulance Service's Patient Report Form (PRF) confirm that an ambulance was requested at 2.00pm.

102. The senior nurse noticed that the man had spat out his airway. She continued to maintain his breathing manually. She decided to move him to the healthcare centre at this stage, to provide more privacy for him and to have more

equipment on hand if it was required. She did not think that she could best continue to care for him in the holding room.

103. A Healthcare Officer (HO) arrived bringing a trolley from the healthcare centre to help move the man. The HO and the SO then assisted the senior nurse place him onto a stretcher. Accompanied by the two nurses they proceeded with him to the treatment room in the prison's outpatients' department. This took approximately ten minutes, and was necessarily slower than usual as the senior nurse had to maintain his airway throughout.

104. The senior nurse remained with the man in the healthcare centre, monitoring him until the paramedics arrived. He became restless and irritable. He tried to cough his airway out and the nurse assisted him to remove it. He moved his right arm and leg, but it was noticeable that there was no movement from the left side of his body.

105. According to the PRF, the ambulance arrived at the prison gates at 2.07pm. The SO went to meet it and he brought the paramedics up to date as regards the man's condition. He escorted them to the healthcare centre and the PRF confirms that the paramedics reached the man at 2.10pm. Meanwhile, an officer had gone to collect the escort bag which the officers escorting the man to hospital would have to take with them.

106. Whilst staff and paramedics were responding to the man's collapse, the PO put the arrangements in place to escort him to hospital. The PO instructed two officers to escort him. A risk assessment was carried out and it was designated an emergency escort. The governor oversaw the restraint arrangements, indicating that a 'double cuff' should be used initially. In his statement, the SO said that he discussed the use of a closeting chain with the governor. (A closeting chain allows a ratchet cuff to be attached to both the prisoner and the escorting officer, with a length of chain in between. This allows medical treatment to continue during an escort out of the prison without the officer obstructing the procedure.) Once the governor had authorised the use of the closeting chain until the man's condition improved, the SO attached one cuff to the man and the other to the officer.

107. A second PO explained during a conversation with my investigator that double cuffing is standard practice on all escorts out of Glen Parva. He said that a closeting chain would be used when a prisoner is semi-conscious. He was the dispatching officer for the man's escort. The dispatching officer checks that the escort is properly staffed and that staff have all of the necessary equipment as they leave the prison. He could not recall the specific details of his checks that day.

108. However, the SO recalls that the dispatching officer checked the application of the cuffs to the man and the officer and then authorised the ambulance's departure from Glen Parva, with both officers escorting. In interview, one officer recalled that he had volunteered to accompany the man to provide him with some comfort and continuity of care.

109. The PRF indicates that the ambulance left Glen Parva at 2.32pm. It arrived at Leicester Royal Infirmary (LRI) at 2.40pm.

Events at Leicester Royal Infirmary

110. The closeting chain used during the journey from Glen Parva was removed from the man in the hospital at 3.15pm after he had been anesthetised. The escorting officer noted in the bedwatch log that the dispatching officer had authorised the chain's removal over the telephone. No restraints were reapplied at any point during the rest of the man's time in hospital. At 4.00pm, the man had a computerised tomography (CT) scan before returning to the Accident and Emergency Department's resuscitation area.

111. Just after 4.15pm, the escorting officer spoke to the medical staff and was told that the man had suffered a 'large bleed'. A short while later, medical staff confirmed that he would be transferred to the Queen's Medical Centre (QMC) in Nottingham in order to undergo surgery. The escorting officers were told that his condition was such that he might not recover, and medical staff advised that the prison should contact his next of kin. The other escorting officer telephoned the governor and indicated that the man's family should be contacted.

112. Having received permission for a single officer escort, the first escorting officer travelled in the front seat of the ambulance with the man in the rear with the medical staff. The second escorting officer travelled separately in a taxi because there was insufficient space in the ambulance for him. The ambulance left the LRI at 5.43pm, travelled under a 'blue light' (meaning that the journey was treated as an emergency), and arrived at the QMC at 6.14pm.

113. At about 6.00pm, staff at Glen Parva spoke with the man's family. They wished to visit him at the hospital and made preparations to set off from London. They would subsequently telephone Glen Parva again later that evening in order to obtain directions to the QMC in Nottingham.

Events at the Queen's Medical Centre

114. The man underwent an operation in theatre at the QMC. It began at about 6.30pm, only minutes after his arrival. The operating neurosurgeon performed an emergency craniotomy. This meant entering the man's brain via his skull in order to evacuate the haematoma (large blood clot) which had formed as a result of the bleeding in the right side of his brain. However, the operation would ultimately prove unsuccessful.

115. The escorting officers had been told that the man's prognosis was poor. They passed the information onto the duty governor during a telephone conversation at 6.50pm, at which point it was confirmed that the next of kin were on their way.

116. The officers were relieved at 8.15pm and a further two officers took over the bedwatch. The man was located in the Intensive Care Unit (ICU) at the QMC after his operation. The escorting officers were asked to wait outside, as there

was no room for them in such a busy ward with other patients present. Having contacted the prison at 9.10pm, and with the duty governor's permission, the escorting officers spent the rest of the night in or around the family room, away from the ICU.

117. The bedwatch log indicates that the man's family arrived at the QMC at 11.30pm. They remained at the hospital throughout the night and were based both in the family room where the prison officers also sat, and in another room close by. These rooms were situated just down the corridor from the ward where the man was located. The main waiting room was fairly large, with about 20 chairs in it. Staff spoke with members of his family on several occasions during the night.

118. At 1.05am, staff at the QMC explained to the man's relatives both the seriousness of his condition and its rarity. They answered questions from the family. Between 5.00am and 6.00am, a consultant reviewed his condition. At about 8.00am, a further two officers took over the bedwatch. At 9.15am, the prison and the hospital discussed the need for officers to remain on bedwatch, and the Governor confirmed that both officers should stay with the man.

119. Shortly after 9.30am, the officers on the bedwatch were informed by medical staff that the man had been diagnosed with brain stem death, and that consequently his family would be asked to consider switching off his ventilator. His pupils were dilated and unresponsive. The situation was explained to the family with the aid of an interpreter at 10.45am, and their permission was sought. The ventilator was switched off shortly afterwards, and the man was declared dead at 11.10am.

120. At 1.40pm, the Governor and Glen Parva's family liaison officer arrived at the hospital to speak with the family and answer their questions.

121. The cause of death was subsequently found to be the development of a spontaneous intracerebral haematoma. This means that a blood clot had developed within the right side of the man's brain. The post-mortem completed by a Professor found that the bleeding resulted from a ruptured Berry aneurysm. (This type of aneurysm is found at the base of the brain, and can grow in size and then spontaneously rupture. The underlying cause of the aneurysm was most likely a weakness that the man was born with, namely an abnormal set of blood vessels in the brain.)

122. A consultant neuropathologist, found the rupture of the aneurysm had resulted in extensive bleeding within the man's brain. The pressure exerted by the haematoma (or blood clot), which was 4cm by 5cm in size, caused his brain to die probably even before he was operated on. The damage was sadly irretrievable and, in the assessment of the consultant neurosurgeon who completed a medical report with regard to the man's case, surgery was probably futile.

The police investigation

123. A police investigation of the man's death by Leicestershire Constabulary took place, during which time my own investigation was suspended. The police found that no individual had been neglectful in their duties to such an extent that they had either contributed to or failed to prevent his death. The police concluded that he died of natural causes.

ISSUES

Clinical care

124. When my Family Liaison Officer and my investigator at the time visited the man's relatives in March 2007, the family expressed a number of concerns about his death which I address within this section of my report. The clinical review of his case, conducted by the clinical reviewer, has been of particular assistance in answering many of the family's questions. The review is annexed in full to my report. The investigator who completed this report visited the man's family again in January 2009. He provided the family with a copy of the clinical review, and has taken account of the issues that the family still felt needed to be addressed.

Response to the man's headaches

125. The family are concerned that medical staff in Feltham and Glen Parva ignored the man's headaches and did not treat them with due concern. He complained of a number of headaches in the weeks before his collapse. He told his family about these headaches and that he did not feel that his symptoms were being taken seriously enough. His mother was sufficiently concerned about her son to consult a solicitor in February 2007. She was already worried about him before he collapsed.

126. The clinical reviewer explains why the headaches the man reported would not have been particularly exceptional, and places his rare condition into context. He stresses that only one or two per cent of headaches about which people complain to healthcare staff, either in the community or in prison, actually have a serious cause. Approximately 98 per cent of headaches referred to a clinician are not the result of a serious or potentially fatal condition. This is why patients are invariably prescribed paracetamol or a similar drug.

127. Whether in the community or in custody, the clinical reviewer considers that it is not usually possible for a nurse or doctor to address what presents as a simple headache as a possible symptom of a very serious illness, unless other symptoms are reported in addition.

128. When he spoke with my investigator, the clinical reviewer commented that, in the community if a patient presents with ongoing headaches but no 'red flag symptoms' (signs that might suggest a serious underlying cause for the headache), there are a number of steps that the doctor might take. They include ongoing observation, the keeping of a 'headache diary', and the prescription of different medications.

129. The clinical reviewer estimated that a General Practitioner would realistically manage the treatment of these headaches for up to three months in the community before considering referring the individual to hospital. The doctor might try out different types of pain relief and medication in order to resolve the headaches. Only after these options were exhausted or if the symptoms

changed to suggest a different diagnosis, would the patient be referred to hospital.

130. The clinical review highlights the rarity of the man's condition within the population as a whole. The clinical reviewer comments that the type of bleed in his brain which he suffered is experienced by about one person in every 10,000 each year. It is particularly rare and unfortunate to find this condition in somebody so young. This type of aneurysm is predominantly associated with individuals aged between 40 and 50 years.

131. The consultant neurosurgeon who reviewed the man's case, commented that, with the benefit of hindsight, the headaches which he reported were undoubtedly the result of an enlarging aneurysm. However, he concurred that these types of aneurysms are exceptionally rare, particularly in someone as young as the man. As a result, it was not reasonable to expect healthcare staff at the prison who examined him to have diagnosed his condition until other symptoms presented themselves - something which did not occur until the weekend that he died.

132. The clinical reviewer believes that, again with the benefit of hindsight, the vomiting and possible faint or collapse which the man experienced in January might have been linked to an early, much smaller bleed in his brain. He cannot be sure what happened in the gym on that day, as the recorded entries do not make this episode of ill health entirely clear. It is possible that the vomiting was unconnected to the eventual aneurysm which caused his death. Equally, it could be that this was a collapse brought on by a small bleed in his brain.

133. The man's family have said that, despite fainting, he was forced to go to the gym and was told that he would be deprived of visits if he did not do so. My investigator has found no supporting evidence in the prison records. Unfortunately, the passage of time since my investigation started has meant that there is now no realistic means available of determining whether this was the case.

134. The development of eye pain from 1 February onwards at Feltham may well have been associated with an expansion of the aneurysm in the man's brain. The clinical reviewer considers that it would not realistically have been possible to have diagnosed the man's underlying condition prior to his reports of eye pain. This newly reported symptom, following a series of headaches, correctly resulted in a referral to a doctor by a nurse at Feltham. The referral was made when the nurse assessed him in the middle of the night after he reported a severe headache and a pain behind his right eye.

135. However, when the man was examined by the prison doctor later that same day, it seems that the doctor did not make a further referral or prescribe any significantly different medication. He treated the man for a headache and said that he did not find him to be in any obvious distress. In his notes, which were actually made for him by the nurse (something I go on to discuss below), the doctor did not make reference to any eye pain. He maintained in a written

statement that he had taken a full history from the man during the examination, and that he had not presented with any other significant symptoms.

136. The clinical reviewer says that the headaches which the man reported will have been experienced by between 25 and 50 per cent of patients with his condition in the weeks before they suffer a brain haemorrhage. However, this history of headaches is usually only identified retrospectively and does not help medical staff to diagnose the condition at the time. This is because the pain reported is often indistinguishable from everyday headaches. Unfortunately, it is therefore usual for an aneurysm, such as the one the man experienced, only to come to light when a sudden bleed results in brain damage.

137. The consultant neurosurgeon considered what would have happened had a member of healthcare staff made a connection between the man's headaches and a possible aneurysm, and decided that the headaches therefore warranted further investigation. On the balance of probabilities they would most likely have made a referral to a neurologist. Given average waiting times, an appointment with the neurologist would then have been scheduled for four to six weeks from the date of the referral. Having been assessed by a neurologist, the man would probably have been sent for a CT scan or a magnetic resonance imaging (MRI) scan. This would have taken a further four to six weeks to complete. Given that the aneurysm in his brain ruptured a couple of weeks after he first presented with a succession of headaches, even a remarkably accurate suspicion on the part of a nurse or doctor within prison healthcare could not, in all likelihood, have prevented his death.

138. Nonetheless, I note that the consultant neuropathologist who completed the autopsy report following the man's death, did remark that:

> '… if the patient had been referred earlier, the aneurysm could have been detected and different management and treatment would have been followed … '

However, he asked a neurosurgeon to comment of the likely success of any such management or treatment of the aneurysm. The consultant neurosurgeon who operated on the man in February after his collapse, completed a medical report with regard to his condition. He concluded that it was unlikely that the bleed in his brain could have been prevented.

139. The Professor, who completed the post-mortem report, commented that the bleed in the man's brain was the result of a ruptured Berry aneurysm. (He said that the headaches which he experienced before he died were likely to have been linked to small leakages of blood from the aneurysm prior to the major bleed in February.) This type of aneurysm is particular to blood vessels at the base of the brain. It can expand and then spontaneously rupture. The rupture can occur without prior warning and is highly likely to result in death.

140. The man's family point out that he had been an apparently fit and healthy young man. However, the medical experts who have explored his condition found that he died as a result of an undiagnosed aneurysm. It appears to have been a

condition with which he was born. The only significant indication of there being anything seriously wrong appeared three days before he collapsed, when his eye began to hurt, and then deviated away from its normal position.

141. The clinical reviewer discussed current surgery trends with the consultant neurosurgeon. He was told that a recent audit of time from diagnosis to operation showed that the most common time to operate on this condition was around three days after diagnosis in the United Kingdom.

142. In layman's terms, there is a balance to be struck between the risk involved in early intervention in an unstable ongoing condition and the risk of delaying the operation, possibly resulting in a complete rupture of the aneurysm. The consultant neurosurgeon explained that surgeons have to strike the right balance between preparing adequately for what is a very delicate operation, and not waiting so long that the aneurysm may bleed catastrophically. If a surgeon was to enter the brain too quickly, without the appropriate preparation, this could be hazardous, just as waiting too long could also be dangerous.

143. The man collapsed two to three days after his right eye first started pointing outwards (this is referred to as a deviated eye in medical reports). This was the first significant indication, coming after a succession of headaches, of the expanding aneurysm which caused his death. The rupture of this aneurysm occurred at about the same time as the likely start of any surgery, had an accurate diagnosis of his ‘deviated eye’ been made on 1 or 2 February and had he been immediately referred to hospital.

144. The clinical reviewer also indicates that medical intervention in a case like the man’s does not offer the patient a significant chance of survival. Had surgery taken place before the aneurysm ruptured, then he would have faced a distinct possibility of either dying during the operation, or sustaining brain damage if he survived.

145. The man’s family wanted to know why he was not seen more often by a doctor, despite telling staff about his headaches. Having spoken with medical staff, the clinical reviewer ascertained that he usually presented with a generalised headache. It was only three days before his collapse that he began to complain of an additional symptom, namely the eye pain. As I have already outlined, staff would not have had any reason to believe that a more serious illness lay behind his headaches until his condition deteriorated further. Consequently, they prescribed paracetamol during the January consultations, a reasonable decision at the time.

146. The man’s requests for medical assistance and his reports of headaches usually took place in the out of hours periods, when a doctor was not in the prison. On these occasions, the clinical reviewer has satisfied himself that staff would advise the man to ask for an appointment with a doctor if the problem persisted. However, it would seem that these were predominantly episodic headaches, which were not so severe at the time as to cause the nurses to call upon the out of hours service. The man was assessed by a number of different healthcare staff towards the end of January in Feltham. It is unfortunate that

one particular nurse did not build up a more cohesive or continuous picture of the headaches he was experiencing. When he was assessed by the prison doctor in February, after complaining of a headache and eye pain the previous night, the doctor did not recall him saying that he had any eye pain during their appointment.

Whether the man sustained an injury whilst he was held in custody which might be linked to the cause of his death

147. Whilst the man was held in Feltham, he suffered a fracture to his thumb after fighting with another prisoner in November 2006. He was also restrained by staff on two occasions, in December 2006 and February 2007. The clinical reviewer has concluded that the man did not suffer any significant injury as a result of any of these incidents. He found that he died as a result of an undiagnosed and unrelated condition. In his assessment, the aneurysm the man experienced was neither triggered nor aggravated by an external event such as a fight, nor by the use of control and restraint procedures by prison staff.

148. As regards the fracture to his thumb, sustained in November 2006, the man visited the Leicester Royal Infirmary on two occasions to have the injury properly treated. After the use of control and restraint procedures in December 2006, he was assessed by a nurse later the same day. The nurse confirmed that he had not suffered any injury as a result of the restraint used.

149. Perhaps the most pertinent incident was the use of control and restraint by staff at Feltham in February 2007, two days before the man collapsed. He had taken off his clothes and doused himself and the floor in water and shower gel to try to prevent officers from transferring him to Glen Parva. In these circumstances, staff used control and restraint procedures to facilitate the transfer. I examine this incident in detail later in this report.

150. The Professor's post-mortem report identified 'a considerable number of old injuries'. However, he confirmed that these injuries were not linked to, and neither caused nor contributed to, the man's death.

151. Finally, as I have already outlined, the investigation by the Leicestershire Constabulary found that no individual had been neglectful in their duties to such an extent that they contributed to the man's death. The police concluded that he died of natural causes.

Whether the man was fit to be transferred from Feltham to Glen Parva in February 2007

152. The clinical reviewer expresses concern about the actions of the nurse who assessed the man as fit to transfer to Glen Parva in February. She did so after the use of control and restraint procedures by officers at Feltham. She had not actually consulted with the prison doctor during her assessment, even though she claimed to have done so at the time. The man complained of feeling dizzy to her.

153. The clinical reviewer considers that the nurse was probably placed under some pressure by prison staff to deem the man fit for transfer, due to overcrowding problems at Feltham on the day. He also believes that officers would have been reluctant to have had their decision to transfer him undermined by having to return him to his cell, given the effort involved in removing him from it in the first place.

154. Consequently, when she failed to reach the prison doctor by telephone, the nurse deemed that the man was fit to be transferred anyway. She subsequently made a statement in which she claimed that she had spoken with the doctor. The doctor has always denied that he was consulted about the transfer. This matter has since been investigated by Serco, the provider of healthcare at Feltham. A copy of the investigation, conducted by a Senior Investigations Officer is annexed to this report.

155. The Senior Investigations Officer found that the nurse had made a telephone call to Albatross Unit where the doctor was working. However, from the evidence provided by the doctor, an officer who took her telephone call and another nurse who was also present, the doctor never came to the telephone to speak with her.

156. The officer spoke with the nurse and relayed information to the doctor. He did not ask him to come to the phone, and he did not pass him the handset. The investigation established that the nurse did not consult directly with the doctor in February regarding the man's fitness to transfer to Glen Parva. There was some suggestion that the other three professionals involved had essentially formed a coalition against the nurse. The Serco investigation found that this was not the case.

157. As a result of the complaint made against her by the doctor, the nurse was suspended from work in February 2007. Following the conclusion of the investigation by the Senior Investigations Officer, a disciplinary hearing was held in July 2007. As a result of the hearing, the nurse was issued with a final written warning. Her conduct in February was considered to be seriously below the standards of normal nursing practice. The warning lasted for a period of 12 months. (The nurse returned to work in August 2007 and continues to work at Feltham. The doctor has since left Feltham.)

158. In spite of these events, the clinical reviewer believes that the man would have been fit to transfer (even if the doctor had examined him) and that there was no reason for him not to have been moved in February. He does not believe that the use of force and the transfer had a negative effect on his long term health. He confirms that there were no ongoing or planned hospital appointments or medical tests which he would have missed as a result of leaving Feltham.

159. From the evidence available, the clinical reviewer concludes that, had a doctor examined the man before he left Feltham, there would not, at that stage, have been any illness evident which would have led to the transfer between prisons

being blocked. There is no evidence that the man himself told staff that he was too unwell to transfer that day.

160. An officer told my investigator that the man did not appear either particularly agitated or upset when she settled him into Glen Parva later that day. She asked him how he felt, and he made no complaint to her at that time. The officer who was the reception officer at Glen Parva also recalled that the man presented unremarkably when he arrived at the prison. However, he did complain of dizziness to the nurse in reception and was prescribed paracetamol.

161. With regard to the use of control and restraint in February at Feltham, this was properly documented by all the members of staff involved. The correct procedure is described, and restraint was stopped when the man agreed to co-operate. Control and restraint procedures are used by prison staff when a prisoner refuses to comply with reasonable instructions. In this instance, he was being told that he had to move to another prison. It is not unusual for prisoners to be transferred out at short notice in order to ease overcrowding. Few welcome that fact, but prisoners cannot choose where they are located.

162. Because Feltham is the only young offenders' institution in the London area, it feels the population pressures most acutely. Feltham receives a large number of young adults from the courts every day, and its operational capacity is routinely tested. For these reasons, and because staff cannot be seen to allow a prisoner to disobey an order to transfer without good reason (in case this encourages further ill discipline), I do not believe it was unreasonable that force was used to move the man to the reception area.

163. Prison Service Order (PSO) 1600 states that:

> 'When healthcare staff (registered nurse, hospital officer or doctor) are on duty in the establishment they MUST attend a planned C & R intervention.'

None of the statements made in the 'Use of Force' forms by the officers involved indicates that a member of healthcare staff was either requested or present during the control and restraint process used to transfer the man to the reception area. The incident took place on a Friday morning, at a time when several nurses would have been in the prison.

The Governor of Feltham should ensure that all staff are reminded of the requirements of Prison Service Order 1600. The planned use of force should always involve the attendance of a member of healthcare staff.

164. I also note that the incident was not taped using a video camera. This is recommended in PSO 1600 during the planned use of control and restraint. However, in this situation, given that the man was undressed, it might have been deemed inappropriate to video the use of force.

Reasons for the man's transfer to Glen Parva

165. When my investigator spoke with them, the man's family could not understand why he was transferred out of Feltham where he was closer to them. According to the police investigation conducted into his death, he was transferred out of Feltham on both occasions as a result of overcrowding. His transfer was apparently an operational decision and not a reflection on his conduct. As I have already outlined, the clinical reviewer concludes that his health was not affected detrimentally by the transfer. (I do of course sympathise with the view that transferring a young man a hundred miles from his family is thoroughly undesirable.)

166. The family also recall that the judge at Crown Court indicated at the man's hearing that he should remain at Feltham, and should not be transferred away from the London area where his relatives were close by. However, as my investigator told the family during his visit in January 2009, a judge's comments do not place the Prison Service under any obligation. The pressures of overcrowding supersede such opinions as a judge may express. However unwelcome the practice may be, it is an unfortunate fact that even young offenders may be located at some distance from their families because of prison overcrowding.

Sharing a cell

167. The man's family have said they wanted him to share a cell with another prisoner so that someone could check on his health. A Cell Sharing Risk Assessment was completed at Feltham in January 2007 in which it was noted that he did not wish to share a cell at the time because he wanted to address his quick temper. However, he did subsequently ask to share a cell with another prisoner when he arrived at Glen Parva in February. This was agreed, and staff noted that both prisoners seemed pleased with the arrangement. The prisoner provided the police with a statement regarding his friend's health. He seems to have assisted him whilst he became progressively more unwell during his final weekend at Glen Parva, bringing him meals and such like.

Use of restraints

168. The man's family wanted to know if he was transferred to the Queen's Medical Centre in cuffs. I can confirm that this was not the case. He was initially cuffed to one of the escorting officers using a closeting chain (which consists of a length of chain with cuffs at either end) for the journey from Glen Parva to the Leicester Royal Infirmary (LRI). The closeting chain was removed soon after his arrival at the LRI, and he remained uncuffed from that point onwards, including during the journey to the Queen's Medical Centre (QMC). Two officers remained with him until he died. They did not stay at his bedside throughout as this was not deemed either necessary or appropriate.

The journeys from Glen Parva to the LRI and then from the LRI to the QMC

169. The man's family wanted to know whether the ambulance journeys from Glen Parva to the LRI, and then from the LRI to the QMC, took longer than they should have done. The timings regarding the calling and arrival of an ambulance differed slightly, depending on the various statements and documents provided. My investigator therefore obtained a Patient Report Form (PRF) from the East Midlands Ambulance Service. This is likely to be the most accurate record of events available. It is kept by the paramedics themselves as a matter of routine during every emergency call out.

170. The PRF confirms that the ambulance was requested at 2.00pm. The ambulance began its journey to Glen Parva at 2.01pm and arrived at the gates at 2.07pm. The paramedics reached the man at 2.10pm. Having prepared him for the journey, the ambulance departed Glen Parva at 2.32pm and arrived at the LRI at 2.40pm.

171. Having undergone tests at the LRI during the afternoon, it was decided that the man would be operated on at the QMC in Nottingham. He left the LRI in an ambulance at 5.43pm, and arrived at the QMC at 6.14pm. A blue light was used by the ambulance driver to ensure the quickest journey possible. By 6.30pm, he was in the operating theatre.

172. Consulting the Automobile Association (AA) website, my investigator has ascertained that the journey from Glen Parva to the LRI is a distance of 3.4 miles, and should take about nine minutes to drive. This seems to correspond with the time it took the ambulance to reach Glen Parva, given that an ambulance was called at 2.00pm and reached the prison seven minutes later. The journey from the prison to the LRI took a comparable eight minutes.

173. As regards the later journey from the LRI to the QMC, this is a distance of 26.9 miles, and is estimated to take an average 34 minutes to travel. The ambulance actually made the journey in slightly less time in February 2007, probably due to its 'blue light'. I believe therefore that I can reassure the family that the times taken to transfer the man in the ambulance were reasonable.

Whether the man's treatment at Glen Parva was discriminatory

174. One of the concerns which the man's family has about his treatment in prison is the possibility that he was the victim of possible discriminatory treatment (racist bullying) perpetrated by staff at Glen Parva. Unfortunately, when my investigator and family liaison officer spoke with the family on two separate occasions, they were unable to identify any specific officers. Indeed, whilst they said that one unnamed officer at Glen Parva had apparently bullied him, another had treated him with respect.

175. The man's family told my investigator that an officer had thrown his copy of the Qur'an across his cell in January, the day of his transfer from Glen Parva to Crown Court. I have passed this allegation to the Governor of Glen Parva and ask that he bring it to the attention of the Race Equality Officer so that the matter can be investigated further.

The Governor of Glen Parva should commission further investigation into the allegation made by the man's family concerning events in January 2007.

176. It is certainly true that the man was reluctant to return to Glen Parva in February, and became so agitated that he refused to transfer out. As we have seen, he stripped himself and doused his cell in water and shower gel. Officers at Feltham used control and restraint procedures to take him from his cell to the reception area.

177. The Deputy Head of First Days in Custody at Feltham has confirmed that around the time the man was transferred out, staff were observing a considerable degree of reluctance on the part of black prisoners to transfer from Feltham to Glen Parva. Prisoners were telling staff at Feltham that, as black men originating from the London area, they did not feel at ease in Glen Parva. The Deputy Head of First Days commented that this was a recognised problem which was probably at its worst around the time that the man died. It would seem that he was not alone in his reluctance to transfer to Glen Parva.

178. The Head of Diversity at Feltham confirmed that complaints from prisoners from a black or minority ethnic background reached a peak in January 2007. Their complaints related to their concern at the prospect of being transferred to Glen Parva where they perceived that they would receive differential treatment.

179. In liaison with staff at Glen Parva, staff at Feltham took steps to address this problem. The Head of Diversity visited Glen Parva in April 2007 to explore with the Diversity Manager at Glen Parva at that time how the situation could be improved. The Head of Diversity visited Glen Parva for a second time, and the Diversity Manager also visited Feltham. Their co-working led to both members of staff receiving a Performance Recognition Award from REAG (Race Equality Advisory Group) for building a dialogue between the two prisons. The then Director General of the Prison Service, now Director General of NOMS, presented both men with the award in late summer 2007.

180. When the Head of Diversity spoke to my investigator, he explained that his co-working with Diversity Manager had discovered the cause of the prisoners' discontent. The strong feelings black prisoners had been expressing resulted largely from the perception of life at Glen Parva rather than the reality. There had been a lack of awareness of the particular circumstances at Feltham on the part of staff at Glen Parva, and vice versa. A failure in communication, seemingly now largely rectified, was deemed to be at the heart of the problem.

181. For example, staff at Glen Parva could not understand why Feltham was sending them an apparently disproportionate number of prisoners from a black or minority ethnic background. However, they failed to understand that approximately 80 per cent of prisoners at Feltham fall into this category. The situation is entirely reversed at Glen Parva, where a minority of prisoners define themselves as having a black or minority ethnic background.

182. The Head of Diversity commented that prisoners perhaps had false expectations of life at Glen Parva when they were transferred out of Feltham, as Feltham is relatively well resourced. Black prisoners perceived that they were being deprived of showers, food and such like at Glen Parva. However, the co-working by the two YOIs found that these conditions were a result of generally poorly equipped facilities, rather than a consequence of racial discrimination. Black and minority ethnic prisoners had been interpreting a less well resourced regime as receiving differential treatment.

183. A governor told my investigator that the situation has greatly improved and he estimated that the resistance from black prisoners transferring from Feltham to Glen Parva is now 'a tenth' of what it once was. There are still some complaints, but not to anything like the same degree. The Head of Diversity confirmed that he has only received one complaint about transferring to Glen Parva since May 2007.

184. The Head of Diversity told my investigator that the man had not, unlike several of his fellow prisoners, made any complaints in relation to racial discrimination at Glen Parva whilst he was held at Feltham on either occasion.

185. I have confirmed that the man never made a complaint to my office about his treatment. The Chair of the Independent Monitoring Board at Glen Parva in 2008 told my investigator that he never submitted any applications to the IMB either. She also indicated that, in 2007, the IMB at Glen Parva received no complaints from any prisoners specifically with regard to alleged racist treatment by staff.

186. The Race Equality Officer at Glen Parva has further confirmed that the man made no formal complaints using a prisoner complaint form, either of a general nature or relating to racial discrimination, whilst he was held at Glen Parva on either occasion. Over the 2006-2007 period, 58 prisoners at Glen Parva made complaints about racial discrimination. This was apparently a comparable figure to previous years.

187. The Race Equality Officer has provided my investigator with additional information which helps to illustrate life as it would have been for a young adult in Glen Parva in 2006 and 2007. I hope that this will be useful to the man's family.

188. There were 29 members of staff from a black or minority ethnic background when the man was a prisoner at Glen Parva, which equated to 5.9 per cent of the overall staffing. This compares with around 8 or 9 per cent of the population of the East Midlands as a whole (and with about 38 per cent of the population of Leicester).

189. At the time the man was held at Glen Parva, 28.6 per cent of prisoners described themselves as being from a black or minority ethnic background. The average percentage of adjudications against prisoners from a black or minority ethnic background was almost identical to the proportion of the population which they constituted during the months he was there. This

certainly does not indicate a pattern of racial discrimination in the adjudication process. More detailed figures are provided in the table below:

Month	*Percentage of adjudications which Involved prisoners who defined themselves as black or minority ethnic*
October 2006	30.25%
November 2006	29.1%
December 2006	25.42%
January 2007	35.25%
February 2007	23.37%
Average	*28.68%*

190. My investigator has also spoken with the man's criminal solicitor. He confirmed that the man never asked him to make a formal complaint on his behalf to either Feltham or Glen Parva in relation to racial discrimination, or indeed any other matter. The solicitor said that he would have written a letter to the Governor of the relevant prison if he had asked him to.

Record keeping at both Feltham and Glen Parva

191. The clinical reviewer has examined the man's clinical records. He notes that entries made at both prisons were difficult to decipher, and that some entries made by nursing staff were too brief. He believes that healthcare staff may well benefit from training relating to record keeping. However, he notes that both prisons were due to implement an electronic patient records system imminently, and that this development should improve standards. In general, he considers the man's records to have been 'of a reasonable standard'. However, he makes the following recommendation, which I endorse.

    The Heads of Healthcare at both Feltham and Glen Parva should ensure that medical records are correctly signed and dated and that all relevant details of the examination and plans for management of the patient's health are recorded. The member of staff should also print their name.

192. I note that the clinical reviewer has previously made a very similar recommendation in relation to the self-inflicted death of a prisoner at Glen Parva in June 2006.

193. In regard to record keeping, he highlights the fact that, just before the man was transferred to Glen Parva in February, an entry was made by a nurse to record actions taken by the prison doctor when he assessed the man in February. Although the entry seems to accurately reflect the decisions made about the man's healthcare by the doctor, staff should record their own actions and findings. Healthcare professionals should not make entries for other members of their team in retrospect. However, the clinical reviewer does not consider that the nurse's actions had a negative impact on the care the man received. I endorse his recommendation.

The Head of Healthcare at Feltham should ensure that staff make their own records, and do not record the actions of colleagues. The Head of Healthcare should address the action of the nurse.

194. The nurse had the opportunity to read my draft report during a period of advance disclosure. (Any members of staff who are directly criticised during an investigation are entitled to correct any factual errors within 21 days before the report is sent to the man's family.) The nurse said that she could not recall making any notes of the doctor's assessment. However, his medical record indicates that she did make such an entry for the doctor in February. I have not therefore amended my recommendation.

The failure to request the man's medical records from his doctor

195. In the man's case, neither Feltham nor Glen Parva obtained a copy of his medical history from his community General Practitioner. The clinical reviewer has reviewed a summary of his previous medical history prior to entering custody provided to the Leicestershire Constabulary by his doctor following his death. The clinical reviewer has confirmed that there was no significant relevant medical history contained within the clinical records which the prisons overlooked to the man's detriment.

196. Nonetheless, it is of concern that there was the potential for an oversight with serious consequences to have occurred. The clinical reviewer has ascertained that both prisons now intend to request medical summaries from doctors when a new prisoner enters custody. I note that he has completed two previous clinical reviews in relation to the deaths of prisoners at Glen Parva. In both those reports, he identified the same failing to obtain the prisoner's medical records and made the same recommendation.

The Heads of Healthcare at both Feltham and Glen Parva should ensure that medical summaries are requested from community GPs in the case of every new prisoner.

The care the man received in January

197. The clinical reviewer is satisfied that the man was examined after he felt unwell and vomited in the gym in January. He was taken directly to the healthcare centre to be assessed by the prison doctor. However, the clinical reviewer remains unsure from the records available whether the man only vomited on this occasion (as a result of a less serious illness), or if he actually collapsed as well. If he did collapse in January, then it may have been as a result of an initial bleed. This possible collapse might have been the first indication, aside from headaches, of the more serious condition that would eventually cause his death.

198. It is encouraging that a member of the healthcare staff visited the man on his unit in the evening to check on his wellbeing. They also advised officers on the unit to observe him and to call the healthcare team if he developed a rash. It is unfortunate that they did not identify themselves in his medical record.

The care the man received after arriving at Glen Parva in February 2007

199. The clinical reviewer considers that the man did not present with any symptoms of a significant illness when he underwent the reception process at Glen Parva in February. It is persuasive that the officer, who helped the man to settle into Unit 15 once he had left the reception area, could not recall there being anything obviously wrong with his eye on the day of his arrival. She confirmed that the man had not complained about his health on that first day, and there was nothing in either his behaviour or appearance which gave her cause for concern at that time.

200. The man's health seems to have deteriorated rapidly from February onwards. The clinical reviewer believes that he became increasingly unwell during the night. As I have already described, his cellmate observed that he became sensitive to light and noise. He also said that the man experienced eye pain, and that one of his eyes began to point outwards, away from the other.

201. The man's cellmate said he rang the cell bell during the night and alerted staff, who told him that they would ask a member of the healthcare team to attend. However, nobody attended to him during the night, and there is no record of any of the events described by the cellmate. He has subsequently been released from custody and my investigator has been unable to contact him.

202. The clinical reviewer believes that the cellmate was describing a clear sign that a more serious condition was causing the man's headaches, namely the deviation in his eye. He believes that, had a medically qualified member of staff made this observation on the night and linked it to a history of headaches, they might well have been alerted to the seriousness of his condition.

203. During the next two days, the officer, who had inducted the man onto the unit, observed his deteriorating health and repeatedly asked a member of the healthcare team to assess him as quickly as possible. The clinical reviewer commends the persistence of this officer in trying to secure an assessment of the man by a doctor or nurse.

204. When she spoke with my investigator, the officer expressed her frustration regarding the provision of healthcare at Glen Parva over that weekend. In all, she made four telephone calls to the healthcare centre asking that the man be examined. It was only as a result of her persistence that the senior nurse eventually came to assess him. I endorse the clinical reviewer's commendation of the officer and would be grateful if the Governor could bring my comments to her attention.

205. However, it would have been good practice if the officer had noted her escalating concerns about the man in the unit's observation book and thus have kept night staff and other unit staff informed of the developing situation. She did not do this. As the officer told my investigator, she was a relatively inexperienced officer at the time, and she has reflected since on what occurred

over that weekend at Glen Parva. She recognises that there were aspects of her own practice that could have been improved upon.

The Governor of Glen Parva should remind all staff of the importance of writing relevant information in the wing observation book so that other staff on the wing / newly arriving staff are aware of events.

206. The officer told my investigator that the senior nurse was, to the best of her recollection, the member of nursing staff with whom she spoke when she called the healthcare centre for the second time. The nurse confirms this. The officer was increasingly concerned about the man's symptoms, but was told by the nurse in the early afternoon that nobody would come to Unit 15 to assess him that day.

207. Although a formal triage policy was not introduced at Glen Parva until December 2007, nurses were expected to assess prisoners once they had filled in the appropriate application form requesting an assessment. The man had made an application with the officer's help early that morning. The officer had also communicated her concern about him over the telephone twice. The current Head of Healthcare has confirmed that 24 hour nursing cover at Glen Parva meant just that at the time. A nurse should have been able to competently assess a prisoner, having been informed of symptoms of eye and head pain. In failing to visit Unit 15 on the Saturday and assess the man, I am sorry to say that the nurse failed to fulfil her professional duties as the team leader in the healthcare centre that day.

208. When the nurse did visit the man in his cell, the officer felt the examination was cursory and said that the nurse did not examine his eye. She told my investigator that the nurse did not actually make an attempt to do so, contrary to the nurse's own assertion. The officer does not remember any refusal on the man's part to allow the nurse to look at his eye. On the contrary, she said that he had complained of eye pain repeatedly across the weekend. She remembered that the assessment was carried out in the doorway to the cell and lasted less than two minutes.

209. In his clinical review, the clinical reviewer is critical of the nurse's failure to examine the man's deviated eye when she visited him in his cell in the morning. The nurse told the clinical reviewer that she feared being accused of assault if she examined his eye against his wishes. She maintained that he had been reluctant to let her examine his eye, and had kept it tightly shut. The nurse did not include this information in her statement to the police nor in her staff statement made shortly after his death.

210. The clinical reviewer considers the nurse's failure properly to examine the man to be 'extremely disappointing'. He comments that examination of his eye was clearly warranted, given the pain he was reporting. He believes that such an examination would have alerted the nurse to the fact that his condition was very serious. I concur with the clinical reviewer when he suggests that a medical examination, conducted in the presence of the officer, would have been in the

man's interests, and would not realistically have resulted in disciplinary action being taken against the nurse.

211. At a meeting with the man's family in January 2009, their representative expressed the family's incredulity to my investigator that he would refuse to have his eye examined by the nurse after he had been experiencing such pain over the weekend. They called into question the nurse's version of events. Contemporaneous accounts are usually to be preferred to those submitted subsequently, and I note that in neither her initial statement to the police, nor in her staff statement, did the nurse recall the man's refusal to let her look at his eye.

212. Whilst the nurse by all accounts acted quickly and efficiently in response to the man's collapse that afternoon, there is criticism to be levelled with regard to her professional conduct prior to the emergency response. Her failure to triage him, despite the officer communicating her growing worries for his health during her telephone messages, was a serious error of judgement. She should have ensured that either she or a colleague examined him in February after speaking with the officer. Had she performed a thorough examination that Saturday, she would undoubtedly have identified the man's deviated eye. This should then have prompted either an immediate hospital referral or calling the out of hours doctor.

213. When the nurse did assess the man on the morning of Sunday, it would seem that her examination was not comprehensive and that no proper assessment of his eye was attempted. Whilst any referral at this late stage would not, in the clinical reviewer's opinion, have changed the eventual outcome, the nurse's actions appear to have been below the standard expected.

214. My investigator interviewed the officer and received the clinical review from the clinical reviewer after the nurse was interviewed by an Assistant Ombudsman in July 2008. To ensure fairness, the investigator therefore wrote to the nurse in March 2009, outlining the criticism that would be made of her actions as a result of the new evidence and offering her the right to reply.

215. In her response dated March 2009, the nurse confirmed that she had spoken once on the telephone with the officer on the afternoon of Saturday. She said that she had not taken another telephone call from the officer that day. If another call had been made to the healthcare centre earlier on, she had not been made aware of it. The nurse denied that the officer had been insistent about the need for the man to receive medical attention during the telephone call in February. She commented that, had the officer been insistent, she would have attended his cell as soon as she was able.

216. Regardless of whether the officer was insistent or not, the nurse accepts that she was told by the officer over the telephone that the man required assessment. It was therefore her responsibility as team leader to ensure that either she or another nurse examined him on the same day.

217. The nurse suggested in her response that the officer should have brought the man to the healthcare centre in February if she was so concerned about him. Indeed, had the nurse asked the officer to bring him to her during their telephone call, this might have been a reasonable course of action. However, I do not think it is reasonable to expect an officer (with no medical training) to decide that a patient is so unwell that she should take him to the healthcare centre. The responsibility for assessing the man lay with the nurse (who had been told of his symptoms) rather than the officer. Additionally, taking him to the healthcare centre after being told that he would not be assessed that day could have meant bringing an unwell prisoner into a potential conflict between two members of staff.

218. In a letter dated April, the nurse provided my investigator with a further statement. She said that it was 'accepted practice' at the time that healthcare staff did not always assess prisoners on the same day as they asked to be examined. She commented that staffing levels and the number of prisoners meant that this was 'simply not possible'. She indicated that healthcare staff therefore relied on information from the officer requesting the assessment in order to assign priority to the examination. She said that she could not recall why she was unable to attend Unit 15 to assess the man in the afternoon, but said that she would have given a reason to the officer at the time.

219. The nurse's assertion that it was 'accepted practice' at the time that prisoners were not assessed on the same day as they made an application is at odds with the opinions of the clinical reviewer and the Head of Healthcare at Glen Parva. Both consider that a prisoner reporting symptoms of eye pain and a headache should have been assessed on the same day.

220. I have already made reference to the Head of Healthcare's comments in this regard in paragraph 208. The clinical reviewer remarks in his clinical review that the officer was not qualified to make medical decisions and that it was inappropriate for the nurse to rely on the opinion of a prison officer when prioritising medical assessments. He thinks that a nursing assessment of the man should have occurred as a matter of routine. He considers that it is 'alarming' that the nursing staff did not proactively examine a prisoner who reported symptoms of eye pain and a headache.

The Head of Healthcare at Glen Parva should consider whether a disciplinary investigation should be carried out into the actions of the nurse in February 2007.

221. The nurse had the opportunity to read my draft report during a period of advance disclosure. (Any members of staff who are directly criticised during an investigation are entitled to correct any factual errors within 21 days before the report is sent to the man's family.) She submitted the following response:

> 'I cannot accurately recall or even remember any specific events of February 2007. I only vaguely recall a phone call from the officer on that day.

I will comment though if an officer states they are concerned seriously about a prisoner I never hesitate to respond. It is my opinion that the officer has more insight into the prisoners as they see them on a daily basis so will pick things up even if they are unaware of any severity. They are aware if a prisoner is or is not always complaining about medical problems. I always value their input and concerns and will act accordingly.

I have never refused to go and see a prisoner if the officers say they have concerns as I am aware they do not have medical insight so need support from Healthcare.

I do not recall any insistence from the officer regarding the man - that is why I dealt with going to see him when I did on the Sunday after a phone call. I cannot recall any urgency either being stated.

I have no recollection of any conversation pertaining to the doctor going on on the Saturday or that an appointment had been refused until the following day. I was unaware at the time of seeing the man that an appointment had been made for Sunday. I went on my own visit to decide this.

My recollection of Sunday morning is that I spoke to the officer because she said that the man was still unwell with a headache and eye pain.

I went to visit him on my rounds and went on what I observed at the time and what I was presented with. He had his eye tightly shut I noticed but I do not recall him having it covered with anything.

I observed him get up off his bunk watching for any abnormal leaning to one side or any lack of coordination. I also observed his gait and the colour of his skin. Black people visibly pale when they are seriously poorly. All of this seemed normal. There was no mention of any vomiting. I recall wanting to look in his eye but the expression on his face and not being given verbal agreement stopped me doing this. I gave pain relief to see if this would help before he came to see the doctor.

On reading the report and my own feelings regarding the incident I would certainly be more thorough and ask more accurate questions as I never want to be put in a position where I could have done more. My career has always been about helping the sick and early intervention.

I am also considering returning to Accident and Emergency to bank in order to keep my skills updated. I am also reading my Minor injury book to read up on Red Flags and problems that mimic other things.'

222. I have not amended my original recommendation as a result of receiving the nurse's letter. However, any disciplinary hearing should take into account her response, which I felt it was important to include in its unedited form.

223. The clinical reviewer believes that there was a clear failing with regard to the out of hours healthcare provision at Glen Parva over the weekend of 3 and 4

February. The prison's healthcare policy clearly states that all medical problems will initially be triaged by nursing staff when a doctor is not on site. However, when the officer rang the healthcare department and reported the man's ill health on a morning in February, no assessment by a nurse took place. Instead, he was offered an appointment with the doctor on the following day.

224. When the officer persisted, and again spoke with a member of the healthcare team (the nurse) in the afternoon, a nurse was still not sent to assess the man. I share the clinical reviewer's criticism of the provision of healthcare at Glen Parva in this instance. Without question, a nurse should have made an assessment of the man at some stage after the officer twice reported his symptoms and asked to have him examined.

225. When she spoke to my investigator, the officer expressed her frustration regarding the failure to send a nurse to examine the man. In total, she made four telephone calls on two days to the healthcare centre before a nurse came to see him. The officer said that she accurately described his symptoms to the nursing staff she spoke to, including his worsening headache and eye pain. Like the clinical reviewer, I am alarmed that nursing staff did not prioritise a patient who they were told was experiencing this combination of symptoms.

226. As an officer with only a few months experience at that stage, the officer did not feel she was in a position to contest the decision made by the member of the healthcare team. She was unaware at the time that nursing staff had an obligation to come and perform an initial assessment on the man the same day, even if a doctor was not in the prison. She told my investigator that, had she both had a little more experience and been aware of the relevant policy, she would have insisted that a nurse came and assessed him.

227. The clinical reviewer unfavourably compares the prison's response to the man's symptoms (as described to the healthcare team by the officer) to that available in the community. To illustrate this, he telephoned the local nurse triaging service in the community, presenting them with a theoretical patient with the general symptoms of eye pain and headache which he was experiencing.

228. The triaging service said that they would carry out a medical assessment of the patient within one hour. The clinical reviewer believes that, following such an assessment, the man would have been referred to hospital. Furthermore, had the severity of the eye pain or the altered vision been reported, then it is likely that an ambulance would have been called. The clinical reviewer concludes that the prison fell short of the standard of healthcare expected in the community.

The Head of Healthcare at Glen Parva should ensure that nursing staff triage all prisoners if ill health is reported during the out of hours period. If the combination of eye and head pain are reported, then nursing staff should triage the patient within one hour.

A review of the failure to triage the man in February should be carried out.

229. The clinical reviewer also notes that few of the nurses who are responsible for triaging prisoners in Glen Parva are as well qualified as their counterparts in the community. Few have the necessary qualifications and training in the assessment of general illness and the delivery of primary care.

230. Glen Parva used to have one nurse from a mental health background and another from a general nursing background in attendance overnight if prisoners became ill. The clinical reviewer is concerned that this staffing level has now been reduced to one nurse, potentially exposing a mental health nurse to a situation where they are unqualified to treat a condition such as the man's. I endorse his recommendation regarding the recruitment of nurses at Glen Parva.

The Head of Healthcare at Glen Parva should ensure that nurses who are responsible for the assessment of prisoners' health during out of hours periods either have the necessary training in general illness, or are working towards the relevant qualifications.

231. Conversely, the clinical reviewer commends the delivery of healthcare at Feltham, where mental health services are delivered by separate nursing staff. Only nurses trained in general illness are involved in the delivery of primary care to prisoners. He praises this model, and I endorse his remarks.

232. Despite the failings of healthcare staff at both Feltham and Glen Parva highlighted by the clinical reviewer, he believes that any insight into the man's condition in the days prior to his collapse could not, on the balance of probabilities, have prevented his death. Had a member of the healthcare staff properly examined his deviated eye in February, then the clinical reviewer considers that he would likely have been admitted to hospital. However, as both the consultant neurosurgeon and neurologist have also concluded, the aneurysm in his brain would still have ruptured.

The response to the man's collapse in February

233. The clinical reviewer is of the opinion that the staff's response to the man's eventual collapse was 'prompt and appropriate'. He commends the third officer, who arrived first in the holding room, for being able to place the man in the recovery position until nursing staff attended. When my investigator spoke with the first officer, despite her frustration with their failure to examine him earlier in the weekend, she praised the response of the prison's healthcare team to his collapse as being both quick and efficient.

234. Whilst my investigator was provided with some statements prepared by staff at Glen Parva shortly after the man's collapse, they were not comprehensive. The incident was not properly documented. Not all staff who attended the holding room gave a statement, and consequently some details were not recorded. For example, no log appears to have been taken to record the chain of events minute by minute.

The Governor of Glen Parva should ensure that all staff involved in an emergency prepare a written statement recording their actions as soon as is practicable after the event. The Senior Officer overseeing the incident should also ask an officer to record a log of events as they happen.

The care for the man's family

235. The man's relatives told my family liaison officer at their initial meeting that they had felt frustrated with the lack of information forthcoming from the prison after he died. They said that the Governor had rung his mother a month after his death to ask if she had any questions, but the family felt that this was too late and no longer wanted direct contact at that stage.

236. My investigator has been provided with a copy of the prison family liaison officer's log. This details actions taken with regard to the man's family. There are no entries in the log after the day he died. This would seem to lend credence to the family's feeling that they did not receive any follow up contact from staff in the weeks after he died. If this is indeed the case, it is extremely disappointing.

The Governor should review his contingency plans for a death in custody to ensure that they emphasise the duty of care to the bereaved family.

CONCLUSION

237. I recognise that the man's death at such a young age has had a profound impact on his family. That his death took place whilst he was in prison has caused the family still further grief and has given rise to a number of questions which they needed to be answered fully. I hope that my report has provided his relatives and friends with a greater understanding of the events which took place.

238. My investigation has discovered failings in the healthcare which the man received at both Feltham and Glen Parva. I also recognise that other staff clearly had his welfare at the forefront of their minds. I hope that the family will gain some degree of consolation in knowing that lessons will be learnt from my investigation.

239. I conclude that the man died of natural causes, almost certainly the result of a congenital weakness.

240. Finally, I would like to repeat my apology that this report of my investigation was delayed for so long.

RECOMMENDATIONS FOR GLEN PARVA

1. The Governor of Glen Parva should commission further investigation into the allegation made by the man's family concerning events in January 2007.

   The prison accepted this recommendation. The Governor commissioned the Head of Healthcare to carry out an investigation of the events as alleged.

2. The Governor of Glen Parva should remind all staff of the importance of writing relevant information in the wing observation book so that other staff on the wing / newly arriving staff are aware of events.

   The prison accepted this recommendation. The Governor agreed to publish a Notice to Staff reminding them that accurate up to date information must be recorded in the observation books on all units.

3. The Head of Healthcare at Glen Parva should consider whether a disciplinary investigation should be carried out into the actions of the nurse in February 2007.

   The prison accepted this recommendation. The Governor agreed to commission the Head of Healthcare to carry out an investigation in relation to the nurse's conduct in February 2007 in consideration as to whether disciplinary action should take place.

4. The Head of Healthcare at Glen Parva should ensure that nursing staff triage all prisoners if ill health is reported during the out of hours period. If the combination of eye and head pain are reported, then nursing staff should triage the patient within one hour.

   The prison accepted this recommendation. The Head of Healthcare agreed to issue a Notice to Staff stating that clinical triage should take place within a one hour period when prisoners report both head and eye pain. This requirement will also be reflected in the annual appraisal process for healthcare staff.

5. A review of the failure to triage the man in February should be carried out.

   The prison accepted this recommendation. The review will be carried out as part of the investigation into the nurse's conduct.

6. The Head of Healthcare at Glen Parva should ensure that nurses who are responsible for the assessment of prisoners' health during out of hours periods either have the necessary training in general illness, or are working towards the relevant qualifications.

   The prison partially accepted this recommendation and gave the following response:

'Given the wide range of skills expected for nursing in this environment it is expected that all registered nurses would have a basic competency in assessing prisoners' healthcare needs. However it is not feasible for all nurses to have an additional qualification other than that required to become a registered nurse. This is due to the requirement to have a good cross section of mental health and general trained nurses. If there is any doubt in relation to a prisoner's ill health then the registered nurses are able to access a doctor 24 hours a day. All nurses are offered minor injury training and also basic life support training.'

7. The Governor of Glen Parva should ensure that all staff involved in an emergency situation prepare a written statement recording their actions as soon as is practicable after the event. The Senior Officer overseeing the incident should also ask an officer to record a log of events as they happen.

   The prison accepted this recommendation and gave the following response:

   'Procedures are currently in place to ensure this action takes place through the security incident reporting process and also through the documents completed when control and restraint procedures are used. However, a notice will be published to staff reminding them. Contingency plans will be amended to require log keeping in the event of an incident.'

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8. The Governor of Glen Parva should review his contingency plans for a death in custody to ensure that they emphasise the duty of care to the bereaved family.

   The prison accepted this recommendation. The death in custody contingency plan will now require that a trained Family Liaison Officer is involved in supporting the bereaved family.

RECOMMENDATIONS FOR FELTHAM

9. The Governor of Feltham should ensure that all staff are reminded of the requirements of Prison Service Order (PSO) 1600. The planned use of force should always involve the attendance of a member of healthcare staff.

   The prison accepted this recommendation. A Governor's Order has been issued to all staff reminding them of the procedures laid out in PSO 1600. Training for all nursing staff who might be involved in planned removals has been provided by control and restraint instructors.

10. The Head of Healthcare at Feltham should ensure that staff make their own records, and do not record the actions of colleagues. The Head of Healthcare should address the actions of the healthcare nurse.

    The prison accepted this recommendation. The introduction of the electronic patient record keeping system means that staff cannot make entries on behalf of their colleagues. The actions of the healthcare nurse have been addressed by her employers, Serco Health.

RECOMMENDATIONS FOR GLEN PARVA AND FELTHAM

11. The Heads of Healthcare at both Feltham and Glen Parva should ensure that medical records are correctly signed and dated and that all relevant details of the examination and plans for management of the patient's health are recorded. The member of staff should also print their name.

    Glen Parva accepted this recommendation and gave the following response:

    'Glen Parva has an electronic patient record keeping system in place that is now used by all nursing staff in place of manual records ensuring that all entries are legible and easily identifiable.'

    Feltham gave the following response:

    'Each member of healthcare staff has a unique password to access and maintain the electronic patient record keeping system. This ensures that their name is correctly recorded against each entry they make in the clinical record. All electronic clinical records are audited.'

12. The Heads of Healthcare at both Feltham and Glen Parva should ensure that medical summaries are requested from community GPs in the case of every new prisoner.

    Glen Parva accepted this recommendation and gave the following response:

    'All prisoners arriving at Glen Parva are asked for their doctor's details. Requests for medical information are actioned by the reception healthcare team at the earliest opportunity.'

    Feltham gave the following response:

    'With an average of 50 to 60 new prisoners each night this has proved impractical. Any prisoner with a disclosed medical condition or previous medical history will be assessed by a doctor who will request their medical notes from their community doctor.'

THE FAMILY'S RESPONSE TO THE DRAFT REPORT

The man's mother's solicitor provided a response to the draft report on behalf of the family in December 2009.

The family were disturbed to read about the use of control and restraint procedures in February 2007 at Feltham without the presence of a member of healthcare staff. The man's mother thought that, had a nurse been present, they might have alerted the officers to her son's recent headaches. She considered that this information might then have influenced the use of force. The family are upset that the proper procedures were not followed.

The man's family expressed their concerns about the actions of the reception nurse at Feltham. They were upset that the prison doctor did not have an opportunity to assess him before he was transferred. The family also expressed their concerns about the actions of the senior nurse at Glen Parva. They did not accept her explanation of events.

The man's mother accepted my explanation for the delay in producing the draft report. However, she reiterated that the length of time it took to complete the investigation was unacceptable. She expressed particular concern that the delay in producing the report prevented my investigator from being able to interview the cellmate.

The man's mother asked what attempts were made during the investigation to contact the cellmate. Unfortunately, when the investigator inherited the investigation in November 2008, the better part of two years had passed. The investigator had no forwarding contact details for the cellmate. He relied on a police statement taken from him at the time of the man's death.

The man's family asked my investigator to provide the cellmate's forwarding address so that they could pursue their own investigation. As I have indicated, the investigator does not possess up to date contact details. The cellmate wrote on his police statement that he would not have a fixed address following his release in March 2007.

My investigator checked the Prison Service's Inmate Information System (IIS) but no discharge address was recorded. The name of a probation officer was mentioned, and my investigator telephoned him. The probation officer confirmed that he has not supervised the cellmate for several years. IIS indicated that he was represented by Hodge, Jones and Allen, the same solicitors who represent the man's mother. The investigator has passed this information on to the solicitor.

Finally, the man's family took the opportunity in responding to my report to confirm that they felt let down by the lack of contact from the prison following his death.