PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at hospital
In October 2012, while a prisoner at HMP Pentonville

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the report of the investigation into the death in hospital of a man in October 2012, while a prisoner at HMP Pentonville. He was 47 years old. The post-mortem report showed that the cause of death was abscesses on the brain. I offer my condolences to all those who knew him.

A clinical review was undertaken of the clinical care the man received in custody. HMP Pentonville and HMP Brixton cooperated fully with the investigation.

The man suffered from mental illness, drug addiction and had a history of self-harm. He was sentenced to an indeterminate sentence for public protection in 2006 and because of his mental illness he was transferred from Brixton prison to a secure hospital for treatment in April 2008. In March 2011, he was returned to Brixton because he was regarded as suffering from psychopathy, personality disorder and delusional disorder and these conditions were apparently not amenable to treatment. He subsequently transferred to Pentonville in June 2012 when Brixton's role changed.

From the time the decision was made to return the man to prison he began to refuse food and this continued after he returned to prison. He also refused to allow staff to treat self-inflicted wounds to his arms to prevent infection. It is possible that this decision led to an infection in his brain which caused his death. He said that he would continue to refuse food and treatment until he was returned to hospital. He was regarded as a risk of suicide and self-harm and was closely monitored throughout his time in prison. Prison staff made many active attempts to intervene with him to encourage him to eat and accept medical treatment, but he continued to refuse and was assessed as having the capacity to do so.

In line with the views of the clinical reviewers, I make two recommendations for potential learning from the man's case about the need to access specialist wound treatment advice and the need for fully multi-agency assessments of prisoners with specific mental health needs. However, I also note that, particularly as he was not considered suitable for a secure mental health setting, the reviewers conclude staff at both prisons were left to cope with managing a complex and challenging individual with little advice or support from specialist NHS services. In these circumstances, I am satisfied that he probably received the most appropriate care that was feasible in a custodial setting and that staff could not have altered his decision to refuse food and treatment nor, ultimately, prevented his death.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2013**

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SUMMARY

1. On 5 April 2006, the man was remanded into custody at HMP Brixton on charges of aggravated burglary and robbery. He had a history of mental illness, self-harm and drug addiction and had previously served custodial sentences in England and Scotland. On 27 October 2006, he was convicted and sentenced to an indeterminate sentence for public protection.

2. On 21 April 2008, the man was transferred to a medium secure unit at a hospital for assessment and treatment of his mental illness. He remained at the secure unit until 21 March 2011, when he returned to Brixton because his condition was regarded as untreatable. He had not wanted to return to prison and told Brixton staff that he had been refusing food since January 2011 and had self-harmed at the hospital because of this. Staff immediately opened a self-harm monitoring document and he was closely monitored.

3. The man continued to refuse to eat after he returned to prison custody, although he took fluids. He said he would eat again only if he was returned to hospital. He had extensive support from healthcare professionals but frequently refused to be examined. He was assessed as having the capacity to refuse food and treatment. Because of a change of role at Brixton, he transferred to the inpatient unit at HMP Pentonville on 26 June, 2012. Throughout this time he continued to be monitored as a risk of suicide and self-harm. Because of his refusal to eat, his physical health steadily declined and he refused treatment for infections to long-standing self-inflicted wounds to his arms.

4. During his time at Pentonville, the man spent several weeks in hospital as his physical health deteriorated. His last hospital admission was on 24 September 2012, when he was moved to the Intensive Care Unit at hospital. He remained there until he died in October 2012.

5. Pentonville were unable to trace any living relatives and arranged and paid for the man's funeral.

6. The investigation found that the man received appropriate care in prison custody and that prison staff could not have done anything more to alter his decision to refuse food or, ultimately, to prevent his death. We make two recommendations about healthcare procedures for prisoners with mental health problems and wound treatment.

THE INVESTIGATION PROCESS

7. On 4 October 2012, the investigator issued notices announcing the investigation to staff and prisoners at Pentonville inviting anyone with any information relevant to the investigation to contact him. No one came forward as a result. He visited Pentonville on 8 October 2012 and obtained copies of the man's relevant prison records.

8. The local PCT appointed two clinical reviewers to review the man's clinical care at Pentonville. One clinical reviewer reviewed his medical records and discussed aspects of his treatment with the investigator. The other clinical reviewer and the investigator also discussed his care and conducted joint interviews with members of prison staff.

9. HM Coroner for Inner North London District was informed of the investigation and provided the investigator with a copy of the post-mortem report. A copy of this report has been sent to the Coroner.

10. The man did not give details of his next of kin when he entered custody. Pentonville established that his parents and brother were dead and, despite extensive checks, were unable to trace any other relatives.

HMP PENTONVILLE

11. HMP Pentonville is a local prison serving the courts of North London and holds up to approximately 1,300 prisoners.

12. Whittington Health, Camden & Islington NHS Foundation Trust, and Barnet, Enfield and Haringey NHS Mental Health Trust provide health services, including substance misuse, mental health and psychiatric care.

HM Inspectorate of Prisons (HMIP)

13. HM Inspectorate of Prisons conducted an unannounced inspection from 24 February to 4 March 2011. HMIP noted that Pentonville had a large and transient prison population, and its prisoners had some of the highest incidence of mental ill health and substance misuse of any local prison in the country.

14. As part of the inspection process, inspectors considered Pentonville's inpatient facility and noted that:

> "The inpatient beds were occupied for most of the time. Although allocated as 16 mental health and six primary care, there were often times when the specialities overlapped."

15. Inspectors also noted that the prison did as much as they could to ensure that prisoners who needed to be transferred under the Mental Health Act were dealt with as quickly as possible.

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In its 2011/12 report for Pentonville, the IMB commented:

> "There has been (for reasons not fully understood) a serious and sharply increasing problem of prisoners with mental health and personality disorders, far beyond the resources of the Mental Health Team to cope with as well as they would wish. Reported incidents of self-harm (generally prisoners cutting themselves) increased very significantly over the year. Because of the limited space in the Healthcare Centre many of the less seriously mentally ill prisoners are housed on the wings. (Most in-patients held in the Healthcare Centre are there because of mental rather than physical health issues.) The IMB takes the view that further resources are urgently needed to tackle these issues."

Previous deaths at Pentonville

17. The man's death is the eighth apparent self-inflicted death at Pentonville since January 2010. There are no direct similarities between the findings of these investigations and that of his.

HMP BRIXTON

18. At the time the man was there, HMP Brixton was a local prison serving courts in South London. The prison became a category C prison in June 2012, with a particular emphasis on resettlement. The inpatient unit has now closed. Healthcare services are commissioned by NHS Lambeth and delivered by a group led by Care UK, including the South London and Maudsley NHS Foundation Trust with pharmacy and other services provided by Lambeth Community Health.

HM Inspectorate of Prisons (HMIP)

19. HMIP last conducted an inspection of Brixton in December 2010. Inspectors noted that there was a structured regime for inpatients with mental health problems, including sessions with an occupational therapist and a weekly ward round by a consultant psychiatrist. The report also said that a specialist registrar psychiatrist was available daily and at least four registered mental health nurses were on duty most days.

Independent Monitoring Board (IMB)

20. The most recent IMB annual report for Brixton covers the period 1 September 2011 to 31 August 2012. The IMB commented that, for most of the reporting period, D wing (the Healthcare wing) had a number of very disturbed prisoners. The report noted the considerable forward planning that was required for the re-role to a Cat C prison, without a healthcare wing and with different prisoner needs. The IMB stated that the healthcare contractors met all the key targets set by NHS Lambeth commissioners, and improved performance generally.

Suicide and self-harm monitoring

21. Prison Service Instruction (PSI) 64/2011 'Management of prisoners at risk of harm to self, to others and from others - Safer Custody' details prison procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be regular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Previous deaths at Brixton

22. Since 2010, there have been six deaths at Brixton. Three of these have been from natural causes, two apparently from drug-related issues and one hanging. There are no similarities between those investigations and the circumstances of the man's death.

KEY EVENTS

23. The man was born in February 1965. He had a history of mental illness, self-harm and drug addiction. He had served several custodial sentences in England and Scotland. He told health and custodial staff that he had served in the Rhodesian Army during the civil war, was affected by the execution of his brother and suffered from post-traumatic stress syndrome. None of this detail has been verified.

24. On 5 April 2006, the man was remanded into custody at HMP Brixton on charges of aggravated burglary and robbery. He was convicted and sentenced to an indeterminate sentence for public protection on 27 October 2006, to serve a minimum of six years. On 21 April 2008, because of mental illness, he was transferred to a medium secure unit at a hospital for assessment and treatment.

25. On 19 January 2011, a forensic psychiatrist assessed that the man suffered from psychopathy (where the individual lacks conscience and empathy, is manipulative, volatile and whose condition does not respond to treatment), personality disorder (a limited range of emotions, attitudes and behaviours with which to cope with everyday life) and delusional disorder (irrational beliefs, held with a high level of conviction, that are highly resistant to change). He said that, in his view, a referral to Broadmoor Hospital would not be accepted as he did not pose any grave or immediate danger.

26. Following the psychiatrist's report, the psychiatrists at the medium secure unit decided that the man should returned to prison custody as his condition was not amenable to treatment. Because of this decision, he began to refuse to eat, though it was recorded at the hospital that he had been observed eating biscuits when he drank tea. A report completed by a psychiatrist at the unit on 7 March, highlighted the risks that low body weight and infected, self-inflicted wounds posed to his physical health. He returned to Brixton on 21 March. The unit did not provide Brixton with a discharge letter or summary of ongoing care.

27. When the man arrived at Brixton, prison staff immediately opened an ACCT suicide and self-harm monitoring document because of his history of self-harm and recent food refusal. A psychiatrist and a prison doctor saw him that morning. The psychiatrist knew him from the medium secure unit and prescribed diazepam (for anxiety), lorazepam (for severe anxiety), methadone (for opioid addiction) and zopiclone (for insomnia). He told the doctor that he was shocked to have been sent back to prison from hospital. He said he had no thoughts of self-harm and suicide, though he knew he would die eventually as he had chosen not to eat. He also said that he would continue to refuse treatment of two long-standing self-inflicted wounds to his arms.

28. A full ACCT assessment was completed by prison staff and the psychiatrist. An ACCT caremap was put in place to support him. The caremap suggested he should be moved to healthcare as an inpatient, receive ongoing support from the mental health team and the visiting psychiatrists and be given a television in his cell. He was assessed as being at high risk of self-harm. The level of observation was set at constant until an ACCT review two days later.

29. On 23 March, the man attended an ACCT review held by the Duty Governor the psychiatrist. He said that he would tell staff if he felt like harming himself

but he had no current thoughts of suicide. He said that he would not let staff treat his existing wounds. He continued to maintain that he wanted to be treated in hospital for his mental illness. The ACCT caremap was reviewed and the level of observation was reduced to hourly observations, day and night, with three recorded conversations to be made during the day. His level of risk remained the same.

30. Between 24 March 2011 and 25 June 2012, the man had over 1000 individual, face to face, interventions with healthcare professionals including nurses, prison doctors and psychiatrists. He frequently refused to be examined which meant that staff were unable to monitor his weight and blood pressure or to treat the wounds on his arms. He continued to refuse food though he occasionally ate rock cakes and biscuits. Staff adhered to Brixton's food refusal policy and documented his food intake and when they offered him food supplements. He was a chain smoker and spent all his time in his cell, watching television and drinking lots of tea. He did not associate with other prisoners and was sometimes noted to be rude to staff.

31. On 3 May, a multi-agency meeting was held which noted the man's diet, repeated self-harm and the risk of sepsis (infection) from his untended wounds. A CPA (Care Programme Approach) meeting was also held, attended by a psychologist from the medium secure unit, in accordance with the provision of after-care under Section 117 of the Mental Health Act on 11 July 2011. No outcomes from this meeting were recorded.

32. The man was frequently assessed by psychiatrists and found to have the mental capacity to decide to refuse to eat and receive treatment. The psychiatrists referred him for assessment to be admitted back to a secure hospital for treatment several times, but each time it was decided that there was no medical benefit in him being transferred.

33. The ACCT document remained open. Regular reviews were completed and the level of risk remained assessed as high. By April 2012, medical observations had been increased to every 15 minutes due to the man's rapidly declining health.

34. On 26 June 2012, the man transferred to HMP Pentonville because Brixton had changed its role and the inpatient unit was closing. He was immediately admitted to Pentonville's healthcare inpatient unit where medical staff assessed him. The healthcare team noted the treatment and medication that he had received at Brixton, that he was on an open ACCT and that he continued to refuse to eat or receive treatment for the wounds on his arms. A nurse recorded his blood pressure as 110/71 (the normal range for blood pressure is 100/70 to 140/90). They agreed that his daily food and fluid intake should be monitored.

35. The man's ACCT plan was reviewed. A psychiatrist recommended 30 minute medical observations with hourly recorded ACCT observations. His level of risk of self-harm remained assessed as high.

36. Staff continued to monitor the man carefully. He remained in his cell all day watching television and not mixing with other prisoners. He took his antipsychotic medication and methadone but maintained his refusal of any

treatment for the wounds on his arms. Although he would not eat he drank tea. He remained a heavy smoker. Regular ACCT reviews were held and there was no change to the level of risk or the level of observations.

37. On 4 July, a psychiatrist saw the man in his cell and recorded that he had not had any solid food and only drank tea. He noted that his personal hygiene was very poor and that sometimes he would not allow staff to monitor him. His blood pressure was recorded as 77/50 at 5.24pm and 92/60 at 7.28pm, both of which were low. His weight was 64.3kg (10st 1lb).

38. From 5 to 24 July, the man was monitored closely by staff as his physical health slowly deteriorated and ACCT reviews continued. His daily routine did not change. He continued to take his medication but sometimes refused to be examined.

39. On 25 July, a psychiatrist assessed that the man's mental state and reasoning had deteriorated and he no longer had the capacity to make informed decisions about his care. A prison doctor referred him for assessment and treatment at hospital. A risk assessment was completed which authorised him to be accompanied to hospital by two officers using an escort chain (a two metre chain with a handcuff at either end attached to the prisoner and an officer). The chain was to be removed for treatment purposes.

40. The man's ACCT remained open while he was in hospital with two hourly ACCT observations. While he was in hospital, healthcare staff at Pentonville remained in contact with the hospital about his condition. A consultant psychiatrist at the hospital told them that he had been assessed for admission to the medium secure unit again, but the assessment remained that he suffered from a severe personality disorder and that a transfer to a secure hospital was not appropriate.

41. Hospital staff assessed the man again and decided he did have capacity to take decisions. He signed a statement that he did not want to be fed by tube, or have any treatment using a needle or cannula, but declined to sign a formal advance directive. He started to eat meals from 5 August and was able to move around the ward independently. His blood pressure was persistently low, no higher than 95/50. His weight was recorded as 55.6kg (8st 10lb) on 11 August.

42. On 31 August, the man was discharged from the hospital back to the inpatient unit at Pentonville. The hospital discharge letter gave details of his treatment, medication, food and fluid intake. He was prescribed diazepam, methadone, folic acid (vitamin B supplement) and forceval (a food supplement). His ACCT was reviewed and it was noted that he walked into the healthcare unit unaided. His assessed level of risk and observations remained unchanged.

43. On 1 September, the man was monitored throughout the day by a nurse, who recorded that he had refused to eat his lunch but ate much of his evening meal. For the next week or so he refused to have his blood pressure and weight measured but continued to be closely monitored by healthcare staff. He mostly remained in bed and refused meals. He turned down offers to help him with his personal hygiene. On one occasion, he agreed to have his blood pressure taken, which was 114//68 and weight was recorded as 53kg/8st 5lb.

44. On 12 September, a psychiatrist and substance misuse specialist saw the man in his cell and noted a steady decline in his health. The doctor told him that his current 70mg dose of methadone was no longer safe and recommended that the dose should be reduced by 5mg per day until withdrawn completely.

45. On 13 September, a doctor saw the man and recorded that he was alert and able to move around his cell, though he was emaciated and weak. His blood pressure was recorded as 110/68 and his weight as 49.2kg (7st 10lb). She referred him to hospital. He was deemed to be a medium risk to the public and he was accompanied by two officers restrained by an escort chain which was to be removed during treatment.

46. The next evening, on 14 September, the man was discharged back to Pentonville as the hospital did not feel that there was any treatment that they could offer. A nurse saw him when he arrived back in the healthcare unit and recorded that he was upset and hostile. Between 15 and 23 September, he refused food and began to drink less. An ACCT review undertaken by a prison doctor and a nurse did not change the level of risk or observations.

47. On 24 September, a nurse saw the man at 10.50am. He told her he was in pain and she recorded that he appeared confused, disorientated, agitated, weak and pale. His blood pressure was recorded as 166/72. She spoke to a prison doctor, who recommended that he should be sent to hospital as an emergency. A risk assessment was completed and he was accompanied by two officers but without restraints. The ACCT was reviewed and the level of recorded observations was changed to two per day (with hourly entries in the bedwatch record).

48. The man was taken to hospital and, after a brain scan, was transferred to the Intensive Care Unit. A prison doctor spoke to a doctor at the hospital and was told that he had undergone a craniotomy (a surgical operation in which a bone flap is temporarily removed from the skull to access the brain) that had revealed several abscesses on the brain, one of which had been drained. He was being treated with antibiotics.

49. On 29 September, a hospital doctor told Pentonville healthcare staff that the man's condition continued to deteriorate. The hospital had asked the police to trace his relatives but the police had not been able to find any. The hospital then decided to withdraw treatment in line with its clinical policies. He was transferred to a general ward for end of life care at 3.00pm the next day and he died several days later.

50. The post-mortem showed that the man had several cerebral abscesses which caused his death. As no relatives were been traced and Pentonville arranged his funeral.

ISSUES

Assessment of risk

51. When the man returned to prison in 2011, an ACCT plan was immediately opened and his mental state and risk of self-harm or suicide was continually assessed at both Brixton and Pentonville. The ACCT plan was appropriately reviewed at regular intervals throughout his time in custody.

52. We agree that it was appropriate to open an ACCT when the man returned to Brixton. His risk factors indicated that he might be at risk of suicide or self-harm. We also agree that he remained at risk while in prison. The ACCT plan was appropriately managed and reviewed and appropriate changes were made to the level of observations when indicated.

Right to refuse food

53. Guidance to staff on prisoners who refuse food is contained in Prison Service Instruction (PSI) 64/2011. The instruction states:

> "Some prisoners may decide to refuse food and/or fluids, or medical treatment for a variety of reasons. These decisions will be valid provided that the prisoner is deemed to have the mental capacity to make the decision. Mental capacity can only be assessed by a healthcare professional."

54. The PSI notes that the decision to refuse food is not considered in law to be a form of self-harm. Regarding mental capacity the instruction states:

> "The Mental Capacity Act 2005 provides clear guidance that any individual has the legal right to refuse any treatment including food and/or fluid or resuscitation if they are mentally capable. The Act states that a person is assumed to have capacity unless it is established that they lack capacity and must not be considered unable to make a decision merely because they make an unwise decision."

55. In January 2010, the Department of Health issued "Guidelines for the clinical management of people refusing food in immigration removal centre and prison". This guidance states:

> "A thorough assessment of nutritional status should be undertaken at the outset of the fast, including establishing levels of recent food intake and usual body weight and performing a specific nutritional examination. Regular reassessments of a food-refusing individual's physical and mental state should be undertaken within limits dictated by the individual's compliance. Soon after an individual is identified as embarking on a period of refusing food, a case conference should be considered to explore further any ameliorating factors and assist care planning."
>
> "Full documentation of the individual's wishes is essential to demonstrate that the individual is not only refusing all forms of feeding but understands the likely consequences of doing so."

56. The man was frequently assessed by psychiatrists at Brixton, Pentonville and the hospital. He was judged to have had the capacity to refuse food and treatment at all times except on one occasion when he was transferred for the first time to hospital on 25 July 2012. Hospital doctors assessed that he did have the capacity to refuse food and treatment and this remained the case on his discharge back to prison.

57. Although the clinical reviewer thought that the man's personality disorder and sense of injustice at being returned to prison meant that he could have been judged to lack the capacity to make decisions about his care, he was satisfied that doctors appropriately assessed his mental capacity and his ability to make a considered decision. He was frequently told about the implications of refusing to accept food and treatment. We consider that healthcare staff made appropriate assessments of his mental capacity to decide whether or not to eat or accept treatment and reviewed this frequently.

Mental health care

58. The man had a history of mental illness, self-harm and substance misuse. On 24 April 2008, he was transferred for treatment to a medium secure unit at a hospital under the Mental Health Act 1983 (as amended by the Mental Health Act 2007). During his time there he was assessed for transfer to Broadmoor high security hospital three times. On each occasion, psychiatrists assessed that the risk he posed to others was not high enough to meet the criteria for mental health management in a high security setting. A psychology report, dated 7 March 2011 and completed at the unit, noted that he had a diagnosis of "a personality disorder with evidence of emotionally unstable, dissocial and paranoid types, as well as his substance misuse".

59. The clinical reviewers have commented on the man's mental health care after his transfer from the medium secure unit back to prison custody. They noted that, although Brixton did not receive a discharge summary from the unit after he returned to custody, psychiatric services, GPs and the substance misuse team were all involved in his management.

60. A multi-agency meeting was held on 3 May 2011, which noted the man's diet, repeated self-harm with open wounds and the risk of sepsis. A CPA (Care Programme Approach) meeting was held in accordance with the provision of after-care under Section 117 of the Mental Health Act on 11 July 2011, attended by a psychologist from the medium secure unit. However, no outcomes were recorded and no further CPA meetings were held. It is not clear if he had an identified care-coordinator.

61. The clinical reviewers highlighted that, at Brixton and Pentonville, the multi-agency approach to monitor and care for prisoners suffering from mental illness could be improved. We note that extensive efforts made by many staff at Brixton and Pentonville to engage with and care for the man. However, we endorse the clinical reviewer's findings and make the following recommendation:

The Heads of Healthcare at Brixton and Pentonville should ensure that the Care Programme Approach (CPA) is applied to all prisoners who meet the criteria.

62. The clinical review noted that healthcare staff at Brixton and Pentonville made several referrals for the man to be assessed for admittance to a medium or high security hospital setting. In July 2012, he saw a doctor from the medium secure unit at Pentonville. The doctor concluded that he was seeking to "escape the harsher regime" of prison through his food refusal and self-harm. At interview, he said that his physical health was not a relevant consideration when deciding whether he should transfer to psychiatric hospital. The doctor concluded that he should be referred to a therapeutic environment in the Prison Service.

63. The clinical reviewers have made recommendations about mental health assessments and care pathways involving health service provision that fall outside the Prisons and Probation Ombudsman's remit. We will share this report and the clinical review with the Department of Health.

Physical health care

Self-harm wound management

64. The man had a long standing history of self-harm. When he returned to prison, he had two wounds in his arms which he had inflicted while at the medium secure unit. He said he had made these wounds to help reduce his stress levels. The clinical reviewers noted that, after he returned to prison, there was a care plan to help manage his wound treatment. He was told how to look after his wounds after he refused to let staff treat him and staff regularly discussed wound management with him.

65. We are satisfied that while the man was in prison he was given appropriate information about his wounds care. However, the clinical reviewers believe that a referral to a tissue nursing specialist would have been appropriate. It is important that as much as possible is done to ensure that wounds do not become infected. It is possible that these wounds contributed to the infection that led to the abscesses on his brain and his eventual death. We make the following recommendation:

The Heads of Healthcare at Brixton and Pentonville should ensure that, where necessary, patients with open wounds are referred to a specialist tissue nurse.

Nutritional status

66. While at the medium secure unit the man refused certain foods, ate only specific food groups or refused to eat altogether. He also refused to be weighed. When he arrived at Brixton in March 2011, he told staff that he intended to refuse food and would only eat again once he returned to hospital. He maintained this position throughout his time in custody.

67. The clinical reviewers have assessed Brixton's management of the man's nutritional care and believe that he was managed in accordance with their food refusal policy. Staff documented the food that he ate and he was given additional milk. He was also offered food supplements, but he refused to take them as he said that he was allergic to them. While he was at Pentonville, the

clinical reviewers found that the food and fluid charts were not kept so well and lacked detail of what food was offered to him. However, we are satisfied that he had the right and capacity to control his food intake and that both prisons managed his food refusal satisfactorily.

Overall assessment of care

68. The clinical reviewers have considered the overall care that the man received during his time in custody, taking into account that multiple cerebral abscesses were the cause of his death. They conclude:

> "It must be presumed that the cerebral abscesses resulted from sepsis from untreated and infected wounds caused by self-harm in the context of poor nutrition. His frequent refusal to accept wound care, medical investigations and treatment with antibiotics were direct antecedents to his death. These decisions and behaviours were manifestations of his mental disorder.
>
> "His care cannot be compared to care that would be offered in the community. The complexity of his needs would always require admission to a specialist setting.
>
> "It is not possible to determine whether he would have died if he had either been in the community or detained in psychiatric hospital rather than in prison. His behaviours in the medium secure unit and prison were similar, particularly in respect of his self-harm.
>
> "[We conclude] that staff at both HMP Brixton and HMP Pentonville were left to cope with managing a complex and challenging individual with little advice or support from specialist NHS services."

RECOMMENDATIONS

1. The Heads of Healthcare at Brixton and Pentonville should ensure that the Care Programme Approach (CPA) is applied to all prisoners who meet the criteria.

   HMP Pentonville

   Accepted: All patients in Pentonville have CPA applied if they meet the criteria. However as a general principle we accept the recommendation.

   HMP Brixton

   Not Accepted: All patients in Brixton have CPA applied if they meet the criteria. This is in place and was when the man was under our care.

2. The Heads of Healthcare at Brixton and Pentonville should ensure that, where necessary, patients with open wounds are referred to a specialist tissue nurse.

   Accepted

   HMP Pentonville

   Guidance on referral pathways to tissue viability service to be issued to all Pentonville clinical staff

   HMP Brixton

   We have nurses who are trained in wound management and where patients require special tissue viability input they are referred by the GP.