



**Investigation into the death of a man
at HMP Pentonville in June 2012**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

January 2013

This is the report of the investigation into the death of a man at HMP Pentonville in June, 2012. The post-mortem report indicated that this appeared to be a sudden unexpected death in a person suffering from epilepsy. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was commissioned to conduct a review of the clinical care the man received in custody. Pentonville cooperated fully with the investigation.

The man was remanded into custody in March 2012 and sentenced to 12 months imprisonment in May. He suffered from paranoid schizophrenia, mild learning difficulties and epilepsy. The man suffered frequent seizures while in prison and was in a single cell when he collapsed. He had not been seen or checked for four hours. Despite resuscitation efforts the man could not be revived and was pronounced dead a short while later.

The clinical reviewer found that the management of the man's epilepsy was not as good as it should have been. Assessment on arrival at the prison should have been more thorough. The man often refused to comply with treatment and medication, and because of previous experience, an assumption was made that he would refuse to see a neurologist to assess his frequent seizures. While this may have been the case, a referral should have been discussed with him. In addition, clinical decisions were not always recorded.

This is a sad case of a prisoner with complex needs dying in unfortunate circumstances. Because of an altercation on the vulnerable prisoner unit where the man lived he was moved to another landing where he had to spend most of his time locked in his cell. He was also in a single cell and so no longer benefited from a cellmate who could alert staff if he had a fit. Healthcare staff were not consulted before the man moved and there were no regular checks on him.

Better communication between healthcare and prison staff would have improved the man's management. His epilepsy was not well controlled and his compliance with his medication was not satisfactorily monitored. The post-mortem report indicates that the man had not been taking his anti-epilepsy medication, contrary to the information in his clinical record. The clinical reviewer has made a number of recommendations, which I endorse, aimed at improving the management and care of prisoners with uncontrolled epilepsy.

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.

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Prisons and Probation Ombudsman

January 2013

CONTENTS

Summary

The investigation process

HMP Pentonville

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man suffered from paranoid schizophrenia, mild learning difficulties and epilepsy. He was remanded to HMP Brixton on 16 March 2012. He was prescribed anti-epilepsy medication and an antidepressant.
2. At Brixton, the man saw a mental health nurse regularly. On 31 March, he experienced an epileptic seizure and was taken to hospital to be checked as a precaution. He suffered further epileptic seizures on 3 and 10 April. Because of concerns about his behaviour, the man was twice monitored as a risk of suicide or self-harm. A mental health consultant decided that he was not so unwell as to warrant admission to the prison's inpatient unit.
3. On 13 April, the man moved to HMP Pentonville following a court appearance. The reception nurse recorded that he should have a ground floor cell because of his epilepsy. Because of his offences, the man was held in the vulnerable prisoner unit. His mental health seemed to stabilise a little. He continued to be monitored as a risk of suicide or self-harm until 2 May. He was given an injection of antipsychotic medication on 16 May.
4. The man suffered seizures on 16, 18 and 23 April, 3 and 14 May and 1 June. He was reluctant to accept help after a seizure and healthcare staff did not refer him for further assessment by a neurologist because they considered that he would not be willing to attend an outpatient appointment. Instead, the lead GP decided to manage the man's seizures by increasing his anti-epilepsy medication.
5. On 22 May, the man was moved from a shared cell on the vulnerable prisoner unit to a single cell on a different landing because of his behaviour. There was no consultation with healthcare staff about this, despite his recent seizures.
6. On 2 June, an officer saw the man at 7.15am during the morning roll check. He was not checked again for four hours as he could not be let out of his cell to associate with the general population on his wing because he was a vulnerable prisoner. An officer went to unlock the man for his medication and lunch at 11.15am and found him collapsed. Despite the best efforts of nursing staff he could not be revived. The post-mortem report concluded that it was most likely that the man's was a sudden unexpected death in a person suffering from epilepsy.
7. Our investigation has raised concerns about the care offered to prisoners with epilepsy. A care plan was not drawn up for several days after his arrival at Pentonville. He moved from a shared to a single cell without prison officers seeking the advice of healthcare staff. Afterwards, no checks were put in place to monitor his seizures. Although staff recorded that the man was taking his anti-epilepsy medication regularly, the post-mortem results showed no trace of the drug in his body, suggesting that he did not actually take it. The clinical reviewer, believes that the man did not receive clinical care

equivalent to that available in the community. We make seven recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

1. The investigator issued notices to staff and prisoners at HMP Pentonville telling them about the investigation and inviting them to contact him with any relevant information. There was no response from prisoners.
2. The investigator visited Pentonville on 12 June to collect documents relating to the man's time in custody. He spoke to the Governor of Pentonville and the duty governor on 2 June, and viewed the man's cell.
3. A clinical reviewer was commissioned to review the clinical care the man received in custody. His clinical review is annexed to this report.
4. The investigator visited Pentonville to interview six staff on 28 June and 25 July. He was accompanied by the clinical reviewer during his second visit. The investigator subsequently wrote to the Governor providing initial feedback about the investigation.
5. The investigator informed the local coroner of the investigation, who will be sent a copy of this report.
6. One of the Ombudsman's family liaison officers contacted the man's aunt, his next of kin, to explain the purpose of the investigation and allow her to raise issues she wished us to consider. The man's aunt wanted to know whether her nephew had been checked as he should have been; whether he had experienced any seizures in prison and how these were managed; and asked whether the man had received the appropriate medication and care for his seizures and mental health. The man's aunt said the Coroner's office had mentioned a lump on the side of her nephew's body. We have checked the post-mortem report, which does not mention a lump on the man's side.
7. The man's aunt said that the contact from Pentonville's family liaison officer had been good. The officer arrived at her home a couple of hours after her nephew's death, attended the funeral and offered the financial assistance. She also appreciated receiving a letter of sympathy from the Governor. The man's aunt was provided with a copy of our draft report. She did not wish to make any comments on it for inclusion in this final version.

HMP PENTONVILLE

8. HMP Pentonville is a local prison serving the courts of north London and holds up to 1,310 prisoners.
9. 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.

Independent Monitoring Board (IMB)

10. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who help to ensure that proper standards of care and decency are maintained. The most recently published IMB annual report for Pentonville covers the year to March 2011. The board commented that the vulnerable prisoners' unit (VPU) was usually full and sometimes required overspill accommodation. The regime for such prisoners was very limited. The IMB noted that the number of vulnerable prisoners on G2 landing (because of a lack of space on the vulnerable prisoner unit, G1 landing) had been a problem at times during the year. The IMB considered that there was more stability in GP provision and that the general standard of primary care at Pentonville was improving.

HM Inspectorate of Prisons (HMIP)

11. HM Inspectorate of Prisons conducted an unannounced inspection of Pentonville 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. Primary mental health services were regarded as needing development but secondary services were seen as well structured to meet the needs of prisoners. Primary physical care was described as 'well advanced' but some prisoners had difficulty getting to nurse led clinics. There was good access to a GP and management of prisoners with long term conditions was judged to be good. Inspectors found that vulnerable prisoners (VPs) on G1 usually felt safe but there was insufficient room to hold all VPs there and overspill arrangements on G2 or other wings were not satisfactory.

Previous deaths from epilepsy

12. There have been no deaths similar to the man's at Pentonville. We have investigated a number of previous deaths in prison resulting from epilepsy. One case at Maidstone in 2007 had a number of similarities with the man's, such as the failure to review the man's epilepsy more regularly and the need to be reviewed by a doctor after a seizure. The need for prison and healthcare staff to work together more closely to monitor prisoners with chronic conditions such as epilepsy was identified, as was the issue of whether prisoners with epilepsy should have the opportunity to share a cell.

KEY EVENTS

13. The man suffered from paranoid schizophrenia, mild learning difficulties and frequent epileptic seizures. The man was occasionally homeless and suffered with mental health issues. He came under the care of his Community Mental Health Team (CMHT) and spent periods in secure mental health institutions.
14. The man had last been released from Pentonville on 24 November 2011. During that period of imprisonment, he had been an inpatient in the healthcare centre for several weeks. Dr A, the lead GP at Pentonville, explained that the man had regularly suffered from epileptic fits during this period and was well known to the healthcare team. He sometimes refused to take his anti-epilepsy medication (sodium valproate) if he suspected that his dose had been altered. Because of this, his prescription was changed from tablet to liquid form because it was far harder for him to notice any change in the dose.

HMP Brixton

15. On 14 March 2012, the man was arrested for breaching the terms of an order. He was bailed by the police on 15 March, but was still in the custody area of Islington Police Station when he was charged with a further offence.
16. The following day, 16 March, the man was committed to Snaresbrook Crown Court for the breach of the SOPO. He was remanded into custody and taken to HMP Brixton. It was recorded on the Person Escort Record (PER) which accompanied him from the court to the prison that he suffered from schizophrenia, epilepsy and possible learning difficulties.
17. Nurse A, who assessed the man in reception, recorded that he suffered from epilepsy, had last experienced a seizure two weeks earlier and was not taking his medication. She noted a diagnosis of paranoid schizophrenia and referred the man to the mental health outreach team and the GP.
18. Dr B assessed the man later that evening. The man had a copy of his medication care plan but refused to answer any questions. The doctor prescribed two doses daily of Epilim (the brand name for sodium valproate, the same anticonvulsant that he had been taking for his epilepsy in the community), a forthcoming monthly injection of haloperidol (an antipsychotic for his schizophrenia), a daily dose of procyclidine (to reduce the side effects of the antipsychotic) and a daily dose of citalopram (an antidepressant).
19. The man applied for vulnerable prisoner status because he was charged with sexual offences and moved to B wing (which served as the vulnerable prisoner unit, or VPU, at the time). The man was assessed as a standard risk for cell sharing so he was able to move into a double cell. No concerns about self-harm were recorded. Dr B completed the healthcare assessment section of the cell sharing risk assessment (CSRA) and recorded that the man suffered from psychosis and extremely disturbed behaviour.

20. On 19 March, Nurse B from the mental health outreach team assessed the man and accepted him onto the team's caseload. The man's first antipsychotic injection was due on 11 April. His case was discussed by Dr C (a psychiatrist) at a referrals meeting on 22 March.
21. On 31 March, the man was taken to Camberwell Magistrates' Court and then returned to Brixton. Later that day, he was found by officers unconscious on the floor of his cell, although he was breathing normally. Nurses believed that he had suffered an epileptic seizure. Although the man had apparently been taking his anti-epilepsy medication regularly, he had not received his medication that morning. He was taken to hospital.
22. While at hospital, the man told an escort officer that he hoped that he had another fit and died. Consequently, when he returned from hospital to Brixton in the evening, staff began Assessment, Care in Custody and Teamwork (ACCT) self harm monitoring, but this ended the next day. Staff recorded that the man should sleep on the bottom bunk because of his epilepsy.
23. On 3 April, the man suffered another epileptic seizure. Later that afternoon, Nurse B went to see the man but he refused to talk. The same day, Dr D wrote in the clinical record that the man should be reviewed within 24 hours because of the increasing frequency of his seizures. On 4 April, Dr E reviewed the man at the mental health outreach clinic. The man was restless, irritable and occasionally incoherent. He left before the doctor could complete the assessment.
24. On 8 April, the man had another seizure on the wing. Afterwards, he was resistant to taking his anti-epilepsy medication, but an officer managed to persuade him to cooperate. The next day, Dr F assessed the man as 'very paranoid'. He recommended that the man should move to D wing (the inpatient unit) because he was a risk to himself and others.
25. At 9.00am on 10 April, the man suffered another short epileptic fit and collapsed. He recovered, refused treatment and returned to his cell. Nurse C recorded that the man was having seizures very often which required further investigation. However, he refused to see doctors and was reluctant to cooperate with nurses. He refused to see Dr G, who thought that the man would benefit from seeing a neurologist, but noted that his uncooperative attitude might prove a problem.
26. On 11 April, Dr G tried to speak to the man again. However, as soon as the doctor mentioned fits, the man swore and told the doctor to leave. Nurse B gave the man his monthly haloperidol injection the same morning. Dr C amended the frequency of his haloperidol prescription to every four weeks, because it had been incorrectly recorded as fortnightly. The next injection was due on 9 May. Nurse B saw the man afterwards and noted that, although he was complying with his haloperidol injection, he was 'acutely unwell'. The nurse planned to admit the man to D wing and checked that he was on the waiting list, as there was still not an available bed.

27. On 12 April, Nurse B added a mental health care plan to the clinical record. Later that day, Dr G (a consultant working on D wing) assessed the man with Nurse B. The man was reluctant to comply and said that Nurse B was hassling him and that he did not need help from D wing staff. Dr G and Nurse B discussed moving the man by force to D wing, but it was felt that this was unnecessary. Because he had received his haloperidol injection and did not appear 'overtly psychotic', Dr G decided that he should remain on the VPU and be reviewed regularly. Staff also began a second period of ACCT self harm monitoring on the same day, 12 April, because of the man's worrying behaviour. This lasted until 2 May, when the document was closed at Pentonville.

HMP Pentonville

28. On Friday 13 April, the man left Brixton to appear at Snaresbrook Crown Court and was taken to Pentonville after his court appearance. On arrival, he was assessed by Nurse A at Pentonville, who recorded his diagnosis of epilepsy and noted his monthly haloperidol injection. The man refused to see a doctor.
29. Prison staff completed another CSRA. They recorded the man's status as a vulnerable prisoner and assessed him as a standard risk. Nurse A at Pentonville added to the CSRA healthcare assessment that the man was subject to ACCT monitoring and that he should be held on a ground floor landing due to his epilepsy. The man spent his first night at Pentonville on A wing.
30. The next morning, 14 April, the man moved into a cell on G1 landing, the VPU. Dr A, lead doctor at Pentonville, one of the GPs, prescribed him the same medication he had been given at Brixton. He was initially given sodium valproate tablets for epilepsy as there was no liquid available. The man would only swallow some of his tablets because he was suspicious of them.
31. On 16 April, the man suffered another epileptic seizure in the exercise yard. He was treated by Nurse B at Pentonville but became aggressive and refused further help. The man's cellmate told the nurse that the man had spat out his epilepsy medication several times over the weekend. Nurses C and D at Pentonville went to see him, but he continued to refuse treatment and became abusive. Shortly afterwards, the man went to the medication hatch and allowed Nurse D to take a quick check of his blood pressure. However, he would not agree to a proper assessment and would not sign a disclaimer form. Later, he apologised for his aggressive behaviour and agreed to tests.
32. The same day, Nurse B from Brixton completed a handover with the Pentonville mental health in-reach team's administrator on the telephone. The man met Mental Health Nurse B in Pentonville (who normally works as a substance misuse charge nurse but who was completing a period of work experience with the mental health in-reach team). The man refused to answer questions about his previous mental health problems.

33. On 18 April, the man had another seizure lasting about seven minutes. He was placed in the recovery position but became agitated with Nurse C at Pentonville and told her to leave him alone. The man refused further treatment and the nurse did not force the issue as she did not want to cause him stress or trigger another seizure. She spoke to his cellmate and advised what to do if he had another fit.
34. Staff suspected that the man had not been taking his medication, so later that morning he was assessed by Mental Health Nurse D (a community psychiatric nurse working for the mental health in-reach team). The nurse did not observe any acute psychotic symptoms. Nurse D planned to refer the man's case to the next multidisciplinary team meeting. However, his case was not discussed at this meeting.
35. The next day, 19 April, Nurse C at Pentonville added an epilepsy care plan to the man's clinical record, advising staff what to do when he suffered a seizure. She advised that staff should make sure that he collected his medication, call for a nurse if he experienced a seizure, not make a fuss afterwards because this aggravated him and monitor the frequency of the seizures.
36. On 23 April, the man suffered another fit in the exercise yard. Afterwards, he was drowsy and confused. Nurses F and G attended, checked him and advised him to rest in his cell and take his anti-epilepsy medication.
37. On 26 April, the man was assessed by Dr B (a consultant psychiatrist at Pentonville). The doctor recorded that the man's cellmate had witnessed four epileptic fits in the previous week. It was unclear whether the man was taking his anti-epilepsy medication. The doctor was unable to complete a formal assessment because the man refused to cooperate, but she observed him on the wing and did not see any indication of 'distress related to mental illness'. She was concerned by his frequent seizures and thought that he might be spitting out his sodium valproate liquid. She wrote in the clinical record that a GP should review the man's fits.
38. On 30 April, staff from the man's local community mental health team (CMHT) in Hackney visited him and found his mood to be stable. On 3 May, the man suffered another epileptic fit and suddenly fell to the floor. When Nurse H tried to check him, he became aggressive and the nurse had to withdraw because he felt unsafe. After this incident, an officer told Dr A (the lead GP) that the man was having frequent fits and asked her to review him. Dr A wrote in the clinical record that the man had a history of non-compliance with his anti-epilepsy medication. She booked him an appointment for 10 May.
39. The man experienced another seizure on 6 May. His cellmate told Nurse I that he had been fitting on the floor for about seven minutes. On 10 May, the man appeared in court and was unable to attend appointments with Dr D at Pentonville and Dr A (the lead GP).
40. Based on the number of fits the man had been experiencing, Dr A increased his dose of anti-epilepsy medication on 10 May without seeing him. She told

the investigator that she knew that the man would refuse to take the anti-epilepsy drug if he knew it was altered. The doctor decided that it was in the man's best interests to increase the dose without telling him and then review his progress a month later.

41. On 13 May, the man had an argument with his cellmate on the VPU. His cellmate asked to move cells because he was afraid that the man might lose his temper again. On 14 May, the man suffered another epileptic fit. Nurse H had to end his follow-up assessment when the man became threatening towards him. The next day, 15 May, Mental Health Nurse J (a community psychiatric nurse working for the mental health in-reach team) was assigned as the man's keyworker.
42. Nurse K gave the man his monthly haloperidol injection on 16 May. (This had originally been scheduled to take place a week earlier, on 9 May.) Nurse L assessed the man two days later, on 18 May. The nurse did not identify any symptoms of a psychotic illness.
43. On 21 May, the man moved into a different cell on the VPU and the next day, 22 May, he was moved off the VPU (G1 landing) altogether after he punched another prisoner during an argument. Staff noted the recent increase in the man's aggressive behaviour and the fears of his previous cellmate. He was placed on the basic level of the Incentives and Earned Privileges scheme (IEP). (The IEP scheme offers sanctions and rewards based on conduct.)
44. The man was given a single cell on G2 landing. Healthcare staff were not consulted about this move or the implications. G2 is a general landing with a small number of cells designated for vulnerable prisoners when the VPU is full. As a result, the man could not associate freely on G2 landing. He could not associate with the prisoners on G1 landing either because he had antagonised some of them. He was not working. His opportunities to leave his cell were therefore very limited. Staff told the investigator that they usually took G2 vulnerable prisoners down to G1 landing a couple of times a week to allow them time out of their cells but it is not apparent this happened with the man.
45. On 25 May, the man was sentenced to a total of 12 months imprisonment. That day, Nurse L added a new care plan to the man's clinical record, about the need to monitor the man's compliance with his anti-epilepsy medication and the need for a review with the pharmacy technician. He noted that the man required education about the importance of taking his medication and the consequences of not doing so.
46. On 1 June, the man did not attend an appointment with Dr C (a psychiatrist). At about 3.30pm that afternoon, Nurse M checked the man after he experienced another seizure in his cell. The man was drowsy after his fit. After the nurse checked him, he was placed in the recovery position on the cell floor and then, as he was on a general wing, the cell was locked for the man's own safety. Officer A kept checking on the man through the observation panel. The officer later opened the cell for Nurse M to check the

man, but he was very agitated and once again refused treatment. The nurse asked the officers to continue to monitor the man. Officer A told the investigator that the man later came out of his cell and was talkative and pleasant.

Saturday 2 June

47. On Saturday 2, June, Officer A completed a roll check of G2 landing as usual at about 7.15am. She told the investigator that she looked into every cell through the observation panel and made sure that she obtained a response, either verbal or physical, from each prisoner. She told the investigator that she checked everybody and that the roll check was unremarkable. She could not remember specifically checking the man's cell because it had not seemed significant at the time, but she did recall checking that part of the landing because she had unlocked a nearby cell to check a prisoner who she could not easily see through the observation panel.
48. Prisoners at Pentonville are given a breakfast pack the previous evening so they are not unlocked for breakfast. Between 8.30am and 9.00am on Saturdays, officers unlock prisoners from the general population for chapel attendance, visits and medical treatment.
49. The man did not press his cell bell that morning. Officer B was responsible for G2 landing and explained that staff usually waited until lunchtime (11.15am) to unlock the vulnerable prisoners living in the 'VPU overspill' cells on G2 landing. These prisoners are let out before the prisoners from the general population, to collect their lunch and their medication. Nurse N, who was dispensing medication that morning, said that she had made a mental note that the man needed to collect his anti-epilepsy drug.
50. The man remained in his cell that morning while other prisoners had an association period and their weekly kit change. Officer N told the investigator that it had been an unremarkable morning. The wing staff then locked up the rest of the prisoners so that the few vulnerable prisoners on G2 landing could be unlocked for lunch.
51. At about 11.15am, Officer B went to unlock the man, who no one had seen or made a check on since Officer B's roll check at 7.15am. The officer looked through the cell door observation panel and could not see the man at first. He then noticed him lying on the floor at the back of the cell. His legs were visible between the toilet privacy screen and the bed. The officer went in and found the man collapsed and unresponsive. He was lying near the wash basin with his chest towards the floor but his head and neck were wedged at an awkward angle between the rear wall and the toilet. His eyes and mouth were wide open and the colour had drained from his face. His lips were grey and his skin was cold. He had no pulse and was not breathing. The officer shouted for Officer C and SO A who were both working on G2 landing and called a 'Level 1' emergency over the radio network (Level 1 indicates that a prisoner's life is in danger).

52. Nurse N arrived immediately because she had been working at the hatch nearby. The duty governor and Nurse O also arrived. They asked for an ambulance to be called, which was requested by gate staff at 11.20am. The way in which the man had fallen between the toilet and the wall meant that staff could not easily move him to begin cardiopulmonary resuscitation (CPR). Officer D entered the cell and, with Officer C and Officer D's help, forced the toilet bowl from the wall and removed it from the cell. Officers B and C were then able to turn the man onto his back to allow Nurse O to begin CPR.
53. Nurses M, P, Q (who brought the emergency response bag) and R (who brought oxygen and the defibrillator) all joined Nurses N and O in the cell. Nurse O began chest compressions. Her fellow nurses gave the man oxygen using a mask, but it was difficult for them to form a seal with the mask as the man's jaw had locked open. As the man was lying in a pool of water from the removed toilet bowl, the nurses did not attach the defibrillator because of the risk of electrocuting themselves and the man.
54. An ambulance crew arrived at 11.26am and at 11.30am, with officers' help, they moved the man down the cell to an area next to the bed where there was more space. More paramedics arrived in the cell at 11.39am and four paramedics treated the man. They continued to try resuscitation for the next forty minutes. They stopped CPR at 12.19pm. A forensic medical examiner arrived and pronounced the man's death at 12.35pm.
55. The duty governor led a hot debrief meeting at 1.50pm to check on the welfare of staff. The duty governor asked senior officers to review all prisoners subject to ACCT self harm monitoring.
56. The man had not nominated a next of kin, but Officer F (a trained family liaison officer) and the chaplain found an address for his aunt in his records. They went to the address but there was nobody there. They telephoned and discovered that his aunt had moved several years previously. They went to see her and broke the news of her nephew's death. They offered to help her break the news to the man's mother who lives in America, but his aunt told them that she would do this herself.
57. The man's funeral was held on 29 June. The prison contributed towards the cost in line with national guidance. Officer F attended on behalf of her colleagues.
58. The post-mortem report showed no sign of any alcohol or drugs that might have caused the man's death. The toxicology report confirmed only traces of citalopram. The report noted:

'The man appears to have died quite suddenly, as evidenced by the severe generalised congestion of all of his organs. There is a suggestion that he suffered a seizure prior to death. Autopsy reveals no significant pathological changes. Of the many causes of sudden death that may have been possible here, toxicology appears to exclude a fatal overdose (although it does suggest that the man had not been

taking any anti-epilepsy medication). It is most likely therefore that death is due to a sudden unexpected death in a person suffering from epilepsy (SUPEd). This is a well recognised condition but the cause of this is unknown - a disturbance in the neurological control of breathing or the heart rhythm is suspected. This is a diagnosis of exclusion and requires there to be no other recognisable macroscopic, microscopic or toxic cause of death, which appears to be the case here.'

ISSUES

Clinical care

59. The man had uncontrolled epilepsy, paranoid schizophrenia and learning difficulties. He was a patient with complex needs. He died after suffering an epileptic seizure while living in a cell on his own. He had frequently experienced fits in the weeks before his death. The clinical reviewer completed a review of the man's clinical care in prison. These are his main findings:

'The clinical care received by the man cannot be considered to be broadly similar with care he might have received in a community setting. During his stay in HMP Pentonville between the middle of April and the beginning of June, he had no medical assessments or clinical care provided by a doctor despite having a need for such clinical care.'

'[The man's] physical health needs were not properly assessed... He did not receive a complete assessment at reception... he had not seen the nurse who looks after long term conditions by the time he died.'

'There was limited co-ordination between the clinicians providing care to the man. This resulted in an overall weakness in the clinical care he received.'

'There appears to be no consideration of the man's compliance with his anti-epilepsy medication.'

'There was insufficient co-ordination between the prison staff and the medical staff about the need to ensure that the man was not in a single cell. This had an unfortunate outcome in this case.'

Management of Epilepsy

60. Pentonville healthcare staff did not complete a care plan for the man's epilepsy until 19 April, six days after his arrival. However, Nurse C's care plan was useful and practical. Nurse L added another care plan to the clinical record on 25 May. Each care plan was filed in a different section of the electronic patient record. The Primary Care Trust's own internal clinical review found that the man should have been case managed by their healthcare team within 24 hours of admission because of his complex needs. We make the following recommendation based on the clinical reviewer's findings:

The Head of Healthcare should ensure that patients with complex needs undergo a full assessment as soon as possible after arrival with a clear and detailed management plan entered in the correct section of the clinical record.

61. Nursing staff responded promptly whenever they were told that the man had suffered a seizure. They acted sensibly in adapting their aftercare to accommodate the man's hostility. However, he was never seen by a GP.
62. Although the man frequently experienced seizures in custody, he was not referred to a neurologist for further investigation. On 3 and 10 April, healthcare staff at Brixton recorded concerns about the frequency of his seizures and suggested further investigation. However, no outpatient referral was made at either prison.
63. Dr A (the lead GP) told the investigator that she had experience of dealing with the man during his previous sentence. She explained that he was resistant to any help after a seizure or to further investigation of his symptoms. She told the investigator that the healthcare team had considered referring the man to a neurologist during his previous sentence but he had refused to cooperate. She said that she decided not to make a referral during the most recent sentence because she knew that he would not agree and decided to increase his dose of anti-epilepsy medication and monitor his progress instead. No one discussed the possibility of seeing a neurologist with the man again during this final period in custody.
64. The PCT's internal clinical review acknowledged the man's resistance to medical intervention but found that consideration should have been given to an outpatient appointment with a neurologist. They concluded that Dr A's decision making should have been evidenced in the clinical record. She should have asked the man if he was willing to be referred to hospital and noted his answer in the clinical record. The clinical reviewer comments in his clinical review:

'...for the man, there was a clear need for a medical review and more could have been done to facilitate these appointments. If his non-attendance at the other missed appointments was his decision, this should have been clearly recorded in the notes.

'There was no active medical intervention in relation to his epilepsy. There are many entries from the nurses who attended to him after each fit. References are made to a medical review but one never occurred. It would have been appropriate to ensure that he was medically assessed after these repeated fits. This should have been both by the GP and also a neurologist.

'...there is no clear evidence of any discussion with the man about any further assessment of his condition... No advice has been sought from a neurologist and no arrangements been made for a neurological review.

'It is evident from the records that the man was unwilling to engage with clinical staff in relation to his epilepsy. However, this could have been documented and further advice could have been sought even if he would have been unwilling to accept any advice offered.'

65. Prisoners with conditions like epilepsy fall under the care of the chronic illness Nurse D. The nurse told the investigator that she never managed to review the man because he would not engage with her. The man was very resistant to any form of intervention, which clearly made the nurse's task difficult. However, with the number of fits the man experienced, we think that a review should have been scheduled, or the reason for the lack of review evidenced in the clinical record. We make the following recommendations based on the clinical reviewer's findings:

The Head of Healthcare should ensure that prisoners with epilepsy are assessed by a specialist nurse as soon as possible after arrival.

The Head of Healthcare should ensure that epileptic patients having regular and uncontrolled seizures are offered a prompt medical review and referred to a specialist for further investigation. Where the prisoner refuses to engage this should be clearly documented in the clinical record.

Compliance with medication

66. The man was prescribed sodium valproate, an anti-epilepsy drug. If he did not take it there was an increased risk of him suffering a seizure. Nurses dispensed the drug at the medication hatch and were supposed to watch him swallow the liquid. If he did not attend to take his medication, the nurse was supposed to speak to him and either dispense the medication or record why he did not want to take it.
67. Our interviews showed that the man was sometimes unwilling to take his medication at the dispensing hatch. The nurses tended to go and see him after the medication round and they or prison officers would try to persuade him to take the drug. There are several references in the clinical record to the man not taking his anti-epilepsy medication. However, healthcare staff did not devise a clear plan to monitor the man's compliance and there was some uncertainty about whether he was actually taking the drug.
68. The electronic clinical record suggests that the man was given his anti-epilepsy medication twice a day every day at Pentonville, except on 24 May. However, the post mortem report concludes that the man had probably not been taking his anti-epilepsy drug, because there was no trace of it in his blood or urine following toxicology tests. There is a clear contradiction between these two pieces of evidence. We make the following recommendation based on the clinical reviewer's findings:

The Head of Healthcare should ensure that staff accurately record prisoners' compliance with anti-epilepsy medication and clearly document a plan to improve compliance if the prisoner is reluctant to engage.

Allocation to a single cell

69. The clinical reviewer comments in his clinical review:

‘There was no communication between the prison staff and the healthcare team before the man was moved to a single cell.’

70. On 13 May, the man’s cellmate asked to move cells because he was worried about his behaviour. On 22 May, the man assaulted a prisoner on G1 landing (the VPU). Officers decided to move him to a cell on his own on G2 landing, the vulnerable prisoner ‘overspill’ area. The man was moved to a single cell not only because he was considered a threat to other prisoners, but also because he had been put on the basic IEP regime. The SO told the investigator that, since prisoners on the basic regime are not allowed televisions, it would have been unfair to make another prisoner share the cell as they would also be deprived of a television.

71. The SO explained that the intention was for the man to spend two weeks on the basic regime in a single cell on G2 landing, before returning to G1 landing and reintegrating with the vulnerable prisoner community by finding him an appropriate cellmate. This plan is not recorded in any of the documentation.

72. Officers did not consult healthcare staff about the implications for the man if he suffered a seizure while locked in a single cell. Dr A (lead GP) thought that there was an obvious risk associated with leaving an epileptic prisoner alone in a cell for long periods of time. Previously, healthcare staff had asked the man’s cellmate to keep an eye on him. Although the man suffered frequent seizures, no consideration appears to have been given to ensuring regular checks after he moved to the single cell, even though his location on G2 meant an unsatisfactory regime in which he was left alone in his cell for long periods of time.

73. The PCT’s own internal clinical review identified the need for more joint working at Pentonville between prison and healthcare staff with regard to patients who experience seizures. We make the following recommendation based on the clinical reviewer’s findings:

The Governor and Head of Healthcare should ensure that prisoners with uncontrolled epilepsy living in a single cell are subject to an appropriate level of monitoring by prison and healthcare staff.

Missed healthcare appointments

74. On 10 May, The man missed appointments with Dr A (lead GP) and Dr B because he was attending court. This explanation for his absence is not included in the clinical record and there is no evidence of the appointments being rebooked. It is the responsibility of the clinician to either reschedule an appointment or make an entry in the clinical record explaining why this is not necessary. There were also a number of other missed healthcare appointments the reasons for which were not clear.

75. The Head of Healthcare told the investigator that the electronic clinical record is supposed to be updated automatically with court appearances to avoid these sorts of clashes. However, he said that this system is not entirely reliable, especially when the court date has only been recently scheduled.
76. Dr A (lead GP) told the investigator that appointments missed because of court appearances are normally automatically rebooked. However, because she made a clinical decision and increased the man's dose of anti-epilepsy medication in his absence, she decided that there was no need to reschedule the appointment. Instead, she planned to let the man start taking the increased dose and then review him about a month later. We make the following recommendation:

The Head of Healthcare should ensure that reasons for missed appointments are recorded and where they are not rebooked, the reasons for this decision are entered on the clinical record.

Mental health treatment

77. The clinical reviewer comments in his clinical review:
- ‘[The man’s] mental health needs were appropriately assessed by a nurse. His mental state was considered stable and there appeared, on all the times he was seen, to be no deterioration in his condition. He was not described as having an affective disorder. His challenging behaviour was not considered to be the result of a deteriorating mental state.’
78. In contrast to his anti-epilepsy medication, the man complied with his monthly anti-psychotic haloperidol (depot) injection. He was supposed to receive a monthly injection of haloperidol. He was given a dose on 11 April at Brixton, with the next scheduled for 9 May. However, this was given a week late at Pentonville, on 16 May. There is no evidence in the clinical record to explain why the haloperidol injection was given a week late, although it might have been because of the man's court appearance.
79. The manager of the mental health in-reach team explained to the investigator that it is best practice to give haloperidol every four weeks to ensure continuity of treatment. Although the man's haloperidol was given a week late, he explained that a diminishing (but still effective) dose would have remained within his body.
80. Although staff had had serious concerns about the man's mental health at Brixton, and had considered moving him to the inpatient psychiatric unit, he was not allocated a keyworker from the Pentonville mental health in-reach team until 15 May, over a month after he transferred there.
81. The man was checked shortly after he arrived at Pentonville by Nurse B on 16 April and Nurse D on 18 April. Both nurses planned to have his case discussed at a multidisciplinary team (MDT) meeting. However, the man's

case was not discussed at the subsequent MDT meetings held on 19 and 26 April as would be expected with new cases. We make the following recommendation:

The Head of Healthcare should ensure that new patients assigned to the mental health in-reach team are promptly allocated a keyworker and have their cases discussed at the next multidisciplinary team meeting.

Complaint to the IMB

82. The IMB received an anonymous complaint from a prisoner on G wing after the man died. The note was handwritten and the signature illegible, and amongst a number of statements, the author alleged:

‘...hours before his death, everybody in the wing heard the man crying, screaming and shouting that he was dying and characteristically, no official came to his rescue.’
83. The investigator discussed this allegation with wing staff. Officer B was in charge of G2 landing from 8.45am on the morning the man died. He told the investigator that the man tended to press his cell bell if he had a problem. He recalled that the man had no difficulty in talking to staff if he had a problem. Officer B said that the man did not scream or shout that morning and did not press his cell bell (which we have confirmed from the electronic cell bell record). Officer B described the man as a very polite prisoner whose occasional outbursts were not malicious but rather a result of his mental health problems.
84. The SO who was in charge of G wing on 2 June. He told the investigator that he and his officers were on G2 landing overseeing the association period during the morning. The SO explained that the pool tables were outside the man’s cell and therefore lots of prisoners and staff would have heard if he was making a noise.
85. The author of the note did not contact the investigator to provide any further evidence after the notices from our office were displayed inside the prison. No other prisoners came forward with similar allegations. In the circumstances, we are satisfied that there is no additional evidence to support the anonymous allegation made to the IMB.

CONCLUSION

86. The man experienced frequent epileptic fits. We consider that prison and healthcare staff should have worked more closely together to manage his care as soon as he arrived in Pentonville. A doctor should have properly reviewed him and should have referred him for further assessment at hospital when he continued to experience seizures. Some decisions about his care were not fully documented in his clinical record.
87. There was no discussion about the man's move to a single cell. Prison officers should have consulted healthcare staff before doing so and, if the man was unable to share, then the frequency of his fits should have prompted some form of monitoring. We accept that the man did not always comply with his treatment and medication, but there was a need for better monitoring and communication about his management.

RECOMMENDATIONS

For the Head of Healthcare:

1. The Head of Healthcare should ensure that patients with complex needs undergo a full assessment as soon as possible after arrival with a clear and detailed management plan entered in the correct section of the clinical record.

The Head of Healthcare accepted this recommendation and provided the following response:

‘We have introduced a system of case management which would identify patients with either two or more long term conditions or a level of complexity in their case management which would require closer management of the individual’s care plan.

‘Care plans are now placed in [the electronic clinical record] in the template section of the clinical tree.

‘Further work is currently ongoing to fully utilise the built in Care Planning Tools available on [the electronic clinical record].’

2. The Head of Healthcare should ensure that prisoners with epilepsy are assessed by a specialist nurse as soon as possible after arrival.

The Head of Healthcare accepted this recommendation and provided the following response:

‘All patients identified with epilepsy are referred to the Long Term Conditions Nurse Specialist for assessment.

‘Ongoing care and management will be provided by this nurse specialist with GP support if it is required.’

3. The Head of Healthcare should ensure that epileptic patients having regular and uncontrolled seizures are offered a prompt medical review and referred to a specialist for further investigation. Where the prisoner refuses to engage this should be clearly documented in the clinical record.

The Head of Healthcare accepted this recommendation and provided the following response:

‘Where a patient is having increased or uncontrolled seizures the long term conditions nurse will refer him to the GP for assessment.

‘The clinical decision to refer to secondary level care for further assessment will be taken at this point by the GP.

'Such decisions and the plan of care are expected to be recorded clearly within the clinical record; including where refusal to engage has been an issue.

'Clinical staff have been advised as to the essential nature of this requirement.'

4. The Head of Healthcare should ensure that staff accurately record prisoners' compliance with anti-epilepsy medication and clearly document a plan to improve compliance if the prisoner is reluctant to engage.

The Head of Healthcare accepted this recommendation and provided the following response:

'Patients are risk assessed for suitability to self manage their medication. If patients are compliant with their medication management they will have this medication 'in possession'.

'Patients deemed not suitable for 'in possession' medication will have to attend for medication daily.

'Non compliance at this stage is now reported routinely and follow up advice offered to the patient to encourage compliance.'

5. The Head of Healthcare should ensure that reasons for missed appointments are recorded and where they are not rebooked, the reasons for this decision are entered on the clinical record.

The Head of Healthcare accepted this recommendation and provided the following response:

'A guidance instruction on non-attendance has been issued to all staff and compliance is regulated via audit.'

6. The Head of Healthcare should ensure that new patients assigned to the mental health in-reach team are promptly allocated a keyworker and have their cases discussed at the next multidisciplinary team meeting.

The Head of Healthcare accepted this recommendation and provided the following response:

'Weekly multi-disciplinary meetings take place in the mental health team. All referrals are discussed and allocated where eligibility criteria is satisfied.

'Information is passed onto prison staff via [the electronic prison record] to ensure personal officers are alerted to mental health team involvement in cases.'

For the Governor and the Head of Healthcare:

7. The Governor and Head of Healthcare should ensure that prisoners with uncontrolled epilepsy living in a single cell are subject to an appropriate level of monitoring by prison and healthcare staff.

The Governor and the Head of Healthcare accepted this recommendation and provided the following response:

'The safer custody lead will review the current procedures with the head of healthcare and ensure that we have a suitable system in place.

'Healthcare advice is that single cell occupancy for epileptic patients should be avoided.'