Investigation into the death of a man at HMP Isle of Wight in January 2010

Report by the Prisons and Probation Ombudsman for England and Wales

May 2011

This is the report of an investigation into the death of the man. The man died in his cell at Parkhurst, HMP Isle of Wight in January 2010, following a serious of seizures. He was 24 years old.

I extend my condolences and those of my colleagues to his family. I hope that my report goes some way to answering some of the questions I know they have raised. I must also apologise for the delay in completing my report.

The man's death was investigated by one of my senior investigators and one of my family liaison officers. The clinical reviewer on behalf of Isle of Wight Primary Care Trust, provided a clinical review of the man's healthcare treatment during his time in Parkhurst. I am grateful for his report which is annexed to this report.

My investigation raises a number of issues with regard to the healthcare provided to the man on the night he died and I make a number of recommendations in respect of this. However, I appreciate that many of the decisions taken by staff were made with extreme weather conditions in mind.

The first post mortem into the man's death was inconclusive. His seizures were possibly caused by a pre-existing brain injury. It is thought these were caused by a previous head injury which may have been sustained from one of two incidents that occurred whilst the man was at HMP Brixton, some months before he transferred to the Isle of Wight. Subsequent neurological examinations confirm that his head was injured in the months and years before he died and that the injuries were a factor in his death. However, due to the lack of documentation my report raises further questions about what happened at Brixton and which, regrettably, I am unable to answer.

I will send a copy of this report to the Governor of Brixton as well as to the Governor at the Isle of Wight.

The 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

Jane Webb
Deputy Ombudsman **May 2011**

CONTENTS

Summary

The Investigation Process

HMP Isle of Wight - Parkhurst

Key Events

Issues

Conclusion

Recommendations

SUMMARY

Convicted on 25 January 2007 for a number of serious offences, the man was returned to the custody at HMP Brixton where he had spent the majority of his time on remand.

On 1 May 2008, the man told staff that he had been assaulted by two prisoners who came into his cell and slapped him across the face. He was seen by a nurse who recorded that there were no signs of injury and no further treatment was required. The man did not tell staff the names of those involved. He was moved to another wing for his own safety.

Approximately two months later, the man was found unconscious in his prison cell. The prison doctor recorded that he had bruising around both eyes and had suffered bleeding to his nose. The man was semi-drowsy and uncooperative, and was immediately taken to Kings College Hospital. He was deemed fit for discharge from the hospital later that day. Although he had been admitted due to a suspected drugs overdose, the discharge letter recorded that there was no indication that this was the case. Over the following days, he man was observed by healthcare staff as confused, withdrawn and disorientated.

No further significant entries were made in the man's prison record and he remained at Brixton for another year until he transferred to HMP Isle of Wight, Albany, on 8 July 2009. (In 2009, HMP Albany, HMP Parkhurst and HMP Camp Hill were joined operationally as a cluster of prisons known as HMP Isle of Wight.) On his arrival at Albany, no specific medical issues were highlighted.

On 24 September, the man had a seizure and was taken to St Mary's Hospital on the Isle of Wight which is next door to the prison. No cause for the seizure was identified and he returned to the prison later that day. One of the conditions which was considered as a possible diagnosis was sickle cell anaemia, which is more prevalent in people like the man who are of African or Caribbean descent. A few days later the man was seen by the prison doctor who referred him to a consultant neurologist at St Mary's. Although there is evidence that the referral letter was received, no appointment was subsequently made. My investigator was told that this was due to a long waiting list at the hospital and limited resources to escort prisoners to appointments.

The man was reported to have suffered another seizure on 4 November. One of the prison doctors made arrangements for an urgent brain scan. This took place on 10 November at St Mary's, but the results were inconclusive.

On 21 December, the man was transferred from the Isle of Wight Albany site, to the Parkhurst site for reasons of safety. On his arrival at Parkhurst he was assessed by a member of the healthcare team. It was reported that he was fit and well but wanted to see a doctor as he was experiencing some pain in his right arm.

During the evening of 5 January 2010, the Isle of Wight experienced, what was described as, the worst snow fall for 30 years. This caused extreme difficulty for travel on the island, with many roads closed.

In the early hours of the following day the man suffered what was to be the first of a series of seizures which eventually led to his death. An Operational Support Grade officer went to his cell. He contacted and received guidance from a nurse based in the healthcare unit of the Albany site. When the man's condition deteriorated over the following hours, he was attended by one of the prison doctors, who due to the adverse weather conditions had been trapped at St Mary's Hospital, a short distance from the prison. Despite attempts by the doctor, staff, and paramedics to treat the man, he died before his transfer to the accident and emergency department at St Mary's could be facilitated.

My investigation identifies concerns about transferring records when prisoners move from one prison to another. I also comment on the health care provided for prisoner with seizures and abnormal test results. I am concerned about the arrangements in place for booking outpatient appointments and the availability of escort staff to facilitate these appointments. Consideration should also be given to the location of emergency equipment and also to the health care arrangements during the night. Finally I comment on the policy for staff to go into a cell at night and the arrangements for telling the family that their relative has died.

THE INVESTIGATION PROCESS

1. One of my investigators from my office, carried out the investigation into the man's death. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at HMP Isle of Wight, Parkhurst site. The notices were displayed around the prison and invited staff and prisoners to contact the investigator with any information relevant to my investigation.

2. The man obtained documentation relating to the time that the man spent at Parkhurst and visited the prison to interview staff. He also spoke with the man's cellmate. During the course of the investigation, my investigator provided feedback to the controller of Parkhurst.

3. My investigator also liaised with Parkhurst's Independent Monitoring Board (IMB). (IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained.) The Prison Officers Association was made aware that an investigation into the man's death was being completed. My investigator also liaised with a Detective Sergeant (DS) from Hampshire Constabulary, acting on behalf of the coroner. My investigator was in contact with the Coroner's office and a copy of this report will be sent to Her Majesty's Coroner for the Isle of Wight, to assist him with his enquiries. A copy of this report will also be sent to the National Offender Management Service.

4. My investigator also asked for information relating to the man from HMP Brixton. Despite my investigator contacting Brixton prison on several occasions, the prison was not able to produce all of the information requested. Therefore my investigator drew from limited medical records, incident reports and observation logs to describe what happened to the man during his time at Brixton. A copy of this report has also been sent to the Governor of Brixton. In response to the draft report Brixton produced a number of additional documents relating to the man's time at the prison. Following receipt of this information and feedback from the National Offender Management Service several amendments have been made to the draft report.

5. A clinical review was undertaken on behalf of the Isle of Wight Primary Care Trust (PCT) by the clinical reviewer, consultant in public health. He was assisted in undertaking his review by a panel appointed by the PCT. Together with my investigator, the clinical reviewer conducted interviews with some of the staff who provided care to the man during his time on the Isle of Wight.

6. As part of the investigation, confirmation was sought from the man's general practitioner (GP) in the community as to whether there was history of the man suffering from seizures or epilepsy. The man's GP confirmed that there was no previous history and that the man only went to his practice once, complaining of abdominal pain.

7. One of my family liaison officers contacted the man's mother, as his next of kin, to discuss the purpose and scope of the investigation and give her the opportunity to raise any questions or issues she had about his death. My investigator and my family liaison officer met the man's mother and other relatives who raised the following concerns:

    - Whilst in Brixton, the man was physically attacked by another prisoner. His family told my family liaison officer that, although the man reported this to the prison authorities, no action was taken. The man's mother was concerned that the man may have been subject to bullying at both Brixton and Albany prisons.

    - The man's mother said that, whilst in Brixton, the man was admitted to hospital for a week. She expressed her concern about not being informed of this by the prison.

    - Despite his epilepsy diagnosis in November 2009, the man did not attend a scheduled hospital appointment on 21 December.

    - The man's family also raised a number of additional concerns about the sequence of events in the early hours of 6 January 2010, specifically the lack of urgency in responding to the man and the delay in requesting an emergency ambulance. They feel strongly that the man could have survived had he received more immediate medical attention.

8. I hope that this report helps clarify the family's concerns and any other issues that remain unclear, helping them to better understand what happened to their son and the healthcare he received in custody.

   The man's mother and her legal representative received a copy of my draft report. No further representations were made in response to the findings, their preference being to raise matters directly with the Coroner at the inquest.

HMP ISLE OF WIGHT - PARKHURST

9. HMP Isle of Wight was inaugurated on 1st April 2009. It is the organisational amalgamation of the former Albany, Camp Hill and Parkhurst prisons. The three sites are roughly equal in size, with a total operational capacity of just under 1,700 places. The prison governor took up post following the amalgamation. Each site has its own director, who reports to the governor. Before his death the man lived on both the Albany and latterly Parkhurst sites.

10. Parkhurst was a high security prison until the mid 1990s, when it was converted to its current role. It now caters for long-term and life sentence category B prisoners and remand prisoners from the Isle of Wight courts. Parkhurst has five wings.

11. Health services at HMP Isle of Wight are commissioned by the Isle of Wight Primary Care Trust (PCT) and healthcare at Parkhurst is clustered with both Albany and Camp Hill. There are three nurses on duty at Parkhurst from 7.30am to 6.00pm from Monday to Friday. General Practitioners (GPs) from a local community practice attend Parkhurst for four three-hour sessions each week. Evenings and weekends are covered by on call GPs from the same community practice. Prisoners with more serious conditions or clinical needs are referred to the local hospital. (Beacon Healthcare provides the current general practice contract for the Isle of Wight prison healthcare.)

12. A new inpatient healthcare centre was completed and opened in October 2009 and is situated on the Albany site. Previously the healthcare centre for the three prisons was situated on the Parkhurst site. During the night, a nurse is based in the healthcare centre on the Albany site. Although unable to leave the healthcare centre to attend to the needs of prisoners in Albany or either of the other sites, the nurse can give medical advice over the telephone to staff on any of the three Isle of Wight sites.

13. The last full inspection of Parkhurst by Her Majesty's Chief Inspector of Prisons, was in December 2008, which is before the prisons were clustered and whilst Parkhurst had its own inpatient unit. In her report Her Majesty's Chief Inspector of Prisons commented that "Health services were unacceptably weak" at Parkhurst. On the provision of healthcare at the prison. She wrote:

   "Staffing levels in primary [health] care and inpatients were minimal, and there were vacancies across the cluster. This resulted in a limited health service for prisoners. There was only one member of the health services team on duty at night, based on the inpatient unit [a new inpatient unit has now opened at Albany], who was expected to attend to incidents at Parkhurst and provide telephone advice to staff at Albany and Camp Hill."

14. The Chief Inspector's team were also shown evidence of several breaches of the NHS standard of a maximum 18-week wait from first referral to consultation with a secondary care provider. Appointments were cancelled by the prison due to lack of staff and by the hospital for a variety of reasons.

15. The Inspectorate returned to the Isle of Wight in October 2010 and their most recent report is awaited. I understand that the Inspectorate remains concerned about healthcare at the prison and have some concerns about the level of healthcare cover outside of the core day.

16. The man's death is the eighth natural cause death to have occurred at the Parkhurst site since the Ombudsman took on the responsibility for the investigation of deaths in custody in April 2004. However, there appears to be no similarities with regard to these deaths and that of the man.

KEY EVENTS

17. On 25 January 2007, the man was convicted of multiple serious offences. He was sentenced to 14 years imprisonment, which was later reduced to 12 years. After conviction, he was held at HMP Brixton, where he had spent the majority of his time on remand.

18. On 1 May 2008, the man approached a senior officer to say he was being bullied because two mobile phones had been found in his cell the previous day. He told staff that two prisoners had entered his cell and slapped him several times across his face. The man was seen by a nurse who recorded that there were no signs of any injury or that he was suffering from any discomfort. The nurse noted that no further treatment was required. Officers placed the man on victim support and Rule 45 (at his own request), and he was also moved to a different wing. (Rule 45 is when a prisoner is segregated from other prisoners, either for disciplinary reasons or for their own protection. Victim support is used to support those who experience bullying.) However, the man would not name the prisoners involved in the incident and as the perpetrators could not be identified no further action was taken.

19. One of the prison doctors wrote in the man's medical record that the man had been found unconscious and in a drowsy state in his cell. However, the wing observation book contradicts the doctor's record of events. It records that staff responded to the man after he had been heard shouting for assistance. In the medical notes the doctor records that the man had suffered bruising around both eyes and was bleeding from his nose. The doctor noted that staff had observed the man as having what he described as three, "vacant attacks" and that he was semi drowsy and uncooperative. It was also noted that the man had a superficial laceration below his left ear. At 12.40pm, as a consequence of his presentation, the man was admitted to the accident and emergency department of King's College Hospital. It was recorded in the orderly officer's observation log that the man had been admitted to hospital due to a head injury and a suspected overdose. The man returned to the prison at 6.00pm, returning to his cell on C wing.

20. A discharge letter from King's College Hospital, written the same day, reported that the man had allegedly taken an overdose. However, it reported that his paracetamol and salicylate levels (a measurement of aspirin in the body) were normal. He was deemed fit for discharge from hospital, but the hospital doctor advised that he would require a psychological assessment. No other significant information was recorded on the discharge letter.

21. Two days later, on 26 July, the man was further assessed by the doctor. He noted that the man appeared confused and withdrawn. He reported that the man had urine soaked clothes, stared into space, and ignored all speech directed toward him. The doctor encouraged him to attend to his personal hygiene. The man was asked if he was okay and he replied that it was a "personal matter". There is nothing recorded to suggest that further enquiries were made as to the cause of this behaviour. The doctor made a

recommendation that the man be admitted to the healthcare centre. At around 4.00pm the man was transferred to D wing.

22. Whilst in healthcare the man remained under regular observation by healthcare staff, his confused and disorientated state was again recorded on several occasions. On 28 July, the man was assessed by the prison's psychiatrist. The prison's psychiatrist recorded that the man denied any thoughts of suicide or harming himself. The man's confused and disorientated state continued until 31 July. However, on 1 August, staff recorded in his medical records that he was no longer confused, was well orientated, and that he had no physical or mental symptoms of illness. The man transferred back to C wing.

23. For the following year nothing of any significance was recorded in the limited prison records. On 8 July 2009, the man transferred to HMP Isle of Wight, Albany. My investigator has been unable to establish the reason for his transfer. (Although prisoners from London courts often go to the Isle of Wight.) On his arrival at Albany, the man was medically assessed, but no specific medical issues were highlighted.

24. The man was moved to the prison's segregation unit on 3 August, for disobeying an order from an officer. This was one of a number of adjudications whilst the man was in custody. ('Adjudication' is the term used to describe a prison hearing after a prisoner has allegedly broken a prison rule.) While the man was in prison, he was placed on report four times for fighting, twice for disobeying a lawful order, and for possession of an unauthorised article (a mobile telephone). There was also security information that indicated the man had links to drugs.

25. On 24 September, the man had a seizure on the wing. A nurse recorded in the man's medical record that he appeared to have had a fit, and presented as agitated. An ambulance was called and the man was taken to the Accident and Emergency Department at St Mary's Hospital, Newport. No cause was identified for the seizure and the man was discharged and returned to the prison.

26. Five days later, on 29 September, the man was seen by one of the prison's general practitioners (GPs). He wrote in the man's medical record that the man presented with symptoms of dizziness and appeared anaemic. As a consequence of his assessment, the doctor wrote to the neurology department at St Mary's Hospital, seeking an appointment for further investigations to be completed. The doctor reported that the man had recently had a tonic clonic seizure recently. (A tonic clonic is a seizure that happens in two stages. The first, tonic, stage, is when the body's muscles contract and a person becomes stiff. They might cry out, and breathing can become irregular. The second, clonic, stage happens when the limbs jerk. This is caused by the muscles contracting and relaxing in quick succession.)

27. In his letter to the neurology department the doctor reported that, although the man had been admitted to St Mary's Hospital previously, his condition had not been fully investigated due to a shortage of doctors. He said the man had been discharged and had been well, except for experiencing some dizziness. The doctor said that no signs of neurological disease had been found, but the man

did have a sickle cell trait and he appeared pale. Some blood investigations were started. The doctor asked that the man be referred to a consultant neurologist with a view to further investigations. (Sickle cell trait is an inherited condition in which a person has abnormal haemoglobin in the red blood cells. Haemoglobin is the main substance of the red blood cell. It helps red blood cells carry oxygen from the air in the lungs to all parts of the body. The condition is more common in people of African and Caribbean descent.)

28. A letter dated 15 October was sent from Southampton University Hospital Trust addressed to Albany healthcare. The letter invited staff to contact them to arrange an appointment for the man with their consultant neurologist. The prison had to respond within two weeks or the referral would be cancelled. (However, the letter was not received by the prison healthcare unit until 12 November.)

29. On 3 November, the man was said to have been seen by staff to have apparently taken a handful of unknown pills. The man assured staff that he had not taken any. He was assessed by healthcare staff and discharged without any further treatment.

30. The following day, 4 November, healthcare staff were told that the man appeared to have had another fit, although this was not witnessed by staff. The man was reviewed by a second prison doctor, on 6 November. The doctor did not identify anything unusual and noted that the man was still awaiting a neurology appointment. He recorded in the man's medical record, "CT brain requested as appointment with neurologist might take very long time to materialise". (Computerised tomography (CT) is a test that uses X-ray equipment and computer software to create pictures of the inside of the body, including the brain.)

31. The man had a CT scan of his brain on 10 November, at St Mary's Hospital. In the clinical report of the scan, it was noted that the man had previously had two episodes of suspected convulsions, but had no history of epilepsy or head injury and "there is marked symmetrical atrophy of the frontal lobes. The remainder of the cerebral hemispheres look normal". (Symmetrical atrophy of the frontal lobes is where there is a marked decrease in the size of the front part of the brain. This can cause dementia like symptoms, particularly in respect of speech, for example repeating words over and over, not remembering words or phrases and can also affect a person's behaviour and personality.)

32. The CT scan results were not, as should have been, forwarded to the consultant neurologist at St Mary's Hospital. In a letter to the clinical reviewer, the consultant neurologist said that he was not aware that the man had had a second convulsion or of the results from the CT scan.

33. On 11 November, a third prison doctor, reviewed the CT scan report. The doctor noted in the medical record that the man should be recalled for a further assessment on 2 December, to ensure that the situation was under control and that everything was in place with regard to his general health needs. The appointment on 2 December did not take place. In interview the doctor accepted

that the appointment did not appear to have taken place and offered no explanation. In response to questions raised by the clinical reviewer, as to why the man was not seen on 2 December, the healthcare centre at Albany said,

> "He [The man] was definitely on the waiting list for Albany, however at around the time the recall would of happened the man was located in the segregation unit and was then subsequently transferred to Parkhurst."

(My investigator has not found any evidence that the man was in the segregation unit at this time.)

34. The letter from Southampton University Hospital Trust about the man's referral to a consultant neurologist was received at the prison on 12 November. The same day Albany's healthcare department tried to arrange an appointment for the man at the neurology department at St Mary's Hospital. The prison was informed that St Mary's breach date, the target date for which the neurology department was to have offered an appointment by, was 12 January. The first member from the prison's healthcare centre explained that escorts to healthcare appointment have to be booked in advance. At that time, it was not possible to facilitate an appointment before March. The hospital was not able to book an appointment that far ahead and agreed to get back in touch with the prison with a revised appointment.

35. In interview the prison doctor explained that healthcare staff rely on prison staff to provide escorts for pre arranged hospital appointments. Therefore, only four prisoners a day are able to attend outpatient appointments at the hospital. The doctor explained that the member of the prison's healthcare centre was probably attempting to book a March appointment for the man when escort staff would be available.

36. A further attempt was made to book a neurology appointment on 18 November, by a second member of the healthcare staff. The second member of the healthcare staff noted her contact with St Mary's Hospital. She said that she was informed that the hospital were only taking patients names and numbers and that they would be in contact when clinic dates became available. The first member of the prison healthcare staff attempted to book a further appointment on 1 December. However, she was informed that the neurology department was still unable to offer an appointment date for the man.

37. In a statement by the neurology department at St Mary's Hospital, annexed in the clinical reviewer's clinical review, the department says that the prison contacted them on only two occasions, 12 November and 1 December, to book an appointment. According to the statement, on both occasions the prison was informed that they "…did not have sufficient clinic capacity available to appointment the patient."

38. The man was again moved to the segregation unit, having become aggressive with other prisoners on 12 December. The following day, during routine medical rounds on the unit, the man told the nurse that he would have another fit if he

remained on the unit. However, during his time in the segregation unit, no further fits were recorded. The man was returned to the wing two days later.

39. On 18 December, The man was moved back to the segregation unit, for his own protection. It was alleged by other prisoners that the man had made inappropriate racist comments to them. Staff therefore decided that it was unsafe for him to remain on normal location at Albany. As threats had been made against him by other prisoners and his cell had been vandalised. On 21 December 2009, the man was transferred to the Parkhurst site of the Isle of Wight prison.

40. Although Parkhurst and Albany are part of the same prison, the man was assessed by a member of the healthcare team on his transfer. He told the nurse that he was fit and well but would like to see a doctor as he was experiencing some pain in his right arm.

41. On 5 January 2010, the Isle of Wight Council released a severe weather warning. They reported that the Meteorological Office was predicting a high risk of showers, turning to heavy sleet or snow during the evening and that priority would be given to keeping the islands' primary roads safe. That evening, the council reported that heavy snowfall had caused major traffic delays across the island. It was reported that continuing snow showers were making it extremely difficult to completely clear the primary road network. People were advised not to travel unless absolutely necessary. The snow fall was reported as the worst on the island for 30 years.

42. After the day and evening regime is completed, a prison enters night state. Night state is when the prison is fully locked up for the night and staffing levels are reduced to a minimum. The role of the staff on duty is to monitor the security of the wing and the prisoners held there. During the night, as well as officers and operational support grades (OSGs), there is a senior officer (SO) on duty, referred to as the night orderly officer. The night orderly officer is responsible for the prison and in the event of an incident staff will refer to them for advice and instructions. If necessary, the night orderly officer in turn will contact the on call duty governor for advice.

43. At Isle of Wight prison, there is only one nurse at the Albany site overnight for all three prison sites. The nurse is not allowed to leave the healthcare centre to attend either the main Albany site or the Parkhurst and Camphill sites, but can provide advice to officers on the telephone. There is no healthcare professional on site at night at Parkhurst.

January 2010

44. At about 1.00am on the day the man died, the man and his cellmate were watching television. The cellmate explained to my investigator that he was in bed and the man was sitting in a chair with a magazine talking to him. He said that the man started to chew on his thumb and then stopped talking. The cellmate said that he asked the man a question but did not receive a reply. He

saw that the man’s fists were tightly clenched, his eyes were rolling, his lip went down on one side and he was dribbling from the corner of his mouth. The cellmate asked the man if he was ok, but did not get a response.

45. Ten minutes later at approximately 1.10am, the cellmate pressed the cell alarm bell and an OSG responded. When the OSG looked into the cell he saw that the man was on the floor and appeared to be having a fit. The OSG told my investigator that he did not go in to the cell because it was a double cell and he was on his own. The OSG explained to my investigator that officers are not permitted to enter a double cell on their own. They either had to wait for other staff to arrive or get permission from the night orderly officer. This was for security reasons, to prevent prisoners feigning an emergency and overpowering staff.

46. During his interview with my investigator, the OSG said he had received first aid training when he was a life saving instructor, and had also been on a first aid course when he first joined the Prison Service. However, he said he had not received any recent training. Whilst standing outside the cell, he asked the man’s cellmate to hold the man’s head to prevent it from hitting the floor, and he took out his radio to contact the control room. The radio battery was faulty and so he walked to the office, a short distance away, to report the incident.

47. At 1.11am, the OSG contacted the officer in the prison’s control room to report that the man was having a fit. The officer contacted the SO, who was the night orderly officer and told him what was happening. The SO said that he would go to the wing. The officer in the prison’s control room contacted the OSG to inform him that the SO would be there shortly. At this point, the OSG returned to the cell and asked the cellmate to look after the man as best he could.

48. At 1.13am the OSG contacted the control room again to report that the man had stopped fitting. A few minutes later the SO and the night orderly officer’s assistant, arrived on the wing. During this time, the OSG asked the cellmate to put the man into the recovery position. When the OSG saw the SO and the night orderly officer’s assist arrive on the wing he called them to the cell. The SO and the night orderly officer’s assist then entered the cell and attended to the man, who was still lying on the floor. They spent some time trying to get a response from him and at that point there was some movement, but he was unable to speak very much. As time went on, the man became more lucid and he started to respond to the officers. The officers asked him if he had taken any medication, whether legal or illegal, or had had any alcohol. They also asked the man whether he had any pain or if he had banged his head. During their assessment of the man, the night orderly officer’s assist asked for some protective gloves and OSG left the wing to obtain them, returning a few minutes later. The officers then lifted the man on to the bottom bunk of the bed and advised him to try and rest. All of the officers then left the vicinity of the cell and the SO contacted Albany healthcare to tell them of what had happened and seek advice.

49. The SO spoke to the nurse in the Albany healthcare unit. The nurse told my investigator that one of his duties during the night was to offer medical advice over the telephone to officers from any one of the three Isle of Wight prison sites. The nurse said that he would do this by accessing the electronic computer records of prisoners in order to assist him provide advice about a prisoner.

50. The nurse told my investigator that the SO explained that the man had had a fit and asked if he was a known epileptic. The nurse said he checked the electronic medical records and found that the man had a history of seizures which he confirmed to the SO. The nurse said he asked how long the fit had lasted and was told by the SO that the seizure had lasted for about five minutes. During interview with my investigator the SO said that the nurse had told him that,

    "… as long as the fits aren't lasting more than ten minutes it shouldn't be a problem because of starving the brain of oxygen and things like that, so he was happy with that and that would have been it at that point … He advised us to make sure he [the man] saw healthcare in the morning."

51. As a consequence of his contact with the SO, the nurse made the following entry in the man's electronic medical record.

    "At 1.45 spoke with [night orderly officer] Oscar 1 – The man located in D wing experienced seizure, found on floor, cellmate states lost consciousness, generalised chaotic movements of all four limbs, lasting for approximately five minutes, sitting up and becoming more lucid at time of phone call. Vision entries suggest that this is not a new problem – awaiting St Mary's specialist neurology follow up will advise D wing's clinic manager."

52. The man's cellmate told my investigator that, after staff had left the cell, the man became more active. He said the man got out of bed and put some magazines away in a locker before returning to bed.

53. At 2.13am, the man's cellmate used the cell bell again. The OSG went to the cell and found that the man was on the floor. The cellmate explained to him that the man had been getting out of bed, fell forwards and appeared to have another fit. The man's cellmate told my investigator that he asked for an ambulance to be called as he did not feel that it was appropriate for the man to remain in the cell. During his interview with my investigator, the OSG said that it was not his decision as to whether an ambulance should be called to an incident. In the event no ambulance was called.

54. The man's cellmate said that during the fit the man continued to kick out, so he tried to help by holding his head to prevent him causing further injury to himself. The fit was much shorter than the previous one, lasting about a minute, and when it stopped, the OSG asked the cellmate to put the man in the recovery position. Again the OSG remained outside the cell. The OSG then contacted the control room to report the incident. The control room contacted the orderly officer. During his interview with my investigator, the SO said:

"When control contacted me I said to control can you ask the OSG to time how long this fit lasts, because of the information I'd had before, as it didn't last more than 10 minutes. Then again when we got there, and it was similar in a sense really, because the fit had finished. My understanding was, from what I was told, that it lasted about a minute on that occasion."

55. The SO went to the wing and was accompanied by two officers. Whilst the OSG remained at the door, the other officers went into the cell to provide assistance. The cellmate told my investigator that he again asked staff to call an ambulance. Although the man was in a very confused state, he was able to sit up. With some assistance from the officers, the man got back into bed. The officers tucked him in more tightly and asked the cellmate to monitor him.

56. During his interview with my investigator, the SO explained that he made contact with the nurse in the Albany healthcare unit for a second time. He said that he told the nurse:

    "… [I] explained to him that [the man] had had another fit, explained to him that this one had only lasted a minute. He said again, as long as they're not lasting more than 10 minutes it's not really a major problem, and I said to him is it a problem that he's now had multiple fits and again he stressed that it's not a problem as long as they're not lasting more than 10 minutes. So on that advice I've again told the OSG to keep a check on the cell and again you know let us know."

    The attending officers left the OSG alone on the wing at about 2.40am and he was told to monitor and time the fits should they happen again.

57. During interview my investigator asked the nurse in Albany healthcare unit whether he thought an ambulance would need to be called if someone had two fits within an hour. The nurse said that, in his opinion, he would not call one at that stage. The nurse also confirmed that he did not consider calling the out of hours doctors' service at that stage.

58. At 2.30pm, the nurse made a note in the man's medical records that the night orderly officer had advised that the second seizure had lasted for approximately one minute. (I note that this entry was not made until after a later entry made at 3.00am. The nurse said that this was because of a computer error.)

59. My investigator asked the SO if he had considered calling an ambulance at this point. The SO said he did not. He understood that he should first seek advice from the nurse based in the Albany site's healthcare centre. He went on to explain that, until October 2009, when the Isle of Wight prison's healthcare centre was based on the Parkhurst site, he would have met the on duty nurse and have escorted them to the prisoner for assessment. The SO said the nurse would then have seen the prisoner, taken his basic clinical observations including his pulse and blood pressure. The nurse would have then made a decision about whether the prisoner should remain at the prison or be moved elsewhere. The SO said that he was not medically trained and, as there were now no nurses based at Parkhurst, this meant that he sometimes had to seek

medical advice about a prisoner who he may have not seen, seeking advice from a nurse who was in a similar position. The SO said that it concerned him that something might be missed when explaining a prisoner's condition. The SO confirmed that he was able to dial 999 if he believed the situation was urgent enough. However, he spoke to the nurse and was told that the man would be fine to be left to see a member of healthcare staff in the morning.

60. At about 2.30am, whilst the OSG was patrolling the wing, he checked on the man again. He told my investigator: "The man was standing up by the bed and it looked like he was talking to the cellmate so I thought well good he's recovered." The OSG said he was therefore surprised when the cell bell was activated again 20 minutes later, at around 2.50am.

61. The OSG responded to the cell bell. On his arrival at the cell, he saw that the man was lying at the far end of the cell, almost against the wall. The cellmate explained to the OSG that the man had fallen over and cut his head. Again the OSG remained outside the cell. The OSG put out another call on the radio for assistance. He went downstairs to get two pairs of gloves, two dressings and two swabs in order to clean the man's wound before taking the equipment back up to the cell. He laid the items out so that they were ready for those who attended.

62. While they waited for assistance, the OSG told my investigator, "… it was just me outside talking to the cellmate because he was in a panic". The OSG advised the man's cellmate (through the cell door) to make sure that the man was breathing and was in the recovery position. It is unclear whether the man was conscious during this time. While he was waiting, the OSG said he telephoned the communications department twice to find out what was happening. He was told that the night orderly officer and his assistant were waiting for a doctor to arrive.

63. When the SO was informed of the third fit, he did not go straight the man's wing. When my investigator asked him about this, the SO explained:

    > "… [I did not go to the wing] at that point, not straightaway. Again, because my information is it's not a problem, it's fits and things like that, what I did on this occasion was I spoke to, I radioed back to control room. I got to the point when I thought if I ring Albany again are they just going to tell me the same thing again really, it's still multiple fits, they're still not lasting more than 10 minutes. I at that point just felt I wasn't happy with that, that to me wasn't enough, so I decided to contact control and got control to get me … IDOC [IDOC, now known as Island Health Line, is the Isle of Wight's out of hours GP Service]."

64. The SO telephoned IDOC and spoke to a nurse. He provided her with the man's details including his symptoms, age and ethnicity. He was told that a doctor would telephone him back. In a report of the services provided by Beacon, Island Health Line, it is noted that the SO made the call at 3.07am.

65. In the man’s electronic medical record the nurse in Albany healthcare unit noted that at 3.00pm he had a, “further seizure – have contacted IDOC for advice on management.”

66. A few minutes later the third prison doctor, who was coincidentally, one of the prison doctors who had previously been involved in the man’s care, telephoned the SO to discuss the situation. The doctor was stranded at St Mary’s Hospital due to the extreme weather conditions and working as an out of hours’ GP. He said that he would walk across the road from the hospital to the prison. The doctor arrived at Parkhurst at about 3.25am. The SO, along with other staff, accompanied the doctor to the wing.

67. At 3.30am, the man had a fourth fit. The fit lasted about one minute and stopped just as the doctor, the SO and the two officers arrived on the wing. According to the OSG they arrived at 3.31am.

68. The OSG updated the doctor and the officers on the latest situation, including the fourth fit. The SO said they were told that the man appeared to have stopped breathing during his last fit. They went straight to the cell and unlocked the door. The doctor explained to the investigator that when he went into the cell, the man was lying on the floor in the recovery position with his head away from the door. The man’s muscles were tense but there were no active jerking movements. The doctor checked his blood pressure and his pupils for their response to light. The man did not respond to his name being called, although the doctor explained to my investigator that it is not uncommon for someone not to respond to their name immediately after a fit.

69. However, the doctor was more concerned that, even though the man’s pupils reacted normally to light, he could not get a response to deep pain stimulus. The doctor explained that if someone does not respond to their name, it is possible to induce a pain response from someone who is conscious, for example by pinching their Achilles tendons. The doctor said he was concerned that he did not appear to be getting a response from the man. He said the man was scoring low on the Glasgow Coma Scale, (an objective way for medical staff to measure someone’s state of consciousness). The doctor decided it was necessary to admit the man to hospital for further observation and treatment. The man’s cellmate told my investigator that the man did not reply to any of the questions he was asked and was obviously distressed. During the course of the doctors’ medical examination, a chair was placed outside the cell for the man’s to sit on.

70. At 3.46am, the doctor contacted ambulance control and requested an ambulance. At that time, he requested an urgent but non-blue light response. He told the investigator:

    > “My feeling was that he [the man] was stable in terms of his cardiovascular and respiratory output, there were no signs of any obstruction, the fits could be managed on an ad hoc basis and the other thing that one had to bear in mind was the weather conditions, all the ambulance crews were scattered

across the island. My feeling was that we could maintain the situation over the next hour and that was the discussion we had."

71. At 3.53am, the SO contacted the officer in the control room, and advised that the man would be going to hospital. Once this had been arranged, the SO decided, given that the doctor, the OSG and the two officers were all in attendance, that there were enough staff on the wing to deal with the situation. The senior officer left the wing to arrange the paperwork necessary for the man to be escorted out of the prison. The SO also arranged for two officers to be on standby, ready to escort the man to hospital. As the ambulance was not due to arrive for about an hour, the officers carried on with their normal duties. Then, at about 4.50am, both officers went to D wing. On the way there, they collected the escort bag, used to carry items such as handcuffs, and the escort record.

72. At the same time as the Ambulance Service received the request from the doctor that their vehicle with stretcher capability was requested elsewhere on the Isle of Wight to back up another paramedic crew. There were just four Ambulance Service vehicles available that night for the whole of the Isle of Wight. Only one had a stretcher, the other three vehicles were four by four vehicles which cannot carry someone on a stretcher. This arrangement was in line with the normal contractual arrangements that the Isle of Wight Ambulance Service has in place. That night they also implemented a clinical triage support desk to assess 999 calls and send the most appropriate resource to the incident.

73. At 4.05am, the SO asked the control room to contact the duty governor to inform him of the situation. As duty governor he had to be informed that a prisoner was being taken out to St Mary's Hospital.

74. While they were waiting for the ambulance, the man's consciousness was variable. The doctor told my investigator:

    "… he never responded to [his] name but there was obviously purposeful movements, he tried to rise up, he tried to move around the cell. And I suggested to him that the best place for him was on the floor in the recovery position and he was just to lie still whilst the ambulance crew came to collect him. There was never any sign of respiratory obstruction or anything else like that … up until that point and there was nothing coming out of his mouth that caused me concern."

75. At 4.43am, the man had a fifth fit. The doctor explained to my investigator that this fit was different to the previous ones. The first four fits had all been tonic clonic, meaning that the man's movements were jerky and he moved forwards and backwards. The doctor said:

    "This fit was totally different to the ones that preceded it in that it was a full body muscle spasm. Everything just went into complete, for want of a better phrase, contraction. So much so he actually came up off the ground and went back down and as he came down it was perfectly obvious that this was significantly different. So that was the point at which I felt for his carotid pulse, couldn't feel it, realised that he wasn't breathing and rolled him over onto his

back to commence cardio pulmonary resuscitation." (A carotid pulse is taken from the main artery in the neck.)

76. The doctor started cardio pulmonary resuscitation (CPR) and continued for two to three minutes. (CPR is an emergency procedure which is attempted in an effort to revive someone in cardiac arrest.) When the escort officer arrived on the wing, ready to escort the man to hospital, he took over from the doctor and continued CPR. During this time, the doctor asked whether an emergency ambulance should be called and, at 4.47am, one of the officers radioed the control room requesting an emergency ambulance. The officer in the control room, requested the attendance of a blue light ambulance straight away. He had to provide very little detail as the Ambulance Service was already aware of most of the details of the incident due to the previous telephone call from the doctor. The doctor continued to give mouth to mouth resuscitation whilst the escort officer administered chest compression at approximately 15 compressions per two breaths, which is in line with national guidance.

77. Four minutes later, at 4.51am, the officer again radioed the control room and this time asked for a defibrillator. (A defibrillator is a small portable machine that searches for an irregular heart rhythm. If one is found, the defibrillator can deliver an electric shock to reset the rhythm.) The officer in the control room contacted the SO, asking him to collect the defibrillator. The only defibrillator in the prison was in the treatments room, which is below D wing. The SO was already on his way to the wing at this point and he therefore collected the defibrillator, arriving on the wing about a minute later, at 4.52am.

78. The doctor and the escort officer attached the defibrillator to the man. The defibrillator repeatedly advised "no shock". Staff continued with CPR.

79. The doctor explained to my investigator that, during the resuscitation attempt, the man produced quite a lot of liquid from his mouth. He said the man's abdominal muscles had contracted during the fit which caused him to aspirate, meaning that he had forced the content of his stomach into the back of his throat, which had then gone down into his lungs. The doctor tried to maintain an airway. The doctor told the investigator that he considered clearing the man's airway, but was concerned that if his oxygen levels dropped, it would decrease his chances of survival. The doctor therefore decided to continue with the CPR rather than spend time clearing the back of the man's throat.

80. At 4.52am, the ambulance crew arrived at the prison's main gate in a four by four vehicle. The snow at the prison was reported by the paramedics to be five to six inches deep by this time. The paramedics were escorted to the wing by a third officer and arrived at 5.01am. The paramedics then attempted to clear The man's airways and insert a short tube, via his mouth into his throat, to improve his breathing. The paramedics reported that when they tried to ventilate the man, he vomited. When a paramedic checked for sounds of breathing, he believed he could hear fluid on the man's lungs.

81. Resuscitation was attempted for 30 minutes by the paramedics and the doctor. However, the man's pupils did not respond to light and despite having applied suction to clear his airways, his oxygen levels were poor. Eventually at 5.22am the doctor pronounced that the man had died.

82. The SO contacted the control room so that the duty governor could be informed of the man's death. The SO was then instructed to start the contingency plans for dealing with a death in custody.

83. Shortly before the man died, the cellmate was moved to another cell on D wing where he spent the rest of the night. The SO arranged for the man's cell to be sealed to await the arrival of the coroner and the police. He also informed the man's cellmate that the man had died. The SO arranged for one of the prison's Imams to visit the man's cellmate and he was later seen by the doctor in order to talk the evening's events through.

84. At 5.50am, the prison's family liaison officer, was contacted at home to inform her of the man's death. Due to the poor weather conditions on the Isle of Wight that evening, the decision was taken that it would not be possible to tell the man's family, in London, of his death in person. At 8.05am, the prison liaison officer telephoned the Metropolitan Police to speak to staff at the police station closest to the man's mother's home. However, she found that the local Police Station did not open until 1.00pm. The prison liaison officer therefore spoke to the Metropolitan Police control room, who agreed to send an officer to break the news of the man's death to his mother.

85. The prison family liaison officer then contacted the family liaison officer at HMP Brixton, to ask him to assist the police. In addition, the chaplain at Brixton, said he would pay a pastoral visit to the man's mother the following day, as he knew her son quite well when he was at Brixton prison.

86. When the family liaison officer enquired whether the police had spoken to the man's mother, she was informed that they would not break the news until 6.00pm that evening. The prison liaison officer therefore contacted the prison liaison officer in Brixton to explain the latest situation. The officer said that he would go to the man's mother's house himself and put a letter through the door asking her to contact him. At 5.20pm, the man's mother telephoned the prison liaison officer at Brixton, who then broke the news to her of her son's death. I will consider the appropriateness of this decision later in the investigation report.

Post mortem

87. A post mortem examination of the man was conducted on 8 January by the Home Office Pathologist. The pathologist suggested that the man's death may well have resulted form a neurological disorder capable of generating seizures. He reported that initial appearances suggest that the man may have received significant head injuries in the past, possibly by a fall on to the back of the head. However, the autopsy was inconclusive and further tests were required on the brain, and from toxicology.

88. A subsequent neuropathlogical examination of the man's brain, performed by the consultant neuropathologist at Frenchay Hospital reported that the man

> "… had sustained cranial trauma months to years prior to his death. The trauma had caused severe bruising of the brain (contusion); swelling of brain tissue (infarction), bleeding into the layers of tissue that cover the front of the brain (the arachnoid and dura) and into the spaces between them (the subarachnoid and subdural spaces); and the formation of fibrous scar tissue extending over and into the brain. The distribution of the injuries to the brain suggests forceful impact of the front or back of the head against a hard surface. Injuries of this type carry a high risk of subsequent epilepsy."

89. The consultant neuropathologist also reported that during the hours prior to the man's death, the supply of blood to his brain fell below the level needed to maintain the viability of nerve cells, causing irreversible damage.

90. In a supplementary report to his original report of 8 February, the Home Office pathologist assessed that either of the incidents reported at Brixton could have been the cause of the relevant head injury. He said,

> "This pattern of injury could have been brought about by a very heavy blow or blows, or by a fall on to the back or front of the head, although the latter site is much more likely to have shown obvious evidence of impact at the time, because of the comparative lack of hair there."

91. The pathologist concluded that pre-existing brain injury was highly relevant to the circumstances of the man's death. The Home Office pathologist accordingly recommended that the cause of death was modified to read:

    a) Sudden death in epilepsy.
    b) Old blunt force head injury.

ISSUES

Clinical Care

The man's time at Brixton

92. The man's family expressed their concern that he had been assaulted whilst at Brixton. On 1 May 2008, the man alleged that he was slapped in the face by two prisoners because of an issue over mobile telephones. He was seen by a nurse at the time and no injuries were noted. Unfortunately, the man did not name the alleged attackers and no further action was taken against the perpetrators. (It is not unusual for prisoners to decline, for a variety of reasons, to provide further details when they have made an allegation of this nature.)

93. On 24 July, the man was found, in what the first prison doctor reports as being unconscious and in a drowsy state with bruising around both eyes and a bleeding nose. The prison recorded that this was due to a head injury and a suspected overdose. However, when he was assessed at hospital, no evidence was found to support the view that he had overdosed. The man returned to Brixton that evening and spent a few days in healthcare. He was confused and withdrawn, although no cause for his mental state was identified.

94. Again, it is not possible to be sure about what happened to the man or to explain how he came to be found in his cell. It is also not known what action, if any, was taken by staff outside healthcare to follow up this incident. Despite my investigator's best efforts, not all of the man's records from Brixton were available for this investigation. In his clinical review the clinical reviewer concluded that in his view,

    "… the episode of illness that the man experienced between 24 July and 2 August 2008, is unlikely to have resulted from an overdose or from an epileptic seizure, but is compatible with the man having sustained a head injury as a result of an assault with the later complication / consequence of post trauma seizures."

95. My investigator has been unable to establish with any certainty what happened to the man whilst he was a Brixton due to the lack of records relating to the time that he spent there. Although some wing sheets were available, they did not cover the period relating to the above incidents. In my reports I often comment on record keeping within the Prison Service and the importance of keeping records securely and transferring them with a prisoner whenever they move from one prison to another. It is concerning that not all records relating to the above incidents can be accounted for. As a consequence I make the following recommendation to the Governor of Brixton.

    The Governor of Brixton should remind all staff of the need to keep records securely and to satisfy himself that when prisoners are transferred to another establishment all of their prison records accompany them.

Care given to the man following his seizure on 24 September 2009

96. On 24 September 2009, the man was taken to the accident and emergency department at St Mary's Hospital, Isle of Wight, following an apparent seizure. No cause could be found for the seizure and he returned to prison. On 29 September, he was seen by a prison doctor who referred him for a neurology appointment at St Mary's. No connection was made with the incident that had occurred in Brixton in July 2008 at that time. The clinical review panel concluded that this was likely to have been the man's first seizure.

97. The panel reviewed the appropriateness of the care the man received on this occasion and concluded that it was "normal" for a patient not to be prescribed medication after one seizure. Given the information available to staff in September 2009, the panel finds that the man's care at this time was appropriate.

Care given to The man following his seizure on 4 November 2009

98. The man's next seizure occurred on 4 November. The clinical reviewer reports that although this was not observed by staff it was accepted that a seizure had taken place. The man was assessed by one of the prison doctors two days later. The doctor noted no abnormal neurological findings and recorded that the man was awaiting a neurological appointment. The doctor arranged for a CT scan to be taken for fear that the neurological appointment "… might take very long to materialise".

99. The clinical reviewer and the clinical review panel identifies that the CT brain scan taken on 10 November showed an abnormality. However, this information was not passed on to the consultant neurologist at St Mary's Hospital, who was unaware of the apparent second seizure. The consultant neurologist advised the clinical reviewer and the clinical review panel, in retrospect, that:

> "If I had been told of a second convulsion I would have either asked for the appointment to be brought forward or written with advice. However the investigation ordered from primary care was similar to that which I would have organised and the findings of atrophy would not have altered the management advice I would have given".

100. In conclusion, the clinical reviewer and the clinical review panel write that:

> "In respect to prisoners who are not acutely withdrawing from alcohol/drugs, are without an established diagnosis of epilepsy and have suffered more than one seizure, they should be referred urgently for a neurology opinion and if this is delayed, the neurologist should be contacted for advice on the management of repeat seizures. If potentially relevant, significantly abnormal laboratory/imaging result are received following an outpatient referral having been made (regardless of the specialty), these findings should be passed by the professional who ordered the test onto the consultant due to see the case."

I concur with the clinical reviewer's findings and as such make the following recommendation.

The Head of Healthcare should remind all clinicians that prisoners who suffer from more than one seizure should be referred to a neurologist. When there is a delay in getting an appointment, staff should contact the neurologist for advice on the management of repeat seizures.

The Head of Healthcare should remind all clinicians that abnormal clinical test results are effectively communicated to those involved in a prisoner's care.

Neurology appointment

101. The clinical reviewer and the clinical review panel conclude that:

> "… had the man been in the community he is likely to have experienced a similar wait for a neurology outpatient appointment, however he/ his relatives might have pressed (as did prison healthcare) to be seen in neurology outpatients before the end of 2009."

102. My investigator established that despite the fact that the hospital referral/appointments letter was sent on 15 October, it was not received by the prison until 12 November, by which time the deadline for responding had passed. That same day, the prison healthcare attempted to make an appointment for the man. However, the next available escort for the man to be taken to hospital was in March 2010. The neurology department advised healthcare staff that they were unable to assist by making an appointment that far in advance. The hospital's own target required that the man was seen before 12 January. Despite two further attempts by the prison to make a neurology appointment, none was made.

103. My investigator was unable to establish the exact reason for the delay in the man's appointment being made. Although, in response to enquiries from the clinical reviewer St Mary' Hospital told the clinical review panel that they did not have sufficient clinic capacity to offer the man an earlier appointment. My investigator also established problems booking outpatient's appointments within healthcare at the prison. During his interview with my investigator the third prison doctor said:

> "We have terrible issues getting any patient out of the prison to be seen in hospital. We average 30% of expected hospital appointments. On a good day when we get 100% we get four patients out, two in the morning, two in the afternoon across the three [prison] sites. The endless negotiations that are involved trying to find suitable dates, because we are working so much further into the future [to arrange appointments] than the hospitals are, creates a terribly complex situation and one that is very difficult, so as you can see form the notes in this situation the sort of dates that we were trying to get the man out for, the neurologist and neurology department weren't able to offer us because for reasons I'm unaware of to be honest with you but as I said just

the general principle of getting patients out for outpatients appointments is very time consuming and very difficult."

104. The 'breach date' (latest possible target date) for the man's neurology appointment at St Mary's Hospital was 12 January. The doctor told my investigator that, had the man been in the community, the hospital would have been obliged to see him by that date. My investigator asked the doctor whether he thought the man did not receive the same service as he would have in the community. The doctor agreed that the man's access to healthcare services had been affected by being in custody because the prison had difficulty fitting in with the hospital arrangements for booking outpatient appointments.

105. My investigator asked the doctor whether there would have been a different outcome if the man had seen a neurologist. The doctor said:

"My feeling is that had he seen a neurologist a diagnosis would still not have been clear in that he would have been referred for further investigations which again would all take time to arrange so quite possibly we would have a tentative diagnosis anyway, I don't think if had only had one appointment with a neurologist we would have moved that much further forward."

106. An individual's health is paramount, irrespective of whether or not they are in prison custody and should be equitable with that of the wider community. It is therefore essential that prisoners who are required to attend important outpatient appointments at hospital do so promptly and that their attendance of such appointments is not compromised by the availability of escort staff. I note that, in her recent inspection, the Chief Inspector recommended that prisoners should be able to attend appointments at outside hospitals without cancellations or delays. I make a similar recommendation.

The Governor and Head of Healthcare should review the prison's policies and procedures to avoid delays and cancellations when booking prisoners' outpatient appointments and escort arrangements.

107. The man's family wanted to know whether prison staff were briefed about the man's history of seizures whilst he was in custody. In the review, the clinical reviewer clarified that officers are trained in first aid, including responding to individuals having seizures. Although, the man had suffered a number of seizures during his time in prison no formal diagnosis had yet been made. However, confidential medical information is not passed on by healthcare staff to officers unless there is a considered reason for doing so. The clinical reviewer for example goes on to comment that prisoners will often tell staff about themselves and any medical issues they may have, such as if they are diabetic. in the man's case, if he was to continue to be at risk of having seizures, I would expect officers to be made aware of that risk and how to manage seizures while waiting for a healthcare professional to attend.

The man's first and second seizures

108. The man had a seizure shortly after 1.00am. Officers contacted the healthcare unit, located on the Albany site, for advice. The night time healthcare provision at Parkhurst meant that the nurse was unable to leave the unit on a different site, so the man would only have been seen by a doctor if he had been taken to hospital or one had come to the prison. When the SO first contacted the nurse, he advised that, as the man had stopped fitting, was conscious and comfortable, a transfer to hospital was not required.

109. Both the clinical reviewer and the clinical review panel reviewed the way that the man's first seizure was dealt with by medical staff. They conclude that, in the circumstances, it was not necessary after the first seizure for him to be transferred to hospital.

110. The clinical review panel also considers the second seizure, which occurred approximately an hour later and concludes that:

> "… in hindsight and having been able to consider the case in detail, two fits close together (approximately an hour apart) represented a significant progression in the man's undiagnosed and un-medicated condition in less than ideal circumstances. The panel further understood the significant disruption to the prison system of a transfer to hospital at night but considered that a referral to the emergency department at that point was the most appropriate course of action and is what is likely to have occurred had the man been in the community."

111. The clinical reviewer added that, "Had he been transferred at that stage further seizures may have been controlled/ prevented." The panel also comments on the weather conditions that night:

> "Due to the extreme weather conditions that night, transfer to the hospital would have been difficult. The Isle of Wight Ambulance Service had only one ambulance that could take a stretcher case in the snow. Sitting cases could be transported more readily and at that stage a sitting transfer might have been attempted, although there would have been a risk of a further seizure occurring during the transfer."

112. It is not sensible to speculate whether the man would have died had he been transferred to hospital after his second seizure. The weather was a relevant factor that night, as it might have impacted on the speed at which the man could be transferred to hospital. However, the medical need was the most important factor that should have informed the decision whether or not to send him to hospital. Given the conclusions of the clinical review, I conclude that the man should probably have gone to hospital after the second seizure. Therefore again, I do not think that he received the same level of care as if he had been in the community. I therefore recommend the following:

The Governor, Head of Healthcare and the Primary Care Trust should review the management of seizures and the appropriate thresholds for transferring prisoners to hospital.

The man's third and fourth seizures

113. There were no healthcare staff present during or after the man's third fit and care was provided by his cellmate, under the supervision of the OSG. I will comment later in this report on the man's cellmate being relied upon to look after the man.

114. As the man's fourth fit started, when the doctor arrived on the wing. The fit lasted about a minute and by the time the doctor reached the cell it had finished. The clinical review noted that the doctor who attended was only on duty at St Mary's Hospital due to the weather conditions. It was a fortunate coincidence and improved the treatment given to the man. However, it was not part of the usual night time arrangements and cannot be relied upon should another prisoner be in the same situation. The panel concluded that:

    "The doctor did his best to help the man in very difficult circumstances, however, had he not been available, the panel concluded that the man is likely to have been transferred to St Mary's potentially before he suffered his fifth and fatal fit. In retrospect and even given the very difficult weather conditions the panel is concerned that following his fourth fit, the man was unconscious on a cell floor, although under constant medical attention."

115. Shortly afterwards, the doctor spoke to ambulance control to request an ambulance. It was agreed that this one would be sent in the next hour based on the doctors' assessment of the man's medical condition at that time. The clinical review did not make any specific comment on this. In light of the fact that I have already commented that it would have been appropriate to transfer the man to hospital after the second seizure, I make no further recommendation.

The man's fifth fit

116. The man had a fifth fit at 4.43am. The clinical review panel concludes that,

    "… the attending doctor did his best to help the man in very difficult circumstances, however, had he not been available the man is likely to have been transferred to St Mary's, potentially before he suffered his fifth and fatal fit."

    However, the panel concludes that, at that stage: "… everything possible was done to save the man".

117. While the doctor was attending to the man, he requested a defibrillator. The machine was not on the wing and the SO received a radio call asking him to collect it from the treatments room. Coincidentally, the SO was near the treatment room when he received the request and therefore arrived with it shortly afterwards. However, had the senior officer not already been on his way over to the wing, it would have taken longer to arrive. The importance of a

defibrillator being available quickly cannot be underestimated, and in many cases a delay of only a few minutes can significantly affect the chances of effective resuscitation.

118. During his interview with the investigator, the SO also explained that he was not defibrillator-trained, although he thought that the escort officer was. He told my investigator that defibrillator training had been asked for by staff for some time.

119. As part of the clinical review, the clinical reviewer says:

> “The panel noted that the fifth fit was different in nature in that he vomited and immediately aspirated stomach contents. The attending doctor commenced cardio pulmonary resuscitation but the quantity of vomit meant that the facemasks that were available were not adequate. There was some delay in obtaining a defibrillator but when this was obtained it advised ‘no shock’ and in my view this is what the machine is likely to have advised had the defibrillator been obtained earlier.”

120. During his interview with the doctor, my investigator asked if there was anything that could have helped him treat the man that night. The doctor suggested that wings at the prison should have resuscitation masks in the “Laerdal model”. (A self-powered emergency aspirator capable of clearing a patient’s airway.)

121. In light of the above issues, the clinical reviewer and the clinical review panel make the following recommendations:

The Governor and Head of Healthcare should review access to resuscitation equipment, including face masks, on the prison wings.

The Governor and Head of Healthcare should consider placing defibrillators at strategic points throughout the establishment and ensure that sufficient staff are trained in their use.

122. The clinical review concludes:

> “In respect to the events of the morning of 6 January 2010, the panel noted the very difficult circumstances and that staff tried to help the man, but concluded that had he been in the community, in normal weather conditions, he is likely to have been hospitalised before he suffered his third fit although he may still have died”.

The review notes that the prison staff who assisted the doctor that night and who were first aid trained, were of great assistance.

123. However, the clinical review panel goes on to conclude that,

> “Finally, in my view the man did not receive care equivalent to that he would have relieved in the community in that he is likely to have reached hospital before his fifth fit although his prognosis might have been poor.”

124. Although I agree with the clinical reviewer's and the panel's conclusions, I am obliged to consider the appropriateness of staff's response given the extreme conditions. Unfortunately, on that night, weather conditions were far from "normal" and I recognise their impact on the care that the man received.

Night time Healthcare provision at Parkhurst

125. Until October 2009, there was night time healthcare cover at the Parkhurst site. However, since the building of a new healthcare centre on the Albany site, healthcare cover for Parkhurst and Camphill is now based there. This means that there is no member of healthcare staff on the Parkhurst site at night. Should medical assistance be required at night, staff are able to contact the nurse in Albany by telephone to seek advice. The nurse is unable to attend any incidents.

126. The SO explained to my investigator:

> "I have stressed my concerns since [the man's death] at Parkhurst and I've pointed out that at 1.15am when I got the first call I would have gone straight to our old healthcare, picked up the nurse, go over with Oscar 2. the nurse would see him then, the nurse would have taken his pulse, his blood pressure, his blood saturation through a little machine they've got and at that point they will have made the decision he needs to go out or doesn't need to go out. I'm not medically trained, I'm giving third party information over the phone without witnessing it myself and I believe in the age old thing of, probably not right to say it, Chinese whispers things get lost in conversation and do I explain it in the same way that I've been explained it, do I stress that it's urgent or not urgent, without that person actually seeing it who assesses the urgency of it? I know I'm allowed to ring 999 if I believe it's that important, but if I've spoken to a nurse who has told me it shouldn't be a problem, make sure he sees healthcare in the morning, and again after the second occasion it was written in the obs book [the wing observation book is a record of any issues staff should be aware of] again must see nurse or healthcare first thing in the morning."

127. During his interview with the investigator, the nurse in the Albany healthcare unit explained that, in his opinion, he did not consider that two fits in less than an hour was a reason to call an ambulance, particularly as they were followed by reported signs of recovery. However, had there been another seizure, he would have said that the man should be taken to accident and emergency. In interview the nurse told my investigator that it was difficult to interpret a prisoner's condition when given information by an officer over the telephone adding that it would be easier if he was able to see the prisoner in person. (I have already considered the appropriateness of this judgement above and do not comment on it further.)

128. In the man's case, the SO decided to contact the out of hours' doctor service after the third fit. This is predominantly a telephone service, but GPs provide advice and can visit a patient if they believe the situation is serious enough based on the information they are provided. In the man's case, this also meant

that he received direct care from a medical professional who came to the prison. The doctor was only on duty at the hospital because of the weather conditions.

129. I fully understand that three independent sites making up the Isle of Wight prison cause difficulty providing healthcare during the night. However, I am surprised that a prison of this size, some 1,700 prisoners, does not require more than just one nurse based on duty on the Albany site. The nurse who is based in the healthcare centre at Albany, cannot attend incidents at any of the sites because they cannot leave the inpatients' unit.

130. In considering whether the arrangements are satisfactory, my investigator made enquiries at HMP Sheppey which has a similar clustered arrangement with three prisons holding a similar number of male prisoners. There each of the two closed prisons has two nurses on duty each night who provide emergency treatment to prisoners as required.

131. From the investigation of a recent death in Albany, which occurred after the man, I understand that the Primary Care Trust are reviewing night time healthcare arrangements. Nevertheless I make the following recommendation:

The Governor, Head of Healthcare and the Primary Care Trust should work together to ensure that night healthcare provision sufficiently meets prisoners' needs across the Isle of Wight prison estate.

Going into cells at night

132. Having responded to the cell bell on the first occasion that night, the OSG said he did not go into the cell because staff are not permitted to enter a double cell at night on their own. They either wait for other staff to arrive or get permission from the night orderly officer. During his interview with the investigator, the SO explained that a member of staff should not enter a cell at night on their own unless they felt it was a life threatening situation. The SO said,

> "I think it depends on your own judgment of what's going on, if something looks absolutely life threatening with the duty of care and preservation of life they would contact control".

If a situation is not life threatening, the individual need of a prisoner must be weighed against the security of the prison. During a night shift, there are fewer staff in the prison and the risk is that prisoners can feign an illness and then overpower an officer who goes into a cell alone. However, during this investigation, no-one who was interviewed suggested that the man's fits were ever regarded as anything other than genuine.

133. It is understandable that the first time the OSG arrived at the cell he needed time to assess the situation. At that time, the situation was not life-threatening. However, it is harder to understand why he maintained that position over the course of a number of hours when the situation became more serious.

134. There is no record that the OSG asked if he could enter the cell that night. The SO the night orderly officer, did not suggest that the OSG should go into the cell. Consequently the responsibility fell to the man's cellmate, to care for the man for substantial amounts of time. Whilst the advice from healthcare initially suggested that the situation was not "life threatening", by the third fit staff were sufficiently concerned to seek a medical opinion elsewhere.

135. The man's cellmate looked after the man for 40 minutes, while the OSG stood outside talking to them, awaiting the arrival of a doctor. Understandably, the cellmate found this responsibility very distressing. The cellmate followed the instructions he was given to put the man in the recovery position. However, this arrangement was no substitute for someone trained in first aid (like the OSG) to assist the man. Nevertheless, there is nothing to suggest that not entering the cell directly contributed to the man's death.

136. The then the National Offender Management Service Chief Operating Officer, wrote to all Governors on 26 January 2010. This followed concerns raised by my office in previous investigations regarding staff understanding of when they can enter a cell at night. Although the letter was sent after the man died, it is clearly relevant to this investigation. The letter outlined that all staff must be aware of local procedures for what they should do if faced with a potentially life-threatening situation when there are no other staff in the immediate vicinity.

137. I am concerned that the OSG believed he could not go into the cell in the circumstances. There was no discussion about whether it would be appropriate for him to do so. I recognise that the man's condition worsened as the night unfolded. However, I do not think it was reasonable for the man's immediate healthcare needs to be administered by a prisoner with a member of staff giving instructions through the door. As soon as the OSG realised that the situation was genuine, I believe that he should have gone into the cell. At least, he should have sought permission from the night orderly officer. I therefore make the following recommendation:

The Governor should ensure that all staff working at night, including operational support grades, are aware of the prison's policy regarding entering cells in an emergency.

Radios

138. When the OSG took out his radio to contact the control room he found that the battery was faulty and so instead he walked to the office to report the incident. Whilst there is nothing to suggest that this contributed to the man's death, it could be crucial in other incidents. Although I make no formal recommendation, I would ask the Governor to remind staff that radios should be checked before they go on duty to ensure that they are in working order.

Breaking the news of the man's death to his family

139. Prison Service Order (PSO) 2710 on the Follow Up to Deaths in Custody explains the role of the prison's family liaison officer. Whilst there is no single view on the most appropriate way to make first contact with a family, the preferred approach is that it should be made directly by the prison. Ideally, the family should be informed face to face by a prison family liaison officer, with a chaplain or a Governor. Where face to face contact is not possible, it should be followed swiftly by face to face contact.

140. When a face to face visit by the prison's family liaison officer is not possible, an officer from another prison, located closer to the family, should be asked to break the news. The PSO accepts that at times it might be necessary for the police to break the news but that this should not be seen as an "easy option" and it is generally poor practice to do so.

141. Following the man's death, the family liaison officer at Parkhurst initially contacted the police to ask them to break the news to his mother. It was good practice to follow up later in the day. The family liaison officer asked about progress contacting the man's mother, and was told that contact would not be made until that evening. A family liaison officer from HMP Brixton therefore agreed to deliver a letter to the man's mother asking her to contact Parkhurst on her return. The news of her son's death was then given to her over the telephone.

142. I would normally expect the prison's family liaison officer to break the news of a death in person. This includes when the death is at a prison on the Isle of Wight, unless the distance is so considerable that it is impractical and would lead to a significant delay. Whilst it is accepted that on this occasion snow on the Isle of Wight might have prevented travel, it is questionable whether it was appropriate to have approached the police to break the news of the man's death to his family. It is not normally the role of the police to do this and, as it turned out, there was a delay of some hours in informing the man's mother of her son's death because the police were not able to do so until the evening.

143. When this delay was identified, the family liaison officer at Brixton delivered a letter to the man's mother asking her to contact Parkhurst. There was no certainty that his mother would receive the letter. It also meant that the man's mother was told of her son's death by telephone. If the family liaison officer at Parkhurst could not break the news in person, the family liaison officer at Brixton could, and in my view should, have broken the news in person instead, in line with the guidance. It was Parkhurst's responsibility to make sure that the news of the man's death was broken to his family. I therefore make the following recommendation:

The Governor of Parkhurst should ensure that the family is informed of a prisoner's death in person by a prison family liaison officer.

CONCLUSION

144. The man's first recorded seizure took place on 24 September, after his transfer to the Isle of Wight. A further un-witnessed episode took place on 4 November, before a serious of seizures led to his death in the early hours in January 2010. Although the seriousness of his condition had been recognised by healthcare staff at the prison and arrangements made for him to be seen by a consultant neurologist, he was unable to do so before he died. Although a subsequent emergency CT scan was taken, the results were not forwarded to the consultant neurologist. However, the clinical review concludes that had the results been forwarded the management of the man's case would not have altered.

145. I make several recommendations with regard to the man's treatment by healthcare at HMP Isle of Wight under the guidance of the clinical review panel and I concur with their final conclusion. I don't think that the man received the level of care that he would have had in the community, in particular he should have been taken to hospital before his fifth seizure.

146. Perhaps more concerning is that the post mortem into the man's death raises the possibility that the serious of seizures that the man experienced in the months leading to his death resulted from a pre-existing brain injury, which could have been caused by the incidents that took place at Brixton. The post mortem concludes that the man's pre-existing brain injury was highly relevant to the sequence of events that took place.

147. I regret that my own investigation has been unable to shed any further light on the incidents that took place at Brixton prison. As a consequence, and given the lack of evidence available to me, I believe it would not be appropriate for me to comment further on these incidents but simply report my findings to the reader.

RECOMMENDATIONS

1. The Governor of Brixton should remind all staff of the need to keep records securely and to satisfy himself that when prisoners are transferred to another establishment all of their prison records accompany them.

   No response -

2. The Head of Healthcare should remind all clinicians that prisoners who suffer from more than one seizure should be referred to a neurologist. When there is a delay in getting an appointment, staff should contact the neurologist for advice on the management of repeat seizures.

   Accepted - Updated local guidance for Prison Healthcare staff and prison colleagues have been developed and issued to clarify actions requried – based on and to ensure compliance with national Institute for health and Clinical Excellence (NICE) guidelines. N.B. New guidelines on epilepsy are expected to be released by NICE in March 2011.

3. The Head of Healthcare should remind all clinicians that abnormal clinical test results are effectively communicated to those involved in a prisoner's care.

   Accepted - All prison Healthcare staff have been reminded of the need for abnormal clinical test results to be effectively communicated to those involved in a prisoner's care. Staff were reminded that in simple terms, this means that if an individual staff member is the first to come into possession or knowledge of a patient's test results and he/she is either concerned or unsure of the implication (or if the result has been clearly indicated as abnormal) he/she has a duty to bring it to the attention of those involved in the patient's care and particularly the person responsible for leading that care.

4. The Governor and Head of Healthcare should review the prison's policies and procedures to avoid delays and cancellations when booking prisoners' outpatient appointments and escort arrangements.

   Accepted - Work has and is ongoing in respect of this area of challenge. A number of changes introduced recently are aimed at developing better understanding and liaison between the Prison, Prison Healthcare and the local hospital in order to improve the booking systems. A new software package has recently been introduced to inform this process. A new contract for the provision of neurology services to prisoners in HMP Isle of Wight is currently under discussion between the commissioners and the provider of these services.

5. The Governor, Head of Healthcare and the Primary Care Trust should review the management of seizures and the appropriate thresholds for transferring prisoners to hospital.

   Accepted - As for 2. above.

6. The Governor and Head of Healthcare should review access to resuscitation equipment, including face masks, on the prison wings.

   Accepted - The provision of resuscitation equipment was already the subject of review and action at the time of the man's death. Outcome was that in May 2010 – NHS Isle of Wight purchased and provided to HMP Isle of Wight six Automated External Defibrillators (AEDs) and associated equipment (including masks). Under a Memorandum of Understanding signed and dated 18th May 2010, these were deployed to the Gyms and Night Orderly Offices of each of the three prison sites making up HMP Isle of Wight.

7. The Governor and Head of Healthcare should consider placing defibrillators at strategic points throughout the establishment and ensure that sufficient staff are trained in their use.

   Accepted - As for 6 above.

   In addition, an AED is located in the Primary Healthcare Centre on each site and the Inpatient Unit (IHU) at Albany. This makes a total of 10 AEDs.

   A training session for Night Staff in the use of AEDs is planned to increase the number of trained staff in post. This will increase the number of trained staff in the vulnerable area of State 'A'.

8. The Governor, Head of Healthcare and the Primary Care Trust should work together to ensure that night healthcare provision sufficiently meets prisoners' needs across the Isle of Wight prison estate.

   Accepted – Work is ongoing in respect of ensuring clarity and equity of access to healthcare across the 24 hour day. Simple written guidance and a clear flow chart for prison staff on accessing healthcare services has recently been updated and circulated

9. The Governor should ensure that all staff working at night, including operational support grades, are aware of the prison's policy regarding entering cells in an emergency.

   Accepted – Work on this action has commenced and all staff at HMP Isle of Wight have been sent a personal copy of the Safer Custody produced video on actions to take when entering a cell and use of anti-ligature knife. Currently 71% of staff has confirmed they have viewed the video and this is recorded as training.

   The Night Orders have been reviewed by Security and Operation Group and are now in place. The review clearly sets out our policy on entering cells in an emergency. Governor Grades conducting Night Visits have been clarifying any training issues with regular night staff and providing information with respect to entering a cell in state 'A'.

10. The Governor of Parkhurst should ensure that the family is informed of a prisoner's death in person by a prison family liaison officer.

Accepted – Since the introduction of Death in Custody Lead this action is carried out in all cases. The Contingency Plans have been amended as requested. HM Prison Isle of Wight now has a lead governor grade on Death in Custody who deploys the Family Liaison Officer to deliver the message to the family. The system now employed ensures the deployment of trained Family Liaison Officers and has, due to long distance visits, used the FLO of nearby establishment's where appropriate. When this occurs, our FLO is still deployed to help the family and to five further information as near to time of death as practicable.