PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a resident at The Pines Approved Premises in May 2014, while in the custody of HMP Ford

Our Vision

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

This is the investigation report into the death, from epilepsy, of a man in May 2014 at The Pines Approved Premises, Bournemouth, whilst in the custody of HMP Ford. He was 43 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received in prison was conducted. Both Ford and The Pines cooperated fully with the investigation.

The man was serving an indeterminate sentence for public protection and had been a prisoner at Ford open prison since November 2013. He had suffered from epilepsy since he was 13 years old. His epilepsy was mostly controlled by medication. When he experienced fits, it was usually because he had forgotten to take his medication. At the time of his death, he had been released from Ford temporarily to spend three nights at The Pines as part of his preparation for release. On the night of 28 May, he returned from spending the day with his uncle. His uncle rang the next morning and told staff that his nephew had left his medication behind. Staff went to look for him, but found him dead in the bath. His death was from epilepsy.

I am satisfied that the man received an appropriate standard of clinical care at Ford. He was responsible for managing his own medication both in prison and at the approved premises and I am satisfied that there is nothing that staff, in either setting, could have done to prevent his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2015**

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SUMMARY

1. In 2008, the man was sentenced to an indeterminate sentence for public protection. He had a history of drug addiction. He had been diagnosed with epilepsy when he was 13, which was controlled by medication. He managed his own medication, but sometimes forgot to take it, which resulted in a fit.

2. In November 2013, the man transferred to HMP Ford, from HMP Swaleside. Ford is an open prison for category D prisoners (the lowest of the four prison security categories). Subject to risk assessments, prisoners approaching the end of their sentence can be released on temporary licence from Ford to help them resettle into the community. He had completed previous successful periods of day release and, on 26 May 2014, he was released on temporary licence to spend three nights at The Pines Approved Premises in Bournemouth, as part of his preparation for release.

3. A few days later his uncle, who he had spent the previous day with, telephoned The Pines to say that his nephew had left his epilepsy medication at his home. Staff went to check him and found him unresponsive in the bath, apparently dead. Staff called an ambulance and attempted cardiopulmonary resuscitation. Paramedics arrived and pronounced him dead. A pathologist concluded that the cause of death was most likely the result of his epilepsy.

4. We are satisfied that the man received a good level of care during his time at Ford. He was responsible for managing his own medication and taking it appropriately. His medical records showed that two of the three seizures he had while he was at Ford, were caused by him not taking his medication. These omissions were not considered sufficiently serious to raise any major concerns about his ability to manage his condition.

5. The man was responsible for managing his own medication during his temporary stay at The Pines. Although there was no formal risk assessment at the approved premises, there was one at the prison, and we are satisfied that this was appropriate. Although this did not affect the outcome for him, the investigation found that of the three staff on duty, only two were first aid trained. We make one recommendation about this.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at Ford and The Pines Approved Premises, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

7. The investigator obtained copies of the man's medical records, relevant extracts from his prison records and records relating to his time at The Pines. She interviewed seven members of staff at the approved premises on 4 June. Another investigator took over the investigation on 1 September.

8. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

9. We informed HM Coroner for Bournemouth and Poole of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers wrote to the man's uncle, his nominated next of kin, on 23 July, to explain the investigation. He did not identify any specific issues for the investigation to take into account. He received a copy of the draft report. He pointed out some factual inaccuracies. This report has been amended accordingly.

11. The draft report was issued for consultation with the prison service. They pointed out some factual inaccuracies. This report has been amended accordingly. The action plan has been added to the end of this report.

HMP FORD

12. HMP Ford is an open prison in West Sussex which holds approximately 500 men. NHS Sussex commissions healthcare services which are provided by Sussex Partnership NHS Foundation Trust. A prison healthcare centre is open on weekdays from 8.15am to 5.15pm (7.00pm on Wednesdays). West Sussex Out of Hours Service covers other times.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Ford was in August 2012. The Inspectorate found health services were assessed as similar to those provided by a good community GP practice. Three-quarters of prisoners surveyed said their quality of healthcare was good. Medication was well managed and almost all prisoners had their medication in possession.

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure prisoners are treated fairly and decently. In its most recently published annual report for the year to October 2013, the IMB noted 88 percent of prisoners who attended the healthcare centre had rated the quality of service as good or very good.

Previous deaths at HMP Ford

15. The man was only the second prisoner to die from natural causes at Ford in five years. There were no similarities between the two deaths.

THE PINES APPROVED PREMISES

16. Approved Premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are supported to register with a GP. However, the registration and management of medical appointments remains the responsibility of the individual resident.

17. At the time of the man's death, The Pines, Bournemouth was one of two approved premises, managed by the Dorset Probation Trust. The premises has 16 beds. He was in a single room on the first floor, which had its own shower facilities. The bathroom is in a separate room. Most residents have finished their prison sentences and have a key worker to discuss their progress and wellbeing. Staff give a brief induction to the premises for short term residents like him, released on temporary licence from prison, and check they comply with the conditions of their licence. The Pines is staffed 24 hours a day by probation employees; there is a duty manager system for evenings, weekends and bank holidays.

KEY EVENTS

18. On 18 March 2008, the Crown Court sentenced the man to an indeterminate sentence for public protection with a minimum period to serve of four years before he could be considered for release. He started his sentence at HMP Swaleside. He, who had a history of heroin addiction, completed a detoxification programme in June 2010. In October 2011, he was assessed as suitable for open prison conditions and he transferred to HMP Ford on 1 November 2013. One of the requirements at Ford is that prisoners are assessed as suitable to have medication 'in-possession' (where prisoners keep supplies of their own medication in their rooms to self-administer, as they would in the community).

19. The man had been diagnosed with epilepsy when he was 13 years old. Records show he had 12 epileptic fits over a four year period between 2010 and 2014. Nine of these were at Swaleside and at least one of the fits at Swaleside was the result of not taking his medication.

20. When he arrived at Ford, the man disclosed his history of epilepsy for which he took tegretol, an anti-convulsant. He was assessed as suitable to have his medication in-possession and signed an in-possession medication contract on 1 November 2013.

21. A prison GP reviewed the man on 2 December 2013 and noted that he had approximately two seizures a year and his last fit had been five months previously. In fact, records show that he averaged four fits a year and his last fit, at the time of the GP's review, was in August 2013.

22. The man had an epileptic fit on 9 December 2013. Healthcare staff considered that this was because he had not taken his medication at night. On 11 December, a doctor referred him for a neurology review of his epilepsy at hospital. A neurologist queried the need for an appointment "if his epilepsy is stable". As healthcare staff considered his epilepsy was stable they did not make a further referral. On 18 December, he discussed his compliance with his medication with a mental health nurse and she arranged for him to have a dosing box to organise his medication and help him remember to take it. He had another fit on 21 December, and a nurse reviewed him on 23 December. It is not clear if this fit was a result of not taking his medication.

23. On 7 April 2014, the man went to the prison healthcare centre with symptoms of heroin withdrawal and told staff he had relapsed. He tested positive for benzodiazepines (tranquilisers that are often taken illicitly) and told the nurse practitioner he had had started using heroin regularly again since he had arrived at Ford. Although he did not test positive for opiates, a doctor prescribed suboxone (a heroin substitute).

24. The man had another fit on 27 April, as a result of not taking his medication the previous day. A doctor reviewed his medication on 30 April and advised him about taking it regularly to avoid seizures.

25. As part of his resettlement, the prison agreed a number of day releases for the man, which he completed successfully. The healthcare staff at Ford did not have any concerns, either from a safeguarding or a health perspective, that his epilepsy and recent fits should affect his suitability for release on temporary licence. It was expected that when he was eventually released from prison, he would be required to stay at an approved premises for a time as part of his licence conditions. In preparation for this, the prison granted him temporary release to The Pines Approved Premises in Bournemouth, starting at 9.15am on 26 May and ending on 29 May at 6.15pm. This meant he would be away from the prison for three nights.

The Pines

26. The man arrived at The Pines on 26 May at 1.30pm. A probation service officer gave him a brief induction. She did not complete a health questionnaire or formal medication in-possession assessment. She allowed him to keep his medication with him because he was only staying for a short while as a temporary resident and he would be spending most of his time with his family. His had medication for epilepsy and champnix (to help give up smoking). There is no record that he was still taking suboxone at this time.

27. The man's offender manager indicated when referring him to The Pines in March that he had epilepsy for which he took prescribed medication. As he was at The Pines temporarily, staff did not assign him a key worker. He was due to meet an offender manager on the morning of 29 May to assess how his release on temporary licence had gone.

28. On 28 May 2014, the man spent the day with his uncle in Bournemouth and returned to The Pines for the 11.00pm curfew. CCTV footage from The Pines shows that at 5.16am the next morning he went to the staff office as he had locked himself out of his bedroom, while running a bath. An approved premises assistant went back to his room with him and opened the door.

29. At 8.10am, the man's uncle telephoned The Pines to tell them his nephew had left his epilepsy medication at his home and he had not been able to contact him on his mobile telephone. Another approved premises assistant said he would check on him. He knocked on his door, but got no reply. Staff are not allowed to go into a resident's room by themselves, so he asked another assistant to come with him. They went into the room, but he was not there. Another resident said that the bathroom door had been closed for some time. They asked an operational support manager to come.

30. The manager opened the bathroom door and found the man in the bath, with his mouth and nose under the water. He was not breathing and did not have a pulse. The manager lifted him from the bath and one assistant called an ambulance. Although the manager reported that rigor mortis (the stiffening of the body after death) was present, the ambulance operator advised him to start chest compressions, so he did. At 8.28am, an emergency ambulance arrived. Paramedics pronounced him dead at 8.59am.

Informing the man's next of kin

31. The local police informed the man's uncle, his next of kin, of his death. Ford appointed a family liaison officer. He went to see the man's uncle at his home, later that day. In line with national guidance, the prison made a contribution to his funeral expenses.

Support for staff and residents

32. Managers at The Pines offered support to the staff. Residents at The Pines were told individually by staff of the man's death. Keyworkers offered individual support to any resident who wanted to discuss their reactions, with the option of additional services (including counselling) if necessary.

33. Ford did not hold a debrief as the man was not in the prison at the time of his death. The duty manager and the safer custody manager informed prisoners on his wing and a notice informed all staff and prisoners. A member of the safer custody team spoke to prisoners considered at risk of suicide and self-harm, in case they had been affected by his death.

Post-mortem

34. A post-mortem examination concluded the man died as a result of epilepsy. However, the level of epilepsy medication was within the usual therapeutic range and he was unlikely to have missed a dose.

ISSUES

Clinical care

35. The clinical reviewer considered that the man's death from epilepsy was unexpected and could not have been anticipated by healthcare staff at Ford or by staff at The Pines. He noted that his compliance with his epilepsy medicine regime was sometimes poor and that, whenever he missed his evening dose, he was at risk of having a seizure. However, the post-mortem showed his level of epilepsy medication was within the usual therapeutic range suggesting that he had not missed a dose.

36. The clinical reviewer commented on the impracticality of staff supervising the man taking his epilepsy medication as his evening dose was due at a time when healthcare staff were no longer on site. He always collected his medication on time and Ford had no evidence he was misusing his medication. The clinical reviewer considered that Ford's approach was appropriate for an adult person with full mental capacity. We agree that it is appropriate for prisoners in open prisons to be responsible for managing their own medication and have the autonomy they would have in the community. It does not appear that he missed his dose the night before he died.

37. The man admitted to taking illicit drugs while in prison. The clinical reviewer commented that opiate misuse lowers the seizure threshold, as do other instability factors, such as stress, fatigue and infection. However, a drug and alcohol test, administered at the approved premises the night before he died, to check his compliance with the conditions of his temporary licence, was negative.

38. The clinical reviewer concluded the standard of clinical care provided to the man was equal to that he could have expected tor receive in the community. He did not make any recommendations.

In-possession risk assessment

39. The probation service officer said she allowed the man to keep his medication in his possession, because he "presented as well and was only staying for a short period of time" and because he would be eating with his family, not at The Pines. (His medication needed to be taken with food.)

40. The Deputy Head of Dorset Probation Service told us that an in-possession medication risk assessment was not carried out for several reasons: the man's medication was not due to be kept within the approved premises but at his uncle's home, where he planned to spend the majority of his time; his medication was not considered high risk and; no difficulties were identified.

41. Although national guidance states that approved premises are required to keep records relating to each resident, including in-possession medication risk assessments, we accept that in the man's circumstances it was proportionate and reasonable not to conduct one. He had been assessed as suitable to

manage his own medication at the prison and it is difficult to see how staff at The Pines could have reached a different conclusion, especially when he had also been assessed as suitable for temporary release in the community as part of his preparation for release.

Emergency response

42. The Approved Premises Manual 2014 states “all staff involved in the supervision of residents should attend an emergency first aid course”. However, of the staff on duty at the time of his death, only two had relevant training. Although it would not have changed the outcome for him, it is important that there are sufficient first aid trained staff on site, in line with national guidance. We make the following recommendation:

The Manager of The Pines should ensure that staff have up to date first aid training in line with national guidance.

RECOMMENDATION

1. The Manager of The Pines should ensure that staff have up to date first aid training in line with national guidance.

Action Plan

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	**The Manager of The Pines** should ensure staff have up to date first aid training in line with national guidance.	Accepted	All permanent staff have at least Basic First Aid at Work training, with a number having the full 4 day, examined, First Aid at Work qualification. The manager ensures that staff receive refresher training within a 3 year period of the initial training and for most staff this will be due in 2015. The manager will arrange the relevant refresher training via the Civil Service Learning site and will review the proportion of staff who hold the full qualification. The manager, together with the deputy, will review rotas to provide assurance regarding the presence of appropriately trained staff and ensure that there is never a situation where two staff without at least basic training are on duty at the same time.	**30th June 2015 for refresher training.** **31st December 2014 for the review of the rota**