Investigation into the circumstances surrounding the death of a woman at HMP Cookham Wood in October 2006

Report by the Prisons and Probation Ombudsman for England and Wales

February 2010

This is the final report of an investigation into the death of a woman who died at HMP Cookham Wood in October 2006. The woman who is the subject of this report was discovered unconscious and unresponsive in her cell, and the efforts of prison staff and paramedics to revive her were sadly unsuccessful. The cause was sudden death due to epilepsy. The woman was 44 years old.

I offer my sincere condolences to the woman's family and her many friends at Cookham Wood.

The woman was a foreign national prisoner who, for much of her time in custody, had been appealing against a plan to deport her to Uganda at the end of her sentence. However, shortly before her death she withdrew her claim for asylum.

The woman had reported being a victim of kidnapping and torture by troops in her home country. In custody, she exhibited signs of anxiety and had been placed several times on a regime designed to prevent her from self-harm or suicide. She herself said that she was mentally ill. Psychiatric assessments and frequent contact with the prison's Mental Health In-Reach team (MHIT) did not diagnose an enduring mental illness, and she was thought to suffer from Post Traumatic Stress Disorder (PTSD).

I would like to thank the then Governor of Cookham Wood and his staff for their help during this investigation. The death of this woman was the first at Cookham Wood since my office took responsibility for investigating deaths in prison in 2004. Since the investigation began, Cookham Wood has changed from a prison holding women to one that holds young offenders and juvenile young men under the age of 18.

I much regret the length of time it has taken to complete this report. However, following my receipt of the clinical review I judged it right to request a more in depth analysis of the issues pertaining to epilepsy and the management of the woman's care. The Coroner held a pre-inquest hearing in July 2008 and other matters for consideration arose out of that. I took the unusual step of issuing a revised draft in light of that pre-inquest hearing and representations from the prison doctors and Prison Service regarding some of the content of the original draft report.

In January 2010, the Coroner reopened his inquest into matters touching the death of the woman, but this has since had to be re-scheduled for later this year. I had intended to delay the issuing of this final report until after the conclusion of the Coroner's inquest, but have revised that position in light of the further delay to this process. Inevitably the inquest might lead to greater understanding of some of the more uncertain aspects of this report, which I hope will benefit the woman's family.

A key individual in the care provided to the woman was a nurse who shall be referred to in this report as Nurse A. It is now known that she took a call from a consultant neurologist who was assessing the woman for epilepsy and failed to pass on very important information. There was a very lengthy delay before my investigator was able to trace and interview Nurse A. She was finally interviewed in February 2009.

There are a number of strong recommendations emerging from the clinical review into the woman's death with regard to the management of her fits and the escorting responsibilities of the prison. The clinical review and subsequent Root Cause Analysis (RCA) have also highlighted the importance of maintaining clear and contemporaneous medical notes, an issue not confined to Cookham Wood. The revised draft did not alter the recommendations I made in my original draft, except to additionally recommend consideration of referral of Nurse A to the Nursing and Midwifery Council by Medway Primary Care Trust (now NHS Medway). This final report includes information about the actions the PCT and Prison Service have taken regarding the recommendations made.

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

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

CONTENTS

SUMMARY

This woman, who is the subject of this report, a foreign national prisoner, was a popular prisoner with staff and her peers at HMP Cookham Wood. She was also an anxious woman, fearing that her claim for asylum would be rejected and that she would be deported to Uganda where she had previously been tortured. Without explanation, the woman withdrew her asylum claim shortly before her death and said that she was looking forward to her return to Uganda.

Whilst in prison the woman claimed that she responded to voices in her head telling her to harm herself and to take her clothes off. Although her self-harming was described as superficial, at Cookham Wood she was placed on the F2052SH (a regime designed to support those prisoners in crisis to prevent them from self-harm) on three occasions. She was not subject to this regime at the time of her death.

In May, November and December 2005, the woman suffered fits for which she was referred to the local hospital for further investigation. Investigations to establish whether epilepsy was a cause of her fits were inconclusive as the woman was unable to give a comprehensive medical history and only one of her fits had been observed and recorded. She was seen by a consultant neurologist at a hospital in early August 2006, but a firm diagnosis of epilepsy was never made. The neurologist was not made aware that she had been prescribed anti-convulsant medication since December 2005. The review of the clinical issues has highlighted the time it took for the woman to be referred and seen by a neurologist. The prison doctor prescribed anti-convulsant medication for the woman (a matter of considerable discussion in this report) in contrast to guidance issued by the National Institute for Clinical Excellence (NICE) Epilepsy Clinical Guide 2004. Three weeks before she died, the dosage of the woman's anti-convulsant medication was reduced. It is not clear why this occurred.

In October 2006, the woman was discovered unconscious and unresponsive, alone in her single cell. Prison staff and paramedics attempted resuscitation, but she was pronounced dead. She was 44 years old. The post mortem indicates that the cause of the woman's death was Sudden Unexpected Death due to Epilepsy (SUDEP).

THE INVESTIGATION PROCESS

1. The investigation into the circumstances surrounding the woman's death was opened by one of my investigators when he visited HMP Cookham Wood in early November 2006. Notices had been issued to staff and prisoners informing them of the investigation and offering the opportunity to speak with my investigator. My investigator also wrote specifically to a number of prisoners. None of the prisoners came forward in response to my notice or letters. Some members of staff who discovered and treated the woman were interviewed in the following months.

2. The Governor and his staff produced the woman's core record, medical record and other documents for review.

3. Medway Primary Care Trust (PCT) (now NHS Medway) was commissioned to conduct a clinical review into the care and treatment that the woman received whilst at Cookham Wood. The Medical Director of Medway PCT carried out the review. Following this review I took the unusual step of requesting a more in-depth Root Cause Analysis (RCA) into the matters raised in the clinical review in respect of epilepsy. The RCA was conducted by a panel facilitated by the National Patient Safety Agency with clinical expertise from the Clinical Governance Lead for Medway PCT.

4. One of my Family Liaison Officers contacted the woman's cousin and identified next of kin in October 2006. He was offered the opportunity to meet with my Family Liaison Officer and the investigator to discuss the purpose of the investigation and to raise any concerns or questions the family would like addressed. The Family Liaison Officer met with the woman's cousin and his solicitor in November 2006. The cousin was concerned that the woman's history of fits was not properly diagnosed or managed appropriately whilst she was in prison. He was also concerned that the woman was not the subject of regular observations at the time of her death, despite her history of fits. The family were also concerned about the management of the woman's mental health and wanted to be assured of the efforts that were made to keep the woman alive.

5. My investigator contacted Her Majesty's Coroner by letter to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Following receipt of my draft report in June 2008, the Coroner convened a pre-inquest hearing in July 2008. New information came to light at the hearing and, as a result, I decided to take the unusual step of issuing a revised draft report. This is to reflect certain matters that came to light at that meeting, in particular the identity of the nurse who was involved in the care of the woman at a crucial point. My final report will also be sent to the Coroner to assist with the inquest.

6. This report has been completed by another of my investigators because the original investigator has moved to another job. It has taken much longer than I would have liked due to the complex nature of the clinical review, the RCA and the additional information from the pre-inquest hearing, but I thought it

was necessary to obtain as much information as possible, both for the Coroner's inquest and the woman's family.

7. The nurse identified at the pre-inquest hearing as playing a pivotal role in the care of the woman is referred to in this report as Nurse A. Despite vigorous efforts by my investigator to obtain a response from her, Nurse A could not be interviewed until 26 February 2009. I have therefore been left with no alternative but to reflect those difficulties within this report.

HMP COOKHAM WOOD

8. HMP Cookham Wood opened in 1978 and, at the time of the woman's death, was a closed women's training prison for adult women, taking convicted prisoners with sentences ranging from two weeks to life. There was a separate unit (Sir Evelyn House) which held juvenile young women.

9. At the time the woman died, the main prison could hold up to 168 prisoners. The establishment was based on two wings with three landings on each wing with single cells.

10. Cookham Wood had a type-two healthcare centre (with no inpatient beds and without 24-hour nursing cover). Doctors held daily weekday surgeries and also provided out of hours cover. Provision for mental health was provided by West Kent Mental Health Trust.

11. At the time of the investigation approximately one-third of the prisoners were foreign nationals. A probation officer undertook the responsibilities of a Foreign National Liaison Officer. Quarterly immigration surgeries were held at the establishment.

12. In her unannounced inspection report of Cookham Wood for May 2005, HM Chief Inspector of Prisons said that staff-prisoner relationships were mutually respectful. Most of her earlier recommendations to reinforce respect had been implemented, notably the introduction of a personal officer scheme and better support for black and minority ethnic and foreign national prisoners.

13. In September 2007, Cookham Wood changed its function from being a women's prison to one holding young male offenders. The recommendations made in this report reflect the way prisoners and regimes were managed at the time of the woman's death.

EVENTS LEADING UP TO THE WOMAN'S DEATH

14. In October 2004, the woman was placed in the Care and Separation Unit (segregation unit) at HMP Holloway because she had damaged a bank of computers in the education wing valued at £15,000. The woman said that she was responding to voices in her head, and was referred to the prison's Mental Health In-Reach team (MHIT).

15. The medical record of December 2004 indicates that on 2 December, when she was seen by a visiting psychiatrist, the woman complained of hearing voices in her head telling her to jump out of windows and take her clothes off.

16. In January 2005, the woman was transferred to HMP Send but she returned to Holloway the same day as Send did not have any mental health nurses to treat her. On her return, she was referred to psychology for assessment and treatment. Arrangements were then made for the woman to transfer to HMP Cookham Wood.

17. Five days later the woman transferred to Cookham Wood where she underwent another health screen in early February. The woman was seen by a mental health nurse in early February and her medical record indicates that, whilst she did not feel depressed or suicidal, she continued to hear voices inside her head. She was also finding it difficult to sleep because of nightmares. The woman's referral to the MHIT at Holloway was also noted at Cookham Wood. The medical record said that she was taking respiridone (an anti-psychotic) and venlafaxine (an anti-depressant). The woman was assessed for in cell medication but was considered to be a vulnerable prisoner who might be bullied. Because of this risk she was given her medication under the supervision of healthcare staff. This initial health screen was followed up by a more in-depth assessment by the Mental Health In-reach team at Cookham in February and again later that month.

18. In March, the woman was seen by the MHIT who thought she was not suffering from an enduring mental illness. The MHIT noted that the woman was worried about her application for asylum and that this dominated her thoughts. In April, the woman was seen by a doctor, who will be referred to in this report as Dr B, who advised a change in her medication.

19. In May, healthcare staff attended to the woman who appeared to have suffered a fit. She was taken by ambulance to hospital where she had a blood test and an ECG (a reading of the electrical activity of the heart). She returned to Cookham Wood later that evening. The hospital advised that there should be a follow up referral to a neurologist. The clinical review has established that a letter of referral was not written until October.

20. The medical record notes that in May the woman was distressed about the voices inside her head and that her medication was not working. Healthcare and wing staff gave her support and reassurance.

21. In August, the woman was seen again by the MHIT and it was noted that she was experiencing poor sleep and voices in her head that were telling her to take her clothes off. The woman denied any thoughts of self-harm or suicide. On 29 September, the medical record notes that the woman appeared to be much the same.

22. The medical record notes that on 4 October the woman fell in the dining room although she did not sustain any physical injury. On 10 October, the woman was seen by MHIT after she assaulted another prisoner. The woman said that she was responding to voices inside her head. The medical record indicates that the woman was seen by Dr B for her medication to be reviewed.

23. The woman was seen again by the MHIT on 25 October. It was noted the woman had superficial cuts to her right forearm. Her medical record says that she stated she could not remember when the cuts had been caused and continued to deny any thoughts of self-harm. There was no evidence that a form F213 was completed or that an F2052SH was opened at this time. (An F213 should be completed in all instances where an injury occurs to a prisoner. The F2052SH system was a process in place at the time. It was designed to ensure that as much help as possible was given to a prisoner during a period when she was perceived to be at risk of self-harm or suicide.)

24. On 31 October, Dr B changed the woman's medication as she continued to say that she could hear voices in her head. She was prescribed trazadone for depression and sulpiride which is used for schizophrenia. Dr B wrote in the notes that the woman had been referred to the Neurological Unit of a hospital and that she had refused to see the Post Trauma Stress Counsellor, adding that the woman said she was suffering from a mental illness. According to the entries made in the medical notes, there was no abnormality of level of consciousness observed during interview.

25. The medical record indicates that on 2 November healthcare staff were called to see the woman who appeared to have suffered a fit. Support and reassurance was given to her and she was referred to the doctor. The woman was monitored for hypertension (high blood pressure) on 4 December and again on 5 December.

26. On 20 December, healthcare staff were called again to attend to the woman as she appeared to have suffered a fit (her third on record). On 21 December, the record notes that the woman might have a history of epilepsy. She was prescribed epilim (an anti-convulsant drug) and her response to the medication was to be reviewed in due course. The clinical review states that the woman continued to receive a low dosage of epilim up to the time of her death.

27. By late December 2005, entries in the woman's medical record and core record indicated that she was concerned about parole and feared being released to the care of a hostel rather than a hospital environment.

28. The woman spoke to an officer on 21 February 2006 and said that she was still hearing voices in her head.

29. On 2 March, the woman complained of pain in her right shoulder. She was subsequently referred for physiotherapy on 14 March but this does not appear to have been followed up. The same day, the woman was seen by a nurse, who shall be referred to in this report as Nurse C, from the MHIT who noted that the woman again had superficial scratches to her left arm. The woman continued to deny any thoughts of self-harm, but no attempt appears to have been made to open an F2052SH at this time.

30. On 23 March, the woman was observed to be talking and associating with prisoners quite normally, but during a session with In-Reach she presented as a non-communicative, morose individual who answered each question with "I can not remember". On 6 April, the woman's personal officer noticed that she was increasingly worried about being deported after her sentence.

31. An officer, who shall be referred to as Officer D in this report, made an entry in the woman's history sheet on 12 April that he had recently helped the woman to write to the Home Office enquiring about her claim for asylum. The woman was also trying to get contact details for solicitors to act on her behalf, which Officer D was again trying to help her with. Another officer, who shall be referred to in this report as Officer E, told my investigator that on occasions she would help the woman with correspondence relating to her asylum claim.

32. On 19 April, an F2052SH was opened after the woman told staff that she wanted to die, fearing that she would be deported to Uganda. The woman said that the voices in her head were telling her to harm herself. In light of this, the woman was observed and checked by officers every half an hour. Support and reassurance was given and a change in her medication was considered. On 22 April, the F2052SH was closed in consultation with the woman, although it was noted that she continued to hear voices.

33. The core record indicates that on 25 April the woman's security categorisation was reviewed. However, in view of the seriousness of her offence and the high risk of re-offending, in conjunction with her feelings of self-harm, she was to remain in closed conditions. An entry in the woman's core record for 31 August suggested that she would find it difficult to cope in an open prison.

34. The medical record for 10 May indicates that the woman was still hearing voices inside her head that told her to walk naked. She was seen again by the MHIT on 25 May. On this occasion it was noted that the woman was morose during interview, although she displayed no signs or symptoms of psychosis. She was observed smiling and laughing with other prisoners and healthcare staff both before and after her interview with Nurse C. The decision was made that she did not need to be seen by the Mental Health In-Reach team, but could be looked after by the primary care services.

35. By 13 June, the woman was still on the standard prison regime under the prison's Incentives and Earned Privileges Scheme but had been warned by

staff that she could be downgraded to basic if she received further warnings. The woman had been warned on several occasions for failing to obey instructions, although generally she was a compliant prisoner.

36. On 20 June, the woman told staff that she was going to kill herself. The medical record describes her as low in mood and anxious about her asylum appeal. An F2052SH was opened and the woman was to be observed every hour. Support from discipline officers and healthcare staff was offered and the woman was reminded that she could talk to the Samaritans or a prison Listener (a prisoner trained by the Samaritans to offer support to their peers) at any time. An entry in her F2052SH on 21 June recorded that the woman said that she had nothing to live for if she returned to Uganda. She said she had been told by the Immigration Service that she would be deported in September 2006.

37. Officer E spoke to the woman on 25 June and warned her about taking her clothes off as male officers were carrying out some of the observations required for the F2052SH. Staff told my investigator that the woman was frequently naked, saying that the voices in her head were telling her to do so.

38. On 6 July, the woman's solicitors asked for a report on her mental health that might be used to support her asylum claim.

39. The woman continued to be the subject of hourly checks by prison staff until 27 July when the F2052SH was closed. During that time she was pre-occupied with the status of her appeal to stay in the UK and had been in contact with the Home Office and solicitors. Support mechanisms for the woman were put in place that included the healthcare team, discipline staff, and daily visits by the chaplaincy. The woman claimed that she continued to hear voices inside her head telling her to harm herself and take her clothes off and that the medication she was prescribed was not working.

40. On 1 August, five days after the second F2052SH was closed, the woman was seen to have cuts to the top of her left arm whilst queuing for her medication. She again claimed to hear voices telling her to harm herself and said that she would be killed if she returned to Uganda. She was taken to hospital by ambulance under escort and returned later that day following treatment. An F2052SH was opened once again, and the woman was observed frequently.

41. A letter in the medical record dated 4 August notes that, following investigations by a consultant neurologist at the hospital, a firm diagnosis of epilepsy had not been made. The woman was not able to give a clear history of fits and only one of the fits had been observed by medical staff. The consultant spoke to a nurse at Cookham Wood. The consultant neurologist said the nurse told her that the woman's convulsions appeared to have ceased after stopping her respiridone (anti-depressant) medication. In interview, Nurse A remembered speaking with the consultant neurologist but thought that she told the consultant neurologist that the prison's GP had said something about respiridone having side effects of fits. Nurse A said that she

did not remember telling the consultant neurologist that the woman's fits had stopped because she was no longer taking respiridone.

42. In a letter to the prison, the consultant neurologist advised that, as nothing abnormal was detected, anti-epileptic medications were not appropriate and should not be prescribed. The clinical review has established that the consultant neurologist was not made aware that the woman had been prescribed epilim chrono 200mgs twice daily since December 2005. When Nurse A was interviewed by my investigator, she told him that she did not have either the clinical record or the prescription sheet for the woman available to her, so could not have relayed completely accurate information about medication prescribed. The clinical review suggests that, had the consultant neurologist been made aware of precisely what the woman had been prescribed, she might have come to an alternative decision. ECG tests discounted heart problems as a cause of the woman's fits. My investigator established that the woman was not taking respiridone at the time of her death.

43. On 16 August, the woman was still anxious and upset that she had not heard about her asylum appeal. However, the observations were decreased to one an hour and she was to see the chaplain daily as part of her support plan. It seems that visiting the chaplaincy was a source of comfort and reassurance to the woman. On 30 August, the risk of the woman self harming was considered to have reduced and the F2052SH was closed. The woman was also pleased to learn that the prison doctor had written a report supporting her asylum appeal.

44. On 31 August, the woman attended the quarterly immigration surgery organised by the prison's Foreign National Liaison Officer (FNLO). The FNLO was a probation officer and consequently her time was not dedicated primarily to foreign national prisoners. As noted earlier, there was a high proportion of foreign national prisoners at Cookham Wood and my investigator was told that they presented significant demands on the FNLO. (The FNLO now works for my own office.)

45. The FNLO told my investigator that the woman attended the surgery and spoke to the immigration caseworker who advised her that, as she had appealed for asylum, she would not be entitled to state benefits on release. My investigator was told that following the surgery this information would have been confirmed to the woman in writing by the Immigration Service.

46. The clinical record says the woman wanted to see a nurse, who shall be referred to in this report as Nurse F, on 10 September 2006. She was told she would need to make an application to ask for an appointment. She complained that all the white people were being seen before her. The complaint was flagged and recorded as a racial complaint.

47. On 14 September, the woman was in an agitated mood, complaining of voices inside her head. Her mannerisms were also more pronounced than usual.

48. Four days later (18 September), the woman was placed on another F2052SH and put on hourly observations after telling staff that she was hearing intrusive voices telling her to harm herself and to be naked. The woman made superficial scratches to her left arm.

49. The medical record notes that on 19 September the woman wanted analgesia because of pain in her right armpit. It was noted that, although she had been referred for physiotherapy in March, it had not taken place and so a re-referral was made. On 21 September, the woman was seen by a registered mental health nurse at the RMN clinic and referred to the psychiatrist. Her medication was reviewed again and, after consultation, she was taken off sulpiride.

50. The Medical Director of Medway PCT's clinical review records that on 25 September the woman's dose of epilim was reduced to 200mgs daily (having been 200mgs twice a day). The clinical review establishes that there is no entry in the medical record to explain why this took place or who authorised it.

51. The woman was seen in healthcare on 27 September as part of the F2052SH review. The woman told staff that she continued to hear voices telling her to remove her clothes. It was also noted in the F2052SH that, following a change to the woman's medication, she felt a lot brighter although she was not sleeping well and was experiencing nightmares. Following the review, the F2052SH was closed.

52. The woman was placed on the special sick list on 29 September because she was sleeping poorly and complaining of voices in her head. Staff told my investigator that they sometimes found it difficult to rouse the woman because of the medications she was prescribed.

53. On 4 October, the woman attended the immigration surgery and told the caseworker that she wanted to withdraw her claim for asylum. The prison's FNLO told my investigator that she was surprised to learn that the woman had given up her appeal and wanted to return to Uganda. The decision was in stark contrast to the woman's feelings before. The woman was told by the immigration caseworker that, in light of her decision, deportation papers would be served on her in due course. The woman's cousin told my family liaison officer that, in the days preceding her death, he received a telephone call from the woman saying that she was returning to Uganda. The woman appeared to be excited about the prospect. Staff told my investigator that they were surprised at the woman's decision.

54. The co-ordinating chaplain told my investigator that in the days before her death the woman presented a totally different demeanour and was looking forward to returning to Uganda where she had business interests. The co-ordinating chaplain recalled that the woman often visited the chaplaincy where he thought she found solace and respite.

55. On 12 October, the woman changed jobs in the prison and worked in the larger workshop making tee-shirts. She was pleased about the change but

concerned because her cell had recently been searched by staff. It emerged during the investigation that the checks were routine cell and fabric checks and that the woman had been given reassurance.

56. The record notes that on 12 October the woman was rude and abusive to healthcare staff and was put on a disciplinary report by an officer who shall be referred to in this report as Officer H. At her adjudication hearing, the woman claimed that she swore at a nurse because the voices had told her to do so. The woman's punishment was three days loss of association (so that for three days, during association time, she was not allowed out of her cell to interact with other prisoners). Officer H told my investigator that the woman was apologetic about the incident and accepted the consequences of her action.

57. At 7.28pm on 14 October, an entry by Officer H in the core record indicates that the woman was warned for inappropriate behaviour in the dinner queue. Officer H told the woman that if this behaviour continued she would be placed on a disciplinary report.

58. In a statement following the woman's death, Officer E wrote that on the morning of 15 October the woman had been on association and there was nothing untoward. In view of the woman's recent punishment, it would appear that this was an oversight on the part of officers on the wing. Officer E confirmed that, following her recent adjudication, the woman was not allowed on afternoon association. She remained locked in her cell that afternoon. The woman was not subject to any formal observation regime because she was not on F2052SH procedures.

59. Lunch was served on the wing at about 12.15pm. In a brief note taken during the 'Hot debrief' following the woman's death, it was noted that the woman had been observed at lunch-time chatting cheerfully to other prisoners. Closed Circuit Television (CCTV) images indicate that at 12.34pm Officer E locked the woman's cell. Officer E told my investigator that the woman's demeanour did not raise any concerns. An officer, who shall be referred to in this report as Officer J, told my investigator that after lunch the woman was accidentally unlocked with other prisoners for afternoon association. She tried to hide from staff in the association area, but was easily detected because her physique was such she could not hide easily. This, it emerged, was something that she did to amuse herself. The woman was locked back in her cell (number S2-09). Officer J said that he was not concerned about the woman and that she did not raise any concerns with him, his colleagues or other prisoners that afternoon.

60. The CCTV images for 15 October were supposedly saved by the prison. However, it emerged during the investigation that the prison did not have the appropriate computer software to download the images. When an attempt was made to retrieve them they had been wiped clean. However, a handwritten note of events was made from the CCTV tape before this retrieval process was started.

61. All prisoners were locked behind their cell doors from 12.45pm until 1.45pm. They were then unlocked for afternoon association.

62. The CCTV log indicates that, at about 4.56pm, an officer, who shall be referred to in this report as Officer K, unlocked the woman's cell in preparation for serving the evening meal. Officer K called to her a couple of times but did not receive a response. The officer continued to unlock other prisoners on the wing, and did not consider the woman's lack of response as anything unusual as she was known to be a deep sleeper.

63. Officer K returned to the woman's cell a little later to see if she had woken up. The officer entered the cell and called out to the woman a few more times but with no response. She nudged the woman's arm to elicit a response but there was none. Officer K wrote in her statement that the woman was breathing and so, knowing that the woman was a deep sleeper, she left her cell.

64. At about 5.25pm, an officer, who shall be referred to in this report as Officer L, was completing an F2052SH review on another prisoner. The officer then assisted Officer E to lock up all the prisoners on the landing for the night.

65. At about 5.30pm, Officer E and Officer L were undertaking the roll check of prisoners for the evening. This entailed looking through the flap of the cell door and confirming the number of prisoners in the establishment for the night. Officer E wrote in her statement that the woman was lying on her right side under the covers and that her head was visible from the eyes upwards. Officer E told my investigator that the duvet cover was up to her eyes. The officer also told my investigator that the woman was breathing and that she gave no cause for concern. Officer E said that she was reluctant to wake the woman because she was known to be a deep sleeper. Officer E then went off duty at about 5.45pm.

66. An officer, who shall be referred to in this report as Officer M, unlocked cell S2-09 at about 5.55pm so that the woman could receive her medication. (Prisoners who require medication were unlocked one at a time and queued at the medication hatch.) Officer M called twice to the woman but did not receive a response. Knowing that the woman was a deep sleeper, Officer M shook her arm but again did not receive a response. (In the 'Hot debrief' following the woman's death, Officer M said that she initially thought the woman was praying in bed.) Officer M then called to Officer J who was in the vicinity. Officer J entered the cell and the officers checked for the woman's vital signs but could not find any. When the officers opened her eyelids, the woman's eyes were bloodshot and opaque. In preparation for cardio-pulmonary resuscitation (CPR), the woman was placed on the floor. Officer M then began CPR. In the meantime, Officer J tried to use his face mask to assist in the resuscitation effort but told my investigator that he found it very difficult to get an airway as the woman's jaw was shut. A nurse, who shall be referred to in this report as Nurse N, arrived in the woman's cell and took over from Officer J before he started to assist in CPR.

67. Officer J tried to contact a senior officer, who shall be referred to in this report as Senior Officer P, by using his personal radio to tell him of the situation and to request an immediate 'Code Blue' response. (This call sign is used to indicate to healthcare staff that a person is not breathing). However, the battery in the officer's radio was low and a partial message was sent. Notwithstanding this, Senior Officer P understood the message and immediately contacted the Control Room via his radio and asked for a Code Blue healthcare response. Senior Officer P then went to the cell.

68. An Officer Support Grade (OSG), who shall be referred to in this report as OSG Q, called for an ambulance at 5.57pm. A rapid response paramedic arrived at the establishment at about 5.59pm and was escorted to the cell. The paramedic took over CPR from prison staff. The ambulance arrived at Cookham Wood at about 6.09pm.

69. At about 6.05pm, Officer H was on duty at the medication hatch and heard the Code Blue request over her radio. Officer H told my investigator that because of the urgency and tone of the message she told Nurse N, who was distributing medication at the hatch, to attend immediately. Meanwhile, Officer H locked away the prisoners who were queuing for their medication.

70. Nurse N went into cell S2-09. In her statement, she noted that Officer M had started chest compressions. Nurse N took over from Officer J and continued with resuscitation. Officer J told my investigator that Nurse N instructed him to get the oxygen from a nurse, who shall be referred to in this report as Nurse R, who was on duty at the medication hatch. Officer J ran the short distance to the hatch, and asked for the oxygen. However, Nurse R said that the oxygen was located in the Respite and Care Unit (RCU) where it had been used the night before. Both Nurse R and Officer J went to the RCU but were told that the oxygen could be found in the healthcare centre. Having got the oxygen, they ran to the woman's cell. Officer J said that the time taken to deliver the oxygen to Nurse N was a matter of seconds because of the short distances involved. Nurse R assisted with the effort to resuscitate the woman whilst Officer J was detailed to meet and escort the ambulance from the front gate.

71. Officer H entered the cell and witnessed the CPR efforts being undertaken by Officer M and Nurses R and N. Oxygen was being used on the woman. Officer H remained in the cell and provided a running commentary over her radio to Senior Officer P and another officer, who shall be referred to in this report as Officer S, who was instructed to maintain a written log of events.

72. Despite the efforts of staff and paramedics, the woman was pronounced dead at about 6.19pm. She was certified dead by a doctor at 7.25pm. My investigator was told that all staff who treated the woman had up to date CPR qualifications.

EVENTS AFTER THE WOMAN'S DEATH

73. Following the woman's death, Cookham Wood implemented its contingency plan for a death in custody. Prisoners on the woman's wing who were subject to F2052SH monitoring were checked by Officer S. They were also offered the support of a Listener and the chaplaincy.

74. Staff who had been involved in the discovery and treatment of the woman were taken to the Respite and Care Unit and offered the support of the prison care team. Staff from the juvenile side of the complex were brought in to assist with running the main prison.

75. The woman's cell was closed at 6.25pm to await the arrival of police. The police were contacted at 6.50pm. My investigator contacted the police and they confirmed that the woman's death was not suspicious and not subject to any criminal proceedings.

76. The Duty Governor was contacted by Senior Officer P and was told what had happened. The Duty Governor returned to Cookham Wood and was nominated as the prison's family liaison officer. The Duty Governor also facilitated the 'Hot debrief' and took a note of the events leading up to the woman's death.

77. My investigator was told that a Governor, who shall be referred to in this report as Governor T, was contacted at home and he returned to the prison. Together with the prison chaplain he went to the room of every prisoner and personally informed them of the woman's death. Governor T and the co-ordinating chaplain took time to reassure the prisoners and gave them time to talk about the woman or say a prayer.

78. Immediately following her death, it was established that the woman had not nominated a next of kin and there was some difficulty in identifying one. The Duty Governor told my investigator that the woman's family, primarily her mother, did not speak English and lived in a remote part of Uganda where communication was difficult. The Duty Governor sought the assistance of the Ugandan High Commission but they were unable to help. The Duty Governor also had some contact with the British High Commission in Uganda and explained the situation to a representative, asking for assistance in breaking the news of the woman's death. The Duty Governor then contacted a member of the chaplaincy at HMP Swaleside who had contacts in Uganda. These actions were commendable.

79. Further investigation of the woman's prison telephone records revealed that she had made a number of calls to a number in London. The Duty Governor telephoned the number the following day and ascertained that this was her cousin and her only relative in the UK. The woman's cousin was then told of her death. This was an unfortunate way of being informed, but I judge that it was unavoidable in the circumstances. The cousin became the acknowledged next of kin and liaised with the woman's family in Uganda.

80. Prisoners and staff were formally told of the woman's death by Governor T in October by publication of Notices to Prisoners and Notices to Staff. The woman was popular and prisoners and staff were saddened at her death. A memorial service for the woman took place on that day, and was well attended. My investigator also learnt that a fund was underway to dedicate a memorial in the garden to the woman.

81. The woman's cousin visited Cookham Wood on 18 October, and spoke to a number of staff and prisoners who knew her. He also visited the cell where the woman had died. The cousin has maintained frequent contact with the Duty Governor and has said that he has found the Duty Governor amenable, friendly and sympathetic.

82. The prison agreed to pay towards repatriation of the woman's body and funeral expenses. In an attempt to facilitate communication about the funeral arrangements, the prison also paid for a mobile phone for the woman's mother. I commend this as both a sympathetic and effective way of overcoming the communication difficulties, and have formally identified it as good practice.

83. The woman's funeral took place in Uganda in December 2006.

ISSUES CONSIDERED DURING THE INVESTIGATION

Mental Health

84. The Medical Director of Medway PCT's clinical review says that the woman had mental health problems and had reported hearing voices for many months. The woman was also diagnosed as suffering from PTSD resulting from her experiences in Uganda. However, she refused psychological intervention and maintained throughout her sentence that she was mentally ill and asked to be treated accordingly. Despite various psychiatric assessments and frequent, structured contact with the prison's MHIT, the woman was not diagnosed with an enduring mental illness. I suspect that the threat of deportation weighed heavily on the woman's mind and probably exacerbated her mental state, although some people felt that the woman might have exaggerated her symptoms in the belief that this would support her asylum claim.

85. In response to hearing and responding to the voices inside her head telling her to harm herself and take her clothes off, the woman was prescribed anti-depressant medication which was regularly reviewed by the visiting psychiatrist. The woman was monitored and treated regularly by the MHIT. It is also apparent that her medications made her calm but very drowsy and at times she was difficult to rouse. At the time of her death, the woman was not taking the medication respiridone, and it had been noted that her fits stopped after she was taken off the medication.

86. The woman's cousin asked if the woman received appropriate care from mental health services whilst in prison. I believe the management of the woman's mental and psychological conditions was of an appropriate standard and that it matched what she would have received had she been in the community. This view is supported by the clinical reviewer who says that the woman's treatment "appears to have been regularly monitored and only altered on the advice or instruction of appropriate psychiatric professionals".

Treatment of physical health

87. The woman received regular observation and input from the healthcare team, primarily for her mental health needs and it is evident that she had regular contact with the MHIT in regard to her complaint of intrusive voices in her head. However, it is noted that in March 2006 she complained of pain in her right shoulder and was referred for physiotherapy. This does not appear to have been provided, and no one noticed that it had not been arranged until September when the woman again complained of pain in her arm.

The healthcare manager, in conjunction with the PCT, should ensure there is a robust system in place for appropriate prisoner-patient referrals to other multi-disciplinary health team members (including secondary care services).

88. When the woman harmed herself by making superficial scratches (18 September 2006) and cuts to her upper arm (1 August 2006), she received appropriate care and attention.

Operational matters

89. On discovering the woman unconscious and not breathing, staff responded quickly. However, it emerged at the 'Hot debrief' that an officer's personal radio did not work properly and that the oxygen bottle was not kept where staff expected it to be. I have been pleased to learn that, immediately following the woman's death, new batteries for personal radios were obtained. Radios are critical to maintaining effective communication in all situations.

The Governor should ensure that personal radio batteries are regularly checked by staff to maintain effective and continuous communication.

90. In regard to the location and accessibility of oxygen, whilst this was obtained quickly and did not affect the outcome, I consider it necessary to ensure that staff are reminded of its location.

The Governor, in conjunction with the healthcare manager, should review the location of oxygen and ensure that staff are made aware of its location and accessibility.

91. CCTV was used to monitor the landing where the woman was located and it was working at the time of her death. Following the woman's death the images were downloaded from the hard drive and onto a disk. The disk was then kept secure. However, the prison did not have appropriate software to download the images. Despite efforts to download them, the disk containing the images was destroyed and cannot be recaptured.

The Governor should ensure that arrangements are made for CCTV images to be downloaded using the appropriate computer software.

Management and support during crisis

92. From April 2006 until the end of September, the woman had threatened to harm herself in response to hearing voices inside her head. She had often told staff that she would be tortured and killed if she was deported to Uganda. The woman was placed on the F2052SH regime on three separate occasions. As a result, she was checked regularly and appropriately by staff. It is clear to me that healthcare staff, discipline staff and the chaplaincy gave the woman a great deal of support, comfort and reassurance during her times of crisis. Appropriate and balanced decisions were made in regard to taking her off the F2052SH regime. At the time of her death she was not considered to present a risk to herself and did not warrant formal or frequent observation. The toxicology report showed nothing abnormal in the woman's blood. The Post Mortem found no physical cause for the woman's death. This would indicate that the woman had not deliberately harmed herself (a matter my investigator considered from the outset of this investigation).

Communication of immigration status

93. At the time of the woman's death, approximately one-third of all prisoners at Cookham Wood were foreign national prisoners – some of whom had sensitive and complex immigration status that invariably took time to clarify and resolve. In the woman's case, her application for asylum had been rejected and she was in the process of appealing against deportation.

94. I am content that reasonable efforts were made by the prison to support and help the woman, and that she was made aware of the progress of her appeal through the quarterly immigration surgeries. The foreign national liaison officer (FNLO) and the immigration caseworker were surprised to learn that the woman had withdrawn her application for asylum on 4 October. In the weeks preceding her death, the woman told staff that she was looking forward to returning to Uganda – in complete contrast to her feelings before.

95. There are many challenges to the role of the FNLO. At Cookham Wood at the time, this was a split function with limited resources to assist (what was then) a significant proportion of prisoners. I believe it would be sensible to review the role of the FNLO to ensure that a consistent, timely and effective service is provided to those prisoners who feel anxious or unsure as to their immigration status or future. This might equally apply to Cookham Wood's new function of looking after young male offenders.

The Governor should review the role of the FNLO, not least to ensure that foreign national prisoners continue to receive timely updates as to the status of their immigration case.

Family liaison

96. The woman had refused to provide the prison with any details of her next of kin and none was noted in her records. Following the woman's death, the Duty Governor, the prison's family liaison officer, sought the assistance of the Ugandan High Commission and the British High Commission in Uganda in tracing and informing the woman's family. (The woman's family do not speak English and communication in Uganda is difficult.) I have also noted that the liaison officer sought the assistance of the prison chaplaincy who had some contact with Uganda. Unfortunately, these efforts were not successful but the Duty Governor's initiative should be commended.

97. The Duty Governor noticed that the woman frequently telephoned a number in London. She herself telephoned the number and established that it belonged to the woman's cousin, her only relative in the UK. It emerged that the woman had asked her cousin to be her next of kin but he was initially reluctant to do so. The cousin informed the woman's family of her death and has since taken on the responsibilities of next of kin. Whilst it was unfortunate that her cousin learnt of the woman's death by telephone, I consider that this was reasonable in view of the circumstances. The prison continued to offer

support to the woman's cousin, and this has included visits to Cookham Wood. This support has been favourably commented upon by the cousin.

The Governor should commend the Duty Governor for her initiative in difficult circumstances and for maintaining a good level of support for the next of kin.

98. Unfortunately, things did not go quite so smoothly when it came to the woman's property. The woman had money in her private cash account at the prison. The Governor of Cookham Wood sought guidance from Treasury Solicitors as to whom this money could be sent. The lawyers' advice was that legal documents such as a Grant of Probate or Letters of Administration issued under Ugandan law would be required before the cash could be released. It took several weeks and the intervention of solicitors for the family before the matter was resolved. Throughout this time, the woman's family in Uganda were denied access to much needed funds. This was a regrettable consequence of the woman being a foreign national prisoner.

The Prison Service should issue guidance on the distribution of property belonging to foreign national prisoners in the event of their death whilst in custody.

CLINICAL REVIEWS AND POST MORTEM

99. On 20 October 2006, a Post Mortem was undertaken to identify a cause of death. The report indicated that the woman's death was attributed to Sudden Unexpected Death in Epilepsy (SUDEP).

100. The Root Cause Analysis defines SUDEP as follows: "SUDEP is the sudden, unexpected, witnessed or unwitnessed, non traumatic and non drowning death in patients with epilepsy, with or without evidence for a seizure, and excluding documented status epilepticus, in which post mortem does not reveal a toxicological or anatomic cause of death." Toxicology results did not indicate anything unusual.

101. The clinical review was completed in January 2007 by the Medical Director of Medway Primary Care Trust. Following receipt of the review, my investigator and the Medical Director of Medway Primary Care Trust identified some unanswered questions that required more detailed consideration of issues related to epilepsy and the woman's epilepsy management. I therefore asked the PCT to commission a Root Cause Analysis. This was designed to give a greater understanding of the way healthcare services at Cookham Wood managed the woman's epilepsy and to determine if there had been any link to her death. The Root Cause Analysis (RCA) was conducted by a panel that included a clinical expert and a senior manager from the PCT. Also on the panel was a healthcare manager from another prison. The panel was facilitated by a member of the National Patient Safety Agency (NPSA) and supported by one of my investigators.

102. The RCA says that the woman experienced her first grand mal convulsion on 21 May 2005. Records indicate that there was no previous history of fits prior to this date. The woman was reviewed at a hospital's A&E Department where the opinion of the registrar was: "doesn't need admission or to start antiepileptic medication but needs to be referred to neurologist by her GP or prison medical officer".

103. The three permanent prison doctors wrote to me after I had issued my first draft report. In their letter, the doctors stressed that they were unaware of the woman's first fit on 21 May. The nurses on duty at the prison telephoned the on call doctor for advice and were informed they should send the woman to A&E – which they did. The doctor on call was a locum doctor. The three regular prison doctors were not informed that the woman had suffered a fit and been seen by the local A&E department. Neither were they made aware that any referral of the woman to a neurologist was necessary. This failing occurred both because there was an inadequate handover process between doctors, and because there was no system in place for following up patients who had been to an outside hospital and who might be awaiting further tests, letters or investigations.

The healthcare manager should ensure there are robust systems for handing over important information between clinicians to ensure the continuity of patient care.

104. There is no evidence of a discharge letter from A&E in the medical notes and the entry made on 21 May 2005 might have been interpreted to mean the woman had been referred to a neurologist by A&E ("Returned at 19.00. letter to follow. For FUA [follow up appointment] with neurologist.")

105. On 4 October, the woman had a fall. On 7 October she was seen by a doctor, who shall be referred to in this report as Dr V, who recorded in the medical notes: "has had two fits … last fit witnessed by the nurses. No aura … Refer neurologist." A letter of referral was sent shortly after this consultation, dated 12 October. Although the woman's first fit and attendance at A&E was on 21 May 2005, the prison doctors were not aware of this until the woman was seen by Dr V on 7 October when she saw the entry about the woman's fit and A&E attendance. Unfortunately, the woman did not get seen by the consultant neurologist until 1 August 2006, some 61 weeks after first being seen at A&E.

The healthcare manager should ensure that patients suspected of suffering from epilepsy are referred urgently to a specialist for further investigation and appropriate diagnosis.

106. From this referral (12 October 2005), a letter dated 10 January was received which invited the prison to make an appointment for the woman. An initial appointment date of 31 January 2006 was given (although it is unclear whether this was a date chosen by the prison). On 12 January 2006, a letter from the hospital was sent to the prison saying the prison had requested a cancellation of the appointment for 31 January and requested it be rearranged. The woman was given an appointment for 28 March. On 14 March, the hospital sent a letter changing the appointment to 21 March, but this was not convenient to the prison, so they cancelled and rearranged the appointment for 23 May which was confirmed by a letter dated 16 March. On 17 May, the prison again contacted the hospital and cancelled the appointment. The next appointment available was 1 August 2006.

107. It was seven months from the date of the first given appointment (31 January) until the woman's actual appointment (1 August). Each time a re-arrangement of her appointments occurred there was a subsequent delay of two months. There were, therefore, at least three missed opportunities for the woman to have been seen before her 1 August appointment. However, nobody was monitoring the long delay to which the woman was subject with respect to urgent neurological investigations.

The healthcare manager should devise a system to ensure that, when healthcare escorts are cancelled, the senior clinician prioritises the patient's clinical needs. This decision should be recorded in the patient's notes.

108. By the time the woman was seen by the neurologist, she had been receiving a low dosage of epilim for nearly eight months (since 21 December 2005) and had not experienced any further fits. The Medical Director of Medway PCT's

clinical review says it is not clear why the woman had been free from fits for ten months, although he concludes that it is possible she could have responded to the very low dosage of epilim. However, it does not appear that blood levels were available to determine whether or not a therapeutic level had been achieved at this dose. The Medical Director of Medway PCT says that the prescribed dosage of epilim was significantly below the recommended daily dosage, and he has questioned the efficacy of epilim with other medications that the woman was taking.

109. Best practice NICE Epilepsy Clinical Guidance 2004 states:

> "Diagnosis of epilepsy must be made by a specialist (usually a neurologist).
>
> "An adult with a suspected epileptic seizure should be referred urgently to a specialist.
>
> "Treatment with anti-convulsants should not be commenced prior to a definitive diagnosis except in exceptional circumstances.
>
> "Initiation, continuation and withdrawal of medication should take place under specialist supervision."

110. The Medical Director of Medway PCT's review and the RCA established that the doctor, who shall be referred to in this report as Dr W, had prescribed epilim chrono outside of the NICE guidelines. Dr W told the Medical Director of Medway PCT that his rationale was that the woman had suffered at least three grand mal convulsions and he was concerned that any further fits might prove fatal. Dr W therefore felt justified in prescribing anti- convulsant medication, albeit at a very low dose. He intended to review its effectiveness, but the woman was not seen for follow up appointments.

The healthcare manager should remind staff that all actions stated within the medical record must include a rationale, followed up with a review to confirm the action was undertaken and the outcome.

111. Both clinical reviews recognise that follow up appointments for blood levels should have been carried out, and that the system of communication for prisoners failing to attend follow up appointments was non-existent at the time. However, the consultant neurologist made the point to my investigator that blood levels are not the appropriate way to check if drugs such as epilim chrono are working for a patient. The only value of blood testing would have been to assess whether the patient was actually taking the medication – something that had not been in question with the woman. The best way to know if anti-convulsant medication is working is to see if it stops the fitting, which in this woman's case it appears the low dose had. However, the system for follow up appointments still failed the woman.

The healthcare manager should instigate a system whereby patients who fail to attend for medication or further appointments are followed

up. The follow ups should be recorded appropriately in the patient's medical record.

112. The Medical Director of Medway PCT's review says that the woman was not managed in accordance with the NICE guidance that relates to diagnosis and management of the epilepsies in adults in primary and secondary care. In particular, the guidelines advise that the diagnosis of epilepsy must be made by a specialist (usually a neurologist). An adult with a suspected epileptic seizure should be referred urgently to a specialist. Treatment with anti-convulsants should not be started before a definitive diagnosis is made except in exceptional circumstances. Furthermore, the initiation, continuation and withdrawal of medication should take place under specialist supervision. None of this best practice appears to have been complied with in this woman's case.

113. The clinical reviewers checked the validity of Dr W's decision to start anti-convulsant medication outside the guidance issued by NICE. The consultant neurologist confirmed that in these particular circumstances this was a reasonable course of action to take.

The healthcare manager should ensure that healthcare staff are reminded of the National Institute for Clinical Excellence guidance that relates to the diagnosis and management of epilepsy.

114. At the time the referral letter was written (12 October 2005), the woman was not on any anti-convulsant medication (which was not prescribed until December 2005). I also note that the consultant was not made aware in her telephone call with Nurse A on 1 August 2006 that the woman had been taking epilim for approximately eight months. Both the clinical review and the RCA suggest that, had the consultant been told of this, her advice about the woman's treatment might have been different.

The healthcare manager should ensure that, when a patient is referred to an outside hospital or specialist for further investigation, accurate and up to date information as to the clinical management of that patient must be given to ensure a proper diagnosis and course of treatment.

115. On 25 September 2006, the woman's dose of epilim was reduced although there is no record to indicate the rationale behind the decision or who authorised it. Despite attempts to find out what happened to the woman's prescriptions that day, my investigation has not been able to supply a definitive answer. There is no record of any medication of any kind being administered on 24 September. From 25 September onwards, the morning dose of epilim was omitted. The reason for the omission should have been recorded on the prescription chart, but it was not.

116. The way the prescription had been written could have been interpreted that a line was struck through the 'bd' instruction (bd refers to a prescription to be given twice daily – usually breakfast time and teatime). This might have led a nurse to believe that the prescription had been changed from bd. Dr W

told the Medical Director of Medway PCT that his was the writing on the prescription and the 'line' was a feature of his writing style. Any alteration of this nature should have required it to be written specifically, or at the very least a clearer indication of the prescriber's intention should have been given.

The healthcare manager should ensure that good standards of record keeping in the medical record are maintained, in compliance with the Nursing and Midwifery Council Guidelines for Records and Record Keeping and Department of Health and NHS Code of Practice Records Management.

117. The RCA identifies that the woman might have decided not to attend for her morning dose of epilim. The woman was known to be a heavy sleeper and might have found morning medication difficult to get up for. However, it appears from the records that the woman had attended previously. She does not appear from the records to have been an erratic attendee for her morning medications.

118. The woman had been taking a reduced dose of epilim up to and including the day of her death. The Medical Director of Medway PCT's clinical review concludes, "it is impossible to avoid the conclusion that this may have contributed to her death". On the other hand, the RCA says it is not possible to say whether the reduction in dosage had any contributory part in the woman's death.

119. The evidence from the Consultant Neurologist is that, had she been made aware by Nurse A that the woman was on a low dose of epilim, she would probably have suggested continuation at the current dose as the woman had had no further fits since starting it. Unfortunately, Nurse A failed to pass this crucial information to the Consultant Neurologist. In the circumstances, I consider it appropriate to draw this matter formally to Nurse A's former and current employers attention (Medway PCT and Mayday Nursing Agency/ HMP Wormwood Scrubs).

Medway Primary Care Trust should consider referral of Nurse A's actions to the Nursing and Midwifery Council. If referral is thought to be appropriate, a letter of advice should be sent to her current employer.

120. The Consultant Neurologist says she would not have been critical of a doctor subsequently reducing the dose of epilim (although it is not clear this was the case with the woman's prescription), as there was, at that time, no definitive diagnosis from a consultant, and no further fits.

121. The RCA concludes that there was no toxicological or anatomical cause for the woman's death. The cause of death was recorded as SUDEP. The woman probably suffered from epilepsy (on the basis of the three fits recorded), even though no formal diagnosis had been made. I believe it is not possible to say whether the reduction in dosage of the epilim medication played any part in the woman's death.

122. I have found systematic failures throughout the woman's treatment whilst in prison, but it cannot be concluded that these failures caused her death. Had the woman been seen by the consultant neurologist in a timely way, and had she been prescribed anti-convulsant medication appropriately (with or without any planned reduction), the woman might still have died from SUDEP.

CONCLUSIONS

123. The woman's cousin was concerned about the management of her epilepsy - which was never diagnosed or managed under the care of a consultant. Concern was also raised in regard to monitoring the woman up to the time of her death (although by this time she was not subject to any formal observation). I am concerned that the woman's fits were not managed in a timely or structured fashion within the existing National Health Service guidelines for best practice. In addition, the clinical review and RCA have highlighted that the woman was not actually seen by a consultant neurologist until August 2006 - by which time she had been free from fits for about eight months.

124. The single biggest failure in the woman's care would appear to be that she was not seen urgently by a specialist as she should have been. When she was seen, accurate information about her medication and condition was not relayed to the consultant.

125. The clinical review and RCA have highlighted that the dosage of epilim the woman received was significantly lower than the normal therapeutic level associated with epilepsy and that, in light of other medicines that the woman was taking, its effectiveness might have been reduced.

126. Following investigations by a consultant neurologist, nothing abnormal was detected. Because of the absence of information in respect of the woman having been in receipt of anti-convulsant medication, the consultant neurologist was unable to diagnose epilepsy and advised against prescribing the woman anti-convulsant medication. ECG tests had discounted heart problems as a cause of the woman's blackouts, noting that she was overweight and had been diagnosed and treated some months previously for hypertension.

127. As I have shown, at the time the woman was seen by a consultant neurologist, she had been taking a small dosage of epilim since December 2005. The consultant was not made aware of this. Had the consultant neurologist possessed this information, she says she probably would have recommended continuing on this low dose and monitoring the management of the woman's care. Instead, a reduction in the woman's dose of epilim was followed shortly afterwards by her sudden and unexpected death.

RECOMMENDATIONS

For the Governor

1. The Governor should ensure that personal radio batteries are regularly checked by staff to maintain effective and continuous communication.

   The Governor has accepted and completed this recommendation and says:

   'The 'Radio-Battery Procedure' reads that all batteries will be checked upon their return to the gate. If the battery indicator is below half power then the complete unit will be charged. These guidelines are supplied by the manufacturer to achieve optimum performance.'

2. The Governor, in conjunction with the healthcare manager, should review the location of oxygen and ensure that staff are made aware of its location and accessibility.

   The Governor has accepted and completed this recommendation and says:

   'Oxygen is now located in 3 key areas within the establishment, alongside other emergency equipment. The oxygen can be found within the Orderly office which is central to the prison, in Cedar House the separate unit and within health services.'

3. The Governor should ensure that arrangements are made for CCTV images to be downloaded using the appropriate computer software.

   The Governor has accepted and completed this recommendation and says:

   All images are recorded automatically on the hard drive for a period of 28 days. Any footage required for evidence can be downloaded on to a disc and stored within the security safe. The discs are read only. Access to both the safe and hard drive is limited to minimal staff for security and safeguarding reasons.

4. The Governor should review the role of the FNLO, not least to ensure that foreign national prisoners continue to receive timely updates as to the status of their immigration case.

   The Governor has accepted and completed this recommendation and says:

   Prior to closure as a female prison, the FNLO was an officer working to the Race Relation Officer. Since the re-role to a male juvenile unit, there has been a significant reduction in FNLO work required, but they do now have dedicated time allocated to them.

For the Healthcare Manager

5. The healthcare manager, in conjunction with the PCT, should ensure there is a robust system in place for appropriate prisoner-patient referrals to other multi-disciplinary health team members (including secondary care services).

   The Healthcare Manager has accepted and completed this recommendation and says:

   All referrals from the GP clinic are logged by the nurse running the clinic. The log is then management checked to ensure the referrals have been completed and sent off. There is always a few days delay as the referral letter needs to be typed.

6. The healthcare manager should ensure there are robust systems for handing over important information between clinicians to ensure the continuity of patient care.

   The Healthcare Manager has accepted and completed this recommendation.

7. The healthcare manager should ensure that patients suspected of suffering from epilepsy are referred urgently to a specialist for further investigation and appropriate diagnosis.

   The Healthcare Manager has accepted and completed this recommendation and says:

   All new receptions that identify that they have a condition such as epilepsy or diabetes etc is asked to confirm contact details of the health professional that is currently treating him. We will then write to/ phone the individuals' concerned requesting confirmation of diagnosis and current treatment plan. If appropriate, we will refer to our local hospital to continue treatment (time allowing). In some circumstances it is more appropriate to work with their own identified consultant rather than referring locally as this in most cases hinders care. All other conditions that become known during custody or are suspected of being possible will in the first instance be referred to the GP; the GP will then refer on if appropriate.

8. The healthcare manager should devise a system to ensure that, when healthcare escorts are cancelled, the senior clinician prioritises the patient's clinical needs. This decision should be recorded in the patient's notes.

The Healthcare Manager has accepted and completed this recommendation and says:

If 2 patients external escort appointments clash, we will provide the GP with both sets of clinical records and request that they decide who should attend their appointment. The GP / Nurse will then ensure that they document this within the clinical record.

9. The healthcare manager should remind staff that all actions stated within the medical record must include a rationale, followed up with a review to confirm the action was undertaken and the outcome.

The Healthcare Manager has accepted and completed this recommendation and says:

All staff, including other service providers are issued, on a regular basis, with the establishment's record keeping guidance policy to ensure they are aware.

10. The healthcare manager should instigate a system whereby patients who fail to attend for medication or further appointments are followed up. The follow ups should be recorded appropriately in the patient's medical record.

The Healthcare Manager has accepted and completed this recommendation and says:

The medication policy was reviewed and now reads that anyone who doesn't attend for their medication will be located and asked why they didn't attend. On the 3rd occasion, the health team would refer the individual to the GP to make them aware of the omission of medication. At any time the person maybe required to see the GP or suitable other depending on the reason why they didn't attend initially. All occurrences should be documented in the clinical record.

11. The healthcare manager should ensure that healthcare staff are reminded of the National Institute for Clinical Excellence guidance that relates to the diagnosis and management of epilepsy.

The Healthcare Manager has accepted and completed this recommendation and says:

All relevant NICE guidance is currently being collated and reviewed to ensure that we are doing as the guidance states. Once reviewed, this information will be circulated amongst the health team.

12. The healthcare manager should ensure that, when a patient is referred to an outside hospital or specialist for further investigation, accurate and up to date information as to the clinical management of that patient must be given to ensure a proper diagnosis and course of treatment.

The Healthcare Manager has accepted and completed this recommendation and says:

It is now policy that all young people requiring an external hospital appointment will leave for the appointment with an updated care plan that details current treatment plan and contact name and details should the Specialist require a conversation with someone from health services. In some circumstances, a member of the health team will actually go to the hospital with the person, to ensure accurate information is communicated.

13. The healthcare manager should ensure that good standards of record keeping in the medical record are maintained, in compliance with the Nursing and Midwifery Council Guidelines for Records and Record Keeping and Department of Health and NHS Code of Practice Records Management.

The Healthcare Manager has accepted and completed this recommendation and says:

As noted above, all staff, including other service providers, are re-issued with our Record Keeping Guidance policy on a 6 monthly basis to ensure they are aware. We are also completing a monthly documentation audit to ensure standards are being maintained.

For the Primary Care Trust

14. Medway Primary Care Trust should consider referral of Nurse A's actions to the Nursing and Midwifery Council. If referral is thought to be appropriate, a letter of advice should be sent to her current employer.

NHS Medway has yet to decide regarding this recommendation.

For the Prison Service

15. The Prison Service should issue guidance on the distribution of property belonging to foreign national prisoners in the event of their death whilst in custody.

    The Prison Service has accepted this recommendation in principle saying:

    NOMS will consider including guidance on this subject in the wider review of PSO 2710

GOOD PRACTICE

1. The Governor should commend the Duty Governor for her initiative in difficult circumstances and for maintaining a good level of support for the next of kin.

2. I commend the provision by the prison of a mobile phone for the woman's mother as an effective and innovative way of overcoming the difficulties of communication with Uganda.