PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Stocken in March 2013

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 of a man, who was found dead in his bed at HMP Stocken in March 2013. He was 38 years old. The post-mortem report gave a finding of sudden unexpected death in epilepsy. I offer my condolences to his family and friends.

A review of the clinical care which the man received in prison was undertaken by a clinical reviewer. The prison cooperated fully with the investigation.

The man suffered from epilepsy and mental health problems. He was prescribed antiepileptic and antipsychotic drugs but often did not take them as prescribed. He suffered a number of epileptic seizures but sometimes refused to be taken to hospital. Healthcare staff made numerous references to his non-compliance with his medication in his clinical record but his prescriptions were allowed to expire with no indication if what should happen next. He was not prescribed any antiepileptic medication for two months over the New Year. Prisoners with mental capacity like him cannot be forced to take medication, but the clinical reviewer considers there should have been a coordinated plan to help manage and tackle his non-compliance. Failure to take antiepileptic medication regularly can make sudden unexplained death in epilepsy more likely.

When the man's cell was unlocked on the day he died, staff made no attempt to check him and his death was not discovered until some hours later. This is unsatisfactory and officers should be required to make more efforts to check the wellbeing of prisoners when unlocking cells. Sadly, I acknowledge this would not have altered the outcome for him.

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

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

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1.

SUMMARY

1. The man suffered from epilepsy and mental health problems. He reoffended while released on licence from a previous prison sentence and was recalled to custody on 15 February 2012. He was initially taken to HMP Nottingham, before transferring to HMP Stocken on 24 April.

2. The man was reviewed periodically by a mental health nurse. He was prescribed antipsychotic and antiepileptic medication but he frequently failed to take his medication, despite repeated prompts from staff, and attended an epilepsy clinic just once. His antipsychotic medication was changed and he was prescribed three different antiepileptic medications while at Stocken.

3. The man suffered a number of epileptic seizures, one of which caused him to fracture his nose. Paramedics were called on several occasions, but he declined to go to hospital for further examination. As a precaution on one occasion, prison staff kept him under constant observation because there are no nurses on duty overnight.

4. Staff suspected that the man was being bullied, but there seems to have been no firm evidence of this. His own behaviour was sometimes difficult and disruptive. He spent time on the basic regime and was described as a challenging prisoner to manage. In February 2013, he head-butted his cellmate and spent a fortnight in the segregation unit.

5. In March, the man moved to a single cell on F wing as he was assessed as no longer suitable to share a cell. He was locked in his cell at 4.30pm on a Saturday and unlocked at 8.20pm on the Sunday. The officer who unlocked his cell did not check him. At about midday, an officer went into his cell and found that he had died. Staff did not attempt resuscitation because rigor mortis was present, indicating that he had been dead for some time.

6. Our investigation has highlighted the need to check on prisoners' wellbeing when unlocking them in the morning, in line with Prison Service policy. However, in this case we do not think that it would have been possible to save the man, as the evidence suggests he had died before the time of morning unlock.

7. We share the clinical reviewer's concerns about some aspects of the healthcare offered to the man. Although his own lack of cooperation did not help, his non-compliance with his medication and treatment was not tackled in a strategic, planned way. Prescriptions were left to expire and some of his treatment was neither ended nor actively pursued. We make four recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

8. Notices to staff and prisoners were displayed at Stocken, encouraging anybody with information about the man's death to contact the investigator. Nobody came forward.

9. The investigator visited Stocken on 20 March. He collected copies of the man's clinical and prison records and visited the units where he had recently lived.

10. A clinical reviewer was appointed by the local PCT to review the man's clinical care.

11. On 24 and 25 April, the investigator interviewed ten members of staff. He gave verbal feedback to the Deputy Governor and also wrote to the Governor with initial feedback from the investigation. He interviewed a further member of staff by telephone. The investigation was suspended until August 2013 while we waited for a post-mortem report and the confirmed cause of death.

12. The local Coroner has been sent a copy of this report.

The man's family

13. One of our family liaison officers contacted the man's family to explain the investigation process. They asked why he was living in a single cell and wanted to know how frequent his fits were. They asked why his antiepileptic medication was changed and whether he was taking it regularly. The family wanted more information about how he was found, the timings of locking routines and whether there were checks during the night. They asked whether he had pressed his cell bell overnight. The family said that he had wanted to move prisons and asked why he had not. There is no record that he pressed his cell bell on the night he died and nor is there any record of him requesting to move prisons. The other issues are dealt with in the report.

14. The family received a copy of the draft report. They made a number of comments that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. Their solicitor also questioned whether the man's mental capacity was ever assessed, since this might have affected his compliance with his medication. We have asked the clinical reviewer to comment on this matter.

HMP STOCKEN

15. HMP Stocken is near Oakham in Rutland and holds more than 1000 prisoners. Nurses are on duty from 7.30am until 6.30pm on weekdays and from 8.00am until 2.30pm at weekends. GP surgeries are held daily on weekdays. One mental health team covers both primary care patients and those with more severe and enduring illnesses. An out of hours service is used when healthcare staff are not on duty.

Her Majesty's Inspectorate of Prisons

16. The most recent inspection of Stocken took place in August 2012 and reported a number of improvements since the previous inspection in 2010. The Inspectorate assessed the quality of relationships between staff and prisoners as good with positive interaction. Inspectors also noted some improvements in healthcare provision but commented that more still needed to be done.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their 2012 annual report, the IMB considered that overall Stocken was a well-run, well-motivated prison and that staff worked hard to accommodate prisoners safely and humanely. The IMB considered that, after an extended period of confusion, the healthcare provision continued to improve.

Previous deaths at Stocken

18. In the last five years, we have investigated three previous deaths at Stocken. All were the result of natural causes, but none of the issues were similar to the circumstances of the man's death.

KEY EVENTS

19. The man had a long history of drug misuse and related offending. He was first diagnosed with epilepsy at the age of 13. He had been prescribed sodium valproate (an antiepileptic medication) since 1987. His epilepsy was not well controlled and he had been admitted to hospital with seizures several times over the years.

20. A psychiatrist completed a psychiatric report about the man in 2006. The exact diagnosis was unclear. The psychiatrist described him as a demonstrably odd man of borderline intelligence who struggled to articulate his thoughts. He said that his problems were enduring and his prognosis poor. He stressed the importance of him ceasing his illicit drug misuse and complying with his antiepileptic medication. In the community, he was under the care of a consultant psychiatrist and the dual diagnosis team for his substance misuse and mental health problems.

21. On 15 October 2010, the man was sentenced to 27 months in prison for burglary. He was released on licence from HMP Ranby on 6 October 2011.

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22. On 15 February 2012, the man was recalled to prison after committing further offences of burglary and theft. He was remanded to HMP Nottingham where he was referred to the substance misuse team and the primary care mental health team. He had been using crack cocaine and heroin before his arrest. He was prescribed sulpiride (an antipsychotic drug), sodium valproate to treat his epilepsy and initially methadone (a heroin substitute). Healthcare staff confirmed his prescriptions with his community surgery.

23. The man was referred to the mental health in-reach team and saw a nurse on 2 March. He reported side-effects from the sulpiride but otherwise his mental state was quite settled. In late March and early April, he did not attend the epilepsy clinic and a substance misuse appointment and walked out of consultations with the substance misuse team and a mental health in-reach worker.

24. On 21 March, the man was sentenced to five years in custody at Crown Court.

HMP Stocken

25. On 24 April, the man transferred to HMP Stocken. When he arrived staff were concerned by his bizarre behaviour and requested a mandatory drug test. His eyes were glazed and he struggled to stand up. (There is no record of the result of the drug test.) He initially lived on L wing. His prescriptions for sulpiride and sodium valproate continued. A worker from the mental health team saw him on 30 April.

26. The man moved to M wing on 8 May. A doctor reviewed his antiepileptic medication on 14 May and recommended that he continue sodium valproate. He was prescribed 28 day supplies of sulpiride and sodium valproate the next day, 15 May.

27. On 18 May, the man had an epileptic seizure in his cell. Officers placed him in the recovery position to stop him choking and healthcare staff treated him. Paramedics attended but he was not taken to hospital. He subsequently told the nurse who runs the epilepsy clinic that he had stopped taking his sodium valproate a few days earlier. She strongly encouraged him to start taking his medication again.

28. The man discussed his sulpiride prescription with a mental health nurse on 29 May. The nurse considered that he was stable on his medication but required help with compliance. He attended the nurse's epilepsy clinic on 1 June. She thought that his recent seizure had been caused by his failure to take his medication and initially recommended that a dosette box would help him to remember to take it. However, this option was unsuitable because sodium valproate deteriorates if kept for days in a dosette box. She planned to review him three months later. He was prescribed sodium valproate again on 21 June.

29. On 26 June, staff took the man to the segregation unit after he tried to head-butt an officer outside the gym. A nurse reviewed him and assessed that he was fit to be segregated. He returned to M wing the next day.

30. The man was prescribed sodium valproate on 13 July. A nurse reviewed him on 27 July when he told her that he had not taken his antiepileptic medication for two weeks. She explained that abruptly stopping his medication increased the risk of a seizure but he was adamant that he would not take it and said it gave him headaches and a bad chest. The nurse referred him to the GP for a review of his medication and advised him to take his current medication in the meantime. An epilepsy care plan was entered onto his clinical record on 6 August. The care plan gave very brief instructions to staff about how to care for him when he had epileptic seizures.

31. A mental health nurse saw the man on 20 August. He told her that he was not sleeping and had stopped taking his sodium valproate. She noted that he had not been prescribed sulpiride since he was issued with a 28 day prescription on 15 May. She referred him to a psychiatrist to discuss his medication and spoke to another nurse about him.

32. A mental health nurse saw the man on 31 August after a number of missed appointments. He said that he had not taken his sulpiride since May and his sodium valproate since June. The nurse planned to refer him to the GP to restart his antiepileptic medication and to a psychiatrist to restart his antipsychotic medication.

33. On 13 September, a doctor reviewed the man but did not prescribe any new antiepileptic or antipsychotic medication. A mental health nurse reviewed him

again on 18 September. He said that he felt better and had not suffered any recent fits.

34. A psychiatrist reviewed the man on 20 September. He prescribed olanzapine (a different antipsychotic drug) and recommended that he be referred to a GP to discuss an alternative antiepileptic drug, be monitored for worsening epilepsy control and be seen by the mental health team.

35. On the morning of 26 September, the man suffered a seizure on M wing. A nurse treated him and again noted that he had not been taking his medication. He suffered a further fit during the afternoon and staff ordered an ambulance to take him to hospital. He then suffered a third seizure before the ambulance arrived. He fractured his nose and healthcare staff administered rectal diazepam (a gel administered using a special plastic syringe) to stop him fitting.

36. The man stayed in hospital for a night as an inpatient. Doctors at the hospital prescribed sodium valproate in liquid form because he said that he could not swallow the tablets.

37. When prison healthcare staff treated the man's seizures on 26 September, they noticed a lot of bruising to both of his upper arms, but he would not tell them how this had happened. Staff suspected he had been assaulted but he denied this or that he was being bullied by other prisoners. On 27 September, an officer submitted a security information report indicating that he had learnt from a source that two prisoners, who he named, had recently assaulted him. These two prisoners had also apparently placed him in a choke hold, causing him to pass out. The wing manager was asked to investigate these allegations but there is no record of any formal investigation.

38. When the man returned from hospital on 27 September, a nurse noted that staff would need to monitor his compliance with his medication and take his antiepileptic medication to him if he did not attend the medication hatch. He was not allowed to keep his medication himself; this meant that staff could monitor whether he was taking it. He continued to collect his medication only irregularly. There is no evidence that staff took his medication to his cell if he forgot to collect it.

39. A doctor reviewed the man on 4 October. He was still not complying with his antiepileptic medication and said that it had adverse side-effects. The doctor wrote to a consultant neurologist at the hospital for advice on an alternative treatment.

40. On the morning of 14 October, staff noticed fresh cuts on the man's face, which he said he had got during another fit. A nurse checked him and he stated that he was still not taking his antiepileptic medication. He was found with two unknown tablets which were confiscated. Staff suspected that he was being bullied and conducted an anti-bullying investigation, which concluded that it was most likely that he had suffered a fit.

41. Two nurses checked the man again at about 2.00pm on Sunday 14 October, but he would not engage with them and seemed unconcerned about his own safety if he had another seizure. He still refused to take his medication, even though he was shaking and twitching. The nurses called the out of hours GP to attend. He had another seizure at about 3.30pm and an ambulance was called. The out of hours GP and paramedics treated him. He said that he had not taken his antiepileptic medication since July. The GP encouraged him to go to hospital because he was at risk of further seizures, but he refused. Between 5.50pm on 14 October and 4.00pm on 15 October, prison staff checked him at least every half an hour and recorded their observations.

42. A nurse saw the man on 15 October because of his non-compliance with medication. He tried to explain to him the risks of not taking his medication but thought that his understanding was limited. The GP subsequently re-prescribed sodium valproate and omeprazole.

43. On 28 October, a nurse wrote in the man's clinical record that he was still not taking his medication and she referred him to the GP. A nurse saw him again on 31 October and discussed his non-compliance but he refused to take sodium valproate. A doctor switched his antiepileptic medication to lamotrigine from 5 November after getting advice from the local hospital neurology department. He prescribed an initial lower dose for 14 days and then a higher dose for a further 28 days from 19 November.

44. A doctor saw the man again on 15 November. He was refusing to take lamotrigine because he claimed that the tablets were too small for a man. The doctor tried to explain that the efficacy of the tablets was unrelated to their size, but he did not think that he understood. On 20 November a nurse noted in his clinical record that his compliance with the prison regime was very intermittent and that he was a 'challenging inmate'.

45. In the late afternoon of 22 November, wing staff asked nurses to see the man because he was shaking and twitching. He had a five minute seizure at about 7.00pm and an ambulance was called. At 8.25pm, he was taken to hospital after suffering another suspected seizure. While in the ambulance, he became violent towards the female ambulance crew after they voiced concern that his fit was not genuine. The ambulance returned to the prison. Escort officers consulted their managers and double handcuffed him before the ambulance departed for a second time.

46. The emergency department doctor did not think that the man's seizure was genuine and he was discharged from hospital and returned to the prison at 2.10am on 23 November. When prison staff checked him at 3.00am, he had fallen out of bed. He seemed to be asleep and did not respond verbally. They placed a mattress on the floor, removed any items with which he might hurt himself during a fit and increased the frequency of observations.

47. Later on 23 November, the man had three further seizures and an ambulance was called. Staff administered rectal diazepam because the seizures lasted

more than 15 minutes. He refused to go to hospital and signed a disclaimer to that effect.

48. On the advice of the deputy healthcare manager, at 5.45pm prison managers moved the man to a constant supervision cell on M wing, where he was watched by two officers until 11.15am on 25 November. Officers expressed concern about performing constant supervision for a medical reason and thought that a nurse should be doing this. For this to happen, he would have needed to move to a prison with 24 hour healthcare, or an agency nurse employed to cover the gap in healthcare provision.

49. The man continued to behave difficultly, refusing to cooperate with staff and using offensive language. M wing staff were concerned about their ability to cope with his fits and made representations to prison managers that the frequency and severity of his seizures meant that he should move to a prison with 24 hour healthcare. Ultimately, he did not move prisons because managers considered that there was nothing nurses could do that officers could not, which was to stop him from injuring himself during a seizure and call an ambulance.

50. An officer wrote the following entry in the man's prison record on 27 November which he told the investigator reflected the opinion of his colleagues on M wing at the time:

> 'I feel [his difficult behaviour] is somewhat out of character especially towards staff and most likely a result of his illness and constant epileptic fits. I'm not sure if this is the correct environment as we are struggling to cope with his medical needs. I feel it won't be long until somebody seriously gets hurt.'

51. On the same day, a SO placed the man on the basic regime of the Incentives and Earned Privileges (IEP) scheme because of his recent poor behaviour. He had already received warnings for his deteriorating behaviour. (The IEP scheme is intended to encourage and reward good behaviour and compliance with sentence plan targets. Privileges, such as more visits, can be gained in return for good behaviour. Privileges can be lost if behaviour deteriorates. There are three IEP levels; basic, standard or enhanced.)

52. The man was unhappy when he was told this news and became aggressive and confrontational, grabbing the SO by his uniform. He was restrained, handcuffed and taken to the segregation unit because his disruptive behaviour was considered a danger to others. He was checked by a nurse when he arrived.

53. On 28 November, a nurse checked the man in the segregation unit and noticed that he no longer had a valid prescription for lamotrigine. There was no GP in the prison to write a new prescription. She noted that a GP would need to issue a new prescription the next day, but there is no record of this then happening. He returned to M wing a little later that morning. He was not

charged with any disciplinary offence and remained on the basic level of the IEP scheme.

54. On 5 December, a nurse saw the man and recorded that the issue underlying all of his behavioural problems was his non-compliance with antiepileptic and antipsychotic medication. He was unsure if his volatile and intimidating attitude was personality-based or the result of a psychosis. He noted that he demonstrated no motivation to comply with the wing regime. He had not seen a psychiatrist since September, and no further appointments were scheduled with mental health staff. His privileges were reinstated on 24 December when he returned to the standard level of the IEP scheme.

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55. There is no record that the man had any seizures in January and there were no other reported concerns. On 5 February, he threatened a nurse during an appointment. On 6 February, he moved onto I wing, the drug recovery unit. There is nothing in the records to explain this move and prison staff the investigator spoke to did not know the reason.

56. On 14 February, the man head-butted his cellmate on I wing after an argument about snoring. He sustained a wound to his own head as a result. Staff thought that he might have been trying to engineer a move to a single cell. They did not think he was safe on I wing so he was moved to K wing, the Integrated Drug Treatment System (IDTS) unit, because there was an available cell. He was assessed as a risk to cellmates and held in a single cell. He was placed on a disciplinary charge for assaulting his cellmate

57. Wing staff contacted the mental health team and removed the man's privileges. On 16 February, he attended a disciplinary hearing and pleaded guilty to assault. As a punishment, he spent 14 days in the segregation unit from 18 February. A nurse assessed him as fit to be segregated.

58. On 26 February, the man had three seizures in his cell in the segregation unit and injured his right eye. He was treated by healthcare staff and moved onto a mattress on the floor. Staff monitored him and were told to call an ambulance if he fitted again overnight, but he did not. He was assessed as still fit to stay in the segregation unit and remained there for several more days. The next day a doctor saw him and decided to try prescribing a different antiepileptic drug, levetiracetam, from 28 February.

59. On 3 March, the man moved back onto K wing. He was monitored for antisocial behaviour because of the assault on his cellmate. His daily dose of levetiracetam doubled from 7 March after a week's trial. He was prescribed a 28 day supply not in possession. He returned to the standard IEP regime on 15 March.

60. On 15 March, the man moved into a single cell on the ground floor of F wing. F wing is the Kainos Community unit, where prisoners move to receive treatment and education to address their offending behaviour. He only moved

onto the wing because there was an available cell for him, but after he arrived he was given information about the programme and applied to join it.

Saturday 16 March

61. The man's mother and sister visited him at 2.00pm on Saturday 16 March. At 4.00pm, he collected his tea and breakfast pack for the following morning. He was locked in his cell for the night by an officer at about 4.30pm. He told the officer that his visit had gone well and the officer said that he seemed happy and well. The roll count was completed across the prison and all prisoners were locked up by 4.45pm. He spent the rest of the evening and night locked inside his cell.

62. An evening patrol officer completed a roll check between 6.30pm and 7.30pm. This involves the patrol officer looking into the cell through the observation panel to check prisoners are present but they are not required to obtain a response. An officer observed him through the observation panel while completing a roll check between 8.30pm and 9.30pm.

17 March

63. An officer checked the man through his observation panel at about 6.00am for the morning roll check, but again was not required to obtain a response.

64. Officer A was working on F wing on the morning of Sunday 17 March. He completed a handover with the night staff at which no issues were raised. He carried out a roll check to account for all the prisoners before taking charge of the wing. At about 7.25am, he looked through the observation panel into cell 58 and saw the man lying on his front on the bed with his left arm hanging off the mattress towards the floor. He double checked for blood on the floor or signs of a disturbance but saw none, so he shut the observation panel and moved on to the next cell. He presumed that he was asleep and did not seek a verbal response from him.

65. At about 8.20am Officer B unlocked the man's cell door. He did not look into the cell or obtain a verbal response from him. Prisoners often stay in bed on weekend mornings. They are given breakfast packs the night before so they do not have to come out of their cell to eat until lunchtime. His cell door remained ajar. Cells are unlocked until midday at weekends, during which time the prisoners can associate with the others on the wing, take showers and make telephone calls.

66. Lunch was served at about 11.30am. Officer A was overseeing the lunchtime queue and was told that three prisoners, including the man, had not collected their lunch.

67. Officer A began locking up prisoners at about midday. When he reached the man's cell he saw that he was lying on his front in exactly the same position as he had been during the morning roll check. The officer realised that he had not moved all morning or collected his lunch. He went in and called his

name twice but got no response. He touched him and he was very cold although the room was warm. He was quite certain that he had died so did not attempt to resuscitate him. He left the cell and locked it. He did not want to alarm the other prisoners so he carried on locking the next two cells.

68. The officer then went to find the Senior Officer (SO) and told him that the man had died. The SO and the officer went back to the cell. The SO noted that there was mottling on the man's skin and his arm was rigid and arched. He was certain that he had died several hours earlier. His bed sheets were still neatly and tightly tucked into the bedframe and there was no sign that he had violently fitted or had thrashed about. He appeared to have died in his sleep.

69. The SO contacted the control room to ask the emergency healthcare responder and the orderly officers to attend the wing. Two orderly officers arrived three minutes later and went into the cell with him.

70. The duty governor and a nurse reached the cell a couple of minutes after the orderly officers. The nurse confirmed the presence of rigor mortis. The control room contacted the ambulance service at 12.31pm to ask for a paramedic to come to confirm death. A paramedic arrived at the gate just after 1.00pm and at 1.20pm certified death.

71. A SO and the chaplain acted as family liaison officers and went to the man's parents' home, but they were not there. They then went to his sister's home and informed her and the man's brother at 3.45pm. They then visited the man's aunt and subsequently returned to his parents' home to break the news.

72. Officer A was sent home because he was particularly upset by the man's death. The duty governor telephoned him to check how he was coping. She also led a hot debrief for staff at 2.45pm. The man's cousin was also at Stocken and she notified him of his cousin's death during the afternoon.

73. The funeral was delayed by post-mortem tests and was eventually held on 15 August. The prison contributed to the cost of the funeral in accordance with national guidance. The post-mortem examination found that the man's death was caused by sudden unexpected death in epilepsy, which does not involve any signs of obvious trauma. A toxicology test showed traces of levitiracetam below the prescribed level, which suggested that he had still not been taking his antiepileptic medication regularly.

ISSUES

Clinical care

74. The man's non-compliance with antiepileptic medication made the syndrome known as sudden unexplained death in epilepsy patients (SUDEP) more likely. Patients with epilepsy at Stocken are expected to be identified during the reception health screening, referred to the specialist nurse, placed on a waiting list and seen at the next epilepsy clinic. After arriving in April 2012, he was seen at one of these clinics in June. He was supposed to be reviewed in September, but there is no record of a subsequent clinic appointment. He was not reviewed again at the clinic before he died, despite suffering repeated seizures that caused considerable concern among staff in November. The specialist nurse told the investigator that she had not had the opportunity to hold these clinics as often as she would have liked because of staffing levels.

75. The clinical reviewer reviewed the man's clinical care and considers that the response from healthcare staff each time he had a seizure was good. However, the ongoing management of his epilepsy, to improve his compliance with medication and therefore reduce the likelihood of seizures, was less good. He found that there was little evidence of a coordinated approach to his care.

76. The man was prescribed antiepileptic medication somewhat intermittently. He was prescribed sodium valproate until a doctor sought advice from a neurologist and prescribed a 42 day supply of lamotrigine on 5 November 2012, which would have expired on 17 December. He was not prescribed any further antiepileptic medication until 27 February 2013, when a doctor reviewed him and prescribed another alternative, levitiracetam. There is no evidence in his clinical record that healthcare staff noticed the lack of repeat prescription during this period, that a GP reviewed him or that a care plan was implemented to address his non-compliance.

77. The man's poor compliance with all of his medication was not appropriately dealt with. There are no local healthcare policies for either managing epilepsy or tackling non-compliance with medication. The deputy healthcare manager told the investigator that a GP should review any patients failing to comply with medication within three days. This did not happen in this case. We make the following recommendation :

    The Head of Healthcare should ensure that there is clear guidance for the management of prisoners with epilepsy, which includes care planning and the management of medication.

78. The clinical reviewer notes that the man's compliance with his antiepileptic medication might have been affected by his ongoing mental health issues. He struggled to grasp the importance of taking the medication. Unfortunately, his antipsychotic medication was also prescribed intermittently. Again, staff failed to record their decision making or strategically address the problem with a care plan.

79. Antipsychotic prescriptions were left to expire without any indication as to the next step. The man was being prescribed sulpiride when he moved to Stocken in April. He was prescribed this once on 15 May, but there were no further prescriptions until 20 September, when a psychiatrist prescribed olanzapine. This drug was never represcribed.

80. A mental health nurse reviewed the man in early December. Although he recorded non-compliance with medication as the main concern, no further referral was made. Olanzapine was not re-prescribed but he was not discharged from the mental health team either. He was not seen again by the mental health team before he died. There is no evidence to show that a decision was taken about whether to pursue medication or to discharge him from the mental health team. We make the following recommendation:

The Head of Healthcare should ensure mental health treatment is delivered in accordance with an up-to-date care plan.

81. During November 2012, M wing staff asked managers to move the man temporarily to a prison with 24 hour healthcare. Nurses go home at 6.30pm during the week and 2.30pm at the weekend. M wing staff did not think that they were able to cope overnight with the number and severity of seizures that he was having at the time. They thought that his level of need was too great and he would benefit from being stabilised in a prison inpatient unit before returning to Stocken.

82. Wing staff were also concerned about the time it would take an ambulance crew to reach the man. The prison is in a remote location and an ambulance can take 20 minutes to reach the prison. M wing staff became concerned when they were asked to carry out constant supervision overnight. The only reason prison staff normally do this is because the prisoner is at imminent risk of self-harm. However, on this occasion they were asked to monitor him in case he had any further seizures. M wing managers were concerned that this was a task for healthcare staff and therefore he belonged in a prison with 24 hour nursing as long as he was experiencing frequent severe seizures.

83. Prison managers decided that a transfer was unnecessary because they thought that a nurse could do no more than an officer for the man during a seizure by placing him in the recovery position, preventing him from hitting his head and calling an ambulance. However, we note that he twice needed to be given rectal diazepam, which is administered by a nurse if a patient is suffering a prolonged seizure and cannot swallow medication.

84. We appreciate that moving a prisoner temporarily to a prison with an inpatient unit is not straightforward. However, the situation in November 2012 does not appear to have been ideal and there is no evidence that the prison considered using an agency nurse. There does not appear to be any central guidance about who should perform this type of medical constant supervision in a prison like Stocken, without 24 hour health cover. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there are appropriate and agreed arrangements to manage and supervise prisoners who suffer frequent and severe seizures.

85. There were no further requests from wing staff to transfer the man after November and his seizures appeared to stabilise for a time in December and at the beginning of 2013. We are satisfied that Stocken was an appropriate location for him at the time he died.

Unlock procedures

86. After Officer B locked the man up at 4.30pm on Saturday afternoon, staff went to his cell to complete four roll checks during the night and early morning. During each roll check, staff looked through the observation panel to ensure only his physical presence. They were not required to obtain a verbal response.

87. The officer unlocked the man's cell door 16 hours later. It is almost certain that he was already dead at this time. When he was found at midday, he was in the same position as Officer A had seen him during the 7.25am roll check. Officer B did not establish either through physical observation or verbally that he was alive at the time he unlocked his cell.

88. Our interviews demonstrated that staff at Stocken are reluctant to obtain a verbal response when they unlock prisoners on weekends because the prisoners tend to want a lie in until lunchtime. The Prison Officer Entry Level Training (POELT) manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

89. Prison Service Instruction (PSI) 10/2011 clarifies the responsibility of the unlocking officer:

> 'Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight, apparently from natural causes, but staff unlocking them have not noticed that the prisoner had died. This is not acceptable.
>
> 'Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.'

90. We do not think that obtaining a response and finding the man three hours earlier would have made a difference on this occasion because he was almost

certainly already dead. However, it is important that staff unlock prisoners in line with policy and we make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that there is clear guidance for the management of prisoners with epilepsy, which includes care planning and the management of medication.

2. The Head of Healthcare should ensure mental health treatment is delivered in accordance with an up-to-date care plan.

3. The Governor and Head of Healthcare should ensure that there are appropriate and agreed arrangements to manage and supervise prisoners who suffer frequent and severe seizures.

4. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

ACTION PLAN: The Man - **HMP Stocken**

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that there is clear guidance for the management of prisoners with epilepsy, which includes care planning and the management of medication.	Accepted	All individuals within Stocken prison with known condition of epilepsy will be managed under the NICE guidelines for Epilepsy. They will all have a care plan which is individualised to their specific needs and will have a named nurse who is responsible for formulating and reviewing the care plan as well as overseeing and liaising with others as required. All nursing staff have access to all Local Operating Procedure's and Standard Operating Procedure's and must sign to say they have read and understood each one. Regular reviews of these and the signing sheets take place. The relevant procedures are STKLOP02 – *Guidance for Ordering and Administration of prescribed medications* and STKLOP14 2013	completed	

			To provide offender health managers with a framework to manage consistent medication incidents. The later includes a competency framework for administering medicines. All staff responsible for administering medication are required to undertake this as a minimum yearly or if necessary following any medication errors. All staff at HMP Stocken has undertaken this competency framework in the previous 6 months and evidence of this is held in their staff files. Daily meetings take place in healthcare and within these meetings any individual who has required emergency treatment is discussed within the team with follow up action documented and allocated to an individual nurse to follow up. Any care plan issues will be raised within this meeting together with on going refusal of medication or treatment. All areas of the healthcare		

			team attend this meeting with representatives from pharmacy, primary care, substance misuse and the Mental Health team; this allows the sharing of information across the whole healthcare team.		
2	The Head of Healthcare should ensure mental health treatment is delivered in accordance with an up-to-date care plan.	Accepted	Mental Health care is provided by Northamptonshire NHS trust but as stipulated within the answer to Q.1 there are mechanisms in place to ensure all relevant information is passed between the teams.	completed	
3	The Governor and Head of Healthcare should ensure that there are appropriate and agreed arrangements to manage and supervise prisoners who suffer frequent and severe seizures.	Accepted	Where there is evidence of this for individual prisoners there will be a care plan in place with the appropriate information for nursing staff to manage seizures as they occur. Support is afforded to prison officers from healthcare on how to deal with these individuals in emergency situations and they are advised to contact communications to issues a Code Blue (emergency) for response from healthcare staff immediately.	completed	

			Healthcare staff are available during the hours of 07.30 to 18.30 five days a week (Monday to Friday) and 08.00 to 17.30 (Saturday, Sunday and bank holidays). There is an out of ours on call number for support out of these hours.		
4	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	Governors Order 013/13 issued 14 June 2013 reminding staff of the national requirement that when undertaking a roll check and unlocking prisoner's assurance of the wellbeing of each prisoner located within a cell must be taken. This will require that a response for the prisoner is required to satisfy staff of their wellbeing	completed	