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 in June 2014, at HMP The Verne

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 died of neurosarcoidosis (a condition that causes inflammation in the brain), in June 2014, at HMP The Verne. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to review the clinical care the man received at The Verne. The establishment cooperated fully with the investigation. This investigation was suspended until we received confirmation of the cause of death and the post-mortem report. I regret that this has delayed issuing our report.

The man completed a prison sentence in September 2013, but remained detained under immigration powers while he appealed against a deportation order. He had been at The Verne since 7 May 2014. The man had epilepsy, for which he took anticonvulsant medication, but he did not always take his medication as prescribed. On the morning of the man's death, a prison officer found the man unresponsive in his bed. He called an emergency medical code, but control room staff did not call an ambulance immediately as emergency procedures require. However, it soon became apparent that the man had died some time during the night.

The clinical reviewer was satisfied that the overall standard of care the man received was equivalent to that he could have expected in the community. However, I am concerned that HMP Thameside cancelled an MRI scan without appropriate justification and that healthcare staff at The Verne were not more proactive in following up the man's failure to comply with his medication. I am also concerned that there was a delay in requesting an ambulance, which should have been called immediately. In other circumstances, such a delay could be crucial.

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 **June 2015**

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SUMMARY

1. The man was a citizen of Angola and had lived in the UK since 1994, when he was six years old. In November 2011, the Home Office granted him indefinite leave to remain in the UK but, as he had criminal convictions, warned him that he might be deported if he committed further offences.

2. In November 2012, the man was convicted of robbery and burglary and served a 16-month sentence. In December, the Home Office began deportation proceedings, which the man appealed. At the end of his sentence in September 2013, the man remained in prison for the outcome of his appeal. On 7 May, 2014, he moved to HMP The Verne from HMP Thameside.

3. The man had epilepsy (brought on by a serious head injury when he was hit by a car in 1998). He had a history of epileptic fits but did not regularly collect or take his prescribed anti-convulsant medication to help prevent the fits. He was expected to collect medication in the morning and afternoon, but after he first arrived at The Verne, he did not collect medication on at least 15 occasions, sometimes in both the morning and afternoon. He told a nurse that he often did not wake up early enough to collect his morning medication. The nurse warned him of the risks of not taking it and spoke to the GP who prescribed a weekly supply, so he did not have to collect it each day. The man continued to neglect to take his medication and did not turn up for appointments with the GP on 1 and 3 June to discuss this and medical staff did not appropriately monitor the man's failure to collect his medication.

4. At 7.43am on the day the man died, an officer found him unresponsive in bed and radioed an emergency medical code. When he examined the man more closely, it was clear he had been dead for some time as rigor mortis was present. The control room staff did not call an ambulance immediately, but first waited to get more information, before calling an ambulance at 7.49am. At 7.59am, paramedics arrived and confirmed that the man had died.

5. The clinical reviewer concluded that the man's overall clinical care was equivalent to that he might have expected in the community. However, he had some concerns about medication management and considered that healthcare staff at The Verne should have been more proactive in monitoring his compliance with medication. An appointment for an MRI scan at a previous prison should not have been cancelled, as it could have diagnosed neurosarcoidosis which the man could have been treated for. We are also concerned that control room staff did not follow the medical emergency response protocol, which stipulates that staff must call an ambulance immediately in response to an emergency medical code. While this did not affect the outcome for the man, this could be crucial in a future emergency. We make three recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and detainees at The Verne informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

7. The investigator visited The Verne on 11 June and met a senior manager, the head of healthcare, the prison doctor, a representative of the IMB and the family liaison officer. She obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed five members of staff in person and three members of staff by telephone. She informed The Verne of the preliminary findings of the investigation.

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

9. We informed HM Coroner for Bournemouth and Poole Eastern District of the investigation, who provided the results of the post-mortem examination. We have sent the coroner a copy of this investigation report. The investigation was suspended until we received confirmation of the cause of death and the post-mortem report in December 2014. We regret the delay this caused in issuing this report.

10. One of our family liaison officers contacted the solicitors representing the man's family and explained the investigation process. On 15 October 2014, the investigator and the investigation manager met the man's mother and her legal representative to discuss the investigation. They did not raise any specific concerns, but said they would like a chronology of events and asked whether there was full CCTV footage of the area around the man's cell at the time of his death. The investigator wrote to The Verne, as it appeared that the establishment had not acted in line with national instructions to retain all relevant documentation about a death, including CCTV coverage. The Verne apologised that this had not been done and said that there were now procedures to preserve such records.

11. The man's family received a copy of the draft report. The solicitor representing the family wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

12. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

13. The draft report was shared with NHS England. Changes have been made to the report in regard to the wording of a sentence in paragraph 16 and to paragraph 51 to reflect the medication compliance policy has been implemented since the draft report was issued.

HMP THE VERNE

14. In September 2013, The Verne began the transition from a category C prison to an immigration removal centre (IRC), which was completed on 28 September 2014. The Verne now holds up to 580 foreign national men who face immigration enforcement action. At the time of the man's death, the centre was still being managed under Prison Service procedures. Dorset Healthcare University NHS Foundation Trust (DHUFT) now provides 24-hour healthcare cover, but, at the time of the man's death, healthcare staff worked between 7.30am and 9.00pm each day and used the Dorset out-of-hours service for advice at other times.

15. Detainees have privacy keys to their rooms, so that they can lock their cell during the day. There is no in-cell sanitation so during the night they can leave their room as they please to use communal facilities.

Her Majesty's Inspectorate of Prisons

16. The most recent inspection of The Verne (as an immigration removal centre) in March 2015, has yet to be published. The previous inspection of HMP The Verne, in October 2012, noted that there had been no Healthcare Needs Assessment for over three years, with no plan to monitor and develop services. Prisoners had access to a wide range of care and treatment, and nursing staff were well-qualified and delivered specialist clinics in health promotion and for patients with lifelong conditions. Medicines management procedures were mostly good. There was an in-possession policy, but at the time of the inspection this was under review. Most prisoners had their medication supplied as weekly or monthly in-possession, and were encouraged to take responsibility for re-ordering their medicines a week before they ran out. Medication was not administered after 4.30pm, which meant that some medicines were not dispensed appropriately and were given daily in-possession.

Independent Monitoring Board

17. Each prison and IRC has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that those detained are treated fairly and decently. In its last report for The Verne Prison, covering the period from May 2012 to October 2013, the IMB did not indentify any concerns, other than those highlighted in the report of the October 2012 inspection.

Previous deaths

18. There had been one other death at The Verne in the previous two years. We were satisfied that there were no similarities between the circumstances of the previous death and that of the man.

KEY EVENTS

19. The man came to the UK from Angola in 1994, when he was six years old. On 9 November 2011, he was granted indefinite leave to remain in the UK. As he had been convicted of criminal offences, the Home Office warned him he was likely to be deported if he continued to re-offend.

20. The man was remanded to HMP Belmarsh on 27 October 2012, charged with robbery. On 29 November, he was sentenced to 20 months imprisonment (later reduced to 16 months on appeal). The Home Office started deportation proceedings against him on 12 December 2012, and he appealed against this decision. On 28 January 2013, the man was convicted of burglary and received a 12-month sentence to run concurrently with his 16-month sentence.

21. The man suffered from epilepsy, thought to have been caused by a serious head injury in 1998, when he had been hit by a car. The man was prescribed anticonvulsant medication to take twice a day, but he did not always collect his medication or take it as prescribed.

22. During his sentence, the man transferred between several prisons. Although he had been placed on 'medical hold' on 5 March 2013, while waiting for an MRI scan, he was moved from HMP Belmarsh to HMP Highpoint. (A medical hold usually means that he should not have been transferred until he had had the scan, but ultimately the National Offender Management Service (NOMS) decides whether to transfer.)

23. The man completed his prison sentence in September 2013, but remained detained under immigration powers. On 4 November 2013, at HMP Thameside, the man was referred to a neurologist. Tests at a neurology appointment on 4 February 2014, showed that the level of anticonvulsant in his blood was below the therapeutic range (his level was two and the normal range is five to 12). The neurologist advised he should have an MRI scan and an electroencephalogram (EEG – a recording of the brain's activity), and that his medication should be increased. He planned to review the man in six months. The prison cancelled the MRI appointment, for security reasons, as the hospital had sent the notification directly to the man. There is no evidence that the prison rescheduled the appointment.

24. In the first week of April 2014, the man had a fit. On 15 April, he went for an appointment for a blood test to check the level of anticonvulsant. When he got there, he was not willing to wait and left. On 6 May, the man had another fit and was referred to a doctor. He transferred to The Verne the next day, 7 May, before a doctor saw him.

The Verne

25. The man's prison sentence had expired almost eight months previously, when he transferred to The Verne. An appeal hearing had been arranged for August 2014. Nurse A carried out an initial health assessment and noted that he had been prescribed anticonvulsant and antidepressant medications. His blood pressure was normal, but she referred him for a routine eye test. The man told the nurse he did not have any health concerns. An officer completed a

personal evacuation escape plan (PEEP) and noted that in an emergency, a member of staff should check that he had vacated his room.

26. On 8 May, the man told Dr A that he had had an epileptic seizure two days before. He said he was still feeling low, especially as he was so far from his family, and she advised him to keep taking his anti-depressants. The doctor made a note to refer him to the mental health in-reach team (this referral was not made) and that she would read his medical notes and then review him. He would not be allowed to keep his medications in his room until his mood had stabilised, which meant he had to go to the healthcare centre twice a day to collect them.

27. Dr A reviewed the man's medical record on 9 May and increased the dosage of his anticonvulsant medication, but did not see him. She noted that he had missed an MRI appointment in February and referred him to the neurology clinic.

28. Between 10 and 21 May, the man did not collect either his morning or afternoon medication 19 times. On five of the days, he did not collect any medication at all. On 11 May, he told Nurse B that he had difficulty getting up in the morning and could not get to the healthcare centre in time to collect his medication (dispensing times were between 8.30am and 9.00am). The nurse warned him of the risks of not taking his medication.

29. On 20 May, Nurse B discussed the man's non-compliance with his medication with Dr A. The doctor changed the prescribing arrangement to allow him to have a week's supply at a time to encourage him to take it and reduce the risk of a fit. Dr A sent a task (an electronic alert on the medical information system) to the nursing team to ask them to make weekly compliance checks for the first month, to ensure the man was collecting and taking his medications appropriately. She made an appointment for 1 June to review his compliance with his medication.

30. On 21 May, the man collected his weekly supply of medications from Nurse B. She said that this was the last time he had collected it.

31. On 26 May, the man went to the medical treatment hatch and said he had been asked to see the doctor about his eyes. Nurse C told him that there was no appointment recorded for him and the man left. There were no other significant entries in his medical record over the next few days.

32. The man should have collected another week's supply of medication on 28 May, but did not do so. On 1 June, he did not attend a GP appointment arranged to review his compliance with his medication. Healthcare staff did not record the reason why he did not attend and there is no record that they contacted him about it.

33. On 2 June, Dr A noted that the man had not collected his second week of medication. She booked an appointment for him to see a nurse the next day, 3 June, and noted, "Please ensure seen". The man did not attend and no one went to see him to establish the reason or took his medication to him. Nurse A made another appointment for the next day.

3-4 June 2014

34. On the night of 3/4 June, OSG A, was the night patrol officer on the man's wing. One of his duties was to observe all the landings from the CCTV monitors in the wing office. He also patrolled the landing hourly between the hours of 11.00pm and 5.00am, with an electronic "pegging" check to record that this was done. He did not have to check individual detainees. The OSG said that he did not see or hear anything of the man during the night and early morning of 3 and 4 June.

35. Another detainee (and a childhood friend of the man), told the investigator that, in the evening of 3 June, he and the man had been playing computer games in his room. He said that the man had not complained of feeling unwell and did not seem any different to his usual self. The man went back to his own room at around 2.30am, but later came back and they smoked a cigarette together before the man went back to his own room again. (An edited version of the CCTV footage from the wing shows that the man left his room, walked down the corridor smoking a cigarette and went into detainee's room. The time was not visible.)

36. On 4 June, Officer A started the morning shift and checked each of the detainees' rooms. The officer said that, when he started the check on the man's landing, at around 7.30am, he heard someone's alarm clock sounding. The CCTV footage shows the officer opened the door of each room, looked inside, and appeared to get a response from each detainee.

37. Officer A said he reached the man's room around five or six minutes later and realised it was his alarm clock beeping. He went into the cell and said good morning. As the man did not respond, he tapped his leg and shook him vigorously, but there was still no response. He was concerned and immediately radioed a code blue emergency. (A code blue signifies a detainee is not breathing, alerts other staff including healthcare staff to attend and should prompt control room staff to call an ambulance immediately). According to the communications room log, the officer radioed the emergency code at 7.34am.

38. The man was face down on the bed and Officer A moved him by his shoulder onto his side. He said the man's face was flat and out of shape and it was apparent that rigor mortis was present. The officer thought it was clear that the man had died. He left the cell and locked it while he waited for other staff and nurses to arrive. There was some confusion about his location, so he called down the stairs to the other staff. Custodial manager A, said he arrived about three or four minutes after hearing the code blue. The log shows that he requested an ambulance and, according to the log, the control room staff called an ambulance at 7.49am, five minutes after the code blue at 7.44am. (The ambulance log shows the call was made at 7.52am, but this discrepancy could be due to different clock settings.) At a subsequent debrief staff said that the communications room checked with healthcare staff whether an ambulance was required.

39. Officer B, Officer C, Officer D, Nurse A and Nurse D responded to the code blue call and went to the man's room. The nurses and Officer C brought emergency bags with life saving equipment. Nurse A said that the man was unresponsive and there was a small amount of blood on his pillow and mouth, but no sign of injury. The staff did not attempt cardiopulmonary resuscitation, as it was apparent from the presence of rigor mortis that any attempts to resuscitate would have been futile and undignified. Paramedics arrived at 7.59am and confirmed that the man had died.

Support for detainees and staff

40. The Governor of The Verne issued a notice to all detainees informing them of the man's death and offering support from officers and the chaplaincy team. The other detainee said that he felt well supported. He had been allowed to see the man and say prayers with the prison's Imam, before the man's body was removed.

41. Managers invited the staff involved in the incident to a debrief meeting, where they discussed what had happened and offered the support of the care team.

Family contact

42. Officer E acted as The Verne's family liaison officer from 9.00am. She had difficulty finding the man's next of kin details on his file and eventually, at 11.30am, received his mother's contact details from his immigration caseworker. Due to the distance from The Verne, Officer E, asked a family liaison officer at HMP Brixton to break the news to the man's mother and to pass on Officer E's contact details.

43. Officer E telephoned the man's mother at 3.45pm, offered condolences and arranged to visit that day. Officer E and the Head of Residential Services met the man's family at 9.30pm that evening, explained what had happened and offered their support. The man's family later visited The Verne and collected his belongings.

44. The Verne offered an appropriate contribution towards the man's funeral, in line with national guidance. Unfortunately, the centre initially told his family that they could only use funeral directors they approved, which his family were unhappy about. This issue was eventually resolved and the man's family were able to use the funeral director of their choice. The man's funeral was held on 8 July.

Post-mortem report

45. The post-mortem report shows that the man died of neurosarcoidosis, (a condition that causes inflammation within the brain). The inflammation occurred in the brain stem affecting the centres for cardiac and respiratory control, causing sudden cardiac/respiratory arrest.

ISSUES

Clinical care

46. The man sustained a serious head injury in 1998, which caused him to suffer epilepsy. He did not take his anticonvulsant medication as prescribed, so it was less effective at controlling his fits.

47. Before the man arrived at The Verne, the clinical reviewer found some inconsistent medical care when the man transferred between prisons, including administrative delays, errors and mistakes in medication dosages. He noted that on 24 February 2014, while he was at HMP Thameside, the man missed an appointment for an MRI scan, when the prison cancelled it because the man became aware of the date. Dr A made another referral when he arrived at The Verne. The man's Consultant Neurologist advised that a diagnosis of neurosarcoidosis could not have been expected and the possibility of the MRI diagnosing the condition would have been very low (around 15%). However, we are concerned that Thameside cancelled this appointment without appropriate justification.

48. The Prison Service's National Security Framework does not require hospital appointments to be cancelled automatically when prisoners become aware of the time and date, although our experience is that prisons often believe this to be the case. The security guidance expects that the prisoner's condition and the urgency of the treatment required should be taken into account when taking a decision and a risk assessment about the likelihood of the prisoner planning an escape. If necessary, additional security arrangements can be put in place rather than cancelling appointments. In this case, the man was no longer a serving prisoner and we are not satisfied that there was sufficient information to justify cancelling his appointment in February 2014. We make the following recommendation:

    The Director of Thameside should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

49. The clinical reviewer concluded that, overall, the clinical care the man received at The Verne was equivalent to that he might have expected in the community. However, the maintenance and continuity of his medication fell below the expected standard. In his review, he has made recommendations on these matters, which the National Offender Management Service and the relevant healthcare providers will need to address. We do not repeat them in this report as they were not directly related to the circumstances of his death.

Compliance with medication

50. When the man first arrived at The Verne, nurses became aware that he was not collecting and taking his anticonvulsant medication as prescribed. He told them he found it difficult to get up in time to go to the medication hatch in the morning. On 20 May, the GP then prescribed a weekly supply of medication for him to keep in his room rather then attend to collect it each day. The GP asked nurses to check weekly to ensure the man was taking his medication. The man died two weeks later, but there is no evidence that nurse checked this or

discussed it with him, even when Dr A asked them to ensure that he was seen on 3 June, the day before he died, when she noted he had not collected his second week's supply of medication.

51. The Verne does not have a policy for managing medication compliance. When interviewed in July 2014, the Healthcare Manager, said that failure to collect medication would normally be followed up within two days, or immediately if the detainee was diabetic. She said that she was preparing a medication compliance policy, which would include a process to alert nurses when a patient did not attend for critical medication, but we understand this had not yet been implemented. Since the draft report was issued, the medication compliance policy has been implemented.

52. Ultimately, it was the man's responsibility and choice whether to take his medication as prescribed. There is no suggestion that he lacked capacity to make decisions about his care and medical treatment and it is apparent that the healthcare staff at The Verne warned him about the consequences of not taking his medication. However, the clinical reviewer considered that The Verne should have better systems to help ensure that detainees take critically important medication. He considered that rather than making an appointment for a review, healthcare staff should have been more proactive and acted immediately by taking the medication to him. We make the following recommendation:

    The Healthcare Manager at The Verne should ensure that there is a system to identify when detainees do not collect critical medication and that healthcare staff take appropriate urgent action.

Calling an ambulance

53. In line with national instructions, The Verne's medical emergency codes protocol states that it is mandatory for the control room to call an ambulance immediately an emergency medical code is called and wait for updates from the scene. Officer A called a code blue at around 7.44am. In the meantime, while waiting for additional staff to attend, he checked the man and found evidence of rigor mortis, so he did not attempt resuscitation. A custodial manager arrived a few minutes later and contacted the communications room, who then requested an ambulance at 7.49am, five minutes after the code blue had been called.

54. We are concerned that the control room staff did not act in accordance with the mandatory emergency codes protocol, as they waited for authorisation before requesting an ambulance. Although the delay would not have made a difference to the outcome for the man, five minutes can be critical in getting appropriate medical care in an emergency. We make the following recommendation:

    The Manager of The Verne should ensure that control room staff call an ambulance as soon as an emergency medical code is called.

RECOMMENDATIONS

1. The Director of Thameside should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

2. The Healthcare Manager at The Verne should ensure that there is a system to identify when detainees do not collect critical medication and that healthcare staff take appropriate urgent action.

3. The Manager of The Verne should ensure that control room staff call an ambulance as soon as an emergency medical code is called.

ACTION PLAN: The man – HMP The Verne and HMP Thameside

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and Function Responsible
1	The Director of Thameside should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.	Accepted	Prisoners will not miss hospital appointments unless there are properly justified, exceptional and fully recorded clinical or security reasons. If a prisoner misses an appointment, the reason for this will be recorded by the Healthcare Manager and Security Manager.	Completed Healthcare Manager / Security Manager
2	The Healthcare Manager at The Verne should ensure that there is a system to identify when detainees do not collect critical medication and that healthcare staff take appropriate urgent action.	Accepted	There is a clear system in place which identifies patients that do not collect critical medication daily and weekly.	Completed
3	The Manager of The Verne should ensure that control room staff call an ambulance as soon as an emergency medical code is called.	Accepted	Local instructions have now been reviewed and published to ensure that control room staff are aware of the need to call an ambulance as soon as an emergency medical code is called.	Completed Head of Safer Detention