PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Littlehey in March 2011

Report by the Prisons and Probation Ombudsman for England and Wales

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This is the report of an investigation into the death of a man who died in March 2011 at HMP Littlehey. He was 47 years old. The cause of his death was hypertrophic cardiomyopathy[1]. I offer my condolences to the man's family and friends.

Following the man's death, Cambridgeshire Police investigated the circumstances, however the Crown Prosecution Service (CPS) eventually decided that criminal charges would not be brought. This investigation was therefore delayed by over 14 months as it was not possible to begin until the police and CPS had completed their work. I am sorry for the consequent delay in the issue of this report.

One of my investigators conducted the investigation. A review of the man's medical care was undertaken by a clinical reviewer. Littlehey prison cooperated fully with the investigation.

The man was prescribed clozapine, a rarely used drug for the treatment of schizophrenia. The drug is not suitable for people with certain heart conditions. Although there were indications that he had an enlarged heart these were not followed up appropriately even when he missed a number of relevant appointments. It cannot be ruled out that this was a contributory factor towards the man's death.

On the night of 9 March 2011, the man collapsed in his cell. The senior officer in charge of the prison went to the man's cell, assessed him, and thought he had experienced a fit. Although he was unconscious an ambulance was not called and the senior officer left him in his cell. None of the prison staff who attended were first aid trained. The man was found dead the following morning.

The investigation found a number of serious omissions in the man's care at both HMP Pentonville and HMP Littlehey. Important tests and referrals which might have indicated that clozapine was an unsuitable drug were not undertaken. The emergency response when the man was found collapsed in his cell was woefully deficient and there appears to have been a failure in the duty of care towards him. I have therefore recommended that the Governor of Littlehey undertakes disciplinary investigations into the actions of the staff involved.

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 Newcomer CBE
Prisons and Probation Ombudsman **February 2013**

[1] Hypertrophic cardiomyopathy is a condition where the heart muscle becomes thickened.

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SUMMARY

1. The man died in March 2011, when he was 47 years old. The cause of his death, provided by the post mortem, was hypertrophic cardiomyopathy. He suffered from schizophrenia[2] and was prescribed the drug clozapine[3] from 2004. Clozapine is contraindicated[4] in patients with heart problems, in particular cardiomyopathy, and can only be prescribed by a psychiatrist.

2. Due to concerns over his mental health, the man spent periods as an inpatient at a mental health hospital between 2002 and 2010. Over the same time period tests showed he had a heart abnormality. This led to four referrals over the years to heart specialists, but he never attended any of his appointments. Throughout this period, his prescription of clozapine continued.

3. On 21 May 2010, the man was charged with sexual assault. In police custody he said that he was taking medication for schizophrenia. On 24 May the man was remanded to HMP Pentonville after appearing at court.

4. The man continued to be prescribed clozapine by his community psychiatrist from the Barnet, Enfield and Haringey Mental Health NHS. During his stay at Pentonville he had a heart scan (echocardiogram) that showed problems with his heart. Despite this test result, he was not referred to a cardiologist (heart specialist) for further action.

5. The man was later transferred to HMP Littlehey on 4 February 2011. He continued to be prescribed clozapine.

6. On an evening in March, the man's cell mate raised the alarm after finding him unconscious. He believed his cell mate might be dead. Prison staff went to the cell immediately. The senior officer examined the man and found him unconscious and could not rouse him, but said he was breathing. For reasons that are unclear the senior officer believed that the man's unconsciousness was due to an epileptic fit and assessed that he would "sleep it off". He was subsequently left in his cell overnight and never regained consciousness.

7. The investigation makes six recommendations which refer to a number of serious omissions in the care the man received. Medical information was not transferred between prisons and important tests and referrals were not undertaken. The failure to refer the man for medical attention in the hours before his death, after prison staff found him unconscious was a serious breach of the prison's duty of care.

[2] Schizophrenia is a mental illness. Symptoms include hallucinations (such as hearing voices), delusions (false ideas), disordered thoughts, and problems with feelings, behaviour and motivation

[3] Clozapine is known as an atypical antipsychotic. Its use is limited to patients with schizophrenia who are non-responsive to, or intolerant of, other antipsychotic drug treatments.

[4] In medicine contraindication is a condition which makes a particular treatment or procedure inadvisable.

THE INVESTIGATION PROCESS

8. One of the Ombudsman's investigators visited HMP Littlehey on 16 March 2011, and met the Governor and some of his staff. Notices about the investigation and its terms of reference had already been sent to the prison to invite anyone with any information to contact the investigators. The investigator also met representatives of the Prison Officers' Association, the Police Liaison Officer and the Head of Healthcare. He visited the wing where the man lived at Littlehey.

9. The police were concerned that prison staff had not acted appropriately when they were first alerted to the man having breathing problems. As a result, the police seized all prison documentation and subsequent interviews were completed with a number of staff, under police caution. The police shared key documentation including prison staff witness interview statements with the investigator, but the PPO protocol with the police meant that our investigation was suspended until the outcome of that investigation.

10. Following submission of the police report to the Crown Prosecution Service, it was decided that no criminal charges would be brought. This process took approximately 14 months. Once this office was informed by the police of the CPS decision, the investigator was able to resume his investigation in June 2012.

11. The investigator informed the prison once again of the Ombudsman's investigation. Staff and prisoners were asked to contact him if they had any relevant information. He conducted several interviews with staff and one prisoner. After the interviews, the initial findings of the investigation were fed back to the Governor.

12. The investigator also visited HMP Pentonville as part of his investigation and interviewed the doctor who was responsible for the man's care there.

13. A clinical reviewer was commissioned by Cambridgeshire Primary Care Trust (PCT) to provide a clinical review report on the man's medical care.

14. One of the Ombudsman's Family Liaison Officers (FLOs) contacted the man's family and informed them of the investigation. They had no specific questions for the investigator to consider. The man's daughter and her legal representative received a copy of my draft report as part of the consultation period. They decided their concerns may be better placed to be raised directly with the Coroner at the inquest. I would like to thank them for their consideration of the report.

15. The report has been disclosed to those members of staff who have been directly criticised, none of whom made any further comments following this disclosure.

HMP LITTLEHEY

16. HMP Littlehey is a category C male prison outside the village of Perry in Cambridgeshire. (Category C prisoners are those who cannot be trusted in open conditions but who are unlikely to try to escape.) It holds a maximum of 1.220 with up to 480 young adults accommodated in a new young offender unit opened early in 2010.

17. Health services at Littlehey are commissioned by NHS Cambridgeshire. Medacs Healthcare Group provides locum GPs at the prison six days a week. On-site specialist services include dentistry, optometry, podiatry and physiotherapy. Nurse-led clinics are held for life-long conditions such as asthma and diabetes. There are no inpatient beds at Littlehey. The nursing team works during the day on weekdays and on Saturday mornings. At other times cover is provided by an out of hours service.

Her Majesty's Inspectorate of Prisons (HMIP)

17. The most recent HMIP report was an unannounced full follow up inspection conducted in November 2011. Inspectors commented that healthcare services were generally good, but considered the healthcare department was too reliant on locum doctors. Inspectors noted that, "The medical provider, Medacs, used a high number of locum staff, which resulted in inconsistency in prescribing and decision-making" and sometimes there was no medical cover at all. Inspectors noted good partnership working with the local NHS Cambridgeshire supported by prison management.

Independent Monitoring Board (IMB)

18. All prisons have an IMB made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. In its latest report for the year from February 2011 to January 2012, the IMB commented that:

> "The Board believes that the Healthcare department generally offers a caring environment for the prisoners within HMP Littlehey. Medical services offered within the prison are supplied by the local Primary Care Trust (PCT). The provision of GP services by Medacs continues to cause concern, particularly with the supply of temporary cover. The prison is working with the PCT to remedy this inconsistent medical service".

Previous deaths at Littlehey

19. This office has investigated 18 deaths at Littlehey. None of the circumstances of those other deaths are similar to this man's.

Background information about clozapine (drug prescribed to the man)

20. Clozapine is a drug used in the treatment of schizophrenia. It is known as an atypical antipsychotic. Its use is limited to patients with schizophrenia who are non-responsive to, or intolerant of, other antipsychotic drug treatments or patients with psychosis in Parkinson's disease when other treatment strategies have failed.

21. The manufacturers of clozapine, Novartis, who have branded the drug as Clozaril, have established the Clozaril Patient Monitoring Service (CPMS) to provide blood monitoring of patients receiving Clozaril (clozapine). CPMS guidance is that:

> "All Clozaril-treated patients must be under the supervision of an appropriate specialist physician (usually a psychiatrist). All specialists wishing to prescribe Clozaril and all pharmacists with the responsibility for dispensing Clozaril must be registered with the CPMS by signing an agreement."

22. CPMS stipulate the frequency of monitoring of blood tests to detect neutropenia, which is where the drug can cause the number of white cells in the blood to be diminished and thus render the patient susceptible to infection. Guidelines then instruct when it is safe for the patient to receive the drug depending on the level of the white cells.

23. All UK doctors are issued with a copy of The British National Formulary (BNF) which is used as the main source of information on prescribed drugs. This states that antipsychotic drugs should be used with caution in patients with cardiovascular disease. For clozapine it states that 'fatal myocarditis and cardiomyopathy (have been) reported'. The BNF's guidance to clinicians is: "specialist examination required if cardiac abnormalities or history of heart disease found. If myocarditis or cardiomyopathy suspected, clozapine should be stopped and patient evaluated urgently by cardiologist."

24. Clozapine can be prescribed only by a consultant psychiatrist. While the man was in prison, he was mainly under the care of a community consultant psychiatrist from the Barnet, Enfield and Haringey Mental Health NHS Trust. His medication was issued through the outside hospital's pharmacy in Tottenham.

KEY EVENTS

25. The man was born in London in August 1968. He had 14 previous convictions dating back to 1981. These included acts of using threatening behaviour, insulting words and behaviour, attempted burglary, theft and conspiracy to rob. A psychiatric report written in May 2010, noted that the man had started using cannabis at the age of 16 and began using cocaine at the age of 20. He also was a heavy drinker.

The man's health before his imprisonment at Pentonville

26. The man had been treated for mental health problems since 1996 and had received a variety of diagnoses including paranoid schizophrenia, schizoaffective disorder and dissocial personality disorder. In February 1997 he was remanded by a court to a mental health hospital for a report on his mental condition under section 35 of the Mental Health Act 1983. He was discharged a month later. In April 1997, he was sentenced to four years imprisonment for a sexual offence. In 1999, he was released on licence after serving two years.

27. In November 2001, the man sustained a serious head injury while under the influence of crack cocaine. He was treated in a brain injury rehabilitation centre where testing revealed he had borderline learning disability with memory loss.

28. A consultant psychiatrist on the Community Rehabilitation Team from the mental health hospital provided a summary report about the man for the investigator. He noted that for a number of years the man had been seen by psychiatrists from the North London Forensic Service and later Barnet, Enfield and Haringey Mental Health NHS Trust. In August 2002, he was admitted as an inpatient to the mental health hospital complaining of low mood and hallucinations telling him to kill himself or someone else. He remained at the hospital for around three years.

29. During his time in hospital the man was thought to have had a heart murmur. On 26 June 2004, he had an ECG[5] test which produced an abnormal result. His consultant psychiatrist faxed the ECG to a registrar at a further hospital. He wanted to start him on clozapine, an antipsychotic medication, and this was agreed by the doctor at the hospital. A care plan was initiated under which he would receive weekly ECGs. His psychiatrist prescribed clozapine in June 2004. The man later produced positive test results for cocaine in August and September 2004.

30. On 12 November 2004, while still an inpatient at the mental health hospital, the man's consultant psychiatrist referred him to see a consultant cardiologist at a further hospital, for assessment. Further tests had revealed a new heart murmur and a slightly enlarged heart. According to the consultant psychiatrist's report, the man was still smoking crack cocaine. An echocardiogram (which takes pictures of the heart and gives images like those seen on a radar screen)

[5]ECG (electrocardiogram) is a test that measures the electrical activity of the heart.

was requested. As the man's heart rate was faster than normal, his clozapine was stopped for a few days at the end of November 2004, but then restarted.

31. In December 2004, it was noted that the man was still awaiting echocardiogram and cardiology outpatient appointments, which had been requested the previous month. In February 2005, his psychiatrist made a further referral to the hospital cardiology department as the man's ECGs consistently showed abnormalities.

32. Later in 2005, the man was discharged from the mental health hospital to a residential care home. It does not appear that he saw a cardiologist before he was discharged.

33. On 13 July 2006, the man was again admitted to the mental health hospital. He said he was experiencing auditory hallucinations associated with his recent use of crack cocaine. After examination he was again found to have abnormalities with his heart. A referral was sent to the Cardiology Department at a further hospital on 31 July.

34. By the beginning of August 2006, the man's mental state was said to have settled and he was discharged from hospital back to his residential home. He continued to attend the mental health hospital regularly as an outpatient and was still taking clozapine.

35. Following a change of address, the man's care was transferred to the Haringey Community Rehabilitation Team. He was seen by a new psychiatrist in December 2009 and, following an ECG in February 2010, heart abnormalities were again identified. The psychiatrist contacted the man's GP (general practitioner) in April 2010, and sent a copy of the ECG and recommended a referral to a cardiologist.

36. The consultant psychiatrist's report states that the mental health notes show no evidence of the man ever being seen by a cardiologist. He checked with the hospital and was informed that, although cardiology appointments had been made, he had not attended them.

37. On 21 May 2010, the man was arrested and detained in police custody, charged with sexual assault. He told the police that he was taking clozapine for schizophrenia. He appeared at a magistrates' court on 24 May and was remanded into prison custody at HMP Pentonville.

The man's arrival at HMP Pentonville

38. The man arrived at Pentonville in the evening of 14 May. A nurse who carried out his routine reception healthcare screening noted on SystmOne (the electronic medical record) that he had a history of substance misuse which included taking crack cocaine and that he was taking psychotropic medication for schizophrenia. The nurse recorded that the man's mood was depressed, but that he said he had no thoughts of wanting to harm himself. He was referred to see the prison doctor.

39. The prison doctor recorded that the man was cocaine dependent, had a history of schizophrenia and had no current thoughts of self-harm. A referral was made for him to be seen by the mental healthcare team as he had been a patient under the care of a mental health trust hospital. The doctor noted that the man was taking clozapine tablets (300mg to be taken at night and 100mg to be taken in the mornings).

40. During the man's first few days at Pentonville, prison healthcare staff liaised with the police and the mental health hospital about his medical condition. They received a letter from the police psychiatric nurse as well as confirmation from the mental health hospital that he was taking clozapine and had been under their care. Healthcare staff were to liaise with the hospital about his medication. A subsequent mental healthcare meeting took place on 25 May where the man's health was discussed in more detail and more information about his medical condition was sought. He was also to undergo a psychiatric assessment under the instruction of the court.

41. It was agreed with the mental health hospital that until a new consultant psychiatrist was identified as being responsible for the man's care (either in prison or in a secure hospital if he was transferred), he would remain with his named consultant registered with the Clozaril Patient Monitoring Service. His clozapine would be dispensed by the mental health hospital's pharmacy and Pentonville would arrange for him to have the blood tests needed while he was being prescribed clozapine.

42. On 28 May, a doctor reviewed the man who said he felt well and had no health concerns and no affective or psychotic symptoms. He was still taking clozapine and had experienced no adverse side effects. He was noted to be calm and cooperative. He said he had no thoughts of self-harm or hallucinations. His next monthly clozapine bloods tests were due on 1 June.

43. Following the court instruction, a psychiatric assessment (dated 27 May) was conducted. The report noted that the man showed no active mental health symptoms and that there was no need for his diversion to hospital under the Mental Health Act. He was assessed as fit to attend court. However, the psychiatrist had some concerns about the man having a possible learning disability and requested a forensic learning disability assessment. This was carried out on 2 June by a consultant forensic psychiatrist at Pentonville. He considered that the man did not show signs of illness at their interview and had not been mentally unwell at the time of the offence. He concluded that the man did not have a learning disability, and noted he was settled and had no issues with his medication.

44. During the man's stay at Pentonville he continued to receive regular blood tests while he received clozapine. His medical record noted that his blood tests were completed and monitored by a prison doctor. His blood test results were mostly noted as "normal".

45. Clozapine is associated with an increased risk of heart disease. If heart disease is suspected, clozapine should be stopped and patients immediately referred to a cardiologist. This should also prompt regular ECGs. The doctor who was in charge of completing and monitoring the man's blood tests was not aware that there had ever been any concerns about his heart and it is not clear that the man knew that potential problems had been identified for further examination in 2004 and 2005 which had not been followed up. He did not mention any heart problems to healthcare staff at Pentonville.

46. On 13 July, it was noted on SystmOne that the man had been in contact with a patient with tuberculosis (TB). As a precaution a chest X-ray was ordered to see if there was any evidence of TB in his lungs. His X-ray report completed by a consultant radiologist at outside hospital, dated 27 July, stated "There is significant cardiac enlargement. The lung fields look essentially clear. Hypertension?" [The radiologist is asking the question: has the patient got high blood pressure, also known as hypertension, which can lead to an enlarged heart].

47. On 21 July, the man attended court and pleaded guilty. He was to return to court at a later date to be sentenced.

48. A note in the man's medical record indicated that a nurse carried out an ECG on 9 August. No reason is recorded for conducting this test. Two days later the doctor in charge of completing and monitoring the man's blood tests requested the ECG results. The nurse she spoke to said she would chase the results as they were not available at the time.

49. The doctor saw the man on 12 August. She reviewed his chest X-ray result of 20 July and noted the possibility of him having an enlarged heart. At the time, the man complained of suffering from shortness of breath and feeling tired. The doctor found nothing abnormal when she examined him. His blood pressure reading was 145/92mmHg (which is considered as slightly raised). The doctor noted that she was waiting for the ECG result carried out a few days earlier and would review the man in a week's time when the ECG result was available.

50. It is recorded on SystmOne that the man had an appointment with the doctor in charge of completing and monitoring his blood tests, on 19 August, however he did not attend. The reason is not recorded.

51. On 25 August 2010, a routine echocardiogram[6] was ordered by the doctor. Two days later it is noted in the man's medical record that a nurse carried out a routine ECG test. No results were recorded on SystmOne for this or earlier ECG tests.

52. The echocardiogram test was carried out at hospital on 14 October 2010. The results showed that the man's heart muscles were severely enlarged, but with overall good pumping action. The report was filed in his notes on 15 December

[6] An echocardiogram test gives good information about the structure and function of the heart.

2010, bearing the doctor's signature but with no date. There are no comments in the notes to show that this test was acted upon.

53. The doctor told the investigator that she did not recall seeing the echocardiogram report filed in December 2010 which showed an abnormality with the man's heart. In a statement for the investigation, she said:

> "My ordinary practice when receiving an echocardiogram report such as this would be to refer the patient for urgent specialist cardiology review. I simply do not know why I did not refer [the man] on reviewing the report but I deeply regret that I did not do so. With hindsight and on reflection I believe I must have read the report incorrectly, or if I read the report correctly then I planned to refer him but failed to do so. I do remember that I was very busy at the time and that I was the only consistent GP liaising with a lot of locums, which meant I had a large workload. I do not mention this as an excuse but as an explanation as to why this may have occurred."

54. The doctor further explained that Pentonville had staffing problems at this time. A number of locum doctors had been employed and were not given full access to the medical computer system. In addition she was also the only doctor reviewing large amounts of medical paperwork and reports. It was not unusual for her name to be assigned to patients' treatments, even though she might not have been responsible for them. Her name often appeared as having filed blood tests results in patients' records, even though she might not have been the person who requested them.

55. The doctor also said she was not directly responsible for monitoring or reviewing the man's medication. Neither was she fully aware of the problems associated with clozapine and patients who might have abnormal hearts.

The man's transfer to HMP Littlehey

56. On 22 December 2010, the man was sentenced to 30 months imprisonment with an extended license period of 2 years and 6 months.

57. On 3 February 2011, a nurse at Pentonville completed a medical discharge summary report in preparation for the man's transfer to HMP Littlehey the next day. The summary was to be forwarded to Littlehey with the man's medical record. It noted that he was currently taking clozapine and that he had been referred for an echocardiogram on 25 August 2010. It did not record the outcome of the echocardiogram.

58. The man transferred to Littlehey on Friday, 4 February 2011. As part of the routine reception screening process a cell sharing risk assessment, to check his safety and suitability to share with others, was completed by an officer. This recorded him as low risk. The man said he had no problems with sharing a cell, but preferred a single cell. His reception health screen was carried out by a nurse who noted that he had a history of schizophrenia and was prescribed

clozapine. From reception the man was taken to E wing, the prison's induction wing.

59. The next day, 5 February, an officer interviewed the man as part of his prison induction. He noted that the man was respectful and communicated well and said he was happy to be at Littlehey where he felt safe and settled. He disclosed to the officer that he used to hear voices but was okay now. He accepted guilt for his offence and understood he would be assessed for the prison's Sex Offender Treatment Programme (SOTP).

60. A nurse carried out a secondary health screen and noted again the man's history of schizophrenia and his medication. The man said he had used cannabis and crack cocaine regularly and that he had a family history of psychiatric conditions. He was considered able to work in the prison, with no need for any restrictions on his location or cell occupancy. The man made no reference to having a heart problem. The nurse referred him to the mental health team because of his mental health history and medication.

61. The man completed his induction and then moved to another cell on E wing, which he shared with a fellow prisoner. The man's cell mate told the investigator that he already occupied the bottom bunk bed so the man had the top one. From the outset, the man had slept on his mattress on the floor every night. He told his cell mate that this was a protest at not being given his own cell. He also said he had pains in his legs which made it difficult for him to climb on and off the top bunk. The man's cellmate said this was the only health related issue that he ever mentioned to him. He also said that the man was a very heavy snorer and made lots of noise when he slept.

62. On 9 February, a doctor reviewed the man's medication and noted that he was to continue on his current dosage of clozapine 100mg tablets, one in the morning and three at night. He had to go to the medication hatch each day to collect it and had regular contact with the nurse who dispensed his drugs. The nurse told the investigator that the clozapine the man had arrived with was about to run out and she was unaware exactly how to obtain a further supply as the details about the administration and prescribing of his clozapine had not been provided by Pentonville. As the labelling indicated the clozapine was issued by the mental health hospital's pharmacy, the same was contacted for further advice.

63. The mental health hospital explained that the man's clozapine was supplied under the authorisation of his community mental health co-ordinator and that patients on clozapine needed regular blood tests every four weeks. The results had to be faxed to the mental health hospital's pharmacy who would then authorise the clozapine and its dosage and post the medication to the prison. The man's new supply of medication was due on 21 February, so the nurse arranged a blood test urgently.

64. Later on 9 February, around 5pm, an RMN and a prison doctor saw the man for a mental health triage. The man reported no concerns, and said he did not have a history of deliberate self-harm or suicide and reported no symptoms of

illness. He told the nurse and doctor that he had spent two years in a mental health hospital from 2009, and after his discharge his care was monitored by the Haringey Community Rehabilitation team.

65. When a prisoner who has an ongoing or chronic health condition transfers to another prison, healthcare staff are expected to review and familiarise themselves with the patient's history from the medical records. This is to ensure continuity of care and to check they are receiving the correct treatment. The man's full medical record was available to healthcare staff when he transferred to Littlehey, but there is no evidence to indicate that they reviewed this in any detail. Had this been done the healthcare staff might have identified that possible concerns about his heart had been recorded, most recently in April 2010, but no action had been taken.

66. The man saw the nurse who dispenses his drugs on 14 February. He complained of a skin abscess (swelling) on his right temple and was prescribed flucloxacillin (an antibiotic) 250mg, four times a day for a week. He also received his blood tests, which were reviewed the following day by a doctor. The results were noted as abnormal however this was expected. [The results show a slightly raised total white cell count. Clozapine can cause reductions in the total number of white cells in the blood; an elevation of this nature would therefore not be a cause for concern.] The results were faxed to the mental health hospital's pharmacy, as required.

67. On 18 February, the man was seen by a doctor in relation to his skin abscess. He had had the swelling for about a week which was 5 x 5cm in size. The doctor considered it to an infected sebaceous cyst[7] and noted that he was already on antibiotics. He further prescribed the same antibiotics for another week.

68. The man had his next monthly blood tests on 3 March. The results were reviewed and recorded on 4 March, by a doctor. They were normal and no further action was noted.

69. On 7 March, the man told the nurse who dispenses his medication he was having difficulty climbing on and off his top bunk bed and wanted to move cells. As she was not responsible for cell allocation, the nurse completed a medical form for the attention of E wing staff and stated that "[The man] has top bunk which he has great difficulty in climbing on and off". She asked if he could have a bottom bunk. There is no further reference to this in the man's prison records.

Events the day before the man's death up to 10.30pm

70. During the day before the man's death, his cell mate said there were no unusual occurrences. The man took his daily clozapine medication as normal and between 4.30pm - 4.45pm, he and his cell mate had tea in their cell as they usually did. The man's cell mate said the man appeared fine and they chatted.

[7] Sebaceous cysts most often arise from swollen hair follicles.

In the evening, prisoners are unlocked for about an hour from 6.00pm during which time they can socialise with each other, make telephone calls and have showers. When their cell was unlocked, the man left and returned to the cell at 7.00pm.

71. His cell mate told the investigator that he and the man started to watch television at around 7.00pm. The man wanted to go to bed shortly after this, which his cell mate said was not unusual. He helped him put his mattress on the floor and within five minutes, he appeared to fall asleep. He said that the man's snoring was slightly quieter than usual. His cell mate had no concerns about him at this point.

72. An officer started the nightly count of prisoners (known as the roll check) on E wing at around 8.00pm. He said all appeared fine with the man and his cell mate. The man had previously told him that he preferred to sleep on the floor so he was not concerned to see him doing this.

73. The man's cell mate was dozing in and out of sleep when he was woken around 9.50pm by the man, who had shouted out to him that he had pains in his chest and thought he was dying. His cell mate said that the man held his chest for about 20 seconds and looked flushed. He told his cell mate that he was going to have to stop smoking. His cell mate offered to call for staff assistance by ringing the emergency cell bell, but he said he would lie on his side and would be okay. After this, his cell mate turned the volume down on the television as the man was obviously trying to get back sleep. A short while after his cell mate noticed that the man's snoring appeared to have been replaced by abnormal breathing. He described the noise as a death rattle which sounded like an exhaling, wheezing, breathing noise. His cell mate became very concerned as he believed something was seriously wrong with the man, so he rang the emergency cell bell.

Events that evening between 10.30pm and 10.36pm

74. The officer responded straightaway to the emergency cell bell at 10.30pm. As he got near the cell, he heard what he believed to be a snoring noise. He opened the cell observation panel and his cell mate told him he was concerned about the man and thought he was possibly in a coma. He said he was not well, was unsure if he was breathing and that he might be dying.

75. At interview, the officer said that the man's cell mate had told him that the man had been twitching but this had stopped and he could not be woken. His cell mate told the investigator that he had not made any mention of the man's body twitching to anyone.

76. The officer saw the man lying on his mattress in front of the cell door. He was on lying on his right side, uncovered and his shirt was raised. He could see the man's stomach and torso moving in and out, an indication that he was breathing. He asked the man's cell mate to shake him to try and get a response and wake him up. The man did not respond when shaken. He then asked him to get a cup of water and drip some water onto the man's face. He

did this twice but the man still did not respond. There was still clear movement from his stomach area. Concerned that the man had not responded to voice or physical stimulation, the officer decided to contact the night orderly officer (NOO, the person in charge of the prison at night). He went back to the wing office and telephoned the NOO.

77. The NOO was on G wing and the officer explained the situation. He said he told the NOO that the man had apparently been twitching but stopped and, although he was breathing, was unresponsive and could not be woken. The NOO said he would come to the wing straightaway to check. The NOO's account is that the officer told him that the man had had an epileptic fit.

78. The man's cell mate described to the investigator that at the time he called for help the cell was full of a "horrific" smell and he believed the man's bowels had opened. The officer also said at interview that the cell had a bowel smell.

79. The officer returned to the cell within three minutes. He realised that the snoring noises had now stopped. When he looked through the observation panel again, the man was lying in the same position, but his stomach movements were less clear, leading the officer to believe the man might not be breathing. He radioed the communications room to raise the alarm. The message taken and recorded in the communications room log book was detailed as occurring at 10.36pm. It noted "Urgent assistance req E Wing/ prisoner not breathing".

Events that evening between 10.36pm and approximately 10.40pm

80. While he waited outside the man's cell, the officer considered whether to break his sealed key pouch[8] to enter the cell. However, because of the security implications of entering a cell with two prisoners he decided to wait for staff back-up. He was not familiar with either prisoner and the man's cell mate was in a "hyped up, upset, distressed" mood which made the officer concerned that his safety could be compromised.

81. HMP Littlehey's Night Orderly Operating Procedures states that cells must not be unlocked during night state without the authority of the NOO who should normally be present**.** If a cell is occupied by two prisoners then it should be unlocked with three Officers present. In an emergency situation however, staff have a duty of care to prisoners, to themselves and to other staff and the preservation of life must take precedence. Where there appears to be immediate danger to life, then cells may be unlocked without the authority of the NOO (but subject to a risk assessment of the situation) and an individual member of staff may enter the cell on their own.

82. The NOO was on the way to E wing when he heard the urgent radio call and arrived there in less than a minute. Three officers (all assistant orderly officers) also responded to the emergency call, in that order.

[8] Night patrol officers do not have keys to cells but carry a sealed pouch which contains a cell key which should only be used in emergencies. Night Orderly Officers do carry keys.

83. The officer who was first on scene briefed the SO on what had happened. The man's cell mate had moved the man's mattress back from the door so the staff could enter the cell and he then sat on a chair at the back of the cell. The NOO unlocked the cell door and went in. The man was lying on his mattress on the floor with his feet towards the door and his head level with the bed, which was on the right side of the cell. His head was on the pillow and he was in the recovery position[9]. The man's cell mate said that when the cell door was opened, two of the officers refused to come in because of the bad smell. They remained in the doorway.

84. The NOO said the cell mate was in a panic as he believed the man was dead. He told the investigator that his cell mate said the man suffered from fits and slept on the floor to prevent himself from injury if he had a fit and fell from the top bunk.

85. The NOO said he could not recall when he last received first aid training but believed it was at least five years previously. Nonetheless, he said that he checked the man for signs of life, found a pulse on his wrist and that he was breathing, as he said he felt a flow of air coming from his mouth. He also felt under the man's shirt, and his chest was moving up and down and he felt a "good regular heartbeat". His body was warm and he had good circulation in his finger tips which he tested by pinching them. The NOO's opinion was that the man was alive. To try to reassure the man's cell mate of this, the NOO told him to put his hand on the man's chest to feel his heartbeat. The man's cell mate told the investigator that he did this reluctantly as he did not believe he had the relevant training. In any case, he said he did not feel a heartbeat.

86. The man did not wake up or otherwise respond during the NOO's examination. He said that his experience of people fitting was that they would enter into a deep sleep and wake up anything from four to nine hours later and be confused. He said he told the man's cell mate this. When asked whether he tried to rouse the man, the NOO said he shook and pinched him and, although he said the man made an initial groan noise, he did not respond. Again the NOO told the investigator that he "wasn't unduly concerned about that because the information that I'd been given [by the officer and the man's cell mate] was that they'd suspected he'd had a fit".

87. The NOO decided to leave the man where he was to recover from what he regarded as a fit and told his cell mate to ring the cell bell if he had any further concerns. He asked the officer to check both prisoners throughout the night. The NOO said that all the staff that had attended the wing with him were experienced and if they had had any concerns about his actions, they would have spoken to him about them.

88. The other officers who were present appear to have limited recollections of events. The first officer from that group who responded said he stood in the doorway with two of his colleagues when the NOO went in to the cell. He said he saw the NOO bend down and check the man for signs of life, and talking to

[9] The recovery position is considered by health practitioners as the best position for a casualty who is unconscious and breathing.

the man's cell mate at the same time. He did not recall what was said, but believed there was a reference to the man having had a fit. He was aware that the man did not respond at all while the NOO checked him. The officer said he was told by the NOO that the man was all right and would "sleep it off".

89. The second officer from that group of three to respond had a similar account. He said that he arrived at the cell just after the door had been opened. He stood at the doorway and his attention was on the man's cell mate, whom he tried to reassure that the matter was being dealt with. He recollected that the NOO said something to the man's cell mate and the officer who had first responded to the incident about the man having had a fit and that he would be okay. He also believed that the man would be okay. He said that the officer who first responded to the incident was told to keep an eye on him.

90. The Control Room log recorded that at 10.40pm they were contacted and told "No further assistance req" in relation to the emergency call that had been made at 10.36pm. Taking into account the time the NOO took to get to the cell and open it, it therefore appears the whole incident was dealt with in less than three minutes.

91. The third officer from that group of three said he was on G wing when he heard the emergency radio message for staff to attend E wing. His recollection was that the message indicated staff were needed immediately because a prisoner was suspected of having a fit or a seizure. By the time he got there, staff had already attended to the man and were leaving his cell. He therefore did not see him. The officer said he was told by the other officers that the prisoner (the man) had had a fit and his cell mate would be keeping an eye on him.

92. The second night orderly officer on 9 March was in the gate area[10] when she heard the radio call for assistance on E wing. For security reasons, during night state staff in the gate area are locked in. The officer said she did not attend E wing immediately because she had to wait for a member of staff to unlock the door. When she arrived the NOO and other officers were leaving the unit. The NOO told her that the prisoner they had attended to was okay. The second NOO said she did not know or ask whether staff had entered the man's cell. Nor did she know exactly was wrong with him. She said she had no further conversation that night about the incident.

Events between 10.40pm that evening to 6.00am the following morning

93. When the prison staff locked and left the cell, the cell mate put a blanket over the man to keep him warm. He opened the window to try and clear the smell.

94. Although not recorded, the officer who was the first to respond to the earlier incident said he checked on the man approximately every hour throughout the rest of the night by looking through the observation hatch and using his torch. Each time he saw the man lying on his side on the floor under the blanket. He remained in the same position all night.

[10] The main entrance into the prison, the gate is responsible for checking the ID of all staff, prisoners, visitors and contractors who are going into or out of the prison.

95. The following entry was made retrospectively by the officer who first responded to the incident in the wing observation book after the night's events. He recorded (no time was written when it was done),

> "[The man's cell mate] rang cell bell @ 22.40hrs, saying [the man] was complaining of chest pains and appeared to have a fit and he could not wake [the man] up, was clearly breathing and snoring loudly. NOO was informed **[& attended]** (these words have been crossed through on record). [The man] still would not wake up as he was tired from fit. Urgent message was put out over the net when [the man] stop snoring & breathing was not clear & cell mate was not sure if he was breathing. NOO attended & deemed [the man] was ok & breathing, but could not wake him, Day staff to be aware"

Events from 6.00am

96. The man's cell mate said he slept intermittently overnight. When he got out of bed in the morning around 6.20am, the man was not making any sound. He checked him and found him to be unresponsive, his face looked green and his body was cold and stiff. He rang the cell bell and the officer who was first to respond the previous evening, responded. He told the officer he thought the man was dead. The officer immediately telephoned the NOO.

97. The officer told the second NOO who answered the telephone that he thought the man was dead. The NOO was with her and he quickly went to the man's cell, where he found him unresponsive and had no pulse. His body was stiff indicating that rigor mortis was present. The NOO decided that cardio pulmonary resuscitation (CPR) would not be appropriate as the man had clearly been dead for some time. The Communication Room and an ambulance was requested at 6.30am. Paramedics arrived quickly and at 6.50am, pronounced the man dead.

Support for staff and prisoners

98. The duty governor came to the prison and at 8.30am held a 'hot debrief' meeting with all staff who had attended the man's cell to ensure they were appropriately supported. Members of the Care and Support Team were present. Prisoners on the wing were spoken to individually and offered support and reminded of the services of Listeners and Samaritans. The man's cell mate was moved to the Listener Suite with a Listener for support (Listeners are prisoners trained by the Samaritans to offer confidential support). He was also spoken to by the prison chaplain and the Governor. The Governor issued a notice to all staff and prisoners informing them of the man's death.

Family contact

99. An officer along with a prison chaplain were assigned as the family liaison officers (FLO). They visited the man's mother at around 9.15am that morning and broke the news of her son's death. The FLOs maintained contact with the

man's family and arranged for them to visit the prison and to return his personal property.

100. The prison chaplain assisted the family with the arrangements for the man's funeral which was held on 31 March, and conducted by the chaplain at his family's request. The prison contributed towards the cost.

Post mortem report

101. A post mortem examination was performed by a consultant forensic pathologist on 11 March 2011. In his opinion, the cause of death was hypertrophic cardiomyopathy. A toxicology report completed by a member of staff from the Forensic Science Service indicated that a small amount of alcohol was found in the man's urine, but not in his blood. She concluded that this was probably a result of post mortem redistribution[11] and that he was unlikely to be intoxicated. Clozapine was detected in his blood at a level that was above the 'normal' therapeutic level but at the bottom end of the range associated with fatalities with the drug. The drug level could have increased due to post mortem redistribution. No other drugs were found in the man's body.

102. In the consultant forensic pathologist's opinion, clozapine could have had a role in the man's death. He said, "I have seen the toxicology report of [Forensic Science Service] …. It is apparent that the level of clozapine identified is above the normal therapeutic range. However it is noted that the deceased was apparently prescribed a relatively large dose of this drug and that this drug is subject to post mortem re-distribution which may give rise to falsely elevated levels of a drug in post mortem samples. Nevertheless bearing in mind that this drug is potentially cardiotoxic I cannot exclude a possible role for it in making an ultimately fatal heart rhythm disturbance more likely. I am aware that drugs of this kind have been implicated in promoting sudden dysrhythmic death. With this in mind it should be determined what precautions were being taken, particularly as the deceased had previously been investigated for heart disease."

[11] Post mortem redistribution refers to the changes that occur in drug concentrations after death.

ISSUES

103. The clinical review was conducted by the Associate Medical Director, NHS Cambridgeshire. He makes a number of recommendations about healthcare systems and practice. His view, with which we agree, is that healthcare practices did not ensure that the man's care and treatment was in line with guidelines for patients being prescribed clozapine. However, it is not possible to know whether, in practice, this changed the outcome for the man.

Clinical care

Before the man's imprisonment

104. The clinical reviewer notes that there were several missed opportunities before the man's imprisonment, to detect whether he might have had a heart problem.

105. The summary report provided by the consultant psychiatrist indicates that there had been some concerns about the man's heart for a number of years. Between 2002 and 2010 psychiatrists had detected potential heart abnormalities which had led to four referrals to cardiologists. It does not appear that he ever attended any of the appointments. The man gave little indication that he was aware of a potential heart problem and no diagnosis of hypertrophic cardiomyopathy was made before his death.

106. Although we do not know why the man never saw a heart specialist, it remains the responsibility of a referrer to follow up and make appropriate prescribing decisions on drug safety even if a patient does not attend appointments. It is not known whether the man had a heart problem before he started taking clozapine but he should have had a proper cardiological assessment before continuing on the drug once the possibility of potential heart abnormalities was identified. The manufacturer of clozapine has made it clear in its guidance that patients taking the drug that have known or suspected heart disease including cardiomyopathy need further assessment and possible cessation of the drug.

107. The PPO' s remit does not cover the standard of care the man received in the community, but we will share this report and the clinical review with the Barnet, Enfield & Haringey Mental Health NHS Trust.

The man's stay at HMP Pentonville – the prescribing of clozapine

108. While still under the care of psychiatrist from the Barnet, Enfield & Haringey Mental Health NHS Trust, the man received his clozapine regularly at Pentonville. When she received the results of an echocardiogram carried out on 14 October 2012, that the man's heart muscles were severely enlarged, it was the doctor's responsibility as the referrer for the tests, to arrange further medical tests to be conducted by referring him to a cardiologist. This was not done.

109. After the man's death, a professor in clinical cardiology at the University of East Anglia completed a Medico-Legal Report for the police. He reported that "[the

man] should have been sent to see a cardiologist for an expert opinion and he should then have been risk assessed from the point of view of his hypertrophic cardiomyopathy." However, he also noted that "had an assessment been requested this would have taken some months, and it was unlikely that [he] would have received treatment before the date of his death". Nevertheless, the guidance indicates that if myocarditis or cardiomyopathy is suspected, clozapine should be stopped and the patient evaluated urgently by a cardiologist.

110. The prison doctor accepted that there had been a mistake and agreed that the man should have been referred for cardiology assessment. The clinical reviewer and the investigator were in no doubt of the genuineness of the doctor's intentions and her ability to perform her duties. Previous deaths in custody investigations at Pentonville have also highlighted the heavy workload for the lead prison doctor. Pentonville is a large local prison with a high turnover of prisoners and there is a need to ensure that medical services are appropriately resourced. It was in 2010 when the man was at Pentonville and we understand that the GP situation is now much improved so we make no recommendation about that. However, it is important that healthcare test results are always appropriately followed up. We make the following recommendation:

The Head of Healthcare at Pentonville should ensure there is full and timely scrutiny of investigation results with timely follow up and onward referral of abnormal results.

Information transfer between prisons

111. The arrangement for prescribing and issuing the man's clozapine were unusual because of the particular restrictions associated with the drug. He had been under the care of psychiatrists from Barnet, Enfield and Haringey Mental Health NHS Trust for a number of years and the Trust was responsible for prescribing his clozapine. This arrangement continued while he was in Pentonville.

112. When the man transferred to Littlehey, the consultant psychiatrist from the Barnet, Enfield and Haringey Mental Health NHS Trust was not told of his move. This meant that he retained clinical responsibility for his prescriptions while at Littlehey rather than the usual expectation that care should be transferred to a psychiatrist from the Cambridgeshire NHS.

113. When the man transferred to Littlehey, Pentonville did not provide sufficient information about the process for obtaining further supplies of clozapine and who was responsible. This should have at least been outlined in the healthcare medical discharge summary note written by healthcare at Pentonville. Healthcare staff at Littlehey had to rely on obtaining a contact telephone number from the man's medication packet to make further enquiries.

114. When a prisoner moves prisons it is important that key healthcare information and prescribing responsibilities are reviewed and passed to an alternative clinician if appropriate. There was poor communication in the man's case

which resulted in important information not being immediately available to inform a more comprehensive medical assessment. This was particularly important in this man's case as clozapine is not a frequently used drug, and few healthcare staff would be familiar with the prescribing arrangements. We make the following recommendation:

The Head of Healthcare at Pentonville should ensure that comprehensive summaries of prisoners' healthcare needs, including their prescriptions, are provided when a prisoner transfers to another prison.

The role of prison staff the night before the man's death

The first officer to respond to the incident

115. On the evening of his death, the man told his cell mate that he had chest pains. He apparently became unconscious soon after and his cell mate used the emergency cell bell to get help. We consider that the officer acted correctly in going quickly to the cell, summoning help from the senior officer in charge of the prison and then raising an emergency alarm when he found that the man could not be roused and appeared to have stopped breathing.

116. The man's cell mate was clear in his evidence provided to the police and the investigator that he did not say that the man had had a fit. The officer who first responded to the incident also made no mention at the time that the man had a fit and he did not say so in his interview. However, the entry in the wing observation book made by the officer states that he had had a fit and which is what the NOO said he had been told. The exact time of the observation book entry is not known. It appears to have been made after the events of the evening before as a briefing for staff coming on duty in the morning. It is possible that the account was influenced by the NOO's views about the situation.

The night orderly officer (NOO)

117. When the NOO first examined the man, he said he was breathing. He also said that the man's cell mate and the officer told him that he had had a fit. Both the man's cell mate and the officer say they did not tell the senior officer this. What there is agreement on is that all three who were in the cell at the time, the NOO, the officer and the man's cell mate, had tried to elicit a response from the man and all were unable to rouse him.

118. An epileptic seizure is normally referred to as a fit. The man's medical records do not show any indication of epilepsy. The post mortem tests indicated no signs of him having epilepsy.

119. Littlehey's Night Orderly Officer Operating Policy and Procedure in place at the time of [the man's] death provides clear instructions of what to do if a prisoner reports or complains of being ill during night state. It makes clear that: "*Where the complaint is more serious or in obvious need of attention at the time, the NOO should contact the on-call doctor for instructions or advice. If the*

complaint is one of urgent medical assistance beyond rendering first aid, the NOO should contact the Ambulance Service and prepare to facilitate escort/bedwatch procedures. The Duty Governor must be informed when a prisoner is to leave the establishment. This is the responsibility of the night orderly officer, but the NOO failed to follow this procedure.

120. The clinical reviewer states that even if the man had had a fit, he should have woken up soon after, and the NOO or another prison officer should have stayed with the man to wait for him to wake up to make sure he was okay. Instead, the NOO asked the officer to check on him, which he did hourly but only by just looking through the prison door hatch, which did not allow a proper assessment. The NOO also had the option of contacting the prison's out of hours doctor for advice, but chose not to do so.

121. Medical evidence from the man's post mortem examination report states:

> "With this degree of cardiac disease the deceased (man) was vulnerable to sudden dysrhythmic death[12] at any time. The history suggests that he had an acute cardiac event which caused him to collapse and become unconscious. It is not entirely clear how long he then lasted alive but [he was] apparently unconscious until he finally succumbed. However it is apparent from the history provided by the ambulance service that he was in rigor mortis at the time of their attendance and so would appear to have been dead for some hours at that time."

122. The report goes on to say that:

> "In my opinion it is likely that had the deceased been transferred to hospital immediately following his collapse his prognosis would have been markedly improved and I see no fundamental reason why he would not have survived had he been taken to hospital, bearing in mind that the history suggests that he survived sometime after first collapsing."

123. We consider that the NOO made a serious error of judgement by not ensuring the on-call doctor or an ambulance was called when the man was found collapsed. He had no medical training and should not have made the quick assessment he did that the man did not require medical help, even if he believed the man had had an epileptic seizure. He remained in the cell no longer than approximately three minutes. The NOO's decision meant that the man was left unconscious on the floor of his cell until he was found dead the following morning. We consider that the NOO as the night orderly officer in charge of the prison, did not exercise an appropriate duty of care towards the man. We therefore make the following recommendation:

[12] Sudden arrhythmic death syndrome, is a term used to describe sudden death due to cardiac arrest

The Governor of Littlehey should carry out a disciplinary investigation into the circumstances and actions of the NOO on that evening into the following morning in relation to his failure to seek medical assistance when attending an unconscious prisoner.

Actions of other staff on the night

124. Three other officers also attended the wing in response to the emergency call. Each was interviewed by the investigator and the clinical reviewer. None dispute that the man was unconscious. Their accounts of the night's events were unsatisfactory and lacked any detail of what happened when they attended the man's cell.

125. Two officers stood at the man's door when it was opened, but they were unable to give a comprehensive account of the conversation between the NOO and the cellmate about the man's condition. We find it surprising that neither of them seemed to have entered the cell and relied entirely on the NOO alone to check the man. A third officer arrived on the wing after the man's cell door was locked, and the second NOO arrived when staff were leaving the landing. They therefore did not see the man. The third officer to arrive on the wing said he was told the prisoner had had a fit and would be okay.

126. The communications log recorded that staff were requested to attend the man's cell for an emergency situation as a prisoner was not breathing. This is a very clear, succinct and urgent message. If he was unconscious and, if he had had a fit as stated by the NOO, he would still need some medical intervention. The second NOO was the second in charge of the prison that night and best placed to challenge the NOO's decision. Despite the emergency call that a prisoner was not breathing, she evidently accepted without any question, that the prisoner did not need medical assistance. While this seems surprising, we are aware that some emergency calls turn out not to be as urgent as first thought, and the second NOO had no reason to disbelieve the assurance of the NOO and the other officers who had attended the man's cell that he was now okay.

127. It is a matter of concern that none of the officers present on the wing challenged the NOO's actions or entered the man's cell to check on him. We are also concerned that some of these staff were unable to give the investigator a satisfactory account of the events that night. All prison officers have a duty of care towards prisoners and all of the officers on duty should have been aware of the need to call an ambulance whenever a prisoner is found unconscious. It is surprising that none of the other officers present seemed to consider this or question the NOO's decision.

The Governor should carry out a disciplinary investigation into the actions of all officers who attended the man's cell on that night.

First aid training

128. In prisons, particularly those that do not have a 24 hour healthcare service, prison officers are usually the first to attend an emergency. In this case, the

NOO first entered the man's cell, two officers were stood at the cell doorway. The consensus from these three members of staff was that the man was still alive at that time but unconscious. Although they all accepted he was unconscious, none of then called the on-call doctor or an ambulance.

129. The NOO said he assessed the man but had no recent first aid or resuscitation training. Neither had the two officers and they made no attempt to examine the man or attempt resuscitation. It is a concern that, especially in a prison without healthcare cover at night, none of the prison staff who attended the emergency, including the night orderly officer in charge of the prison, had up to date first aid and resuscitation training.

130. We consider that the Prison Service has a duty to ensure that there are sufficient first aid trained staff on duty at all times to act as first responders in an emergency. We make the following recommendation:

The Governor should ensure that there are sufficient numbers of staff on duty at all times who are have had recent first aid training

Emergency codes

131. When the officer found the man unconscious he radioed the communications room to raise the alarm. The message taken and recorded in the communications room log book was noted "Urgent assistance req E Wing/ prisoner not breathing".

132. While there was no delay in getting the emergency message out, many prisons use a code system to indicate the nature of the emergency. We think this is to be recommended. The use of such codes allows staff attending the emergency to prepare mentally for what they might encounter and helps ensure that appropriate staff attend with the correct equipment. In some emergencies, control room staff are required to call an ambulance if a code indicating a prisoner is not breathing is used. This helps saves valuable time and would have ensured that an ambulance was called in the man's case.

The Governor should introduce an emergency code system, which includes instructions about when an ambulance should be called.

CONCLUSION

133. The man was prescribed clozapine, a rarely used drug for the treatment of schizophrenia. Despite evidence of an enlarged heart, appropriate follow up from doctors was not made over a number of years. The drug was not suitable for people with heart problems but it is not possible to know whether this contributed to the man's death. Information about his prescription was not passed to Littlehey in an effective way.

134. On a night in March 2011, the man told his cellmate he was experiencing chest pains shortly before collapsing. Urgent assistance was summoned and the senior officer in charge of the prison went to the man's cell, assessed him, and thought he had experienced a fit. Although the man was unconscious, the on-call doctor or an ambulance was not called and the senior officer left him in his cell. None of the prison staff who attended were first aid trained. He was found dead the following morning.

135. We conclude that prison staff did not fulfil their duty of care towards the man.

RECOMMENDATIONS

1. The Head of Healthcare at Pentonville should ensure there is full and timely scrutiny of investigation results with timely follow up and onward referral of abnormal results.

   The National Offender Management Service accepted this recommendation, writing:

   "All investigation results for either blood tests or other clinical tests requested are reviewed on a daily basis by the duty GP. Any results warranting onward referral to secondary care are actioned at this point."

2. The Head of Healthcare at Pentonville should ensure that comprehensive summaries of prisoners' healthcare needs, including their prescriptions, are provided when a prisoner transfers to another prison.

   The National Offender Management Service accepted this recommendation, writing:

   "HMP Pentonville now operates the System1 clinical records system in common with all prisons in England. Patient medical records including all prescription information is automatically transferred to the receiving prison."

3. The Governor of Littlehey should carry out a disciplinary investigation into the circumstances and actions of the NOO that night and into the following morning in relation to his failure to seek medical assistance when attending an unconscious prisoner.

   The National Offender Management Service accepted this recommendation, writing:

   "A disciplinary investigation into the circumstances and actions of [the NOO] on the night [in] March 2011 in relation to his failure to seek medical assistance when attending an unconscious prisoner has been completed."

4. The Governor should carry out a disciplinary investigation into the actions of all officers who attended the man's cell that night.

   The National Offender Management Service accepted this recommendation, writing:

   "The disciplinary investigation completed in response to recommendation 3 incorporated the actions of all who attended the man's cell [that night]."

5. The Governor should ensure that there are sufficient numbers of staff on duty at all times who are have had recent first aid training.

   The National Offender Management Service accepted this recommendation, writing:

"An annual training programme has been put in place to ensure sufficient staff are on duty who are trained in first aid."

6. The Governor should introduce an emergency code system, which includes instructions about when an ambulance should be called.

The National Offender Management Service accepted this recommendation, writing:

"The Night Operating Policy now includes the following:-
In all cases where a prisoner (or member of staff) is unconscious and/or unresponsive an ambulance must be called."