

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ashley Young, a prisoner at HMP Wandsworth, on 16 January 2019.

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ashley Young died of bronchopneumonia as a result of epilepsy on 16 January 2019 while a prisoner at HMP Wandsworth. He also had a narrowing of the arteries to the heart and a blood clot in an artery to the lungs which contributed to but did not cause his death. Mr Young was 35 years old. I offer my condolences to his family and friends.

Overall, the clinical reviewer was satisfied that the standard of healthcare that Mr Young received at Wandsworth was equivalent to that which he could have expected to receive in the community. When staff saw that there was a sudden and major change in Mr Young's behaviour four days after his arrival, he was moved to an inpatient mental health unit and was promptly sent to hospital for assessment when his health did not improve.

However, it would have been better if staff had discussed his epilepsy in detail at his second health screen and developed a care plan for him.

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

Sue McAllister CB
Prisons and Probation Ombudsman

February 2020

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Summary

Events

1. On 4 January 2019, Mr Ashley Young was sentenced to 28 days in prison for theft and was sent to HMP Wandsworth.
2. At his initial health screen, Mr Young told a nurse that he had epilepsy and schizophrenia. Mr Young tested positive for cannabis and cocaine. A prison GP prescribed Mr Young an immediate-release sodium valproate for epilepsy. (His usual prescription was slow-release sodium valproate.)
3. On 7 January, a nurse carried out Mr Young's second health screen. That day, a prison GP prescribed slow-release sodium valproate.
4. At about 8.00am on 8 January, an officer saw Mr Young in his cell and noticed that he looked scruffy and dirty. The officer later saw him standing near the medication hatch, looking confused and disorientated. The officer reassured him and told him that she would get someone to help him.
5. At about 12.15pm, two nurses saw Mr Young in his cell to give him his depot injection (a slow-release antipsychotic medication) for schizophrenia. The officer who saw him earlier opened the cell door and saw that he looked a lot worse. Mr Young was mumbling to himself inaudibly, he did not make eye contact and was incontinent of urine and faeces. The nurses said that he needed to go to an inpatient mental health unit so that this sudden and significant change in his behaviour could be assessed.
6. At about 3.30pm, prison staff walked Mr Young to the prison inpatient mental health unit, known as the Addison Unit. A nurse tried to assess him. He was fully conscious but uncommunicative and uncooperative. He refused to shower or provide a urine sample.
7. A psychiatrist saw Mr Young in his cell and was concerned that he had had a seizure because he had soiled himself but, was also concerned that he may have taken an illicit substance.
8. At 9.55am on 10 January, a consultant forensic psychiatrist saw Mr Young at his cell door. He tried to assess him, but Mr Young was curled up on the bed asleep and did not wake up.
9. At 11.35am, a nurse saw Mr Young who had again been incontinent of urine and faeces. Healthcare staff cleaned him and the cell and took his observations. The nurse arranged for Mr Young to be placed under constant observation.
10. The psychiatrist said that at 3.00pm, he went back to see Mr Young who was able to walk slowly but appeared dazed and confused. He said that Mr Young did not speak or respond to staff. The psychiatrist spoke to a prison GP and they decided to send him to hospital for assessment.
11. At 7.36pm, an ambulance arrived at Wandsworth and paramedics saw Mr Young before they took him to hospital. He was escorted by two officers and restrained

with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). He was admitted to hospital.

12. On 13 January, Mr Young's condition deteriorated, and he was transferred to the intensive care unit. The Head of Security reviewed the level of restraints and agreed for them to be removed. At 10.38am on 16 January, Mr Young died of bronchopneumonia as a result of epilepsy.

Findings

13. The clinical reviewer found that overall, the care that Mr Young received at Wandsworth was equivalent to that which he could have expected to receive in the community.
14. His epilepsy was appropriately identified at his initial health screen and he was promptly moved to the Addison Unit when he became unwell.
15. However, the clinical reviewer said that it would have been good practice if the nurse at Mr Young's second health screen had discussed his epilepsy in detail (for example, whether he had any warnings before a seizure). She noted that this might have contributed to the development of a care plan.
16. Although there is no evidence that it had an impact on the outcome for Mr Young, a prison GP also prescribed a slightly different type of epilepsy medication to Mr Young's usual medication and he had five doses of this before a prison GP re-prescribed his usual medication.

Recommendations

- The Head of Healthcare should review the approach to the management of epilepsy at Wandsworth and ensure that healthcare staff have an appropriate approach to planning the care of prisoners with epilepsy in line with National Institute for Health and Care Excellence (NICE) guidelines.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact him.
18. The investigator obtained copies of relevant extracts from Mr Young's prison and medical records.
19. NHS England commissioned an independent clinical reviewer to review Mr Young's clinical care at the prison. They jointly interviewed six members of staff at Wandsworth on 18 March.
20. We informed HM Coroner for Inner West London District of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
21. One of the Ombudsman's family liaison officers contacted Mr Young's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
22. We shared the initial report with the Prison Service. There were no factual inaccuracies and their action plan has been appended to this report.

HMP Wandsworth

23. HMP Wandsworth is a local prison in London and holds up to 1,628 men in eight residential wings. St George's University Hospital NHS Foundation Trust provides physical healthcare services at the prison. Mental health services are provided by South London and Maudsley NHS Foundation Trust. There is an inpatient unit for up to six prisoners (the Jones Unit) which caters for prisoners with a wide range of general medical, rehabilitative and health-related respite needs and an inpatient unit for up to 12 prisoners with complex mental health needs (the Addison Unit).

HM Inspectorate of Prisons

24. The most recent reported inspection of HMP Wandsworth was conducted in March 2018. Inspectors found that most prisoners were satisfied with the quality of health provision but lengthy waiting times for appointments were a recurring theme. They considered the range of primary care services and visiting specialists was appropriate and external hospital appointments were well managed. They were concerned that systems to address prisoners' social care needs were weak and that prisoner carers were used for inappropriate lifting.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2019, the IMB reported that they were very encouraged by the increase in the number of officers. They were pleased that progress had been made to adapt a number of cells for wheelchair users. The IMB was concerned that the availability of illicit drugs remained a major problem. They were also concerned that the 12-bed Addison Unit was unfit for purpose with insufficient beds and cells frequently waiting to be repaired.

Previous deaths at HMP Wandsworth

26. Mr Young was the tenth prisoner to die at Wandsworth since January 2017. Six of the previous deaths were from natural causes and three were self-inflicted. There were no significant similarities with the previous deaths.

Key Events

27. On 4 January 2019, Mr Ashley Young was sentenced to 28 days in prison for theft and went to HMP Wandsworth.
28. When he arrived at Wandsworth, a nurse carried out Mr Young's initial health screen. Mr Young told him that he had epilepsy, that he had last had a seizure seven days ago and that he took sodium valproate. He also said that he had schizophrenia for which he had injections. Mr Young said that he had been admitted to a mental health unit for a few weeks the previous year. Mr Young tested positive for cannabis and cocaine. He told the nurse that he was not withdrawing from heroin or alcohol and that he had smoked £10 to £20 of crack cocaine daily for the past ten years. The nurse referred Mr Young to the prison inreach mental health team.
29. A prison GP noted that Mr Young's depot medication for his schizophrenia was due and referred him to the inreach team. The prison GP also prescribed Mr Young sodium valproate for epilepsy, but an immediate-acting type rather than the slow-release type that he had been prescribed before. Mr Young had five doses of the drug in this format.
30. On 5 January, a nurse from the inreach team reviewed Mr Young who told him that he had last had his depot medication on 5 December.
31. On 7 January, a nurse carried out Mr Young's second health screen and noted that the Forward Trust drug services were due to see him. He did not discuss Mr Young's epilepsy in detail (for example, whether he had any warnings or aura before a seizure). That day, a prison GP re-prescribed the slow-release sodium valproate.
32. On 8 January, a nurse wrote to the community mental health trust to ask for details of Mr Young's antipsychotic medication.

Events of 9 and 10 January

33. At about 8.00am on 9 January, an officer went to Mr Young's cell to answer the cell bell. She saw that Mr Young's cellmate was upset and did not want to be in the cell with him. Mr Young was standing at the back of the cell. The officer said that he looked scruffy and dirty.
34. Later that morning, the officer walked past the medication hatch on the wing and saw Mr Young standing nearby. She said that he looked confused and disorientated. Mr Young told her that he was not alright. She said that his fingernails were very dirty, that his jumper had dried specks of red on it, that his hair was greasy, and he did not look as though he was looking after himself. She reassured him and told him that she would get someone to help him.
35. The officer telephoned the inreach team, who said that they would see Mr Young later that day. At about 12.15pm, two nurses went to Mr Young's cell. They planned to give him his depot injection of aripiprazole for schizophrenia. The officer opened the cell door and saw that Mr Young was sitting on the top bunk.

- She said that his hands were near his chest, with his fingers curled and his head low, and that he looked a lot worse than he had earlier in the day.
36. A nurse went into the cell and tried to speak to Mr Young who was mumbling to himself inaudibly. Mr Young did not make eye contact and his speech made no sense. The nurse saw that Mr Young was incontinent of urine and faeces. The nurses said that he needed to go to the Addison mental health unit so that the sudden and major change in his behaviour could be assessed.
 37. At about 3.30pm, prison staff walked Mr Young to the Addison Unit. The nurse tried to assess him. He was fully conscious but not communicating and did not cooperate when he tried to assess him. Mr Young refused to shower or provide a sample of urine. The medication chart shows that Mr Young took his epilepsy medication.
 38. A psychiatrist saw Mr Young in his cell. The psychiatrist tried to assess Mr Young, but he did not cooperate, he did not speak and made noises. The psychiatrist was concerned that Mr Young had had a fit or had taken an illicit substance because he had soiled himself. The psychiatrist said that they would discuss Mr Young at the team meeting the next day but, in the meantime, asked staff to observe Mr Young every 15 to 30 minutes and to try to provide physical care.
 39. At 9.55am on 10 January, a consultant forensic psychiatrist saw Mr Young at his cell door. He tried to assess Mr Young, but he was curled up on the bed and would not wake up. He noted that Mr Young looked very thin.
 40. At 11.35am, a nurse saw Mr Young who was again incontinent of urine and faeces. Healthcare staff cleaned him and the cell and took his observations. Mr Young's temperature was normal (36.2°C), his pulse was normal (74 beats per minute), his blood pressure was normal (104/84) but his blood oxygen saturation level was low (92%). The nurse gave him oxygen and placed him under constant observation.
 41. The consultant forensic psychiatrist, said that he went back to see Mr Young, who was able to walk slowly but appeared dazed and confused. He did not speak and did not respond to staff. He said that he saw Mr Young eat a reasonable amount of food without difficulty and that he did not choke. Mr Young was again incontinent of urine and faeces. He spoke to a prison GP and they decided to send him to hospital for assessment.
 42. At 3.56pm, the consultant forensic psychiatrist, wrote a referral letter to the hospital and explained that he was sending Mr Young to hospital for urgent assessment of a sudden onset of delirium.
 43. At 4.38pm, an officer telephoned the ambulance service who said that because it was not an emergency, the ambulance would arrive within four hours. At 7.36pm, an ambulance arrived at Wandsworth and paramedics saw Mr Young before they took him to hospital. The Head of Healthcare at Wandsworth, noted in the escort risk assessment that Mr Young had mental health concerns, was not engaging with staff and posed a low risk. He authorised the use of a single cuff for Mr

Young. Two prison officers escorted him to hospital and restrained him with an escort chain.

44. On 13 January, Mr Young's condition deteriorated, and he was transferred from the specialist neurology ward to the intensive care unit. The Head of Security reviewed the level of restraint and said that it should be removed.
45. Healthcare staff remained in contact with hospital staff. At 10.38am on 16 January, Mr Young died of bronchopneumonia as a result of epilepsy.

Contact with Mr Young's family

46. On 13 January, the Head of Safer Custody appointed the Head of Offender Management, as the family liaison officer (FLO) and a senior manager, as the deputy family liaison officer.
47. On 14 January, the FLO spoke to hospital staff who said that they had spoken to Mr Young's next of kin. The FLO telephoned Mr Young's next of kin who told the FLO that she had been to the hospital to see Mr Young and that his prognosis was not good. The FLO spoke to prison staff at the hospital and told them that Mr Young's next of kin could visit him at any time.
48. On 16 January, Mr Young's next of kin were with him when he died. The FLO went to the hospital and offered Mr Young's family her condolences.
49. Mr Young's funeral took place on 7 June, and Wandsworth contributed to its cost in line with national instructions.

Support for prisoners and staff

50. The prison posted notices informing other prisoners of Mr Young's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Young's death.

Post-mortem report

51. A post-mortem examination established that Mr Young died of bronchopneumonia (a lung infection) caused by epilepsy. He also had coronary artery atherosclerosis (a narrowing of the arteries to the heart) and a pulmonary thromboembolism (a blood clot in an artery to the lungs) which contributed to but did not cause his death.
52. Analysis of a sample of Mr Young's hair showed that he had used cocaine, morphine, heroin and codeine in the six months before he died.

Findings

53. The clinical reviewer found that overall, the care that Mr Young received at Wandsworth was equivalent to that which he could have expected to receive in the community. A nurse appropriately noted Mr Young's epilepsy at his initial health screen. Although no one saw Mr Young having an epileptic seizure, they promptly moved him to the Addison Unit when he became unwell and when his health did not improve, they appropriately sent him to hospital for further assessment. It was appropriate that prison and healthcare staff agreed that Mr Young should share a cell because of his epilepsy.
54. We cannot say why Mr Young became acutely unwell on 9 January. While there is evidence that Mr Young had used cocaine, morphine, heroin and codeine sometime during the six months before he died and was known to have used crack cocaine daily, there is no evidence to show if he had used an illicit substance immediately before he became unwell.
55. Although a prison GP promptly re-prescribed Mr Young's usual epilepsy medication, it was an immediate-acting type rather than the slow-release type that he had previously been prescribed. Mr Young had five doses of this medication before a prison GP re-prescribed his usual slow-release medication. The clinical reviewer said that she was unaware of any authoritative literature to indicate that that this might have had a significant effect on Mr Young, but noted that it was beyond her expertise to comment further.
56. While the clinical reviewer noted that Mr Young did not always engage with staff at Wandsworth, she also noted that the nurse who carried out Mr Young's second health screen could have asked him for more information about his epilepsy such as triggers, warnings or aura before a seizure and they could, on this basis, have developed a care plan for him in line with National Institute for Health and Care Excellence (NICE) guidelines. We therefore make the following recommendation:

The Head of Healthcare should review the approach to the management of epilepsy at Wandsworth and ensure that healthcare staff have an appropriate approach to planning the care of prisoners with epilepsy in line with National Institute for Health and Care Excellence (NICE) guidelines.

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