Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Amarjit Singh, a prisoner at HMP Pentonville, on 21 November 2021

A report by the Prisons and Probation Ombudsman

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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

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Amarjit Singh died of causes consistent with epilepsy on 21 November 2021 at HMP Pentonville. He was 41 years old. I offer my condolences to his family and friends.

When Mr Singh returned to Pentonville from hospital following a seizure healthcare staff did not assess him for over a week before he died, a concern highlighted more generally by HM Inspectorate of Prisons following their inspection of Pentonville in July 2022. The clinical reviewer concluded that this was not appropriate and that the clinical care Mr Singh received was not equivalent to that which he could have expected to receive in the community.

When Mr Singh's cellmate raised concerns with an officer about Mr Singh's health on the night of 20 to 21 November, the officer did not seek further assistance from the prison's night nurse. It was not until Mr Singh's cellmate raised the alarm the following morning that Mr Singh was found to have died.

Mr Singh's emergency cell bell was not answered for around 40 minutes on the night that he died, seemingly because the control panel in the staff office had been tampered with to prevent bells from ringing. I am satisfied that the prison has taken action to rectify this. Prompt response to emergency cell bells can be critical in an emergency and may save lives.

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

Adrian Usher
Prisons and Probation Ombudsman **July 2023**

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Summary

Events

1. On 30 September 2021, Mr Amarjit Singh was sentenced to eighteen weeks in prison for common assault of an emergency worker and failure to comply with court orders. When he arrived at Pentonville, a GP noted Mr Singh's history of epilepsy.

2. On 1 November, a medical emergency code blue was called as Mr Singh was having a seizure. (A code blue is used in a life-threatening medical emergency and triggers an automatic request for an ambulance and for healthcare staff to attend.)

3. On 9 November, Mr Singh was admitted to hospital after another seizure. Hospital staff excluded a cerebral bleed or brain haemorrhage, and discharged Mr Singh to Pentonville. However, the hospital did not provide a discharge letter and, when he returned, healthcare staff at Pentonville did not assess him for over a week before he died.

4. At around 11.30pm on 20 November, Mr Singh's cellmate rang the emergency cell bell, concerned that Mr Singh might be having a seizure. An officer answered the cell bell around 40 minutes later and asked Mr Singh's cellmate to assess Mr Singh to establish whether he was having a seizure. The officer concluded that Mr Singh was asleep and took no further action.

5. At around 7.10am the following morning, Mr Singh's cellmate found him unresponsive in bed and rang the emergency cell bell. Officers responded and went into the cell. They described Mr Singh as being stiff and considered that he had died. They did not therefore attempt resuscitation.

Findings

6. There was a delay of around 40 minutes when Mr Singh's cellmate pressed the emergency cell bell on the night of 20 to 21 November 2021. The control panel in the staff office had been tampered with, seemingly to prevent the alarm from sounding when a cell bell was pressed. We are satisfied that action has been taken to rectify this very serious issue, but the Governor must ensure that this does not happen again.

7. The officer who answered the cell bell in the early hours of 21 November asked Mr Singh's cellmate to carry out what was in effect a clinical assessment. The officer did not call an emergency code blue or seek advice from the emergency response nurse, as he should have. The Governor took disciplinary action to address the officer's lack of appropriate action.

8. The clinical reviewer was concerned that healthcare staff did not review Mr Singh after he returned from hospital following a seizure. He found that the clinical care that Mr Singh received was not equivalent to that which he could have expected to receive in the community.

Recommendation

- The Governor and Head of Healthcare should introduce a robust process to ensure:
    - healthcare staff are informed when the prisoner has returned from hospital;
    - healthcare staff see the prisoner within 24 hours of their return; and
    - healthcare staff obtain the discharge summary and outcome of the admission from the hospital.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Singh's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Singh's clinical care at the prison.

12. The investigator interviewed six members of staff at Pentonville.

13. We informed HM Coroner for St Pancras and Camden of the investigation. She provided us with a copy of the post-mortem and toxicology reports. We have sent the coroner a copy of our report.

14. The Ombudsman's family liaison officer wrote to Mr Singh's family to explain our investigation and to ask if they had any matters they wanted us to consider. They asked if Mr Singh had regular epileptic fits, what treatment and care he received and about the circumstances of his death. We have addressed these issues in this report and the clinical review.

15. Mr Singh's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Pentonville

16. HMP Pentonville is a local prison in London that holds around 900 prisoners. The prison primarily serves the courts of north and east London. Practice Plus Group, in partnership with Barnet, Enfield, and Haringey Mental Health Trust, provides 24-hour healthcare services at the prison.

HM Inspectorate of Prisons

17. Inspectors carried out a full inspection of HMP Pentonville in April 2019. They found that the prison was delivering weak outcomes for prisoners in most areas and unacceptably poor outcomes in safety. Inspectors found that Pentonville had implemented the Prisons and Probation Ombudsman's healthcare recommendations well but less so for those not related to healthcare.

18. Inspectors returned to Pentonville in February 2020 to conduct an independent review of progress. They reported that the prison had made little meaningful progress in addressing concerns and implementing recommendations from their previous inspection. Inspectors noted that this was highly concerning and the worst progress they had seen in any progress review.

19. In November 2020, inspectors carried out a short scrutiny visit and found that some progress had been made following previous inspections. Inspectors reported that healthcare services were reasonable, but many prisoners complained about the access and quality of healthcare services. Inspectors reported that interpreting services were poorly used and that many Prisons and Probation Ombudsman recommendations had not effectively been resolved.

20. The most recent full inspection of HMP Pentonville was in July 2022. Inspectors found that despite improvements being made, since their last full inspection in 2019, outcomes for prisoners were still not good enough. Inspectors reported that the prison did not consistently notify the healthcare team of patients coming back from court, including when they attended by video link, or after a hospital admission. They concluded that this could mean that prisoners' health and wellbeing needs were not being met.

Independent Monitoring Board

21. 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 March 2022, the IMB reported patchy communication about medical appointments led anxious prisoners to generate more healthcare-related applications to the IMB. They identified that appointments had been scheduled and that the relationship between prison and healthcare staff was good.

Previous deaths at HMP Pentonville

22. Since January 2020, there have been four deaths from natural causes and four self-inflicted deaths at Pentonville. There was a further death from natural causes after Mr Singh died. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

23. Mr Amarjit Singh had served previous custodial sentences. From March 2018, Mr Singh attended hospital several times following epileptic seizures.

24. In August 2021, Mr Singh was remanded in police custody. The police doctor prescribed levetiracetam (a drug used to treat epilepsy), and Mr Singh continued to take the drug when he subsequently spent three weeks at HMP Thameside. However, after Mr Singh was released from prison, he did not register with his community GP and, consequently, his medication was stopped.

25. On 30 September 2021, Mr Singh was sentenced to eighteen weeks in prison for common assault of an emergency worker and failure to comply with court orders.

26. Mr Singh arrived at Pentonville late that evening. His behaviour was noted as being "refractory" (difficult) when he arrived, and the reception nurse was unable to assess him. However, a GP at Pentonville reviewed him in the presence of a Sikh officer who spoke Punjabi and who translated aspects of the consultation, as it was noted that Mr Singh had difficulty speaking English.

27. The GP identified that Mr Singh had a history of epilepsy. He made plans for Mr Singh's account of his medical history to be reconciled with his medical records. The GP concluded that following his assessment, no immediate healthcare intervention was needed.

28. On 1 October, healthcare staff reviewed a summary of Mr Singh's GP records. As Mr Singh's GP had never prescribed him levetiracetam, it did not show up on the summary.

29. On 27 October, a nurse saw Mr Singh. He had been booked into her clinic, but she did not know why. She noted that Mr Singh had been referred to a neurologist by his GP practice two days earlier, and she told him about this. She also noted that, following the medical record reconciliation, she could see that Mr Singh had been prescribed levetiracetam at Thameside and asked the pharmacy at Pentonville to recheck his care records. (There is no evidence that the nurse's request to the pharmacy team was actioned.)

30. On 1 November, staff called a medical emergency code blue as they thought that Mr Singh was having a seizure. (A code blue is used in a life-threatening situation and triggers an automatic request for an ambulance and for healthcare staff to attend.) Mr Singh was assessed but healthcare staff found that there was no evidence that he had had a seizure.

31. On 9 November, wing staff called a code blue as Mr Singh had been found having a seizure. A GP at Pentonville attended. Mr Singh was taken to hospital by ambulance because of the possibility that he had sustained a head injury as a result of his seizure.

32. Mr Singh was assessed in hospital, and once a cerebral bleed and brain haemorrhage were excluded, he was discharged to Pentonville that evening. Mr Singh was taken back to his cell, without being seen by a nurse in Reception. (One

of the escort officers said that he could not recall details of the escort to hospital or what happened when Mr Singh returned to Pentonville.)

33. A nurse tried to contact the escorting officers during the day to get information about Mr Singh but was unable to get through. He asked his colleagues to try again that evening. There is no evidence that this happened, and there is no evidence that anyone contacted the hospital for Mr Singh's discharge summary letter. No further entries were made in Mr Singh's medical records about his admission to hospital.

34. On 19 November, a nurse made an entry in Mr Singh's medical records saying that, due to staff shortages, the prison had been unable to complete an initial healthcare screen.

Events of 20 November

35. Mr Singh's cellmate said that they got on well. He told police that Mr Singh had been worried about his "lack of medication". (There is no evidence that Mr Singh raised concerns about his medication with healthcare staff.)

36. Between 5.13pm and 9.13pm, Mr Singh and his cellmate were checked four times during routine checks.

37. The cellmate said that he and Mr Singh watched television together and shared food that evening. He said that Mr Singh appeared normal, and they went to bed at around 9.00pm.

38. The cellmate told police that he woke up later that evening and heard Mr Singh making choking and groaning noises, which were quite quiet and sounded as if Mr Singh was having a seizure. He said that Mr Singh was not moving much, and he noticed that he was sleeping face down.

39. At around 11.31pm, the cellmate rang the emergency cell bell as he was concerned about Mr Singh and thought that he may be having a seizure. He said that he remained awake, lying in his bed, until the cell bell was answered around forty minutes later. He said that Mr Singh continued to make groaning and choking noises, which lasted around ten to twenty seconds, and that while he waited for the cell bell to be answered, he did not notice Mr Singh move in the bunk bed above him.

Events of 21 November

40. At around 12.14am, Officer A answered the cell bell. The officer said that the cellmate told him that Mr Singh had had a seizure earlier in the day but did not say at what time. He asked the cellmate to check on Mr Singh to see if he was still having a seizure, if he was bleeding or if he had urinated. He said that the cellmate noted no movement to indicate that Mr Singh was in distress and from what he could see from outside the cell, he believed that Mr Singh was sleeping. He said that the cellmate confirmed that Mr Singh appeared asleep. The cellmate then returned to his bed to sleep. The officer was at the cell for around a minute. He

said that because Mr Singh did not present with any signs of distress, he left the cell and returned to the wing office.

41. In his police statement, the cellmate said that when Officer A arrived at the cell door, the officer told him not to touch Mr Singh. He said that the officer told him that if Mr Singh was having an epileptic seizure, it would wear off by the morning. He told police that the officer said that if he (the cellmate) touched Mr Singh, he might urinate himself. The cellmate said that he listened to the officer's instruction not to touch Mr Singh and went back to his bed.

42. At 1.06am, Officer A checked the cell for around ten seconds, using a torch. He said that he had gone back to the cell to make sure that Mr Singh was okay and said the occupants of the cell were sleeping.

43. At 5.39am, Officer A completed the morning roll check. The officer looked into the cell for around two seconds. He said both prisoners appeared to be asleep and there were no concerns.

44. At around 7.00am, the cellmate woke up. Around five minutes later, he put on the television and called out to wake Mr Singh, but he did not respond. He said that he then checked on Mr Singh and found him lying face down and unresponsive. He rang the emergency cell bell. (CCTV footage shows that the cell light was switched on from within the cell at around 7.05am and that at 7.10am, the emergency cell bell was rung.)

45. While carrying out his morning roll check, Officer B noticed that the cellmate had rung the emergency cell bell. The officer arrived at the cell at around 7.47am. The officer said that the cellmate told him that Mr Singh was not responding. The officer asked him to shake Mr Singh and shout his name to get a response. The cellmate said that Mr Singh was cold and would not wake up. At around 7.48am, the officer radioed a medical emergency code blue. The control room operator called an ambulance at around 7.49am. The officer opened the cell door as a Custodial Manager (CM) approached the cell.

46. Officer B took the cellmate away from the cell. At around 7.50am, the CM left the cell and used his radio to ask for an ambulance to attend. The officer returned to the cell around fifteen seconds later.

47. At around 7.55am, two nurses arrived at the cell and officers told them that Mr Singh had died. One nurse asked the officers to move Mr Singh to the floor of the cell. Two CMs and Officer B moved Mr Singh to the floor. They described Mr Singh as stiff and cold, his hands were clutched together, and he had a fixed expression on his face. The nurses checked for signs of life but found none. They therefore did not try to resuscitate Mr Singh. At around 8.04am, paramedics arrived and, at 8.07am, they confirmed that Mr Singh had died.

Contact with Mr Singh's family

48. An officer was appointed as the family liaison officer (FLO). Mr Singh had not nominated a next of kin at Pentonville, but the police identified his brother.

49. On the morning of 22 November, the FLO and a Sikh chaplain broke the news of Mr Singh's death to his brother by telephone due to COVID-19 restrictions in place. They later visited him. The prison contributed to the cost of Mr Singh's funeral in line with national instructions.

Support for prisoners and staff

50. After Mr Singh's death, a prison manager debriefed the staff involved in the incident to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

51. The prison posted notices informing other prisoners of Mr Singh's death and offered support.

Post-mortem report

52. A post-mortem examination established that Mr Singh's death was consistent with epilepsy.

Findings

Emergency cell bell

53. Officer A took 40 minutes to answer the emergency cell bell after Mr Singh's cellmate rang it at around 11.31pm on 20 November 2021. He said that the delay was a result of several cell bells on the landing not working. He said that it was not until he went to the wing that he noticed that the cell bell light outside Mr Singh's cell was on. The cell bell had not rung in the wing office as it should have. There was another delay of around forty minutes when the cellmate rang the cell bell at 7.10am on 21 November. Again, the bell was only answered when an officer on the landing identified that the cell bell light was on outside the cell.

54. This fault was identified on 21 November, after Mr Singh's death, and an additional officer was deployed to patrol the affected cells until an engineer was able to repair the fault on 26 November. The engineer established that a data cable in the wing office had been disconnected, which meant that when the cell bell was rung, there was no indication in the wing office. We have seen evidence that this was not the first time that this fault had been identified and that Pentonville suspected that the cable box might have deliberately been damaged to silence a number of cell bells on the wing. The prison has investigated but did not identify a perpetrator.

55. A forty-minute delay is considerable and, in an emergency, could clearly make a difference to the outcome for a prisoner. Since the prison identified the failure of the emergency cell bell system, they have put in place a new process to highlight any future failures and to provide a daily analysis of cell bell response rates. We are satisfied that Pentonville has taken appropriate action and therefore make no recommendation.

Failure to summon medical assistance

56. PSI 03/2013 on medical emergency response codes requires Governors to have a protocol to provide guidance on communicating the nature of a medical emergency and sets out that there should be no delays in calling an ambulance. Pentonville's local policy reflects this and specifically refers to epileptic seizures as an example of when an emergency code blue should be called. It says that if a medical emergency code is radioed, an ambulance must be called immediately. Local instructions also state that staff have a duty of care to prisoners and where there is or appears to be an immediate danger to life, cells may be unlocked, following a risk assessment.

57. The cellmate said that Mr Singh had had a fit or seizure on the night of 20-21 November. Officer A did not respond to the incident as he should have done. He should not have asked the cellmate to carry out what was effectively a clinical assessment of Mr Singh and should not have relied on that information to inform his subsequent (in)action. The clinical reviewer concluded that Mr Singh should have received a proper clinical assessment in the early hours of the morning of 21 November but could not say whether this would ultimately have resulted in a different outcome for Mr Singh.

58. On the basis of the information the cellmate gave, Officer A should immediately have called a code blue. This would have resulted in a nurse attending and the control room calling an ambulance immediately. However, he took no action, and he failed in his duty of care for Mr Singh.

59. Following Mr Singh's death, the Governor held a disciplinary hearing about Officer A's actions. The officer accepted that he had failed to call a code blue when he should have, and that he wrongly thought that it was best to leave Mr Singh sleeping rather than disturb him. He was issued with a final written disciplinary warning.

Clinical care

60. The clinical reviewer concluded that overall, the clinical care that Mr Singh received was not equivalent to that which he could have expected to receive in the community.

61. The clinical reviewer was concerned that there was no follow-up review or assessment when Mr Singh was admitted to hospital on 9 November, following a seizure.

62. During the investigation, the clinical reviewer discussed with staff the procedures in place at Pentonville for prisoners who return from hospital. Prison staff said that prisoners who returned from hospital often returned straight to their wing. They said that if the hospital provided a discharge letter or prescription, it would be handed to a member of the reception team. The clinical reviewer noted that clinical staff, including the Head of Healthcare, said that most prisoners passed through Reception before going back to their wing.

63. The NHS service specification for primary care services, medical and nursing for prisons in England 2020 requires the healthcare provider to arrange to see a prisoner within 24 hours of their return from hospital.

64. Healthcare staff did not see Mr Singh when he returned from hospital, they never received his discharge summary and did not try to obtain it or to establish the outcome of his hospital visit.

65. We note that His Majesty's Inspectorate of Prisons also reported in their most recent report that the prison did not consistently notify healthcare staff when prisoners came back from court, having attended either in person or by video link, as well as after a hospital admission, which could mean that their health and wellbeing needs were not met. We make the following recommendation:

    The Governor and Head of Healthcare should introduce a robust process to ensure:

    - **healthcare staff are informed when the prisoner has returned from hospital;**
    - **healthcare staff see the prisoner within 24 hours of their return; and**
    - **healthcare staff obtain the discharge summary and outcome of the admission from the hospital.**

66. The clinical reviewer made a number of recommendations about other failures in healthcare processes which are not directly related to Mr Singh's death but which the Head of Healthcare will need to address.

Inquest Verdict

67. The inquest hearing into the death of Mr Singh concluded on 8 September 2023. It confirmed that the medical cause of Mr Singh's death was epilepsy related. It established that Mr Singh died in his cell between approximately 12.30am and 8.00am on 21 November, as the result of a seizure.

68. The inquest noted that Mr Singh was attended to by a prison officer who did not seek medical attention. The coroner concluded that Mr Singh's death was of natural causes, contributed to by neglect.

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