

**Investigation into the circumstances surrounding  
the death of a man who was a prisoner at HMP Pentonville  
on 10 September 2006**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**September 2007**

This is the report of an investigation into the circumstances surrounding the death of a man. The man died in the National Hospital for Neurology and Neurosurgery in London on 10 September 2006, whilst in the custody of HMP Pentonville. The causes of death were brain swelling and herniation, subarachnoid haemorrhage, cerebral infarction and intraventricular haemorrhage, and ruptured secular aneurysm of the right middle cerebral artery. The man was 43 years of age.

I would like to extend my condolences to the man's family and friends for their sad loss. I appreciate that it is difficult to lose a loved one at any time, but especially so when they are relatively young, die suddenly and are in custody.

This investigation was carried out by one of my colleagues. In addition a doctor from Islington Primary Care Trust conducted a clinical review of the man's medical care and treatment for which I am most grateful.

I am indebted to the former Governor of Pentonville for making the necessary facilities available to my investigator. I also thank the appointed prison liaison officer for his support.

I am pleased to report that all of the recommendations made in my draft report have been accepted by Pentonville.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

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## SUMMARY

The man was remanded into custody on 24 August 2006 and sentenced on Thursday 7 September. It was his first time in prison. He was an apparently fit and healthy man aged 43.

On 7 September the man returned to Pentonville after being sentenced at Snaresbrook Crown Court. The man was in the reception area when he suddenly collapsed. He appeared to have suffered a major epileptic fit. There was no significant medical history available to the prison to indicate that the man had an underlying subdural haematoma (accumulation of blood on the brain).

Following the first seizure, the man appeared to recover fully and complained of a headache. A doctor from the prison arrived in the reception area after a nurse went to find her. The man had three further seizures in quick succession while the doctor was attending to him. Treatment was administered and the man's vital signs were observed. The London Ambulance Service was called and the man was initially taken to the Whittington Hospital. He was later transferred to the National Hospital for Neurology and Neurosurgery. Whilst in hospital, the man underwent two operations.

The prison doctor telephoned the man's family personally to tell them what had happened and make them aware of the seriousness of his condition. Although not on duty, the doctor telephoned the hospital from her home over the weekend for an update on the man's condition.

In hospital, the man was initially under the escort of two officers. This was then reduced to one officer following a risk assessment on Saturday 9 September. The plan was for Release on Temporary Licence (ROTL) to be considered on Monday morning. However, the man sadly died on Sunday 10 September.

The man's family has expressed concern about the presence of prison officers at his bedside. My report questions why ROTL was not considered sooner.

In addition to this investigation and the clinical review, Pentonville commissioned its own internal enquiry which identified some shortcomings. I am pleased to record that these have now been addressed and new systems are up and running. None of the shortcomings would have altered the outcome in the man's case.

A post mortem examination concluded that the man died of natural causes.

## INVESTIGATION PROCESS

1. My practice in deaths from apparently natural causes is to conduct an initial review to determine the extent of the investigation required. My investigator contacted Pentonville on 12 September 2006 and spoke to the Governor who acted as the prison liaison officer. He outlined the facts as he knew them and it was agreed that all documents pertaining to the man would be sent to my office. In turn my investigator forwarded notices to staff and prisoners via the Governor. These notices were to announce my investigation and invited staff or prisoners to make themselves known to the investigation team if they felt they had any relevant information. In the event, no one came forward.
2. My investigator visited Pentonville and interviewed a number of staff to clarify events and the actions taken.
3. One of my family liaison officers contacted the man's family to explain the role of my investigator and to allow them the opportunity to raise any concerns they would like to be explored. The family raised a number of issues:
  - Did the man complain of headaches in the days prior to his collapse?
  - Could the fits have been alcohol induced?
  - Did the man receive a phone card on his reception into prison?
4. A clinical review of the man's healthcare needs was commissioned from Islington Primary Care Trust. A doctor, who was an experienced and highly qualified general practitioner, carried out the review.
5. My investigator contacted Her Majesty's Coroner by letter, to inform him of the nature and scope of the investigation, and to request a copy of the post mortem report. A copy of my report was sent to the Coroner to assist him with his inquiries.
6. My investigator began a period of maternity leave in May 2007. One of my Assistant Ombudsmen attended the inquest when it was concluded in June 2007. He also arranged for this final report on the circumstances of the man's death to be issued.

## HMP PENTONVILLE

7. HMP Pentonville is a large local category B prison with an operational capacity (maximum crowded capacity) of 1,127. It holds adult males both on remand and following sentence. Although much refurbishment has taken place, the original four cellblocks are much as they were when the prison first opened in 1842.
8. Ms Anne Owers, HM Chief Inspector of Prisons, commented in her January 2005 inspection report that Pentonville had showed, "it was a prison that lacked systems to ensure fundamental aspects of safety and decency, and where prisoners were routinely locked in their cells for most of the day." In June 2006, she issued a highly critical follow-up report which said of Pentonville: "...Its population, always transitory, had become even more so with an increase in remand and unsentenced prisoners, who accounted for over 60% of the population. Overcrowding, old buildings and inadequate facilities severely inhibited the prison's ability to deliver a safe, decent and purposeful environment for its prisoners."
9. There have been nine deaths in Pentonville since I was given the responsibility for investigating all deaths in custody in April 2004. Two of the nine were deaths from natural causes. There are no recommendations made in respect of these previous deaths which are directly relevant to the circumstances of the man's death.

## KEY EVENTS

10. On arrival at Pentonville following his remand on 24 August 2006, the man was seen by a healthcare worker as part of the reception process. The man was asked a series of questions about his current health and his past medical history. When asked if he had ever received treatment from a psychiatrist, the man said that his GP was supposed to have referred him to one following an overdose. The man also said that he had received antidepressants in the past. These two issues were not explored any further at this stage. The man was asked about his use of drugs and alcohol. The man said that he usually drank about four pints at the weekend, but had not had any alcohol in the week prior to coming into prison.
11. The man was asked about his physical health and replied that he had seen a doctor in January for a problem with his left arm. The man also said that he had an outstanding out patient appointment in October. There was no further information recorded about this. The man was asked if he had received any physical injuries within the last few days. He said that he had been involved in a motorbike accident the previous Saturday whilst on private land. The man said that he had injured his right knee, but had not received any treatment. Asked if he had any concerns about his physical health, the man said that he suffered from stress. The healthcare officer who completed the form recorded that the man appeared stable and identified two bruises on his face.
12. Five days later, a prison doctor saw the man (a consultation recorded in his clinical record). The man told the doctor that he was depressed and had been for two years. An attempted overdose was discussed and the reason behind it. The man also said that his appetite was poor and that he was not sleeping properly. The consultation concluded with a request for blood tests. It also noted that the man was not actively suicidal.
13. The prison phlebotomy clinic records note that the man did not attend his appointment for blood tests on 30 August.
14. The court had ordered a psychiatric assessment on the man. This was carried out on 1 September by a consultant psychiatrist. The psychiatrist's report explored the man's personal life and the relationship he had with his partner. The consultant concluded that the man was of normal intelligence and, whilst he was depressed, he was not mentally ill. He concluded that the man was fit to plead.
15. The man was sentenced on 7 September 2006 to nine months' imprisonment. He returned to Pentonville in the afternoon and, whilst in the reception area, suddenly collapsed and began to fit. My investigator was told that the collapse was captured on CCTV. However, on viewing the video supplied by Pentonville, my investigator found that the CCTV footage was from a different day. On enquiring further with Pentonville about this, it appears the correct tape has been lost.

16. It had been believed that the Coroner was also in possession of the CCTV footage. Unfortunately, when my investigator enquired about this, it appears that the tape held by the Coroner does not show the man's collapse either.
17. At about 2.50pm a prisoner working in the kitchen, saw the man begin to fit and alerted staff. Two nurses attended to the man. He was in the large holding room of the reception area, on the floor, and appeared to be having a Grand Mal (major epilepsy) type of fit. One nurse went to fetch oxygen and an officer went to get a wheelchair. The fit lasted only a short period of time, estimated to be about two minutes. The man appeared to recover fully. He was conscious and was responding to the nurse. He engaged in conversation with her about his family and children. At this point another nurse arrived. (This nurse was Hotel 9, the code for the prison's emergency healthcare responder.)
18. After being called over the radio, the emergency response nurse arrived in reception with only a blood pressure machine rather than the full emergency medical bag. The man's blood pressure and pulse were taken, although no oxygen saturation levels or neurological observations were made.
19. Officers helped the nurse to get the man into a wheelchair as they wanted to move him to a more private and quiet area. The man was taken to another holding room, normally used for vulnerable prisoners. The man's clinical records were requested in order to check his previous medical history.
20. Officers assisted the man when he asked to use the toilet. He also complained of a headache. The nurse tried to contact the prison's on call doctor at the time. She made telephone calls to B and G wings, as it was thought that the doctor might be there doing consultations.
21. Another nurse (male nurse) arrived in reception, having gone to ensure that the Hotel 9 call was being managed appropriately. The original attending nurse gave a verbal handover to the male nurse, who was her senior. The male nurse observed that the man was sitting at a table with his head in his hands. He carried out further observations on the man, although these are not recorded, before leaving to find the doctor.
22. The male nurse visited B and G wings but the doctor was not there. He was told a message had been left for her in the segregation unit. The nurse found the doctor in the reception area of healthcare and informed her of the situation.
23. When the doctor telephoned reception and spoke to the nurse there, she was told that the man had requested paracetamol. The doctor initially authorised the administration of two paracetamol. She then briefly attended the inpatient unit before leaving for reception.
24. At about 3.40pm, the doctor arrived in reception. This was approximately 50 minutes after the man's initial fit. The man was sitting alone at a table in the reception area with his head down. The nurse had left to get the paracetamol. The doctor assessed the man using the Glasgow Coma Scale (GCS), a scoring method used to ascertain a patient's level of consciousness (the higher the

25. The male nurse and the emergency response nurse returned to reception where they found the doctor and an officer trying to move the man to a side room out of the view of others. Whilst the man was being moved, he had a third fit. The doctor asked for a 999 ambulance to be called. The man had a further fit in quick succession. The call was made to the London Ambulance Service at 4.04pm.
26. The doctor gave the man rectal diazemuls 10mg and inserted an intravenous line. Oxygen was also given. The man's vital signs (pulse, blood pressure and pupils) were checked and the observations recorded in his medical notes.
27. The clinical record shows that the man went on to make a further partial recovery. The doctor noted that the man had left sided hemiparesis (paralysis of one side of body) and ipsilateral left sided upper motor neurone weakness of his face. The man asked to go to the toilet again and two nurses escorted him. On his return the doctor saw that his left pupil had become dilated and sluggish, although it did return to normal after about two minutes.
28. The man was monitored until the arrival of the ambulance. He remained confused and agitated and was responding poorly to commands.
29. The ambulance arrived at 4.13pm and took the man to the Whittington Hospital, arriving at 4.35pm. The man was escorted by two officers. There are no further entries in his clinical record.
30. That evening the doctor spoke with the man's family and advised them of the potentially life threatening situation. The doctor also made contact with the hospital over the following weekend, though she was not on duty.
31. On the evening of 7 September, the man was transferred from the Whittington Hospital to the National Hospital for Neurology and Neurosurgery. The transfer took place after a large subarachnoid haemorrhage (bleed on the brain) had been diagnosed by a CAT scan. The neurological registrar from the hospital contacted the prison doctor for confirmation of the man's medical history. The man underwent surgery in the early hours of Friday 8 September. It is understood that he required a further operation on Saturday 9 September and subsequently died on Sunday 10 September at 3.00pm.
34. After a risk assessment carried out on 9 September by a Governor, the decision was made to reduce the number of officers required on his bedwatch from two to one. An entry made by an officer notes, "I have asked about the possibility of temp releasing him." It appears that release on temporary licence (ROTL) may have been raised as a consideration. However, Pentonville were unable to

substantiate this by way of producing any documents. Another entry refers to the decision for release being refused. My investigator spoke to the duty governor in charge of the prison for that weekend about the entries pertaining to ROTL. The governor said that it was considered, but realistically would not have been achievable until the Monday morning. ROTL decisions are made by a multi-disciplinary board, consisting of medical staff, a probation officer and the Governor. The duty governor visited the hospital on Sunday 10 September and spoke to the family. I understand that the family found the presence of an officer oppressive, especially when the man was reliant on a life support machine. My investigator spoke to the officer, who told her that she telephoned the prison and spoke to the governor at around 4.00pm. She told the governor of the poor prognosis for the man and raised the possibility of releasing him. The governor said that he would look into it. At 6.00pm, a further call was made to the prison. The officer was told that the man would be released on temporary licence, and that a governor grade would attend the hospital shortly. However, instead of the expected governor grade, another officer turned up. This second officer had been told that there had been a change in plan and that the man would have a single officer bedwatch rather than be released. Unfortunately, the family had already been told of the original plan for release on licence.

35. Following the man's death, a letter of condolence was sent to the family along with an offer to help with funeral expenses. The family was also invited to visit the prison.
36. A decision was made by the prison to wash the man's clothes before they were returned to the family. This was well intentioned, but has caused upset to the family. I suggest that a family should always be consulted about such matters first. The prison has accepted this wholeheartedly, and there is thus no need for me to make a formal recommendation about it.
37. There was no significant information that suggested that the man had felt unwell during the morning of Thursday 7 September. Nor were any concerns about him recorded on his prisoner escort records (PERs).

## **ISSUES**

### ***Family concerns***

*Did the man suffer from headaches prior to his collapse?*

38. There is no evidence in the man's clinical record to suggest that he complained of headaches prior to the events of the afternoon of 7 September. The man was asked a number of questions about his health when he arrived at the prison. He did not mention to staff that he had suffered from frequent or recent headaches. The only mention of a headache appears after his initial fit.

*The man's family are concerned that his fit may have been alcohol induced.*

39. The sudden withdrawal from alcohol after a period of sustained heavy and prolonged use may result in fits or delirium tremens. These withdrawal symptoms are likely to occur within the first few days after an individual has stopped drinking.
40. The man did not give a history of alcohol misuse that would have caused concern or alerted staff to a need for a supervised detoxification programme. Furthermore, the fits he experienced were over two weeks after his reception into prison.
41. The cause of death was given as a subdural haematoma followed by a subdural haemorrhage. These conditions are usually as a result of a burst aneurysm.

*The family wanted to know if the man received a phone card on his arrival at Pentonville?*

42. My investigator obtained a copy of the call records report. This shows the number of calls made, to whom and when. It would appear from this record that the man attempted to make a total of four calls. One call was made on 30 August and the other three on 31 August. It appears that the numbers dialled were not on the man's allowed list and therefore he was not put through. The prison liaison governor looked into this matter. It seems that the man had £5.00 credit on his phone card. However, for a reason that has not been identified, the man's numbers were not activated.

### ***Admission to hospital***

43. As part of my investigation, I monitor the entries in a prisoner's bedwatch log. This is to ensure that the entries show that the prisoner-patient has been treated with appropriate respect and decency. The entries on the bedwatch log for the man have been completed to the expected standards.
44. Nevertheless, it is of concern that misinformation was given about the possibility of releasing the man on licence. Indeed, I question why a decision could not be taken about ROTL just because it was a weekend. On the basis

**The Governor should remind staff that, when ROTL is being considered for a prisoner transferred to hospital, this must be fully documented.**

***Clinical care***

45. The prison doctor told my investigator that she spoke to the hospital on Saturday and Sunday to get an update on the man. The doctor made these calls over the weekend when she was off duty, and as a result the information was not recorded in the man's clinical record. It is disappointing that healthcare staff on duty that weekend do not seem to have inquired of the hospital as to the man's condition.

**The Head of Healthcare should remind healthcare staff that, where a prisoner has been admitted to hospital, a member of staff from healthcare should routinely telephone the hospital for an update on the patient's condition. This should then be documented in the prisoner's record.**

46. The review of the man's medical care carried out by the PCT doctor concludes that the health assessments and treatment given to the man on his initial arrival at Pentonville were appropriate and complete. The clinical reviewer clarifies that there was nothing in the man's medical history or his examination that would have aroused any suspicion about an underlying subarachnoid haemorrhage.
47. The clinical reviewer says that the man's first seizure was managed appropriately by nursing staff. However, she comments on the delay in obtaining the duty doctor. Although not significant on this occasion, it could have been.
48. In the clinical reviewer's opinion, the man's subsequent seizures were also managed appropriately. However, there was a slight delay in getting the appropriate medical equipment to the scene. Again, this did not affect the outcome in the man's case but could do in future emergencies.
49. The clinical reviewer comments on the fact that only one set of observations was recorded in the man's clinical record, although he had several seizures in quick succession. She notes that it would be good practice to document any clinical observations made during an acute emergency.
50. The clinical reviewer judges that there was little support offered immediately afterwards, or at a later date, to those staff who had attended to the man. This is very disappointing.
51. The clinical reviewer makes five recommendations, all of which I endorse.
52. During the course of this investigation, Pentonville carried out its own internal review. The review panel was chaired by the Head of Healthcare at the prison.

53. My investigator subsequently made enquiries of the liaison governor at Pentonville and the prison doctor. Apart from the first recommendation, all have now been implemented. I commend the Governor and Head of Healthcare for identifying the learning from the tragedy of the man's death at an early stage and for implementing the recommendations so promptly.

## RECOMMENDATIONS AND GOOD PRACTICE

I endorse all five recommendations made by the doctor in her clinical review. I add a further two (numbered six and seven below), although I accept that none of these recommendations would have changed the outcome for the man. The response from Pentonville to my recommendations appears in italics following each recommendation.

I have also identified one example of good practice.

### **1. The system for summoning medical staff in an emergency should be reviewed as mobile phone reception is not reliable throughout the prison.**

*Alternative means of summoning medical staff are to be investigated and implemented as part of the review of the Emergency Medical Response. The mobile phone remains in use. When doctors are entering areas of known lack of mobile reception they now inform communications. Security are unable to provide an alternative radio frequency system for doctors.*

### **2. The system of having only one Hotel 9 (emergency equipment) bag in the prison should be reviewed. Such equipment should be easily accessible in all areas of the prison.**

*Pentonville has addressed this issue and emergency grab bags will be made available throughout the prison rather than only one being available.*

### **3. Clinical observations made during a medical emergency should be documented at the time, preferably in the medical record, or in a suitable alternative manner if this is not feasible.**

*It is the duty of the Team Leader to ensure that a member of the emergency team is designated to record all observations made contemporaneously.*

### **4. One person should be identified as the team leader in the event of a medical emergency requiring co-ordination of several nursing and other staff. The team leader should ensure that the lead clinician's instructions are carried out by the most appropriate person and if available a single person should be detailed to record any observations made.**

*All permanent GP staff have undergone ALS (advanced life support) training and the nurses have done ILS (intermediate life support) training. These courses have taught them the importance of having a designated team leader and ensuring each person has a purpose and role in the event of an emergency (ie, person to record observations, person to collect grab bag etc).*

**5. Staff involved in a medical emergency should have access to a debriefing session, and ongoing support as necessary after the incident.**

*Pentonville recognised that this was essential for the welfare of staff and therefore in future staff will attend a debrief following any serious/critical incidents.*

**6. The Governor should remind staff that, when ROTL is being considered for a prisoner transferred to hospital, this must be fully documented.**

**7. The Head of Healthcare should remind healthcare staff that, where a prisoner has been admitted to hospital, a member of staff from healthcare should routinely telephone the hospital for an update on the patient's condition. This should then be documented in the prisoner's record.**

*Note to be sent to all staff reminding them of this. Each bed watch to be allocated a lead clinician to liaise with the relevant hospital.*

***Good Practice***

**I commend the prison doctor for taking the time to talk to the man's family and explain the poor prognosis for him. I also note her compassion for her patient in phoning the hospital on Saturday and Sunday from home to check on the man's condition.**