

**Investigation into the circumstances surrounding the
death of a man in hospital in January 2007
whilst in the custody of HMP Pentonville**

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

February 2008

This is the report of an investigation into the circumstances surrounding the death of a man, a foreign national, at the local hospital in January 2007. The man had been remanded to HMP Pentonville on 17 January 2007 and was in poor health when he arrived. He was transferred to hospital the next day, but was discharged straight back to Pentonville. The following day he was admitted to another hospital. He died of meningitis, following a decision by the hospital doctors to stop his treatment. The man's family were not aware that he was in hospital until approximately nine days after his death. He was 38 years old.

The loss of any family member is distressing, but especially so whilst they are in custody. I offer my sincere condolences to the man's family and friends.

The investigation was undertaken by one of my colleagues. She experienced some difficulties both in obtaining information and maintaining regular contact with Pentonville's liaison officer during the early stages of this investigation. These difficulties hindered her ability to piece together the man's experience in custody, and contributed to the delay in issuing this report. A second liaison officer was appointed in June 2007 and the investigative process improved markedly thereafter. Particular thanks go to the FLO for gathering all relevant documentation and ensuring it was made available.

The clinical reviewer from Islington Primary Care Trust carried out a clinical review into the care and treatment the man received whilst in Pentonville. I am grateful to him for completing the review.

The man had been diagnosed in 1990 with a debilitating, and ultimately, terminal illness. He was living in his home country at the time. He came to Britain in 2002 to seek treatment and employment.

Although the man's care was dedicated, it was disappointing to learn that the response to his death was at best, formulaic, and at worst, careless. Unfortunately, Pentonville did not sufficiently follow its own death in custody procedures, and this may have contributed to his family's upset. My report makes nine recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

On 15 January 2007, the man was arrested and taken into police custody. He had been found in a confused state in a hotel near the family home. He was due to appear in court the following day, but was taken ill whilst waiting in the court cells. A forensic medical examiner (FME) examined him and decided he was not fit to appear. He was taken to the Accident and Emergency Department at the local hospital. He was discharged the same day and returned to police custody where he spent a second night in the police cells. On 17 January, the man appeared at the Magistrates' Court and was remanded in custody for an outstanding driving offence. The court remanded him for two days, pending community psychiatric reports, and ordered him to reappear in court on 19 January.

Following his arrival at Pentonville, he saw a reception nurse for an initial healthcare screening, and was then seen by the locum doctor. The man presented with symptoms of vomiting, diarrhoea and confusion. He went straight to the healthcare unit, by-passing the first night in custody process.

Once in the healthcare unit, clinical observations were taken again and the man was assessed by the nurse on duty. He was made as comfortable as possible, and given medication for the vomiting. The following morning (18 January), he was seen again by the doctor and nurse. Their intervention resulted in the preparation of a nursing plan in an attempt to establish a diagnosis, and provide clinical care to meet the man's needs. The man disclosed to both the nurse and the doctor that he was HIV positive, and had been for many years. Samples were sent to the local pathology laboratory and he was monitored throughout the day.

The man's health continued to deteriorate. His confusion worsened and the nurse noticed that he was unable to stand up. The doctor saw him again and found that his confused and weak condition hindered his ability to complete the healthcare assessment. An urgent blood sample was taken. At 5.00pm, an emergency ambulance was called. The man was taken to the Accident and Emergency Department at the local hospital. He was examined and discharged back to the prison a few hours later with suspected stomach problems.

The man slept through the night but, in the early hours of 19 January, he tried to get out of bed and was found on the floor of his cell. At 7.00am, his observations were repeated and he presented as weak, restless and in pain. The doctor who had seen him a day earlier was surprised to find him had been discharged from hospital. The doctor ordered an urgent blood test to confirm whether the man had the HIV virus, and contacted the infectious diseases team at the specialist hospital to secure a bed for him. The man's health deteriorated further and he was transferred to the hospital by ambulance that afternoon. At the same time, the prison doctor faxed a form to the Magistrates' Court to confirm that the man was unfit for his court appearance that day.

The man remained in hospital for four days. His condition deteriorated further and he suffered two seizures. On 22 January, he lost consciousness. The hospital asked Pentonville to contact his next of kin and a number of attempts were made to

locate his family, but unfortunately without success. The man was placed in intensive care, but at approximately 1.45pm on 23 January doctors decided to terminate his treatment. He was pronounced dead soon after.

The man's family were not aware until about 31 January that he had been in hospital and subsequently died. They were contacted by a nurse at Pentonville, but it is not clear exactly when the nurse telephoned. What is clear is that the news was delivered by phone and that the information given was inaccurate.

The man was later flown back to his home country where his funeral took place. The Governor at the time of the man's death assisted with the cost of the funeral.

My investigator found it difficult to gather all the information to carry out an initial investigation. Gaps remain due to apparently missing documentation, and Pentonville's lack of logkeeping of events. The documentary evidence that has been made available gives the impression that Pentonville systematically failed to follow its own policies and procedures in managing a prisoner's stay in hospital. I remain hopeful that this is an impression given by lack of information, rather than a true picture. My investigation has also highlighted the need for Pentonville to urgently review the way staff handle a death in their custody. More positively, the care the man received whilst in prison custody was dedicated and compassionate. However, the clinical review urges healthcare to improve its communication both internally and when sharing information with outside hospitals.

THE INVESTIGATION PROCESS

1. On 4 February 2007, my investigator opened the investigation by telephone and was briefed about the circumstances leading to the man's death. The investigator requested all prison and medical files and began to identify the key issues and the staff who interacted with the man during his brief time at HMP Pentonville. The investigator discovered that significant documentation was missing from the man's records and requested that it be forwarded to her.
2. The investigator visited the healthcare unit at Pentonville on 11 May and interviewed a number of prison and healthcare staff. The investigator again requested the additional documentation. The Head of Safer Custody acting as the prison's Family Liaison Officer (FLO), was asked to arrange further interviews for the staff who were unavailable.
3. The Investigator contacted the prison's Family Liaison Officer on 13 May, but received no response. After a further two weeks, the investigator contacted the Governor on 24 May, and then again on 29 May. The Family Liaison Officer contacted the investigator on 30 May and was again asked to send the missing documentation. He told the investigator that he would be leaving the Prison Service in the near future. The FLO was provided with a short briefing about the immediate concerns arising from the investigation. These included: a gap in the man's custodial record from 19 – 23 January, why the man's family had not been traced and informed of his condition earlier, and whether Pentonville had notified the relevant agencies to try and locate them. The FLO welcomed the feedback and confirmed that he would arrange for all documentation to be made available to my investigator at the earliest opportunity.
4. The documentation was not forwarded to my office. The investigator was later told that the FLO had now left and another officer had been appointed as the new liaison officer for this investigation. The investigator contacted the new FLO, summarised the issues and requested the outstanding documentation. The investigator visited Pentonville for the second time on 26 June, and received some of the documentation. The FLO arranged for the remaining interviews to take place the same day. Additional documentation was subsequently received and two further interviews took place between 28 June and 6 July.
5. The Coroner was informed of the Ombudsman's investigation. The post mortem report concluded that the man's cause of death was due to:
 - 1a Cryptococcal meningitis
 - 1b HIV

The Coroner decided that the original inquest should be adjourned, pending this report's findings, and it is rescheduled for 12 October 2007. The Coroner will receive a copy of this report to assist with his enquiries.

6. Islington Primary Care Trust were asked to complete a clinical review into the care the man received whilst at Pentonville. They identified a medical practitioner to carry out this task.
7. The Head of Healthcare commissioned a separate review into the healthcare the man received whilst at Pentonville. This internal review was undertaken by a panel of healthcare representatives and seven key healthcare staff were interviewed. The panel made three recommendations and concluded that, in the main, the man received a satisfactory standard of care that fell within professional guidelines.
8. One of my Family Liaison Officers (FLOs) contacted the man's next of kin shortly after the investigation was opened. The FLO explained my role and provided information about the investigation process.
9. On 26 April, the FLO and the investigator visited the man's family. They asked a number of questions. The first question is outside my terms of reference and they were referred to an alternative source of advice. I have tried to address their other concerns, but regret that my answers are incomplete. I hope they find the information helpful, and this report helps them to understand the events leading up to the man's death.
10. The man's family raised the following concerns:
 - Given the man's confused and disorientated state, why was he remanded in police custody on 15 and 16 January 2007 and not taken straight to the nearest hospital?
 - Why was he discharged from the local hospital and placed back in Pentonville's care when he was in poor health?
 - The man had been in the custody of Pentonville in 2005. The prison had next of kin details on that occasion. Why were these details not used to contact his family when he was remanded in custody in January 2007?
 - Contact with the man's family was not made until around 31 January, nine days after his death. The man's family found the delay unacceptable and difficult to understand.
 - Who authorised the decision to end his life support without the knowledge or consent of his family?
 - The man's mobile phone was in his prison property and his family contact details were stored on the phone. Why was this not utilised to contact them when he came into custody, or when he was transferred to hospital, or when he died?

- When the man's mobile phone was returned to his family, all records of calls received or missed and messages sent or received were erased. Why?
 - When contact was made with the man's family, they were given conflicting information about the date of his death and which hospital he had been in. This caused even greater distress, particularly when his next of kin were trying to keep other family members outside the UK informed.
 - The man's family received a phone call from a nurse who confirmed that the man had been at the local hospital. The nurse also mentioned they were in possession of the man's watch. Why was this not returned with the rest of his belongings?
11. A draft copy of this report was sent to the man's family and the prison service. The man's family reiterated their concerns. I will send them a copy of this report. The prison service accepted all the recommendations, on the proviso that one recommendation be reworded slightly.

HMP PENTONVILLE

11. HMP Pentonville is a category B local prison, principally serving the eastern and north eastern parts of Greater London. Opened in 1842, the four original cellblocks remain in use, albeit they have been refurbished. Pentonville holds remand, unsentenced and sentenced adult males and has an operational capacity of 1,127 prisoners. There are now seven residential wings and a new healthcare unit.
12. Pentonville receives a high number of prisoners directly from the local courts and population pressures are something the prison constantly tries to manage. Reception staff can process anything from 60 to 100 prisoners per day. Pentonville remains one of the busiest and most overcrowded prisons in England and Wales.
13. Her Majesty's Chief Inspector of Prisons inspected Pentonville in 2002 and carried out a follow up inspection in June 2006. The follow up report, published in July 2006, recorded a prison still failing to operate basic systems in most areas of prison life. Inspectors found that a number of recommendations made in 2002 had not been achieved in the four years between inspections, and a disappointingly low number had been partly achieved. Lack of information from the courts still hindered Pentonville's attempts to carry out a thorough assessment of prisoners.

Reception and First Night in Custody

14. The Inspectorate found that Pentonville was still struggling to introduce an effective reception, first night in custody and induction programme. New arrivals were routinely taken to the first night centre on A wing to begin their induction process, but inspectors found that prisoners sent to other wings, due to their different status, were not necessary in receipt of a full induction programme. In addition, a free telephone call to family or friends was not routinely offered in reception, nor offered to new arrivals in the first night centre. The 2006 inspection report said, "Only 21% of respondents to our survey, against a comparator of 53%, said they had received a free telephone call."
15. Inspectors found that there was no system in place to permit new arrivals to retrieve telephone numbers stored on their mobile phones in reception. The report made a further recommendation to rectify this oversight.

Healthcare

16. The healthcare centre is a purpose built facility, separate to the main prison. Opened in 2005, the centre offers 32 in-patient beds and a primary care clinic designed to mirror a community GP practice. The Inspectorate found in 2006 that medical staff were still undertaking unnecessary tasks, and not all GPs had received adequate induction to prepare them for working in a prison setting.

KEY FINDINGS

The man's arrest on 15 January 2007

17. The man was initially in police custody following his arrest on 15 January 2007. He was detained overnight at a police station. The man refused medical attention whilst at the police station.
18. The man appeared at the Magistrates' Court on 16 January in relation to an outstanding driving offence dating from March 2006. The man was observed every few minutes by the escort officers transferring him to court. His Prisoner Escort Record (PER) described him as 'very confused'. Entries made by one officer, described him as 'unsettled'. The man undressed then dressed, stood up and sat down again, on numerous occasions. He also talked to himself.
19. The man arrived at the Magistrates' Court at 12.11pm, but did not appear in court that day. About an hour after he was placed in the court's holding cell, a forensic medical examiner was called to see him. Following an examination, the man was transferred to the local hospital where he was seen in the Accident and Emergency Department. His PER form said that the hospital doctor felt there were no medical concerns. The man was then discharged back into the custody of the police.
20. The man spent the night at another police station and was medically assessed by the forensic medical examiner that evening. No concerns were recorded and the man was considered fit to be detained.
21. At 9.30am the following morning, the man was again accepted into the custody of the court. He was placed in a holding cell where he was checked regularly by staff. He appeared in court at 2.20pm, and was remanded in custody until 19 January pending a community psychiatric nurse assessment and a probation report.

The man's reception at Pentonville

22. On 17 January 58 prisoners were processed through reception. The man arrived at Pentonville at approximately 7.10pm. He had a small amount of property with him, included clothing, a watch and a mobile phone. His possessions were recorded on the appropriate prisoner property record. His PER form identified that he was considered to be at risk of suicide and self harm, but this was not written down in any subsequent prison records. A security indicator initial assessment carried out by an officer support grade (OSG), registered the man as a new reception who had been convicted of a driving offence the previous year. The officer ticked that there were no known risks.
23. The man had a core record opened when he arrived in reception. His personal details, index offence, prisoner status, length of sentence and the date of his next court appearance were recorded on the document. The inside cover is used to record information about a prisoner's home address and next of kin.

The next of kin field was left blank, as was the man's last period in custody. The reception officer signed the core record as required, but the space reserved for a prisoner's signature was also blank.

24. The staff nurse was on duty in reception that evening. During the local internal review after the man's death, the nurse told the panel that the man was supported by two escort officers. She said she went to enquire why he needed assistance. The man told her that he had been suffering from sickness and diarrhoea for about three days and had lost his appetite. The nurse decided that the locum doctor should see him. The staff nurse instructed the officers not to search him due to the potential risk of cross infection.
25. The doctor was in reception that evening. Accompanied by a nurse, the doctor went to see the man and carried out a series of observations. The doctor told the local review that, on examining the man, he noticed "some ECG stickers" on his chest and asked why they were there. The man said that, before coming into the prison, he had been to hospital where he had been placed on a drip. He then walked unaided to be searched by officers. He was offered something to eat, which he accepted. The man was interviewed by a nurse as part of the first reception health screening. Details of his medical history and clinical presentation in reception were recorded.
26. The man was again seen by the locum doctor who interviewed him further. The doctor noticed that the man was weak and lethargic, and presented as confused. The locum doctor recalled that the man muddled his answers, but did mention that he had a cough which had persisted for about three weeks. The locum doctor recorded the man's medical history on the electronic monitoring information system (EMIS). He prescribed an injection for the nausea (metaclopramide) and some tablets. The doctor asked the clinical nurse specialist for tuberculosis to see the man the following day.
27. The medical team in reception that evening debated whether to send the man to an outside hospital straight away. The locum doctor decided to admit him to the prison healthcare unit for observation overnight. The man was taken from reception and located in the healthcare unit. The duty doctor saw the man on his arrival in healthcare and a clinical entry in his medical record noted the reasons for admission as, 'Investigations of diarrhoea and vomiting, confusion and body weakness'.
28. The EMIS information provided staff with an overview of the man's medical history. The electronic record showed that he was not registered with a GP, had no mental health issues or chronic diseases. He was not prescribed medication before coming into prison, but presented in reception with physical health concerns including diarrhoea and vomiting. It was also noted that he was unsteady on his feet. The duty nurse gave him the medication prescribed by the prison doctor and then made him as comfortable as possible. The man was then left to settle down for the night.
29. At approximately 5.00am, the duty nurse found the man on the floor of his cell in a confused state. The nurse asked him if he had fallen. The man denied that he

had and said he wanted to use the toilet. The duty nurse asked him to go back to his bed, which he did with some difficulty. The nurse told the internal review that this was due to the man's "general body weakness".

30. On the morning of 18 January, the man saw the charge nurse, the man's 'named nurse' and therefore responsible for his overall nursing care. The charge nurse began an evaluation of the care he required and completed a nursing care plan. The nurse recorded the man's symptoms and stressed the need to keep him isolated until a formal diagnosis was made. The nurse told my investigator that the full admission process was hindered because the man was not well enough to complete his assessment.
31. At approximately 9.30am, the prison doctor saw the man as part of his morning rounds. The prison doctor asked him a number of questions to which he replied that he was much better. When interviewed, the doctor told my investigator that the man presented as confused and was unable to answer all the questions put to him. The doctor said he did establish that the man had been diagnosed as HIV positive some 17 years earlier. The man had experienced symptoms of nausea and diarrhoea for many years, but was no longer vomiting. The doctor recorded this in his medical record. After the doctor finished his examination, he compiled a treatment plan for nursing staff to follow. The plan included:
 - collect and send samples to Path Lab. Review date 22 January
 - maintain fluid balance chart, administer medication and monitor effects
 - document all observations twice daily, update GP of any progress, liaise with agencies to share data
 - weigh the man daily.
32. The man was monitored, and the observations taken by his in charge nurse were entered on his medical record. At approximately 3.30pm, the prison doctor saw him again. The man explained that he was not strong enough to stand up, but that he had had something to eat and drink. The prison doctor decided to move the man to the West Ward as this would give nursing staff easier access. The charge nurse relocated the man with the help of the wing nurse. The charge nurse recalled the man's condition and said that the man told her he was HIV positive. The nurse told my investigator that she did not record the conversation because she felt it was confidential.
33. The charge nurse grew increasingly concerned about the man's health and asked the prison doctor to review him again. The doctor noticed that he had been incontinent of urine. An intravenous drip was set up and he was given oxygen. His observations were taken and the doctor instructed a member of the nursing staff to call for an ambulance. At approximately 5.30pm, a first response vehicle arrived at Pentonville followed by the ambulance. The prison doctor told my investigator that he drafted a handwritten note to the local hospital that explained his reasons for referring the man. The note was given to the paramedic. Unfortunately, the note was not duplicated in the man's medical record and it is unclear what information was passed to the hospital. When asked about the content of the referral letter, the prison doctor told my investigator that he could not remember the details but that he would have

written about the collapse. When asked if it was normal practice to telephone or write to the hospital doctor, the doctor said that, depending on how urgent a referral was, you might or might not get the chance to ring. If a referral was particularly urgent, “often a letter is satisfactory”.

34. The man’s medical record refers to a slight delay before the ambulance arrived. The original ambulance was apparently diverted to a road traffic accident and a rapid response vehicle was appropriately sent as an interim measure.
35. The man left Pentonville at 6.30pm and arrived at the local hospital 15 minutes later, accompanied by two escort officers. He was attached to one of the officers by a closing chain. The risk assessment for the hospital visit was authorised by the Deputy Governor. It said:

“Just received into custody on 17/01 – very little known about him. Possible mental health issues so please treat with caution. Cuffed at all times.”

36. The man remained in the Accident and Emergency Department for just over four hours. In that time he was examined by a triage nurse and his observations and blood were taken. At 9.30pm, the triage nurse told officers that the man’s test results were back. Until the duty doctor had seen him, she was unable to say whether he would stay in overnight.
37. At 10.30pm, the man was seen by the doctor on duty. Following an examination, the doctor discharged the man and wrote a letter to the prison doctor. The letter said that the man had been diagnosed with diarrhoea and that Pentonville’s healthcare unit should repeat a blood test within two days. The man left the hospital and arrived back at Pentonville at around midnight. On arrival, the man was located back on the West Ward where his observations were taken again. The night duty nurse noted the contents of the hospital doctor discharge letter in the man’s medical record.
38. The man remained confused and unsteady on his feet throughout the night. He woke up at approximately 2.00am on 19 January, asking for some food. The nurse gave him a breakfast pack, which he ate, before going back to sleep. The man slept until 7.00am, but presented as weak and in some distress when he woke up.

Friday 19 January – Monday 22 January

39. When the wing nurse came on duty at around 7.45am, he found the man half in and half out of bed. The nurse helped him back into bed, took his observations, and then called the prison doctor. The doctor told my investigator that he was surprised to see the man back at Pentonville. The doctor said that the hospital discharge letter recorded the diagnosis as hyponatraemia, which meant that the man was low in sodium. The discharge letter made no reference to the man’s HIV status and so the doctor arranged an urgent blood test. He discussed the man’s condition and the blood test with the infectious disease team at the

specialist hospital. The prison doctor told my investigator that he telephoned the hospital registrar and secured a bed for the man.

40. The wing nurse's notes from that morning were entered on an Evaluation of Patient Care form. The notes explained that the prison doctor expected the result of the blood tests by 1.00pm. He told staff that the man would need to be prepared for admission to hospital.
41. At around 3.00pm, an ambulance was called to take the man to the hospital. According to his Prisoner Escort Record, he was placed in restraints and accompanied by two officers. As with the risk assessment of 18 January, a member of the healthcare unit filled in the medical officer's section of the risk assessment form. The prison doctor said that the man was unable to stand unaided and was likely to be in hospital for a few days. The doctor ticked that the man was fit to be restrained and there was no medical reason for removal of restraints during treatment. Missing from the risk assessment was any input from other prison departments. This included both a governor's approval of the escort strength and restraints required, and the relevant security information. Both the despatching officer and escort officers ticked the appropriate boxes on the Prison Officer Escort Checklist to say that a copy of a full risk assessment had been seen and read.
42. When the man arrived at the specialist hospital, he was taken to the Accident and Emergency Department. He was x-rayed and underwent a Computed Tomography (CT) scan that uses technology to create a three dimensional image of a specific body part. (It is relevant to what follows that a CT scan is considered moderate to high in radiation as a diagnostic technique.) The escort officer completed a bedwatch log for the first few hours in hospital and recorded all the man's medical interventions as follows:

17:30	Doctor completed a number of tests and believes he has some neurological problems ... x-ray will take place before we go up onto a ward ... he [the man] will be admitted for at least one week.
18:40	Taken for a CT scan.
19:05	Back to A&E and to x-ray.
19:35	Moved to Medical Admissions Unit.
43. A governor, who is a trained family liaison officer (FLO), told my investigator that he was duty governor from 12.30pm on 19 January until 12.30pm on 22 January. He explained that he knew the man had been transferred to hospital and had asked the escort officers to keep him informed of the man's condition. The FLO did not recall making any decisions about removal of restraints, nor did he recall receiving a telephone call from either officer notifying him of any proposed changes in security arrangements. The FLO also confirmed that he did not carry out any management checks whilst duty governor.
44. In the absence of a full risk assessment, the documentation given to my investigator does not stipulate whether the man was restrained for the CT scan. It seems unlikely, if not physically impossible, that the man was attached to an

officer during such a medical procedure. It seems particularly unlikely that hospital staff would in fact permit prison officers to be in a radioactive area. I therefore assume that the man's restraints were removed before he was scanned, but that authorisation was either not sought or was obtained, but not recorded appropriately. I deal with the issue of restraints later in the report.

45. At 7.45pm, two escort officers took over the escort duty. According to the bedwatch log, the man underwent a lumbar puncture at 10.00pm to check for any infection in the brain. The log does not indicate whether restraints were in place for this procedure or, if they were removed, who gave authorisation for the change in security. In the restraints check and contact log, elsewhere in the booklet, one of the officers ticked that the man's restraints were checked and secure at 10.00pm that evening and remained that way for the rest of the night.
46. Two other officers relieved the night duty officers at approximately 8.55am on the morning of 20 January. One of the officers logged that the man received medication intravenously and that his observations were taken.
47. The man was relatively quiet until 2.55am on 21 January when he removed a needle from his arm. A nurse replaced the needle later that morning. A senior officer (SO) and a prison officer took over day duty at 7.00am and were given a verbal handover. The man was put on a drip at 8.40am and spent the rest of the morning sleeping or watching television. The man took some fluids and ate breakfast and lunch.
48. At 2.25pm, a doctor took another sample and told the officers that the man had meningitis. The officers were assured that they were not at risk. The SO made a note of the development. After another officer shift change, the man underwent a second lumbar puncture. An officer, on night duty, logged this at 9.15pm and wrote "... lots of fluid and pressure has built up in spine and brain. The man (sic) is very poorly." The officer reported the information to the communications staff at Pentonville.
49. Throughout the early hours of 22 January, the man's condition worsened. At 4.30am, after nursing staff had made regular observations, the man underwent further tests. Nursing staff became increasingly concerned and, at 6.45am, he was sent for another CT scan. Approximately 20 minutes later, the man's heart stopped. The escort officer made the following three entries in his bedwatch log:
 - 7.05am Crash team called, the man (sic) arrested, heart stopped. Crash team revived him.
 - 7.10am Prison contacted and updated. Prisoner is not cuffed at this time.
 - 8.05am Permission granted by duty gov to leave cuffs off (via comms).
50. Shortly after the man's heart stopped, he was moved to the intensive care unit. Two escort officers kept a detailed log of his progress and noted that he was now on a ventilator. At around 2.50pm, an officer was approached by a duty nurse and asked to arrange for the prison to notify the man's next of kin. The

officer noted that the man appeared to be losing his battle for life, but did not record when the prison was told of the hospital's request. The escort officer did try to contact communications at 6.00pm, but the telephone line was engaged. Another escort officer successfully got through five minutes later. The log did not say whether the officer repeated the hospital's request for the prison to find the man's family.

51. At some point that afternoon, the Officer Support Grade (OSG), who worked in security, was told to assist in finding the man's next of kin. It is not clear from the documentation who asked the OSG to assist. The OSG contacted the local police. From 3.00pm to 7.20pm, he logged their efforts to locate the man's next of kin. Two addresses were found, one in Essex and one in Cleveland. Both were followed up by the local police forces, but the man was not known at either address.

23 January

52. At 7.00am, the two escort officers took over the bedwatch duties. An hour later, one escort officer contacted Pentonville to see if the man's family had been located. At 8.45am, the officer contacted the prison again and spoke to the head of security. The escort officer explained that a nurse had asked for the man's family to be contacted "within the next couple of hours". The deputy governor who was also duty governor that day, attended the daily management meeting. The head of healthcare told the deputy governor that the man was in very poor health and there was concern that he might not live. At around 1.50pm, the hospital nurse spoke to the escort officer again and said that the man's treatment would be stopped. Pentonville's communications staff were informed immediately. A few minutes later, the man died. He was officially pronounced dead by the hospital doctors at 1.55pm.

Events following the man's death

53. The deputy governor was making her way to the hospital to carry out a management check when she learnt en route that the man had died. She spoke to both escort officers on arrival, before speaking to the nurse who had cared for the man. She told the nurse that prison staff were still trying to notify the man's next of kin, but this had proved difficult. The deputy governor recalled that the nurse felt it was terribly sad that the man's life had ended without his family's knowledge. She left the hospital by taxi with both officers and accompanied them back to Pentonville.
54. The prison's family liaison officer was told of the man's death that afternoon. He told my investigator that he began to follow the death in custody contingency plan. He contacted the relevant agencies, including the police and coroner. The FLO then arranged for the man's property to be gathered, ready to be returned to his family, and spent the next few days attempting to locate his next of kin. My investigator asked for a copy of the contingency log, but unfortunately it has not been forwarded.

55. The deputy governor told my investigator that she asked the FLO to go through the man's mobile phone and use the numbers listed to trace his next of kin. The deputy governor could not recall when she spoke to the FLO, but said it was probably the day the man died. My investigator asked the FLO whether he checked the man's phone as requested. He told my investigator that he noticed the contacts list stored on the phone, but did not feel it would be appropriate to contact individuals without knowing their relationship with the man. The deputy governor told my investigator that, as far as she was aware, the FLO had exhausted this avenue of enquiry without any success.
56. Between 23 and 30 January, the FLO contacted the Embassy, again without any success. He delegated responsibility for following other avenues of enquiry to a nurse, who was not a trained FLO. The nurse knew that the man would have been treated at his local hospital before coming into prison and, on 25 January, began to make enquiries. He faxed the Strategic Health Authority and waited for a response. He also asked one of his colleague, a ward sister to fax the hospital. When interviewed the nurse was uncertain which hospital eventually provided details of the man's next of kin, but thought it was the HIV outpatients clinic at the first local hospital. The nurse emailed the FLO regularly throughout this period to update him on his progress.
57. On 30 or 31 January, the ward sister obtained the contact details for the man's cousin. She telephoned the cousin and informed him of the man's death, but unfortunately gave incorrect details of the hospital. Following her conversation with his next of kin, the ward sister emailed the FLO with an update. She said:
- "... have informed a relative of the man's death and he was very shocked and upset as he had no idea he was unwell and has not seen him in over a year, although he did know he was in prison. I have told him that he died in intensive care at the local hospital and have given him the hospital details ..."
58. The ward sister's email also explained that the man's cousin put the phone down before she could make arrangements for a family visit. She told the FLO that she thought a senior member of staff should contact the man's family and offer a visit. The ward sister passed the man's cousin's mobile phone number to the FLO.
59. The nurse also telephoned the man's family to correct the information previously given by the ward sister. It is not clear from the documentation when this was, but his email to the FLO, dated 1 February, said the following:
- "I phoned the man's cousin back later as he had been so upset. I confirmed with him that it was the specialist hospital, rather than the local hospital ... I have given him my contact details if he should wish to come and discuss."
60. In his last email to the FLO on 7 February, the nurse confirmed that he had the man's watch and would pass it to the FLO ready to return to the man's family.

61. The FLO telephoned the man's family shortly after the ward sister had broken the news of his death. He arranged a visit to the family between 31 January and 2 February, but was unable to recall exactly when it took place. The FLO asked the duty SO to accompany him on the visit. The man's family asked a number of questions, particularly in relation to the hospital transfers. The duty SO told my investigator that the FLO could not provide any answers to their concerns. The man's family then enquired about funeral arrangements and expressed a wish to fly his body back to his home country. The FLO reassured the man's family that he would make enquiries by speaking to the then Governor. He assured the man's cousin that he would contact him shortly with a decision.
62. Both the FLO and the duty SO passed their contact details to the man's family before they left. On either 2 or 3 February, the man's cousin contacted the duty SO to discuss the funeral and told her that the man's body was due to be flown to his home country the following Thursday. This did not give the duty SO much time to explore the possibilities of assisting with the cost and, as the FLO was on annual leave, she was not sure how best to proceed. She approached the head of residence, who advised her to speak to the Governor. The duty SO secured a contribution towards the man's funeral costs and liaised with the funeral directors to arrange payment. The duty SO visited the man's family again to return his property in person. The man's family said they were happy with the arrangements she had made, and thanked her for the visit.
63. The funeral took place in the man's home country and was attended by his family.

ISSUES

Reception and first night process

64. The man by-passed the usual process of first night and induction on A wing, as the doctor appropriately prioritised the man's physical health needs and located him in healthcare. However, this meant that he missed some of the reception process and first night routines, including a telephone call to his family. The nurse said that, in his experience, if an inpatient requested a phone call then one would be arranged. Similarly, if a patient was particularly unwell, a call could be arranged. However, as a rule, telephone calls did not happen. He added that officers did not deliver any reception or first night services to prisoners located in healthcare. I must stress that, even if telephone access had been provided, the man might not have chosen to contact his cousin. For this reason, I make no formal recommendation. However, I draw the Governor's attention to the benefits of implementing a local protocol to appropriately induct prisoners irrespective of where they are located.

Clinical care

65. A clinical reviewer was appointed by Islington Primary Care Trust to carry out a review of the healthcare the man received whilst at Pentonville. She took over the review from another reviewer. The clinical review concluded that, overall, the man's care mirrored the care he would have received had he been in the community. In summarising the medical interventions the man received, the clinical reviewer said the care afforded to him whilst he was in Pentonville was appropriate and timely. Despite my comments below, the clinical reviewer said that the fatal outcome of the man's illness was probably inevitable in the light of the provisional post mortem findings of cryptococcal meningitis secondary to HIV infection.

66. The man was already in poor health when he arrived at Pentonville on 17 January. His health caused such concern in reception that the locum doctor on duty felt it necessary to admit him straight to the inpatient facility. The man never saw the main prison. Instead, he was cared for by the doctor and nursing staff on duty throughout his short time in Pentonville's custody.

67. Albeit brief, the care afforded to him at Pentonville was dedicated. In the short time he spent in healthcare, he received a number of medical interventions, including constant observations, blood tests, a full nursing care plan, and two referrals to local hospitals. The doctor who referred him to the local hospital the day after he came into custody was genuinely surprised to see him return to Pentonville, and felt he was too ill to remain in prison. The prison doctor therefore wasted no time in securing a bed for the man at the specialist hospital.

68. The man was perhaps too ill to have been remanded in custody. Yet the care he received might well have been to a higher standard than he would have received in the community. Being in prison does not appear to have affected the quality or level of nursing care and treatment.

69. The clinical reviewer commented that the doctor who assessed the man at the local hospital on 18 January 2007 may have underestimated the severity of his condition. It is possible that inadequate communication from the prison doctor was a contributory factor. The prison doctor sent the man to hospital, without apparently telephoning to explain his condition which would be the usual practice in a primary care setting. The hospital report did not mention the man's HIV status, so it is possible that the hospital was unaware of it. Communication between the prison and the hospital appears to have been inadequate. This may have contributed to the decision by the doctor to discharge the man from hospital rather than admit him for further tests and observation.

When a prisoner is sent to hospital, the referring prison doctor should speak to the duty doctor at the receiving hospital to ensure they are fully briefed about the clinical concerns. A copy of any referral letter should be kept in the patient's prison medical record.

70. The prison doctor recorded at 3.30pm that he was waiting for the test results before deciding on the next course of action, and seemed to be unaware of the delay in getting the samples to the hospital. From the interviews carried out for this investigation, it appears that there are routine courier deliveries between the prison and hospital. The man's sample needed a special delivery.

When urgent blood tests are required, the doctor should be informed of any delay in the samples being sent to or reaching the laboratory.

Record keeping

71. The clinical reviewer has observed that the nursing notes recorded during 18 January until 4.00pm do not appear to have been made contemporaneously. Part of the record was made on a continuation sheet, which was then abandoned but used again later, so that the written record is out of sequence. During 19 January, there is only one written record made after 7.00am, but it was not timed.
72. The nursing observation chart has also not been filled in correctly. The temperature has not been recorded at all on the chart, although it is recorded in the written record. The blood pressure is recorded graphically on the chart in the space meant for the pulse record so it is impossible to see the pulse recording. The chart has no entries after 7.00am on 19 January.
73. The man's medical record does not contain all the clinical interventions he apparently received. A conversation he had with a nurse at reception about his HIV status was not logged. (As noted earlier, the reception nurse told my investigator that she considered it to be confidential.)
74. The record made by the prison doctor was in the main clear and full. However, he did not document which blood tests he ordered on 18 January, just writing 'Urgent bloods'. The documented information about the blood tests was insufficient to allow another doctor to take over the care of the patient safely. The doctor who saw the man at 9.30am recorded 'Urgent bloods' as part of his

action plan, but the report from the specialist hospital suggests that the samples did not actually arrive at the hospital laboratory until 5.32pm.

Nursing notes should be made contemporaneously with all events recorded. Nursing observation charts should be completed correctly. Notes should contain sufficient detail for another clinician to take over the care of the patient.

Communication between the prison and the hospital

75. Although it would not have altered the outcome for the man, my main concerns relate to his stay in hospital. This is not a comment on the care he received in hospital, but rather about how his stay in hospital appears to have been managed by Pentonville. Prisons have a continuing duty of care to prisoners who remain in their custody but are temporarily located in an external facility, for example an NHS hospital. There are a number of aspects, both operationally and in relation to healthcare provision, where practice could be improved. I deal with these below.
76. Throughout the man's stay in hospital, the only record of his condition was recorded in the bedwatch log. Bedwatch officers are not medically qualified and do not make medical records or contribute to clinical decisions. The prison doctor was unaware that healthcare staff are required to maintain regular contact with outside clinical environments. No contact between healthcare and the hospital was recorded, and the doctor said he would not expect staff to maintain contact.

The Head of Healthcare should ensure that staff are made aware of the requirement in PSO 3050, Continuity of Healthcare, section (c) 'Continuity of Care between Establishments', to contact outside clinical environments, and to obtain updates on prisoners' health and record these appropriately.

77. The man's family were not given the opportunity to be consulted by the hospital over the termination of his treatment. I deal with the issue of contacting them later in my report. I have been unable to verify whether the prison were aware or involved in the decision to terminate the man's hospital treatment. Best practice would have included a case conference to discuss how best to manage the man's care. I would expect that an issue as serious as terminating an individual's medical treatment to be managed as part of multi-disciplinary discussions and the decisions reached fully recorded.

Risk assessments and bedwatch

78. When the man was first referred to the local hospital on 18 January, he was accompanied by two prison officers and placed in restraints. The risk assessment completed for the transfer was reviewed by the deputy governor who told my investigator that she was happy with its content. For the man's second and final transfer to the specialist hospital the following day, the risk assessment was incomplete.

79. Once a risk assessment has been completed, it is checked by the discharging officer and escort officers before the prisoner leaves the prison. All the staff overseeing the man's second transfer ticked the appropriate boxes to say they were in possession of a full risk assessment. It is possible that the first risk assessment was used to cover the man's second transfer to another hospital the next day. The deputy governor agreed that staff might have assumed that the original security arrangements and instructions were valid, considering they were only compiled a day apart. However, it was her view that the second form should still have been filled out fully. I concur with the deputy governor's opinion as prisoners' health and circumstances may change rapidly.
80. Pentonville's local operating instructions for hospital escorts and bedwatch set out the procedures prior to a prisoner's discharge. The instructions state at paragraph 2.1:

"Prison Management must undertake a risk assessment (annex A) to decide the level of an escort and restraint required for safe custody of the prisoner."

The instructions also provide that the assessment for urgent transfers must be completed within two hours of the move. This is the responsibility of the orderly officer and/or duty governor. At the very least, the prison should have confirmed that the original assessment remained valid.

81. As far as I can tell from the available documentation, the same level of security was maintained for the duration of the man's stay in hospital, even when his health was clearly failing. I find it hard to believe that this level of supervision was required as the man's condition had worsened and his security risk clearly lessened. Changes to his security arrangements that should have appeared as amendments to his risk assessment were not recorded.

The Governor should remind both prison management and staff of the local instructions and their individual responsibilities to complete, check and amend risk assessments as necessary. Reviews should be timely, and consider the reduction of risk when a prisoner's health deteriorates.

Restraints

82. The man's bedwatch log from 19 to 23 January, gives rise to a number of concerns about the use and removal of restraints for medical interventions. It appears from the log that he underwent two scans and lumbar punctures. However, at no point is there any evidence to indicate whether the restraints were removed, and if so, what procedure the officers followed. In addition, there is no record of the duty governor authorising any changes to the security arrangements.
83. The first and only record of permission to remove restraints appeared at 7.05am on 22 January when the man's heart stopped. This entry explained that the officer telephoned the prison and indirectly obtained authorisation to remove the man's restraints. He told my investigator that he could not remember how the

removal of restraints was arranged. The officer could not remember who first asked for the restraints to be removed, nor the reason for the request, nor whether he or the duty governor first authorised their removal. He said that it would be highly unlikely for a prisoner to remain in restraints if it would interfere with emergency treatment. He added that it would be too dangerous for an officer to remain attached to a prisoner if electric shock treatment were used.

84. The officer also confirmed that he was unaware of the 'Removal of Restraints' forms located at the back of the bedwatch pack. My investigator told him that the forms should be completed by the escort officers and the duty governor whenever restraints were removed from a prisoner in hospital. In this case, the form was blank.

The Governor should ensure that prison management and staff are familiar with their responsibilities to both act and accurately record their actions when the removal of restraints is appropriate.

85. The man's health deteriorated rapidly following his arrest. He was disorientated and unable to walk unaided when he left Pentonville on the second occasion. Once at the hospital, he underwent a series of medical interventions and deteriorated further. Whilst I understand that the balance between security and compassionate care of individual prisoners is difficult, I question the rationale that left him in restraints. I share the concerns of the bedwatch officer about an officer's safety, and extend these to the other medical interventions the man experienced. I find it hard to believe that an officer remained attached to the man whilst he underwent scans, and assume that the missing documents (including the management checks) would have provided reassurance that this was not the case. But in any event, I question why a low security risk prisoner, who was quite obviously in very poor health, needed to be physically restrained at all. In the absence of a reasoned judgement in the documentation, this appears to have been undignified, unnecessary and unacceptable.

Management checks

All prisoners moved to outside clinical environments are subject to management checks. At Pentonville, local operating instructions require governor grades, principal officers or senior officers to carry out the duty once every 24 hours. The first management check for the man's bedwatch was due on Saturday 20 January. As it was the weekend, a senior officer was identified as being responsible for this check. According to the documentation, no check in fact took place. After repeated requests for a copy of the management check folder detailing all checks, my investigator was told that Pentonville's security staff could not find it. My investigator requested a list of all contact between escort officers and communications staff during the man's bedwatch period. At the time of writing, my investigator was still waiting for this record. Bedwatch documentation including the management checks are important information and should be stored safely in accordance with local operating instructions.

The Governor should remind the Head of Security of paragraph 11.3 of the local policy which says management check folders must be stored in the Governor's secretary's office and returned there immediately after use.

After a death in custody: Notifying next of kin and record keeping

86. When the man arrived at Pentonville, he did not provide details of next of kin. It is entirely at a prisoner's discretion whether he or she gives emergency contact information, although reception officers are encouraged to obtain the information wherever possible. Prison Service Order 0500 'Reception' states at paragraph 3.5:

"Staff should not be left in a position where, in the event of an emergency, the appropriate contact details are not available."

87. Prisons do not routinely keep substantial back records of individual prisoners. Nor are they required to do so. The FLO told my investigator that, if a prisoner was discharged more than three months ago, records would not usually be kept on the system or in hard copy. Additionally, the Prison Service computer system is not equipped to store the volume of data that would be generated by recording the details of every prisoner who came through the prison gate.

88. The absence of next of kin details presented prison staff with difficulties when the man's health deteriorated. No attempt seems to have been made to trace them until the hospital asked the officers to do so, and this was only after the man's heart stopped. Attempts were made, involving two police forces, but without success. The man lived for another day and a half, but died without his family's knowledge.

89. Regrettably, it then took a further nine days for Pentonville to notify the man's family of his death. The FLO was specifically asked to trawl through the man's mobile phone to look for a possible contact telephone number, but told my investigator that he did not feel comfortable doing this. The deputy governor was left with the impression that this avenue had been explored.

90. The man's cousin was eventually notified some time around 31 January. My investigator has uncovered a number of concerns about this contact. The man's cousin was not told of the man's death by a trained family liaison officer, instead, he was told by a nurse over the telephone and not in person. The information was initially inaccurate, and a further telephone conversation was made to correct the error. Nor did the FLO keep a log of attempts to contact the man's family and their concerns. Thus my investigator was not provided with an accurate account of the liaison. Neither do I know when the home visit took place, whether the prison chaplaincy team was asked to attend the visit, why some of the man's property was not returned to his next of kin, or why, when the mobile phone was returned, it did not contain all the data his family expected to be stored.

91. The delegation of family liaison responsibilities to healthcare staff, who were not trained in the role, compounded the errors. Although it was the efforts of the

nurse acting on behalf of the FLO and the ward sister that eventually led to the man's family being traced, it would have been preferable for trained Family Liaison Officers to have broken the news. Pentonville currently has four staff trained in this role. The nurse was not aware of the operational procedures for deaths in custody and, in his experience, the two sides of the prison operate separately. I remain concerned that healthcare staff were delegated the responsibilities for the initial family liaison.

92. I sympathise with Pentonville's predicament when faced with no family details. I also appreciate that individual prisons do not have the capacity to archive prisoners' back records. However, I find it difficult to understand why the prison waited until the hospital requested the man's next of kin details. Given the seriousness of his condition, I see no reason why the search could not have begun as soon as the man was admitted to hospital.
93. The deputy governor confirmed that the person responsible for overseeing the notification of next of kin, arranging family visits, organising the release of property and collating all the paperwork for the investigation fell to the head of safer custody who was also the FLO. This is a senior post, and the deputy governor said it would have been assumed that the FLO was carrying out the tasks as required. I make the following recommendations:

The Governor should ensure that only trained FLOs are entrusted with maintaining contact with the bereaved family.

The Governor should remind prison staff that, in accordance with PSO 2710, in the event that a death occurs in an outside hospital a log of all agencies contacted should be recorded as part of local contingency plans.

RECOMMENDATIONS

When a prisoner is sent to hospital, the referring prison doctor should speak to the duty doctor at the receiving hospital to ensure they are fully briefed about the clinical concerns. A copy of any referral letter should be kept in the patient's prison medical record.

The prison service accepted the recommendation. In response, they said:

All doctors (including locums) to be informed of the necessity of contacting the appropriate hospital team. Photocopies of referral letters will be scanned into the EMIS medical record.

When urgent blood tests are required, the doctor should be informed of any delay in the samples being sent to or reaching the laboratory.

The prison service accepted the recommendation. In response, they said:

Urgent blood tests are done by the GP at the time of request and sent by courier. This is recorded on the EMIS medical record, including time blood taken, time of despatch and the time of results received.

Nursing notes should be made contemporaneously with all events recorded. Nursing observation charts should be completed correctly. Notes should contain sufficient detail for another clinician to take over the care of the patient.

The prison service accepted the recommendation. In response, they said:

All nursing notes are electronic as well as hard copy. This includes all care plans which are updated on a twice daily basis or more frequently if and when required. Nursing notes are now in line with NHS national guidelines.

The Head of Healthcare should ensure that staff are made aware of the requirement in PSO 3050, Continuity of Healthcare, section (c) 'Continuity of Care between Establishments', to contact outside clinical environments, and to obtain updates on prisoners' health and record these appropriately.

The prison service accepted the recommendation. In response, they said:

The lead GP will maintain contact with outside trusts about patients in outside hospital, and in the absence of the lead GP the head of nursing will carry out the check. A check will be made on alternate days with the medical team looking after the patient. To support this, on alternate days, the senior nurse will check the status of the patient in outside hospital in the afternoon, and disseminate the information to healthcare managers and the appropriate staff within the establishment. Notes will be added to the patient's electronic record.

The Governor should remind both prison management and staff of the local instructions and their individual responsibilities to complete, check and amend risk assessments as necessary. Reviews should be timely, and consider the reduction of risk when a prisoner's health deteriorates.

The prison service accepted the recommendation. In response, they said:

An extra line will be inserted into the bed watch management checks book asking whether any change in circumstances warrants an amendment to the risk assessment.

The Governor should ensure that prison management and staff are familiar with their responsibilities to both act and accurately record their actions where the removal of restraints is appropriate.

The prison service accepted the recommendation. In response, they said:

A notice to all staff will be issued reminding all staff of their responsibilities.

The Governor should remind the Head of Security of paragraph 11.3 of the local policy which says management check folders must be stored in the Governor's secretary's office and returned there immediately after use.

The prison service accepted the recommendation. In response, they said:

Head of Operations to update local policy to show that folders are now stored in security.

The Governor should ensure that only trained FLOs are entrusted with maintaining contact with the bereaved family.

The prison service did not accept the recommendation. In response they said:

With reference to recommendation 8 that a Governor should ensure that only trained family liaison officers (FLOs) are entrusted with maintaining contact with the bereaved family, I would say that although it is preferable for this to happen, it is not mandatory for prisons to have a trained FLO so we would be unable to accept this recommendation in its current form. Would you consider amending this recommendation to "The Governor should ensure that only trained FLOs, *where possible*, are entrusted with maintaining contact with the bereaved family.

The Governor should ensure that only trained FLOs, *where possible*, are entrusted with maintaining contact with the bereaved family.

The Governor should remind prison staff that, in accordance with PSO 2710, in the event that a death occurs in an outside hospital a log of all agencies contacted should be recorded as part of local contingency plans.

The prison service accepted the recommendation. In response, they said:

A logsheet created of all agencies contacted will be added to the contingency plans.