

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Curtis Cadman, a prisoner at HMP Lincoln, on 21 November 2022**

**A report by the Prisons and Probation Ombudsman**

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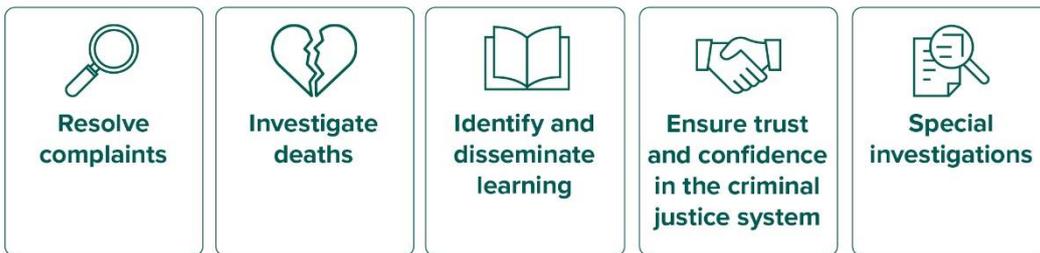
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## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO



## WHAT WE VALUE



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

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

Mr Curtis Cadman died of heart disease at HMP Lincoln, on 21 November. He was 50 years old. I offer my condolences to Mr Cadman's family and friends.

The investigation found that Mr Cadman's clinical care was equivalent to that which he could have expected to receive in the community.

The welfare check on the morning of Mr Cadman's death fell short of the required standards, but I am satisfied that the Governor has since taken steps to increase staff awareness of their responsibilities when conducting such checks.

I consider that Lincoln's policy on managing medical emergencies should be strengthened, to clarify that control room staff should not wait for authorisation to request an ambulance when a medical emergency code is called.

I am concerned that the Early Learning Review of Mr Cadman's death did not explore the fundamental issues highlighted in this report, relating to staff actions before and immediately after Mr Cadman was found dead.

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

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**November 2023**

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## Summary

### Events

1. Mr Curtis Cadman was remanded to HMP Lincoln on 10 November 2022. He had a history of substance misuse and was placed on methadone maintenance and benzodiazepine detoxification. Healthcare staff monitored him closely and reviewed medical problems unrelated to his cause of death.
2. At around 7.50am on 21 November, a prison officer conducted a welfare check. He thought Mr Cadman was asleep but spoke to his cell mate. At around 8.10am, Mr Cadman's cell mate tried to wake him up, but found that he was cold. He alerted an officer, who called a code blue medical emergency.
3. Healthcare and operational staff went to Mr Cadman's cell. Rigor mortis in his face and arms indicated that he was dead, so they did not try to resuscitate him. A paramedic employed at the prison confirmed Mr Cadman's death and that an ambulance was not required.

### Findings

4. Mr Cadman's clinical care was equivalent to that which he could have expected in the community.
5. The morning welfare check was inadequate and did not comply with the expectation that a response should be obtained from each prisoner. The Governor has issued fresh guidance, reminding staff of the requirement to do so.
6. Control room staff did not adhere to the mandatory requirement to request an ambulance when the code blue was called. They consulted the custodial manager, who advised several minutes later that an ambulance was not needed. The sequence of events documented on the incident log suggests a poor understanding of the medical emergency procedures, rather than individual error.
7. The Early Learning Review found no learning points. Given that wellbeing is one of the aspects considered, it is disappointing that there was no reference to the welfare check that took place around 20 minutes before Mr Cadman was found, or an examination of whether it was appropriately handled. In addition, the review did not address the failure to automatically request an ambulance in response to the code blue.

### Recommendations

- The Governor should review Lincoln's local guidance on medical emergency response codes to remind control room staff that, in the event of a medical emergency code, they should not wait for authorisation to request an ambulance.
- The Prison Group Director for East Midlands should share the Ombudsman's report with the regional safety lead.

## The Investigation Process

8. HMPPS notified us of Mr Cadman's death on 21 November 2022.
9. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Cadman's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Cadman's clinical care at the prison. The investigator and clinical reviewer jointly interviewed two healthcare staff on 31 January 2023. The interviews were conducted using Microsoft Teams video conferencing. Additionally, they conducted individual interviews with a prisoner, a paramedic employed at the prison and a member of the substance misuse team.
12. We informed HM Coroner for Northeast Lincolnshire and Grimsby of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
13. The Ombudsman's family liaison officer contacted Mr Cadman's partner to explain the investigation and to ask if she had any matters she wanted us to consider. She did not reply.
14. The initial report was shared with HMPPS. They found no factual inaccuracies.

## Background Information

### HMP Lincoln

15. HMP Lincoln holds up to 729 remanded and convicted men, in four residential wings. It serves the courts of Lincolnshire, Nottinghamshire, and Humberside. Nottinghamshire Healthcare NHS Trust provides health services, with 24-hour nursing cover.

### HM Inspectorate of Prisons

16. The most recent inspection of HMP Lincoln was in December 2019 and January 2020. Inspectors reported that Lincoln was a much safer prison since the previous inspection in 2017.
17. Inspectors noted that there had been an increase in healthcare staff, with regular clinical supervision and training, as well as a systemic approach to learning lessons. New prisoners received a comprehensive health screen and appropriate specialist referrals. There was integrated clinical and psychosocial substance misuse treatment, which met individual needs and was reviewed regularly. The substance misuse team's location in the healthcare department enabled good communication with the primary care and mental health teams.

### Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2022, the IMB reported that the prison had made an 'extraordinary' effort to keep the prison running during the COVID-19 pandemic and continued to provide all healthcare services. There had been improvements to stop the diversion of medication.

### Previous deaths at HMP Lincoln

19. Mr Cadman was the eleventh prisoner at Lincoln to die since November 2019. Six of the previous deaths were from natural causes and four were self-inflicted. We have highlighted deficiencies in welfare checks at Lincoln in previous investigations, as well as the need to comply with the medical emergency response procedures.

## Key Events

20. Mr Curtis Cadman was remanded to HMP Lincoln on 10 November 2022, charged with burglary. It was not his first time in prison.
21. At his initial health screen, a nurse recorded that Mr Cadman had a history of substance misuse, notably cocaine, benzodiazepines, zopiclone (sleeping pills) and methadone. He had engaged with We Are With You (WAWY), a provider of substance misuse services in the community and at the prison. A local pharmacy confirmed that his prescription was 80ml of methadone, collected three times a week. Mr Cadman had also been diagnosed with deep vein thrombosis, nerve pain from an accident and depression. (Mr Cadman's secondary health screen was completed on 13 November.)
22. A GP at the prison then reviewed Mr Cadman. She prescribed methadone (taking into account that he had not had a dose for two days), benzodiazepine detoxification and medication to relieve withdrawal symptoms. The methadone was to be increased gradually to his community dose. Substance misuse reviews were scheduled for 5 days and 13 weeks. Mr Cadman was closely monitored for the next five days, and the GP reviewed him on 15 November.
23. On 18 November, Mr Cadman had injuries to his face and shoulder that he attributed to dozing off and falling from the toilet. He was sent to hospital for assessment and returned the same day. (After his death, intelligence reports suggested that the injuries were due to assault.)
24. On 19 and 20 November, Mr Cadman's leg was swollen, hot and red. There were no signs of infection and a nurse provisionally diagnosed cellulitis, arranging for him to attend the wound care clinic on 21 November.

## Events of 20/21 November 2022

25. At interview, Mr Cadman's cell mate said that during the evening of 20 November, Mr Cadman felt as though he was 'rattling' (withdrawing from drugs) and had gone to bed on the top bunk, at around 6.00pm or 7.00pm. This was unusually early for Mr Cadman, as his normal pattern was to stay awake for most of the night. The cell mate had not heard him snore before, but he was snoring noisily. He was lying on his front, and when he tried to wake him up, he acknowledged him but put his head down straight away.
26. On 21 November, Officer A signed to confirm that he had completed the welfare check for Mr Cadman's cell between 7.50am and 7.52am. He said in a statement that he and the cell mate had said good morning to each other, but Mr Cadman was always asleep during the morning checks. Using the light from the television, he looked into the cell and thought Mr Cadman was breathing. The cell mate said that the officer had shouted Mr Cadman's name but did not check him.
27. At around 8.10am, the cell mate tried to wake Mr Cadman so that he could get his methadone at 8.15am. His arm felt "dead cold", so he went onto the landing and told Officer B that Mr Cadman seemed to be dead.

28. Officer B called a code blue medical emergency, which indicates that a prisoner has breathing difficulties or is unresponsive. Two nurses went to the cell, followed by other officers, healthcare staff and a Custodial Manager (CM). They did not attempt resuscitation, as there were clear signs of rigor mortis in Mr Cadman's jaw and arms. A paramedic at the prison confirmed Mr Cadman's death.

### **Contact with Mr Cadman's Family**

29. At 9.55am, the family liaison officer (FLO) and the prison chaplain broke the news of Mr Cadman's death to his partner, at her home. They gave her information about the processes to be followed and offered support. The FLO telephoned several times in the following days and they both visited again on 30 November.
30. The prison contributed to the costs of Mr Cadman's funeral, which was held on 19 January.

### **Support for prisoners and staff**

31. A CM debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.
32. Mr Cadman's cell mate was moved to a cell in the first night centre for the next few days. He received support from the safer custody, mental health and prison chaplaincy teams and was referred to the trauma nurse.
33. The prison posted notices informing other staff and prisoners of Mr Cadman's death and offering support.

### **Post-mortem report**

34. The post-mortem report concluded that the cause of Mr Cadman's death was ischaemic heart disease. The use of methadone and cocaine contributed to but did not cause Mr Cadman's death.
35. HM Coroner noted that, "Methadone was detected at a concentration within its quoted potentially toxic to lethal ranges which overlap due to the development of tolerance. Diazepam and Pregabalin at therapeutic levels and a low level of Quetiapine were also detected. There was also evidence of previous Cocaine use. The combined use of Methadone and Cocaine may increase the risk of cardiac arrhythmia or other adverse cardiac events..." (Mr Cadman had been prescribed diazepam and pregabalin, but not quetiapine.)

## Findings

### Clinical care

36. The clinical reviewer concluded that Mr Cadman's care at Lincoln was of a good standard and equivalent to that which he could have expected to receive in the community. However, she made a recommendation about the need for clinical observations when a patient presents with signs of an infection. As this was unrelated to the cause of Mr Cadman's death, we do not repeat it in this report, but the Head of Healthcare will need to consider it.

### Morning welfare checks

37. Prison Service Instruction (PSI) 75/2011, Residential Services, says:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable.

“The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”

38. Officer A and the cell mate both thought that Mr Cadman was asleep when the welfare checks were completed on 21 November. The officer said that he was familiar with the normal behaviour of prisoners on his wing and Mr Cadman was always asleep during the morning checks. He thought he saw Mr Cadman breathing. The cell mate said that officers would normally say good morning if a prisoner was awake. If they were asleep, they would check but not disturb them.
39. Rigor mortis appears in the face around two hours after death, progressing to the limbs over the next few hours, completing in six to eight hours. Given that it was found in Mr Cadman's face and arms, he had been dead for at least two hours at the time of the welfare check. It is therefore clear that the check was not compliant with instructions to obtain a response to ensure a prisoner is alive and well.
40. The Governor issued a staff information notice on 16 May 2023, *Welfare Checks of Prisoners – Gaining a Response*. It states, “welfare checks MUST be carried out on ALL prisoners ... All staff must satisfy themselves that when unlocking a cell door, the prisoner in question is alive and well ... This can take the form of a verbal or physical acknowledgement, positive signs of breathing, the prisoner moving in the cell or in bed, or any other indication that the man in question is alive.”
41. Welfare checks are essential to ensure the safety and wellbeing of all prisoners, particularly so for those vulnerable to substance misuse. We consider that the check on Mr Cadman was inadequate. However, as tangible steps have been taken

to address the issue of welfare checks since Mr Cadman's death, we make no further comment.

## Emergency response

42. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes and Lincoln's local protocol, *Healthcare Assistance & Code Red/Blue* set out the actions staff should take in a medical emergency. Both instructions state that if an emergency code is transmitted, an ambulance must be called automatically. In addition, paragraph 5.2 of the PSI notes the mandatory requirement for local procedures to reflect that staff should not wait for a member of the healthcare team or a prison manager to attend the incident before an ambulance is called. The expectation is that an ambulance can be stood down if it is not required.
43. It was recorded on the prison's incident log that a code blue was called at 8.15am and that the custodial manager, duty governor and emergency response nurse acknowledged it. At 8.20am, a member of staff in the communications room radioed to ask a CM if an ambulance was required. They recorded that an ambulance was unnecessary and that, at 8.24am, the CM had telephoned the control room to confirm this and ask for the incident to be stood down. The prison paramedic noted in Mr Cadman's medical record that the custodial manager had asked whether an ambulance was needed and he had said no.
44. East Midlands Ambulance Service have no record of a request for an ambulance for Mr Cadman on 21 November and the prison's own records show that an ambulance was not requested after the code blue.
45. Although the prison's local guidance explicitly states that an ambulance should be called immediately in such circumstances, it does not inform staff that authorisation is unnecessary. The departure from the expected procedure did not affect the outcome for Mr Cadman and we accept that an ambulance was not needed. However, the process recorded on the incident log and the interval of 5-9 minutes between the emergency code and the definitive decision about an ambulance suggests a systemic problem rather than human error. We recommend:

**The Governor should review Lincoln's local guidance on medical emergency response codes to remind control room staff that, in the event of a medical emergency code, they should not wait for authorisation to request an ambulance.**

## Early Learning Review

46. The Early Learning Review completed on behalf of the Prison Group Director, concluded that there were no learning points arising from Mr Cadman's death. While we appreciate that such reviews are completed immediately after the incident and with limited information, we are concerned that this review did not fully explore the available evidence on two key issues.
47. Mr Cadman was found within 20 minutes of a welfare check. The review acknowledged that he was cold, and staff had stated that resuscitation had not been attempted due to rigor mortis. Therefore, under the subheading, 'health and

wellbeing' it would have been helpful for an examination of, or at the very least, reference to the welfare check and whether it had been sufficiently thorough. While we do not expect the reviewers to be aware of the timescales for the development of rigor mortis, it was clear from accounts of Mr Cadman's condition that he had been dead for some time. We believe the question of when a prisoner was last seen alive is one that should be routinely considered and, in this instance, the failure to address the welfare check was an obvious omission.

48. Actions around the emergency response would also have benefitted from more depth. The review noted that there had been a code blue and that an ambulance was not required but did not address the failure to comply with the mandatory requirement to request an ambulance. The conversations between the control room and other staff were documented in detail in the incident log. While there was no detriment to Mr Cadman, it was a learning point for the future.
49. If early learning reviews are to be of immediate value after prisoners' deaths, they need to have more substance than a chronology of events and potential issues should be examined more critically. We recommend:

**The Prison Group Director for East Midlands should share the Ombudsman's report with the regional safety lead.**

## **Inquest**

50. The inquest was held from 8 to 16 August 2024. The jury concluded that Mr Cadman died from ischaemic heart disease and that his use of prescribed methadone and illicit cocaine contributed to his death.

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