Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Charleston Cullen, a prisoner at HMP Nottingham, on 25 May 2022

A report by the Prisons and Probation Ombudsman

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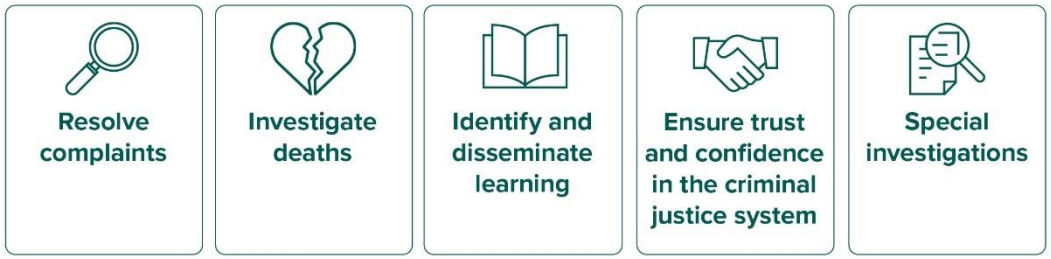
OUR VISION

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

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Charleston Cullen died in hospital on 25 May 2022, of ischaemic heart disease (reduced blood supply to the heart) while a prisoner at HMP Nottingham. He was 54 years old. We offer our condolences to Mr Cullen's family and friends.

4. The clinical reviewer found that the physical health care Mr Cullen received was not of a reasonable standard and partially equivalent to that which he would expect to receive in the wider community. Mr Cullen was not assessed by healthcare staff when he discharged himself from an emergency hospital admission, and poor communication with the hospital meant that changes to his medication were not identified. The clinical reviewer made four recommendations which the Head of Healthcare will need to address.

5. We are concerned that Mr Cullen was restrained when he went to hospital on 13 May, even though he had poor mobility and had been provided with a Zimmer frame by the prison. He remained restrained until 25 May, when hospital staff started cardiopulmonary resuscitation (CPR).

6. We were also concerned that Nottingham did not provide the investigator with all requested documentation about the use of restraints when Mr Cullen went to hospital, which meant that we could not fully determine whether the decision-making process was appropriate. However, the evidence we have seen strongly indicates that restraints were not appropriate.

Recommendations

- The Head of Healthcare should ensure that all prisoners returning from inpatient stays in outside hospital are treated in line with expected standards, including that:
    - all prisoners returning via Reception are seen and assessed by healthcare staff; and
    - hospital discharge summaries are received and any changes in treatment and medication are actioned.
- The Governor should ensure that all evidence relevant to a death in custody is retained and that the evidence is made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.

- The Governor and the Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that in all cases:

    - healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and

    - authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer, to review Mr Cullen's clinical care at HMP Nottingham. The clinical reviewer's report is annexed to this report.

8. The PPO investigator investigated the non-clinical issues relating to Mr Cullen's care, including Mr Cullen's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The investigator and the clinical reviewer interviewed two members of staff on 20 July and 10 August 2022.

10. The PPO family liaison officer wrote to Mr Cullen's next of kin, his brother, to explain the investigation and to ask if he had any matters they wanted us to consider. He did not respond to our letter.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Nottingham

12. Mr Cullen was the seventh prisoner to die at HMP Nottingham since May 2020. Of the previous deaths, five were from natural causes and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Cullen's death and our investigation findings for the previous deaths.

Key Events

13. On 9 February 2004, Mr Charleston Cullen was sentenced to life imprisonment for murder and arson, with a minimum term of 11 years and 7 months.

14. On the 20 September 2019, Mr Cullen was released on licence. This was subsequently revoked on 26 April 2022, and Mr Cullen was sent to HMP Nottingham on 27 April.

15. On 27 April, a nurse and a prison GP, assessed Mr Cullen as part of his reception health screen. They referred him to the mental health team and added him to the complex care caseload due to his complex medical history. Mr Cullen's medical conditions included but were not limited to; ischaemic heart disease, heart failure, Chronic Obstructive Pulmonary Disease (COPD, the term for a group of serious lung diseases) and chronic kidney disease stage 4 (severe kidney failure).

16. At 5.00pm on 9 May, Mr Cullen collapsed and complained of chest pain. Prison staff called an ambulance and paramedics took Mr Cullen to hospital.

17. We cannot say if Mr Cullen was restrained during the hospital escort as Nottingham did not provide these records.

18. On 11 May, Mr Cullen returned to Nottingham after discharging himself from hospital. Healthcare staff noted that Mr Cullen had appeared at the medicine hatch to collect his medications, however there was no discharge summary or information relating to any changes in his medication. There is no evidence that he was assessed on his return to prison.

19. On 12 May, a prison paramedic, saw Mr Cullen because he had complained of numbness in his legs and hands in the early hours of the morning. He arranged for Mr Cullen to have an electrocardiogram (ECG) the next day.

20. The ECG was carried out the following morning. The prison paramedic noted that the results were abnormal. He carried out a welfare check and, at 12.09pm, requested an ambulance. Ambulance paramedics arrived and took Mr Cullen to hospital.

21. HOT debrief minutes provided by Nottingham state that Mr Cullen was handcuffed by a single cuff while a hospital inpatient, which was removed when cardiopulmonary resuscitation (CPR) was administered at the end of his life. Nottingham did not provide the escort risk assessment document and we have not therefore seen the evidence used to justify this decision.

22. On 17 May, healthcare staff received the hospital discharge summary, which related to Mr Cullen's earlier stay in hospital. This showed that there had been an increase in his furosemide medication (used to treat heart failure).

23. On 25 May, Mr Cullen died in hospital.

Post-mortem report

24. A post-mortem examination established that Mr Cullen died of ischaemic heart disease (reduced blood supply to the heart).

Inquest into Mr Cullen's death

25. The inquest into Mr Cullen's death was held on 24 June 2024 and a verdict of natural causes was recorded. The coroner concluded that Mr Cullen's death was due to ischaemic heart disease.

Findings

Clinical Findings

26. The clinical reviewer concluded that the physical care that Mr Cullen received at HMP Nottingham was not of a reasonable standard and only partially equivalent to that which he could have expected to receive in the community.

27. The clinical reviewer was concerned that Mr Cullen was not reviewed by healthcare staff when he returned to Nottingham on 11 May, having discharged himself from hospital. She noted that Mr Cullen had left hospital without being medically discharged, therefore there was a possibility that he was still unwell and healthcare should have undertaken an assessment on his return.

28. The clinical reviewer was also concerned that Mr Cullen returned to prison without any discharge paperwork or information about changes to his medication. This meant that healthcare staff were not aware that one of his medications had increased. The discharge summary was not received by healthcare until 17 May. We make the following recommendation:

    The Head of Healthcare should ensure that all prisoners returning from inpatient stays in outside hospital are treated in line with expected standards, including that:

    - **all prisoners returning via Reception are seen and assessed by healthcare staff; and**

    - **hospital discharge summaries are received and any changes to treatment or medications are actioned.**

Providing evidence to the Prisons and Probation Ombudsman

29. PSI 58/2010 requires prisons to provide evidence to the Ombudsman's office for the purpose of our investigation. Nottingham did not supply all the escort risk assessment documentation. This adversely affected our investigation and meant that we could not determine whether the decision-making process when Mr Cullen was escorted to hospital on 9 May and 13 May was appropriate. We make the following recommendation:

    The Governor should ensure that all evidence relevant to a death in custody is retained and that the evidence is made available to the PPO, in line with PSI 58/2010.

Restraints, security and escorts

30. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk

of escape, the risk to the public and takes into account the prisoner's health and mobility.

31. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

32. On 9 May, Mr Cullen was taken to hospital after he had collapsed and had chest pain. He remained an inpatient for two days. Mr Cullen was admitted to hospital again on 13 May, following an abnormal ECG, and resided in hospital for the rest of his life.

33. We were not provided with the prisoner escort records or risk assessments for either hospital admission. However, other information provided by the prison details that Mr Cullen was restrained by a single cuff on his final admission. The handcuff was only removed when it was clear that CPR was needed.

34. It is documented within the medical records that Mr Cullen had mobility issues and, on 28 April, he was provided with a Zimmer frame. On 8 May, Mr Cullen collected his medications from the medical hatch in a wheelchair and, on 9 May, he was moved to a different cell which was closer to where the medication hatch was located. We have seen no evidence to indicate that Mr Cullen was a high risk of violence or of attempting to escape. Our ability to full consider this matter has been hampered by a lack of information. However, based on the information that we have seen we do not think that it was appropriate that Mr Cullen was restrained given his limited mobility and his general poor health. We therefore make the following recommendation:

The Governor and the Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

- **healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

Mark Judd
Acting Assistant Prisons and Probation Ombudsman **May 2023**

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