Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marc Uzzell, a prisoner at HMP Bristol, on 28 December 2022

A report by the Prisons and Probation Ombudsman

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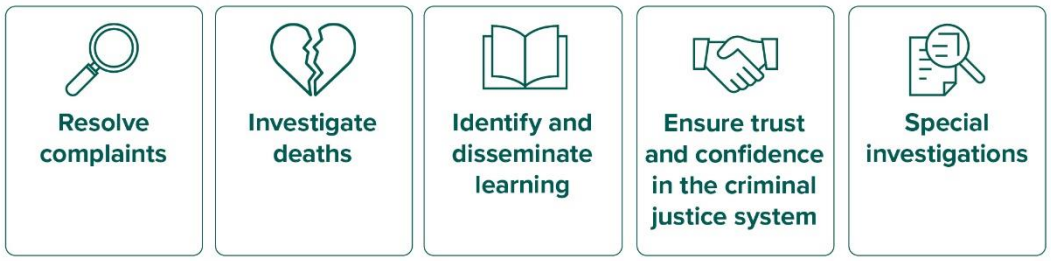
OUR VISION

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

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

Mr Marc Uzzell died in hospital on 28 December 2022, while a prisoner at HMP Bristol. He was 42 years old. The cause of his death was cavitating pneumonia. I offer my condolences to Mr Uzzell's family and friends.

The investigation found that poor and unsafe clinical handling when Mr Uzzell initially reported feeling unwell led to delay in assessing and treating him. His clinical care was therefore only partly equivalent to that which he could have expected to receive in the community. A further concern is that healthcare staff did not record the reasons for dispensing over the counter medication in the days before Mr Uzzell became seriously unwell.

Mr Uzzell's records were poorly documented and key documents were mislaid by operational staff. Consequently, some elements of the circumstances around his death are unverified.

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 **January 2024**

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Summary

Events

1. Mr Marc Uzzell was remanded to HMP Bristol on 13 December, charged with violent offences.

2. Reception health assessments identified no immediate health needs. However, between 19 and 22 December, healthcare staff dispensed over the counter painkillers three times.

3. In the early hours of 24 December, Mr Uzzell reported that he had coughed up blood and a nurse assessed him. He remained unwell, with worsening symptoms and, at around 9.00am that morning, another nurse reviewed him. She found that Mr Uzzell needed to be assessed by a critical care team and sent him to hospital. (The nurse also notified the Head of Healthcare of her concerns about the previous assessment by her colleague.) Mr Uzzell was escorted by two prison officers and double handcuffed.

4. On 25 December, Mr Uzzell's condition deteriorated. A prison manager asked staff to inform Mr Uzzell's partner that he was in hospital, but she arrived to visit him before this was done.

5. Mr Uzzell did not recover and died on 28 December.

Findings

6. The clinical reviewer concluded that the actions of the nurse who assessed Mr Uzzell when he first reported symptoms of illness were unsafe and his clinical care was therefore only partly equivalent to that which he could have expected to receive in the community.

7. Healthcare staff did not record the reasons for dispensing painkillers to Mr Uzzell in the days before he became seriously unwell.

8. The nurse who first assessed Mr Uzzell on 24 December did not record his clinical observations, or tell healthcare day staff that he was unwell during the morning handover. This led to a delay in seeking appropriate treatment. The nurse's actions, as well as his unwillingness to cooperate with the PPO investigation, have been referred to the Nursing and Midwifery Council.

9. Record keeping by operational staff was poor in a number of areas and important documents were mislaid and unavailable for the investigation. Examples included omissions in documenting the emergency response; an electronic risk assessment; and contact with Mr Uzzell's family. The escort risk assessment, Person Escort Record and bedwatch logs for Mr Uzzell's hospital admission were not provided.

Recommendations

- The Head of Healthcare should ensure that agency staff are clinically competent to be assigned to the role of lead emergency nurse.
- The Head of Healthcare should ensure that when staff dispense over the counter (non-prescribed) medication, they record the reason in patients' medical records.
- The Governor should ensure that staff fully document all significant interactions and decisions in prisoners' personal records as well as other relevant documents; and implement robust auditing.
- The Governor should ensure that documents are securely stored and promptly provided to the Prisons and Probation Ombudsman following a death in custody, in line with Prison Service Instruction 58/2010.

The Investigation Process

10. HMPPS notified us of Mr Uzzell's death on 28 December 2022. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

12. NHS England commissioned an independent clinical reviewer to review Mr Uzzell's clinical care at the prison.

13. We informed HM Coroner for Avon of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Uzzell's partner to explain the investigation and to ask if she had any matters for the investigation to consider. She asked if the prison had refused a request by hospital staff to contact her and if Mr Uzzell had asked staff not to disclose that he was unwell.

15. We sent a copy of our report to Mr Uzzell's partner. Her solicitor replied on her behalf and raised several issues which have been dealt with in correspondence.

16. The initial report was shared with HMPPS. They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan is attached as an annex.

17. The IMB suggested clarification of the change of healthcare provider (paragraph 21) and the report has been amended accordingly.

Background Information

HMP Bristol

18. HMP Bristol serves the local courts and holds up to 614 adult men. Oxleas NHS Foundation Trust provides healthcare services and Doctor PA provides GP services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Bristol was in July 2023. The inspection report has yet to be published, but HM Chief Inspector of Prisons invoked the Urgent Notification process to raise immediate, urgent concerns. He listed several reasons, including that Bristol remained one of the most unsafe prisons in the country. He noted 'chronic and intractable' problems and that the prison scored the lowest healthy prison test scores for safety and purposeful activity.

20. Inspectors found that the healthcare provision was insufficient to meet the needs of prisoners. The Chief Inspector concluded that it would take long-term concerted effort to make Bristol a decent and safe prison.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2022, the IMB reported that the prison's health provision (provided at that time by Inspire Better Health) was generally good and comparable to that available in the community. The healthcare department had introduced a new application form and updated service book, which had improved the prioritisation of requests.

Previous deaths at HMP Bristol

22. Mr Uzzell was the seventh prisoner at Bristol to die since December 2019. Of the previous deaths, four were self-inflicted, one was from natural causes and one related to substance misuse. There have since been seven deaths, six self-inflicted and one apparently due to homicide. We have previously raised the issue of poor record keeping and secure retention of documents.

Key Events

23. Mr Marc Uzzell was remanded to HMP Bristol on 13 December, to await trial for several violent offences. It was not his first time in prison.

24. A nurse conducted a reception health screen. Mr Uzzell's pre-existing medical conditions included sciatica, anxiety, depression, as well as a history of self-harm and substance misuse. The nurse consulted a GP at the prison who said that Mr Uzzell did not need to undergo alcohol detoxification but should be monitored for symptoms of alcohol withdrawal. Mr Uzzell's blood pressure was raised, but he was otherwise fit and well.

25. On 14 December and 15 December, Mr Uzzell had mental health and substance misuse assessments, as well as a secondary health screen. Referrals were made to the mental health team and the physiotherapy service.

26. On 19, 20 and 22 December, healthcare staff dispensed ibuprofen and paracetamol to Mr Uzzell, but did not record why he had asked for them. On 22 December, Mr Uzzell requested a medical appointment due to sciatica in his lower back.

Events of 24 December

27. Shortly after midnight on 24 December, Mr Uzzell rang his cell bell and told staff that he had coughed up blood. Nurse A, an agency nurse, went to see him. Nurse A recorded that Mr Uzzell complained of vomiting blood and mentioned the possibility of an abdominal injury while playing sport. No clinical observations or plans for monitoring were recorded, but he gave Mr Uzzell a sample pot.

28. At around 9.00am, Nurse B assessed Mr Uzzell, as he still felt unwell. He said that he was still coughing up blood and it had become progressively worse; he had right-sided chest pains; and he had felt cold and flu symptoms for around two weeks.

29. Nurse B took clinical observations. She then calculated an overall score of 7, using the National Early Warning Score 2 (NEWS2 - a clinical assessment tool to detect acute illness). This score indicated the need for an urgent assessment by a critical care team, with the possibility of high dependency. (Later that day, Nurse B emailed the Head of Healthcare expressing concerns about Nurse A's clinical assessment of Mr Uzzell.)

30. An ambulance was requested at 9.20am and paramedics arrived at 9.38am. Mr Uzzell was taken to hospital. Although short of breath, he was alert and walked to the ambulance. Two prison officers escorted Mr Uzzell and he was double handcuffed.

31. During the afternoon/evening of 25 December, the duty governor reviewed the security risk assessment. As Mr Uzzell's condition had worsened, the duty governor authorised the removal of his handcuffs.

32. Healthcare staff obtained updates on Mr Uzzell's condition. He was diagnosed with sepsis, flu and bleeding in his lungs and admitted to the intensive care unit. (The Head of Healthcare visited him on 28 December.)

Contact with Mr Uzzell's family

33. On 25 December, the duty governor gave approval for Mr Uzzell to telephone his family, but the escort officers said that he had declined to call. One of the officers later explained that Mr Uzzell had been reluctant to speak to his family when he was first admitted to hospital as he was poorly, but had planned to contact them on Christmas day.

34. In the evening, the duty governor consulted the hospital and was told Mr Uzzell had deteriorated. He then asked prison staff to inform his family that he was in hospital. Before the prison made contact, Mr Uzzell's partner arrived at the hospital (there is no record of how she was informed). During his partner's visit, the prison's family liaison officer telephoned to introduce herself and provide contact details. She followed this up with a text message giving further information about her role and offering support.

35. Mr Uzzell did not recover and died on 28 December.

36. Shortly after Mr Uzzell's death, the family liaison officer sent a text message to his partner to offer condolences. She kept in touch over the following weeks to give advice and support.

37. In line with national policy, the prison contributed to the costs of Mr Uzzell's funeral, which was held on 8 February 2023.

Support for prisoners and staff

38. The prison posted notices informing staff and prisoners of Mr Uzzell's death and offering support.

Cause of death

39. No post-mortem examination was carried out. The coroner accepted certification by a hospital doctor that the cause of Mr Uzzell's death was cavitating pneumonia (a rare and severe complication of a lung infection).

Findings

Clinical findings

40. The clinical reviewer concluded that Mr Uzzell's care was generally good. However, due to the poor clinical response when he first reported feeling unwell, it was only partly equivalent to that which he could have expected to receive in the community.

41. In this report, we reflect the issues directly linked to the cause of Mr Uzzell's death. However, the clinical review report has an additional recommendation which the Head of Healthcare will need to consider.

Assessing and monitoring Mr Uzzell when he became unwell

42. The clinical reviewer noted that National Institute for Health and Care Excellence (NICE) guidelines on the management of acute upper gastrointestinal bleeding advises clinical observations should be taken as a minimum when a patient reports vomiting blood and they should be referred for further assessment as this could be a symptom of internal bleeding.

43. After examining Mr Uzzell, Nurse B informed the Head of Healthcare of her concern that his previous clinical observations had not been recorded by Nurse A and that he had not been discussed in the morning handover meeting.

44. Despite many attempts over several months, Nurse A initially failed to attend for interview or engage with this investigation. He maintained that he had already provided a statement to the Head of Healthcare, who disputed this. Nurse A later submitted a statement to the clinical reviewer. He said that Mr Uzzell was alert, he saw no blood in the cell and advised him to contact healthcare if his symptoms persisted. He also said that he had spoken about Mr Uzzell during the handover to healthcare day staff, but we found no evidence to corroborate this.

45. The clinical reviewer considered that the clinical assessment and actions of Nurse A were unsafe and that recording of Mr Uzzell's clinical observations would have presented a better understanding of his condition and stability. The failings meant that there were clear delays in Mr Uzzell being appropriately assessed and treated when he first reported his symptoms. However, it is not possible to say if this contributed to the outcome.

46. Nurse A's actions and lack of engagement with this investigation are currently subject to investigation by the Nursing and Midwifery Council. We recommend:

    The Head of Healthcare should ensure that agency staff are clinically competent to be assigned to the role of lead emergency nurse.

Record keeping when dispensing medication

47. Healthcare staff dispensed painkillers to Mr Uzzell three times in the five days before he became acutely unwell. The reasons for his requests were not recorded in his medical record, so we do not know whether there were any links to his illness.

48. The clinical reviewer drew attention to the NHS strategy *Making Every Contact Count*, in which clinicians are encouraged to use routine day-to day interactions to help improve patients' health. We agree with the clinical reviewer that this was a missed opportunity to discuss and record any concerns, as well as providing an accurate audit trail of Mr Uzzell's health. We recommend:

The Head of Healthcare should ensure that when staff dispense over the counter (non-prescribed) medication, they record the reason in patients' medical records.

Record keeping and the provision of evidence to the PPO

49. Prison Service Instruction (PSI) 58/2010 *The Prisons and Probation Ombudsman*, says that the PPO must have unfettered access to documents during investigations.

50. The investigation was hindered by several examples of poor record keeping and a lack of key documents in many areas. Therefore, the events described in this report are largely undocumented and we cannot be certain of the facts. Examples include:

- It was unclear whether the medical emergency procedures were followed. The control room log contained no references to either an emergency code, or to the request, arrival and departure of the ambulance. A prison manager said that the control room would have recorded this information had there been an emergency code.
- The prison was unable to find the escort risk assessment, PER and bedwatch logs for Mr Uzzell's journey and admission to hospital. We were therefore unable to establish whether the use of double handcuffs was proportionate, or corroborate the details around their removal.
- An electronic bedwatch risk assessment, dated 28 December, was mostly incomplete with no decisions recorded, no named author and it was unsigned.
- There was no record of how and when Mr Uzzell's next of kin was informed of his admission to hospital and limited information about decisions around contact before the family liaison officer was appointed.

51. Good record keeping is vital for continuity of care and shared understanding of decisions. We recommend:

The Governor should ensure that staff fully document all significant interactions and decisions in prisoners' personal records as well as other relevant documents; and implement robust auditing.

The Governor should ensure that documents are securely stored and promptly provided to the Prisons and Probation Ombudsman following a death in custody, in line with Prison Service Instruction 58/2010.

Inquest

52. At the inquest, held on 9 June 2025, the Coroner concluded that Mr Uzzell died from natural causes and that, “The delay in hospital admission increased the speed and severity of the illness and accelerated Marc’s death.”

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Independent Investigations

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