INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF A MAN ON 6 MARCH 2007,

THE DAY OF HIS RELEASE FROM HMP NOTTINGHAM

Report by the Prisons and Probation Ombudsman for England and Wales

October 2007

This is the report of an investigation into the death of a man on 6 March 2007, the day he was released from Nottingham prison. The post mortem examination showed that he died from an overdose of heroin and alcohol. He was 36 years old. I offer my sincere condolences to his family and those touched by his death.

I asked one of my colleagues to conduct the investigation, under my discretionary power to investigate deaths following release from custody. Both my colleague and I would like to thank the Governor and staff at HMP Nottingham for their ready cooperation during the investigation. I am particularly grateful to the Senior Officer who acted as the liaison officer.

Thanks also go to HM Coroner for Nottinghamshire for providing information relating to the police investigation. This was greatly appreciated.

The man was a 'revolving door' prisoner. He was institutionalised and found it difficult to cope outside of prison. He had a history of drug and alcohol use, as well as mental health problems. It is particularly challenging for staff when someone repeatedly returns to prison for short periods. Opportunities for meaningful work are clearly limited.

I conclude that health care staff dealt appropriately with him. Prior to his discharge from prison, he was provided with information that explained the dangers of taking drugs, and that his tolerance to such drugs would have been reduced.

I make one formal recommendation with regard to the recording of prescribed medication. I have also identified an area of learning with regard to the procedures for suicide and self harm reviews that I trust the Governor will address.

Some might think that the duty of care the prison had for the man ended when he was released. I was pleased to see that this was not the attitude of HMP Nottingham. They offered support to his mother, and broke the news to other prisoners. Furthermore, I judge the written information regarding the dangers of overdosing that the prison provides to prisoners on release to be an example of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman
October 2007

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SUMMARY

The man had spent many years going in and out of prison. He had a long history of drug and alcohol abuse.

Staff at HMP Nottingham knew him well. He was described as "institutionalised". His mother felt that he found it difficult to cope outside of prison.

In previous periods in custody, he had received help and support to overcome his addiction. He also suffered with depression, and was on antidepressants, mood stabilisers and antipsychotic medication. It appears that there was a good continuity of care between prison medical staff and his doctor in the community.

The man was vulnerable. He had debts with other prisoners, and when in Nottingham was placed in the vulnerable prisoner unit. At times, he was held in the segregation unit whilst waiting for space to become available. At one point he was subject to suicide and self-harm prevention procedures, but these came to an end after only a day.

Before he was released on 6 March 2007, staff had provided him with a travel warrant. He planned to return to his mother's house in Derby. He also received a notice warning him of the potential dangers of returning to drug use. This specifically explained that his tolerance level was likely to be reduced. He was issued with medication to take with him on release.

The man was freed on the morning of 6 March and travelled to Derby. That afternoon, he was found unconscious in an alleyway. Paramedics attempted to resuscitate him, but he was pronounced dead. The post mortem and toxicology reports show that he died from an overdose of heroin and alcohol.

The investigation found that he had received a good level of support from health care staff in prison. However, his short sentences had presented a significant challenge to prison staff as there was little time to work with him on the problems he faced.

I highlight two areas of good practice and make one recommendation regarding better recording of issued medication.

THE INVESTIGATION PROCESS

Since April 2004, the Prisons and Probation Ombudsman has had responsibility for investigating all deaths that occur in prisons, approved premises and immigration removal centres. The Ombudsman also has the discretion to investigate the deaths of those who have recently been released from prison. As this man died on the day of his release, this investigation was undertaken under my discretionary powers.

I appointed one of my colleagues to conduct the investigation on my behalf. She issued notices to staff and prisoners at Nottingham prison asking anyone with relevant information to contact her. Nottingham provided her with documents relating to the man's time in prison. In addition, the head of healthcare at Nottingham organised an internal review of his clinical care which was shared with my investigator. My investigator reviewed the documentation, and spoke to staff members over the telephone to clarify various issues.

One of my Family Liaison Officers made attempts to contact the man's mother to ascertain whether she would like any involvement in the investigation.

The investigator also made contact with the Derby drug action team. They review all drug related deaths that occur in the community. I agreed to share my report with them. HM Coroner for Nottinghamshire helpfully provided the post mortem report and police statements.

HMP NOTTINGHAM

HMP Nottingham was built in 1890. Since 1997, it has been a category B local prison taking sentenced and remand prisoners from the courts in Nottinghamshire and Derbyshire.

Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, conducted an unannounced inspection of Nottingham in February 2005. She reported that the relationship between staff and prisoners was, in the main, positive and supportive. The reception and induction arrangements were generally good, although the accommodation was cramped and not considered fit for purpose. Ms Owers's inspection report commended the detoxification arrangements. The healthcare department was also praised, particularly the nursing service.

The prison's vulnerable prisoner unit is based on E4 landing. It was described by Ms Owers as safe, but the regime was extremely limited and variable.

KEY EVENTS

The man was well known to staff at Nottingham. He had spent most of the last few years in prison, only being released for short spells.

The year 2007 continued in the same way. He was received into Nottingham prison on 1 January 2007. It was recorded on the reception health screen that he had no history of physical complaints but was taking mood stabilisers (Depacote), anti-depressants (Venlafaxine) and antipsychotic medication (Olanzapine). The man said he had drunk a bottle of wine and eight cans of strong lager during the preceding week. He also said that he had not used illegal drugs in the last month. It was noted that he did not appear to be actively detoxing. He told the nurse he had previously had drug induced psychosis and depression, which had led him to be admitted to Kingsway Psychiatric hospital in 1990.

When questioned about self-harm issues, he said that he had tried to harm himself outside prison. It was also noted that he had tried to take a drug overdose on 30 December 2006, but he said this had been a cry for help rather than a suicide attempt. The nurse asked whether coming into prison would make him feel like harming himself and he replied no. The nurse recorded that he appeared settled and calm, and that he did not feel suicidal. She referred him to the GP for the next day and to the community psychiatric nurse (CPN).

The following day the GP saw him. The doctor prescribed Venlafaxine and Olanzapine. The man was in a stable mood and seemed happy to wait for an assessment from the CPN.

During different spells in custody, the man had spent a number of days in the prison's segregation unit. My investigator spoke with staff from the segregation unit who knew him well. They said that, as he was often in debt with other prisoners, the safest place for him was on the vulnerable prisoner unit (E4 landing). However, the unit only has enough cells for 43 prisoners, so space is often at a premium. As a result, he was sometimes held on the segregation unit to wait for a space to become available.

At his segregation review on 3 January 2007, the man said he was desperate to see the CPN or a registered mental health nurse (RMN). He was assured that someone from the mental health team would see him as soon as possible.

A mental heath assessment was conducted the next day. The man gave a history that included drug induced psychosis, manic depression and panic attacks. He was also experiencing fluctuating moods. He said he was fed up, but did not want to be released as he had nowhere to live and needed support. He talked about the death of his brother from a heroin overdose and his fears for his own safety if he returned to Derby. The nurse concluded that he had become institutionalised and nervous about coping outside of prison,

but was not in a state of “acute crisis”. He was released from Nottingham the same day.

On 5 January, the man was again remanded to Nottingham. During the reception health screen, he said he was a binge drinker. He said he had been homeless for about a year. He provided the same information regarding his psychiatric history and medication as he had on his previous entry into Nottingham. He said that he did not feel like self-harming and the nurse felt he was calm and settled. The nurse referred him to the doctor to have his medication authorised. She noted that there were no acute medical or mental health issues, and that no self harm or suicidal thoughts had been expressed.

Following a court appearance on 8 January when he was sentenced to two months imprisonment, he returned to Nottingham. The escort staff had opened a suicide self-harm warning form due to his recent attempted overdose. However, after another health screen, it was decided that he did not need to be on formal suicide and self-harm monitoring. Again, it was necessary for him to be held on segregation unit to await a bed on the vulnerable prisoner unit. Whilst there, as per the prison policy, nursing staff checked him daily.

The man was released from Nottingham on 5 February. He was remanded yet again two days later. During a further health screen, he said he had been drinking the day before but had not used drugs. The nurse recorded that his mood was stable, he was alert and there were no urgent concerns. When asked if he had any questions he replied ‘no’. Again, he was referred to the doctor to have his medication prescribed.

On 12 February, he told staff that he was feeling low, and suicidal. He did not like being in the segregation unit and wanted to share a cell. Consequently, staff opened an Assessment, Care in Custody, Teamwork (ACCT) plan. (This is a tool used by staff to support, assess and monitor someone they believe to be at risk of suicide or self-harm.) They also found someone to share a cell with him.

The following day, a trained ACCT assessor conducted a full assessment with him and closed the ACCT. He was moved to E wing, and felt happier with staff with whom he was familiar. (There were a number of irregularities relating to the ACCT which are listed in detail later in this report.)

On 1 March, the man requested a travel warrant to Derby, saying that on release he was going to stay with his mother. The prison arranged this. He went to reception to be discharged from Nottingham on 6 March. A prison officer completed the discharge checklist. This is a useful tool to ensure that all the relevant information has been provided to the prisoner, such as the travel warrant and any licence conditions etc. The officer recorded that he had given him “Overdose Prevention Information Sheet”, and the man had signed to this effect. A copy was also saved on file.

Prior to his release he was issued Venlafaxine 37.5 mg and Depacote 250 mg. Records do not show whether he was released with this medication. The maximum amount of tablets that he could have had on release was:

- Venlafaxine 37.5 mg 42 tabs (antidepressant)
- Depacote 250 mg 42 tabs (mood stabiliser)
- Olanzapine 10 mg 21 tabs (antipsychotic medication)

After being released, he telephoned his mother to say he was coming to Derby.

At approximately 4.00pm that afternoon, he was found unconscious in an alleyway in Derby. Paramedics attempted to revive him, but he was pronounced dead at the scene.

Post mortem results indicated that the cause of death was an overdose of heroin and alcohol. The toxicology report found that that he was not a regular/heavy user of heroin. Levels of prescribed medications detected in the urine were consistent with therapeutic dosing and were not a significant factor in his death.

Prisoners on the vulnerable prisoner unit were told individually by staff and offered support. As there was no formal responsibility for the prison to break the news, I consider this to be good practice. The Governor issued a notice to staff to inform them of the man's death.

The Governor wrote to the man's mother, offering his condolences and assistance. This was both compassionate and went beyond what is formally required when someone dies following their release. I consider this to be a further area of good practice and commend the Governor's actions.

ISSUES

The man was a troubled man who struggled to cope outside of prison. In 2007, he was only out of prison for a few days at a time. Each time he was received into HMP Nottingham, a health screen was conducted.

Prior to 2007, the man had received support from drugs services in prison, and had been referred to services outside of prison upon his release. On his multiple admissions this year, he did not list drug use as a problem. He had apparently not used drugs during his short spells outside of prison. I can only assume that his abstinence meant he did not trigger a referral to prison drug services again.

Each time the man arrived in prison the doctor promptly organised his prescribed medication to ensure continuity of treatment.

He was generally held in the vulnerable prisoner unit. When this was full, he was held in the segregation unit until a place became available. No one could defend such a practice and it is manifestly very far from ideal. However, it is an almost inevitable outcome given current prison population pressures. During his time in the segregation unit, the man was seen by a nurse every day.

On 12 February, the man told staff that he was feeling suicidal and an ACCT was opened. The following day, a trained ACCT assessor conducted a full assessment with him and closed the ACCT. The assessment section of the ACCT had not been completed. The written record of the assessment was poor, and the decision to close an ACCT should have been taken a multidisciplinary team not by an individual. This was discussed with the safer custody manager who had already identified it as an issue. The safer custody manager said that he had spoken with ACCT assessor. Whilst I make no formal recommendation, the governor should satisfy himself that there are appropriate procedures in place to monitor the completion and quality of ACCT assessments. This should include ensuring documents are fully completed and that the reasons for closure are given.

Prior to his release on 6 March, staff had checked that he had somewhere to live and given him a travel warrant. They used a checklist to help ensure that they provided him with necessary information. Staff routinely provide prisoners with an information sheet, detailing the dangers of taking drugs once released and warning them their tolerance is reduced. The man signed to say he had received the information.

Nursing staff issued him with medication to take with him on release. However, the medication dispensed was not recorded in the medical record. When the police found him, they found the medication on him.

Clinical staff must ensure that medication dispensed to prisoners is recorded in the clinical record.

RECOMMENDATIONS AND GOOD PRACTICE

Clinical staff must ensure that medication dispensed to prisoners is recorded in the clinical record.

Good Practice

Although Nottingham prison had no formal need to do so, they wrote to the man's mother offering their condolences and assistance. They also broke the news to fellow prisoners on the vulnerable prisoner unit.

Nottingham issued written information in the form of the "Overdose prevention sheet" to the man, warning of the potential dangers of the decrease in tolerance to drugs.