Investigation into the death of a man whilst in the custody of HMP Nottingham in October 2010,

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of an investigation into the circumstances surrounding the death of the man, a prisoner at HMP Nottingham. The man died in October 2010. The results of the post mortem showed that the man died as a result of polydrug toxicity, meaning that two or more drugs had been taken in combination. He had overdosed on drugs in the community and had hoarded his medication whilst he was in prison. The prison's suicide monitoring procedures had correctly been put in place three times and had last been closed seven months earlier.

I would like to offer my sincere sympathy and condolences to the man's family for their loss. One of my family liaison officers contacted the man's family at the start of the investigation and I am grateful for their contribution.

The investigation was carried out by one of my investigators. I would like to thank the Governor of Nottingham and his staff for their co-operation during the course of our enquiries. In particular, I am grateful to the Governor of the wing for his full and ready co-operation during the investigation.

I also thank Nottingham City Primary Care Trust for appointing the clinical reviewer to review the clinical care that the man received while he was in custody. He had complex physical and mental health needs. Like the reviewer, I judge that he received a standard which was equitable, if not better, to what he could have expected in the community.

I make four recommendations regarding risk assessments for medications, healthcare input in the self harm and suicide prevention process, briefing locum doctors and reviewing the caseloads of the prison's mental health nurses. I recognise the good practice adopted by Nottingham in the use of restraints. I commend the engagement between healthcare staff and the man although I think that they should have been part of the arrangements to monitor the risk that he might harm himself. I also commend the actions of the staff who responded to the emergency.

The version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **July 2011**

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SUMMARY

1. The man was born in April 1958 and lived in the Nottingham area. He was married and had three grown up children. He also had two grown up children from previous relationships. The man was diabetic which affected his eyesight and mobility. He also suffered from depression and was prescribed medication by his doctor in the community.

2. On 9 April 2009, the man appeared at Nottingham Magistrates' Court and was remanded into the custody of HMP Nottingham. On arrival at the prison, the man told staff that he took medication for diabetes and neuropathic pain. He said that he had a history of mental illness and self harm and had previously been treated in hospital and was referred to the doctor and mental health team. The man returned to the same court on 25 January 2010 and received a mandatory life sentence, with a minimum term of imprisonment of 25 years.

3. The man had ongoing contact with prison healthcare staff for treatment and medication for his diabetes and depression. As a result of the man's history of self harm he was subject to the prison's suicide prevention monitoring procedures (Assessment, Care in Custody and Teamwork or ACCT) on three separate occasions. On occasions, the man exercised his right to refuse treatment and medication against medical advice.

4. At approximately 8.30am on 10 October 2010, the man was found unconscious in his cell and emergency medical assistance was called. Healthcare staff monitored the man until the paramedics arrived and took over his care. As soon as he stopped breathing, the paramedics assisted by healthcare staff, began cardio pulmonary resuscitation (CPR). Having given emergency treatment to the man for a period of time the paramedics decided to transfer him to hospital. On arrival at hospital an emergency team consultant confirmed that the man had died at 9.55am.

5. Nottingham followed the requirements of Prison Service Order 2710 'Follow up to death in custody' and offered financial assistance towards the cost of the funeral.

6. It is the clinical reviewer's opinion that the care and attention the man received at Nottingham was equitable to that which he could have expected to receive in the community.

7. I make four recommendations regarding risk assessments for medications, healthcare input in the self-harm and suicide prevention process, the briefing of locum doctors and a review of the caseloads of mental health nurses. I recognise the good practice adopted by Nottingham in the use of restraints. I also recognise and commend the quality of engagement between healthcare staff at Nottingham and the man and the actions of the staff who responded to the emergency situation.

THE INVESTIGATION PROCESS

8. My investigator visited HMP Nottingham on 14 October 2010. He studied all relevant prison records relating to the man, including his medical records. My investigator met the Governor of Nottingham, and members of the Independent Monitoring Board. He went to the wing to see the man's cell. Notices were posted to staff and prisoners in Nottingham about the investigation and inviting anyone who had information they felt relevant to the investigation to come forward. No prisoners came forward. My investigator returned to Nottingham on 2, 4 and 18 November and interviewed 13 members of staff. The interviews were recorded and the transcripts are attached to this report.

9. Nottingham City Primary Care Trust appointed the clinical reviewer, a medical practitioner, to review the man's clinical care on their behalf. My investigator discussed aspects of the man's treatment with healthcare staff at Nottingham and with the clinical reviewer. I thank the clinical reviewer for her comprehensive and considered report.

10. My investigator wrote to Her Majesty's Coroner to inform him of the nature and scope of the investigation. A copy of the post mortem report was made available. The investigator maintained contact with the Coroner to update him on the progress of the investigation. Upon completion, a copy of the investigation report will be sent to the Coroner to assist in his enquiries into the man's death.

11. One of my family liaison officers contacted the man's family at the beginning of the investigation and offered them the opportunity to raise questions and concerns for us to consider. My family liaison officer and investigator met with the man's family on 15 November 2010, and they raised the following concerns:

    - What level of care and treatment did the man receive whilst in prison?
    - What day of the week was the man given his medicine dosette box?
    - In the man's contact with healthcare staff and the mental health team were there any signs that he intended to end his life?
    - Were the man's enhanced status and privileges properly applied and given during his time in prison?
    - Did the man's cell ever get searched whilst he was in prison? If so, when and why?
    - The man told his family that he was tripped up by a prison officer, is this correct?
    - Were the belts sent into the man subsequently taken away from him?
    - Were the gloves sent into the man because of poor circulation in his hands, subsequently taken away from him?
    - The man had told his family that he might be moving prisons. Was this the case and, if so, why?

12. I trust this report answers any questions the man's family may have and helps them better understand the treatment he received and the events before and after his death.

The Man

13. The man was born in April 1958 and lived in the Nottingham area. He was married and had three grown up children. He also had two grown up children from previous relationships.

14. The man was diabetic which affected his eyesight and mobility. In addition he suffered from depression and was prescribed medication by his doctor in the community. He also received treatment at the Queens Medical Centre (QMC), Nottingham.

15. The man appeared at Nottingham Magistrates' Court on 9 April 2009 and was remanded in to the custody of HMP Nottingham. He had further court appearances at Nottingham Crown Court on 9, 23 and 24 April 2009, and was remanded in custody on each occasion.

16. On 21 December, the man appeared again at Nottingham Crown Court and was convicted of murder. When he returned to the same court on 25 January 2010, he was given a mandatory life sentence, with a minimum term of imprisonment of 25 years. The case surrounding the man's conviction had been reported extensively in the local and national press and television.

17. Whilst in prison the man was actively involved with the chaplaincy and regularly attended the bible study group and church services.

HMP NOTTINGHAM

18. HMP Nottingham is a local prison serving the courts in the Nottinghamshire area. For most of the time the man was at the jail, it accommodated 550 adult male prisoners, approximately 50 percent of whom are on remand. The remainder of the population were either convicted awaiting sentence or sentenced and undergoing assessment before being transferred to a suitable training prison. In February 2010, Nottingham became a community prison holding 1,060 prisoners. The physical expansion included a new offender management unit, reception, visits suite, health centre and workshops.

19. Her Majesty's Chief Inspector of Prisons (HMCIP) conducted an announced inspection of Nottingham in February 2010. The Chief Inspector's report made the following comments:

> "Health services were commissioned by NHS Nottingham City Primary Care Trust. CitiHealth NHS Nottingham provided primary care services and Nottinghamshire Healthcare NHS Mental Health Trust provided a mental health in-reach service.
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> "The health care centre provided GP and specialist clinics. The mental health in-reach team was based in the same building that housed pharmacy and dental services. Medicine administration and, on occasion, some minor treatments were carried out in treatment rooms on each of the wings. All areas used for the treatment and care of patients were appropriately equipped, clean and well decorated.
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> "Health services provided 24-hour cover. A range of clinics was available, including some provided by visiting specialists. Good arrangements with the PCT facilitated the acquisition of specialist equipment when required.
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> "There was an in-possession policy and steps had been taken to increase the provision of medicines in possession. In-possession risk assessments were documented and could be carried out by doctors, nurses or the pharmacist.
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> "There was a good mental health service, including six mental health nurses in primary care, who met twice weekly with the secondary care in-reach team. Routine referrals were seen within seven days and urgent ones within 24 hours.
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> "A chaplain met new arrivals as soon as possible after arrival, usually within a day, and prisoners received information about the chaplaincy on reception. They provided pastoral care to bereaved or distressed prisoners."

20. The Independent Monitoring Board (IMB) is made up of representatives from the community. The Board monitors day-to-day prison life to ensure proper standards of care and decency for all prisoners. The IMB's latest annual report,

for the period 1 March 2009 to 28 February 2010, commented on the change of role for Nottingham as follows:

> "The change of role from local to a community prison means that, in the future prisoners with short sentences, 12 months or less, will stay at HMP Nottingham and will be released directly back into their local communities. Prisoners dispersed elsewhere in the country will return to HMP Nottingham for the remaining three months of their sentence prior to release. This change from a local to a community prison has involved changes in organisation to bring the prison arrangements into line with the community it will serve. In future, the core activity of the prison will be to reduce re-offending."

21. In their report the IMB also commented on the healthcare provision at Nottingham and said:

> "The Partnership Board has been reinstated and is now meeting regularly, attended by the Governor, Head of Prison Health, senior managers from the PCT and a representative of the IMB. The PCT has carried out a thorough Health Needs Assessment of the prison following enlargement. One of the difficulties with this exercise has been the lack of solid information about the health of prisoners in HMP Nottingham. Information has been collected on the Prison Health Care System One database from its introduction in June 2007 but when compared with national statistics there are large discrepancies suggesting that staff need further training in recording health related data."

22. Prior to April 2010 the last self inflicted death in custody at Nottingham was in July 2005. The man's death was the third to occur since April 2010, the other two deaths were due to natural causes.

Assessment, Care in Custody and Teamwork

23. The rules that govern all aspects of running a prison are set out in a series of documents called Prison Service Orders (PSOs). PSO 2700 – 'Suicide prevention and self-harm management' details prison procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self harm. Any member of staff can start the ACCT process by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training.

24. After the ACCT assessment has taken place, a multi-disciplinary ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and is encouraged to contribute to the decisions being made. An ACCT CAREMAP is drawn up with details of each of the actions required to keep the prisoner safe and identifies who is responsible for carrying out each action. Case reviews are

held at regular intervals, usually monthly, to review the actions and the prisoner's level of risk.

Restraints

25. On each occasion when a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that the prisoner is in hospital and amended where necessary.

KEY EVENTS

26. On 9 April 2009, the man appeared at Nottingham Magistrates' Court and was remanded into the custody of HMP Nottingham. On arrival at the prison the first nurse who saw the man recorded that he was diabetic, registered partially sighted and walked with the assistance of a stick. The man told the nurse that he had mental health problems had a psychiatric support in the community and had received treatment at the Queens Medical Centre (QMC). The man also said that, in the weeks immediately before coming into custody, he had taken an overdose of some of his prescribed medication in an attempt to end his life.

27. The nurse recorded that the man was prescribed the following medication:

    - insulin (for diabetes)
    - metformin (for diabetes)
    - fluoxetine (for depression)
    - amitriptyline (for neuropathic pain)
    - pregabalin (for diabetic neuropathy - damage to the nerves that allow a person to feel sensations such as pain)
    - ramipril (for heart disease and high blood pressure)
    - simvastatin (for high cholesterol)
    - amlodipine (for high blood pressure)
    - tramadol (moderate to severe pain relief)
    - oxycodone (moderate to severe pain relief)
    - aspirin.

28. Due to the man's medical history the nurse referred him to the doctor, diabetic clinic and the mental health team. Due to his history of mental illness and declared attempt at self harm, the nurse opened an Assessment, Care in Custody and Teamwork (ACCT) plan. Healthcare administration staff contacted his community doctor for details of his medication and confirmed with the QMC that he was under the care of the community doctor for his diabetes.

29. Later that same evening the first prison doctor, who saw the man in his cell the man told the doctor that his wife used to monitor his diabetes and he ate regularly. He told the doctor that he felt well at that time and had just eaten a good meal. The doctor confirmed that the man's medication would be issued to him by staff each day to that he took it properly and that it was safely administered, along with a care plan to monitor his diabetes.

30. The second nurse who saw the man on three separate occasions during the night to monitor his blood sugar levels. The nurse recorded that the man had slept well and no issues were raised.

31. The next day a full ACCT assessment was undertaken by a Senior Officer (SO) and an officer together with the man. There was no member of the healthcare team present. The man said that he had been depressed all his adult life, felt isolated as this was his first time in prison and he had not had any contact with his wife since his arrest as he was unsure of what to say. He also told the

officers that he had previously taken overdoses of his medication. An ACCT caremap was put in place to support the man. The caremap suggested a referral to the mental health team, visits from the chaplaincy, access to the Samaritans and his legal representative, the provision of writing paper and envelopes and the stimulus of television, radio and music. The officers thought that the man was at low risk of self harm but nevertheless made an urgent referral for a mental health assessment. The level of observation was set at hourly throughout the day and night, with four documented conversations during the core day, until the ACCT assessment was to be reviewed three days later.

32. The same day the man was seen by a third nurse as he complained of feeling unwell. He told the nurse that he had not eaten his dinner. The nurse took the man's blood sugar level which was 2.0mmol/L (millimoles per litre – measure of sugar levels in the blood) and gave him a sugary drink. (Most healthy adults maintain glucose levels above 3.9 mmol/L. If glucose levels fall below 3 mmol/L symptoms of hypoglycemia will occur. This is an inadequate supply of glucose to the brain, the effects can range from vaguely feeling unwell to seizures, unconsciousness, and rarely permanent brain damage or death.) After five minutes, the nurse recorded that his blood sugar levels had risen to 2.3mmol/L. The nurse advised him that he should eat regular meals because of his diabetes. The nurse returned some 25 minutes later to re-check The man's blood sugar and noted that it had increased further to 4.5mmol/L.

33. That night, the second nurse saw the man at 10.18pm to check his blood sugar level, which was 6.4mmol/L. The man refused his medication of insulin, metformin and simvastatin as he said that he had diarrhoea. The nurse gave him lomperamide (for diarrhoea) and gave him two cartons of milk and two slices of toast. The nurse noted that the man had some sandwiches in his cell. The nurse told him that she would return in approximately four hours to check his blood sugar level.

34. At 2.09am on 11 April, the man used his cell bell to seek assistance as he felt light headed and dizzy. The second nurse went into the man's cell and found him sitting on the bed. His blood sugar level was recorded as 2.7mmol/L. The nurse gave him a Hypostop (glucagon based medication to prevent diabetic hypoglycemia) but he did not like the taste. The nurse then gave him two slices of toast and jam, two cartons of milk, and a large cup of sugary tea. The nurse recorded that the man was to have a Hypostop in his cell along with dextrose sweets. The nurse told the man that she would let him sleep and would return in approximately two hours to check his blood sugar level.

35. The nurse returned to the man's cell at 4.51am, recording his blood sugar level as 12.8mmol/L and gave him a packet of dextrose sweets. At 9.13am, a fourth nurse saw the man whose blood sugar level was 13.5mmol/L. The nurse advised the man to eat after having taken his insulin and provided him with bread and jam so that he could make sandwiches whenever he needed to. The man told the nurse that he no longer had diarrhoea.

36. Later that afternoon, the first prison doctor contacted the QMC regarding The man's diabetic treatment. The hospital confirmed that the man had been under the care of the community doctor but had not attended any outpatient appointments in the previous 12 months. However he had been admitted to hospital a few days prior to entering custody due to an overdose of insulin.

37. On 13 April, an ACCT review took place. At the review there was a SO and an officer and the man, but no members of the healthcare team were there. The man said that he was still overwhelmed by the situation he found himself in. He said he was unsure how he felt about self harm or suicide but he could not see how he could do it in prison. The man said that he not had any contact from his family but he knew how to contact them if he wished. The ACCT caremap was reviewed and the level of observation was maintained, with a further review to be conducted in three days time, and the level of risk remained low.

38. The next day healthcare staff received faxed confirmation of the man's medication from his community doctor's surgery.

39. During the next five days the man had daily contact with healthcare staff for the issue of his medication and checks of his blood sugar level. He could walk around the wing including negotiating the stairs without any difficulty.

40. Another ACCT review took place on 16 April with three members of the staff and the man but again without anyone from healthcare. The man said that he had no thoughts of self harm and was aware of the support that was available to him. He had a lot of medical issues and continued to receive interventions and monitoring from healthcare staff. It was agreed that the ACCT plan was to be closed as the man was aware of how to seek help and support if required. At the time that the ACCT plan was closed, the man had not been assessed by a member of the mental health team.

41. On 20 April, the man had an outpatient appointment at the QMC to review his insulin medication but he refused to attend. He signed a disclaimer to confirm that he was aware that his refusal was against medical advice, detrimental to his health and that he understood its consequences. Later the same day, a second prison doctor reviewed the man's medication and authorised a repeat prescription of oxycodone.

42. The next day the community diabetic specialist nurse, saw the man to review his diabetic medication. The nurse recorded that the man was currently prescribed the insulin Humulin R but thought that the insulin Novo Rapid would be better. This was because Insulin Novo Rapid was a safer option in the event of an overdose. It can be injected at meal times and was fast acting. The nurse also confirmed that the man was to have Levemir insulin at evening meal times. The man told the nurse that he wished to lose weight but did not want to go to the gym. The nurse noted that the man's weight was 96.6kg and reassured him that the gym staff would support him in gym activities.

43. The same day, a nurse from the mental health team, saw the man to assess his mental health. The man told the nurse that he had suffered from depression for more than 30 years and had been prescribed antidepressant medication. The man said that he had been advised by his solicitor not to speak to anyone and was frustrated by this but understood the rationale behind the advice. He told the nurse that he had felt suicidal before entering custody and had previously taken overdoses of his medication. He added that he had experimented with his medication to find the right balance which would be sufficient to sedate him whilst he took a huge overdose of insulin. The man said that he could see no way to do this in prison. He also told the nurse that he did not know how he would cope if he was convicted of the crimes for which he had been charged.

44. The recorded that the man was calm throughout the assessment but was very guarded and not willing to discuss matters fully. The nurse put a mental health care plan in place which included continuing to take fluoxetine, fortnightly sessions with one of the mental health team, the frequency of which could be increased to meet the man's need, and accessing support services such as the chaplaincy and Samaritans. Despite the man's reference to killing himself, she did not open an ACCT plan.

45. On 23 April, the second prison doctor reviewed the letter from consultant psychiatrist, dated 23 March, which had been forwarded to healthcare by the man's community doctor two days earlier. The consultant psychiatrist had seen the man on 20 March when he said that his mood was low and he wished that his life was over. He told the psychiatrist that he thought that his family would be able "to move on" if he committed suicide. The consultant psychiatrist recommended an increase in the prescribed fluoxetine to 40mg and the second prison doctor increased the dose accordingly. Despite the consultant psychiatrist's reference to the man's risk of suicide, the second prison doctor did not open an ACCT plan.

46. Seven days later, a fifth nurse saw the man and noted that he was eating and drinking normally and weighed 95.7kg, his blood sugar was 8.1mmolL and his blood pressure was 120/80. (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) The man complained of neuropathic pain (pain, numbness and tingling of all peripheral nerves) and the nurse noted that he was already prescribed a 10mg dose of amitriptyline. She referred him to the doctor to consider increasing his dose.

47. The man saw a sixth nurse later the same day to treat an ulcer on his left ankle. The nurse cleaned and dressed the wound and recorded that this was to be reviewed in seven days time.

48. On 1 May, the second prison doctor increased the man's prescription of amitriptyline from one 10mg tablet per night to two per night, in line with the nurse's recommendation. The doctor further noted that this could be slowly increased to a maximum of five if required.

49. Six days later, a seventh nurse saw the man in the diabetic specialist nurse clinic. He felt well, his blood glucose level was good and he continued to have his medication issued to him. The nurse explained the importance of consistent levels of carbohydrate in his diet. The nurse also noted that the man still experienced neuropathic pain and was prescribed amitriptyline accordingly.

50. Later that afternoon an eight nurse who saw the man to assess and re-dress his ulcerated ankle. The nurse noted that the ulceration was not caused by the man's footwear and scheduled a review in five days time.

51. On 12 May, a ninth nurse saw the man and reviewed his ulcerated ankle. The nurse recorded that his ankle had improved and renewed the dressing. Later that same evening at 10.40pm, the nurse was issuing the man's amitriptyline and observed him conceal the tablets in his hand. The man told the nurse that this was accidental. The nurse asked for his cell to be searched to look for any hidden medication, a review with a member of the mental health team and for his medication to be issued at the evening meal time.

52. The man's cell was searched the next morning and 41 amitriptyline tablets were found in one of his socks. The second prison doctor authorised that no more amitriptyline was to be prescribed.

53. Later that morning, the nurse from the mental health team conducted a mental health review with the man. He told the nurse that other prisoners called out to him from their cells and made reference to the reason he was in prison. He said that he found it strange that he could not remain anonymous in prison. The nurse told the man that his case had received a lot of publicity. The man also told the nurse that he was very disgruntled about no longer having his amitriptyline medication. The nurse asked the man if he had stored any of his medication and he replied "why would I?" He became upset when the nurse challenged him about the number of amitriptyline tablets found in his cell. The man said that he had attempted to take an overdose of medication before coming into prison. The nurse told the man that he needed to be truthful when he saw healthcare staff which he accepted.

54. As a result of his intervention with the man, the nurse from the mental health team opened an ACCT plan as he was in very low mood and at risk of harming himself.

55. That evening, a full ACCT assessment was conducted by two officers but no healthcare staff were there. The man said that he felt very low due to his court case and having to come to terms with the possibility of a very long prison sentence. He said that he had good support from his family but was unsure whether that support would be there if he was found guilty. An ACCT caremap was put in place which included hourly observations by staff, visits from his family members and the chaplaincy, reading materials and access to the Samaritans if required. It was thought that the risk of self harm was low. A review date was set for one week's time.

56. On 20 May, the man saw the second prison doctor as he complained that, despite taking other pain relief medication, he still experienced severe neuropathic pain. The doctor told the man that he could only be prescribed amitriptyline again if he was supervised when taking it at the evening meal time which he accepted.

57. The same day an ACCT review took place with two other officers and the man but no one from healthcare. The man said that overdosing was the only way that he had attempted suicide in the past and he did not see that he would have the opportunity to use this method again. He said that he felt alright at that time. The ACCT support conditions were reviewed and the level of observation was maintained with a further review to be conducted four days later.

58. A further ACCT review took place on 24 May with a SO and an Officer and the man, but no one from healthcare. The man said that he felt low one day and then fine the next. He said he had been like this for some 30 years. He said that he was happy with his medication and he had no other concerns. The SO recorded that the man appeared in good mood and set a review date in seven days time with no changes to the level of observation or the level of risk.

59. The man saw the second nurse three days later for a review of his diabetes. The nurse recorded that the man's weight was 92kg which was 3.7kg less than when he came into prison. His blood pressure was 125/86 and the nurse noted that he was already prescribed medication for high blood pressure.

60. On 30 May, an ACCT review took place conducted by with a SO and an officer and the man present but yet again without any healthcare input. The man said that he had no more thoughts about harming himself and having his medication issued by nursing staff helped to keep him safe. The SO recorded that the man was "calm and engaged well" but recommended that the ACCT plan remained open even though there was a low risk immediate of self harm. A review date was set for a week later and no changes were made to the level of observation or the level of risk.

61. Six days later the man saw the second prison doctor at 8.48am as he complained of darkening vision in the previous 24 hours. The doctor immediately referred the man to the Ophthalmic Casualty Department at QMC. An escort risk assessment was completed that authorised two officers to escort him with an escort chain which could be removed when he was being treated.

62. The man was taken to the hospital and the hospital staff diagnosed that he had macular oedema (fluid and protein deposits on or under the macula of the eye, a yellow central area of the retina) in his right eye. A referral was made for him to be seen in the ophthalmology outpatient department five days later.

63. A further ACCT review took place on 8 June, between the man, a SO and an officer. There was still no healthcare input despite the man's mental health issues. The man said that he had settled to life in prison and felt he could approach staff at any time if he had any concerns or felt low. He said he had no thoughts of self harm or suicide. The SO recorded that the man interacted

well with staff and it was agreed that it was appropriate for the ACCT plan to be closed.

64. On 10 June, the man returned to the ophthalmology outpatient department at the QMC. The escort risk assessment confirmed the same level of escort and restraint, to be removed when he was being treated. The hospital consultant, diagnosed that the man had moderate nonproliferative diabetic retinopathy (PDR - blood vessels that grow along the retina and in the clear, gel-like vitreous humour that fills the inside of the eye, which can bleed, cloud vision, and destroy the retina). The consultant recorded that the man needed to be reviewed regularly but no treatment was required at the time.

65. Between 11 June and 31 August, the man had 23 separate interventions with healthcare staff. They included diabetic reviews, medication reviews, mental health reviews and a visit from the podiatrist (foot care). During the same period he failed to attend nine scheduled appointments, including one with the optician. The man regularly attended chaplaincy services and the bible study group.

66. On 1 September, the man had an appointment with the consultant at the ophthalmology outpatient department at the QMC to review the diagnosis of PDR. However he refused to attend despite encouragement from prison staff and signed a disclaimer to that effect.

67. From 2 September to 2 November, the man had 17 separate interventions with healthcare staff. They included diabetic reviews, mental health reviews, the dentist and the optomertrist (eye care). During this same period he failed to attend two diabetic clinic appointments and two mental heath team reviews. He continued to be actively involved with activities organised by the chaplaincy team.

68. The man had another appointment with the consultant at the ophthalmology outpatient department at the QMC on 3 November to review the diagnosis of PDR. However he again refused to attend despite encouragement from staff and signed another disclaimer.

69. During the period from 4 November to 24 January 2010, the man had 30 separate interventions with healthcare staff which included doctor's appointments, diabetic reviews and mental health reviews. He declined five more appointments, two with the doctor, two with the diabetic nurse specialist and one with the 'over 50s' nursing specialist.

70. The man appeared at Nottingham Crown Court on 21 December 2009 and was convicted of murder, but was to be sentenced at a later date. He continued to participate regularly in chaplaincy activities. At interview, two officers both said that The man was seen every day. He always spoke to staff and was polite, mixed well with other prisoners on the wing and gave no cause for concern.

71. On 25 January 2010, the man reappeared at Nottingham Crown Court and was sentenced to 25 years in custody. On his return to prison he saw a second

nurse from the mental health team. The man told the nurse that he had been well aware of the length of sentence which he could expect. The nurse recorded that the man expressed no concerns.

72. The man saw the first prison doctor a week later as he complained of a frozen right shoulder and pain on urination. The doctor gave the man a depo-medrone injection (anti-inflammatory steroid medication) and also prescribed tramadol modified-release tablets (for moderate to severe pain relief) one to be taken every 24 hours.

73. The seventh nurse saw the man on 15 February. He assured the nurse that he did not have any suicidal thoughts but said that he had considered refusing all of his medication. Due to the risk that he would not take his medication, the detrimental effect this would have on his health and his low mood, the nurse opened a third ACCT plan.

74. Later that evening the initial ACCT assessment was undertaken by a SO and an Officer with the man present. He said that he "felt low and had a sense of hopelessness". He explained that this was due to a combination of his poor health, the publicity surrounding his conviction and the length of his sentence. He said that he had suffered from depression for 20 years and had overdosed in the past but did not have the opportunity to do so in prison as he was supervised when taking his medication. He told the staff that he had made a list of the medication that he would stop taking but had no other thoughts of harming himself. The ACCT action plan included a minimum of three conversations with staff during the day and hourly observations at all other times. He was referred back to the mental health team. The man was reminded of the access to the chaplaincy and the Samaritans. It was assessed that th man was at low risk of self harm. A review date was arranged for 22 February.

75. Two days later the man had a mental health review with a third mental health nurse, who recorded that the session allowed him to talk through his feelings and emotions following his sentence. He told the nurse that the most difficult issue for him to deal with was the reactions of his family. The nurse arranged to see the man again in a week's time.

76. An ACCT review took place with the man on 22 February, conducted by a SO but no other staff were there. The man said that he felt frustrated about lots of things but did not intend to take his own life. However, he felt that there was no point in prolonging his life as he had no future. The SO recorded that the ACCT plan was to remain open and reminded the man of the support available from healthcare, chaplaincy and the Samaritans. A review date was set for 1 March and no changes were made to the level of observation or the level of risk.

77. On 1 March, the ACCT review was conducted by another SO who was alone with the man. The man told the SO that he was due to see the seventh nurse later that afternoon and would tell the nurse that he intended to stop taking his medication. He said that, by not taking his medication, he would eventually die.

A review date was arranged for 8 March and no changes were made to the level of observation or the level of risk.

78. The man saw the seventh nurse in the diabetes clinic that afternoon as arranged. He was physically well but remained in a low mood. He told the nurse that he did not want to prolong his life and planned to stop taking his medication, including insulin, from the following week. He said that he fully understood that this would increase the risk of long term complications to his health. He said that he had no suicidal thoughts and was keen to continue to be supported by the mental health nurse. The nurse noted on the ACCT plan that the man intended to stop taking his medication and also told wing staff about his plan. The nurse referred the man to the doctor the next morning.

79. The next morning the first prison doctor saw the man to discuss his desire to stop taking his medication. The doctor recorded that the man was rational and realised that his health would slowly deteriorate. The doctor considered that the man was within his rights to refuse to take his medication and he could change his mind at any time. Healthcare staff would continue to offer his medication to him and provide any support that he required. During the rest of the day the man was offered his medication on three separate occasions but he only accepted the prescribed pain relief.

80. The next day the man continued to refuse his medication apart from pain relief. On two separate occasions, nurses asked to test his blood sugar levels but he refused.

81. The man had a mental health review with the third mental health nurse on 4 March. The nurse thought that he appeared calm and in better spirits than when they last met on 16 February. The man discussed, at length, the reasons for refusing his medication. He was aware of the likely deterioration to his health and the effect that this might have on his family. The nurse assessed that the man's reasoning was not impaired by any mental health disorders and would see him again in a few days' time.

82. Throughout the rest of the day, the man continued to refuse his medication or to have his blood sugar level tested. He also refused his medication the following day.

83. On 6 March, the third mental health nurse recorded that the man had changed his mind about accepting his medication after speaking to his daughter and he now wanted to resume taking it all. He took all his prescribed medication the next day and no concerns were recorded.

84. Two days later, on 8 March, the man saw the second nurse for a review of his diabetes. He said that he felt well in himself and would continue to take his medication. The nurse recorded that the man's weight was 95kg, blood sugar 7.6mmol/L and blood pressure 110/84.

85. Later that afternoon an ACCT review took place with a SO and an officer and the man but no healthcare staff. The man said that he had now decided to take his medication and felt much better. He explained that refusing his medication was a ”blip” and he knew that he could approach staff for support if he felt low. The man said that he had no more thoughts of suicide or self harm. The SO assessed that the man’s risk of self harm remained low and the ACCT plan could be closed.

86. The next day the man saw the third mental health nurse for a further mental health review. The nurse thought that his mood had noticeably improved. They discussed his medication and how it was administered. The nurse concluded that the man would benefit from having more control of his medication and having it in his own possession rather than administered by a nurse. However, before this could be arranged, a risk assessment had to be completed along with a referral to the doctor.

87. The risk assessment for the man was completed on 23 March. It noted his history of depression but that the risk that he would harm himself was low. The first prison doctor confirmed that the man could have his medication in his possession, with the exception of amitriptyline which would continue to be issued and observed by nursing staff whilst it was taken. The man was therefore allowed seven days’ medication, which was prepared in a dosette box (a sectioned box that separates out medication to be taken each day).

88. On 6 April, the man saw a third prison doctor, as he complained about falling asleep early in the evening after taking the amitriptyline at the evening meal medication round at about 5.00pm. The doctor decided that there was no reason why the man should not have the amitriptyline together with his other medication at night time, including insulin, and amended the prescription accordingly.

89. From 7 April until 15 July, the man had 28 separate interventions with healthcare staff including doctor’s appointments, diabetic reviews, mental health reviews, and appointments with an optician and a podiatrist. He continued to regularly participate in chaplaincy organised activities and no concerns were raised by wing staff.

90. On 16 July, the second prison doctor attended a Primary Care Turst (PCT) medication risk assessment meeting, to consider the medications which should not be given to prisoners unless they were supervised. Amitriptyline was assessed as a medium risk medication and could therefore be prescribed for prisoners to have in their possession. Accordingly, the man’s prescription of amitriptyline was amended so that he could have it in his possession in his cell, along with the other medication in his dosette box.

91. Eleven days later, the man saw the second prison doctor because he had experienced paresthesia (pins and needles) in his left hand for seven days. The doctor thought that this was linked to the man’s long standing neuropathy and recommended that he should wear a wrist/hand support for two months. If

this did not ease the man's discomfort, then a referral to the hospital would be required.

92. The seventh nurse saw the man for a diabetic review on 9 August. His weight had increased to 98kg. He told the nurse that he ate two packets of biscuits a week and drank several bottles of fresh orange juice. The nurse advised the man to stop drinking the orange juice and have no more than one packet of biscuits per week. The nurse also stressed to him the need to exercise more.

93. Two days later the man went back to the QMC for an appointment with the hospital consultant at the ophthalmology outpatient department. The escort risk assessment confirmed the previous level of escort and the restraints which were to be removed when he was being treated. The hospital consultant assessed that the sight in the man's right eye would benefit from argon laser treatment (lasers allow precise treatment of a variety of eye problems without risk of infection) which was to be arranged for a later date.

94. The next day, a fourth mental health team nurse conducted a mental health review with the man. The man told the nurse that his memory was not as good as it was before he came into prison but there was no family history of dementia. The nurse asked him if he did puzzles and crosswords but he said he did not. The nurse was concerned that the man's symptoms might be signs of dementia or brain disease, so recorded that he would discuss his case with the doctor.

95. On 24 August, the man was randomly selected for drug testing as part of the prison's mandatory drug test policy. At interview, the second governor explained that a percentage of prisoners are chosen at random by computer to be tested for drugs each month. Prisoners who have prescribed medication are still tested to confirm that they have not taken any illicit drugs. The test showed that the man had only taken his prescribed medication.

96. Nearly three weeks later, on 6 September, the man saw the fourth mental health nurse as he complained of a headache for the previous week. The nurse took the man's blood pressure which was 132/98. The same nurse saw the man on 9 and 14 September and on each occasion recorded that his blood pressure was 142/110. Due to his consistently high blood pressure, the nurse referred the man to the doctor. The second prison doctor saw the man on 16 September, and increased the man's prescribed dose of ramipril from 5mg to 10mg. The doctor requested that the man's blood pressure was checked each week and the ramipril medication would be reviewed in six to eight weeks.

97. The next day the third mental health nurse saw the man for a mental health review. The man told the nurse that he was worried that his short term memory loss was an early sign of dementia. The nurse told the man that it was possible that his memory loss was a side effect of depression and that counselling was to continue.

98. On 27 September, the man saw the seventh nurse as he complained again about headaches. The nurse noted that the man had a recent increase in the

prescribed amount of ramipril. His blood pressure was 160/100. The nurse also noted that the man's blood sugar levels were well controlled, although he appeared to be gaining weight. The nurse referred the man to the doctor.

99. The second prison doctor saw the man three days later. His blood pressure was 168/96. The doctor repeated that it was to be checked weekly and he would be reviewed four weeks later when the change in the ramipril dosage should have taken effect.

100. Between 1 October and 9 October, no interventions between healthcare staff and the man took place including the blood pressure checks instructed by the second hospital doctor. There is an entry in the prescription chart that the man was issued with a seven day supply of medication in a dosette box on 7 October. There is no indication that wing staff were concerned and no concerns are recorded in the wing history sheets. The man continued to participate in chaplaincy activities. At interview the Quaker Chaplain, said that the man had given no suggestion that he was going to harm himself or take his own life and, if she had any concerns, then she would have informed staff immediately.

Events in October

101. At approximately 8.30am, an officer went to unlock the man's cell for breakfast. During interview for this investigation, the officer said that she could hear the man snoring as she approached his cell door. On opening the cell observation hatch, the officer could see the man lying on his bed on his right hand side, with his headphones on. The officer called to the man but got no response. The officer opened the cell door and went inside. She called to the man again but he continued to snore. The officer said that there did not appear to be "any cause for emergency" at that stage, and she thought that he was in a deep sleep. She left the cell and went to ask her colleague to help her wake the man up.

102. Her colleague told my investigator that she was detailed to supervise prisoners collecting their medications from the treatment room that morning, which was directly opposite the man's cell. From where she stood, she could hear the man snoring and the officer who had unlocked the man's cell calling to him to wake up. The officer asked her to help wake the man and they went into the cell together. The colleague said that it was not unusual for the man to have his headphones on listening to music. The officer who had unlocked the man's cell moved the man's headphones to one side and called good morning to him but still got no response. The colleague touched the bottom of the man's feet but he did not respond. The officer who had unlocked the man's cell explained that the man was usually up and ready in the mornings and, as he had failed to respond, she thought that something was not right. The officers went to the treatment room to get assistance from healthcare staff. The SO who was on the wing had heard the officers calling to the man so he also went into the cell and attempted to wake him but without success.

103. The seventh nurse and a Healthcare Assistant (HCA) were working in the treatment room that morning. Officers explained that the man was breathing but they could not wake him and asked for help. The nurse asked the HCA to go and check his blood sugar level as he was diabetic and might be in a diabetic coma. During interview, the HCA told my investigator that when she went to the man he was on his bed and snoring. She attempted to wake him but without success. She took the man's blood sugar level, which was recorded as 12mmol/L, and immediately went back to the treatment room to tell the seventh nurse the result. At interview, the nurse said that the blood sugar level was not dangerously high and it gave her no concerns.

104. However, the nurse thought it was unusual for the man not to be first in the queue in the mornings for his medication, so she went with the HCA to his cell. On arrival at the man's side, the nurse saw his chest rise and fall and she attempted to wake him by gently shaking his shoulders and calling his name. His breathing remained deep and he continued to snore. The nurse noted that the man had a good colour but there was a lot of saliva on his pillow. The nurse checked the level of insulin in the man's blood which was normal and took his blood pressure which was 90/60 (low blood pressure) with a high pulse rate of 90.

105. The nurse said that she noticed that the man's hands and fingers were red and swollen and lifted his arm which just flopped back down. The nurse went on to say that she found the man's dosette box and noted that it was empty apart from a few metformin and simvastatin tablets. There were no amitriptyline tablets in the box. At this point, the nurse assessed that an emergency ambulance was required. The time of the nurse's request for an ambulance, made on the radio, was recorded as 8.56am.

106. Whilst waiting for the paramedics to arrive, the nurse continued to monitor the man's condition. He continued to snore and breathe deeply and his pulse rate increased to 110. The nurse said that she did not move the man as his airway was good, he had a pulse and she wanted to sustain that.

107. The paramedics arrived at 9.02am and took over the man's care. Shortly after their arrival, he stopped breathing and the paramedics, assisted by healthcare staff, began cardio pulmonary resuscitation (CPR) (Cardio pulmonary resuscitation is a technique whereby oxygen is pumped around the body using a combination of chest compressions and rescue breaths.) The paramedics moved the man out of his cell into the wing to give them more room to work. Having given emergency treatment, the paramedics decided to transfer him to hospital.

108. An escort risk assessment was made which authorised three officers to escort the man (due to the potential for media interest) but without using restraints. Three officers escorted the man in the ambulance. At interview one of the officers said that he and the other two officers helped the paramedics transfer the man to the ambulance on a stretcher trolley.

109. The ambulance left the prison at 9.43am and the paramedics continued with CPR on the way to the hospital. On arrival at QMC, two officers got out of the ambulance while an emergency team from the hospital including an accident and emergency consultant, assessed the man. At 9.55am, the accident and emergency consultant confirmed that the man had died. One of the officers asked the accident and emergency consultant to make an entry in the Person Escort Record Form (PER) to confirm his assessment and the time of death. The officers contacted the duty governor at the prison to tell them that the man died.

110. A hot debrief was held in the prison with the staff involved in the incident. Members of the care team were available to offer support to staff and a member of the care team went to the QMC to offer support to the escort officers. (Hot debriefs should be held as soon as possible after a death in custody to ensure that staff have an opportunity to discuss any issues arising.) Prisoners were offered support from staff, the chaplaincy and made aware of the services provided by the Samaritans.

Family contact

111. A governor and a nurse were appointed as the prison's family liaison officers and left in the early afternoon to go to break the news to the man's wife. On arriving at the address at approximately 2.00pm, they found no one at home. They then went to the man's daughter's address but found no one at home there either. They returned to the man's wife's home, but she was still not in. The governor obtained a mobile telephone number from a neighbour and was able to speak to the man's wife and asked her to return home as soon as possible. The governor and the nurse waited at her home until she arrived, when they broke the news of her husband's death and offered condolences and support.

112. In the days that followed the governor maintained regular contact with the man's wife and the prison offered financial support towards the cost of funeral expenses. I am satisfied that staff at Nottingham appropriately followed PSO 2710 'Follow up to death in custody'.

ISSUES

Clinical care

113. The clinical reviewer, has carefully considered the overall clinical care given to The man and concludes:

> "In my opinion the man received clinical care equal to or exceeding that which he would have had as a patient in the community. He was able to access clinical nursing care more readily than community patients and was followed up appropriately and had easier access to help from mental health nurses if he wished to use their support."

114. There were occasions during his time at Nottingham when the man refused to attend hospital appointments and take his medication. Healthcare staff explained the seriousness of the consequences of refusing treatment and medication.

115. The clinical reviewer has, in her report, examined and commented upon specific areas of care that the man received whilst he was at Nottingham. I include her comments in the following sections. The clinical review is the first annex to this report.

Assessment, Care in Custody and Teamwork

116. The man had a history of self harm and had planned how to take his own life. Staff at Nottingham correctly opened an ACCT plan on three separate occasions when it was assessed that he was at risk of self harm. The last ACCT plan was closed on 8 March 2010 and there were no further concerns raised regarding the man's risk of self harm.

117. I am satisfied that, despite his history, the man gave no indication to healthcare staff, uniformed staff or the chaplaincy that he was planning on taking his own life in the weeks immediately leading up to his death.

118. However, I am very concerned that healthcare staff were hardly involved in any of the ACCT assessments or review processes. On each occasion it was healthcare staff who correctly instigated the ACCT process and they continued to have frequent contact with him for his various physical and mental health conditions. In the clinical review the clinical reviewer states:

> "I note from the medical record and the interview transcripts that the man was on three separate ACCT documents due to concerns about self harm – the second ending in March 2010 following the period of medication refusal. Instigation of these ACCTs seems appropriate and good practice. However, I understand that after opening each ACCT by healthcare they had no further input and were not involved in the decision to close the ACCT process. As a clinician this seems a missed opportunity to share information between different 'agencies' – in this case non clinical (ie prison) staff and healthcare staff. In the community it is good practice for

such liaison to happen between different agencies for example in the form of case conferences or multi disciplinary team meetings, particularly in complex high risk psychiatric cases with physical co-morbidities (I would consider the man to fall into this category)."

119. There is clear guidance contained in PSO 2700 'Suicide Prevention and Self Harm Management' as to which staff that need to be involved at the first case review. The guidance states:

> "The Unit Manager must chair the first Case Review and appoint a Case Manager (it may be the same person) (minimum grade of Senior Officer or Band 5 Nurse). Where the at-risk prisoner has severe mental health problems, the case manager can still be from the unit on which they are located. However in this event, the mental health professional must be invited to case reviews (and given as much notification as possible of the review time) and the Case Manager must seek their advice about how the individual is managed.
>
> "Where it is clear that there are mental health or drug/alcohol issues, an appropriate member of healthcare staff must be invited to make a contribution to the first review, in writing or by telephone if they are unable to attend at such short notice."

120. For the staff to be involved in subsequent ACCT case reviews the guidance contains the following:

> "One of the attendees must be the named Case Manager (and failing that, the Manager responsible for the prisoner's location), one a residential officer who works in the area where the prisoner is located and the other an appropriate member of non-discipline staff. Where referrals have been made to specialist staff or those staff are already involved in the care of the prisoner, they must be invited to attend the next case review. Where attendance is not possible, they must provide input in writing or by telephone to that case review (and subsequent reviews if requested)."

121. It is my opinion that, given the man's mental health issues and previous history of self harm, a member of the mental health team should have been involved throughout each of the three ACCT processes. Given that they saw him so often, I expect that they would have been able to offer further insight into his moods and the risk that he might harm himself. There is no record that healthcare staff were even consulted before closing each ACCT document.

122. In addition, the ACCT reviews of 22 February and 1 March 2010 were each conducted by a senior officer on their own and this is not acceptable. I therefore make the following recommendation:

I recommend that the Governor and Head of Healthcare review the ACCT process to ensure that all the appropriate staff are involved at each review stage, in particular for prisoners with complex mental health problems.

Supervising the man taking his medication

123. On entering custody the man was supervised when taking his medication due to his history of self harm and his previous planned method of overdosing on medication as the means to end his life. Despite this supervision, the man was found to have hoarded 41 amitriptyline tablets in May 2009.

124. The second prison doctor told the investigator at interview that prisoners are assessed for the risk to be allowed to have medication in possession. If they are assessed as low risk, then they are permitted to have up to a maximum of two weeks of low risk medication and one week of medium risk medication. A risk assessment for in-possession medication for the man was conducted on 23 March 2010, a little more than three weeks after the third ACCT plan was closed. It was assessed that the man was of low risk and so he was allowed to have medication in his possession. At the time of the man's assessment amitriptyline was classed as a high risk medication and he continued to be supervised in having this medication.

125. However, in July 2010, the PCT conducted a review of medications, amitriptyline was down graded to a medium risk medication and deemed safe to give prisoners in their possession. As a result amitrptyline was given to in possession to all the prisoners who were prescribed it. This included the man, despite his previous record of hoarding medication.

126. I am very concerned that in the man's case, despite having tried to harm himself, despite having hoarded amitriptyline before and despite being on three separate ACCT plans, amitriptyline was prescribed to the man in possession without any further assessment.

I recommend that the Head of Healthcare review the procedures and training for staff involved in conducting in-possession medication risk assessments.

127. The second prison doctor did go on to explain at interview that the man could have easily taken a fatal dose of insulin at any time as the amount he had in his possession, 300 units, would certainly have been a toxic dose.

128. In the clinical review the clinical reviewer considered the issues and outcome of the man taking an overdose of his medication. In her report the clinical reviewer said:

> "I understand that the dose it is thought that he took ie 5 x 75mg should not have proved fatal but of course he may have been able to hoard previous supplies despite the risk of spot cell checks. Other drugs were also missing from the dosette and found in his blood stream at post mortem although not in toxic amounts but which could have possibly suppressed his respiratory system and compromised survival.
>
> "… where a patient has such a strong history of medication overdose and premeditated intent of suicide, where several health care professionals

have clearly stated grave reservations about self administration of potentially dangerous drugs, clinicians need to be extremely cautious about allowing patient autonomy and clinicians with little or no prior knowledge of the patient should not, where possible, make unilateral decisions about such autonomy without consultation.

"I am concerned that a locum doctor felt she was able to change amitrptyline to a self administered night time dose without this being further discussed (and despite the very recent written concerns from other health professionals regarding manipulative behaviour around medication issues) when she did not know the patient well and the records suggest she only met him once."

129. I agree with the man's comments and make the following recommendation:

I recommend that the Head of Healthcare should ensure that a robust system is in place for briefing locum doctors, and other visiting health professionals, about at risk or vulnerable prisoners.

Mental health care

130. The man was appropriately referred to the doctor and the mental health team regarding his history of mental illness on the day that he came into prison. He was seen later the same day and there were well documented interventions with members of the mental health team throughout his time in custody. The healthcare team ensured that the full details of the man's mental health history, treatment and medication was obtained from his doctor in the community and hospital specialist.

131. The third mental health nurse told the investigator at interview that he had built up a good rapport with the man during his counselling sessions. Given the quality of their relationship, it is particularly disappointing that the nurse did not take part in the man's ACCT plans. The nurse said that initially the man had found it difficult to cope with life in prison but appeared to have overcome his difficulties through participation in chaplaincy activities.

132. The nurse commented at interview that each member of the mental health team did have a large caseload and that not all informal conversations with prisoners were recorded. When asked if the man gave any indication in the weeks leading up to his death that he was going to take his own life the nurse said:

"I never at any point felt alarmed about him or felt that things had significantly changed in terms of his mental status, certainly in terms of developing any ideas of doing any harm to himself."

133. The clinical reviewer has considered in detail the mental heath care that the man received and has made the following comment:

"From the medical records it is clear that the man had a history of profound depression, he was under the care of a psychiatrist and had a

history of medication overdose (amitriptyline, fluoxetine, pregabalin, tramadol and insulin) within the few weeks before his arrival at HMP Nottingham. At initial assessment the records state that he had suicidal thoughts. Throughout the medical record there are frequent documentations of face to face consultations with psychiatric nurses and other health care staff where mental health issues are described in some detail. These suggest an individual who is very often troubled and distressed, very often low in mood and contemplating a bleak future and having thoughts of self harm. There were also significant life events for the man.

"A patient's mood and situation change, as may have done in this case regarding worries about dementia and a pending divorce, and their behaviour may become unpredictable again. In this case the consequence was fatal."

134. I am satisfied that the level of intervention between the mental health team and the man was appropriate to meet his needs. I accept that the man gave no sign to staff that he was contemplating taking his own life in the weeks before his death.

135. I am concerned however, that not all the informal interventions with the mental health team were recorded in the man's case. Whilst I believe that these would not have affected the outcome, it is essential that all interventions are recorded to provide a complete record of a patient's care.

I recommend that the Head of Healthcare should regularly review the mental health case loads to ensure safe practice. Nurses should record informal discussions in the medical record to provide a complete picture of the prisoner's mental state, particularly for other clinicians involved in their care.

Diabetic care

136. When considering the man's care and treatment of his diabetes, the clinical reviewer said:

"The medical records indicate that the man had comprehensive diabetic care throughout his time at HMP Nottingham. NICE guidelines regarding the care of insulin dependent diabetic care have been followed.

"On a day to day basis the prison staff responded appropriately to situations where the man felt his sugar levels were dropping, and he appears to have had access to appropriate foods in the event of onset of a hypoglycaemic episode.

"The man had been experiencing side effects from metformin and this was picked up by the clinical staff and the formulation of the drug changed to good effect."

137. I agree with the clinical reviewer that the management and treatment of the man's diabetes were appropriate to meet his needs and safeguard his wellbeing.

Neuropathic pain management

138. In respect of the man's neuropathic pain management and medication, the clinical reviewer states that:

> "The medical records indicate that the man was reviewed appropriately with regard to symptoms and medication for his neuropathic pain.
>
> "I note that the dose of amitriptyline was increased on three occasions as a result of clinical assessment and I consider these increases appropriate.
>
> "Overall I consider that the health care team provided satisfactory care for monitoring and treatment of the man's peripheral neuropathy."

139. I am pleased to note from the well documented medical records that staff at Nottingham ensured that the man's neuropathic pain was monitored and managed appropriately.

Emergency response

140. The staff response to the man's need for assistance was swift and professional. In particular I wish to recognise the efforts of the officer who unlocked the man that morning and her colleague who, based on their knowledge from dealing with the man every day, correctly identified that he was not just asleep but there was something wrong with him and summoned medical assistance. This is commendable for two new serving officers still in their probationary year. Unfortunately I have investigated other deaths when prisoners were snoring heavily and no action was taken. Even though the man could not be revived, I believe that the response by the two officers helped to ensure that everything possible was done for him.

141. The clinical review makes the following comments regarding the emergency response:

> "When the man was found unconscious appropriate action was taken. Initially this was by the non clinical prison staff who despite their junior position recognised that the man's unrousable state was abnormal, tried to rouse him appropriately and then summoned clinical help. Blood pressure and pulse and respiratory rate were taken. A blood glucose was taken quickly to establish whether hypoglycaemia was a cause. It was very rapidly established that amitriptyline tablets were missing from the dosette tray. Thus a presumption that an overdose had been taken was made quickly. The paramedics were called without delay and arrived promptly. Before they arrived the man stopped breathing and CPR was commenced. A defibrillator was put in situ appropriately.

> "The records clearly record the sequence of events and actions carried out and I commend the staff for their judgement and clinical response in this emergency situation."

142. The clinical reviewer and I recognise and commend the actions of all the staff who responded the emergency situation.

Use of restraints

143. Unfortunately there have been too many reports where the Ombudsman has been critical of the use of restraints when prisoners are under escort in outside hospital. It is pleasing therefore to recognise that Nottingham ensured that the man was treated with dignity and respect and that no restraints were used when he was taken by emergency ambulance to hospital.

144. I would also like to recognise the good practice adopted by one of the officer who escorted the prisoner in the level of detail that he entered on the Person Escort Form. Not only did this ensure that he provided a contemporaneous record of the sequence of events once the man arrived at the hospital, but also the length of time the escorting officers remained with him until they returned to the prison.

Other family issues

Allegation of being tripped by a member of staff

145. The man's family said that he alleged that he had been deliberately tripped by a member of staff, but he did not say exactly when this took place or give the name of the member of staff involved. There is no record of the man making a complaint that he had been tripped by a member of staff.

146. There is a complaints procedure in place in prisons where prisoners can raise a concern or complaint in writing to the Governor of the prison. The procedure is explained as part of each prisoner's induction and should be publicised on each prison wing. Each complaint is recorded and then investigated, with the prisoner receiving a written response of the outcome of the investigation.

147. The governor in charge of the wing confirmed at interview that he used to be the governor in charge of the wing where the man lived and knew him from there. The governor thought that the man would have been likely to have complained, and rightly so, if there had been such an incident. There is no record that the man complained about being tripped by a member of staff, and the investigator could find no evidence that this happened.

Enhanced status and privileges

148. The man's family wished to know if his enhanced status and privileges were properly applied and given throughout his time in prison. The investigator has looked at the records and confirmed that there was only one occasion when the

man was not allowed to have association as an enhanced prisoner. He was granted enhanced status and privileges throughout his time at Nottingham. The one occasion, identified by the investigator, was on 23 August 2010 when none of the enhanced prisoners on the man's wing were allowed evening association due to staff shortages.

149. The governor of the wing explained that an enhanced prisoner would have association every day whereas a standard prisoner would only be permitted association every other day. However there are rare occasions where, due to staff shortages on a particular evening, some prisoners would not get association. He confirmed that this was the reason why the man did not have evening association on 23 August.

Non receipt of property

150. The man's family were concerned that he did not receive two belts that were taken into the prison for him.

151. A prisoner's personal property is logged on individual property cards (F2056C and F2056D). Upon review of the man's property card, the investigator found that the man received two belts while at Nottingham, the first on 14 May 2009 and the second on 11 September 2010. When the belts were given to the man, he signed to say he had received them.

Permission to wear gloves

152. The man told his family said that he had not been allowed to wear the gloves which he used to reduce his neuropathy pain. The investigator found a complaint that the man had made against unidentified members of staff who commented on him wearing gloves. The incident was investigated by the prison's Diversity Manager, who replied to the man. She explained that it was difficult to investigate his complaint because he was unable to identify who the members of staff that made the comments. However, if he could identify the staff, the matter would be fully investigated. There is no record that the gloves were taken from the man.

153. At interview Governor Foster confirmed that the man made this complaint on 10 February 2010 and had been unable to identify the members of staff. The governor of the wing explained that if there was a medical reason why a prisoner was required to wear gloves then it would be allowed.

Transfer to another prison

154. The man's family were under the impression from the man that he was to be moved to another prison. There was no evidence that the investigator found that indicated that such a transfer was planned.

155. The governor of the wing explained at interview that Nottingham is a community prison that serves the courts of Nottinghamshire and Derbyshire. A remanded or sentenced prisoner will be sent to Nottingham initially and those with a

sentence of less than one year remain there. A prisoner with more than a year's sentence would be considered for transfer. As the man was serving a sentence of at least 25 years, he would have been transferred in due course, to a prison that ran appropriate offending behaviour courses identified as part of his sentence plan. His records show that the man was assessed in May 2010 and the prisons identified for his sentence progression were HMP Ryehill and HMP Long Lartin, which are both in Warwickshire, and HMP Isle of Wight.

156. The governor confirmed that the man would have known which prisons were being considered for him, but it could take up to 12 months before a place became available. No plans for a transfer had been made at the time of his death.

CONCLUSION

157. I judge that attention was paid to the man's health needs and appropriate treatment and care was provided. I agree with opinion of the clinical reviewer that the standard of health care the man received at Nottingham was equitable, if not greater, to that which he could have expected to receive in the community. There were occasions where the man exercised his right to refuse treatment and medication even though this was against medical advice. I commend the quality of engagement between healthcare staff at Nottingham and the man.

158. The man was correctly placed on the ACCT suicide monitoring process due to his history of self harm. However, I am concerned however that there was no mental health team input into any of the ACCT processes. The ACCT arrangements are designed to be multi disciplinary so that a holistic assessment can be made of the prisoner's needs and appropriate support provided. Whilst I am pleased that the man had a good relationship with the mental health nurse, it is unfortunate that the nurse did not contribute to any of the three ACCT plans. I am also concerned about the appropriateness of the assessment for in possession medication given the man's history of self harm and hoarding of medication.

159. I believe that the man was treated with dignity and respect both at Nottingham and when he was taken to hospital. Following the man's death I am satisfied that Nottingham appropriately followed the guidance given in PSO 2710, 'Follow up to death in custody'.

RECOMMENDATIONS

1. I recommend that the Governor and Head of Healthcare review the ACCT process to ensure that all appropriate staff are involved at each review stage, in particular in cases that involve prisoners with complex mental health problems.

   Accepted

   Safer custody SO attends morning briefing regularly. HC duty manager to check clinical notes and arrange healthcare attendance where input would be beneficial.

2. I recommend that the Head of Healthcare review the procedures and training for staff involved in conducting in-possession medication risk assessments.

   Accepted

   Staff receive regular training (fortnightly in medicines management to include all standard operating procedures. The mental health nurse that worked with the patient was fully aware of the policy and procedures, and the in possession status of the medication was changed in an agreement with the patient to increase his level of control as part of the rehabilitation and therapeutic intervention. However, we will revise the in possession risk assessment to highlight where the risk status is over ruled by the prescriber for those who administer, and will continue with regular education and updates for staff.

3. I recommend that the Head of Healthcare should ensure that a robust system is in place for briefing locum doctors, and other visiting health professionals, about at risk or vulnerable prisoners.

   Accepted

   Locum doctors are no longer in use at HMP Nottingham. However, in the event that this occurs, an experienced member of staff will work with the doctor to ensure that they are fully aware and following the agreed standard operating procedures.

4. I recommend that the Head of Healthcare should regularly review Mental Health Nurse case loads to ensure safe practice and for nurses to record informal discussions in the medical record to assist building a complete picture of a patient's mental state particularly for other clinicians involved in the patient's care.

   Accepted

   Mental health case loads continually reviewed by the Team Leader for Primary Mental Health. Review of individual case loads to be included in monthly staff supervision time.