PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in October 2014 at HMP Nottingham

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, who died of a twisted bowel in October 2014, at HMP Nottingham. He was 46 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at the prison was undertaken. It is disappointing that the prison was unable to provide the investigator with all the data requested.

The man had been at Nottingham since 4 July 2013. He had a history of substance misuse and had successfully completed a methadone detoxification programme. On the morning of his death, he complained of stomach pains. Shortly afterwards, he collapsed on the wing. He recovered sufficiently to be able to walk to the healthcare unit where a nurse assessed him. No one told the nurse that he had collapsed. A doctor prescribed medication for stomach pain on the nurse's advice, but did not examine him.

Later that morning, the man collapsed again. A nurse took him to his cell and gave him his medication. Just after midday, he fell out of bed, banged his head and was unresponsive. An officer radioed a code blue emergency (indicating a prisoner is not breathing or unresponsive) and asked the duty nurse to attend. The duty nurse did not come immediately but, after a second call, other nurses arrived quickly and began cardiopulmonary resuscitation. Paramedics arrived and took him to hospital. He did not respond to treatment and hospital doctor confirmed that he had died.

The nature of the condition from which the man died can develop suddenly and deteriorate rapidly and I understand it would have been difficult to predict or prevent his death. However, the clinical reviewer did not consider that the standard of care he received in prison was equivalent to that he could have expected to receive in the community. He was concerned that a doctor did not examine him, although he had collapsed twice, and about the qualifications of nurses working in the prison's healthcare unit to deal with acute illness. Although it did not affect the outcome, I am concerned about the delay in emergency response nurse attending. The investigation also identified a need for better family liaison arrangements.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2015**

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SUMMARY

1. On 4 July 2014, the man was remanded to HMP Nottingham. He successfully completed a methadone detoxification programme by 30 July. His community GP records indicated a history of indigestion and duodenitis (an inflammation of the first part of the small intestine) and that he had had a positive test for helicobacter pylori (a bacterial infection that can cause inflammation of the stomach and duodenum). The information from the GP's summary was not entered in his prison medical record.

2. At 7.50am on a morning in October, the man complained of stomach pain. At 8.05am, he came out of his cell and appeared well, but at 8.20am, he collapsed. A nurse asked an officer to take him to the healthcare unit. He was able to walk without help to the healthcare unit, and told the duty nurse he had been sick in the night and had a griping pain in his stomach. He did not mention that he had collapsed earlier. The nurse examined him and a doctor prescribed medication for stomach pain, on the advice of the nurse. The doctor did not examine him. The nurse told him to rest and keep hydrated.

3. At 10.03am, the man collapsed again. A nurse helped him back to his cell, and gave him the medication the doctor had prescribed. He said he did not want any lunch.

4. At 12.10pm, the man fell out of bed and was unresponsive. An officer radioed a code blue emergency and also asked the duty nurse (the first emergency responder) to attend. A mental health nurse was on the wing at the time and assessed him. She asked the officer to call the duty nurse again as he had not arrived quickly. Other nurses were concerned when they heard a second call and went to the wing, taking emergency equipment.

5. At 12.16pm, the man stopped breathing, and nurses began cardiopulmonary resuscitation. They attached a defibrillator, which detected no shockable heart rhythm. The duty nurse did not arrive until 12.26pm. Paramedics arrived at 12.30pm and took him to hospital. At 1.12pm, a doctor pronounced him dead.

6. The clinical reviewer considered that, because of the cause of death, the outcome would have been the same, but did not consider that the standard of care the man received at Nottingham was equivalent to that he could have expected to receive in the community. He had a number of concerns including poor records and communication and a lack of training. We are concerned about the length of time it took the duty nurse to respond to the emergency and that initial communication with his family after his death was poor. We make four recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed ten members of staff at Nottingham in December 2014 and January 2015. We are concerned that, despite repeated requests, the prison did not provide CCTV footage or cell bell records.

9. NHS England commissioned a clinical reviewer to review the man's care at the prison.

10. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation who provided the cause of death. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's son, his nominated next of kin to explain the investigation process. He asked why healthcare staff had not observed his father after he had complained of sickness the night before his death.

12. The man's family received a copy of the draft report. They did not make any comments. The prison also received a copy of the draft report and the response to the recommendations has been added to the end of the report.

HMP NOTTINGHAM

13. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire and holds over 1,000 men.

14. Nottinghamshire Healthcare Trust provides health services at the prison. There is no inpatient unit. Prisoners who need nursing care are located in an enhanced care area on F Wing, where nurses are on duty 24 hours a day. Prisoners on detoxification and integrated drug treatment system programmes are supported on A Wing.

Her Majesty's Inspectorate of Prisons

15. The most recent inspection of Nottingham was in September 2014. The Inspectorate noted that an experienced nurse manager led service delivery, but staff vacancies had affected provision and waiting times. A core group of flexible and well-motivated staff, supported by regular agency staff, and primary mental health nurses covered all essential activities and were available twenty-four hours a day. All new arrivals were screened for substance misuse needs at reception, although those arriving in the afternoon had to wait too long to see a doctor.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report, for the year to February 2014, the IMB repeated previous concerns about the lack of healthcare staff involvement in prisoner induction programmes. The IMB noted that an increasing reliance on agency healthcare staff had the potential to affect the continuity of care for prisoners.

Previous deaths at Nottingham

19. The man's death was the fifth from natural causes since 2010 at Nottingham. We have previously identified the need for all available information about a prisoner's health and risks to be recorded and shared quickly with relevant staff.

KEY EVENTS

20. On 4 July 2014, the man was remanded to HMP Nottingham for breach of bail conditions and charged with actual bodily harm. At a reception health screen a nurse noted he had been prescribed methadone but wanted to stop taking it. The nurse referred him to the drug intervention programme (DIP) team. He started a methadone detoxification programme, which he completed on 30 July.

21. On 11 July, a pharmacy technician noted that the man's community GP had sent a summary of his medical history to the prison. This showed a history of indigestion and duodenitis (an inflammation of the first part of the small intestine) which had been investigated by an endoscopy. He had also had a positive test for helicobacter pylori (a bacterial infection that can cause inflammation of the stomach and duodenum). This information from the GP was not summarised in his prison medical record.

22. Between July and October, nothing significant was entered in the man's records. At 7.50am on a morning in October, he rang his cell bell and told an officer he had stomach pain. The officer said he would need to see the nurse, who would be on the wing from 8.00am. At 8.05am, the officer unlocked him and noted that he appeared okay.

23. At 8.20am, a senior manager noticed the man sitting on the stairs talking to other prisoners. He told her he felt unwell and faint and she advised him to stay sitting down while she got medical help. When she looked back, she saw him had collapsed on the floor. She shouted for help and a nurse, who was administering medication on the wing, came.

24. The man said he had stomach pain, but the nurse found it hard to assess him properly because of the noise on the landing. He was able to walk unaided and an officer took him to the healthcare unit.

25. At 8.38am, in the healthcare unit, the man told a nurse that he had been sick in the night and had a griping pain in his stomach. He did not say that he had just collapsed on the wing. The nurse noted he had a temperature of 34.7 degrees (37 degrees is normal), and his abdomen was soft with no abnormalities. The nurse asked a prison GP to prescribe hyoscine for him (usually prescribed for abdominal cramps associated with opiate withdrawal). The GP prescribed the medication but did not examine him.

26. Just after 10.00am, the man collapsed on the wing again. A nurse helped him back to his cell and gave him the medication the doctor had prescribed. She assumed that the doctor had examined him, and did not take any clinical observations. She checked his blood glucose, which was slightly raised. She noted that he looked dehydrated, and advised him to drink more fluids. She arranged for blood tests later that day, but said that she had no significant concerns about his condition at the time.

27. At 12.00pm, an officer noticed that the man had not collected his meal and he took it to his cell. He was lying on his bed and gestured that he did not want it.

28. At 12.10pm, the man's cellmate told an officer that the man had fallen out of bed and banged his head and was not responding. The officer alerted a colleague, who radioed a code blue (indicating an emergency when a prisoner is not breathing or unresponsive) and asked the duty nurse to attend. The control room called an ambulance as soon as the emergency code was received. A mental health nurse was passing by at the time and checked the man, who was still unresponsive. She asked an officer to radio for the duty nurse again.

29. Two nurses were administering medication on another wing. They had heard the initial request for the duty nurse and, when they heard the second call, were concerned that no one had arrived. They collected an emergency bag and went immediately to the man's wing.

30. At 12.16pm, a nurse noted that the man had stopped breathing. She was unable to feel a pulse and began cardiopulmonary resuscitation assisted by colleagues. The duty nurse is expected to respond first to medical emergencies. He arrived ten minutes later.

31. The nurses attached a defibrillator to the man but this did not find any shockable heart rhythm, so they continued cardiopulmonary resuscitation until paramedics arrived at 12.30pm and took over. The paramedics took him to hospital. Hospital staff continued emergency treatment but he did not respond. At 1.12pm, a hospital doctor pronounced he dead.

Notifying the man's next of kin

32. At 1.30pm, the prison appointed a senior manager as the family liaison officer. The man's next of kin, his son, lived near Birmingham. The Governor asked the family liaison officer to contacted HMP Hewell and HMP Birmingham to see if someone could go to see the man's son and inform him of his father's death. Hewell said they had no available staff and the family liaison officer was unable to get through to Birmingham on the phone.

33. At 3.10pm, after making further checks, the family liaison officer discovered that the address the prison had for the man's son was incorrect. At 5.00pm, he rang him to ask for his correct address. He said that he would be visiting with some important news, but did not tell him his father had died. At 7.15pm, he and a senior prison manager went to see him. They informed him of his father's death, offered condolences and support.

34. The funeral was held on 31 October 2014. The prison contributed to the costs in line with national guidance.

Support for staff and prisoners

35. The prison issued notices to prisoners and staff informing them of the man's death and offered support to anyone affected. A senior manager debriefed the staff involved in his care and the emergency response and offered support.

Staff checked prisoners being monitored as at risk of suicide or self-harm in case they had been adversely affected by the news of his death.

Post-mortem

36. The post-mortem report concluded that the man had died from bowel ischaemia (lack of blood supply to the bowel) caused by volvulus (twisted bowel). This is a natural cause of death, which can develop suddenly and deteriorate rapidly.

37. Toxicology tests indicated the presence of metabolites of Black Mamba (sometimes known as 'Spice') a synthetic form of cannabis, in the man's body. The quantity could not be measured.

ISSUES

Clinical Care

38. The clinical reviewer noted that the man was dead within four hours of first reporting abdominal pains. The cause of death was a natural but uncommon one, which develops quickly and has a poor prognosis unless rapidly recognized and treated. He had no obvious risk factors for this condition, but the clinical reviewer considered that an awareness of his history of duodenitis and gastritis should have made staff consider his abdominal pain as more significant and prompted a more thorough assessment and examination. Although the prison had received a summary of his medical history from his community GP, no one had entered this on his electronic prison medical record (SystmOne).

39. The clinical reviewer noted that the healthcare unit at Nottingham is heavily reliant on nursing staff. Two part time doctors are present for only a limited time each day. A nurse saw the man at 8.38am and asked a GP to prescribe medication to reduce stomach cramps usually associated with drug detoxification. The GP made an entry about prescribing 'symptomatic' medication, but there are no medical notes to support this decision. The clinical reviewer considered that this was a surprising prescription as the man had completed his detoxification by 30 July. He believed that if the doctor had examined him there might have been a different interpretation of his symptoms. Even if the diagnosis was not immediately apparent, this might have resulted in a more formal review later.

40. A nurse told us that he had not had any formal training in examination of the abdomen or minor illness management. The clinical reviewer considered that nurses working in the unit need advanced clinical skills training, so they are in a proper position to assess prisoners, particularly in acute situations. When there is a handover of a prisoner from the nurse to the doctor, the doctor should make a clinical entry, if only to show that the doctor had received and considered the information, but this was not done.

41. The man's cellmate said in a statement to the police that the man had been in pain from 2.00am the night before his death. He had vomited several times during the night, was in considerable discomfort, and sweating badly. He said that he had asked an officer for paracetamol for him, but the officer said that medication would not be available until the morning. The investigator could not find any prison record to support this account and whoever the officer was, did not record anything in his record or in the wing observation book. Despite a number of requests to the prison for CCTV footage and cell bell records for his wing that night the prison had not provided them. The cellmate has since been released and we have been unable to find him to speak to him about this. No member of staff on duty in the prison that night has accepted that they spoke to the cellmate.

42. The man told a nurse the next morning that he had been sick during the night, but no other member of staff we interviewed was aware of this. The nurse noted this information, but did not draw it to the attention of the doctor. The GP told us that he was not aware that the man had been ill during the night.

43. The GP and nurse both said that they had not known that the man had collapsed on the wing before an officer took him to the healthcare unit. A nurse and officer did not tell this nurse and another nurse did not make any record of this. It is clear that communication between healthcare staff and others was poor.

18. On the basis of the clinical reviewer's findings, we have a number of concerns about the man's clinical care. Nurses in key positions did not have adequate training; there were communication problems and poor medical record keeping which meant the complete picture of his condition was not clear. The clinical reviewer noted that the cause of his death meant it was unlikely that his condition would have been detected and his death prevented, but considered that the standard of primary care was not adequate and not equivalent to that he could have expected to receive in the community. We make the following recommendations:

The Head of Healthcare should ensure that all healthcare interactions and interventions with prisoners and their medical history is appropriately recorded in SystmOne so that clinicians can consider it and take it into account when assessing patients.

The Head of Healthcare should ensure that front line nurses have advanced clinical skills training to enable them to assess patients in acute situations effectively and refer to doctors when necessary.

Emergency response

44. A nurse told us that when a code blue is called the duty nurse and the duty healthcare assistant are expected to attend immediately. She was not the duty nurse on the day and had been with a new member of staff dispensing medication on another wing. After she heard the second radio call for assistance, she was concerned that the duty nurse had not responded so went immediately to the man's wing.

45. This nurse and the other nurses had been performing cardiopulmonary resuscitation for ten minutes before the duty nurse arrived. The duty healthcare assistant did not attend. The nurse told us that she felt unsupported by the lack of key healthcare staff during the emergency response. The duty nurse told us that he did not hear the initial call for the duty nurse. A member of the administrative team subsequently located him and told him he was needed. While the delay in the duty nurse attending did not affect the outcome for the man, as other nurses arrived, this could have been crucial in different circumstances. We make the following recommendation:

The Head of Healthcare should ensure that duty healthcare staff are aware of their responsibilities during a medical emergency and there is no delay in attending.

Informing the man's family

46. The man died at 1.12pm and, at 1.30pm, the prison appointed a family liaison officer. However, we are concerned that the prison did not inform the man's son of his death until 7.15pm, nearly six hours later.

47. Prison Service Instruction (PSI) 64/2011, Safer Custody, gives guidance on contacting families after a death. It says that prisons must keep up to date information about a prisoner's next of kin and states, "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source". The PSI notes that where the prisoner has been located a long distance from their next of kin, prisons should consider requesting the assistance of a FLO from the nearest prison.

48. At first, because the prison considered that the man's son lived too far away, they asked for help from two prisons nearer to his address. The prisons were unable to assist because of staffing pressures. Then the family liaison officer decided to go in person and deliver the news. It was at this point that he discovered the address the prison had for the man's son was incorrect. (There was a difference between "Avenue" and "Drive" and the former did not exist.) He rang the man's son to ask for his correct address but did not tell him that his father had died; he said that he had important news and arranged to visit him that evening.

49. We consider that the prison unnecessarily delayed contacting the man's son by first trying to arrange help from other prisons. His son lived only about an hour's drive away from Nottingham, which we do not consider is too far to travel. However, this was further complicated by the fact that his son's correct address was slightly incorrect. While PSI 64/2011 says that the news should be broken in person by a member of prison staff, there is also a requirement to inform families quickly. Although from the best of motives, we are concerned that when the family liaison officer telephoned the man's son this would have made him very anxious for some hours until the prison staff arrived and told him his father had died. In the circumstances, informing him by telephone with a follow up visit as soon as possible might have been preferable. We make the following recommendation:

The Governor should ensure, in line with Prison Service Instruction 64/2011, that prisoners' families are informed promptly when a prisoner dies, by staff from Nottingham unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.

Post-mortem indication of drugs

50. We asked the clinical reviewer for his opinion of the presence of metabolites of Black Mamba or Spice in the man's body after his death. The clinical reviewer said that the presence of such metabolites would indicate that he had probably taken the substance on the day or in the days leading up to his death. He did not consider that the use of such drugs would have contributed to his death, but it is possible that the drug could have altered his perception and possibly reduced his level of pain.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all healthcare interactions and interventions with prisoners and their medical history is appropriately recorded in SystmOne so that clinicians can consider it and take it into account when assessing patients.

2. The Head of Healthcare should ensure that front line nurses have advanced clinical skills training to enable them to assess patients in acute situations effectively and refer to doctors when necessary.

3. The Head of Healthcare should ensure that duty healthcare staff are aware of their responsibilities during a medical emergency and there is no delay in attending.

4. The Governor should ensure, in line with Prison Service Instruction 64/2011, that prisoners' families are informed promptly when a prisoner dies, by staff from Nottingham unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that all healthcare interactions and interventions with prisoners and their medical history is appropriately recorded in SystmOne so that clinicians can consider it and take it into account when assessing patients.	Accepted	All information received from community providers is scanned into the SystmOne record and accessible to all clinicians that require it. A standard operating procedure for the management of faxed clinical information will be developed and a funding bid will also be developed for the employment of a notes summariser to further support this process.	Offender Health 31 July 2015
2	The Head of Healthcare should ensure that front line nurses have advanced clinical skills training to enable them to assess patients in acute situations effectively and refer to doctors when necessary	Accepted	All nurses that provide triage will complete clinical skills assessment training. A bid will be submitted to fund the employment of an advanced nurse practitioner to support the GPs in the management of patients with an acute presentation.	Head of Healthcare 31 August 2015
3	The Head of Healthcare should ensure that duty healthcare staff are aware of their responsibilities during a medical emergency and there is no delay in attending.	Accepted	A standard operating procedure to be developed to ensure all staff are aware of their responsibilities in response to medical emergency.	Head of Healthcare 31 May 2015
4	The Governor should ensure, in line with Prison Service Instruction 64/2011, that prisoners' families are	Accepted	The relevant part of PSI 64/2011 has been copied to all managers to remind them of their responsibilities.	Governor 31 March 2015

	informed promptly when a prisoner dies, by staff from Nottingham unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.		Death in custody contingency plans have also been updated to include this instruction.	