Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shalane Blackwood a prisoner at HMP Nottingham on 5 August 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Shalane Blackwood was found unresponsive in his cell, in the segregation unit, at HMP Nottingham on 5 August 2015. He died of a massive internal haemorrhage and a burst duodenal ulcer. He was 29 years old. I offer my condolences to his family and friends.

Mr Blackwood died in very distressing circumstances. In the last weeks of his life his behaviour became very strange and he would not engage with staff. A psychiatrist considered Mr Blackwood's presentation was possibly drug induced, as Mr Blackwood admitted using a new psychoactive substance. At the time of his death, the psychiatrist had referred him to a secure psychiatric hospital for treatment. It is possible that Mr Blackwood's poor mental health and difficult presentation masked some of his physical symptoms but he had never mentioned any stomach problems at Nottingham, although he had some months earlier, at his previous prison.

While the investigation found some aspects of his care and treatment which could have been better, particularly in relation to his management in the segregation unit, I consider it would have been very difficult for staff at Nottingham to have identified he had a serious physical problem and prevent Mr Blackwood's sudden and unexpected death.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2016**

Contents

Summary

Events

1. In February 2015, Mr Shalane Blackwood was recalled to prison from a previous sentence and remanded to HMP Liverpool charged with further offences. In March, he began to report that he was in pain, initially from headaches and then when he urinated. A GP prescribed medication for anxiety and pain relief.

2. On 8 April, Mr Blackwood said he had taken an overdose of medication because he was in pain. A GP suspected kidney problems but Mr Blackwood refused blood tests to check. He insisted he needed an X-ray, which the GP did not consider necessary. Later that day, he cut himself and officers began suicide and self-harm prevention procedures, known as ACCT. Mr Blackwood said he had little faith in the prison doctors and had cut himself in the hope he would go to hospital for treatment for his stomach.

3. On 10 April, he told a nurse he was constipated and his stomach was swollen but the nurse examined him and found no signs of this. Staff became concerned that Mr Blackwood's mental health was deteriorating and, on 13 April, moved him to the healthcare unit to monitor his mental health. He refused fluids and appeared to be in some discomfort but would not say why. He did not report any further stomach problems during his time at Liverpool. His mental health appeared to improve and staff ended ACCT procedures on 20 April.

4. On 6 May, Mr Blackwood was transferred to HMP Nottingham, to be nearer his family. At an initial health screen at Nottingham, Mr Blackwood did not mention stomach pain. He had little further contact with the healthcare staff and did not report any further health concerns. On 7 July, he was taken to the segregation unit after officers found drugs and a mobile phone in his cell. A nurse assessed Mr Blackwood and did not identify any health concerns.

5. Mr Blackwood appeared generally well and settled in the segregation unit until an incident on 21 July, when he refused to go back to his cell, after a phone call. He aggressively resisted officers, who had to restrain him. Afterwards, he continued to act aggressively and it was agreed that four officers should be present, before Mr Blackwood's cell could be unlocked.

6. Mr Blackwood began to act bizarrely and did not appear to eat, drink or sleep. He was often naked in his cell, which was dirty and covered in urine. Nurses were unable to examine him and he would not engage with them. On 24 July, a manager queried whether he should remain in the segregation unit but the deputy governor decided that there was no other suitable place for him in the prison.

7. Mr Blackwood's mental health deteriorated further and some staff considered that he might have used new psychoactive substances. On 29 July, a psychiatrist assessed him and Mr Blackwood told him that he had been smoking 'Mamba', a synthetic cannabinoid, in prison. The psychiatrist considered that this was the most likely explanation for his presentation. He prescribed medication for anxiety and to help him sleep, but Mr Blackwood refused to take it. On 3 August, the psychiatrist reviewed Mr Blackwood again and decided to refer him

to a secure mental hospital. Mr Blackwood did not mention any physical health problems to the psychiatrist or say that he was suffering from any pain.

8. On 4 August, staff noticed blood on Mr Blackwood's body and in his cell. They thought he might have harmed himself and moved him to another cell. Officers restrained him, while a nurse examined him. The nurse could not find any injuries, which might have caused the blood, but noted that it might have come from his mouth. Officers decided to monitor Mr Blackwood under ACCT procedures.

9. That night, an officer checked Mr Blackwood every hour. At 6.00am on 5 August, the officer told the night manager that Mr Blackwood had not moved for some time. They could not get a response from Mr Blackwood so went into the cell. They found he was not breathing and called for help. Staff and paramedics were unable to resuscitate him. A post-mortem examination found that Mr Blackwood died from a massive internal haemorrhage and burst duodenal ulcer.

Findings

10. Mr Blackwood reported stomach pains at Liverpool but refused to comply with blood tests when a GP suspected kidney problems. While the clinical reviewer considered that there should have been some further follow-up of Mr Blackwood's concerns about stomach pain at Liverpool, he did not report any further stomach problems after 11 April and did not mention any stomach pain at Nottingham.

11. When he was in the segregation unit at Nottingham from 7 July, healthcare staff saw him daily, but the focus of concern from 21 July onwards, was Mr Blackwood's mental health. His difficult behaviour and his frequent refusal to engage with healthcare staff meant that it was difficult to examine him physically, but healthcare staff had little reason to suspect that Mr Blackwood was suffering from a serious physical condition. We do not consider that they could have anticipated his sudden death. We are satisfied that the prison took appropriate steps to address his mental health problems.

12. Mr Blackwood was held in the segregation unit for several weeks, in increasingly poor conditions. We do not consider that segregation units are appropriate for prisoners with acute mental health problems but recognise that alternative options were limited and, at the time of his death, the possibility of a transfer to hospital was being pursued. However, we are concerned that there was no effective care plan for his management in the segregation unit and no level of observations were set until the evening before his death when staff began ACCT monitoring. From 21 July, four officers were required to be present when his cell was opened, which hindered his regime and care, but there is no record that this decision was ever reviewed.

13. We are concerned about the availability of drugs at Nottingham and it is possible that their use affected Mr Blackwood's mental state. Mr Blackwood said that he had used new psychoactive substances freely in the prison and claimed that he had used such a substance in the segregation unit.

14. Officers did not use an appropriate medical emergency code when they found Mr Blackwood unresponsive in his cell. While this does not appear to have affected the outcome, this led to a short delay before an ambulance was called. Not all emergency equipment was available in the emergency bag.

15. We consider it took too long for the prison to inform Mr Blackwood's family of his death. The prison did not hold a critical incident debrief, in line with national instructions.

Recommendations

- The Head of Healthcare at Liverpool should ensure that nurses follow up prisoners' outstanding concerns about their health and refer them to a GP when necessary.
- The Head of Healthcare at Nottingham should ensure that all healthcare staff are trained in the use of SystmOne and how to retrieve records to ensure appropriate continuity of care.
- The Governor should ensure that decisions to increase the number of staff required to be present to unlock a cell are authorised by a manager, recorded appropriately and regularly reviewed.
- The Governor should ensure that prisoners with complex mental health problems are held in the segregation unit only in exceptional circumstances and the reasons, including other options that were considered, should be recorded. Such prisoners should have a nominated manager responsible for coordinating their care with detailed care plans to inform their management and treatment and levels of observations which reflect their circumstances.
- The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances, and that staff are vigilant for signs of its use and are briefed about how to respond when prisoners appear to be under the influence of such substances.
- The Governor should ensure that that prison staff use the appropriate emergency medical code in a life threatening situation, that control room staff request an ambulance immediately and that staff take appropriate emergency equipment to the scene.
- The Governor should ensure that when a prisoner dies, the next of kin is informed without undue delay.
- The Governor should ensure that after a death at the prison, staff are supported in line with national instructions.

The Investigation Process

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

17. The investigator visited Nottingham on 10 August 2015. She obtained copies of relevant extracts from Mr Blackwood's prison and medical records.

18. NHS England commissioned a clinical reviewer to review Mr Blackwood's clinical care at the prison. The clinical reviewer and the investigator jointly interviewed healthcare staff at Nottingham on 10 November. The investigator interviewed other staff in November and December 2015, and January and February 2016.

19. We informed HM Coroner for Nottingham of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Mr Blackwood's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. The family liaison officer and the investigator later met Mr Blackwood's mother and her solicitor. She had a number of questions and concerns. In particular, she asked us to take into account the following:

    - The reasons why healthcare staff at Nottingham had not followed up the stomach and bowel problems which Mr Blackwood had complained of at HMP Liverpool.
    - Whether healthcare staff had overlooked Mr Blackwood's physical health needs by focussing on his mental health.
    - Whether segregation unit staff had realised he was in pain and whether he had been given pain relief.
    - The appropriateness of Mr Blackwood's management in the segregation unit and whether he was there too long.
    - Whether Mr Blackwood should have been moved to a hospital.
    - Whether there was an appropriate emergency response.
    - Whether her calls to the prison chaplain and a mental health nurse had been handled appropriately.
    - The reasons why she had heard about Mr Blackwood's death before the prison notified her officially.

21. Mr Blackwood's mother received a copy of the initial report. The solicitor representing her wrote to us pointing out some factual inaccuracies. The report has been amended accordingly.

Background Information

HMP Nottingham

22. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire and holds over 1,000 men. The segregation unit holds up to 12 men. Nottinghamshire Healthcare Trust provides health services at the prison.

HM Inspectorate of Prisons

23. HM Inspectorate of Prisons last inspected Nottingham in September 2014. Inspectors reported that the prison was failing in most of its core responsibilities and that the prison was not safe enough. Inspectors judged the overall quality of healthcare as reasonably good and the management of prisoners with substance misuse needs was generally appropriate. The mental health team provided a good and improving service.

24. Half of the prisoners surveyed by the Inspectorate reported that it was easy or very easy to get drugs in prison, although inspectors found that work to reduce drug supply seemed to be having an impact. Inspectors described the environment in the segregation unit as reasonably good, although they were concerned that prisoners often had little to do.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to February 2015, the IMB reported that the prison regime was often restricted because of lack of staff, although this had eased towards the end of year as more officers had been recruited. The IMB considered that the mental health team was working at maximum capacity. The IMB commended the work of officers in the segregation unit but said the unit was not always staffed with selected and trained officers, which made it difficult for them to identify and manage risks or engage positively with prisoners. The IMB welcomed efforts to detect illegal mobile phones, but was concerned about the availability and use of new psychoactive substances.

Previous deaths at HMP Nottingham

26. There have been six natural cause deaths at Nottingham since 2012. One of the other prisoners had died from a perforated duodenal ulcer and gastrointestinal bleeding, which had not been detected. In another sudden death caused by a twisted bowel, the prisoner had been using a new psychoactive substance, which might have masked his pain.

Assessment, Care in Custody and Teamwork

27. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the

perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances

28. New Psychoactive Substances (NPS) are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.

29. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence, and intimidation.

30. In July 2015, we published a Learning Lessons Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

HMP Liverpool

31. On 24 January 2014, Mr Shalane Blackwood was released from prison on conditional licence, after serving 22 months of a 44 month sentence for possession of a firearm and putting a person in fear of violence. From November 2014, in breach of his licence conditions, Mr Blackwood did not attend probation appointments. On 10 February 2015, he was arrested for alleged offences of affray, kidnap and blackmail. On 11 February, his licence was revoked. He was recalled to prison and remanded to HMP Liverpool to await trial for the new charges. He had a history of using cannabis and crack cocaine.

32. At an initial health screen at Liverpool, Mr Blackwood told a nurse that he was physically well, did not have any mental health problems and did not feel suicidal. He said he was not taking any medication and he had not used drugs or alcohol in the previous month. He weighed 76.3kg and his blood pressure and other clinical observations were in the normal range.

33. On 23 February, at a further health screen and mental health assessment, Mr Blackwood told a mental health nurse, that he had persistent headaches. On 27 February, he told another nurse that he was finding it difficult to cope in prison because his partner had recently given birth to twins; one had died and the other was critically ill in hospital. He said that he did not have any feelings of suicide or self-harm. That day, Mr Blackwood asked to transfer to HMP Dovegate to be nearer his family.

34. On 3 March, Mr Blackwood told a GP that he was suffering from headaches and feeling anxious. The GP prescribed citalopram, an antidepressant, and ibuprofen and paracetamol for the headaches.

35. On 18 March, Mr Blackwood told a GP that his mood was still low. He reported pain when he urinated and asked the doctor to screen him for sexually transmitted infections. The GP prescribed doxycillin (an antibiotic) and arranged for him to be tested.

36. Throughout March, staff at Liverpool tried to arrange a transfer to a number of prisons in the Midlands. On 22 March, Mr Blackwood climbed on the landing railings, in protest at the lack of progress with his transfer request, and was taken to the segregation unit. On 24 March, HMP Nottingham agreed to accept Mr Blackwood.

37. On 25 March, Mr Blackwood told a GP that he was suffering from toothache, for which the doctor prescribed ibuprofen and paracetamol. The GP noted that Mr Blackwood did not have any facial swelling and had requested a dental appointment.

38. On 30 March, Mr Blackwood was taken to his daughter's funeral. On 1 April, he moved from the segregation unit to a standard prison wing.

39. On 5 April, Mr Blackwood was found, apparently collapsed on the floor of his cell. A nurse noted that he was holding his eyes tightly together and woke up after

about a minute. She took his clinical observations, including blood pressure, oxygen saturation and pulse rate. All were within the normal range.

40. On 8 April, Mr Blackwood said that he had taken an overdose of co-codamol and ibuprofen. Mr Blackwood told a GP that he had taken the tablets because he was in pain. He said that he could not feel anything in his groin, but he did not have pain when urinating, any symptoms of sexually transmitted infection, urethral discharge or any lumps in his testes. He said he had erectile dysfunction and his lower back area was tender. The doctor thought this might be a kidney problem and needed blood tests but Mr Blackwood said he needed an X-ray. The GP was unable to convince him otherwise, and Mr Blackwood left the room. Later that day, a nurse went to see Mr Blackwood to take some blood for tests, but he refused to give blood.

41. At 5.00pm, Mr Blackwood told a member of the chaplaincy team that he would cut himself if he could not speak to his pastor from his home church. The chaplain contacted the pastor, who agreed to speak to Mr Blackwood but Mr Blackwood cut his arms 50 minutes later. He refused treatment for the cuts.

42. Officers began Prison Service suicide and self-harm prevention procedures, known as ACCT. That evening, Mr Blackwood told an officer that the prison healthcare team was letting him down. He said he was in pain and the doctor did not know what he was talking about. At 10.32pm, a nurse noted that Mr Blackwood had again refused treatment for his cuts and would not allow him to take his clinical observations.

43. At 9.35am on 9 April, a chaplain went to see Mr Blackwood and noted in his prison record that there was a lot of blood on the cell floor. Mr Blackwood said that he did not feel well and had severe stomach pain. He said the doctor he had seen the day before, did not know what he was doing and that his home pastor was a healer, which was why he had wanted to speak to him.

44. That afternoon, an officer assessed Mr Blackwood as part of ACCT procedures. Mr Blackwood said that the only thing that was frustrating him was his stomach pain. He said that he had cut himself to try and get to hospital as he wanted treatment for his stomach. He did not agree with a GP that his pain was stress-related. He said that he would not harm himself again.

45. A mental health nurse attended Mr Blackwood's first ACCT case review that afternoon. Officers had told the nurse that they were concerned about Mr Blackwood's mental health. Mr Blackwood told the nurse that he had thought he would be taken to hospital if he cut himself and would not cut himself again. He said he was worried about his health, had no appetite, and was no longer eating. He was reluctant to discuss his issues further but said that he had not had any previous mental health problems and that he had never harmed himself before. He said that the chaplaincy team and his family had supported him after his recent bereavement.

46. The nurse noted that there was no clear evidence of psychosis, but it had not been possible to draw any conclusions about Mr Blackwood's mental health. He told Mr Blackwood that he would review his clinical notes and find out if there

was any plan of action about his recent lower back and stomach pain. There is no record that this was followed up.

47. On 10 April, the nurse saw Mr Blackwood again, after a manager thought his mental state had deteriorated. The nurse recorded that Mr Blackwood was stressed. He told him that he had been constipated and wanted to be checked in hospital. He showed the nurse his stomach and said it was swollen but the nurse noted that it was flat and not at all distended. Mr Blackwood then left the room and said there was nothing the nurse could do for him.

48. On 11 April, wing staff remained concerned about Mr Blackwood and asked a member of the mental health crisis team to see him. At first, Mr Blackwood refused to engage but then said he had been refusing food because of a bowel problem. The member recorded that Mr Blackwood's cell was filthy; he was very unkempt and had an unpleasant body odour. He noted Mr Blackwood had some elements of psychotic symptoms, such as acting bizarrely, restlessness and pacing up and down in his cell. The member considered that Mr Blackwood should be moved to the healthcare unit but there were no beds available at the time. He recorded that he would book him to see the doctor, but there is no record that Mr Blackwood saw a GP again before he left Liverpool.

49. The next day, Mr Blackwood told a nurse that he had eaten a little but would only eat packaged food, as he believed his food had been tampered with. On 13 April, a mental health worker saw Mr Blackwood on 13 April. He thought that Mr Blackwood showed signs of mental illness, related to his recent bereavement. Mr Blackwood was pacing up and down his cell stating that he was God and his body was not his own. He said that he had not eaten for three days and refused to take any medication. The mental health worker arranged for Mr Blackwood to be constantly supervised in a gated cell in the healthcare unit.

50. For the next few days, Mr Blackwood engaged little with staff in the healthcare unit. He appeared to be in discomfort and refused fluids, but would not say what his problems were.

51. On 15 April, Mr Blackwood refused to attend an ACCT case review, but agreed to move to a standard cell in the healthcare unit. Staff continued to monitor him using ACCT procedures. On 20 April, at a case review, a member of the healthcare team noted that Mr Blackwood was calm, polite, made good eye contact but looked around suspiciously. He said he would not harm himself but wanted to move to a prison in the Midlands, nearer to his home and family. He said that he did not want to be managed under ACCT procedures, had no psychotic symptoms and had not received mental health treatment before. The case review ended ACCT monitoring, although the member had disagreed with this decision.

52. On 21 April, a nurse checked Mr Blackwood's wound, which had healed. The nurse applied a new dressing. Mr Blackwood did not receive any further healthcare treatment at Liverpool.

HMP Nottingham

53. On 6 May, Mr Blackwood transferred to HMP Nottingham. At an initial health screen, he told a nurse that he did not use drugs or alcohol, and had no thoughts of suicide or self-harm. He told her that he had erectile dysfunction but did not mention any stomach problems. She told the investigator that she had not read his medical record from Liverpool, as SystmOne (the computerised medical record) would only let her view notes about prisoners' care at Nottingham. (In fact SystmOne does allow clinicians to see previous records.)

54. On 12 May, Nottingham obtained Mr Blackwood's community GP records, which showed that his GP had not prescribed any medication before he went to prison in February. At a second health screen later that day, a healthcare assistant noted that Mr Blackwood weighed 76kg and his clinical observations were all within the normal range. There is no record that Mr Blackwood mentioned any stomach or back problems.

55. On 9 June, Mr Blackwood was reported to have attempted to assault an officer who intervened when a visitor was passing him drugs. The visitor was banned from the prison and Mr Blackwood was placed on closed visits (behind a screen with no physical contact with visitors). He was moved to the basic regime level, (which meant that he lost privileges such as having a television in his cell) and charged with a disciplinary offence.

56. On 23 June, officers found an illicit mobile phone and television in Mr Blackwood's cell. He was charged with an offence against Prison Rules again. Later that day, he complained of swollen glands and a nurse have him ibuprofen for pain relief.

57. On 27 June, Mr Blackwood was involved in a fight with another prisoner. When officers intervened, Mr Blackwood allegedly assaulted an officer and staff used control and restraint procedures to stop him. According to the report of the use of force, Mr Blackwood did not have any injuries. He told a nurse that he did not need any healthcare intervention and just wanted something to eat. He was charged with a disciplinary offence and moved to the basic regime level again.

58. On 3 July, Mr Blackwood threatened to knock out an officer who told him that, as he was on the basic regime, he was not allowed to use the telephone when he came back after spending some time in the exercise yard. Officers escorted Mr Blackwood back to his cell.

59. On 7 July, officers found drugs and a mobile phone in Mr Blackwood's cell. (He was charged with disciplinary offences as a result and, because of the seriousness of the charges, they were referred to an independent adjudicator - a district judge. The hearings had not been completed when Mr Blackwood died.) Staff moved Mr Blackwood to the segregation unit.

60. A nurse assessed Mr Blackwood and recorded that he had no injuries and there were no medical reasons why he should not be segregated. Healthcare staff saw Mr Blackwood daily for routine segregation checks.

61. A member of the chaplaincy team saw Mr Blackwood each day, and a duty governor most days. His continued segregation was reviewed and agreed again

on 10 and 17 July. The Head of Safer Prisons noted that he engaged in the reviews and did not raise any health problems, at the review on 17 July, noted he appeared very dirty. On 20 July, a nurse saw him and noted that he did not raise any concerns.

62. At 2.00pm on 21 July, an officer recorded in the segregation history sheet that Mr Blackwood was behaving badly, shouting and threatening officers but then became compliant and apologetic. The officer wrote that staff did not trust him and until there was another officer (making four in total) on the unit, he would not be unlocked from his cell. Mr Blackwood was not happy about this.

63. At 2.45pm, the fourth officer arrived and Mr Blackwood was unlocked from his cell. He phoned his mother and became aggressive and argumentative during the call. Staff considered ending the call but allowed it to continue, as he calmed down. After the call, Mr Blackwood started to go back to his cell but walked past it and began talking to the prisoner in the next cell. Officers asked him to go back to his cell but Mr Blackwood refused and started running around the landing. Staff used control and restraint procedures and brought Mr Blackwood to the floor. Mr Blackwood was reported to be kicking out, and struggling hard to free himself. A SO noted that Mr Blackwood was very aggressive with extremely high levels of strength. As Mr Blackwood did not calm down, the SO asked another officer to press the general alarm. Other officers arrived, handcuffed Mr Blackwood and took him to his cell. He was not injured. In his report of the incident, an officer described Mr Blackwood's strength as phenomenal, and he wondered whether he had taken drugs. Mr Blackwood continued to shout and be aggressive after staff left him in his cell.

64. The investigator viewed CCTV footage of the incident and was satisfied that it was reasonable for staff to use force to try to control Mr Blackwood. There was no evidence of any apparent injuries to Mr Blackwood. An officer noted in the segregation observation book that Mr Blackwood did not sleep that night.

65. As a result of Mr Blackwood's behaviour, staff apparently assessed him as a high risk to others and decided that four officers needed to be present before they unlocked his cell. We have not seen the risk assessment or record of this decision, other than a reference in an intelligence report from 21 July that it had been authorised by the senior management team. The Head of Safer Prisons told the investigator that at the time there were only three officers based in the segregation unit in the afternoon. This meant they could not unlock Mr Blackwood without an additional officer present.

66. On 22 July, a nurse recorded that she had seen Mr Blackwood, who had not raised any issues about his health. She noted that Mr Blackwood was a "four–man unlock". The Head of Safer Prisons was the duty governor and recorded that Mr Blackwood was on his bed and said he was fine. A chaplain noted that Mr Blackwood had not raised any concerns that day.

67. The next day, 23 July, an officer noted in Mr Blackwood's prison record that he had been awake throughout the night for the second night running and was muttering to himself randomly. A nurse saw Mr Blackwood again and recorded that she had observed him through door observation panel because he was on "four-man unlock". She said he was standing by the wall, but she could still see

him clearly and could not see any signs of any medical issues. A chaplain noted that Mr Blackwood did not respond when he visited him. The Head of Safer Prisons did not see Mr Blackwood on her duty governor's rounds that day, as he was naked and refused to put clothes on. She recorded that he was shouting at the time.

68. At 9.18pm, a nurse tried to check Mr Blackwood after segregation staff reported that he was shouting and acting bizarrely. Mr Blackwood was still naked and refused to talk to her. She asked that someone from the mental health team should see him when they came on duty the next day. An officer recorded that Mr Blackwood spent the night crying out and did not sleep.

69. On Friday 24 July, a nurse went to check Mr Blackwood but could not see him in the cell as there were not enough staff to unlock him and he was to the side of the observation panel. She spoke to him and he did not raise any issues about his health. A member of the chaplaincy team tried to chat with Mr Blackwood during the morning, but recorded that Mr Blackwood seemed oblivious to him and he was concerned about his mental health.

70. A nurse from the mental health team went to see Mr Blackwood in the afternoon, as another nurse had requested. He told the investigator that Mr Blackwood had deteriorated "spectacularly" since he had last seen him earlier that week. He wrote in his medical record that Mr Blackwood was naked, incoherent and unpredictable. The nurse was not clear if Mr Blackwood was eating or drinking properly and his cell floor was covered in food, water and urine. Mr Blackwood told the nurse that he was looking for a mouse in his cell. He thought he was in heaven but did not know how or when he got there. The nurse concluded that Mr Blackwood was paranoid. He could not take any physical observations because Mr Blackwood was incoherent and not engaging.

71. The nurse told the Head of Safer Prisons he was concerned about Mr Blackwood's mental health. She noted that he was due to have a segregation review that day but, because of his behaviour, and the nurse's concerns about his mental health, she was not happy to authorise his continued segregation. The nurse and Head of Safer Prisons considered that the most suitable environment for him would be a cell in the enhanced care area on F Wing, where he could be monitored over the weekend and assessed on Monday 27 July.

72. The Head of Safer Prisons contacted the deputy governor to explain her concerns about Mr Blackwood remaining in the segregation unit. The governor told the investigator that she decided that Mr Blackwood should remain in the segregation unit, because she considered he was too great a risk to staff and there would be insufficient staff to unlock him in the enhanced care area. Although there was a nurse on duty in the enhanced care area, staff would not be able to be offer showers and exercise or check him frequently.

73. The Head of Safer Prisons told us that after the deputy governor had decided that the enhanced care area was not suitable for Mr Blackwood, another nurse agreed that Mr Blackwood was fit for segregation. The nurse told the investigator that he did not remember much about that day, but he thought that Mr Blackwood had been using a new psychoactive substance (NPS), which was led to his behaviour at the time. He asked for an urgent secondary mental health

assessment for Mr Blackwood and the Head of Safer Prisons signed the authority to continue segregation.

74. Over the next days, officers continued to record concerns about Mr Blackwood's mental state. On 25 July, an officer noted that Mr Blackwood remained incoherent, and that he needed an urgent mental health assessment. On 26 July, there were insufficient staff available to unlock Mr Blackwood and a nurse from the mental health team was unable to assess him.

75. On 27 July, an officer recorded that Mr Blackwood had remained awake on six consecutive nights. He periodically screamed and acted bizarrely. He sometimes pressed his cell bell but did not respond to staff when they answered it. The Head of Safer Prisons held a segregation review on 27 July, with a nurse and a member of the Independent Monitoring Board. Mr Blackwood did not attend because of his "unpredictable behaviour'. She authorised his continued segregation.

76. On 28 July, an officer recorded that Mr Blackwood was aggressive, with clenched fists and wild eyes. He had spent the previous 48 hours naked and covered in custard. The officer was concerned that Mr Blackwood would assault a member of staff if he were unlocked.

77. That afternoon, a mental health nurse tried to assess Mr Blackwood but recorded that officers could not unlock him, so she had spoken to him through the cell door. Mr Blackwood was naked, difficult to comprehend and, at some points, he seemed to be talking to someone else in the cell. He seemed unsteady on his feet, and she noted that segregation staff had not seen Mr Blackwood eat hot food for three days or drink a hot drink for a week. They could not say for certain if he had drunk any water. She recorded that she was not able to assess his physical health, although she noted from his medical history that he had previously complained of stomach trouble. She questioned whether he had taken an illicit substance since he had been in the segregation unit, although she noted that his condition did not seem to be improving. She decided that she should ask the visiting psychiatrist to review Mr Blackwood as soon as possible.

78. The next day, Wednesday 29 July, the psychiatrist saw Mr Blackwood in his cell. He recorded that Mr Blackwood had admitted that he had been smoking "Mamba", a new psychoactive substance (NPS) in prison, including the day before. He described Mr Blackwood as "floridly abnormal" in presentation and agitated, but was also lucid, articulate and orientated to time and place. He wrote that he assumed that Mr Blackwood's presentation was drug-induced until proven otherwise. Mr Blackwood said that he did not have any thoughts of harming himself and that he would accept medication. He prescribed diazepam (a sedative) and zopiclone to help him sleep.

79. The psychiatrist added longer accounts of his consultation in Mr Blackwood's medical record on 3 and 4 August. (The latter added on his behalf by his personal assistant). He said that Mr Blackwood looked distressed when he went to see him. He was naked and rocking while curled in a ball on the floor. Occasionally he grunted or shouted, but the psychiatrist was surprised that he then became quite articulate. He knew the date and that he was due in court that day, although he thought he was in HMP Lincoln. (He said that he had been in

Nottingham recently). Mr Blackwood said that he had used a small amount of mamba the night before (28 July), but had used it more freely when he was on a standard wing. (The psychiatrist noted that he had asked staff in the segregation unit about this, but they said it was unlikely that he had used Mamba in the unit.) Mr Blackwood said he had not slept for three days and he felt tired.

80. The psychiatrist noted that, if Mr Blackwood had mania, he would be more likely to feel energised. If he had not been told that Mr Blackwood had a stutter, he might have thought he had a formal thought disorder. Mr Blackwood said he did not have a history of major physical health problems and was not taking medication. He recorded that he had considered whether Mr Blackwood should be monitored under ACCT procedures but decided he did not, as he had not had any thoughts of suicide or self-harm. He discussed Mr Blackwood's location with staff, and agreed that the segregation unit was a suitable location for him at that stage.

81. On 30 July, Mr Blackwood refused to take his medication and would not allow a nurse to check him for signs of dehydration. He remained naked and did not respond to officers when they asked him to put clothes on. That night an officer recorded that Mr Blackwood persistently used his emergency cell bell, but would not engage with him when he went to answer it.

82. The next day, Friday 31 July, Mr Blackwood remained naked and would not engage with the Head of Safer Prisons when she tried to talk to him. A nurse noted in his the medical record that he refused medication. (In the segregation history sheet she recorded that she had administered the medication as prescribed.) A member of the chaplaincy team noted that he did not think Mr Blackwood had improved in the previous week, although officers had said he was more "with it". Healthcare staff discussed Mr Blackwood at their weekly multidisciplinary meeting, and accepted him on to the secondary mental health team's caseload.

83. On Saturday 1 August officers unlocked Mr Blackwood's cell in order that a nurse could give Mr Blackwood medication and take his observations. He did not engage with her. She wrote that he was lying naked on a mattress, surrounded by a pool of urine. His eyes were open and he was breathing. She could not get his consent to take clinical observations, and segregation officers said that they had not seen him eat or drink for a week. She did not consider that he had mental capacity to refuse food and medication and to lie in urine. She also thought he had lost a lot of weight.

84. The nurse discussed Mr Blackwood with the duty governor and segregation officers. They agreed that she should speak to the out of hours mental health services and ask a GP to see Mr Blackwood that afternoon.

85. At 10.55am, the nurse spoke to the out of hours mental health team, who asked why a capacity assessment had not been done and said that they would seek further advice. There is no record that they provided further advice to Nottingham, although she tried to contact them again later that day.

86. That afternoon, a prison GP went to see Mr Blackwood. He did not respond when she knocked on the door. She noted that the cell was in disarray, and

there was food and urine on the floor. Mr Blackwood was pushing tissue around the floor, when he noticed someone at the door and briefly asked who it was. She noted that staff reported Mr Blackwood was not eating or drinking, but she was not formally qualified to assess someone's mental capacity to take such decisions. She considered that it would be appropriate to move Mr Blackwood because of the risk of infection. The duty governor agreed. The nurse asked the mental health team to conduct a capacity assessment on Monday, if the out of hours team had not done so.

87. At 5.20pm, a team of officers went into Mr Blackwood's cell and took him to the shower room. Mr Blackwood was distressed initially, but calmed down and rinsed himself for about a minute. He then sat down and refused to engage with the officers, who moved him to a clean cell. Mr Blackwood resisted but, the nurse recorded that he did not have any injuries. He refused to let nurses take clinical observations and told them that they were there to kill him. One nurse recorded that he looked genuinely frightened and distressed. She noted that the mental health team would review him on Monday 3 August.

88. The next day, Sunday 2 August, a nurse, went to see Mr Blackwood, who was wearing jogging bottoms. He told her that he did not want the medication, which the psychiatrist had prescribed. He asked for a box of cereal and she noted that there was food, water and possibly urine over the floor. He advised Mr Blackwood to take his medication, but he refused again.

89. An officer took Mr Blackwood's lunch and pudding to his cell. When he went back later, the food was still in the same place, untouched. In the evening, a nurse took medication to Mr Blackwood's cell, but he refused to take it. She recorded that, although his cell was untidy, he did not seem unkempt. An officer recorded that Mr Blackwood had been very vocal through the night, shouting and ringing his cell bell, but did not respond to staff.

90. At 9.38am on Monday 3 August, a nurse from the mental health team went to assess Mr Blackwood. When she arrived, he was on his bed talking to himself. He refused medication and would not engage with her or any of the officers, who remained concerned that he was not eating or drinking and that his mental health was deteriorating. She wanted to take his clinical observations and officers unlocked the cell door. Mr Blackwood was calm but would not come out of the cell to allow her to take the observations. She noted in Mr Blackwood's segregation history sheet that she would ask her manager to ask the psychiatrist to see Mr Blackwood that afternoon.

91. The psychiatrist saw Mr Blackwood at approximately 2.50pm and wrote a referral letter to a medium secure hospital seeking a place for Mr Blackwood, which would have allowed compulsory treatment under the Mental Health Act. He included a record of their meeting in the letter. He wrote that Mr Blackwood had appeared more distracted and engaged less well. He had looked at the psychiatrist briefly before curling up in a ball and had rocked back and forth. The psychiatrist said that segregation unit staff were confident that he had not been smoking in his cell, which was two doors down from the unit office, since he had been moved there. He also noted that Mr Blackwood responded to unseen

stimuli at least twice. He said it was not possible to assess Mr Blackwood physically, because of his mental state.

92. Also on 3 August, the Head of Residence chaired a segregation review. Other staff attended. She noted that Mr Blackwood had mental health issues and had been referred several times to the mental health team. She decided that segregation could continue. A member of staff did not support the decision to maintain segregation.

93. On Tuesday 4 August, a nurse saw Mr Blackwood in his cell. He did not engage with her or accept medication. While serving lunch, an officer noticed blood on Mr Blackwood's body. A Nurse went to the segregation unit and she recorded that there was a noticeable amount of blood on his body and in his cell, which was covered in urine and water. Officers moved Mr Blackwood to a sterile cell, although he was violent and spat at some of the officers. A mental health nurse and the mental health matron also attended. They noted that Mr Blackwood was sitting on the bed in the new cell but was not responding.

94. At the same time, officers began ACCT procedures, because they were concerned that Mr Blackwood had been behaving bizarrely for almost three weeks and might be at risk of harming himself. As part of the immediate action plan, officers were required to observe Mr Blackwood every hour and to record their observations.

95. The control and restraint team went into the cell and restrained Mr Blackwood so that healthcare staff could assess whether he had cut himself. The records indicate that Mr Blackwood resisted at first but then became more compliant. An officer, who was controlling Mr Blackwood's left arm, wrote that the nurse examined his chest and stomach but could not find any puncture wounds. She examined his lower body, but again found no wounds. The officer, who knew Mr Blackwood from his wing, wrote that at one point Mr Blackwood turned his head to him and said, "I am dying". He said that Mr Blackwood looked scared and he tried to reassure him.

96. The nurse recorded that Mr Blackwood's new mattress was smeared with faeces and there was urine on the floor. She did not see any signs of any injuries, although he had some old blood around his mouth. She saw him grinding his teeth at one point and thought the blood might have come from his mouth. She contacted the psychiatrist about the referral to a medium secure hospital, and he said that the letter was being typed.

97. The psychiatrist's referral letter to the hospital was dated 4 August. He asked that Mr Blackwood be treated as an urgent referral, as he was presenting as acutely mentally unwell, although he had no history of major mental illness and it was possible that his current presentation was a result of taking contraband psychoactive substances. He set out Mr Blackwood's history, noting that concerns were raised at HMP Liverpool because he was referring to himself as God and he would only accept packaged food for fear of being poisoned. He noted that he had received an update about blood being found in cell with no obvious explanation. He noted that, as Mr Blackwood required four officers to be present to unlock him, there was no alternative accommodation for him in the

prison. He concluded that he thought that because of Mr Blackwood's condition, inpatient treatment appeared warranted.

98. That afternoon, a nurse spoke to Mr Blackwood's community probation officer, who said that he had presented similarly in the community several years earlier when he was taking steroids. The nurse explained that the psychiatrist had applied for a hospital transfer. The nurse also spoke to Mr Blackwood's mother, who said that his family had not had any previous concerns about his mental health, apart from the episode with steroids. The nurse recorded that Mr Blackwood's mother said that he had been distressed during their last call and had said that he would die. (The nurse recorded this as 28 July, but we believe it was 21 July.) The nurse explained what support Mr Blackwood had received and his possible transfer to hospital. He said he would speak to his mother again the next day about her planned visit to see Mr Blackwood the following weekend.

99. An officer recorded that, at teatime, officers tried to give Mr Blackwood another meal. He spat at them when they tried to talk to him.

100. At around 8.00pm, a nurse went to the segregation unit to see Mr Blackwood. He was lying on his bed, naked, although he thought he had trousers on. She asked him if he wanted some water, but he declined it several times. She did not see any blood in the cell. She completed a Braden assessment, which measures the risk of a patient developing a pressure sore or ulcer. As part of the assessment (which rated Mr Blackwood at high risk of developing a sore), she assessed his sensory perception as "no impairment". The Braden Scale guidance states that this means that the patient "responds to verbal commands [and] has no sensory deficit that would limit ability to feel or voice pain or discomfort".

101. At 9.00pm, an officer recorded that he saw Mr Blackwood move when he checked him and he was lying on his front, naked. Another officer noted in the ACCT record that he checked Mr Blackwood on the hour throughout the night (contrary to national instructions which require checks to be at unpredictable times within the specified frequency). At 3.00am he recorded that he had responded to Mr Blackwood's cell bell. (The cell bell record indicates that Mr Blackwood's cell bell was pressed at 2.20am and 2.50am. The bell was reset after 33 seconds and 15 seconds on each occasion, which means it was answered in those times. In a statement to the police, the officer said that he had answered both bells.) The officer recorded that Mr Blackwood was lying on his bed moaning and would not speak to him. In his statement, he said that he thought Mr Blackwood was talking to someone in his cell and at 3.00am, Mr Blackwood was asleep on the floor next to the bed.

102. At 4.00am, the officer noted in the ACCT record that Mr Blackwood was lying face down on the floor, next to the bed. In his statement, he said that he spent longer than the other times observing Mr Blackwood, but he had not been concerned about him because of his previous sleeping patterns and behaviour. At 5.00am, he noted that Mr Blackwood was on the floor, and was quiet. He noted in the ACCT record that there had been noises and shouting from Mr Blackwood until 3.30am. In his statement, he said that he did not have any concerns.

103. At 6.00am, the officer checked Mr Blackwood again. He was still in the same position, and he mentioned this to the night orderly officer (the manager in charge of the operation of the prison) who was in the segregation unit at the time. She went to Mr Blackwood's cell, and banged on the door to try and get a response. When Mr Blackwood did not respond, she radioed other staff to attend because there was supposed to be four officers present to unlock him. The officer said that officers arrived moments later, and she opened the cell door. She tapped Mr Blackwood on the leg, but he did not move. A custodial manager arrived and entered the cell with her. He tapped Mr Blackwood's foot with his hand, and he realised that he was cold. They tried to move Mr Blackwood onto his back, and the manager realised that Mr Blackwood was dead, as he was not breathing and did not respond.

104. The custodial manager started chest compressions. A nurse recorded in the medical record that she responded to an emergency call for the healthcare responder at 6.00am. No one used a medical emergency code. When she arrived at the cell at 6.04am, Mr Blackwood was on the floor lying in urine. He was cold and she noted in his medical record that rigor mortis had already set in. However, she continued to attempt resuscitation, but had to send someone to bring oxygen, as there was none in the emergency bag. She attached a defibrillator, but it found no shockable heart rhythm.

105. A communications officer called an ambulance at 6.06am. The night orderly officer thought she had asked for an ambulance to be called, but she was not sure. Paramedics arrived at 6.15am, and took over resuscitation. At 6.52am, they declared that Mr Blackwood had died.

Contact with Mr Blackwood's family

106. At 8.30am, an officer was telephoned at home and asked to act as family liaison officer. He arrived at the prison at 9.30am.

107. The deputy governor, the officer and a prison chaplain left Nottingham at 10.20am to visit Mr Blackwood's his mother to inform her of his death. They arrived at around 11.00am, but no one answered the door. They tried several telephone numbers but could not get through to anyone. At 11.40am, a friend of Mr Blackwood's brother arrived and said that she was aware that Mr Blackwood had died. Mr Blackwood's brother then came out of the house and said he was going to collect his mother from work. Mr Blackwood's mother's brother-in-law then arrived and gave the officer her mobile number. The officer called Mr Blackwood's mother, who said she would return home. The deputy governor explained what had happened and offered condolences and support.

108. The officer remained in contact with Mr Blackwood's family until September when the family said they did not want any further contact. The prison offered a contribution to funeral costs in line with national instructions.

Support for prisoners and staff

109. A senior manager debriefed the staff involved in the emergency response, to give them the opportunity to discuss any issues arising and offer support. The night orderly officer said that she had not been happy with the support offered. The

care team did not attend the debrief and the night orderly officer said she did not receive any further support. There was no follow-up critical incident debrief, as should have happened.

110. The prison posted notices informing other prisoners of Mr Blackwood's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Blackwood's death.

Post-mortem report

111. A post-mortem examination found that Mr Blackwood had died as a result of a massive internal haemorrhage and burst duodenal ulcer. The pathologist noted that, other than tattoos on the upper chest and neck, there were no other external marks of note. Mr Blackwood's stomach and bowel contained a lot of fresh blood. A toxicology report found traces of new psychoactive substances in Mr Blackwood's blood and urine, and traces of ibuprofen in his urine. His weight was recorded as 75kg, one kilogram less than when he arrived at Nottingham.

Findings

Clinical care

112. The clinical reviewer found that some aspects of Mr Blackwood's care in prison were not equivalent to that he would have expected to receive in the community.

113. In April 2015, when Mr Blackwood complained that his lower back are was tender he said he had taken an overdose of ibuprofen and co-codamol. The GP considered that this might be caused by kidney problems and wanted to take blood tests but Mr Blackwood refused to give blood. He wanted an X-ray, which the GP did not consider was needed.

114. The next day, 9 April, Mr Blackwood said he had stomach pain and a nurse said he would review his clinical notes and find out if there was any plan of action about his lower back and stomach pain. There is no evidence that the nurse followed this up. The next day, Mr Blackwood said he was constipated and his stomach was swollen but the nurse examined him and found that his stomach was flat and not distended. On 11 April, he told another nurse that he had a bowel problem and the nurse said he would refer him to a GP. There is no record that a GP at Liverpool saw Mr Blackwood after that.

115. We cannot know whether the pain Mr Blackwood described at Liverpool was related to the ulcer and bleed that caused his death and note that, after 11 April, Mr Blackwood did not complain of any stomach related pain again. There is no record that he asked to see a GP after that and he had declined to cooperate with the GP's initial investigations into the pain. However, healthcare staff at Liverpool should have followed up his symptoms, as they said they would do. We make the following recommendation:

    The Head of Healthcare at Liverpool should ensure that nurses follow up prisoners' outstanding concerns about their health and refer them to a GP when necessary.

116. When Mr Blackwood arrived at Nottingham on 6 May, he had had no significant contact with anyone from the healthcare team at Liverpool for over two weeks. He did not disclose any stomach or bowel trouble to a nurse, who completed his reception health screen. She said she was not able to view his previous medical history on SystmOne, the electronic prison medical record. We recognise that had she seen the record, it is unlikely that this would have led to any further referral as Mr Blackwood did not identify any problem and did not complain of any further stomach problems while he was at Nottingham. However, it also meant that the nurse was unaware of his recent self-harm, which he did not mention.

117. SystmOne, used properly, should ensure inter-prison access to clinical records to promote continuity of care. It is dangerous to rely solely on an individual prisoner's account of his medical history. It is important that all those using SystmOne are trained and confident in its use. We make the following recommendation:

The Head of Healthcare at Nottingham should ensure that all healthcare staff are trained in the use of SystmOne and how to retrieve records to ensure appropriate continuity of care.

118. The clinical reviewer identified some other concerns about Mr Blackwood's treatment. He noted that Mr Blackwood had been prescribed ibuprofen for some time. This can cause adverse gastrointestinal symptoms, but there is no record that anyone had ever considered prescribing a proton pump inhibitor, to reduce gastric acid. Although Mr Blackwood was not eating or drinking regularly, there were no fluid or diet balance charts. There also appeared to be a lack of trained staff to make mental capacity assessments. He has made recommendations about these and other issues in his clinical review, which the Head of Healthcare will need to address.

119. The clinical reviewer noted that, once Mr Blackwood's mental health started to deteriorate, it was difficult for staff to assess him and he often refused to engage with them. The requirement for him to be unlocked by four officers, which we discuss below, also made assessments difficult. When healthcare staff were able to carry out clinical observations, Mr Blackwood refused to let them. On the morning of 1 August, Mr Blackwood would not allow a nurse to take his clinical observations. Later that day, officers moved him to a new cell as they were concerned about the unhygienic state of his cell. They showered Mr Blackwood but he again refused to let nurses take his clinical observations. On 3 August, the psychiatrist was concerned about Mr Blackwood's lack of diet and fluid intake. He wanted to do a physical assessment but said that this was not possible due to Mr Blackwood's mental state. A nurse fully examined Mr Blackwood's body for signs of injuries on 4 August, the day before he died, but she was unable to take his clinical observations, as he refused to cooperate.

120. In the light of Mr Blackwood's presentation, the primary focus of healthcare staff's attention was his mental health. We are satisfied that this was reasonable and there was little indication of any physical health problems. He was under the care of the primary and secondary mental health team and mental health nurses saw him frequently in the segregation unit. A consultant psychiatrist assessed him twice and promptly referred him to a medium secure hospital the second time he saw him. Although we consider he should have had an earlier mental capacity assessment to check whether he was capable of making decisions about his treatment and care, we consider that, overall, Mr Blackwood received an appropriate standard of mental health care at Nottingham.

121. The psychiatrist did not record whether he had considered there were any possible physical causes for Mr Blackwood's bizarre behaviour. NHS Choices refers to ten physical conditions that can cause psychosis, but these do not include stomach-related problems. While there is no record that healthcare staff considered whether there were any physical health issues that were masked by Mr Blackwood's apparent psychotic episode, we note that Mr Blackwood never complained of any pain, even at the times, when he was described as lucid. Sadly his mental health made it very difficult to assess him properly, but we consider that it would have been difficult for healthcare staff at Nottingham to

have identified Mr Blackwood's serious physical health condition and prevented his death.

Mr Blackwood's management in the segregation unit

122. Mr Blackwood was taken to the segregation unit after he was found with illicit items during a search. His segregation was reviewed as required.

123. On 21 July, Mr Blackwood refused to return to his cell. Officers used control and restraint techniques to return him to his cell and, subsequently, four officers were required to be present whenever his cell was unlocked. It is not clear from the segregation documents who made this decision. There is some reference to a risk assessment and an intelligence report of 21 July indicated that the senior management team had made the decision, but we have not seen a copy of the risk assessment to confirm this. Nor is there any record that the need for four officers to be present when Mr Blackwood's cell was unlocked was ever reviewed after 21 July.

124. Although it is possible that further reviews would have maintained this level of unlock, we are concerned that this meant there were times when staff were unable to unlock Mr Blackwood because there were not enough staff on duty in the segregation unit. This meant that healthcare staff could not always assess him appropriately (although we accept that when he was unlocked he usually refused to engage with staff) and it also affected decisions about whether he could be moved to the enhanced care area.

125. Requiring such a high level of staff to be present when unlocking a prisoner in the segregation unit can affect their care and mean that prisoners do not have access to an appropriate regime. When this is necessary, managers should ensure that the segregation unit is fully staffed to allow all prisoners a decent basic regime, including access to showers and time in the open air each day. We consider that risk assessments for additional staff for unlocking a prisoner should be authorised by a senior manager, with the reasons clearly recorded in the segregation records and in the prisoner's individual prison record. Risk assessments should be reviewed at least at each segregation review. We make the following recommendation:

    The Governor should ensure that decisions to increase the number of staff required to be present to unlock a cell are authorised by a manager, recorded appropriately and regularly reviewed.

126. On 24 July, the deputy governor and a nurse were concerned about Mr Blackwood's mental state and thought that the segregation unit was no longer an appropriate location for him. There is no inpatient unit at Nottingham but the nurse suggested a move to the enhanced care area, where there is a nurse on duty at all times. However, the deputy governor decided against the move, as there would be insufficient officers there to allow him to be unlocked and have an appropriate regime. Although the deputy governor accepted responsibility for this decision, she did not record the reasons and left it to the deputy governor to authorise his continuing segregation.

127. We do not consider that segregation units are appropriate environments for mentally ill prisoners but recognise that in the absence of a properly staffed inpatient unit, the options at Nottingham are limited. The lack of an alternative accommodation for mentally ill prisoners is a concern. We understand that it might have been difficult to manage Mr Blackwood in the enhanced care area without severely restricting the regime for other prisoners, but note that there were often insufficient officers in the segregation unit too. Staff told us that there often not enough officers in the unit to allow all segregated prisoners their basic regime entitlements every day.

128. We recognise that Mr Blackwood was being referred to a psychiatric hospital at the time he died, which would have been an appropriate location. While healthcare staff visited Mr Blackwood frequently, we are concerned that in the interim, there was no care and management plan to mitigate the risks of holding him in the segregation unit and to make sure he was managed appropriately and not left in unhygienic conditions for long periods before his admission to hospital. There is no evidence that his continued location in the segregation unit was reviewed, as should have happened, when staff began ACCT procedures on 4 August.

129. As well as the lack of a care plan, we are concerned that managers did not set a required level of checks, before the ACCT was opened, the day before he died. There is no mandatory national instruction setting out the required frequency of checks for prisoners segregated under Prison Rule 45, for good order or discipline, as Mr Blackwood was, but it is mandatory that all segregated prisoners should be checked at an agreed frequency.

130. Prison Service Order 1700, which governs segregation procedures, says, “All prisoners located in the segregation unit must be observed by an officer at a frequency which is relevant to the individual’s circumstances and will be based upon a case management approach. The observation level should be decided by the person authorising segregation. There are some prisoners that are familiar with segregation and may be at ease with it whilst a prisoner that is not familiar with it may need to be observed on a more regular basis which ideally would be at least hourly. All prisoners subject to Cellular Confinement must be observed at least hourly (unless on an open ACCT plan and this states more frequently)”. We consider that because of the concerns about Mr Blackwood’s health, and the possibility that he might have been taking drugs, he should have been observed at least hourly. We make the following recommendation:

The Governor should ensure that prisoners with complex mental health problems are held in the segregation unit only in exceptional circumstances and the reasons, including other options that were considered, should be recorded. Such prisoners should have a nominated manager responsible for coordinating their care with detailed care plans to inform their management and treatment and levels of observations which reflect their circumstances.

New psychoactive substances

131. We do not know whether the sudden deterioration in Mr Blackwood's mental health was due to his use of new psychoactive substances. On 28 July, a nurse considered that his presentation might be due to use of an illicit substance. Some officers also considered this was a possibility. When Mr Blackwood spoke to the psychiatrist on 29 July, he said that he had used Mamba, a new psychoactive substance, the day before. The psychiatrist considered that this was a plausible explanation for Mr Blackwood's behaviour.

132. Mr Blackwood told the psychiatrist that he used Mamba, a new psychoactive substance (NPS) freely when he had been on a standard wing in the prison. By this time, he had been in the segregation unit for more than three weeks. Although officers in the segregation unit told the psychiatrist that it was unlikely that Mr Blackwood had access to NPS there, one of the experienced segregation unit officers told the investigator that there had been time when they had suspected prisoners in the segregation unit were using such substances. Traces of synthetic cannabinoids were found in his Mr Blackwood's blood and urine after his death, which would suggest he had been using them in the segregation unit.

133. The use of NPS is an increasing problem in prisons. The Advisory Council on the Misuse of Drugs (the Government's independent statutory drug advisers) notes that the short term harms of NPS can include paranoia, psychosis and seizures and that their long term harms are often unknown. We consider it important that Nottingham does all it can to eradicate the use of new psychoactive substances, including in the segregation unit. We make the following recommendation:

The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances, and that staff are vigilant for signs of its use and are briefed about how to respond when prisoners appear to be under the influence of such substances.

Emergency response

134. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system based on the instruction. As is usual, Nottingham's local policy uses code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties. Calling an emergency medical code should automatically trigger the control room to call an ambulance, alert staff to the nature of the emergency and prompt them to bring appropriate emergency equipment.

135. A nurse recorded that she had responded for a call for "Hotel 1" (the radio sign for the healthcare first responder) to attend the segregation unit. No one used a code blue, as they should have done when it was clear that Mr Blackwood was not breathing. Officers and nurses responded immediately, which meant there was no delay in attending to Mr Blackwood. However, the control room did not

call an ambulance until six minutes later and there was no oxygen in the emergency bag.

136. An officer recorded that Mr Blackwood was cold when he touched him and a nurse noted that Mr Blackwood was cold and rigor mortis had already set in. However, a manager had started to attempt resuscitation and the nurse and the paramedics continued. The clinical reviewer considered that this was appropriate. While it is apparent from Mr Blackwood's condition that the delay in calling an ambulance and bringing oxygen, did not affect the outcome for him, in other emergencies this could be crucial. We make the following recommendation:

The Governor should ensure that that prison staff use the appropriate emergency medical code in a life threatening situation, that control room staff request an ambulance immediately and that staff take appropriate emergency equipment to the scene.

Family liaison

137. Mr Blackwood's' mother was concerned about the length of time it had taken to inform her of her son's death and that she had heard about it before the prison informed her. Prison Rule 22 states that the when a prisoner dies, the governor should inform next of kin "at once". Prison Service Instruction 64/2011 requires that where possible, the family liaison officer and another member of staff should visit the next of kin in person and that this should be done quickly to ensure that the prisoner's family does not hear of the death by other means.

138. Prisoners have access to official telephones and some have illicit mobile phones, which make it difficult to stop them informing their friends and families when someone dies. However, we consider it took too long to inform Mr Blackwood's mother. It was more than an hour and a half after Mr Blackwood had been declared dead, before anyone from the prison contacted the family liaison officer and it was three and a half hours before the staff left the prison to go to see Mr Blackwood's mother. We do not consider this meets the expectation of the Prison Rule or the Prison Service Instruction. We make the following recommendation:

The Governor should ensure that when a prisoner dies, the next of kin is informed without undue delay.

Critical Incident debrief

139. A manager held a hot debrief after Mr Blackwood's death but the night orderly officer said that she did not receive any support from the prison's care team. She said that she had asked for a critical incident debrief to be held, but none was organised. She told us this had also happened after a previous death at Nottingham.

140. PSI 08/2010 requires prisons to hold a critical incident debrief within five to ten day after a death. Part of the purpose is to ensure that staff have an opportunity to discuss the impact of what happened and to ensure that appropriate care and support is in place. We make the following recommendation:

The Governor should ensure that after a death at the prison, staff are supported in line with national instructions.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141