

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP  
Nottingham in December 2013**

## ***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 in December 2013 at HMP Nottingham. He died of peritonitis caused by a perforated duodenal ulcer and gastrointestinal bleeding. He was 46 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at the prison was conducted. HMP Nottingham cooperated fully with the investigation.

The man was remanded to Nottingham on Friday 13 December 2013. At a reception health screen a nurse noted he had been treated for a duodenal ulcer. Information about his mental health and substance misuse problems had been received in the prison, but was not taken into account. He did not see a GP that evening, although he was due to see one the following afternoon. However, on Saturday, he collapsed in his cell and was taken to hospital. He returned to the prison that evening, but without a hospital discharge summary. A nurse later noted that the hospital had investigated a possible perforated duodenal ulcer, but this had not shown up on an X-ray.

Despite the man reporting worsening pain over the weekend, no one called a doctor or took him back to hospital. A nurse made an appointment for him to see the GP on Monday 16 December, the day he was also due in court. On Sunday, he said he was ill and in pain, but only given paracetamol. Later that night he set fire to his cell in what appears to have been a cry for help. Officers extinguished the fire by inundating the cell with water and moved him to another cell, but left him in wet clothes for most of the night.

On 16 December, the man said he felt too unwell to attend court. Prison staff believed he was being deliberately difficult and forcibly stripped him of his prison clothes and dressed him for court. They then effectively dragged him onto the escort vehicle. An escort officer was unhappy with what had happened and insisted a nurse should examine him. The nurse later found him unresponsive and with no signs of life. He was taken to hospital by emergency ambulance, but pronounced dead when he arrived.

The clinical reviewer comments that the man's behaviour was that of a distressed man, who was in considerable pain and with mental health issues (and possibly withdrawing from drugs) trying to gain attention. Prison staff appear to have treated this as poor and non-compliant behaviour. Whatever the interpretation, their actions were inappropriate and I do not consider the use of force was lawful. There are also questions about his treatment at hospital and whether he was appropriately discharged on Saturday 14 December. These are outside my remit, but I have drawn the case to the attention of Nottingham University Hospitals NHS Trust. I agree with the clinical reviewer that the medical care he received at Nottingham fell short of that he could have expected in the community and that his death was potentially preventable.

The events leading up to the man's death are shocking. There were serious and systemic procedural failures, but there was also a basic lack of care. Too many staff appear to have acted thoughtlessly and without appropriate respect and regard to his wellbeing. Senior Prison Service managers need to take robust action to satisfy themselves that lessons are learned from this tragic case to ensure such a litany of failures cannot be repeated.

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

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

**January 2015**

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## SUMMARY

1. The man was arrested on 8 December 2013. During his police interview he became ill and was taken to hospital, where he remained until 12 December. On Friday 13 December, he appeared in court and was remanded to HMP Nottingham. When he arrived at the prison, he told the reception nurse that he had a history of a duodenal ulcer and had no (usable) main arteries in either leg, but denied previous drug use. The nurse referred him for a mental health assessment. He did not see a doctor that evening, but the nurse referred him to see the doctor for a medication review the next afternoon. Information about his mental health and substance misuse problems was not taken into consideration
2. The next day, Saturday 14 December, at 2.10pm, before the man had seen the GP, an officer found him collapsed in his cell. He was taken by ambulance to hospital. After a series of blood tests, and an X-ray of his abdomen, the hospital discharged him. As the hospital had not sent a discharge summary or advice about his treatment, a prison nurse spoke to a hospital doctor. She noted that the hospital had investigated the possibility of him having a perforated duodenal ulcer, but could find no evidence of this. He should have been prescribed dihydrocodeine (used for moderate to severe pain.) The nurse reviewed him later that night and gave him paracetamol for pain relief. She thought he looked unwell and took his clinical observations, which were satisfactory. She did not call an out of hours doctor or consider sending him back to hospital. She made an appointment for him to see the prison GP on Monday 16 December, although he was also due in court that day.
3. On Sunday 15 December, the man did not collect his lunch. He said he felt unwell, but no member of healthcare staff saw him. He did not come out of his cell during the day and his evening meal was taken to him. At 9.25pm that night, he set fire to his cell. He ignored requests to move away from the fire when officers used a hose to put the fire out so he got wet. Officers had to carry him out onto the landing and said he became floppy and a dead weight. He asked to be taken to hospital. A nurse attended and noted that his behaviour was odd. He held his breath while being examined which hindered checks and repeatedly said, "Help me. Help me". He appeared to have suffered no ill effects from the fire and officers moved him to the cell next door.
4. At 1.05am, the next morning the man said that he had been sick in his cell, but the night officer did not call the nurse. He subsequently pressed his cell bell twice more and asked for medication. The night officer did not ask the nurse to see him, but told him that he was not due any medication and would have to wait till the morning and speak to the nurse in reception. The nurse had assessed him as fit to attend court, but she did not see him in person to make this assessment or review it after the fire.
5. At 7.05am, the man told officers that he was too unwell to go to court. The night orderly officer spoke to him to encourage him to go but, after taking a

few steps from his cell, he fell to the floor. Prison staff believed that he was pretending to be ill and forcibly carried him through to a holding room in the healthcare area where a nurse said that a doctor would see him before he went to court. However, before a doctor had seen him, two officers carried him to the search area, forcibly stripped him and changed him into his clothes for court. At 7.50am, the officers carried him under his arms to the escort van. His legs were dragging behind.

6. A GEO Amey prison custody officer was unhappy at how the man had been taken to the van and was worried about his appearance. She insisted that a nurse should examine him before they left the prison. At about 8.07am, a nurse came and found him slumped and unresponsive in the cell compartment on the van. He could find no signs of life. The nurse called an emergency code blue and began cardiopulmonary resuscitation. An ambulance was called immediately. Paramedics arrived at 8.15am and a second ambulance arrived five minutes later. Paramedics administered emergency treatment and took him to hospital. At 9.13am, the hospital confirmed he had died.
7. The investigation has identified that a number of key opportunities to help the man were missed during his short time at the prison. On the morning of his death, there were clear signs which should have prompted urgent medical treatment. The standard of healthcare he received at Nottingham fell short of that he could have expected in the community. We consider the use of force, effectively to drag him to the escort van, was unjustified and therefore not lawful. We make nine recommendations.

## THE INVESTIGATION PROCESS

8. 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.
9. The investigator obtained copies of the man's prison medical records, relevant extracts from his prison records and CCTV footage covering the events inside the prison and the escort vehicle on 16 December.
10. The Ombudsman's investigation was suspended on 15 January 2014, for police enquiries and re-opened on 22 April 2014, after the Crown Prosecution Service decided against a criminal prosecution.
11. The investigator interviewed 20 members of staff and one prisoner at Nottingham in May and June. She gave the Head of Operations initial feedback about the preliminary findings of the investigation and followed this up in writing.
12. NHS England commissioned a clinical reviewer to assess the man's clinical care at the prison.
13. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
14. One of the Ombudsman's family liaison officers contacted the man's father, his partner and daughter to explain the investigation. His partner told us that she had received good support from the prison after his death, but she had serious concerns about what had taken place beforehand. She was concerned that he would have been in obvious pain and asked how he had even got onto the escort van before he died. His daughter asked whether there were delays responding to his symptoms and whether he should have been taken to hospital sooner.
15. The man's family received a copy of the draft report. The solicitors representing the family indicated that they were satisfied with the findings.

## **HMP NOTTINGHAM**

16. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire. It holds remanded and sentenced men. Nottinghamshire Healthcare Trust provides healthcare services at the prison. There is no inpatient healthcare unit. Prisoners who need nursing care are located in what is known as an enhanced care area (ECA) on F wing, where nurses are on duty 24 hours a day. GP clinics are held on weekday mornings and there is a Saturday afternoon clinic for new receptions and urgent appointments. There is a GP in reception in the evenings and an out of hours service.

## **HM Inspectorate of Prisons**

17. The most recent inspection of Nottingham was in February 2013. The Inspectorate found that there had been some improvements in healthcare and pharmacy services since the last inspection. There was effective joint care planning between the substance use and psychosocial teams and good exchange of expertise between the mental health and substance use teams to support dual diagnosis needs. There were no day care services, but the mental health team provided one-to-one work to support those having difficulty in coping.
18. Inspectors noted that too few staff had completed the safer custody awareness training and assessment, care in custody and teamwork (ACCT) case reviews were not always adequately multidisciplinary. The care plans for prisoners were individualised but the quality of recording of the interactions with those on ACCT documents varied widely. The Inspectorate noted that significant steps were taken to improve the safety of vulnerable prisoners. Initial assessment and first night procedures had improved, but induction for vulnerable prisoners remained poor. Inspectors said that better oversight of the use of force was needed. The use of force committee was expected to meet monthly, but had not done so for some time. A weekly quality control meeting to review use of force documentation was poorly attended.

## **Independent Monitoring Board**

19. Each prison in England and Wales 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 noted that problems had occurred with prisoners arriving late on Friday evenings without their medication. This sometimes resulted in essential drug therapy being interrupted for up to four days. The IMB noted that this was particularly concerning for those with mental illnesses.

## **Previous deaths**

20. The man was the fourth prisoner to die from natural causes in the last two years at Nottingham. There were no similarities with the circumstances of the previous cases.

## KEY EVENTS

21. The man was arrested for serious offences on 8 December 2013. He had been on a methadone maintenance programme in the community. A consultant psychiatrist assessed him on 8 December and found no acute formal mental illness or disorder to suggest he needed to be held under the Mental Health Act. A police doctor prescribed dihydrocodeine on 8 and 9 December and a number of other medications. Dihydrocodeine is pain relief medication, but is often used to treat drug users in situations where methadone is seen as hazardous, such as in police custody. It is not clear from the records whether this was prescribed as an alternative to methadone or because he had reported being in pain. When the police were interviewing him, he became unwell. He vomited a dark fluid and was taken to hospital. The hospital discharged him back to police custody on 12 December.
22. On Friday 13 December, the man appeared at Magistrates Court and was remanded to HMP Nottingham. He was scheduled to appear at Crown Court on 16 December. His police custody record and prison person escort record (PER) from Court to Nottingham Prison noted he was a methadone user and that he had problems with his legs, related to previous drug use.
23. At 4.14pm the same day, the Derby Criminal Justice Mental Health Team (CJMHT) faxed a letter to the prison. (CJMHT is a service provided by the NHS for people with mental health issues who have come into contact with the criminal justice system through the police or courts.) The letter said that the man had been admitted to a psychiatric hospital in November and had been discharged with a diagnosis of mental and behavioural disorder due to poly-substance misuse. A prison mental health practitioner picked up the fax. He told us that, before he left the prison at 5.00pm, he went to the healthcare department, with a colleague and handed the faxed letter directly to a nurse. He did not scan the letter on to SystemOne (the computerised medical record system). The nurse disputed this account and said that he had never seen the letter. The faxed letter was later found on 16 December, in a tray in the healthcare department, after the man had died.
24. The nurse carried out the man's reception health screen at 6.15pm on 13 December. As well as not having the faxed letter from the criminal justice mental health team, he said he did not have the police custody record or PER which indicated the man's methadone use and his medical treatment when he was in police custody. He told the nurse that he had a history of a duodenal ulcer, had no (useable) main arteries in either leg and was deaf in his left ear. He mentioned a previous stay at the Radbourne Unit, a mental health unit at hospital. However, he would not provide any further details and denied any substance misuse.
25. The nurse noted that the man had said he was prescribed the following medications: omeprazole (to reduce stomach acid), propranolol (for anxiety), zopiclone (to aid sleep), nefopam (for pain) and risperidone (an antipsychotic)

medication). He said that he did not take the risperidone as he did not need it. (He had been prescribed these medications in police custody.)

26. GP reception clinics at Nottingham are held on weekday mornings and Saturday afternoons so the man did not see a GP that night. The nurse referred him to be seen by the prison GP for a medication review the next day. He also referred him to the prison mental health team.
27. The nurse assessed the man as fit for normal location and work. A cell sharing risk assessment concluded that he was high risk (due to the charges against him) and he was located in a single cell.

### **Saturday 14 December**

28. At 12.05pm on 14 December, a healthcare assistant saw the man at the treatment hatch. He had come to collect medication, but the GP had not yet prescribed any for him. The healthcare assistant said he looked pale and said he had a headache. He did not give him anything for the headache.
29. At 2.10pm, an officer (it is not clear who this was) found the man collapsed in his cell. The officer called a code blue (an emergency medical response code which indicates that a prisoner is unconscious or has breathing problems). A nurse arrived a few minutes later and found the officer had put him into the recovery position on the floor of his cell. He was breathing unaided, but only mumbled responses to questions. The nurse asked for an ambulance to be called. The prison's radio log shows that an ambulance was called at 2.20pm, ten minutes after the code blue.
30. The nurse examined the man and checked his blood pressure and blood oxygen saturation. His temperature was 37.6 degrees which was slightly high. The nurse noticed that his left arm had marks that resembled recent needle punctures. He was concerned that his breathing was faster than expected for someone lying on the floor. He told us that the medical observations were not concerning, but he was worried that he looked very unwell which was why he called an ambulance.
31. The paramedics arrived at 2.46pm and at 3.35pm took the man to hospital. He was escorted by three prison officers and restrained by double cuffs. As it was possible that his collapse was self-induced, an officer began Prison Service suicide and self-harm prevention procedures, (known as ACCT). ACCT procedures continued throughout his time at Nottingham.
32. A hospital doctor examined the man, who was initially unresponsive. Later, he told hospital staff that he had pain in his stomach, legs, back and had suffered with a previous duodenal ulcer. He described his pain level as nine out of ten. Hospital staff gave him pain relief and he had a series of blood tests (including a screening test for drugs) and an X-ray of his abdomen. He was discharged from hospital at 7.12pm. The hospital gave no discharge summary, medication or advice about his treatment. (The hospital records

indicate that no worrying cause for the pain was identified and that he had been given advice about when he should seek further medical help.)

33. At 9.00pm, a nurse went to see the man in his cell and then spoke to a doctor at the hospital. She noted that the doctor had said there was a query over whether he had a perforated duodenal ulcer, but they could find no evidence of this after an X-ray, and that he should have been discharged with dihydrocodeine for pain relief. The man told the nurse that he continued to have pain in his abdomen and the nurse said that she would review his pain in one hour.
34. The man should have had a medication review with the prison GP that day, but he was out at hospital at the time. One of the prison GPs noted in his medical record that he had a high prescribed dose of omeprazole. He did not prescribe him any medication.
35. A nurse reviewed the man again at 11.20pm. As there was no doctor to prescribe any other pain relief, she gave him paracetamol. She told us that that he looked unwell that night. His temperature was 37.7 degrees which was slightly high. However, she considered his clinical observations were satisfactory. As he had just been discharged from hospital earlier that evening she decided to make an appointment for him to see the prison GP on Monday morning (16 December) rather than calling the out of hours doctor or arranging for him to go back to the hospital. She said that she had told the night orderly officer that he needed to see the doctor on Monday.

### **Sunday 15 December**

36. The man's ACCT document shows that, on Sunday, he was not able to engage fully. Staff monitored him and entries in his ACCT document show that he was lying in bed, apparently asleep, for most of the day. At 10.25am, an officer attempted to interview him for an ACCT assessment, but noted that he was incoherent and not able to engage and stated that he was in pain. At 12.00pm, a Senior Officer recorded that he had been unable to collect his lunch and 'claims in pain (gall bladder).' He noted that healthcare staff were informed. At 12.25pm an entry indicated that he said he was suffering from stomach cramps and he was given 1g paracetamol. A note five minutes later, said that he had been informed that he should see healthcare staff at tea time for more medication. However, he did not come out of his cell again during the day and staff took him a meal at 4.45pm. After that, he continued to be observed lying on his bed, apparently asleep. There is nothing entered in his clinical record that day to indicate that a nurse or doctor reviewed him and checked his level of pain.
37. At 9.25pm, the man set fire to the chair in his cell using sugar sachets and a rolled up bed sheet. The night orderly officer, two officers and an operational support grade (OSG) went to his cell. He remained lying on his bed and would not move away from the fire when asked. As a result, he got wet when officers used a hose through the inundation point in the cell door to put out the fire. The officers then went into the cell and carried him out to the landing.

38. Two nurses attended and found the man lying on the landing floor. The officers tried to lift him to a sitting position to help the nurses to examine him but they said he was floppy and a dead weight. He repeatedly said, "Help me. Help me." One nurse asked how they could help, but he just repeated, "Help me." The night orderly officer said that he kept asking to go to hospital.
39. The nurse tried to measure the man's oxygen saturation levels but he held his breath, which caused his oxygen levels to reduce. She then placed an oxygen mask on his face to make him believe he was receiving oxygen, but turned the supply off. He then began to breathe normally and his oxygen levels returned to normal. She thought his behaviour was odd, but he appeared to have suffered no ill effect from the fire. Officers moved him to the cell next door.
40. The OSG went to observe the man for ACCT checks at 10.40pm and 11.20pm but each time he did not respond. The night orderly officer opened the cell to check on him both times and he then responded.

#### **Monday 16 December**

41. At 1.05am, the OSG checked the man, who told him that he had vomited in his cell. The OSG said he could not see any vomit and he did not call a nurse. (Subsequent police photographs show a splatter of vomit like substance that appears to contain blood.)
42. At 3.30am, the man pressed his cell bell and asked for medication. It is not clear from the record what medication he wanted and whether this was for pain. An officer told him that he was not due any medication. She recorded in the ACCT document, "Prisoner is really quick activating his bell and getting back into bed considering earlier in the night he said he was dying".
43. The man pressed his cell bell again at 5.25am and asked for medication. Again, it is not clear from the record what medication he wanted and whether this was for pain. The OSG told him to speak to the nurse in reception before he went to court later that morning.
44. During the night of 15/16 December, a nurse completed assessments for all prisoners due to go to court on the morning of 16 December. She assessed him as fit to attend, although he had still not seen a GP.
45. At 5.30am, the night orderly officer took the man some dry clothes, as his were still wet from when the cell fire had been put out. He reminded him he was due to visit court that day.
46. At 7.05am, the night orderly officer asked two morning shift officers to attend the man's cell as he had been told that he was refusing to go to court. Officer A noticed that he looked unkempt. He complained to Officer B that he had pains in his stomach and legs. The officers thought it was strange that the man said he was unable to move his legs, but he was swinging them back

and forward at the same time as he sat on the bed. He said that he wanted to go to court to prove his innocence, but was unable to as he was unwell. He pulled his jogging bottoms down to show the officers his legs and then said he had a pain in his groin and started to pull his boxer shorts down. The officers told him they were not medically trained and requested a nurse to attend to examine him.

47. The night orderly officer then arrived on the wing and cancelled the request for a nurse. He said that he would resolve the issue with the man, without the need for a nurse to attend. An officer and Custodial Manager 1 also attended. The night orderly officer went into the cell. He told the investigator that he could not recall what he said to him. A few minutes later, the man left the cell and walked along the wing, using the wall and fixtures to support himself. CCTV footage shows that he took about seven to eight steps and then fell to the floor.
48. An officer and the night orderly officer picked the man up under his arms and carried him to the edge of the wing with his legs dragging behind him. The custodial manager then took over from the night orderly officer and Officer B to get a nurse to meet them in healthcare.
49. All prisoners due to attend court have to pass through the healthcare department on the way to reception. If they need prescribed medication they stay there until it is administered, otherwise they go straight through to reception. The healthcare area is open plan with two separate holding rooms. When they arrived in the healthcare area a nurse directed the man and the four officers into one of the holding rooms. The nurse knew that he had been booked for a GP appointment that morning and told him that a GP would see him before he left for court. He said the officers were present when he told him this.
50. The nurse did not examine the man and left him alone sitting on the bench in the holding room. He asked another nurse, the nurse in charge, to check on him on his way to the day room where healthcare staff were waiting for the morning handover. When the nurse looked in on him, he was sitting on the floor leaning against the bench.
51. At 7.30am, GEO Amey prison custody officers (PCO) arrived at the prison to take prisoners who were due to attend court in Derby. PCO 1 said that reception officers told them that a prisoner was refusing to walk to the van and would be carried on. They were briefed about what had happened with the man over the weekend, including his attendance at hospital. She told us that officers in reception believed that he was playing up and that there was nothing wrong with him.
52. Custodial Manager 2 updated another custodial manager when she arrived on duty at 7.30am that morning to manage the reception area. She said that the man had been disruptive over the weekend. An officer told her that he was lying on the floor in the holding room and was due to go on the van to Derby which would be the first escort vehicle to leave the prison that morning.

53. Custodial Manager 2 could not find the nurse and telephoned a Principal Officer (PO) for advice. She said that the man was lying on the floor of the healthcare holding room and the escort van was waiting to depart. The PO and Custodial Manager 1 went to see him and the PO told him that he needed to go to court. He said that the man made eye contact and mumbled something, but he could not understand what he said. Despite being present when the nurse told him that he would see a GP before court, Custodial Manager 1 said that he was not aware of this. The officers believed he was being non-compliant and picked him up and carried him in the same manner as before, by supporting him under his arms, out of the healthcare holding room to the reception area. A few minutes later, a doctor arrived to see the man, but could not find him as the officers had moved him to the reception search area ready to go on the escort van.
54. Two officers and a Senior Officer were in the search area that morning and had been told that the man was 'passively non-compliant' and had refused to go to court. The SO told us that as prisoners have to come through the healthcare area before they get to the reception search area, there is an assumption that they are fit to attend court.
55. The PO and Custodial Manager 1 carried the man into the search area and placed him on the floor. He lay on the floor and did not move. He was lifted up to a sitting position and Officer 1 stood behind his back to support him so he would not fall to the floor. The officer said that he looked very grey. He would not undress, so the officers removed his clothes. Custodial Manager 1 said they left his boxer shorts on but he 'checked around them' to make sure he had no concealed items. The officers dressed him in his clothes for court.
56. As officers believed the man was being deliberately non-compliant they decided to put him on the escort van before the other prisoners. CCTV footage shows PCO 2 open cell number three on the van to prepare for his arrival. At around 7.50am, Custodial Manager 1 and the PO picked the man up under his arms and carried him out of reception. Two officers were walking behind. The SO followed a few minutes later. The CCTV shows the man was carried to the escort van under his arms with his feet dragging behind him. The SO and Officer 2 lifted his legs to help get him on to the van. Officer 1 continued to walk behind. He was motionless and did not resist being carried onto the van. Custodial Manager 1 and the PO put him into cell number three. PCO 2 was unable to close the cell door as the man's feet were protruding. The PO put the man's legs inside the cell and tried to hold the door shut with his foot while the door was locked. As the door shut PCO 2 told us she heard him say, "Help me. Help me." She looked through the cell window and as he was on the floor asked Custodial Manager 1 and the PO to position the man properly on the seat, otherwise it was not safe to transport him.
57. PCO 2 opened the cell door and Custodial Manager 1 asked the man to get up. As he did not move, he and the PO lifted the man onto the seat. Custodial Manager 1 told us that the man resisted and pulled off his tie as

they pulled him up. He forcibly lifted him onto the seat and used his knee and body weight to keep him sitting on the seat before the door was shut.

58. PCO 2 was unhappy about how the man had been placed on the escort vehicle and was worried about his appearance. She went back to the reception area and told prison staff that she wanted a nurse to examine the man before they left. PCO 1 remained on the van. CCTV footage shows that she was standing by the side door and checked the man through the cell observation panel twice. She said that the man was sitting and leaning to his right side with his head down. His eyes were open, but he was looking down.
59. While PCO 2 was in reception she was given the man's ACCT document and Person Escort Record. Before this, she and her colleague had not known that he was subject to ACCT monitoring. This had not been mentioned on the escort record and prison staff added this at her request.
60. At about 8.07am, a nurse arrived at the escort van. Three other prisoners were also on the van. When the man's door was opened he was sitting in the seat with his eyes open, apparently lifeless. His pupils were fixed and dilated and there were no signs of life. The nurse pulled him out of the cell onto the floor of the van, called a code blue emergency and began cardiopulmonary resuscitation. Records show that the code blue was called at 8.09am and an ambulance was called immediately.
61. At 8.10am, another nurse arrived at the van with the emergency bag. The first nurse and Custodial Manager 1 were continuing to attempt resuscitation. The second nurse removed the man's shirt and attached a defibrillator, which detected no heart rhythm and advised no shock. The first nurse and the Custodial Manager continued cardiopulmonary resuscitation until paramedics arrived at 8.15am. A second ambulance arrived five minutes later. The paramedics administered adrenaline and saline and then took him to hospital at 8.39am. He was pronounced dead on arrival at 9.13am.

### **Liaison with the man's family**

62. The prison was unable to contact the man's father, his nominated next of kin, as he was away on holiday. They therefore decided to inform his partner of his death. A prison family liaison officer and a Detective Sergeant visited her home at 1.50pm the same day. They informed her of his death and offered support and guidance. The funeral was held on 13 January 2014. The prison contributed towards the funeral costs, in line with national policy.

### **Support for staff and prisoners**

63. A debrief session was held for all the staff involved to discuss what had happened that day, to discuss any concerns and offer support. A Governor's notice informed staff and prisoners of the man's death and offered support. Prisoners identified as at risk of suicide and self-harm were reviewed in case they had been adversely affected by the news of his death.

## **Post-mortem**

64. The post-mortem report showed the cause of death to be peritonitis (inflammation of the abdomen's lining), a perforated duodenal ulcer and upper gastro-intestinal bleeding, secondary to haemorrhagic oesophagitis (bleeding and inflammation of the oesophagus).

## ISSUES

### Clinical care

65. The clinical reviewer considered that the man's death was potentially preventable. He had physical, mental and drug misuse problems and these all contributed to his death in different ways. He found that better record keeping and transfer of information would have made staff more aware of his risks and vulnerabilities. On the morning of his death, there were clear indications of his health problems which were overlooked or misinterpreted. Had these been acted on, this might have led to prompt medical treatment which could have increased his chances of survival. We agree with the clinical reviewer, that his clinical care fell short of that he could have expected in the community and the standard of healthcare he received at the prison is a serious concern. The clinical reviewer also had some questions about his treatment in hospital. This is outside the remit of this investigation but we have drawn the case to the attention of Nottingham University Hospitals NHS Trust.

#### *Reception health screen*

66. The nurse who carried out the man's reception health screen told us that the only information he had before his reception health screen was his cell sharing risk assessment (CSRA) which is used to assess the risk of violence towards a prisoner sharing a cell. The information from his police custody record and Person Escort Record (PER) about his drug use and mental health history was not on the CSRA and he said he was not given the PER or police custody record. He said that he had not seen the faxed letter from the Criminal Justice Mental Health Team outlining the man's mental health and substance misuse problems and there is no reference to these in his reception screen.
67. The man denied any previous drug use and the nurse said he did not appear to be withdrawing from drugs when he arrived at the prison. He therefore did not refer him to the substance misuse team. He told us that he felt it was wrong to make an assumption of drug use based on his claim of a lack of useable arteries in his legs. The clinical reviewer commented that this, and the presence of puncture marks on his arms, (which were noticed later) should have been clear clues to his drug taking. He noted that, although some relevant medical history was picked up at the reception screening, other significant factors were missed.
68. The man's reception health screen was at 6.15pm, two hours after the faxed letter about his mental health and drug use was received. This contained information highly relevant to his clinical condition. If the information had been considered at the reception health screen, his mental health and drug use history would have been better understood and should have led to an assessment and appropriate medication for his mental health and substance misuse problems.

69. It is unclear if some of the man's presentation over the weekend was as a result of withdrawal from drugs, mental health problems, or was because of the considerable pain he would have experienced from a perforated duodenal ulcer. The clinical reviewer considered that there is no doubt that, untreated, each of these would have caused him considerable distress, pain and possible behavioural changes.
70. The nurse said that he started the reception health screens for new arrivals at about 4.00pm on 13 December, which was before the fax arrived. He said he did not recall seeing the mental health nurse that day, who said he had passed him the letter, and that he had only become aware of the letter when it was shown to him on 16 December, after the man's death. A nurse said that she had gone to the healthcare department with the mental health nurse that afternoon and he had passed some documents over. She was unable to say whether or not he had passed the letter to the nurse. It is not possible for us to know what happened with the letter, but there should be a clear and efficient method of ensuring such important information is shared without delay, so that nurses making assessments in reception have all available information.
71. There was also important information in the man's Person Escort Record and police custody record about his health and substance misuse problems which the nurse would have needed, in order to complete an appropriate assessment, including about his risk of harm to himself and others. These documents were not passed to him. Prison Service Instruction (PSI) 74/2011 about procedures for early days in custody, contains mandatory requirements for the PER and other available documents to be examined to assess the risk of self-harm and that all relevant information available about the prisoner should be noted in the appropriate record, and forwarded to other staff as necessary. It says that actions taken in relation to this information must also be recorded and other relevant departments and agencies informed. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all available information about a prisoner's health and risks is recorded and shared quickly with all staff responsible for assessing the prisoner.**

#### *Medical care*

72. The man arrived at Nottingham late on a Friday and was only in prison for three days before he died. He was prescribed a number of medications which he received in police custody but never received any of his prescribed medication at Nottingham. This appears to be because he missed his Saturday afternoon GP appointment for a medication review as he was at hospital at the time. On Saturday evening, a nurse established that he should have been discharged with dihydrocodeine for pain relief. As there was no medical cover to complete a prescription she gave him paracetamol. She did not use the out of hours GP service and said that the on-call service would give telephone advice, but would not attend the prison during the evening or

at the weekend. If a clinical examination was required a prisoner would normally be transferred to hospital. The Head of Healthcare agreed that the service was largely a telephone service, but it would be for the clinical judgement of the GP whether or not to attend the prison. She said that the GP would come in for urgent prescriptions.

73. The clinical reviewer noted that nurses took and recorded observations on Saturday. On two occasions, the man's temperature was noted to be raised. The first time, at 2.15pm on 14 December, a nurse called an ambulance and he was taken to hospital. The nurse said that he was concerned about his appearance and breathing, rather than his temperature and other clinical observations. At 11.20pm, after he had returned from hospital, a nurse noted he had a slightly raised temperature, but did not consider it was necessary to take any action as he had been seen by clinicians at hospital and discharged just a few hours earlier. The clinical reviewer says that even a modest increase in temperature could occur if there had been some leakage from a ruptured ulcer and subsequent inflammation. He noted that the results of the observations were perhaps relied on too heavily, rather than an assessment of his overall clinical condition and history.
74. Although observations were taken on Saturday, we are concerned that there are no clinical entries in the man's medical records for the whole of the daytime of Sunday 15 December and that he was not reviewed by a nurse or a doctor that day, despite his complex medical history. He continued to report pain and did not leave his cell during the day. He was so unwell he was unable to be interviewed for an ACCT assessment. He was never prescribed any medication.
75. The clinical reviewer commented that there do not appear to be adequate arrangements for medical review by a doctor out of hours at Nottingham, especially at weekends, and this is unsatisfactory. However, we note that no one called the out of hours service for advice when the man missed his Saturday GP appointment and had not been prescribed any medication. Instead, the nurse made him an appointment to see a GP on Monday. We consider that a member of healthcare staff should have reviewed him on Sunday, taken observations and ensured that he received his prescribed medication and any necessary pain relief. We make the following recommendations:

**The Head of Healthcare should ensure that prisoners receive all necessary prescribed medication and adequate pain relief, as soon as possible after arrival, using the out of hours GP service if necessary.**

**The Head of Healthcare should ensure that prisoners with complex medical histories continue to be reviewed and monitored by healthcare staff at least daily after being discharged from hospital when they report continuing pain and other concerning symptoms.**

## *Mental health*

76. During his reception health screen, the man disclosed a previous stay at a mental health unit and said he was not taking the anti-psychotic medication which his community GP had prescribed. A nurse referred him to the prison mental health team, but not as a matter of urgency. The brief time he was in the prison meant that no one from the mental health team saw him before he died.
77. The man exhibited some behaviour which was described as odd while he was at Nottingham. When he set fire to his cell on Sunday evening, he kept ringing his emergency bell and then getting back into bed beside the fire. He seemed to be reluctant to assist with being evacuated from the cell. When two nurses examined him he called out for help, but was unable to explain why he needed help. One nurse tried to measure his oxygen saturation, but he held his breath causing his oxygen levels to drop. He agreed that the man's behaviour was odd but took no further action. At interview, the other nurse could not recall if she had been aware of his mental health referral at the time. On the Monday morning, he complained that he had pain in his legs and was unable to move them, but at the same time was swinging them back and forward. Two officers considered this behaviour was strange.
78. Although a number of staff had witnessed what they described as odd behaviour, and knew something of his health problems, they all assumed that the man's behaviour was deliberate non-compliance. (A disciplinary charge was prepared in respect of the cell fire rather than it being regarded as an act of self-harm.) He was also being monitored under ACCT suicide and self-harm prevention procedures at the time yet staff did not appear to identify any particular concerns. The ACCT assessment interview on Sunday morning had been cancelled as he was unwell and in pain and reported to be incoherent. The clinical reviewer considers that the cell fire on 15 December was the action of a distressed man trying to gain attention. He commented that "unfortunately this was interpreted as attention seeking behaviour but in retrospect the distress may well have been caused by the on-going mental health issues and significant symptoms of drug withdrawal". It is very likely that he was in considerable pain at this time and that this was the reason he constantly asked for help and to go to hospital.
79. The Head of Healthcare told us that primary care general nursing staff do not receive any specific training in mental health, other than risk and suicide awareness training. The clinical reviewer says that, with better mental health awareness, when nurses saw the man behaving strangely after the cell fire, they might have interpreted his behaviour differently and not merely assumed he was faking. Prison officers also told us that they did not receive any training in mental health awareness. Prison and healthcare staff need to be aware that difficult or challenging behaviour is sometimes the only way distressed individuals can communicate. The clinical reviewer considered that better recognition of his vulnerability should have ensured better observation and review. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff receive mental health awareness training to enable them to better identify signs and symptoms of mental illness and vulnerability.**

### **The man's fitness for court**

80. A nurse told us that healthcare staff review SystemOne (computerised medical records) when deciding whether a prisoner is fit to attend court. They do not see each individual prisoner. This is usually done the day or the night before the prisoner is due to appear in court. If no concerns are noted in the records then they are assessed as fit for court and the nurse signs the record which is taken to the reception area ready for the next day.
81. The nurse examined the man on Saturday evening after he had been discharged from hospital and had booked him a GP appointment for Monday 16 December, the day he was due to appear in court. On Sunday evening, she assessed him as fit for court before he set fire to his cell. She did not review his assessment later. She told us that, on reflection, she should have amended his papers to show he was not fit for court until he had been assessed by the GP.
82. Officers who went to the man's cell on the morning of 16 December asked for a nurse to attend to assess him as he said he was too unwell to go to court. We consider this was the correct action. However, the orderly officer cancelled the request as he believed it was not necessary. When officers arrived in the healthcare area on the way to reception, a nurse told prison staff that the prison GP should see him before he went to court. A prison doctor said that GPs normally see prisoners from around 8.10am onwards. The man arrived in the healthcare unit at 7.50am. A few minutes later, the doctor went to find him, but he had already been moved to the search area ready to be placed on the van so missed this further opportunity for assessment. The man was then forcibly taken to the escort vehicle.
83. We are concerned that there was no proper assessment of whether the man was fit to attend court. We accept that for most prisoners, who have no significant or acute healthcare issues, an assessment on the records will be appropriate. However, this needs to be assessed if events change. His assessment should at least have been reviewed after the events of the cell fire. When a prisoner reports being unwell after an assessment on the records, the previous fitted assessment cannot be relied on. The next morning when the man reported being too unwell to attend court, a doctor or nurse should have assessed him in person and judged him fit to attend court before officers decided to take him to the escort van. It is clear that he was extremely sick and several opportunities for him to be medically assessed were ignored. We make the following recommendation:

**The Head of Healthcare should ensure that assessments of prisoners judged fit to attend court are reviewed and the prisoner assessed in**

**person when there is a significant change of circumstances or when the prisoner subsequently reports being too ill to attend.**

### **Use of force and the events of 16 December**

84. The term 'use of force' means any type of physical intervention used on another person. Prison Service Order (PSO) 1600 states that use of force will only be justified, and therefore lawful, if four key principles are observed. It must be necessary, reasonable in the circumstances, no more force than is necessary should be used and it should be proportionate to the seriousness of the circumstances.
85. The PSO says that the interpretation of what is reasonable is a matter of fact to be decided in each individual case. Each set of circumstances are unique and are to be judged on their own merits. Factors to be taken into account when deciding what is reasonable will be things such as the size, age and sex of both the prisoner and the member of staff concerned in the use of force and whether any weapons are present.
86. The Prison Service regards the use of force as necessary if there is risk to life, limb, property or risk to the good order of the establishment. PSO 1600 states, "It is not enough that a prisoner be given any 'lawful order' to do something and has refused to do so".
87. On the morning of 16 December, the man was forcibly moved from his cell to the healthcare holding cell. A nurse told the man that the GP would see him before he went to court. The escorting officers were present at the time, but have said that they did not hear what was discussed between the nurse and the man. They then forcibly removed him to the reception search area before the GP had seen him.
88. In the search area, officers removed the man's clothes and dressed him in clothes for court. Although officers said he did not resist, this was still use of force and degrading treatment by officers who should have been able to recognise that he was not well. He was then effectively dragged motionless onto the escort van, pushed into a cell and seat and locked in without any apparent consideration for his health. The clinical review points out that he was clearly in distress and weak and he is concerned that experienced officers did not recognise this.
89. The investigator asked the acting Head of the Prison Service's National Tactical Response Group to view a number of printed images of the CCTV footage of the day. She said the unit is responsible for the operational response and use of force training course for prison officers. She considers that the actions of the officers that day in moving the man from his cell to healthcare, from healthcare to the reception search area and from there to the escort van, and on the van, all amounted to use of force.

90. A number of officers who came into contact with the man described his behaviour as 'passive resistance'. The acting Head of the Prison Service's National Tactical Response Group explained that when prisoners are showing passive resistance, as part of their training officers are advised to follow a set number of actions before using force. This would include actions such as observing the prisoners behaviour, explaining why compliance is required and the consequences of non-compliance. After all suggested actions have been completed planned control and restraint is permitted if force is necessary. Healthcare staff are required to attend all planned control and restraint incidents. Officers did not consider that their actions amounted to planned use of force and therefore did not involve healthcare staff.
91. The acting Head of the Prison Service's National Tactical Response Group said that when the man had to use the wall to support himself she would have expected the officers to have called for healthcare staff or obtained a wheelchair. When he collapsed to the floor, after leaving his cell on the Monday morning, the officers should not have continued to escort him, but should have requested healthcare assistance.
92. She stated that the escort of the man from his cell through the prison and onto the van was not reasonable and not compliant with the standards required by PSO 1600. We agree. We do not consider that the force used to take him from his cell to the escort van that day was necessary or, therefore, lawful. There was an evident disregard for his health and wellbeing and a failure to follow recognised Prison Service procedures. The actions of all the prison staff involved appear to have fallen below the professional standards we would expect to see. We consider that the failings were so serious as to require a full investigation into the actions of the staff that morning and into the understanding and operation of use of force procedures at the prison. We make the following recommendation:

**The Deputy Director of Custody for East Midlands should initiate a disciplinary investigation into the actions of each of the prison staff involved in managing the man on the morning of 16 December 2013 and also satisfy himself that use of force procedures at HMP Nottingham operate in accordance with the law and mandatory Prison Service requirements.**

93. All prison officers are required to be trained in using force and have annual refresher training. The acting Head of the Prison Service's National Tactical Response Group said that ideally staff who have not completed their annual refresher training should not have direct contact with prisoners and should not take part in any planned use of force. Officers who are out of date with their training should only be permitted to use unplanned use of force for reasons of personal safety, risk to life, limb, or the good order of the establishment. When this happens they should be replaced by another officer with up to date training as soon as practicable and should inform the officer in charge of the incident.

94. The PO and night orderly officer, both senior members of staff, were involved in using force on the man on 16 December 2014, yet both were out of date with their training. We make the following recommendation:

**The Governor should ensure that all operational staff attend annual use of force refresher training.**

95. PSO 1600 states that “whenever a member of staff has found it necessary to use force on a prisoner they must record the circumstances that lead up to the use of force and the type of force that was used and why”. This is completed on an Annex A form. The purpose of the member of staff writing this report is to justify their actions and to demonstrate that the force used was lawful. An Annex A form should be completed by all officers involved in the use of force. The available evidence shows that Custodial Manager 1 was the only member of staff to complete one. We make the following recommendation:

**The Governor should ensure that Use of Force forms are completed and stored securely in line with PSO 1600**

### **Emergency response**

96. The emergency response when the man was found unresponsive on the 16 December was quick and an ambulance was requested as soon as a code blue was called. However, this did not happen when he was found collapsed in his cell at 2.10pm on 14 December. The prison’s radio log shows that an ambulance was not called until 2.20pm, ten minutes after the code blue was called.
97. Prison Service Instruction (PSI) 03/2013, which was issued at the beginning of February 2013, required governors to have a medical emergency response code protocol based on the instruction by 28 February 2013. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is called.
98. HMP Nottingham has a Staff Information Notice on medical emergency response Codes which gives clear instruction in line with PSI 03/2013 that an ambulance should be called automatically as soon as an emergency code is called. This was not done on 14 December. It is important that an ambulance is called immediately in a life threatening situation. We make the following recommendation:

**The Governor should ensure that control room staff call an ambulance as soon as an emergency medical code is received.**

## RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all available information about a prisoner's health and risks is recorded and shared quickly with all staff responsible for assessing the prisoner.
2. The Head of Healthcare should ensure that prisoners receive all necessary prescribed medication and adequate pain relief, as soon as possible after arrival, using the out of hours GP service if necessary.
3. The Head of Healthcare should ensure that prisoners with complex medical histories continue to be reviewed and monitored by healthcare staff at least daily after being discharged from hospital when they report continuing pain and other concerning symptoms.
4. The Governor and Head of Healthcare should ensure that all staff receive mental health awareness training to enable them to better identify signs and symptoms of mental illness and vulnerability.
5. The Head of Healthcare should ensure that assessments of prisoners judged fit to attend court are reviewed and the prisoner assessed in person when there is a significant change of circumstances or when the prisoner subsequently reports being too ill to attend.
6. The Deputy Director of Custody for East Midlands should initiate a disciplinary investigation into the actions of each of the prison staff involved in managing the man on the morning of 16 December 2013 and also satisfy himself that use of force procedures at HMP Nottingham operate in accordance with the law and mandatory Prison Service requirements.
7. The Governor should ensure that all operational staff attend annual use of force refresher training.
8. The Governor should ensure that Use of Force forms are completed and stored securely in line with PSO 1600
9. The Governor should ensure that control room staff call an ambulance as soon as an emergency medical code is received.

## ACTION PLAN

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion and function responsible
1	The Governor and Head of Healthcare should ensure that all available information about a prisoner's health and risks is recorded and shared quickly with all staff responsible for assessing the prisoner.	Accepted	The current systems that are in place will be reiterated to staff via briefings to ensure that relevant information is shared with staff who are responsible for assessing prisoners.	31.12.2014  Governor and Head of Healthcare
2.	The Head of Healthcare should ensure that prisoners receive all necessary prescribed medication and adequate pain relief, as soon as possible after arrival, using the out of hours GP service if necessary.	Accepted	The evening reception service now includes provisions to address prisoners' urgent health needs and prescribe medication if this is deemed to be clinically appropriate.  Healthcare staff have access to an out of hours pharmacy to dispense urgent medication.	Completed  Head of Healthcare
3.	The Head of Healthcare should ensure that prisoners with complex medical histories continue to be reviewed and monitored by healthcare staff at least daily after being discharged from hospital when they report continuing pain and other concerning symptoms.	Accepted	The Head of Healthcare will ensure that a care plan is put in place for all patients reporting ongoing symptoms following discharge from hospital. This will include the level of observations required.	31.12.2014  Head of Healthcare
4.	The Governor and Head of Healthcare should ensure that all staff receive mental health	Accepted	A rolling programme of mental health awareness training will be introduced across	30.04.16  Head of Healthcare

	awareness training to enable them to better identify signs and symptoms of mental illness and vulnerability.		the establishment for all staff who have contact with prisoners. Training sessions will be carried out on the prison's designated training days.	and Head of corporate services
5.	The Head of Healthcare should ensure that assessments of prisoners judged fit to attend court are reviewed and the prisoner assessed in person when there is a significant change of circumstances or when the prisoner subsequently reports being too ill to attend.	Accepted	The Head of Healthcare has instructed staff via briefings that in all instances where the prisoner requires medical input prior to court, the escort form should not be signed until the appointment has occurred and the prisoner is assessed as medically fit to attend.	Completed  Head of Healthcare
6.	The Deputy Director of Custody for East Midlands should initiate a disciplinary investigation into the actions of each of the prison staff involved in managing the man on the morning of 16 December 2013 and also satisfy himself that use of force procedures at HMP Nottingham operate in accordance with the law and mandatory Prison Service requirements.	Accepted	The Deputy Director of Custody (DDC) for East Midlands has commissioned an investigation and an Investigating Officer has been appointed. The Terms of Reference set by the DDC include the direction to review the use of force procedures at HMP Nottingham to ensure that they operate in accordance with the law and mandatory Prison Service requirements.	Completed  Deputy Director of Custody
7.	The Governor should ensure that all operational staff attend annual use of force refresher training.	Accepted	A programme is in place for Use of Force refresher training. This now identifies which staff need to undertake refresher training prior to expiry.	Completed  Governor
8.	The Governor should ensure that Use of Force forms are completed and	Accepted	A Governor's Order will be issued to reiterate the requirements within	30.11.14  Head of

	stored securely in line with PSO 1600.		the PSO and inform staff that failure to follow them may result in poor performance processes being applied.	Residence and Safety
9.	The Governor should ensure that control room staff call an ambulance as soon as an emergency medical code is received.	Accepted	Communications staff will continue to call for ambulances as soon as a Code Red or Code Blue call is received. A Governor's Instruction has been issued which reminds staff of this requirement.	Completed Governor