

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Anthony Solomon a prisoner at HMP Nottingham on 27 September 2017**

**A report by the Prisons and Probation Ombudsman**

## 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*

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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.

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

Mr Anthony Solomon died on 27 September 2017 at HMP Nottingham from the toxic effects of new psychoactive substances (NPS). He was 38 years old. We offer our condolences to Mr Solomon's family and friends.

On the day Mr Solomon died, staff failed to answer his cell bell, and it was only after a prisoner alerted staff almost 40 minutes after the cell bell was activated, that staff discovered he had collapsed. This resulted in an unacceptable delay in seeking emergency medical assistance. There was a further delay of four minutes before an ambulance was called because no one had used an emergency code.

Although the clinical reviewer has concluded that the lengthy delay is unlikely to have affected the outcome in Mr Solomon's case, it could make a significant difference in other cases.

We are also concerned that the prison failed to follow its own substance misuse strategy when it had become clear that Mr Solomon was using NPS.

Following its inspection of Nottingham in January 2018, HM Inspectorate of Prisons (HMIP) concluded that the prison was 'fundamentally unsafe' and invoked the Urgent Notification process to alert Ministers to their concerns. We welcome HMIP's decision to do this. Several of the significant failings identified by HMIP featured in this investigation, and we share the concern of HMIP and the Independent Monitoring Board that NPS use is rife among prisoners at Nottingham. HMIP also noted that there had been repeated failures by Nottingham to implement our recommendations following previous deaths in custody.

Urgent action needs to be taken to address these issues.

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

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**March 2019**

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# Summary

## Events

1. Mr Anthony Solomon was remanded into custody at HMP Nottingham on 23 May 2017. He told reception staff he had no history of substance misuse, although prison records show he had used new psychoactive substances (NPS) while in prison custody previously. He was allocated a cell on B Wing.
2. Mr Solomon failed a random drug test in August 2017, having tested positive for NPS. Nottingham did not process the paperwork in time, resulting in no disciplinary action being taken.
3. In July and September 2017, Mr Solomon was assaulted by another prisoner. Intelligence suggests these assaults were linked to his involvement with drugs within the prison.
4. At 1.15pm on 27 September, Mr Solomon's cellmate rang their cell bell because Mr Solomon had suffered a bad reaction to smoking NPS. Staff did not respond until 1.52pm, after a prisoner had alerted them. They called for an ambulance four minutes later. Prison and healthcare staff began cardiopulmonary resuscitation (CPR), which the paramedics continued, but at 2.21pm, they pronounced that Mr Solomon had died.

## Findings

5. We found that the use of illicit substances at Nottingham was rife, particularly on B Wing. We have highlighted the widespread use of drugs, particularly NPS, at Nottingham previously.
6. We found that the prison failed to follow its own substance misuse strategy when Mr Solomon tested positive for NPS. Staff did not refer him for help with his substance misuse as they should have done. Staff also failed to follow the prison's violence reduction strategy after he was assaulted.
7. We are concerned that staff failed to respond to Mr Solomon's cell bell on the day he died. It was not until a prisoner alerted an officer almost 40 minutes after the cell bell was activated, that staff attended. There was confusion among staff over who was responsible for answering cell bells on B Wing over the lunchtime period.
8. The delay in responding to the cell bell resulted in an unacceptable delay in the emergency response. This was compounded by the failure of staff to call an emergency medical code when Mr Solomon was discovered unconscious.

## Recommendations

- The Governor should ensure there are effective supply and demand reduction strategies to help reduce the availability of new psychoactive substances and that staff are vigilant to signs of their use and take appropriate action.

- The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated in line with national and local policies.
- The Governor should ensure that all staff are clear about where they are scheduled to work within the prison and the duties they are expected to perform.
- The Governor should ensure that all cell bells are answered within five minutes.
- The Governor should ensure that all prison staff are aware of, and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance.

## The Investigation Process

9. 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.
10. The investigator obtained copies of relevant extracts from Mr Solomon's prison and medical records.
11. The investigator interviewed five members of staff and Mr Solomon's cellmate at Nottingham on 31 October and 1 November 2017.
12. NHS England commissioned a clinical reviewer to review Mr Solomon's clinical care at the prison.
13. We informed HM Coroner for Nottingham of the investigation who gave us the results of Mr Solomon's post-mortem and toxicology report. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Solomon's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Solomon's partner was critical of the widespread use of NPS at Nottingham and asked the investigator to find out:
  - why prisoners are not searched when they move wings;
  - why Mr Solomon was refused a telephone call on 25 September;
  - why Mr Solomon was late for a visit on 26 September; and
  - whether Mr Solomon was being bullied at Nottingham.
15. We shared our initial report with the Prison Service. They found no factual inaccuracies.
16. We provided a copy of our initial report to Mr Solomon's partner's solicitor. They found no factual inaccuracies.
17. The Coroner invited the clinical reviewer to review his clinical review in light of a report from a Clinical Professor of Critical Care Medicine, about the impact of the delay in responding to Mr Solomon's cell bell. The clinical reviewer amended his review on 19 February 2019 and this has been reflected in this report.

## Background Information

### HMP Nottingham

18. HMP Nottingham is a local category B prison holding approximately 1000 men, serving courts in Nottinghamshire and Derbyshire. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services at the prison.

### HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Nottingham during the week of 8 January 2018, which found the prison to be fundamentally unsafe. On 18 January 2018, HMIP invoked the Urgent Notification (UN) process which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days.
20. Key findings from the inspection included:
  - Over two thirds of prisoners told inspectors they had felt unsafe at some point during their stay at the prison.
  - Only 14% of prisoners said that their cell bell was normally answered within five minutes and there were examples of very long delays.
  - 57% of prisoners told inspectors it was easy to obtain illicit drugs and mandatory drug testing suggested a positive rate of 14%, rising to over 30% when psychoactive substances were included in the data.
  - Levels of violence overall were higher than in comparable prisons and had not reduced since the last inspection in February 2016.

### Independent Monitoring Board

21. 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 latest annual report, for the year ending 28 February 2017, the IMB reported that insufficient staffing levels meant the prison was unable to support its regime, which resulted in often unpredictable cancellations of activity, work and education. The IMB said that with prisoners spending more time on the wing, frustration, bullying, violence and use of NPS became increasingly evident.
22. The IMB noted that illegal drugs, in particular NPS, continued to enter the prison, by a variety of means. Illicit drugs entering the prison were a source of bullying and debt, acute and longer-term health issues and disruption to the prison regime.

### Previous deaths at HMP Nottingham

23. Mr Solomon was the eighth prisoner to die at Nottingham since 1 January 2016. Six of the previous deaths were self-inflicted and one was due to natural causes. Two prisoners have taken their own lives since Mr Solomon's death. Between 13 September and 12 October 2017, five prisoners died at Nottingham including Mr Solomon.

24. In two of our previous investigations, we raised concerns about the prevalence of NPS at Nottingham and the failure of the prison to follow its substance misuse strategy. We also found there was a failure to call a medical emergency code in two previous cases. Initial indications in our ongoing investigations into deaths at Nottingham in September/October 2017, are that NPS continued to be a significant problem at Nottingham during this period, and there were delays in answering cell bells.

### **New psychoactive substances (NPS)**

25. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
26. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. 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.
27. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continues to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

## Key Events

28. Mr Anthony Solomon was remanded into custody at HMP Nottingham on 23 May 2017, on charges of burglary. A nurse assessed him on reception to the prison. He told her he had no history of substance misuse (although prison records showed he had used new psychoactive substances (NPS) during previous periods in prison custody).
29. On 15 July, a nurse examined Mr Solomon following an assault. His eye socket, jaw and kidneys had been affected. He was taken to hospital but was returned to prison the same day. A prison GP prescribed Mr Solomon a week's worth of dihydrocodeine (painkillers).
30. Mr Solomon failed a random mandatory drug test he took on 2 August, having tested positive for NPS. The prison failed to process the paperwork in time, so no disciplinary action was taken against Mr Solomon. He was not referred to substance misuse services.
31. Mr Solomon saw a nurse on 6 September, as he said he had been assaulted. She treated a superficial cut to his left eyebrow. Mr Solomon was unhappy with this and said he should be taken to hospital, but healthcare staff considered it unnecessary.
32. On the morning of 25 September, Mr Solomon asked an officer if he could make a telephone call. She refused his request because all prisoners were locked up and a prisoner could only be unlocked in an emergency.
33. The next day, 26 September, Mr Solomon was not unlocked on time for a visit from his partner. An intelligence report suggested this was due to a disagreement with a member of staff the previous day. Staff were unable to identify who the officer was. An officer apologised for this and the visit was rebooked. Mr Solomon had future visits booked for 29 September, 3 October and 7 October.

### 27 September

34. During the morning of 27 September, a prisoner was moved to B Wing, after being assaulted on C Wing. He was not searched, as the prison's searching policy does not say that prisoners should be routinely searched when moving wings. He was allocated a cell with Mr Solomon, who he already knew.
35. Mr Solomon's cellmate told the investigator he noticed Mr Solomon had a black eye and asked how he had got it. Mr Solomon replied, "Oh the usual" and they did not discuss it further. He asked Mr Solomon whether he still worked on the servery, but Mr Solomon said he had lost his job because he had had some "mamba [NPS] attacks".
36. The cellmate said that a short while later, Mr Solomon made a pipe from some paper and an empty toilet roll tube, put some mamba in it and smoked it. He smoked one or two pipes before emerging from behind the toilet curtain dribbling and looking "out of it". At first, Mr Solomon just walked around the cell and looked "high". Soon after, Mr Solomon kneeled down and then lay down on the

- floor, and he saw he had defecated. The cellmate said he panicked and rang the cell bell to alert staff.
37. The prison's CCTV shows that Mr Solomon's and the cellmate's cell bell was illuminated at 1.15pm. Staff could be seen on the wing after this, although only a nurse walked close by Mr Solomon's cell at 1.21pm. She slipped an appointment card under the door of a cell two doors down from his cell.
  38. An officer who was in the wing office on B Wing, realised that a number of cell bells had been pressed, but nobody had answered them. He said there were seven or eight members of staff in and around the office, but they all told him they were on their lunch break. (This was the case and the officer was the only officer on duty at that time.) The officer told the investigator he decided to answer the cell bells himself. He said the prisoners he responded to had pressed them for minor things, such as asking the time and requesting a toilet roll.
  39. The officer said he returned to the wing office and saw there was a pile of ACCT documents (used to monitor prisoners at risk of suicide and self-harm) on the desk. He realised that those prisoners on ACCTs needed to be checked so he went to their cells to complete them. He said that this was not straightforward, as one prisoner was not in his recorded cell and he had to spend some time finding out where he was. He then returned to the wing office to write up the ACCT paperwork. He said he was aware that some cell bells had been pressed while he was in the office, but he prioritised completing the ACCT paperwork.
  40. Meanwhile, Mr Solomon remained on the cell floor near the toilet and was dribbling. His cellmate said that at some point he began to bang on the cell door for attention. In the meantime, Mr Solomon vomited.
  41. At 1.47pm, staff began to unlock prisoners and a prisoner could be seen on CCTV standing outside Mr Solomon's cell at 1.50pm. He appeared to be talking to someone in the cell. His cellmate said a prisoner had heard him shouting and banging the cell door and asked what was wrong. The cellmate told him to call an officer. The cellmate said he went to check Mr Solomon, asked if he was all right and touched his ear. Mr Solomon's head seemed to roll and he saw that he had urinated. He tried to sit Mr Solomon up and check for a pulse, but was not sure whether he could detect one or not.
  42. At 1.51pm, a prisoner called for an officer. The officer attended the cell immediately and made a call on his radio at 1.52pm requesting assistance. Around 20 seconds later, another officer arrived at the cell and both went in.
  43. A prison paramedic was carrying the healthcare department's responder radio and heard a call for medical assistance. A healthcare assistant was also carrying a radio and responded to the call. They arrived at Mr Solomon's cell at 1.55pm
  44. Mr Solomon was lying in vomit on the cell floor and was unconscious. The paramedic thought that Mr Solomon had died, but there were no signs of rigor mortis so he began cardiopulmonary resuscitation (CPR). He recalled somebody asking whether they should call an ambulance and he replied that they should. A request to call an ambulance was relayed to the communications room, and they

telephoned the ambulance service at 1.56pm. Healthcare staff continued with CPR and used a defibrillator (a life saving device that gives the heart an electric shock in some cases of cardiac arrest) which confirmed Mr Solomon's heart had no shockable rhythm.

45. Paramedics arrived at Mr Solomon's cell at 2.08pm. Prison staff agreed they could move him out of the cell so they had more room and paramedics continued CPR on the landing.
46. At 2.21pm, the paramedics stopped CPR and pronounced that Mr Solomon had died. Staff covered him with a blanket and put up screens around him while they waited for police to arrive.

### **After Mr Solomon's death**

47. An intelligence report submitted on 27 September suggested that Mr Solomon's cellmate had given him a pipe and that wraps of drugs were found in the cell after Mr Solomon had died.
48. The next day, 28 September, another intelligence report was submitted which suggested that Mr Solomon had been assaulted on 15 July, and that this had been reported. There is a note of the assault in Mr Solomon's medical record, but there was no evidence of an intelligence report for 15 July, in the investigator's paperwork. It also reported that Mr Solomon had been assaulted again on or around 14 September, but this had not been recorded at the time, and no action was taken, despite Mr Solomon having visible injuries.

### **Contact with Mr Solomon's family**

49. Mr Solomon's partner telephoned the prison on 27 September to ask whether Mr Solomon had died, as she had received a call from a prisoner using a mobile phone telling her that he had. The Deputy Governor and the Chaplain visited her at 3.50pm, to formally inform her of Mr Solomon's death.
50. The prison contributed to Mr Solomon's funeral, in line with national guidance.

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

51. The Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
52. The prison posted notices informing other prisoners of Mr Solomon's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Solomon's death.

### **Post-mortem report**

53. The pathologist concluded that Mr Solomon died because of the toxic effects of synthetic cannabinoids. The pathologist added that in the absence of a traumatic or natural death, this was the most likely conclusion.

# Findings

## New psychoactive substances (NPS)

54. Mr Solomon had a history of taking illicit drugs while at Nottingham and during previous periods in prison custody. His cellmate said Mr Solomon used NPS prior to his collapse and that NPS use was rife in the prison, especially on B Wing.
55. The PPO's Learning Lessons Bulletin on NPS, issued in July 2015, set out why these substances have become a source of increasing concern in prisons. There is evidence that NPS pose dangers to both physical and mental health. In addition, trading these substances can lead to debt, violence and intimidation. In our Annual Report for 2016-2017, we noted that the number of deaths where the use of NPS may have played a part continued to rise and that there was a greater need than ever for more effective drug supply and demand reduction strategies, including better monitoring by drug treatment services and effective violence reduction strategies.
56. Nottingham has a Substance Misuse Strategy, issued in January 2017. It states the prison will not tolerate the presence of illicit drugs and is committed to eliminating the supply of, and demand for, drugs. It also states that it has systems in place to identify, assess and support prisoners with a drug misuse problem, and that it recognises the specific needs of particular groups, including those from ethnic minorities. The strategy sets out the percentage and frequency of mandatory drug tests and the action to be taken if a prisoner supplies a positive sample. These actions include placing the prisoner on report, resulting in possible disciplinary action, and carrying out an Incentive and Earned Privilege scheme (IEP) review, which could result in the prisoner being placed on a basic regime. (This also applies to prisoners found in possession of mobile phones.) Nottingham clearly failed to comply with its own strategy in this case, as delays meant Mr Solomon did not face disciplinary proceedings after failing a mandatory drug test and an IEP review was not triggered.
57. Nor was Mr Solomon referred to substance misuse services, as he should have been, according to the prison's drug strategy. Substance misuse practitioners would have then carried out a comprehensive assessment of Mr Solomon, and developed a recovery plan for him. This could have included moving Mr Solomon to A Wing, the recovery wing, appointing a key worker or initiating a stabilisation programme for him. This would also have allowed Mr Solomon to be treated either clinically (e.g. detoxification) or psychosocially (e.g. recovery and planning work) or attend group work (e.g. substance awareness and bullying and debt).
58. Part of Nottingham's Substance Misuse Strategy includes a local searching strategy that sets out the nature, frequency and type of searches. Its aim, among others, is to deter prisoners attempting to supply or receive drugs, prevent illicit drugs entering the prison, prevent mobile phones entering the prison, and to inform the prison's intelligence systems. However, its policy does not expect prisoners to be searched routinely when they move wings or cells. The prison

told the investigator this was considered excessive and intrusive. As a result, Mr Solomon's cellmate was not searched when he moved to B Wing.

59. Wraps of drugs were found in Mr Solomon's cell after he died but it was unclear who these belonged to. Also, a prisoner used a mobile phone to contact Mr Solomon's next of kin, before the prison did so. Clearly, the prison's searching policy has been unable to prevent prisoners having access to illicit drugs and phones, among other items, on B Wing.
60. It is clear that illicit drugs, and NPS in particular, pose a very significant threat at HMP Nottingham. The prison paramedic gave the investigator a log that showed the number of times healthcare assistance was requested in August and September 2017. During August, healthcare staff were called out 376 times, of which 119 were NPS related. In September, there were 352 calls, of which 138 were NPS related. This is clearly a huge strain on limited resources at Nottingham and the challenges in delivering the prison's Substance Misuse Strategy are stark.
61. Mr Solomon's death is, though, a clear example of how dangerous NPS can be, and illustrates why prisons must do all they can to eradicate its use. We have made recommendations to Nottingham about NPS before, which we repeat here:

**The Governor should ensure there are effective supply and demand reduction strategies to help reduce the availability of new psychoactive substances and that staff are vigilant to signs of their use and take appropriate action.**

62. Mr Solomon was assaulted on two occasions while at Nottingham, apparently due to his involvement with NPS. Nottingham's violence reduction strategy sets out measures to support victims of bullying, threats and intimidation. It says that suspected bullying should be investigated and, if necessary, escalated to the safer custody team, and measures should be put in place to support the victim. There was no evidence that the reported assaults on Mr Solomon were ever logged or investigated, or that he was supported by violence reduction procedures. We therefore make the following recommendation:

**The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated in line with national and local policies.**

### Answering Mr Solomon's cell bell

63. His cellmate pressed his and Mr Solomon's cell bell at 1.15pm, but the bell was never answered. HMIP has an expectation that cell bells should be answered within five minutes and this is the standard we expect. No one attended Mr Solomon's cell until almost 40 minutes after the cell bell was activated and that was only after another prisoner had alerted staff to a problem.
64. An officer had been scheduled to work on B wing on 27 September and to cover cell bells over the lunch time period. However, he said he was unaware of this. He told the investigator that as far as he was concerned he was scheduled for 'alarm response' duty which meant that he could be called to any part of the prison, but he based himself at B Wing because that was his normal location. He

answered some cell bells because he thought he should help out given that everyone else was on their lunch break, but he was unaware that he was expected to cover the cell bells on B Wing over that period. A custodial manager told the investigator that the department responsible for allocating staff to their jobs had failed to let the officer know he was responsible for lunchtime cover on B Wing on 27 September.

65. The result of this confusion was that nobody responded to Mr Solomon's cell bell and there was a delay of almost 40 minutes before staff discovered that he had collapsed.
66. The clinical reviewer has concluded, "Had the cell call been responded to within recommended times, following the cardiac arrest, death would still have been the most likely outcome. To have survived this cardiac event would have required immediate recognition of cessation of cardiac function, followed by immediate and effective cardiopulmonary resuscitation. This would need to have been performed by an alert third party with up to date training in first aid. Given the circumstances in which this cardiac event happened, it is unlikely that the fatal outcome could have been avoided, even if discipline officers had responded to the cell call within target response times. However, the window of opportunity for any potential chance of a successful resuscitation was lost".
67. It is unacceptable that cell bells went unanswered for so long. Moreover, if the officer had not acted on his own initiative, no ACCT checks would have been carried out during that time either. We make the following recommendation:

**The Governor should ensure that all staff are clear about where they are scheduled to work within the prison and the duties they are expected to perform.**

68. Furthermore, we remind the Governor of the expectation that staff answer cell bells within five minutes and make the following recommendation:

**The Governor should ensure that all cell bells are answered within five minutes.**

### Emergency response

69. PSI 03/2013 requires governors to have a two-code medical emergency response system that ensures an ambulance is called immediately when staff have serious concerns about the health of a prisoner. Nottingham's medical emergency response protocol requires staff to call either a code blue (when a prisoner is unconscious or having difficulty breathing) or a code red (when a prisoner has severe bleeding or burns), which should trigger the control room to call an ambulance immediately. Despite Mr Solomon being unconscious when staff attended his cell, nobody called an emergency code blue. An ambulance was not requested until a prison paramedic asked if one had been called, resulting in a four-minute delay.

70. We make the following recommendation:

**The Governor should ensure that all prison staff are aware of, and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance.**

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