

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marc Maltby, a prisoner at HMP Nottingham, on 12 October 2017

A report by the Prisons and Probation Ombudsman

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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 Maltby died on 12 October 2017. He was found hanged in his cell at HMP Nottingham three weeks after being recalled to prison. He was 23 years old. I offer my condolences to his family and friends.

I am concerned that staff did not properly consider Mr Maltby's risk factors for suicide and self-harm. The initial health screening failed to identify that he had a history of self-harm and substance abuse, and a requested mental health assessment was severely delayed and had not taken place before his death. On the day before his death, Mr Maltby had an altercation with his cellmate and then refused to leave his cell, telling staff he believed he was under threat. Staff did not investigate Mr Maltby's concerns adequately. In addition, although other prisoners told us that Mr Maltby was openly taking new psychoactive substances (NPS) on the wing, staff appear not to have known about his substance misuse and did not challenge or offer him support.

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. I welcome HMIP's decision to do this. Several of the significant failings identified by HMIP featured in this investigation. 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.

Elizabeth Moody
Acting Prisons and Probation Ombudsman

July 2020

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Summary

Events

1. In October 2015, Mr Marc Maltby was sentenced to two years imprisonment. He spent time in custody at different prisons until he was released on licence on 25 November 2016.
2. On 6 February 2017, Mr Maltby breached his licence conditions and was recalled to prison. Four days later, an officer at HMP Lincoln started suicide and self-harm prevention procedures (known as ACCT) because Mr Maltby had self-harmed. On 3 March, Mr Maltby was released from HMP Hull but he was recalled again on 21 September.
3. On 22 September, Mr Maltby arrived at HMP Nottingham. At his initial health screening he told a nurse that he did not have any history of suicide, self-harm or substance misuse but asked to be referred for a mental health assessment. The nurse made the referral but did not fully check Mr Maltby's medical history.
4. On 8 October, a mental health nurse attempted to assess Mr Maltby but she could not find him. She postponed the assessment to a later date. The same day, HM Prison and Probation Service (HMPPS) sent Mr Maltby's recall dossier to the prison but the prison did not issue it to Mr Maltby.
5. On 11 October, there was an incident between Mr Maltby and his cellmate over NPS, and officers moved the cellmate to another cell. Mr Maltby did not want to leave his cell afterwards and he said he was afraid that he was going to be assaulted. He wrote two notes to staff asking to be moved to another prison. He was offered a move to another wing but refused to move because he said he would not be safe there either.
6. On 12 October at around 4.30pm, an officer collected Mr Maltby's meal for him as Mr Maltby said he did not want to leave his cell because he was under threat. He spoke to a supervising officer and asked for a move. At around 6.15pm, Mr Maltby asked for a phone call to his mother, which was refused as it was too late in the day. Mr Maltby smashed up his cell and threw pieces of wood and hot water at the officer through the observation panel of his cell. The supervising officer put a table in front of Mr Maltby's cell door as a shield, and tried to calm him.
7. At around 6.50pm, another prisoner saw Mr Maltby hanging from a ligature in his cell and called for help. A nurse who was on the wing attended immediately. At around 6.55pm, the supervising officer called a medical emergency over the radio. Paramedics arrived quickly. They directed staff to continue with CPR but pronounced Mr Maltby dead at 7.18pm.

Findings

8. Mr Maltby presented with a number of risk factors. We found that staff failed to identify or address them during the initial health screening, and following a violent incident with his cellmate. Staff had not received adequate ACCT training.

9. The prison did not issue Mr Maltby with his recall dossier the next working day after it had been sent to the prison, contrary to national policy. Mr Maltby was therefore unaware of the nature of his recall and the length of time he had to spend in custody.
10. Mr Maltby was referred for a mental health assessment on 22 September 2017. A nurse attempted to assess Mr Maltby on 8 October but because she could not locate him, the assessment did not take place and was re-booked for 20 October. Healthcare staff said that the expectation, is that mental health assessments take place within five days of the initial referral having been made, however Mr Maltby's mental health assessment was rebooked for 38 days after the initial referral. This delay meant that Mr Maltby was not assessed before he died.
11. After the incident with his cellmate, there is no evidence that staff properly supported Mr Maltby or investigated his concerns that he was under threat in line with the prison's violence reduction strategy. Officers submitted no intelligence reports and did not make any records of the incident in the wing observation book, or in the NOMIS records of Mr Maltby and his cellmate.
12. After Mr Maltby's death, prisoners told the police and the investigator that Mr Maltby was openly taking NPS on the wing, but the prison appears to have done little to address this. The toxicology report carried out after his death found that Mr Maltby had NPS in his body. We are concerned that this demonstrates a clear deficit in the prison's drug strategy.

Recommendations

- **The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that staff:**
 - **Identify all the known risk factors of a prisoner during the initial health screening including reviewing available sources of information such as SystemOne records.**
 - **Receive adequate training on suicide and self-prevention procedures.**
- **The Governor and Head of the Offender Management Unit (OMU) should ensure that, in accordance with national policy:**
 - **the Public Protection Casework Section (PPCS) at HMPPS is informed of the return to custody of recalled prisoners without delay; and**
 - **the prison issues the recall dossier to the prisoner the next working day after receipt.**

- **The Head of Healthcare, the Healthcare Commissioners and the Governor should review the mental health care provision at HMP Nottingham. The review should consider the capacity to deliver a seven-day service of mental health assessments and ongoing interventions effectively, and the availability of staff to support suicide and self-harm prevention procedures at the prison.**

- **The Governor should ensure that all staff on duty read the wing observation book and familiarise themselves with any issues that have arisen on the wing, to ensure that they are fully aware of any prisoner vulnerabilities.**

- **The Governor should ensure that:**
 - **all information indicating bullying and intimidation is fully recorded, coordinated and investigated;**
 - **apparent victims are effectively supported and protected with meaningful, long-term solutions, which address their individual situation; and**
 - **staff consider whether victims are at increased risk of suicide or self-harm.**

- **The Governor should review existing policies and their implementation in light of Mr Maltby's death, other recent deaths at Nottingham and the findings of this investigation, to ensure they are effective in reducing the supply of and demand for illicit substances, and that staff are vigilant to signs of illicit drug use and take appropriate action.**

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator visited Nottingham on 24 October 2017. He obtained copies of relevant extracts from Mr Maltby's prison and medical records.
15. The investigator interviewed 14 members of staff at Nottingham between November 2017 and February 2018.
16. NHS England commissioned a clinical reviewer to review Mr Maltby's clinical care at the prison.
17. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation who gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Maltby's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigator to consider. Mr Maltby's next of kin wanted to know:
 - Why Mr Maltby appeared not to have been monitored closely in the days leading up to his death.
 - Whether officers used force against Mr Maltby on 12 October and whether Mr Maltby had any bruises not consistent with ligature marks.
 - Details of the events on 12 October and the emergency response.
19. Mr Maltby's family received a copy of the initial report. They wrote to us through their legal representatives. We have addressed their comments in separate correspondence.
20. The prison service also received a copy of the initial report. Their response to our recommendations and action plan is annexed to this report.

Background Information

HMP Nottingham

21. HMP Nottingham is a local prison holding a maximum of 1000 men and young adult prisoners on remand, convicted or sentenced. The prison serves the courts of Nottinghamshire and Derbyshire. Nottinghamshire Healthcare NHS Foundation Trust provides health services, including mental health services. The prison has 24-hour primary healthcare cover, but mental health care is only available Monday to Friday, 8.00am to 5.00pm.

HM Inspectorate of Prisons

22. 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.
23. 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.
 - Over a third of prisoners felt they felt unsafe at the time of the inspection.
 - Levels of self-harm remained very high and had increased since the last inspection in February 2016. In a survey, 30% of prisoners said that they had been subject to suicide and self-harm prevention procedures (known as ACCT) at some point during their stay, but too many prisoners felt the support and engagement offered was either insufficient or inconsistent.
 - Levels of violence overall were higher than in comparable prisons and had not reduced since the last inspection in February 2016.
 - There were repeated failures to achieve or embed improvements following previous recommendations made by the Prisons and Probation Ombudsman (PPO).

Independent Monitoring Board

24. 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 their annual report, published in July 2017, the IMB was very concerned about the levels of self-harm and violence and believed that staff shortages and the availability of illicit drugs were a factor in this.

Previous deaths at HMP Nottingham

25. Mr Maltby was the seventh death to occur at Nottingham since 1 January 2017. Five of the previous deaths were self-inflicted and one was due to natural causes. One other prisoner has taken his own life since Mr Maltby's death. Between 13 September and 12 October 2017, five prisoners died at Nottingham including Mr Maltby. In some of these investigations we were concerned about

the effectiveness of the mental health services, the availability of NPS in the prison and the inadequate use of the prison's violence reduction strategy.

New Psychoactive Substances (NPS)

26. 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 many 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.
27. 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.
28. 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.

Recall to prison

29. When someone is released from prison on licence or parole, they can be recalled to prison if:
 - they commit another crime or are charged with another crime, or
 - they are behaving in a way that leads their Offender Manager to think they might be about to commit another crime, or
 - they break the conditions of their licence.
30. The length of time a prisoner who has been recalled will have to serve in prison depends on the type of recall they are subject to:
 - Fixed-term recalls: With a fixed-term recall, the individual is recalled to prison but will be released after 28 days. He will be on licence in the community until the end of his sentence.
 - Standard recalls: With a standard recall, the individual is recalled to prison and remains there until the end of his sentence unless the Parole Board decides otherwise. The case will be sent to the Parole Board automatically after 28 days. They will either authorise immediate release or set a date (within one year) for release on licence.

Key Events

31. On 1 October 2015, Mr Marc Maltby was sentenced to two years imprisonment for burglary, common assault and criminal damage. He spent time in different prisons until his release on licence on 25 November 2016. Mr Maltby was diagnosed with dyslexia in 2013 and had a history of anxiety.
32. On 6 February 2017, Mr Maltby breached his licence conditions and was recalled to prison as a fixed-term recall. Mr Maltby told a nurse that he felt that he had unresolved grief and anger issues due to his father dying of a drug overdose in 2015. Four days later, an officer at HMP Lincoln started suicide and self-harm prevention procedures (known as ACCT) because Mr Maltby made scratches to both arms, was tearful and said that he felt under threat and frustrated. On 13 February, officers closed the ACCT monitoring procedures because Mr Maltby was feeling better and no longer felt under threat on his wing.
33. On 3 March, Mr Maltby was released on licence from HMP Hull. While on licence in the community, he was charged with theft. Mr Maltby told his offender manager that he used NPS regularly and he tested positive for cannabis and cocaine.
34. On 20 September, Mr Maltby came to the attention of the police when he was found with someone they were looking for. The next day, Mr Maltby's licence was revoked and he was returned to prison as a standard recall.
35. On 22 September, Mr Maltby was sent to HMP Nottingham from Chesterfield Police Station. The police recorded on Mr Maltby's Person Escort Record (PER, a document that goes with prisoners when they move between police stations, courts and prisons) that he had been recalled to prison and that he had made scratches to his arms in 2017, but he had told police officers that he did not have any self-harm issues.
36. At his initial health screening, Mr Maltby told the nurse that he had no history of self-harm and no history of substance misuse. The nurse did not fully check Mr Maltby's medical history on the SystemOne record but noted that he was vague about his mental health. Mr Maltby asked the nurse to refer him for a mental health assessment, which she did. The nurse noted that Mr Maltby had scratches to his left arm and a possible bite to his ear and referred him to a GP for an appointment on 28 September (which Mr Maltby did not attend). The nurse told the investigator that she assessed that Mr Maltby did not present with any risk factors for suicide and self-harm, and did not refer him to substance misuse services because he said that he did not have substance misuse issues.
37. During the reception process, an officer found that Mr Maltby had a mobile phone in his possession. He told the officer that he was under pressure to bring it into the prison but did not give any names or provide any more information. The officer submitted an intelligence report but found no evidence that Mr Maltby was under pressure.
38. An officer recorded the outcome of Mr Maltby's first night interview on his NOMIS record. Mr Maltby said that he did not have any problems, concerns or any thoughts of suicide and self-harm. Officers located Mr Maltby on D wing, the first

night centre. A supervising officer (SO) (who knew Mr Maltby from a previous sentence), told the investigator that he spoke to Mr Maltby and he did not raise any concerns and appeared fine.

39. On 2 October, Mr Maltby moved to C wing, a residential location. The next day a Community Rehabilitation Company resettlement worker spoke to Mr Maltby and completed Part 2 of his Basic Custody Screening Tool (BCST), a tool to identify a person's needs and plan for their support on release. There is no record that an offender supervisor completed Part 1 of Mr Maltby's BCST as required by PSI 07/2015, early days in custody.
40. Mr Maltby told the Community Rehabilitation Company settlement officer that he was going to need accommodation after his sentence and that he wanted to see somebody from the mental health team because he had felt depressed in the past and had spoken about it with a GP. Mr Maltby said that he had used cocaine in the community but that he did not need any help from the substance misuse team. He also said that he had no debts or financial issues. The Community Rehabilitation Company settlement officer planned to liaise with the housing team and referred Mr Maltby to the mental health team for an assessment. The Community Rehabilitation Company settlement officer told the investigator that Mr Maltby appeared not to be worried, made good eye contact, did not raise any concerns and did not present as having urgent mental health problems.
41. On 6 October, Mr Maltby asked an offender supervisor, and the Community Rehabilitation Company settlement officer about his recall documentation because he had not received it. The settlement officer said that Mr Maltby thought that he was a fixed term recall (although in fact he was a standard recall). His recall paperwork had not been issued to the prison at that point but was sent by email the next day. There is no evidence however, that the prison's Offender Management Unit (OMU) ever issued Mr Maltby with his recall dossier.
42. On 7 October, Mr Maltby was moved to E wing where he shared a cell with another prisoner. Mr Maltby had asked for the wing move because he said that another prisoner had robbed him. The next day, a nurse went to A, B and C wings to carry out mental health assessments. She could not find Mr Maltby and asked an administrative officer to rebook the appointment, which was rescheduled for 20 October.

Thursday 11 October

43. An officer told the investigator that he had to intervene to stop a fight between Mr Maltby and his cellmate and, as a result, moved the cellmate to another cell while Mr Maltby remained the sole occupant of his cell. The officer said Mr Maltby and his cellmate did not tell him the reason for their confrontation. He told us that he 'would have submitted an intelligence report', but we found no evidence that he did so.
44. A supervising officer told the investigator that he vaguely remembered the incident and that Mr Maltby and his cellmate may have had a minor disagreement. He said that Mr Maltby asked him to move the cellmate to another cell because the cellmate was taking NPS in his cell and he did not like

- it. The supervising officer said that he did not know Mr Maltby was taking NPS on the wing, but that the cellmate was well known for his NPS consumption. Another officer also told the investigator that the cellmate was known for taking NPS, and another officer told the investigator that the cellmate's behaviour on E wing had become increasingly challenging because of his use of NPS.
45. We found no record of this incident or the reasons for the cellmate's move in his or Mr Maltby's NOMIS record. Officers did not submit an intelligence report and did not make a note of the incident in the wing observation book.
 46. After Mr Maltby's death, the cellmate said that the incident arose on 11 October because he had found Mr Maltby taking his NPS (that he had 'stashed' in his cell), without his permission. The cellmate said that he became angry with Mr Maltby, threatened him and asked officers to move him to another cell or 'there would be trouble'.
 47. Another prisoner, who said he was a friend of Mr Maltby, told the police that he knew that Mr Maltby had a confrontation with the cellmate over the distribution of some NPS that they had bought. The other prisoner said that 'a couple of punches were thrown', that officers became aware and moved the cellmate to another cell. He also said that because of the incident, Mr Maltby locked himself in his cell as he was in fear of an assault and he wanted to move to F wing where his friends were.
 48. After the incident, Mr Maltby wrote two notes addressed to the officers on the wing, which were placed and recorded in the wing observation book on 11 October. He said he was under threat but did not provide the name of any prisoner who was threatening him. He wrote that he was going to stay behind his door 'for his own protection' and asked for a move to another prison before Christmas because he had 'trouble all over the jail'.
 49. In the evening, a supervising officer spoke to Mr Maltby in his cell and noted that he was very withdrawn. The supervising officer said that he was not aware that Mr Maltby had had an incident with his cellmate. Mr Maltby asked the supervising officer to collect his meal because he said he was under threat and could not leave his cell. The supervising officer told the investigator that Mr Maltby did not name any prisoner or give specific details of the problems he had. The supervising officer said he offered Mr Maltby a move to B wing but he refused because it was one of the largest wings in the prison and he said he would have problems there too. As the supervising officer was going to be on leave until Saturday 13 October, he asked another officer to make a record of his conversation with Mr Maltby in the observation book so that another supervising officer on E wing could deal with Mr Maltby's concerns the next day. The officer did so.
 50. The officer told the investigator that he had no concerns about Mr Maltby on 11 October because the supervising officer was going to help him with a move to another unit and he did not, therefore, take any further action. The supervising officer who was supposed to deal with Mr Maltby's issue, worked on 11 October until the afternoon but did not work on 12 October. He told the investigator that he was not aware of Mr Maltby's incident with his cellmate or of the notes recorded in the observation book. He said that he had good rapport with Mr

Maltby. He said Mr Maltby never gave him any indication that he was under threat, took any drugs on the wing or wanted to kill himself.

Friday 12 October

51. At around 4.30pm, a supervising officer was supervising E wing during association. Mr Maltby pressed his cell bell and asked the supervising officer if he could get his dinner for him because he did not want to leave his cell for his own protection. Mr Maltby said that he 'got beef on the wing' (trouble on the wing). The supervising officer told the investigator that he was not aware that Mr Maltby had written notes to officers saying that he was under threat and he was not aware of any officer's entry in the observation book on 11 October.
52. The supervising officer brought food for Mr Maltby and told the investigator that he had a 'polite conversation' with him. Mr Maltby asked the supervising officer for a move off the wing. He told Mr Maltby that a move was not possible because it was late. The supervising officer however, promised that he would write a note to the supervising officer who was in charge of the wing the following day to make him aware of his request so he could deal with it the next day. The supervising officer told the investigator that Mr Maltby was 'fine' with his response.
53. Later, the supervising officer heard what he described as 'somebody smashing the cell up' on one of the lower landings and he went to the first floor of the wing. He saw Mr Maltby, who was locked in his cell, smashing his observation panel with pieces of wood. Mr Maltby asked for a phone call to his mother because he said it was her birthday. The supervising officer repeated to Mr Maltby that it was too late on the day to allow him a phone call.
54. A prisoner told the investigator that Mr Maltby had smashed the glass of the observation panel of his cell, broken his sink, and was throwing porcelain onto the landing through the broken observation panel. He said that officers tried to calm him down and talked to him, but they were also threatening him. The prisoner said that no officer used force against Mr Maltby because he was behind his cell door.
55. The former cellmate of Mr Maltby told the police that a supervising officer (he did not give the name) shouted to Mr Maltby that if he did not stop smashing his cell up he was going to enter the cell and 'beat the fuck out' of him.
56. The supervising officer brought the wing's ping-pong table and put it in front of Mr Maltby's cell door as a shield (as no screens were available on the wing). He also placed a towel at the bottom of Mr Maltby's cell door to stop water from flooding out. The supervising officer and another officer told the investigator that nobody opened Mr Maltby's cell at any time. The supervising officer said he spoke to Mr Maltby from behind the ping-pong table and through the observation panel for about 15 minutes, trying to calm him down. Mr Maltby continued throwing pieces of wood, sink and hot water at him.
57. The supervising officer told the investigator that he did not use any force or offensive language against Mr Maltby and did not threaten him. He said that he would never speak to a prisoner in the terms described by the prisoner and that

he planned to move Mr Maltby to a clean cell as soon as he calmed down. An officer said that nobody entered the cell because it was too dangerous to do so and that officers left the cell to continue with other duties on the wing. The supervising officer told the police that staff left Mr Maltby alone in his cell hoping that he was going to calm down. The supervising officer said that Mr Maltby used his cell bell numerous times and that staff attended but then Mr Maltby did not require staff assistance.

58. At around 6.50pm, a supervising officer and two officers started unlocking the prisoners on E wing who needed to collect evening medication. One of the officers unlocked a prisoner who, on his return from the medication hatch, noted that the observation panel of Mr Maltby's cell was damaged with many pieces of broken furniture on the floor. The prisoner looked through the observation panel and saw Mr Maltby hanging from a ligature made from a blue towel attached to his cell window.
59. The prisoner shouted to an officer that Mr Maltby was hanging. The officer went to check and shouted for help. A nurse, who was already on the wing giving medication, immediately attended. The officer tried to open the door but she could not do so because pieces of furniture were obstructing it. She said she did not call an emergency code because she panicked.
60. At around 6.55pm, a supervising officer called the code blue emergency (indicating that a prisoner is unconscious or having difficulty breathing). The control room officer called an ambulance at 6.56pm. A supervising officer went to Mr Maltby's cell and tried to open the door, but he could not open it. Another supervising officer helped to open the door and they entered the cell. The second supervising officer cut the ligature with his 'fish knife' and placed Mr Maltby on the floor.
61. A nurse and an officer started cardio-pulmonary resuscitation procedures (CPR). Another nurse arrived, with a healthcare assistant, who brought the emergency response bag. The nurse asked the officers to move Mr Maltby to the landing and continued with CPR. At 7.06pm, paramedics arrived at the prison's gate and two minutes later, they arrived at Mr Maltby's cell. They directed staff to continue with CPR and attached a defibrillator to Mr Maltby's body. No shock was advised and paramedics pronounced Mr Maltby's death at 7.18pm.

Contact with Mr Maltby's family

62. At around 9.45pm, the Deputy Governor and the Chaplain visited Mr Maltby's mother to inform her of his death. They offered her support.
63. On 16 October, acting manager, and a custodial manager from HMP Ranby, were appointed as the family liaison officers (as there were no trained FLOs available at Nottingham). The acting manager maintained contact with Mr Maltby's family and offered support.
64. The prison contributed to the costs of Mr Maltby's funeral, in line with national guidance.

Support for prisoners and staff

65. After Mr Maltby's death, the duty 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.
66. The prison posted notices informing other prisoners of Mr Maltby'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 Maltby's death.

Post-mortem report

67. The post-mortem examination found that Mr Maltby died due to hanging. The toxicology examination found the presence of NPS in Mr Maltby's body. The pathologist said that NPS may have accounted for his altered behaviour leading up to his death but would not have contributed to the medical cause of death.

Findings

Assessment of Mr Maltby's risk

68. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. Mr Maltby's risk factors included his young age, being recalled to prison, a recent history of self-harm, substance misuse issues including NPS consumption in prison and in the community, and perceived fear of violence or intimidation, particularly after the incident with his cellmate.
69. Staff missed an opportunity to identify and fully scrutinise Mr Maltby's risk factors for suicide and self-harm at reception during his initial health screening. A nurse did not use a facility in Mr Maltby's electronic medical records (*SystemOne*) which would have enabled her to check Mr Maltby's past medical, mental health, and substance misuse history. She assessed that Mr Maltby had no risk factors for suicide and self-harm based on his presentation and his reassurances that he was fine. Mr Maltby's medical records provided relevant information on his risk factors such as a history of cannabis and cocaine use, depression and anxiety, anger and unresolved grief issues and a traumatic childhood. It also had information on a recent event of self-harm which had led to ACCT monitoring in February 2017.
70. PSI 07/2015, early days in custody, says that all newly arrived prisoners must be properly assessed at the reception health screening to determine whether they are at risk of suicide and self-harm and it also stipulates that medical records transferred with the prisoner must be examined as part of the prisoner's assessment of his healthcare needs. Prison Service Order (PSO) 3050, continuity of healthcare, says that when a prisoner enters reception efforts should be made to retrieve medical information and it identifies as a source of information the prisoner's records from previous periods in custody.
71. We agree with the clinical reviewer who recommends that all nurses who conduct health screens at Nottingham should understand and use the new SystemOne reception templates, which must include known significant past medical history to ensure optimum risk assessment and support.
72. The investigation also found that members of staff had not received appropriate ACCT training. Mr Maltby's allocated offender supervisor told the investigator that she had never received ACCT training and was aware that some of her colleagues in the OMU had not received ACCT training. A nurse told the investigator that she had not received formal ACCT training. A supervising officer also told the investigator that he had not received any ACCT training during the initial three years that he had been an SO. We make the following recommendation:

The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that staff:

- **Identify all the known risk factors of a prisoner during the initial health screening including reviewing available sources of information such as SystemOne records.**
- **Receive adequate training on suicide and self-prevention procedures.**

Recall procedures

73. PSI 64/2011 and PSI 07/2015 highlight that early days in custody are a particularly vulnerable time for prisoners. Prisoners who have been recalled to prison have a recognised risk factor for suicide and self-harm which is often affected by the uncertainty of their recall terms.
74. PSI 30/2014, Recall Review and Re-release of Recall Offenders, in place at the time of issuing our initial report, says that the prison must immediately identify all offenders returned to custody following recall, and inform the Public Protection Casework Section (PPCS) of HMPPS within 24 hours, or on the first working day thereafter. They must also ensure that recalled offenders are given the recall dossier issued by PPCS within 24 hours of the prison receiving it and explain to the prisoner their right to make representations to be re-released. Although not expressly stipulated the expectation was that the dossier was to be given to prisoners the “next working day”. This has now been added in the Recall, Review and Re-Release of Recalled Prisoners Policy Framework issued in April 2019, which replaced PSI 30/2014.
75. All offenders given a standard recall must have their case referred to the Parole Board no later than 28 days after their return to custody. If the Board directs their release the Secretary of State is obliged to give effect to that direction.
76. A PPCS manager told the investigator that there was an initial delay of five days in PPCS issuing Mr Maltby’s recall dossier to Nottingham because the prison did not inform them of Mr Maltby’s return to custody on 22 September. PPCS became aware on 27 September that Mr Maltby had been recalled to prison but did not send the recall paperwork to the prison until Saturday, 7 October, 10 days later. There is no subsequent record that the prison’s Offender Management Unit issued Mr Maltby with his recall papers. In the circumstances, we would have expected the dossier to have been issued to Mr Maltby on Monday 10 October. In the event, Mr Maltby did not know the reasons for his recall or whether he was a fixed-term or standard recall during the 20 days he was in custody at Nottingham.
77. Mr Maltby’s allocated offender supervisor told the investigator that such a delay in issuing recall dossiers is not rare at Nottingham. She said that there had been cases where prisoners on fixed-term recall had been given their paperwork just before release. She also said that her team struggled to deal with the high numbers of recall prisoners at Nottingham and that recall documentation often remained unattended in the email inbox.
78. We are concerned that the delay in providing Mr Maltby with his recall paperwork could have added to his frustration and anxiety during his early days in custody. We make the following recommendation:

The Governor and Head of the Offender Management Unit (OMU) should ensure that, in accordance with national policy:

- **the Public Protection Casework Section (PPCS) at HMPPS is informed of the return to custody of recalled prisoners without delay; and**
- **the prison issues the recall dossier to the prisoner the next working day after receipt.**

Mental health care

79. We are concerned that staff did not complete Mr Maltby's mental health assessment.
80. The head of healthcare told the investigator that there are no contractual timescales for an initial mental health assessment but the service endeavours to maintain a quality standard of same day or next working day assessment when anybody makes an urgent referral, or five days for a non-urgent referral. The head of healthcare said that the service has been affected by low staff levels and issues with agency staff, which had caused a backlog of referrals and that the average waiting time for non-urgent referrals was 13 days. (a nurse told the investigator that there was a three to four-week backlog.) The head of healthcare said that the team had been working towards improving the service by filling the vacancy gaps and considering extending the service to a seven-day provision
81. In Mr Maltby's case, 16 days had passed before a nurse attempted to review him on 8 October but could not find him on the wing. His assessment was then rescheduled for 12 days later. This means that Mr Maltby's mental health assessment would have taken place 38 days after the initial referral. In the event, he died before the assessment took place.
82. We agree with the clinical reviewer that the delays in carrying out the mental health review was unacceptable. Mr Maltby died before healthcare staff could assess him, which meant that staff missed another opportunity to speak to him and explore his risk factors for suicide and self-harm. We agree with the clinical reviewer that given such considerable delay in attempting to assess Mr Maltby's mental health, his care was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare, the Healthcare Commissioners and the Governor should review the mental healthcare provision at HMP Nottingham. The review should consider the capacity to deliver a seven-day service of mental health assessments and ongoing interventions effectively, and the availability of staff to support suicide and self-harm prevention procedures at the prison.

Safety of prisoners

83. Before his death Mr Maltby had what an officer later described as a confrontation with his cell mate. It appears this was linked to NPS and staff told the

investigator that the cell mate was known for his NPS consumption. They moved the cell mate to another cell.

84. After the incident with the cell mate on 11 October, Mr Maltby isolated himself in his cell and refused to collect his food. That afternoon he told an officer about his fears for his safety and wrote notes to officers saying that he was under threat and asking to be moved to a different prison.
85. The following day, the day of his death, Mr Maltby asked a supervising officer to collect his meal as he did not want to leave his cell for his own protection and asked for a move to another wing as he was getting 'beef' on the wing.
86. Nottingham has a zero tolerance to violence policy and a violence reduction strategy which sets out measures to investigate and support victims of bullying, threats and intimidation. It says that suspected threats and acts of violence should be investigated even if there is no clear evidence, and, if necessary, escalated to the safer custody team.
87. A prisoner said that Mr Maltby and his cell mate 'exchanged punches' and staff were aware of the incident. A supervising officer and two other officers remembered that an incident took place but they did not submit any intelligence reports or record it in the wing observation book. No officer made any entry in Mr Maltby's or the cell mate's NOMIS case notes, although the prison's violence reduction strategy makes it clear that they should have done.
88. We are not satisfied that staff properly investigated the reasons for Mr Maltby's concern that he was under threat. In addition, staff did not properly support Mr Maltby in accordance with violence reduction procedures after the incident with his cellmate. All incidents of violence have a clear emotional and psychological impact on prisoners. The PPO has published a range of publications identifying the links between NPS, violence and suicide, but we are concerned that prison staff do not seem to have recognised or considered that the perceived threats experienced by Mr Maltby might have increased his risk of suicide or self-harm.
89. It would also have been good practice for the supervising officer to have checked the wing observation book to make himself aware of any incidents or prisoner vulnerabilities on the wing. If he had done so, he would have been aware of Mr Maltby's fears (which had been recorded in the wing observation book by one of the officers) when Mr Maltby spoke to him on the afternoon of his death.
90. We note at an inspection in 2018, HM Inspectorate of Prisons found that many prisoners at Nottingham did not feel safe. A prisoner told the police that Nottingham was the most unsafe prison he had ever been in and he felt unsafe.
91. We make the following recommendations:

The Governor should ensure that all staff on duty familiarise themselves with the details of issues arisen on the wing, which have been recorded in the wing observation book, to ensure that they are fully aware of any prisoner vulnerabilities.

The Governor should ensure that all information indicating bullying and intimidation is fully recorded, coordinated and investigated. That apparent

victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation. That staff consider whether victims are at increased risk of suicide or self-harm.

New Psychoactive Substances

92. Prisoners told the investigator that Mr Maltby was addicted to NPS and was openly taking NPS on the wing. The toxicology report found that Mr Maltby was under the influence of NPS at the time of his death.
93. Nottingham has a Substance Misuse Strategy, issued in January 2017. One of its principles is the prison will not tolerate the presence of illicit drugs and is committed to eliminating the supply of, and demand for, drugs. Another principle is that Nottingham has systems in place to identify, assess and support prisoners with a drug misuse problem.
94. The head of drug strategy at the time Mr Maltby died told the investigator that in a survey that the prison carried out three years ago, 80% of prisoners indicated that they had or were taking NPS at Nottingham. A supervising officer told the investigator that a high number of prisoners continue to take NPS and that he frequently had to call for healthcare assistance to deal with medical issues resulting from prisoners taking NPS. Another prisoner also told the investigator that drugs are everywhere at Nottingham and that staff and prisoners raise alarms every day to attend to prisoners who have overdosed on drugs. This is clearly a huge strain on the already limited resources at the prison.
95. The head of drug strategy told the investigator that the prison was working towards addressing the issue of NPS. He said that they were testing prisoners for NPS as part of their Mandatory Drug Testing (MDTs). He also said that staff were being trained on NPS awareness and the prison had circulated notices to staff. He also said he was drafting an update to the prison's drug strategy, adding a chapter dedicated to NPS.
96. We welcome these efforts. However, in the light of Mr Maltby's death and other recent deaths at Nottingham, it is hard not to conclude that the prison's demand and supply reduction policies have not been effective in reducing incidents of illicit substance misuse, including NPS.
97. The PPO's Learning Lessons Bulletin on NPS, issued in July 2015, says that NPS is a source of increasing concern in prisons and there is emerging evidence that there are links to a prisoner's physical and mental health. In addition, trading these substances can lead to debt, violence and intimidation. The evidence suggests that Mr Maltby had taken NPS at Nottingham and it had caused him problems on the wing, including with his cellmate. We have made recommendations to Nottingham about NPS before, and repeat the following recommendation:

The Governor should review existing policies and their implementation in light of Mr Maltby's death and other recent deaths at Nottingham and the findings of this investigation to ensure they are effective in reducing the supply of and demand for illicit substances, and that staff are vigilant to signs of its use and take appropriate action.

Allegations of the use of force on Mr Maltby on 12 October

98. Mr Maltby's family said that they were informed that officers had used force on him shortly before his death, including hosing him down in response to him damaging his cell.
99. The pathologist who carried out the post-mortem examination identified areas of abrasion to Mr Maltby's face that were trivial in severity, but he found no evidence of a significant head injury and no indication of a forcible restraint or inflicted injury. The police did not make any findings about a use of force against Mr Maltby and ruled out any third-party involvement in his death.
100. On the evidence available we are satisfied that that no force was used against Mr Maltby on 12 October because no officer entered Mr Maltby's cell before a fellow prisoner saw him hanging.

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