

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Roy Zwozny, a prisoner at HMP Nottingham, on 21 October 2019

**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.

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

Mr Roy Zwozny died in hospital from bronchopneumonia on 21 October 2019, while a prisoner at HMP Nottingham. He was 67 years old. I offer my condolences to Mr Zwozny's family and friends.

Mr Zwozny arrived at Nottingham on 8 October 2019 with several long-term health conditions, including heart disease and poor mobility. On 20 October, a nurse found him in a confused state with low blood pressure and sent him to hospital, where he died the next day.

The clinical reviewer was satisfied that up to 17 October, Mr Zwozny received a good standard of healthcare at Nottingham, which was at least equivalent to that he could have expected to receive in the community.

However, I am very concerned that, although he required daily care, Mr Zwozny received no care on 18 and 19 October, and the deterioration in his health was not identified until 20 October. I am unable to say whether Mr Zwozny's condition deteriorated before then, or whether earlier intervention could have prevented his death.

I am also concerned that Mr Zwozny was restrained when taken to hospital, despite being very unwell and having very poor mobility.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**July 2020**

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# Summary

## Events

1. On 8 October 2019, Mr Roy Zwozny was sentenced to six months imprisonment for a sexual offence, and sent to HMP Nottingham.
2. Mr Zwozny had several long-term medical conditions, including heart disease and rheumatoid arthritis. He had regular contact and care from clinical staff from his arrival in prison until 17 October. This stopped abruptly and unaccountably on 18 and 19 October. Appointments were postponed until 20 October and the only contact Mr Zwozny had with healthcare staff on those days was to receive medication.
3. On 20 October at around 1.45pm, a nurse visited Mr Zwozny in his cell for routine checks. He was in a confused state, with laboured breathing and low blood pressure. The nurse asked for an ambulance to be called. Mr Zwozny's condition deteriorated while they waited for an ambulance to arrive, so around 2.45pm, the nurse asked for the ambulance to be upgraded. An ambulance arrived shortly before 3.00pm and Mr Zwozny was taken to hospital around 45 minutes later.
4. Mr Zwozny's condition continued to deteriorate in hospital and he died at 1.45am on 21 October. The post-mortem report concluded that he died from bronchopneumonia and cirrhosis of the liver.

## Findings

5. The clinical reviewer was satisfied that up to 17 October, the care Mr Zwozny received at Nottingham was of a good standard and equivalent to that he could have expected to receive in the community.
6. However, she was concerned that Mr Zwozny received no care from clinical staff on 18 and 19 October. She was unable to say whether Mr Zwozny's deterioration began before 20 October, or whether his death was preventable.
7. Staff assessed that Mr Zwozny required a disabled cell but one was not available. They ordered a pressure mattress for him but it was not due to arrive for several days. The interim mattress provided was inadequate as it deflated on its first use.
8. We are concerned that Mr Zwozny, who had very poor mobility, was restrained when he was taken to hospital. Healthcare staff failed to reflect his poor health and mobility in the escort risk assessment.

## Recommendations

- The Head of Healthcare should ensure that prisoners who have care needs are seen by healthcare staff at the agreed frequency.
- The Governor and Head of Healthcare should review the contingencies for older and disabled prisoners, including ensuring that adequate interim pressure mattresses are available.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that the escort risk assessment form is revised to make it clear that:
  - healthcare staff must provide information about the prisoner's current state of health and mobility; and
  - prison staff must take account of this information in assessing what level of restraints, if any, is appropriate.

## 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 him. No one responded.
10. The investigator obtained copies of the relevant extracts from Mr Zwozny's medical and prison records.
11. NHS England commissioned an independent clinical reviewer to review Mr Zwozny's clinical care at the prison.
12. They jointly interviewed healthcare staff and one prisoner at Nottingham on 26 November 2019.
13. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The Ombudsman's family liaison officer contacted Mr Zwozny's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider.
15. Both Mr Zwozny's next of kin responded and expressed concerns about whether he had received appropriate treatment in prison given his state of health. They asked why they had not been contacted before he died, and why he had died so suddenly without his condition being picked up before he was taken to hospital on 20 October. These issues are covered in our report. Mr Zwozny's family raised several other issues which we have addressed in separate correspondence.
16. The initial report was shared with Mr Zwozny's next of kin. They responded and raised several points that do not impact on the factual accuracy of this report, and these have been addressed through separate correspondence.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one factual inaccuracy and this report has been amended accordingly.

## Background Information

### HMP Nottingham

18. HMP Nottingham is a local prison holding a maximum of 1,060 prisoners, although this was capped at 800 men in November 2018 following an Urgent Notification (UN) from HM Inspectorate of Prisons on 17 January (see below). Nottinghamshire Healthcare NHS Foundation Trust provides health services, including mental health care. The prison has 24-hour primary healthcare cover.

### HM Inspectorate of Prisons (HMIP)

19. HMIP carried out an announced inspection of Nottingham in December 2017/January 2018, which found the prison to be “fundamentally unsafe”. Inspectors found that critical areas identified for improvement in previous inspections, and recommendations by the PPO, had not been acted on or sufficiently implemented.
20. In January 2018, HMIP invoked the UN process which committed the Secretary of State to respond publicly to the concerns raised. This resulted in an action plan from the Secretary of State to deliver improvements, including ensuring that recommendations from the PPO were implemented.
21. However, the report from HMIP, found that the leadership of healthcare was good and there was a wide range of clinical expertise. It said that initial health screening was thorough, and that men with long-term conditions and complex health needs received effective care and treatment from suitably trained nurses (which was identified in the report as an area of good practice).
22. The report said that only 49% of prisoners thought they had access to enough suitable clothing.

### Independent Monitoring Board

23. 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 to 28 February 2019, the IMB did not raise any concerns about healthcare provision. They said that stricter criteria for defining vulnerable prisoners (VPs) had led to them all being housed on one wing and a safer environment. They said that the capping of the prison population at 800 following the UN had led to less pressure on resources.

### Previous deaths at HMP Nottingham

24. Mr Zwozny was the ninth prisoner to die at Nottingham since October 2017. Of the previous deaths, six were self-inflicted, one was from natural causes and one was a homicide. There are no similarities between the investigation findings in Mr Zwozny’s case and the findings in the previous investigations at Nottingham.

## Key Events

25. On 8 October 2019, Mr Zwozny was sentenced to six months imprisonment for a sexual offence, and sent to HMP Nottingham. He was placed on G Wing for vulnerable prisoners (VPs) because of the nature of his offence.
26. Mr Zwozny's next of kin said in a letter to the PPO, that Mr Zwozny had not been expecting to be sent to prison and so was totally unprepared. A prisoner who helped Mr Zwozny on the wing, said at interview that Mr Zwozny had said that his solicitor had told him that he would not be going to prison and so had not prepared for it. He arrived with virtually no possessions or clothes.
27. Mr Zwozny came to prison with chronic health issues, including recurrent atrial fibrillation (AF - a heart condition) and suspected heart failure, alcohol dependency, a hearing impairment, and arthritis and obesity which caused significant mobility problems (he used a walking stick to get around). He was promptly assessed on arrival at Nottingham.
28. He was monitored for five days on the wing for his alcohol withdrawal, and he was given medication to help with the effects. The night after his arrival, he was located in a cell on the same level as the medication dispensary because of his limited mobility.
29. On 12 October, Mr Zwozny was unable to walk to the dispensary and the pharmacy technician went to his cell. She said that he appeared unable to get out of bed and the bed and floor were covered in urine. At interview she said that he appeared to be much better on subsequent days.
30. On 13 October, Mr Zwozny was assigned a wing buddy. This is an informal arrangement at Nottingham, where another prisoner volunteers to help out. The wing buddy's objectives according to the medical notes were "to encourage Roy to walk daily and choose better food choices". He also helped with his personal care, although the Clinical Matron said at interview that this was a function that should have been carried out by healthcare staff.
31. A care plan was put into place for Mr Zwozny's AF on 14 October, with a follow up hospital consultation scheduled for 19 November. On the same day, a special pressure relieving mattress was ordered for him.
32. On 15 October, Mr Zwozny was discussed at a multidisciplinary team (MDT) meeting. Staff agreed that he would benefit from a disabled cell, but none were available at that time. They added him to the complex case register and assigned him a nurse. Staff coded Mr Zwozny as 'red' (high priority), which meant that he should be seen daily. She conducted an in-depth assessment of Mr Zwozny and obtained a more suitable temporary mattress for him to use until his ordered one arrived.
33. His wing buddy said at interview that he inflated the mattress for Mr Zwozny, but it was flat by the next morning.

34. Healthcare staff visited Mr Zwozny in his cell on 16 October, and on that day, a nurse noted the need for daily assessments and treatment of pressure wounds and the need for an appropriate mattress and pressure relief cushion.
35. A prison GP saw Mr Zwozny in his cell on 17 October as he was unable to make it to the surgery (which was on another level). He noted the deflated mattress and sent a message to nursing staff about this on SystmOne (the electronic medical record). This message was forwarded to a nurse who was not due back at work until 20 October.
36. On 17 October, Mr Zwozny made two telephone calls to a friend and asked them to send in some money as he had none and could not buy anything. He also said he was cold. His wing buddy said at interview that Mr Zwozny had brought insufficient clothing and the prison clothing did not fit him as he was a very large man.
37. SystmOne shows medication was dispensed to Mr Zwozny on 18 and 19 October, but there was no delivery of any daily care. Following interviews, we were provided with further information showing that care appointments were postponed until 20 October, but no satisfactory explanation was given.
38. On Sunday 20 October at around 1.45pm, a nurse, who had not been on site since her visit on 15 October, made a routine call to Mr Zwozny's cell for daily checks. She recorded that she found him sitting up in bed, but drowsy and incoherent, unkempt and with dirty clothes. She asked for an ambulance to be called. Mr Zwozny continued to deteriorate while waiting for the ambulance to arrive, and she asked for the ambulance call to be upgraded. The prison radio log records that the ambulance was called again at 2.45pm.
39. The ambulance arrived shortly before 3.00 pm and left 45 minutes later. Mr Zwozny was accompanied by two prison officers and restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). The ambulance arrived at the hospital at 4.20 pm, and by this time Mr Zwozny was no longer responsive. Very shortly after his arrival, he was moved to the resuscitation ward.
40. By 9.00pm, the bedwatch officers reported to the prison that Mr Zwozny was very poorly and had sepsis, a chest infection and fluid on his lungs. Within the hour it was reported that the consultant had said that he was too weak to benefit from treatment in the intensive care unit.
41. At around 1.45am on 21 October, Mr Zwozny died at the hospital.

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

42. Mr Zwozny had listed his next of kin but had not supplied any address or contact number. The prison asked the police to locate her, but the police had difficulty contacting her on the night of 20 – 21 October, and it was mistakenly reported back to the prison that she was away on holiday.
43. A Custodial Manager (CM), acting as the prison's family liaison officer (FLO), managed to contact Mr Zwozny's next of kin and her husband on 21 October by telephone. That evening they emailed him to say that another relative would take

over as the next of kin, and the CM contacted her the next day and ensured that she had all the information she needed about visiting Mr Zwozny and the subsequent arrangements.

44. The prison offered to contribute to Mr Zwozny's funeral costs, but the family declined.

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

45. After Mr Zwozny's death, a CM debriefed the escorting staff. Notices were issued to staff and prisoners about Mr Zwozny's death and signposting support.
46. The wing buddy said at interview that he had wanted to light a candle for Mr Zwozny in the prison chapel, but that the chaplain had been unable to facilitate this as he told him there were safety issues due to his status as a VP. However, the wing buddy said he was well supported by the CM on the wing.

#### **Post-mortem report**

47. A post-mortem examination showed that Mr Zwozny died from bronchopneumonia and cirrhosis of the liver. Left ventricular hypertrophy (thickening of the walls of the heart) was listed as a contributory factor.

# Findings

## Clinical care

48. Mr Zwozny arrived at Nottingham with significant health needs which included previously diagnosed AF and suspected heart failure. A care plan for the medical management of his AF was put in place promptly and a cardiology referral was made to a hospital and an appointment was made for 19 November.
49. Good assessments were carried out of Mr Zwozny's care needs and this included monitoring and treatment of his pressure sores. However, the delivery of his daily care ended abruptly and unaccountably on 17 October, with the result that the care that Mr Zwozny received after this date was principally from his wing buddy.
50. The clinical reviewer found that up to 17 October, Mr Zwozny received good care and attention which was at least equivalent to that he could have expected to receive in the community, but that between 17 and 20 October the care was below that he could have expected in the community.
51. The clinical reviewer said she could not say whether the lack of daily care between 17 and 20 October led to Mr Zwozny's death. However, she said it was a glaring oversight, and she could not exclude the possibility that there might have been opportunities to intervene earlier, although Mr Zwozny did not raise any concerns when receiving his medication.
52. We make the following recommendation:  
**The Head of Healthcare should ensure that prisoners who have care needs are seen by healthcare staff at the agreed frequency.**
53. The clinical reviewer made several other recommendations in her report which the Head of Healthcare will need to address.

## Mr Zwozny's location

54. Mr Zwozny was assessed on arrival at Nottingham as needing a single cell on the same level as the medications dispensary because of his health needs and mobility. This was provided for him on G Wing, which is set aside for VPs.
55. Although he was identified as needing a disabled cell on 15 October, there were none available at that time. Healthcare staff at Nottingham said this is a frequent problem because they are having to accommodate increasing numbers of older prisoners with complex needs.
56. Nottingham is not the only prison facing this problem. In June 2017, the PPO published a Learning Lessons Bulletin paper, *Older Prisoners*. We found that there had not been any strategic grip of a tripling of the over-60s prison population in 15 years, and said that "prisons and their healthcare partners have been left to respond in a piecemeal fashion".
57. In this investigation healthcare staff said that the prison had insufficient disabled facilities, and that the only way they can free up disabled cells is to persuade

other prisons to take on some of their disabled prisoners. Staff said that this was a very frustrating and unproductive process.

58. In the case of Mr Zwozny, although he would have benefitted from a disabled cell, we are satisfied that his accommodation was adequate in the circumstances, given the adjustments that were made. He had a wing buddy to support him and encourage him to mobilise. A social care referral was also made, and a special mattress and pressure cushion were ordered for him. However, the mattress provided for him in the interim was inadequate. We make the following recommendation:

**The Governor and Head of Healthcare should review the contingencies for older and disabled prisoners, including ensuring that adequate interim pressure mattresses are available.**

### Restraints, security and escorts

59. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.
60. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
61. On 20 October, a CM completed a risk assessment for Mr Zwozny's transfer to hospital. This concluded that Mr Zwozny was a medium risk to females, but a low risk in all other respects including risk of escape and to hospital staff.
62. The 'Medical Information' section of the form was completed by the assigned lead nurse for the day. He ticked the box saying there were no medical objections to the use of restraints. There is a part of the form in this section entitled *Any other medical conditions likely to influence the escort? (e.g. Physical Ability to Escape, Disability, need for medication etc)*. He left this part blank.
63. The duty governor authorised two officers to accompany Mr Zwozny and restrain him with single cuffs (where the prisoner is handcuffed to a prison officer), with the proviso that these be removed if his condition deteriorated to life-threatening. For practical reasons the single cuffs were exchanged for an escort chain. The escort chain was removed, after permission was received from the prison, when Mr Zwozny was taken for a scan approximately four hours after arrival at hospital. Permission was granted to leave the restraints off while Mr Zwozny was in an unresponsive state.
64. We are concerned that a nurse did not complete the healthcare section of the risk assessment form to say that Mr Zwozny was very unwell and had difficulty walking. We are not satisfied that prison staff took sufficient account of Mr

Zwozny's very limited mobility or his condition when completing the risk assessment.

65. We make the following recommendations:

**The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

**The Governor should ensure that the escort risk assessment form is revised to make it clear that:**

- **healthcare staff must provide information about the prisoner's current state of health and mobility; and**
- **prison staff must take account of this information in assessing what level of restraints, if any, is appropriate.**

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