Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adrian Hall, a prisoner at HMP Nottingham, on 29 December 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T l 020 7633 4100

Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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

Mr Adrian Hall died at HMP Nottingham on 29 December 2020, a few hours after arriving there. The post-mortem examination was unable to ascertain an obvious cause of death, so the pathologist recorded it as sudden unexpected death in an epileptic patient (SUDEP). Mr Hall was 35 years old. I offer my condolences to his family and friends.

The clinical reviewer was satisfied that the clinical care Mr Hall received in the few hours he was at Nottingham was of a good standard and was equivalent to that he could have expected to receive in the community.

There were delays in the emergency response when Mr Hall was found unresponsive. While staff quickly fetched a nurse, they did not call a medical emergency code, which meant there was a delay in calling an ambulance. I cannot say whether it affected the outcome for Mr Hall, but we know that in a medical emergency a delay of a few minutes can be critical.

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 **October 2021**

Contents

Summary

Events

1. On 2 December 2020, Mr Adrian Hall was released on licence to Trent House Approved Premises in Nottingham. On 29 December, he was recalled to prison custody because of suspected drug use.

2. Mr Hall arrived at HMP Nottingham at around 11.50am.

3. At approximately 2.40pm, an officer saw Mr Hall lying on the floor of the holding cell in reception. He fetched a nurse who was nearby. When the nurse arrived, she asked someone to radio for assistance from the healthcare first responder, who was the prison paramedic that day. When the prison paramedic arrived, he asked staff to call a medical emergency code and staff started cardiopulmonary resuscitation (CPR). Ambulance paramedics took over CPR when they arrived, but this was unsuccessful. They pronounced Mr Hall's death at 3.15pm.

4. The post-mortem examination was unable to establish an obvious cause of death. The pathologist recorded Mr Hall's cause of death as sudden unexpected death in an epileptic patient (SUDEP).

Findings

5. The clinical reviewer was satisfied that the healthcare Mr Hall received in the short time he was at Nottingham was equivalent to that he could have expected to receive in the community.

6. We found that staff did not call a medical emergency code as soon as they realised Mr Hall was unresponsive, which delayed an ambulance being called. We cannot say whether the delay affected the outcome for Mr Hall, but we know that in a medical emergency a delay of a few minutes can be critical.

Recommendations

- The Governor and Head of Healthcare should ensure that staff radio the relevant medical emergency code promptly and in line with PSI 03/2013.

The Investigation Process

7. 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.

8. The investigator obtained copies of relevant extracts from Mr Hall's prison, probation and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Hall's clinical care at the prison. The investigator and clinical reviewer jointly interviewed six members of prison staff on 12 February. The investigator interviewed the manager of Trent House Approved Premises on 29 January 2021, the escorting officer from GeoAmey on 8 February, and a member of prison staff on 12 February. Due to coronavirus restrictions, all interviews were conducted by telephone or video.

10. We informed HM Coroner for Nottinghamshire of the investigation. He sent us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Hall's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. A family representative asked the following questions:

    - Why was Mr Hall recalled?
    - What information did the police share with the prison about Mr Hall's medication?
    - What health and welfare screening did Mr Hall have at Nottingham and how long did he have to wait?
    - What efforts were made to resuscitate him?
    - Was there CCTV of the resuscitation?
    - Mr Hall had a bruise on his face, how did this happen?
    - Where was Mr Hall when he was pronounced dead?

    We have addressed these issues in our report.

12. We shared our initial report with HM Prison and Probation Service (HMPPS). They raised a factual inaccuracy, which has been corrected.

13. We provided Mr Hall's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

Background Information

HMP Nottingham

14. 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.

Trent House Approved Premises

15. Trent House is an Approved Premises run by Nottinghamshire Probation Trust. Approved Premises were previously known as probation hostels. They mostly accommodate offenders released from prison on licence who initially require a supervised environment.

16. Every resident attends an induction session and signs to say that he understands the rules. Each resident undertakes not to bring illicit drugs into Trent House, to undergo random drug tests and allow intelligence-led room searches. Residents who test positive for drugs are offered help and advice.

HM Inspectorate of Prisons (HMIP)

17. HMIP carried out an unannounced inspection of Nottingham in January 2020. Inspectors found that the prison had improved since their last inspection and noted a real change. Reception remained a busy area, but there were systems in place to process prisoners quickly and safely. Inspectors noted that prisoners in reception were interviewed privately, with a focus on their safety.

Independent Monitoring Board

18. 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 2020, the IMB noted there had been an improvement to processes and screening of prisoners in reception. The reception area had benefited from a significant refit and they now had a body scanner.

Previous deaths at HMP Nottingham

19. Mr Hall was the fifth prisoner to die at Nottingham since December 2018. Of the previous deaths, three were from natural causes and one was self-inflicted. We have previously made a recommendation about a delay in calling a medical emergency code.

Key Events

Mr Hall's release on licence

20. Mr Hall was sentenced to 30 months imprisonment for grievous bodily harm on 1 February 2019. On 2 December 2020, he was released on licence to Trent House Approved Premises (AP) in Nottingham. Mr Hall had a history of substance misuse but had engaged with the Substance Misuse Team in prison, and said he was drug free.

21. Mr Hall was prescribed sodium valproate for epilepsy and mirtazapine for depression. He left prison with his medication. However, he told AP staff that he had not been given his medication and on 10 December, his community GP also prescribed it.

22. On 25 and 26 December, staff noted that Mr Hall appeared to be under the influence of illicit drugs. Staff searched his room but found nothing.

23. On 27 December, Mr Hall appeared worse than the night before. He was finding it difficult to stand up, only grunted his responses to questions, and was dribbling. There was an overpowering smell coming from Mr Hall's room, that was suspected to be due to smoking drugs. Staff later found suspected psychoactive substances (PS) in Mr Hall's room. They also removed 51 sodium valproate tablets and six mirtazapine tablets.

24. On 28 December, probation staff decided to recall Mr Hall to prison custody, due to his drug use.

Mr Hall's recall to prison

25. Mr Hall was arrested at Trent House at 8.30am on 29 December. Police took him to Bridewell Police Station and arrived there at 8.56am. At 10.03am, a nurse assessed Mr Hall and gave him 300mg of sodium valproate, which staff at Trent House had given to the police. At 11.21am, Mr Hall was released from police custody, and GeoAmey escort staff prepared to take him to HMP Nottingham.

26. One of the GeoAmey escorting officers told the investigator that Mr Hall had seemed fine and did not appear to be under the influence of illicit drugs. He said Mr Hall was quiet, but when asked, he said he was 'just tired'. While at the police station, Mr Hall asked to make a telephone call to probation, and the officer permitted this. There was no reply and Mr Hall became a bit stressed and cross, but the escorting officer told him he would be able to make a telephone call from the prison, and this settled him. The officer said they chatted generally and there were no issues.

27. Once in the van, Mr Hall complained he felt cold. The escorting officer offered to go into the police station and pick up a jumper for him, which he declined. The officer put the heating on for him.

HMP Nottingham

28. Mr Hall arrived at Nottingham at approximately 11.50am. His Person Escort Record (PER – a document that accompanies prisoners between police custody, court and prison which sets out the risks they pose) gave details of Mr Hall's health issues, including epilepsy, anxiety and depression. It noted that he had taken his prescribed medication for epilepsy, sodium valproate, while in police custody. Mr Hall was due his next dose of sodium valproate at 10.00pm that night. Mr Hall's medical summary record noted he had drug induced epilepsy and was on medication for this, as well as an antidepressant.

29. A Supervising Officer (SO) saw Mr Hall in reception and remembered him from his previous time at Nottingham. Mr Hall said he had no issues with drugs or alcohol, and no thoughts of self-harm. At 12.15pm, staff took Mr Hall to a holding cell in reception while the SO added his details to the computer. Unfortunately, the system was down, and the SO was unable to input all Mr Hall's details immediately, which caused a delay in his reception process. (The SO completed the inputting of Mr Hall's details at 1.36pm.)

30. An officer carried out Mr Hall's reception screening interview. She had known Mr Hall for a number of years. She thought he seemed quiet and not himself so asked him if he was alright. Mr Hall said he did not know why he was back in prison and it had been a shock when the police had arrived. He said he wanted to telephone his mother. She told him that he would be able to do so after his healthcare assessment. Mr Hall did not say he felt unwell at any stage. She arranged some lunch for Mr Hall, and he returned to his cell.

31. The officer saw Mr Hall as she passed by his cell a little later. He was sitting down and did not appear unwell. After lunch, at 1.30pm, the SO took Mr Hall's photograph. Ten minutes later staff searched him, and a further ten minutes later staff used the body scanner to check Mr Hall. After this, they returned him to the cell. Staff did not remember Mr Hall looking unwell or causing concern.

32. At approximately 2.40pm, Officer A walked past Mr Hall's holding cell, and stopped to speak to Officer B and another officer. He glanced into Mr Hall's cell and saw he was lying on the cell floor.

33. Officers A and B tried to rouse Mr Hall through the cell door, but he did not respond. Officer B had difficulty opening the door, as Mr Hall was lying against it, but managed to squeeze into the cell. He put Mr Hall into the recovery position and noticed he had blood on his face. Officer A knew a nurse was in reception, so ran to get her.

34. The nurse immediately went to the cell and saw Mr Hall lying on his side on the floor. She asked Officer A, who had picked up some gloves and returned to the cell, to radio for "Hotel 9" (the call sign for the healthcare first responder), who that day was the prison paramedic. She said she was cautious of assessing Mr Hall herself because of COVID restrictions and because she had been in similar situations where the prisoner had "lashed out" when she approached them. She said she managed to reach out to put an oximeter on Mr Hall's finger to check his oxygen level, but the prison paramedic arrived before she got a reading.

35. The prison paramedic saw Mr Hall was laid in the recovery position facing away from the door. He rolled Mr Hall on to his back and checked for a pulse but did not find one. At 2.48pm, he requested someone radio an emergency code blue and continued to assess Mr Hall, while trying to insert an airway into his mouth.

36. A nurse quickly responded to the code blue call. A nurse and the prison paramedic were with Mr Hall, who looked very pale, had a cut on his head, and felt slightly cold. The paramedic had inserted an airway, as Mr Hall was not breathing. The nurse immediately started chest compressions and asked another nurse, who had also responded to the call, to attach the defibrillator. No shock was advised during CPR. The nurse continued chest compressions until paramedics arrived.

37. The first paramedics arrived at Mr Hall's cell at 2.55pm. They attached an automatic defibrillator and continued cardiopulmonary resuscitation (CPR) until 3.15pm, when they pronounced Mr Hall's death.

Contact with Mr Hall's family

38. A custodial manager was appointed as the family liaison officer. He telephoned Mr Hall's mother to tell her that her son had died. (Due to restrictions in place during the COVID-19 pandemic, visits could not be made in person to break the news.)

39. The prison contributed to the cost of Mr Hall's funeral, in line with national guidelines.

Support for prisoners and staff

40. After Mr Hall's death, a prison manager 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.

41. The prison posted notices informing other prisoners of Mr Hall'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 Hall's death.

Post-mortem report

42. The post-mortem examination was unable to ascertain the cause of Mr Hall's death. The toxicology analysis showed no evidence of illicit drug use. It showed therapeutic amounts of sodium valproate and mirtazapine.

43. The pathologist noted that Mr Hall had epilepsy and in the absence of an obvious cause of death, recorded it as sudden unexpected death in an epileptic patient (SUDEP, the term used when a person with epilepsy dies without warning and where the post-mortem fails to establish any other cause of death).

44. The pathologist said the bruise on Mr Hall's forehead was consistent with him having collapsed to the ground. There was no evidence of an underlying significant brain injury and he did not consider that this caused or contributed to Mr Hall's death.

45. At the inquest, the Coroner found that Mr Hall died from cardiorespiratory arrest caused by epileptic seizure. The inquest conclusion was natural causes.

Findings

Clinical care

46. The clinical reviewer was satisfied that the clinical care Mr Hall received in the short time he was at Nottingham was of a good standard and was equivalent to that he could have expected to receive in the community.

Emergency response

47. When an officer realised Mr Hall was unresponsive at about 2.40pm, he put him in the recovery position while another officer, who knew there was a nurse in reception, went to get her. We would have expected staff to have called a medical emergency code blue as soon as they realised that Mr Hall was unresponsive. This would not only have alerted healthcare staff but would have told the control room to call an ambulance immediately. When the nurse arrived in the cell, she asked an officer to radio the healthcare first responder. She too did not call a code blue.

48. No one called a code blue until 2.48pm, when the prison paramedic arrived and asked for the code to be called. There was therefore a delay of eight minutes before an ambulance was called.

49. We cannot say whether the delay affected the outcome for Mr Hall, but we know that in a medical emergency a delay of a few minutes can be critical. We recommend:

The Governor and Head of Healthcare should ensure that staff radio the relevant medical emergency code promptly and in line with PSI 03/2013.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T l 020 7633 4100