

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Davitt, a prisoner at HMP Nottingham, on 23 October 2022

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 Christopher Davitt died in hospital of a stroke on 23 October 2022, while a prisoner at HMP Nottingham. He was 39 years old. I offer my condolences to Mr Davitt's family and friends.

Mr Davitt became unwell with a bad headache on 12 October. Prison healthcare staff sent him to hospital the next day where he was diagnosed with a bleed on the brain. He underwent surgery but died in hospital just over a week later.

The clinical reviewer found that healthcare staff at Nottingham responded appropriately when Mr Davitt became ill and that the care he received was equivalent to that which he could have expected to receive in the community.

I make no recommendations.

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

Susannah Eagle
Deputy Prisons and Probation Ombudsman

May 2023

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Summary

Events

1. On 29 September 2022, Mr Christopher Davitt was sentenced to 26 weeks imprisonment for theft. He was sent to HMP Nottingham.
2. On the evening of 12 October, Mr Davitt complained of a bad headache. A nurse saw him and took his clinical observations, which were all normal. She gave him paracetamol for his headache.
3. On 13 October, staff noticed that there was vomit on the floor of Mr Davitt's cell. Mr Davitt said he felt extremely unwell and was struggling to lift his head or look at lights. A nurse saw him and thought he was showing signs of meningitis (an infection in the brain that causes headache and a stiff neck). She called an ambulance and Mr Davitt was taken to hospital.
4. Hospital doctors diagnosed a bleed on the brain. On 14 October, Mr Davitt underwent surgery.
5. On 20 October, Mr Davitt underwent a brain scan, which showed that he was still bleeding severely.
6. On 22 October, hospital doctors put Mr Davitt on a ventilator to help him breathe and gave him medication to support his blood pressure. Mr Davitt died the next day.
7. A hospital doctor recorded Mr Davitt's cause of death as cerebral infarction (stroke) caused by subarachnoid haemorrhage (bleeding in the space around the brain).

Findings

8. The clinical reviewer found that prison healthcare staff responded appropriately when Mr Davitt became unwell and that the care he received at Nottingham was equivalent to that which he could have expected to receive in the community.
9. We make no recommendations.

The Investigation Process

10. 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.
11. The investigator obtained copies of relevant extracts from Mr Davitt's prison and medical records.
12. NHS England commissioned an independent clinical reviewer to review Mr Davitt's clinical care at the prison.
13. We informed HM Coroner for Nottingham City of the investigation. The Coroner provided us with the cause of death. We have sent the Coroner a copy of this report.
14. The Ombudsman's family liaison officer contacted Mr Davitt's father to explain the investigation and to ask if he had any matters he wanted us to consider. He raised no issues but asked for a copy of our report.
15. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.
16. We sent a copy of our initial report to Mr Davitt's father. He did not notify us of any factual inaccuracies.

Background Information

HMP Nottingham

17. HMP Nottingham is a resettlement and local prison serving the courts of Nottinghamshire and Derbyshire. It has capacity for approximately 900 men. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Nottingham was in May and June 2022. Inspectors said that it was a challenging prison to run, and although it was improving from the low base of previous recent inspections, progress was still required in many areas.
19. Inspectors said that health services were well led but had become stretched since their last inspection in 2020, and that staff shortages were affecting service delivery. However, most essential provision continued and governance and oversight arrangements were robust with good processes to identify and mitigate risk. They said the management of long-term conditions was good.

Independent Monitoring Board

20. 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 2022, the IMB reported that the prison was gradually returning to a more normal regime following the COVID-19 pandemic. This included prisoners having more face to face appointments with healthcare staff.

Previous deaths at HMP Nottingham

21. Mr Davitt was the eleventh prisoner to die at Nottingham since October 2020. Of the previous deaths, two were self-inflicted, one was drug related and the rest were from natural causes.

Key Events

22. On 29 September 2022, Mr Christopher Davitt was sentenced to 26 weeks imprisonment for theft. He was sent to HMP Nottingham.
23. At 8.24pm on 12 October, Mr Davitt rang his cell bell. He rang it again at 8.26pm. When an officer went to Mr Davitt's cell, he saw that Mr Davitt appeared to be in pain and was sweating. Mr Davitt said he had a bad headache and felt very hot. The officer asked for a member of healthcare staff to see Mr Davitt.
24. At 10.15pm, a nurse attended Mr Davitt's cell and took his clinical observations, which were all within normal range. She gave Mr Davitt some paracetamol for his headache.
25. On the morning of 13 October, Mr Davitt attended the wing pharmacy hatch and collected more paracetamol.
26. A short time later, wing staff noticed that there was vomit on the floor of Mr Davitt's cell. Mr Davitt said he felt extremely unwell and was struggling to look at lights or lift his head. An officer began escorting Mr Davitt to the healthcare unit but was then told that healthcare staff would come to Mr Davitt's cell.
27. At approximately 9.20am, a nurse attended Mr Davitt's cell. She noted Mr Davitt was showing signs of meningitis (an infection of the meninges, the protective tissues of the brain, that causes a stiff neck, headache and fever) and called an ambulance. An ambulance arrived at 9.33am and took Mr Davitt to hospital.
28. On 14 October, Mr Davitt underwent surgery for a bleed on the brain.
29. On 20 October, Mr Davitt remained drowsy and had an emergency brain scan. This showed that he was still bleeding severely.
30. On 22 October, hospital doctors put Mr Davitt on a ventilator to help him breathe and gave him medication to support his blood pressure. Mr Davitt died the next day.

Contact with Mr Davitt's family

31. On 14 October, the prison appointed an officer as the family liaison officer (FLO). Mr Davitt had no nominated next of kin.
32. On 21 October, Mr Davitt's aunt called the prison after the police contacted her. She said that she would contact Mr Davitt's brother and see if he could get a message to his father. Mr Davitt's father called the prison shortly after and left his contact details. The FLO called Mr Davitt's father the same day, told him that his son was in hospital and arranged for him to speak with the hospital.
33. Mr Davitt's father was with his son when his life support machine was turned off on 24 October.
34. On 25 October, the FLO called Mr Davitt's father and offered his condolences. The prison contributed to the funeral costs in line with policy.

Support for prisoners and staff

35. The prison posted notices informing staff and prisoners of Mr Davitt's death, and offering support.

Cause of death

36. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Davitt's cause of death as a cerebral infarction (stroke) caused by spontaneous subarachnoid haemorrhage (bleeding in the space around the brain).
37. The inquest conclusion was natural causes.

Findings

Clinical care

38. The clinical reviewer found that prison healthcare staff were responsive when Mr Davitt became ill and that they treated him appropriately. She concluded that the care Mr Davitt received at Nottingham was equivalent to that which he could have expected to receive in the community.
39. We make no recommendations.

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