Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Roberts (aka Michael Kerry), a prisoner at HMP Nottingham, on 16 June 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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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 Michael Roberts (also known as Michael Kerry) died in hospital from an excess of tramadol (a prescription opioid painkiller) on 16 June 2022, while a prisoner at HMP Nottingham. He was 59 years old. I offer my condolences to Mr Roberts' family and friends.

Mr Roberts was prescribed tramadol but was not allowed to keep it in his possession (it was administered by prison healthcare staff). It is unclear how he managed to take an excessive amount. It is also unclear whether it was an intentional overdose as he left no note and gave staff no indication that he intended to take his own life. When Mr Roberts was taken to hospital on 15 June after falling ill, he told no one that he had taken excessive tramadol.

The clinical reviewer found that Mr Roberts' medication was prescribed appropriately. However, the clinical reviewer found that staff did not consistently use the standard clinical tool (NEWS2) to monitor clinical deterioration. This is an issue we have raised with Nottingham several times before and the new Head of Healthcare will need to address this issue.

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

Susannah Eagle
Deputy Prisons and Probation Ombudsman **May 2023**

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Summary

Events

1. On 4 February 2022, Mr Michael Roberts (also known as Michael Kerry) was recalled to prison after being charged with further sexual offences. He was sent to HMP Nottingham.

2. Mr Roberts had a history of self-harm and suicide attempts. He took an overdose in October 2021 while in the community. Prison staff supported him using suicide and self-harm procedures (known as ACCT) from 4 to 26 February.

3. Mr Roberts had heart disease, high blood pressure and diabetes, and had recently had a toe amputated. He also had a history of substance abuse, including the misuse of tramadol and other opiate painkillers. He was prescribed tramadol in prison for foot pain but was not allowed to keep it in his possession (healthcare staff administered it).

4. On 8 February and 24 March, healthcare staff saw Mr Roberts after he complained of chest pain. On both occasions the pain resolved, and no follow up action was required.

5. On 28 April, Mr Roberts was sentenced to 28 months imprisonment. He told staff that he was positive about it as he had expected a longer sentence.

6. At the end of May, a prison GP increased Mr Roberts' tramadol prescription after he complained of increased pain in his feet.

7. On 7 June, Mr Roberts experienced chest pain again. Although his pain subsided, his blood pressure remained high.

8. On 12 June, Mr Roberts complained of pain in his legs and abdomen, and he again had raised blood pressure. He felt a bit better the next day and attended work.

9. However, on 15 June, Mr Roberts appeared unwell when his cell was unlocked. He complained of chest pain, and he had difficulty breathing. Several of his observations were outside normal range. An ambulance took him to hospital. Mr Roberts had two cardiac arrests in the early hours of 16 June, and he died that morning.

10. The post-mortem report concluded that Mr Roberts died from drug toxicity, due to an elevated level of tramadol in his body, which was sufficient to be fatal. Heart disease and chronic granulomatous inflammation (a lung condition) were listed as contributory factors.

Findings

11. It is unclear how Mr Roberts took an excessive amount of tramadol when he was not allowed it in possession. It is also unclear whether it was intentional as Mr Roberts left no note and gave staff no indication that he intended to take his own

life. When he was taken to hospital on 15 June, he told no one that he had taken excessive tramadol.

12. Mr Roberts did not have a history of diverting medications or trading in them. However, very shortly before Mr Roberts died, prison inspectors observed poor supervision of the medication queue on his wing, and the possibility remains that either Mr Roberts or another prisoner diverted their medication for later use.

13. The clinical reviewer said that there were areas of good practice in relation to Mr Roberts' clinical care at Nottingham, including appropriate monitoring of Mr Roberts' long-term conditions, mental health and substance misuse. However, she concluded that aspects of the care Mr Roberts received were not equivalent to that he could have expected to receive in the community.

14. She was concerned that despite Mr Roberts having a significant history of cardiac problems, staff did not create a cardiac care plan until 1 June. Also, when Mr Roberts had chest pain, it was not managed in line with national guidance, and there was not an appropriate follow up to Mr Roberts' high blood pressure.

15. The clinical reviewer also found that staff did not consistently use NEWS2 (a tool to assess clinical deterioration) when Mr Roberts' health deteriorated in June. This is an issue we have raised with Nottingham several times before and which the new Head of Healthcare will need to address.

Recommendations

- The Governor and the Head of Healthcare should ensure that staff always follow the prison's local policy when calling prisoners to the medication hatch to receive prescribed medication.
- The Head of Healthcare should ensure that staff initiate care plans in a timely manner.
- The Head of Healthcare should ensure that staff follow the NICE guidance: Recent-onset chest pain of suspected cardiac origin: assessment and diagnosis.
- The Head of Healthcare should ensure that staff follow the NICE guidance: Hypertension in adults: diagnosis and management.
- The Head of Healthcare should ensure that healthcare staff consistently use the National Early Warning Score (NEWS2) tool to assess unwell prisoners effectively and identify any clinical deterioration.

The Investigation Process

16. 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.

17. The investigator obtained copies of the relevant extracts from Mr Roberts' medical and prison records.

18. NHS England commissioned an independent clinical reviewer to review Mr Roberts' clinical care at HMP Nottingham.

19. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

20. The Ombudsman's family liaison officer contacted Mr Roberts' next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Background Information

HMP Nottingham

22. HMP Nottingham is a resettlement and local prison serving the courts of Nottinghamshire and Derbyshire. It has a current capacity for approximately 900 men. Healthcare for the prison is provided by Nottinghamshire Healthcare NHS Foundation Trust.

HM Inspectorate of Prisons

23. 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.

24. 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. The management of-long term conditions was good.

25. Inspectors found that intelligence reports were up to date and that there had been improvements in limiting the supply of illicit drugs since their last report. They said that the supervision of medication queues by prison officers was good, except for G Wing (the wing Mr Roberts was on), where patients grouped around the hatch and confidentiality was not suitably maintained. They also said that secure storage facilities in cells were not adequate, which increased the risks of bullying and diversion of medicines.

Independent Monitoring Board

26. 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 more face to face appointments with healthcare staff.

Previous deaths at HMP Nottingham

27. Mr Roberts was the eighth prisoner at Nottingham to die since June 2020. Of the previous deaths, one was self-inflicted and six were from natural causes. We have previously made recommendations about the use of NEWS2 (a tool used to assess clinical deterioration).

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Tramadol

29. Tramadol is an opioid based painkiller. It is used to treat moderate to severe pain such as during or after an operation or a serious injury. It is possible to become addicted to tramadol although it is considered to be less addictive than some other prescription opioid pain killers. As with other opioids, tramadol, especially at high doses, can suppress natural breathing. According to NHS guidance, tramadol is dispensed to the prisoner daily and they are not allowed to hold quantities of it in their cell.

Key Events

30. On 4 February 2022, Mr Michael Roberts (also known as Michael Kerry) was recalled to prison after being charged with further sexual offences. He was sent to HMP Nottingham.

31. Mr Roberts self-harmed while he was in police custody and had a history of suicide attempts. When he arrived at Nottingham, staff started suicide and self-harm monitoring (known as ACCT).

32. Mr Roberts had heart problems and high blood pressure. He also had diabetes, and complications from this had recently resulted in the amputation of the big toe of his left foot. He was prescribed tramadol, which was continued by prison healthcare staff. In line with guidance, Mr Roberts was expected to collect the medication daily from the wing medication hatch.

33. On 8 February, Mr Roberts told staff he had chest pain and was seen by healthcare staff. The pains subsided after a few hours and no follow up was required.

34. The same day, the prison's substance misuse services (SMS) team saw Mr Roberts. He admitted to using an extensive range of illicit substances in the past and said that more recently he had a problem with cannabis and the opioid painkillers tramadol and dihydrocodeine.

35. On 22 February, a SMS team member gave Mr Roberts a programme to work through to help with his cannabis use. They also made precautionary appointments for him with a community SMS team when he had court appearances, in the event that the court authorised his release.

36. Staff closed Mr Roberts' ACCT on 26 February as he was settled and no longer required additional support. At a post closure interview on 5 March, Mr Roberts said that he was receiving support from the mental health team as well as staff and peers, and he felt much more positive.

37. On 24 March, Mr Roberts complained of chest pain. Healthcare staff assessed him and considered his pain was consistent with his known angina (where a reduced blood supply to the heart muscles can cause chest pain). The pain subsided after Mr Roberts took his angina medication.

38. On 28 April, Mr Roberts was sentenced to 28 months imprisonment. He said he felt positive about this as he had expected a longer sentence.

39. At the end of May, Mr Roberts complained of increased pain in his feet related to his diabetes. On 26 May, he could barely walk and rated the pain in his legs as ten out of ten. A prison GP carried out a pain review on 1 June and increased his tramadol medication from 200mg to 300mg a day. On the same day, healthcare staff created a cardiac care plan for Mr Roberts.

Events of 7-16 June

40. On the afternoon of 7 June, Mr Roberts complained of chest pain again. His blood pressure and heart rate were raised, but his other observations were within normal ranges. Although his pain settled a little, his blood pressure remained high. A nurse told Mr Roberts if he continued to have pain or if his condition worsened, he should ask for the nurse to come back.

41. There is no record of Mr Roberts asking to see healthcare staff again until the early afternoon on 12 June, when he complained of pain in both legs and in his lower abdomen. His heart rate and blood pressure were both raised again and at very similar levels to those on 7 June. A nurse gave Mr Roberts some pain relief and advised him what to do if his condition worsened. She told him that a nurse would see him again the next day.

42. On 13 June, Mr Roberts felt a bit better and attended work in the morning. A nurse saw him and recorded an improvement in both his blood pressure and heart rate. The nurse scheduled weekly blood pressure readings to monitor Mr Roberts.

43. Healthcare staff next saw Mr Roberts at around 8.35am on 15 June, after wing officers found him unwell and made a code blue radio call (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call an ambulance). Mr Roberts was breathless and had chest pain. His blood oxygen levels were significantly lower than normal and heart rate was higher than the elevated readings of recent days. His blood pressure was a little raised, but less so than on recent days. Mr Roberts was much more ill than he had been over the previous week. An ambulance arrived at around 9.40am and took him to hospital about 20 minutes later. Staff suspected that Mr Roberts was having a heart attack. Mr Roberts did not say anything about taking additional medication or illicit substances.

44. Mr Roberts was given supplementary oxygen by hospital staff to help with his breathing as well as antibiotics. However, in the early hours of the morning of 16 June, Mr Roberts stopped breathing. Although hospital staff managed to resuscitate him, Mr Roberts' heart stopped again a short time later. Hospital staff considered that further active treatment was not in his best interests, and he died shortly before 5.30am.

Contact with Mr Roberts' family

45. Following Mr Roberts' death, the prison tried to identify a next of kin. Mr Roberts had told officers in April that he had no contact with his family following the death of his father the previous year. The prison located a sister and contacted her, but she said that she did not want any involvement following Mr Roberts' death. The prison arranged and paid for his funeral.

Support for prisoners and staff

46. After Mr Roberts' death, staff who were involved were offered support by the Care Team. A staff notice was issued signposting follow up support. The prison also posted notices informing other prisoners of Mr Roberts' death and offering support.

Post-mortem report

47. Toxicology tests found that Mr Roberts had elevated levels of tramadol in his system when he died. The pathologist concluded that it was at a level sufficient to cause death. She recorded Mr Roberts' cause of death as drug toxicity. She listed ischaemic heart disease (when the heart's blood supply is blocked or interrupted by a build-up of fatty deposits in the coronary arteries) and chronic granulomatous inflammation in the lungs (when small lumps of immune cells form in the lungs in response to inflammation) as contributory factors.

Findings

Tramadol toxicity

48. Mr Roberts died from an excess of tramadol. This medication was administered to him by prison healthcare staff, so it is unclear how he managed to take an excessive amount. It is also unclear whether the overdose was intentional. Mr Roberts had a history of drug abuse, including with tramadol. He also had a history of suicide attempts, one of which included a deliberate overdose which involved tramadol (in October 2021 in the community). However, in the days leading up to his death, Mr Roberts gave no indication that he was depressed or experiencing mental health problems.

49. Staff found no suicide note, or unauthorised medications when they searched Mr Roberts' cell, and at no time after he fell ill did he tell staff that might have taken too much tramadol. However, during a previous time in prison in May 2017, Mr Roberts had attempted to hang himself. When he was found, he had stopped breathing and was revived by staff. On that occasion, Mr Roberts had not left a suicide note and had not shown any signs of distress prior to his suicide attempt. Therefore, although there is no evidence to indicate that Mr Roberts deliberately took his own life, that possibility cannot be ruled out.

50. In the weeks leading to his death, Mr Roberts had complained of severe pain in his feet and the GP increased his tramadol dose by a third to manage the pain. If he secreted some of his tramadol for later use, or obtained some from an illicit source, it is also, therefore, possible that Mr Roberts accidentally took too much medication in response to his pain levels.

Collection of medications

51. The clinical reviewer was satisfied that the clinical staff at Nottingham had assessed Mr Roberts' medication needs properly, and that he was prescribed drugs appropriate for his conditions. Staff administered tramadol to Mr Roberts, and he was not allowed to keep any in his cell. Prisoners sometimes pretend to take medications but actually save them for later personal use, or to sell to other prisoners. However, Mr Roberts was not observed doing this at Nottingham, and had no records of attempting to do this during previous sentences.

52. Nottingham has a Safe Systems Of Work (SSOW) document to guide prison officers in the supervision of the collection of daily medications by prisoners. It includes guidance on close observation of prisoners collecting medication, ensuring orderly queues, and preventing groups gathering around the medication hatch.

53. Nottingham's drug strategy document, dated April 2022, identified that diversion of medications had increased and that there was a need to ensure supervision as outlined in the SSOW. HMIP inspectors found the supervision of daily medications to be good across the prison but had some reservations about the adequacy of the supervision on G Wing where Mr Roberts was located. When they were there, they observed groups congregating around the medication hatch. Therefore, we cannot discount the possibility that diversion of medication was a factor in Mr Roberts'

death, as the inspectors were in the prison 24-25 May, and 6-10 June, just before Mr Roberts died.

54. We recommend:

The Governor and the Head of Healthcare should ensure that staff always follow the prison's local policy when calling prisoners to the medication hatch to receive prescribed medication.

Clinical care

55. The clinical reviewer found examples of good practice, in particular the monitoring of Mr Roberts' long-term conditions, mental health and substance misuse. However, she found that there were some aspects of his care that were not equivalent to that he could have expected to receive in the community.

Cardiac care plan

56. Mr Roberts had an extensive history of cardiac issues before arriving at Nottingham and had episodes of chest pain in February and March. However, the clinical reviewer found that staff did not create a cardiac care plan until June. We recommend:

The Head of Healthcare should ensure that staff initiate care plans in a timely manner.

Management of Mr Roberts' chest pain and blood pressure after 7 June

57. The clinical reviewer said that when Mr Roberts presented with chest pain on 7 June, this was not managed in line with national guidelines. She also said that his high blood pressure should have led to an appointment with a doctor. We recommend:

The Head of Healthcare should ensure that staff follow the NICE guidance: Recent-onset chest pain of suspected cardiac origin: assessment and diagnosis.

The Head of Healthcare should ensure that staff follow the NICE guidance: Hypertension in adults: diagnosis and management.

Monitoring of clinical deterioration

58. The clinical reviewer identified concerns about the inconsistent use of the National Early Warning Score (NEWS2) tool. NEWS2 is a nationally recognised tool to facilitate the early detection of clinical deterioration by categorising a patient's severity of illness and prompting nursing staff to request a medical review at specific trigger points. NEWS2 allocates a score of 0-3 for each vital sign: respiratory rate; blood oxygen level; pulse; blood pressure; temperature and level of consciousness. The scores are added together, and a total score is recorded which is their national early warning score.

59. The NEWS2 tool was not consistently used after Mr Roberts became unwell in June. It is a concern that this problem persists at Nottingham despite several previous recommendations and assurances that the problem has been addressed. We note that a new Head of Healthcare recently took up post and hope that they will address this issue. We recommend:

The Head of Healthcare should ensure that healthcare staff consistently use the National Early Warning Score (NEWS2) tool to assess unwell prisoners effectively and identify any clinical deterioration.

Inquest

60. The inquest was concluded on 18 December 2023. It determined that Mr Roberts died from drug toxicity.

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