

**Investigation into the circumstances surrounding the
death of a man in hospital whilst a prisoner at HMP
Nottingham**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

June 2007

This is an investigation report into the circumstances surrounding the death of a man in hospital 25 November 2006. The man was a prisoner at HMP Nottingham and was 51 years old when he died.

The man collapsed in his cell in the prison's healthcare unit. He had been recalled to prison following revocation of his life licence just nine days earlier. A post mortem examination has revealed that his death was due to an acute myocardial infarction (heart attack) and coronary artery atheroma.

I extend my sincere condolences to the man's son, other members of his family and his friends.

The investigation was undertaken by my colleague. I would like to thank the Governor of HMP Nottingham, and his staff for their help and assistance in this investigation. In particular, I must single out a Senior Officer for his involvement as a Liaison Officer with both the man's family and with my office.

As part of the investigation, a clinical review into the man's medical care was commissioned from Nottingham Primary Care Trust. I am grateful to a doctor for the review which is annexed to this report.

I make two recommendations taken from the doctor's review for the attention of the prison partnership board, and have added one recommendation of my own in recognition of the professional actions demonstrated by a number of members of staff. All three recommendations have been accepted by the Prison Service in this final report.

This version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man was a life-sentenced prisoner following a conviction for the manslaughter of his wife. He was transferred from the Prison Service to a mental health hospital in 1997, after being diagnosed with schizophrenia, and detained under section 47 of the Mental Health Act 1983. In 2004, he was released to a supported mental health housing project following a Mental Health Review Tribunal. The man was supervised by Nottinghamshire Probation Area with regard to his life licence.

Whilst the man lived in the supported housing project, he maintained regular contact with his family. In the summer of 2006, he applied to his Probation Officer for permission to travel to abroad for a family wedding (a condition of his life licence was that he could not travel outside Great Britain without the permission of his Probation Officer). Permission to travel was denied. The man appealed against the decision, but was turned down again.

The man then made threats to his supervising officer on two separate occasions. Although consideration was given to recalling the man to prison at this time, a decision was made not to because the threats were seen as his frustration at not being allowed to travel abroad, rather than serious and realistic.

The man's mental health then began to decline, although there is no documented evidence to suggest that the decision was a catalyst for this deterioration. On 10 November 2006, he stayed at a mental health community project overnight. Early the following morning, he became agitated and violent towards a female member of staff and had to be restrained. The man was admitted as a voluntary patient to hospital for his own safety.

Whilst an in patient at the hospital, the man did not show any signs of psychosis or mental illness that would have been sectionable under the Mental Health Act 1983.

On 16 November 2006, the man's probation officer applied for the man's licence to be revoked. the probation officer's reasons were the man's declining mental health, his threats to kill and his assault on a female member of staff. A revocation of licence was issued later that same day. The man was arrested at hospital where he was still a patient in the mental health unit. He was taken to a police station overnight. On 17 November, he was taken to Crown Court where his licence was formally revoked. He was then taken to HMP Nottingham.

During the reception healthscreen at the prison, the man did not mention any physical health concerns. Specifically, there was no mention of chest pains or use of the GTN (angina) spray. (the man had previously been prescribed angina spray, but was not compliant with either the medication or GP interventions.) However, he did ask to be seen by a doctor regarding his physical health. The man was admitted to the prison's healthcare unit for an assessment of his mental health.

During the morning of 25 November, the man became unwell and later collapsed. Healthcare staff performed cardiac pulmonary resuscitation (CPR). Paramedics attended the prison promptly and the man was taken to hospital. He died shortly

after arriving in the Accident and Emergency Department having suffered a heart attack.

My investigation has concluded it was entirely proper for the man to have been recalled to prison. The reception screening at Nottingham was appropriate and the man did not disclose any previous history of chest pain. However, there was unnecessary delay in the man being prescribed Olanzapine by the prison, although this would not have affected his physical well-being or his subsequent cardiac problems on 25 November.

Faxed medical papers from the outside GP arrived at the prison on 22 November. As well as giving information about the man's mental health and supporting medication, they also contained reference to a history of ischaemic heart disease and previous use of GTN spray. This latter information was not picked up or acted upon by prison medical staff. Whilst the clinical reviewer felt that the outcome would not have been different for the man, both his and my report contain a recommendation about medical staff reviewing newly received information as this may save a life on another occasion.

The response by medical staff to the man's collapse on 25 November was prompt and appropriate.

THE INVESTIGATION PROCESS

On 4 December 2006, my investigator received a copy of the man's medical record and prison files. On 7 December, my investigator visited Nottingham to open the investigation into his death. Notices and the Ombudsman's Terms of Reference had been sent to HMP Nottingham in advance of her visit.

My investigator was met by a Senior Officer (SO) the Safer Custody Officer. The SO outlined the circumstances leading to the man's death. Although an offer was made, representatives of the Prison Officers Association and the Independent Monitoring Board did not wish to meet with my investigator. She visited the healthcare unit where the man had been located after his reception into the prison. My investigator spoke to the Governor and informed him of the process of the investigation.

As part of the investigation, a review of the man's medical care was commissioned from Nottingham Primary Care Trust. A doctor carried out the review and I am most grateful for his work.

On 18 December 2006, my investigator and one of my Family Liaison Officers visited the man's son at his home. Also present was the man's son's uncle. The man's son raised several issues:

1. How was the move to independent living accommodation handled? Did this place the man under unnecessary pressure?
2. Was the refusal to let the man travel to abroad a catalyst in his deteriorating mental health?
3. What was the incident or incidents that caused his admission to hospital?
4. Should the man have been sectioned rather than recalled on life licence?
5. How long would the man have been imprisoned before he could have been transferred to the mental health sector?
6. Did the Probation Officer understand the man's cultural background?

On 9 January 2007, my investigator re-visited Nottingham and spoke to several members of staff. On 10 January, my colleague met with the man's probation officer.

On 1 February, my investigator met with a community based mental health project manager and with a welfare rights worker from a charity that provides independent advice about care and health treatment to vulnerable people. Both workers had worked with the man whilst he was living in Nottingham.

HMP NOTTINGHAM

HMP Nottingham is a category B local prison, located three miles from the city centre. It first opened in 1891 and has capacity for 550 prisoners. Two new cellblocks were opened in 1996 and further cellblocks were opened in 2006. A Vulnerable Prisoner Unit (VPU) is located on E Wing. The Healthcare Unit provides 24 hour nursing care.

A report by Her Majesty's Chief Inspector of Prisons, of an inspection at Nottingham in February 2005 notes, 'Prisoners were offered a wide range of clinical services including nurse-led clinics and visiting clinical specialists.' The Inspector also says, 'The Nottingham City Primary Care Trust (PCT) had seconded one of the community managers to lead healthcare services, and there was evidence of dynamic and effective managerial leadership and robust plans for the development of healthcare services.'

The Inspector was generally positive about the medical services provided at Nottingham. Concerning healthcare delivery, her report reads, 'Prisoners with chronic or long term illness receive good care, although the systems were all manually based as the registers were not computerised. Prisoners with one or more chronic illnesses were seen at least monthly or more frequently if required. Individual nurses were responsible for the specific prisoners identified as suffering from diabetes, chronic heart disease or asthma.'

The death of the man was the second natural cause death I have investigated at Nottingham. An action plan, based on my previous recommendations has been completed. None of those recommendations is relevant to this investigation.

KEY FINDINGS

The man's time in supported housing

From March 2004, the man had been living in, a supported mental health project in Nottingham. He met his supervising Probation Officer every three weeks. The man also had some supervision sessions with a Punjabi speaking Probation Officer, as this was his native language. The man went to a voluntary community mental health project, and worshipped at the local Sikh temple. He received a lot of support from the Punjabi community and from a welfare rights charity.

A care plan in the man's prison health records included reference to documents taken from his community mental health file. A risk indicator completed in May 2006 by his mental health worker, noted that he had been harassing a female and had touched her inappropriately. The man had become very angry with her, claiming she was his girlfriend, and had made verbal threats of violence towards her when his attentions were rebuffed. It was also recorded that the woman did not wish to make a formal complaint. The report by the mental health worker noted that the man's mental state was positive and that he was very stable.

As time went by, the man decided that he wanted his own flat and plans were made for him to move to more independent living in Nottingham. The man had signed for the flat and was due to move in November 2006. Some preparations had been made, but there were still more arrangements to make.

The man's probation officer was aware the man was going to move to independent living. He had been keen to do this and it was supported by his mental health worker. However, the logistics of the move and the accommodation set up were causing the man some problems, which he confided in with his son. Those problems concerned setting up his utility arrangements and ensuring he had all the resources for his accommodation. the probation officer believed that the man was being assisted in his move by his key worker and the other agencies who were supporting the man.

The voluntary community mental health project manager, said she was aware the man was moving to independent living. The manager saw the man during a visit to the hostel and asked him to take her to see his new accommodation. The man declined her invitation, saying it was not ready and untidy. The manager said she was conscious that the man was being helped with his move by his key mental health worker.

The probation supervision meeting on 8 November 2006

On 8 November 2006, the probation officer saw the man for a supervision session. Also present was a welfare rights worker who had known the man for many years. The probation officer described the man's behaviour at this meeting as difficult.

The welfare rights worker said that he felt the relationship between the probation officer and the man had broken down, and the man had requested a change of

Probation Officer. The welfare rights worker added that the probation officer had seemed angry and confrontational at the meeting.

The man had previously requested permission to travel to Canada for a family wedding, which had been denied (as noted earlier, it was a condition of his licence that he needed permission to travel abroad). On two occasions, the man had made verbal threats to kill the probation officer, whom he felt was responsible for the rejection of his request to travel. Later, the man apologised to the probation officer. At that stage, the probation officer had decided not to apply for a recall to prison, although the threats to his personal safety would have provided sufficient evidence for such an application. The probation officer was unable to confirm whether the refusal of the request to travel abroad could have been a catalyst for any deterioration in the man's mental health. However, he was aware how disappointed the man had been about the decision.

The probation officer said that the welfare rights worker spoke about the fact that the man could go abroad without the probation officer knowing. The probation officer told them that he would apply for a recall to prison if he found out such a thing had happened. The probation officer felt that the welfare rights worker was not helpful and had been irresponsible to suggest such a thing.

The hostel on 10 November

On 10 November, the man was at a hostel overnight. In the early morning of the next day, he became agitated and his behaviour was described as bizarre. The man was seen to be waving his arms around, pacing the floor and speaking in Punjabi. Night staff had unsuccessfully tried to calm him down. The man threw a cup of tea onto a chair and then assaulted a female member of staff by pushing her against a door. He was restrained by a male member of staff and the police were called. After speaking to staff, the police warned the man about his behaviour. Later that day, the man was admitted as a voluntary mental health patient to hospital. He was prescribed Olanzapine, Lorazepam, Haloperidol and Zopiclone.

The man's mental health worker visited him on 15 November and told my investigator that the man seemed stable and had no signs of psychosis.

The decision to recall the man to prison

The probation officer was not told about the incident at the hostel or the man's admission to hospital until 15 November, when a member of the hostel's staff made contact with him. By this time, the man had been in hospital for four days.

Upon receipt of this information, and after consultation with his line manager (Assistant Chief Probation Officer), the probation officer made an application to the Home Office for revocation of the man's licence. The probation officer and his line manager told my investigator they had taken the decision in the interests of public protection. Even if the man had been sectioned under the Mental Health Act, this might only have been for a short period.

The probation officer's application for recall to prison stated the risk factors as follows:

- A deterioration in the man's mental health and his risk to women had increased.
- The verbal threats to kill the probation officer.
- The assault on the female member of staff at the hostel.

The application also recorded that the man was a voluntary in-patient at the hospital on the psychiatric ward..

An emergency revocation of licence order was issued on 16 November 2006.

At 9.30 pm on 16 November, the man was arrested on the ward at the Hospital. He was taken to a police station. It is not known whether the police had informed staff at the hospital that the arrest of the man was imminent. He was a voluntary patient and therefore could have left the hospital at any time. The emergency revocation licence was acted on as soon as it was received by Nottinghamshire Constabulary.

Following his detention at the police station, the man was examined by the police doctor at 10.18pm. The doctor noted on the detained person's medical form that the man was not displaying any psychotic features, but there was a history of psychotic episodes. The doctor prescribed Diazepam to help the man sleep and relax. It was also noted that the man might require Olanzapine on 17 November. This information would have been passed to the police by staff at the hospital.

On 17 November, the man was taken to Crown Court for a short court appearance to confirm the recall to prison. The man arrived at HMP Nottingham at 2.40pm.

The man's reception into HMP Nottingham

On arrival at Nottingham, the man was seen in reception by a registered mental nurse (RMN). The RMN completed a first reception health screening document. The document noted that the man had answered no to having problems with asthma, diabetes, chest pain, tuberculosis, sickle cell disease and allergies. However, it was also recorded that the man had concerns about his physical health due to high cholesterol. The RMN observed that the man was very vague but co-operative.

The healthscreen also recorded that the man was receiving medication for his mental health problems (Olanzapine 7.5mg per day). He was admitted to the healthcare unit so that his mental health could be assessed, so he could be reviewed by the doctor, and for secondary health screening to be completed. He was not prescribed Olanzapine at this time.

It was not noted in the man's medical notes that he had been arrested at hospital. However, some information was passed by the probation officer to a Senior Officer, the Suicide Prevention Officer, noting that the man would be transferring to the prison from a police station, and indicating that the man had mental health problems and was a suicide risk. The probation officer included his contact details.

There is no evidence from the man's medical notes that the secondary healthscreening took place or that he saw the doctor the next day. His notes record he settled into routine in healthcare, but was reluctant to engage with staff or prisoners. No serious concerns were noted over his mental or physical health in the first few days.

On 20 November, the man was seen by a community psychiatric nurse (CPN). The CPN attempted to assess the man's mental health but he refused to engage with her. She described him as unkempt and unshaven. The man declined to offer details of his next of kin and home address. The CPN then completed a care plan for him. She requested that healthcare staff observe the man for any signs of psychosis, monitor mood and behaviour, and observe any side effects.

On 21 November, the CPN requested that the doctor prescribe the appropriate medication for the man, as he still was not prescribed Olanzapine. On 22 November, a further request by the CPN for medication was noted in the ward diary for the doctor to write up the man's medication. She asked that the medication card be entered into his medical notes.

On 22 November, the RMN noted in the man's medical notes that he appeared to be perplexed for the majority of the time and he was difficult to understand when he did try to make conversation. The RMN recorded that the man's medication had not yet been prescribed and there were no changes to his mental state. No management problems were recorded.

On 23 November, the man's medical notes record that he questioned medication when offered by a nurse. The nurse explained to the man that the medication had been prescribed by the doctor and it would help him. The man took the medication. There is no record of what medication was being offered at this stage or when it had been prescribed by the doctor.

On 24 November, the man was seen by a psychiatrist. The psychiatrist noted that he had known the man for many years. The psychiatrist wrote that: "Normally he [the man] is very pleasant, affable and chatty with no psychotic symptoms. On the other hand when he is ill, psychotic features are not clearly obvious. Today he presents as unstable and angry. Does not know why he is back in prison. Says his probation officer got him recalled because he said to the probation officer that he would live wherever he wished to. Unhappy at being back in prison after many years. I don't think he is as well as he has been over the past years. I asked him about increasing his Olanzapine but he wants to continue with 7.5 mgs daily. Continue 7.5 mgs Olanzapine daily, FU (follow up) by the CPN, review in 4 weeks."

25 November 2006

On 25 November 2006 at 11.00 am, the man woke up and spoke to a nurse. The man agreed to take a shower. He was escorted to reception showers as the showers in healthcare were out of order. Ten minutes later, on his return to the healthcare unit, the nurse noticed that the man appeared unwell. A second nurse joined the first nurse in the man's cell. The second nurse took the man's blood pressure and pulse. His blood pressure was 105/65 and pulse 68 beats per minute.

The two nurses spoke to the man about how he was feeling. The man told the nurses he had stomach pain, body ache and was feeling cold. He also told the nurses that he had been coughing, and streaks of blood had been present in his phlegm over the last few days. The man was reassured by the nurses and given some anti-acid medication.

Both nurses then left him. The first nurse went to find him a jumper to help him warm up. On returning to the man's cell a few minutes later, the nurse looked through the observation hatch and saw him on his bed gasping, breathless and unresponsive. She immediately unlocked his cell, called for help from healthcare staff and radioed for the orderly officer to attend. The communications officer called for an emergency ambulance. The radio log records the time as 11.29am.

The nurse was unable to find a pulse. The man was unresponsive and not breathing. The nurse was joined by the second nurse and they laid the man flat on his back. Both nurses commenced cardiac pulmonary resuscitation (CPR). A few moments later, a senior nurse joined the two nurses. The senior nurse inserted an airway into the man's mouth, and the first nurse used an Ambu bag to pass oxygen into his chest. The senior nurse took over CPR from the second nurse who then attached defibrillator pads to the man's chest. The defibrillator machine advised to shock the man, which the nurse did and a rhythm was recorded.

At 11.35am, the ambulance arrived and the nurses passed care of the man to the paramedics. At 12.00 midday, the man was transported by emergency ambulance to the hospital. On arrival at the hospital, the man was taken to the Accident and Emergency Department. Despite all efforts by the medical staff, the man sadly died at 12.40pm.

The man's son was visited by a governor and a senior officer at 9.30pm that evening to be told the news of his father's death. This delay of nearly nine hours largely resulted from the fact that the man had refused to offer details of his next of kin on reception into Nottingham. An address for his son was only found by healthcare staff after they had made contact with mental health services. In addition, the man's son home is in South London - around a three hour journey from Nottingham.

The following day, the man's son visited HMP Nottingham and saw his father's cell in the healthcare unit. A governor arranged for the prison's Sikh minister to meet him and offer support.

The man's funeral was held at a local Sikh temple in Nottingham and was attended by a governor and a SO. The prison offered financial assistance towards funeral expenses which was accepted by the family.

ISSUES

Clinical review

A review of the man's medical care, including his mental health state, was carried out by a doctor on behalf of Nottingham Primary Care Trust.

The doctor reviewed the man's prison medical record and spoke to the CPN, the man's key mental health worker, and to staff at HMP Nottingham. The doctor obtained additional information from the post mortem report.

Of the attempts to resuscitate the man on 25 November, the doctor noted that the response from nursing staff was immediate, and that the defibrillator had been used once. However, the doctor found an inconsistency between timings noted in the medical notes and those in the post mortem notes. The medical notes record the ambulance crew arriving at Nottingham at 11.30 am, whereas the post mortem report said the ambulance arrived at 12.00 midday. I am confident from the timings on the prison's communication log that the ambulance arrived at 11.35am and left the prison at 12.00 midday.

The doctor commented on specific matters as follows:

- Adequate reception screening completed and the man was appropriately admitted to prison healthcare unit for further assessment. Heart disease risks were not identified. The man had pre-existing heart disease but he failed to inform the prison of this and his medication history.
- No Olanzapine was given from 17 November to the night of 22 November. Although this did not adversely affect the man's mood, the delay in prescribing established long term medication was unnecessary.
- There appears to be no reason why the man should have been sectioned under the Mental Health Act at any time over the two weeks he was under review.
- The man's medical and psychiatric care at Nottingham was appropriate.
- The man was not in possession of a GTN spray. Faxed documents to the prison from the hostel, received a week after his reception into Nottingham, gave details of the man's medical history. These details were not acted on. However, the outcome was unlikely to have changed and the important factor for survival was prompt defibrillation and resuscitation - both of which the man received.
- The routine practice of not prescribing long-term antipsychotic medication to patients transferring into prison until written up by the psychiatric team seems to cause unacceptable delays which are compounded over the weekends.

The doctor makes two recommendations which I endorse:

When the patient, usually on reception screening, volunteers a medication history then the prescription should be verified and the medication written up onto a valid prison drug card the same day, weekends notwithstanding. When a prescription cannot be verified, or deemed unnecessary or inappropriate in the prison setting, then an entry in the medical record should be made as to why the medication has not been written up. This should be discussed at the next clinical governance or therapeutics meeting at the prison.

When new information is received, this should be reviewed by whoever is the responsible medical professional before it is filed into the medical record. This may already be the accepted practice at the prison but the failure to identify new and relevant information in this case should be discussed at the next clinical governance meeting.

The family's questions

How was the move to independent living accommodation? Did this place the man under unnecessary pressure?

The man's probation officer, was aware the man was in the process of moving to new and independent living accommodation and had agreed to the move as part of his licence conditions. The probation officer knew that numerous community-based agencies, including mental health services, were supporting the man in the move. The probation officer believed that these various agencies were overseeing his move to independent living. He was not aware that the man was having any particular problems with the move.

The manager of the voluntary community mental health project was also aware that the man was moving to independent living. During a meeting with the man, she had invited him to take her to see the accommodation. The man had declined the invitation. He told the manager that he did not want her to see the accommodation as it was untidy. The manager understood that the man was receiving help with the move from his key worker and support from the mental health care team.

The man's move to independent living was being supported by his mental health key worker. There is no information in his medical notes that relate to any stress factors associated with this move. I therefore do not feel that the move to independent living placed the man under unnecessary pressure.

Was the refusal to let the man travel to Canada a catalyst in his deteriorating mental health?

The man was unhappy about the refusal to allow him to travel to Canada for a family wedding. It was a key event for him and the refusal obviously caused him great distress. However, under the conditions of his licence, the man was required to inform his probation officer that he wished to travel abroad. The probation officer had then reviewed the risk factors and, after consultation with his line manager, the request was denied. I have not separately considered whether this decision was

reasonable, but it was certainly in line with decisions made on similar matters by probation areas across the country. (the man had been issued with a passport from the Indian Embassy. There was no condition on his licence to say that he could not apply for a passport, just a condition that he not travel abroad without his supervising officers' agreement.)

It is difficult for me to comment on whether the denial to travel abroad and the distress it caused the man could have been the catalyst in his deteriorating mental health. However, the doctor does suggest that the refusal for foreign travel appeared to be the catalyst in the sequence of events that led to the man's recall to prison.

What was the incident or incidents that caused his admission to the hospital?

The incident at the hostel where the man assaulted a female member of staff was considered serious enough for the police to be called. The doctor's clinical review indicates that the man was admitted to hospital as a place of safety rather than as a reflection of his mental health state.

Should the man have been sectioned rather than recalled on life licence?

A report by the man's mental health key worker in May 2006 referred to an incident with a female friend of the man's. The report noted that he had threatened the woman if his attentions were rebuffed. One of the conditions of the man's life licence was that he should inform his probation officer of any intimate relationships with women. Whilst it is unknown if the man believed this relationship to be intimate or reportable to his probation officer, this incident necessarily raised concerns both about his compliance with licence conditions and his potential for violence against women.

On 16 November 2006, the probation officer was informed that the man was an inpatient at hospital by a member of staff at the hostel. After consultation with the probation officer's line manager, he applied for the life licence to be revoked. The application was faxed to the Home Office and the recall was subsequently endorsed by the Secretary of State. Both the probation officer and his line manager felt that the man's mental health problems and recent history of violent behaviour was evidence that public safety was at risk.

During the six days that he was a voluntary patient at the hospital, there was no indication that the man was to be sectioned under the Mental Health Act. As a voluntary patient, he would have been able to discharge himself at any time.

Given the circumstances and presenting risk factors, I judge that recall to prison was the appropriate course of action.

How long would the man have been imprisoned before he could have been transferred to the mental health sector?

In his clinical review, the doctor argues that there was no reason why the man should have been sectioned under the Mental Health Act during his two weeks in prison.

The time that the man would have remained in prison is more complicated. The doctor was of the view that the man was not displaying symptoms of psychosis or other mental illness that would have led to him being sectioned. On 22 November, a case conference was held at the hostel to discuss the man's mental health. The case conference concluded that more information was needed to look at the future for the man and whether a return to a mental health setting would be appropriate. Even if he had been found suitable for treatment under the Mental Health Act, it is not possible to put an exact time on how long such a transfer would have taken.

Did the Probation Officer understand the man's cultural background?

The probation officer was aware that the man was receiving assistance from community based groups. The probation officer told my investigator that the man understood the terms of his licence and did receive occasional sessions with a Punjabi speaking Probation Officer. The probation officer is himself an experienced officer and supervises a client groups from various cultures and religions.

The probation officer had supervised the man successfully for five years. It seems that it was only after he had made a decision that the man did not like (the refusal to allow him to leave the country) that their relationship began to falter.

The probation officer's line manager told my investigator that Nottinghamshire Probation Area's diversity policy is monitored on a regular basis. She confirmed that the man had received sessions with a Punjabi speaking probation officer. She commented that probation officers do not consistently work with clients from their own ethnic background.

Although I fully appreciate the significance of cultural differences between offenders and those supervising them, I conclude that the man's supervision was not compromised because of his cultural background.

Further Issues

The request to change Probation Officers

The probation officer had supervised the man for five years. Most of the sessions were held in the man's accommodation, which the probation officer visited. The officer told my colleague that the man was compliant with these sessions.

The probation officer's line manager had been approached by the welfare rights worker, shortly before the man's recall to prison, and told that the man wanted to change probation officer. The line manager had agreed to meet with the man to discuss this. His admission to hospital followed by the recall to prison meant the meeting did not take place.

The resuscitation of the man

A Principal Officer (PO) was the orderly officer at Nottingham. On receipt of the emergency call from a nurse, he attended the healthcare unit and observed healthcare staff trying to revive the man. Three nurses performing cardiac pulmonary resuscitation (CPR), and used the defibrillator machine. An officer, communications officer, was calm and efficient in dealing with the emergency, and called promptly for an ambulance. This was the officer's first experience in dealing with an incident of this nature. The PO was impressed by the professionalism and team work of these four members of staff. He subsequently wrote a short report to the Governor commending the actions of the staff.

In his clinical review, the doctor has also commented that the attempt at resuscitation was immediate and that the nursing staff had the defibrillator ready very quickly.

I note and also commend the prompt and professional actions of the officer the three nurses.

Notifying next of kin

A governor was the duty governor on 25 November 2006. After receiving the call from an officer at the hospital informing him that the man had passed away, he began to seek out his next of kin details. On reception into Nottingham, and later when seeing the CPN, the man had refused to offer details of his next of kin. An address given by the hostel was visited. This was thought to be that of an uncle of The man's, but he no longer lived there.

The governor contacted the out of hours service for Nottinghamshire Probation. (This was identified as a route to finding next of kin details as The man had been recalled to prison.) As there was no answer, the governor left a voice mail message for someone to contact him urgently. There was no return call from the Probation Area. The prison's healthcare unit then made enquires with Nottingham Primary Care Trust, and in turn mental health services who eventually identified the man's sons address.

The governor and the prison's family liaison officer, then made the journey from Nottingham to South London to tell the man's son the sad news of the loss of his father. It was 9.30pm before they reached South London, eight hours after the man's death.

The out of hours service for Nottinghamshire Probation did not contact the prison until the following morning.

The man's son told my colleagues that he had been treated with respect and kindness when he visited the prison and had no concerns over his father's treatment whilst in Nottingham. This was also noted by the welfare rights worker and the voluntary community mental health project manager.

It is pleasing to note the professionalism of both the governor and family liaison officer in their support of the man's son and his family. I all so think they made

extensive and commendable efforts to obtain an address for the man's next of kin as quickly as possible.

The Governor of Nottingham should commend the actions of the governor, the family liaison officer, the communications officer, and the three nurses.

RECOMMENDATIONS

1. When the patient, usually on reception screening, volunteers a medication history then the prescription should be verified and the medication written up onto a valid prison drug card the same day, weekends notwithstanding. When a prescription cannot be verified, or deemed unnecessary or inappropriate in the prison setting, then an entry in the medical record should be made as to why the medication has not been written up. This should be discussed at the next clinical governance or therapeutics meeting at the prison.

Accepted – To go to the next Drug and Therapeutics Committee meeting for ratification. All staff to be reminded of the need to make appropriate entries in medical records

2. When new information is received, this should be reviewed by whoever is the responsible medical professional before it is filed into the medical record. This may already be the accepted practice at the prison but the failure to identify new and relevant information in this case should be discussed at the next clinical governance meeting.

Accepted – Medical information received into the prison must be reviewed prior to being filed. All information will be initialled by the responsible medical professional before filing.

3. The Governor of Nottingham should commend the actions of the governor, the family liaison officer, the communications officer, and the three nurses.

Accepted – A letter of commendation to be issued by the Governor to those staff as listed.

ANNEXES

1. Documents considered during the investigation