Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Coxall a prisoner at HMP Nottingham on 3 December 2015

A report by the Prisons and Probation Ombudsman
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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.

On 3 December 2015, Mr John Coxall was killed by another prisoner at HMP Nottingham. I offer my condolences to Mr Coxall's family and friends.

On 27 May 2016, Prisoner A was convicted of Mr Coxall's murder.

Homicides in prison are relatively rare, although they have increased in number in recent years. In a learning lessons bulletin on homicides earlier this year, I was unable to identify any particular patterns in these deaths and, as in this case, it is clear that identifying those likely to carry out such killings can be difficult. While Prisoner A had a prolific history of self-harm in prison, there was no information to suggest that he would be a specific danger to any other prisoners at Nottingham, including Mr Coxall. His actions were sudden and unexpected and I consider that prison staff could not have predicted or prevented Mr Coxall's death.

Although they had no bearing on Mr Coxall's death, the investigation found some deficiencies in the operation of suicide and self-harm prevention procedures at Nottingham, which the prison should address.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2017**

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Summary

Events

1. On 15 October 2015, Mr John Coxall arrived at HMP Nottingham after receiving a six month sentence for breaching a restraining order. Mr Coxall occupied a single cell on B wing, a general population wing. Mr Coxall had been in Nottingham before. He settled in well and interacted appropriately with other prisoners and staff. He used a walking stick. On 20 November, Mr Coxall was admitted to hospital with breathing difficulties. On 23 November, he was discharged from hospital with a diagnosis of chronic obstructive pulmonary disease (COPD) and was prescribed medication. He returned to live on B wing.

2. In 2009, Prisoner A was remanded into custody charged with blackmail and threats to kill. In 2011, he was convicted and received a five year custodial sentence. He had a history of drug abuse and a prolific history of self-harm, by cutting, blood letting and inserting objects into his urethra. He had been admitted to secure units on several occasions under the Mental Health Act, for treatment of emotionally unstable personality disorder. The last admission had been on 21 May 2015, when he transferred from Nottingham to Arnold Lodge, a medium-level, secure psychiatric hospital.

3. On 15 September, Prisoner A returned to Nottingham. Staff at Arnold Lodge assessed him as being at medium risk of self harm but at low risk of harm to others. On arrival at Nottingham, he was immediately placed on self-harm prevention measures and occupied a cell on G wing, a wing he had lived on before. G wing is a vulnerable prisoner wing where a third of the prisoners are aged over 60. On 27 October, he told staff he was under threat and wanted to move off G wing. On 6 November, he was moved to a single cell on B wing.

4. On the afternoon of 3 December, during the association period, without warning or provocation, Prisoner A killed Mr Coxall in his cell by strangling him. He was convicted of Mr Coxall's murder on 27 May 2016.

Findings

5. Mr Coxall had been in Nottingham before and there was no evidence to suggest that that he was at risk of attack. When he had breathing difficulties he was appropriately referred to hospital for treatment.

6. Prisoner A had a prolific history of self-harm and we are satisfied that, in this respect, he was appropriately assessed and managed by prison self-harm prevention measures. In the days before Mr Coxall's death, there was no intelligence or evidence to suggest that Prisoner A posed a risk to other prisoners. We are satisfied no one could have predicted or prevented his actions.

7. Although it had no bearing on the outcome for Mr Coxall, we found there were some deficiencies in the management of suicide and self-harm prevention measures at Nottingham which the prison will need to address.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
    - Understanding their responsibilities and the need to share all relevant information about risk;
    - Assessing the level of risk and recording the reasons for decisions;
    - Conducting ACCT reviews as specified in the national instructions.

The Investigation Process

8. 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.

9. On 10 December 2015, the investigator met police officers investigating Mr Coxall's death. In line with the Ombudsman's terms of reference, we suspended our investigation while the police carried out a criminal investigation. Prisoner A was charged with Mr Coxall's murder and was convicted on 27 May 2016. Our investigation resumed on the conclusion of the criminal trial.

10. NHS England commissioned a clinical reviewer to review Mr Coxall's clinical care, and another clinical reviewer to review Prisoner A's clinical care.

11. The investigator visited Nottingham and obtained copies of relevant extracts both from Mr Coxall's and Prisoner A's records. He interviewed eight members of staff at the prison in July 2016. One clinical reviewer joined him for some of the interviews.

12. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Coxall's family to explain the investigation. The family raised issues concerning Mr Coxall's court appearance, legal representation and sentencing which are matters that fall are outside the remit of our investigation. Mr Coxall's family received a copy of the report and found no factual inaccuracies.

Background Information

HMP Nottingham

14. HMP Nottingham is a local prison serving the courts in Nottinghamshire and Derbyshire and holding around 1,060 adult and young adult male prisoners.

15. Nottinghamshire Healthcare NHS Foundation Trust provides primary healthcare services 24-hours a day, seven days a week. GPs provide daytime cover between Monday and Friday with occasional evening and weekend cover. The Gables Medical Practice provides an out-of-hours service at night and on weekends.

HM Inspectorate of Prisons

16. The most recent inspection of Nottingham was conducted in February 2016. Inspectors found there were too many incidents of serious violence and disorder despite real efforts made to address this. Levels of vulnerability, in particular of men with mental health problems, were higher than in many similar prisons, and a number of men had complex combinations of vulnerability and problematic behaviour. Inspectors said a specific area was needed where appropriate therapeutic care and support could be provided for the high number of men with acute mental health problems. Inspectors did find some excellent staff who worked positively with prisoners and were not afraid to challenge or reward behaviour as appropriate, but some wing-based staff remained distant and somewhat dismissive of the men in their care.

Independent Monitoring Board

17. 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 February 2016, the IMB reported that there were increased numbers of prisoners in Nottingham with varying mental health issues ranging from minor to very severe. An integrated primary and secondary mental health team is responsible for their mental health care. The numbers of prisoners now suffering from dementia is also becoming a major issue and provision is being reviewed.

Assessment, Care in Custody and Teamwork (ACCT)

18. 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. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move

around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Previous deaths at HMP Nottingham

19. Mr Coxall's murder was the first homicide at Nottingham since the Prisons and Probation Ombudsman began investigating deaths in prisons in April 2004. Since 2004 there have been nine self-inflicted deaths at Nottingham, two of which occurred in 2016.

Homicides in custody

20. In September 2016, we issued a Learning Lesson *Bulletin Homicides - further lessons*. Unfortunately, 2015-16 saw a rise in prison homicides with six prisoners killed by another prisoner or prisoners. This was the highest annual number of prison homicides since we began investigating deaths in custody in 2004. The bulletin did not identify any particular pattern to the deaths, but does identify a number of areas of learning. These include: the need to better manage violence and debt in prison, not least that associated with the current epidemic of new psychoactive substances; the need for rigorous cell searching to minimise the availability of weapons; the need for careful management of prisoners known to be at risk from others; and the importance of ensuring prisons know how to respond when they have an apparent homicide.

Key Events

Mr John Coxall

21. On 15 October 2015, Mr Coxall was convicted of breaching a restraining order that was imposed by the court to protect a neighbour. He was sentenced to 30 weeks in custody at Nottingham. Mr Coxall was 80 years old, single, had no children and had not had contact with his family for many years. Mr Coxall had served a previous sentence at Nottingham between May 2014 and March 2015.

22. When Mr Coxall arrived at Nottingham he saw a nurse, who completed an initial healthscreen. Mr Coxall was fully independent, used a walking stick, was not being prescribed any medication and had no outstanding medical appointments. An officer saw Mr Coxall to complete the reception and first night documentation. Mr Coxal said he had no thoughts of self-harm and both the officer and nurse assessed that he was not at any increased risk. Mr Coxall was allocated a single cell, B2-15, on B wing, a general population wing.

23. On 20 November, Mr Coxall was having difficulty breathing and he was taken to hospital and admitted for treatment. Healthcare staff maintained contact with the hospital for updates on Mr Coxall's progress. Hospital staff confirmed that Mr Coxall was given a diagnosis of COPD. On 23 November, Mr Coxall returned to Nottingham and a prison GP noted that the hospital had prescribed prednisone (for breathing problems) and doxycycline (an antibiotic). He recorded that Mr Coxall should be seen by a doctor if there was a recurrence of shortness of breath or feeling unwell.

24. A supervising officer (SO) told the investigator that Mr Coxall was a very quiet gentleman who kept himself to himself. He said he regularly saw Mr Coxall at mealtimes and there were no issues with him on the wing. He said Mr Coxall usually remained in his cell throughout the day, watching television.

Prisoner A

25. In 2009, Prisoner A was remanded into custody charged with blackmail and threats to kill. In 2011, he was convicted and sentenced to five years imprisonment. Between 2009 and May 2015, he transferred between several prisons, including HMYOI Glen Parva, HMP Swinfen Hall, HMP Leicester, HMP Lincoln and Nottingham.

26. During this period, Prisoner A was transferred, under the Mental Health Act, for treatment at Sutton Manor Hospital, Essex and Ansel Clinic, Nottingham, both of which were low secure units. He was also transferred to Arnold Lodge, a medium secure psychiatric hospital on two separate occasions. He had received a diagnosis of emotionally unstable personality disorder and had a prolific history of self-harm. He would frequently cut himself, collect and smear his blood, swallow razor blades and insert objects under his skin and into his urethra.

27. On 21 May 2015, Prisoner A was transferred from Nottingham to Arnold Lodge for treatment. After four weeks at Arnold Lodge, he stopped engaging and was placed in seclusion a number of times. He failed to comply with the treatment programme and his self-harming continued. It was finally agreed by the multi-

disciplinary team at Arnold Lodge that he was not benefiting from treatment and he should return to prison.

28. On 11 September, a historical background, clinical, risk management assessment was completed at Arnold Lodge. It concluded that Prisoner A posed a low risk of physical harm to others. He did, however, pose a more likely risk of medium to high level psychological harm such as threats, extortion, or blackmail. The assessment also concluded that he remained a moderate risk of serious harm to himself. The assessment was shared with the healthcare team at Nottingham as part of the discharge summary.

29. On 15 September, Prisoner A transferred back to Nottingham. An ACCT was immediately opened due to his mental health issues and his risk of self-harm. The cell sharing risk assessment noted that he was high risk due to his mental health. The ACCT document remained open for the entire time that he was at Nottingham.

30. Between 15 September and 2 December, a total of eight ACCT reviews were carried out. Seven of these were multidisciplinary. The assessment made was that Prisoner A remained at risk of self-harm and the ACCT should stay open. The levels of observations were appropriately increased and decreased following each review. His medical records show that during this same period there were 13 separate incidents of self-harm. The nature of the self-harm followed the same pattern: cutting, blood letting and inserting objects. In addition to the ACCT reviews, he had four mental health reviews with a member of the mental health team.

31. On 27 October, Prisoner A saw a SO and told her he wanted to move from G wing as he was under threat from other prisoners. He said he had offered to buy canteen items for prisoners once he received £500 that was owed to him from his time at Arnold Lodge. He also said that he had been falsely accused of stealing some illicit drugs from another prisoner's cell. She told the investigator that when prisoners are discharged from secure units, all their belongings and any monies are transferred with them. She confirmed that his prison account did not receive a credit of £500. She also said that there was no evidence that he was under threat or being bullied, and he was seen regularly mixing with prisoners on the wing.

32. On 6 November, Prisoner A moved to B wing and was allocated a single cell, B1-22. The SO told the investigator that he knew him from his previous time at Nottingham and that he was on ACCT procedures due to his continuing self-harm. She said that he was withdrawn, although he would speak to staff. He believed he would probably always be on an ACCT while in prison.

33. On 30 November, Prisoner A saw a prison GP for a mental health review. He asked the GP to prescribe quetiapine (an antipsychotic) as he believed it helped him remain calm and reduced his tendency to self-harm. He showed the GP the cuts he made to his left arm some weeks previously. When the GP asked him why he had cut himself, he said "it was something to do". He denied any thoughts of suicide or self-harm at that time.

34. The prison GP prescribed quetiapine and set a review date with Prisoner A for mid-January. He noted that he was due for release in November 2016, and he intended to refer him to the Nottingham community forensic service in advance of his release. He also recorded that he was aware that he was on an open ACCT; however the ACCT book had not been made available for him to make an entry.

35. The prison GP told the investigator that Prisoner A gave no indication of any intention to harm others, but that self-harm was very much part of his personality disorder.

Events of 3 December 2015

36. CCTV footage of the afternoon of 3 December, shows Prisoner A being unlocked from his cell, B1-22, at 2.26pm. He can be seen walking up to the first floor landing and standing at the far end. At 2.27pm, Mr Coxall was unlocked from his cell, B2-15, and can be seen walking to the far end of the landing. After a short conversation, both Mr Coxall and Prisoner A can be seen returning to Mr Coxall's cell at 2.28pm. They enter and close the door.

37. At 2.31pm, both prisoners come out of the cell and return to the end of the landing. At 2.37pm, they return to Mr Coxall's cell, enter and close the door. At 2.48pm, Prisoner A can be seen coming out of Mr Coxall's cell and walking to the railings, looking over, and then re-entering the cell and closing the door. At 3.27pm, he comes out of Mr Coxall's cell again and walks to the third floor landing, where he can be seen sitting down with a view of Mr Coxall's cell.

38. At 3.31pm, Prisoner A can be seen walking down to the wing office. There, he told a SO that he had "killed the old man" in cell B2-15 and that "voices" had told him to do it. He immediately went to Mr Coxall's cell and found him face down on the floor.

39. At 3.33pm, the SO used his radio to request urgent assistance from healthcare staff and discipline staff. He told the investigator that there is a protocol for emergency codes to be used: code blue for someone found unconscious or not breathing, and code red for blood injuries. He said that he was shocked by what he discovered in Mr Coxall's cell and just shouted for assistance over the radio.

40. Healthcare staff and prison staff responded immediately and started cardiopulmonary resuscitation (CPR). Healthcare staff also used an automated external defibrillator (which monitors the heart rhythm and administers electrical shocks to restore the normal rhythm when necessary). This found no shockable heart rhythm, so CPR continued. A nurse told the investigator that Mr Coxall was cyanosed (having blue colouration to his skin caused by a lack of oxygen in the blood). This indicated that he had not been breathing for some time before he was found.

41. At 3.34pm, the duty governor used his radio and called a code blue emergency, and an ambulance was immediately called. Ambulance Service records show that the 999 call was made at 3.34pm and paramedics arrived at 3.40pm, and took over Mr Coxall's care. After a period of assessment and treatment, at 4.58pm, paramedics pronounced Mr Coxall dead.

42. The duty governor had escorted Prisoner A back to his cell. A SO was detailed to remain with him until security staff arrived. He had his clothing removed for evidential purposes and was given a new set of clothing. His cell was locked and, at approximately 4.00pm, he was taken to the segregation unit. The SO remained outside his cell door.

43. The Head of Safer Prisons and Equality told the investigator that the police were called and she had gone to the segregation unit to see Prisoner A. She said that he was completely relaxed and calm and even asked her whether Mr Coxall had died. He told her that voices had told him to kill Mr Coxall.

44. At 5.20pm, she completed an ACCT review with a SO and Prisoner A. There was no input from the mental health team. She recorded that he had admitted to killing another prisoner by strangling him because voices had told him to do it. Due to his actions and the potential for him to act impulsively, he was assessed as being at raised risk and placed on constant watch. A review was set for the next day.

45. She also completed the Defensible Decision to Segregate a Prisoner form. This is required when any prisoner on an open ACCT is relocated to the segregation unit. She recorded that Prisoner A had been on an open ACCT since 15 September 2015, he had killed another prisoner, he was under constant observation, a police investigation had commenced and the segregation unit was the only suitable location for him. That evening he was arrested and charged with Mr Coxall's murder and taken into police custody. On 27 May 2016, he was convicted of Mr Coxall's murder.

Contact with Mr Coxall's family

46. Mr Coxall had not nominated anyone as his next of kin. The prison asked the police to try and establish whether Mr Coxall had any family. The police found that Mr Coxall did have family who lived in the south east of England and the police broke the news of Mr Coxall's death. The family liaison officer from Nottingham maintained contact with the family after Mr Coxall's death. The prison contributed to the funeral expenses, in line with national instructions.

Support for prisoners and staff

47. Managers debriefed the prison staff involved in the emergency response and offered support. The prison told other prisoners of Mr Coxall's death and offered support. Officers reviewed prisoners assessed as being at risk of suicide and self-harm, in case they had been affected by the news of Mr Coxall's death.

Post-mortem report

48. A post-mortem examination found that Mr Coxall had died from strangulation.

Findings

Assessment of Risk

49. The Prison Service Instruction covering safer custody, Prison Service Instruction (PSI) 64/2011, lists a number of risk factors and potential triggers for self-harm and suicide. These include recall to custody, previous self-harm, mental health issues and drug abuse. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

50. When Prisoner A arrived at Nottingham on 15 September, reception staff appropriately assessed his risk of suicide and self-harm and opened an ACCT to support him because of his history of self-harm and mental illness. The ACCT remained open throughout his time at Nottingham. We consider it was appropriate on 3 December, to move him to the segregation unit and place him under constant supervision.

51. When Mr Coxall arrived at Nottingham on 15 October 2015, there was nothing to indicate that he was at particular risk and needed increased monitoring. Mr Coxall had been in Nottingham before, he had no history of suicide attempts or self-harm and there was no record or indication that he suffered from mental illness. The reception officer and reception nurse assessed Mr Coxall when he arrived at Nottingham. Neither of them considered that he was at raised risk, such that he needed additional monitoring and support using Prison Service suicide and self–harm prevention procedures.

52. We have considered whether there was anything that Nottingham could have done to prevent Mr Coxall's death. There was no intelligence to link Mr Coxall and Prisoner A; there was no reason not to allow Mr Coxall and him to be housed on the same wing, and no reason to have predicted this incident. We do not consider that staff could have been expected to predict and prevent the sudden and unexpected violence towards Mr Coxall.

53. Although it had no bearing on the outcome for Mr Coxall, there were some deficiencies in the management of the ACCT process. Two of the ACCT reviews had no healthcare input. This included the review held on 3 December, when Prisoner A was moved to the segregation unit. Additionally, the ACCT document was not available for a prison GP to make an entry following his intervention with him on 30 November. We therefore make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

- **Understanding their responsibilities and the need to share all relevant information about risk;**
- **Assessing the level of risk and recording the reasons for decisions;**
- **Conducting ACCT reviews as specified in the national instructions**

Clinical care

Mr John Coxall

54. The clinical reviewer assessed Mr Coxall's clinical care at Nottingham. She was satisfied that Mr Coxall received appropriate healthcare at Nottingham which was equivalent to that he could have expected to receive in the community. When he developed breathlessness and was later diagnosed with COPD, the treatment was all delivered in line with national guidelines.

55. The clinical reviewer commented that the emergency response of staff involved followed good practice and appropriate guidance. However, from a nurse's account that cyanosis was already present, it is unlikely that CPR would have affected the outcome for Mr Coxall.

Prisoner A

56. The clinical reviewer assessed that the mental health care Prisoner A received at Nottingham, and other prisons, was equivalent to that he could have expected to receive in the community. He had regular visits from mental health nurses and appointments with a consultant psychiatrist who ensured that any prescribed medication was consistent with what had been prescribed in hospital in the community.

57. The clinical reviewer commented that there had been good communication between a prison GP and the consultant psychiatrist at Arnold Lodge. When Prisoner A self-harmed he received prompt and appropriate treatment. His level of self-harm had been consistent at each prison and at the mental health units. The clinical reviewer assessed that his location had no impact on his presentation or behaviour, and his actions on the 3 December could not have been predicted.

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