

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Armstrong a prisoner at HMP Nottingham on 6 October 2017

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*



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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.

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

Mr Armstrong died after he was found hanged in his cell at HMP Nottingham on 6 October 2017 (eight days after he had arrived at the prison). Toxicology tests showed that he had used new psychoactive substances before his death. He was 40 years old. We offer our condolences to Mr Armstrong's family and friends.

The investigation found that not all staff in reception at Nottingham have received mandatory Prison Service training in suicide and self-harm prevention. This training is vital for all staff, particularly in reception when prisoners are potentially at their most vulnerable. While it was a judgement call whether to begin suicide and self-harm prevention procedures for Mr Armstrong, it is important that staff have the necessary training to give them the confidence to identify and consider risk factors for suicide and self-harm. We are concerned that Mr Armstrong's risk factors were not fully considered when he first arrived at Nottingham.

Following its inspection of Nottingham in January 2018, HM Inspectorate of Prisons (HMIP) concluded that the prison was 'fundamentally unsafe' and invoked the Urgent Notification process to alert Ministers to their concerns. We welcome HMIP's decision to do this. Several of the significant failings identified by HMIP featured in this investigation, and we share the concern of HMIP and the Independent Monitoring Board that NPS use is rife among prisoners at Nottingham. HMIP also noted that Nottingham had repeatedly failed to implement our recommendations following previous deaths in custody. Urgent action needs to be taken to address these issues.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

May 2018

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	7
Findings.....	11

Summary

Events

1. On 29 September 2017, Mr Carl Armstrong was remanded to HMP Nottingham, charged with serious sexual offences against a family member. He had previously served a prison sentence for a similar offence. Mr Armstrong told a prison nurse that he had recently harmed himself, but she chose not to start Prison Service suicide and self-harm prevention procedures, known as ACCT.
2. Prisoners who knew Mr Armstrong said he was withdrawn in prison and was bullied by other prisoners. His cellmate said that he found a ligature in Mr Armstrong's possessions, although he did not report this to prison staff. Both Mr Armstrong's cellmate and neighbour said that he had smoked drugs on the night of 5 October.
3. On the morning of 6 October, Mr Armstrong was alone in his cell as his cellmate had gone to court. At around 12.00pm, his neighbour found him hanged in his cell. Staff removed the ligature and began cardiopulmonary resuscitation but paramedics confirmed Mr Armstrong's death at 12.44pm. Toxicology tests identified that he had used new psychoactive substances (NPS).

Findings

Identifying risk of suicide and self-harm

4. Mr Armstrong had some risk factors for suicide and self-harm when he arrived at Nottingham, and it was a matter of judgement whether he needed to be monitored as at risk. We are concerned that his risk factors were not fully understood or considered. We are also concerned that the reception nurse, who was the only person to whom Mr Armstrong disclosed that he had recently harmed himself, had not received the mandatory training in ACCT procedures.
5. Like many newly arrived prisoners at Nottingham, Mr Armstrong spent a great deal of time locked in his cell. There is little evidence that staff had any meaningful individual contact with him, and this reduced their chances of identifying any issues he might have or any new risk factors for suicide and self-harm.

NPS

6. Our previous investigations have found that Nottingham has a significant issue with the supply and use of NPS. Mr Armstrong's death is also linked to the use of these drugs, and it is our view that Nottingham's Substance Misuse Strategy is not working to address this issue effectively.

Recommendations

- The Governor should ensure that reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk, and that they consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm, and open ACCT procedures when indicated.
- The Governor should ensure that all staff in contact with prisoners are trained in ACCT procedures, in line with the requirements of PSI 64/2011.
- The Governor should ensure that officers have meaningful contact with prisoners during their first weeks in custody, including individual conversations that allow them to get to know prisoners and identify their needs.
- The Governor should ensure there are effective supply and demand reduction strategies to help eradicate the availability of new psychoactive substances and that staff are vigilant to signs of its use and take appropriate action.

The Investigation Process

7. The investigator, issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. He obtained copies of relevant extracts from Mr Armstrong's prison and medical records.
9. The investigator interviewed six members of staff and two prisoners at Nottingham in November 2017, plus a further three members of staff and one prisoner by telephone in November and December.
10. NHS England commissioned a clinical reviewer to review Mr Armstrong's clinical care at the prison.
11. We informed HM Coroner for Nottinghamshire of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
12. One of the Ombudsman's family liaison officers, contacted Mr Armstrong's sister-in-law, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Armstrong's sister-in-law asked for details of what happened on the morning of his death, and whether anyone should have checked on his wellbeing that morning.
13. Mr Armstrong's sister-in-law received a copy of the initial report. She did not make any comments.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Nottingham

15. HMP Nottingham is a local category B prison holding just over 1,000 men, serving courts in Nottinghamshire and Derbyshire. Nottingham Healthcare NHS Foundation Trust provides healthcare services at the prison.
16. D Wing at HMP Nottingham functions as the first night centre and induction wing. The wing can hold maximum capacity of 155 prisoners. All cells are suitable for double occupancy, however for those prisoners assessed as at raised risk they occupy a cell on their own.
17. The fourth floor landing acts as the overspill for the vulnerable prisoner unit, G Wing. Vulnerable prisoners are sometimes held on the third floor landing too, at times of high demand. Prisoners granted vulnerable prisoner status remain on D Wing until a space becomes available on G Wing.
18. The regime on the wing allows general population prisoners association in the morning and vulnerable prisoners in the afternoon. At other times, unless unlocked for appointments or visits, prisoners remain in their cells. There are two meals served; at lunch and evening meal. Prisoners are issued with breakfast packs with their evening meal.
19. On average there are 15 to 20 ACCT documents open on D Wing at any one time.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Nottingham during the week of 8 January 2018, which found the prison to be fundamentally unsafe. On 18 January 2018, HMIP invoked the Urgent Notification (UN) process which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days. The Secretary of State responded on 12 February.
21. Key findings from the inspection included:
 - Over two thirds of prisoners told inspectors they had felt unsafe at some point during their stay at the prison.
 - 57% of prisoners told inspectors it was easy to obtain illicit drugs and mandatory drug testing suggested a positive rate of 14%, rising to over 30% when psychoactive substances were included in the data.
 - Levels of violence overall were higher than in comparable prisons and had not reduced since the last inspection in February 2016.
 - Levels of self-harm were very high and had increased since the last inspection.

- There were repeated failures to achieve or embed improvements following previous recommendations made by the Prisons and Probation Ombudsman (PPO).

Independent Monitoring Board

22. 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 ending 28 February 2017, the IMB reported concerns about the unfairly restricted regime experienced by vulnerable prisoners on D Wing. They highlighted that there were up to 40 vulnerable prisoners on D Wing, none of whom had a work or education place at the time they sampled.
23. The IMB also reported their concern about the levels of self-harm in the prison. They noted that illegal drugs, in particular NPS, continued to enter the prison by a variety of means and use of NPS had become increasingly evident.

Previous deaths at HMP Nottingham

24. Mr Armstrong was the seventh prisoner to apparently take his own life at Nottingham since June 2016, and the fourth to die within the space of three and a half weeks in September and October 2017. Another prisoner hanged himself in the week after Mr Armstrong died. Our report on the death of a man in September 2017 highlighted the significant misuse of NPS at Nottingham.
25. Our findings in investigations into the deaths of two men in January and February 2017 found that prison staff did not properly consider all known risk factors when assessing the risk of suicide and self-harm.

Assessment, Care in Custody and Teamwork

26. 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 (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.

NPS

27. NPS, previously known as 'legal highs', are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can

present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

28. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.
29. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

Background

30. In 2002, Mr Carl Armstrong was sentenced to seven years in prison for sexual offences. He reportedly took an overdose in prison in 2004, although his explanation for this later varied; he once said that it was an accidental overdose while trying to get high but on other occasions said he had tried to take his life.
31. In December 2012, Mr Armstrong was remanded in custody and later sentenced to two years in prison for failing to comply with the notification requirements of the Sexual Offences Act. He was released in November 2014.
32. In July 2015, Mr Armstrong was remanded to HMP Nottingham. In September, he was sentenced to two years in prison for again failing to comply with the requirements of the Sexual Offences Act. During this period in prison, Mr Armstrong told healthcare professionals that he had anxiety and that he had once thought of harming himself. In May 2016, he made “superficial” scratches to his arm. He was released on licence in July.
33. In October 2016, Mr Armstrong was recalled to Nottingham. He frequently spoke of experiencing anxiety and depression, and was prescribed citalopram (an antidepressant). He was released on 5 July 2017.

HMP Nottingham

34. On 29 September 2017, Mr Armstrong was remanded to Nottingham, charged with the rape of a child. His person escort record (a form that accompanies prisoners on all journeys to communicate information including about risk factors) said that he had “attempted suicide” by overdose in 2004. It also said that Mr Armstrong was a drug user who had anxiety and depression. A member of court staff wrote that Mr Armstrong had no current issues and no thoughts of harming himself.
35. A custodial manager (who was then a supervising officer), interviewed Mr Armstrong on his arrival at Nottingham. She recorded that Mr Armstrong said he had no problems or concerns and no thoughts of suicide or self-harm. She said she asked Mr Armstrong if he had recently harmed himself, and he said he had not. She recalled that Mr Armstrong was “quite chatty”. She said she had no concerns about him and did not think it necessary to start ACCT procedures.
36. In reception, Mr Armstrong chose not to apply for vulnerable prisoner status. (Vulnerable prisoners are those who might need to be kept separate from the general prison population for their own protection due to the nature of their offence.) No one recorded why Mr Armstrong did not wish to apply for vulnerable prisoner status.
37. A nurse then assessed Mr Armstrong and recorded that he had scratched his wrist around three hours earlier but had no current thoughts of harming himself. She recorded that he had taken an overdose in 2004 and was currently prescribed sertraline (an antidepressant). The nurse told us that the scratch looked like something Mr Armstrong might have made with his fingernails and, as

it was healing, looked like he had made it around three weeks ago. She thought that her entry about the timing of the scratch reflected what Mr Armstrong had told her at the time. The nurse said she did not consider opening ACCT procedures because Mr Armstrong did not appear distressed and described the scratch he had made as “something silly he had done”.

38. Mr Armstrong gave a urine sample, which tested positive for cannabinoids and benzodiazepines. The nurse referred him to the substance misuse team and made a standard (non-urgent) referral to the mental health team.
39. A prison GP, then assessed Mr Armstrong. He recorded that Mr Armstrong said he was not addicted to benzodiazepines and did not want them prescribed. Mr Armstrong said he used ‘mamba’, an NPS, in the community. The prison GP recorded that Mr Armstrong looked well and was not suicidal. He prescribed a short course of zopiclone (a sleeping tablet). He recorded that he would await confirmation from Mr Armstrong’s community GP before prescribing sertraline.
40. Mr Armstrong moved into a cell on D Wing, the first night centre and induction unit. All new prisoners should be offered a telephone call on their first night in prison. D Wing staff offered Mr Armstrong a telephone call, but he chose not to make one.
41. Mr Armstrong initially shared a cell with another prisoner. He told us that Mr Armstrong understood how prison worked. He said that Mr Armstrong had no issues in prison, although he worried about not seeing his children.
42. On 2 October, Mr Armstrong’s community GP surgery faxed his medical summary to Nottingham. This included the information that he had received sertraline on a trial basis rather than on a repeat prescription. Healthcare staff at Nottingham did not therefore renew the prescription as the mental health team had not yet assessed him. (Mr Armstrong had an appointment scheduled for 10 October.)
43. On the same day, Mr Armstrong told a healthcare assistant, that he was concerned that healthcare staff had not continued his sertraline prescription. He advised him to raise this at his next appointment with the mental health team.
44. On 4 October, a substance misuse nurse, assessed Mr Armstrong. She recorded that Mr Armstrong said he had used mamba every day in the community since his release from prison in July 2017. They discussed the risks of using these drugs. The nurse told us that Mr Armstrong appeared relaxed and calm and said he had stopped using mamba since he came into prison. Mr Armstrong said he had thought about harming himself in the community but no longer thought this way and felt a lot better in prison because he was not smoking mamba. Mr Armstrong said he hoped to be prescribed sertraline again as he thought it had helped him, and she explained that he could raise this at his mental health assessment scheduled for next week.
45. On the same day, Mr Armstrong completed an application for vulnerable prisoner status. No one completed the section of the form in which staff should identify information about the reasons for the application. Mr Armstrong moved into a new cell, and now shared with a different prisoner. Mr Armstrong’s new cellmate

told us that Mr Armstrong appeared to be scared, withdrawn and said that someone had told him to kill himself. He said that Mr Armstrong spoke about suicide but said he would not do anything until after his court case. He said he once heard Mr Armstrong tell an officer that he felt suicidal and upset, and the officer replied that if he still felt the same way the next day, he should ask to speak to someone. He did not know who the officer was. There are no entries in Mr Armstrong's prison records about the conversation.

46. Another prisoner who knew Mr Armstrong from a previous sentence, said he appeared more withdrawn at Nottingham. He said that general population prisoners picked on Mr Armstrong because of the nature of his offence.
47. On 5 October, Mr Armstrong and his cellmate moved to a new cell. Mr Armstrong's cellmate told us that he helped Mr Armstrong to unpack and found a ligature in his belongings. Mr Armstrong told him that it was a "comforter" and he would make another one if he took it from him. The cellmate said Mr Armstrong then smoked a cigarette that he thought might have contained drugs.
48. The prisoner who knew Mr Armstrong from a previous sentence, who now lived in the neighbouring cell, said that Mr Armstrong told him after the cell move that he was going to end his life. He said he reported this to an officer, who told him to, "Go away". The officer told us that he was not on duty on 5 October, and worked on a different wing on 4 October. The prisoner also said Mr Armstrong smoked mamba on the night of 5 October.

6 October 2017

49. At around 7.15am on 6 October, Mr Armstrong's cellmate left the cell to go to court. As D Wing houses a mix of vulnerable prisoners and those from the general population the regime is managed so that they do not mix. General population prisoners spend time out of cell in the morning, and vulnerable prisoners in the afternoon. Mr Armstrong therefore spent the morning in his cell. There was no requirement for any member of staff to check on him, and no one visited him for any other reason.
50. At 11.59am, the prisoner who knew Mr Armstrong from a previous sentence, looked into Mr Armstrong's cell. He told us that he could see Mr Armstrong lying on the heating pipe at the back of the cell, seemingly unconscious, with a "loop" from his neck to the window. He shouted for assistance and then ran to a lower landing and told an officer what he had seen.
51. The officer said that the prisoner told him that Mr Armstrong had fallen on the floor of his cell and that this might be as a result of smoking mamba. He went to the cell, arriving at 12.01pm. The officer said he unlocked the door and found Mr Armstrong lying at the back of the cell, hanging from a ligature made from a bed sheet that was tied to the window catch. He radioed a medical emergency code blue, indicating a life-threatening situation, and cut the ligature. The control room operator recorded this call at 12.01pm, and telephoned for an ambulance immediately.
52. The officer and a colleague laid Mr Armstrong on the floor of the cell, and a third officer began chest compressions. A nurse arrived at 12.02pm and took over

chest compressions, with a second nurse who arrived shortly afterwards. The nurses attached a defibrillator, which found no shockable heart rhythm. They continued chest compressions until paramedics arrived at around 12.17pm. At around 12.44pm, the paramedics confirmed that Mr Armstrong had died.

Contact with Mr Armstrong's family

53. Mr Armstrong chose not to nominate a next of kin when he arrived at Nottingham. After his death, the Head of Reducing Reoffending, identified that Mr Armstrong had named his sister-in-law as next of kin during his previous period in prison. He and a prison chaplain, visited Mr Armstrong's sister-in-law on the afternoon of 6 October, and told her of his death. Mr Armstrong's mother later contacted the prison, having learnt of his death from his sister-in-law. The Head of Reducing Reoffending visited her on 9 October. Nottingham contributed to the costs of the funeral in line with national guidelines.

Support for prisoners and staff

54. After Mr Armstrong's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
55. The prison posted notices informing other prisoners of Mr Armstrong's death, and offering support. The prisoner who knew Mr Armstrong from a previous sentence said that a number of members of staff, including the Governor, offered him support afterwards. A supervising officer told Mr Armstrong's cellmate of Mr Armstrong's death when he returned from court.

Post-mortem report

56. A post-mortem examination established the cause of death as asphyxiation by hanging. Toxicology tests identified that Mr Armstrong had used synthetic cannabinoids (NPS).

Findings

Identifying risk of suicide and self-harm

57. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Nottingham should have recognised Mr Armstrong as being at risk and begun ACCT procedures to support him.
58. Mr Armstrong had some risk factors for suicide and self-harm when he arrived at Nottingham in September 2017. He had attempted suicide in the past, albeit over a decade and several prison terms previously. He had substance misuse issues, although was not withdrawing from drugs, and some mental health issues. Mr Armstrong had been remanded in custody charged with a serious offence against a family member, and had similar previous custodial experience.
59. More significantly, Mr Armstrong had recently harmed himself. He did not reveal this to the custodial manager, but told the prison nurse. It is unclear when he had harmed himself, as the nurse's written and verbal accounts differed. She said that Mr Armstrong did not appear distressed and she did not therefore consider that she needed to start ACCT procedures.
60. We are concerned that the nurse did not give sufficient weight to Mr Armstrong's range of risk factors, including his recent self-harm, when considering his risk. Instead, she relied too much on what he said to her at the time. While this is important, in a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we found that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. However, we recognise that the nurse told us that she has never been trained in ACCT procedures (a mandatory requirement of PSI 64/2011 for all staff).
61. We consider that staff at Nottingham, particularly the prison nurse, should have been more alert to Mr Armstrong's risk factors for suicide and self-harm. While this would not have automatically led them to open ACCT procedures, it should at least have been considered in the light of his ongoing risk factors. We make the following recommendations:

The Governor should ensure that reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk, and that they consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm, and open ACCT procedures when indicated.

The Governor should ensure that all staff in contact with prisoners are trained in ACCT procedures, in line with the requirements of PSI 64/2011.

62. Mr Armstrong's former cellmate and neighbour both told us that he appeared withdrawn and might have been bullied. They also said that he used drugs, and

toxicology tests identified that Mr Armstrong had used NPS before his death. Both bullying and NPS use in prison are recognised risk factors for suicide and self-harm.

63. The regime on D Wing is such that most prisoners spend nearly all of the day in their cells. There is no personal officer scheme and, therefore, little opportunity for prisoners to have significant one to one contact with staff. There were no entries in Mr Armstrong's records to indicate that any member of staff had any meaningful individual conversation with him. This is particularly important in the first weeks in custody and, without such contact, it is more difficult for staff to identify whether a prisoner has any issues or might be more vulnerable to suicide and self-harm. Nottingham have indicated that they will, in the future, introduce a 'keyworker' scheme, an expectation of which is that wing staff have allocated time with prisoners every week. In the meantime, we make the following recommendation:

The Governor should ensure that officers have meaningful contact with prisoners during their first weeks in custody, including individual conversations that allow them to get to know prisoners and identify their needs.

NPS

64. Mr Armstrong said he frequently used mamba in the community, and both his cellmate and neighbour thought he had used drugs the night before he died. Toxicology tests identified that Mr Armstrong had used NPS before his death.
65. The PPO's Learning Lessons Bulletin on NPS, issued in July 2015, sets out why these substances have become a source of increasing concern in prisons. There is evidence that NPS poses dangers to both physical and mental health. In addition, trading these substances can lead to debt, violence and intimidation. In our Annual Report for 2016-2017, we noted that the number of deaths where the use of NPS may have played a part continued to rise and that there was a greater need than ever for more effective drug supply and demand reduction strategies, including better monitoring by drug treatment services and effective violence reduction strategies.
66. One of the principles of Nottingham's Substance Misuse Strategy, issued in January 2017, is that the prison will not tolerate the presence of illicit drugs and is committed to eliminating the supply of, and demand for, drugs. Some positive action was taken for Mr Armstrong and he was referred to the substance misuse team due to his use of NPS in the community. However he continued to use these drugs in Nottingham, seemingly unknown to prison staff.
67. Our investigation into the death of a man at Nottingham in September 2017, who died as a result of the toxic effects of synthetic cannabinoids, found that healthcare staff were called to attend a total of 257 incidents related to NPS in August and September 2017. This is clearly a huge strain on limited resources at Nottingham and the challenges of delivering the prison's Substance Misuse Strategy are stark.

68. We made a recommendation about this issue after the death of a prisoner in September 2017 and repeat it in this report:

The Governor should ensure that there are effective supply and demand reduction strategies to help eradicate the availability of NPS and that staff are vigilant to signs of its use and take appropriate action.

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