

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Darren Capewell a prisoner at HMP Nottingham on 7 February 2018

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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.

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

Mr Darren Capewell died on 7 February 2018, after being found hanged in his cell at HMP Nottingham. He was 37 years old. I offer my condolences to Mr Capewell's family and friends.

Mr Capewell suffered from cerebral palsy, had a history of alcohol and illicit drug use, and a significant history of self-harm. The investigation found that although Mr Capewell received appropriate healthcare during his brief time at Nottingham, suicide and self-harm prevention procedures were not carried out as they should have been.

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. I welcome HMIP's decision to do this. Several of the significant failings identified by HMIP featured in this investigation. HMIP also noted that there had been repeated failures by Nottingham 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**

**August 2018**

## Contents

Summary .....	1
The Investigation Process .....	3
Key Events .....	6
Findings .....	11

# Summary

## Events

## Findings

1. Mr Darren Capewell suffered from cerebral palsy, had a history of alcohol and illicit drug use, and a significant history of self-harm. He had served numerous custodial sentences, many at HMP Nottingham, and had been released from a previous sentence at Nottingham on 29 November 2017.
2. On 5 February, he was remanded into custody at Nottingham. When Mr Capewell arrived, staff immediately began to monitor him under Prison Service suicide and self-harm prevention procedures (known as ACCT) as he had attempted to strangle himself using his shirt while at court.
3. On 7 February, at 4.58pm, an officer found Mr Capewell hanging in his cell. The officer requested an ambulance and began cardiopulmonary resuscitation. Officers and medical staff attended but, at 5.02pm, the on-site paramedic stopped resuscitation and pronounced Mr Capewell dead.

## Management of risk of suicide and self-harm

4. We found that ACCT procedures at Nottingham were not conducted in line with mandatory national instructions. Some reviews were not completed when required, not all case reviews were multidisciplinary, and there were inappropriate assessments of Mr Capewell's risk of self-harm.
5. The ACCT was opened on 5 February but closed on 7 February, despite Mr Capewell making two attempts at self-harm by ligature within the previous 48 hours. Mr Capewell was found hanged in his cell less than 7 hours after the ACCT had been closed.

## Handling information in reception

6. We found that the reception procedures at Nottingham were not conducted in line with mandatory instructions. The reception nurse had not seen the suicide and self-harm warning form completed at court on 5 February. We are concerned that reception procedures at Nottingham could inhibit appropriate risk assessment.

## Clinical care

7. The clinical review concluded that the physical care provided to Mr Capewell was equivalent to that which he could have expected to receive in the community.

## Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - conducting ACCT reviews as specified in the national instructions;
  - assessing the level of risk and recording the reasons for decisions; and

- setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes.
- The Governor should ensure that, in line with national instructions, reception staff examine and record all relevant information about newly arrived prisoners, that all relevant staff see person escort records and suicide and self-harm warning forms and that there is a clear audit trail to demonstrate that this happens.

## 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 prisoners responded.
9. The investigator visited Nottingham on 14 February. He obtained copies of relevant extracts from Mr Capewell's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Capewell's clinical care at the prison.
11. The investigator interviewed ten members of staff at Nottingham in March. Five interviews were conducted jointly with the clinical reviewer.
12. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. She gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Capewell's brother to explain the investigation and to ask whether there were any matters he wanted the investigation to consider. Mr Capewell's brother wanted to know if staff knew that Mr Capewell suffered from cerebral palsy and whether he had been bullied by staff. Mr Capewell's brother was informed the initial report was available, but did not request a copy or make any comment.

# Background Information

## HMP Nottingham

14. HMP Nottingham is a local prison holding a maximum of 1060 men and young adult prisoners on remand, convicted or sentenced. The prison serves the courts of Nottinghamshire and Derbyshire. Nottinghamshire Healthcare NHS Foundation Trust provides health services, including mental health services. The prison has 24-hour primary healthcare cover. Mental health care is available Monday to Friday, 8.00am to 5.00pm.
15. D Wing at HMP Nottingham functions as the Induction wing. The wing can hold a maximum capacity of 155 prisoners. All cells are suitable for double occupancy, although prisoners assessed as being at a raised risk occupy a cell on their own. The fourth landing of D Wing acts as the overspill for the vulnerable prisoner (VP) unit on G Wing. On occasions, the third landing of D Wing is also used when there is a high number of vulnerable prisoners. Prisoners granted VP status remain on D Wing until a space becomes available on G Wing. On average there are 15 to 20 prisoners monitored under self-harm prevention measures on D Wing at any one time.
16. The regime on the wing allows half of the prisoners to have association in the morning and the remainder in the afternoon. At other times, unless unlocked for appointments or visits, prisoners remain in their cells. There are two meals served: lunch and an evening meal. Prisoners are issued with breakfast packs with their evening meal. The majority of prisoners, apart from orderlies, are locked in their cells by 6.00pm, and all prisoners are in their cells by 7.00pm until the following morning.

## HM Inspectorate of Prisons

17. 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.
18. 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;
  - over a third of prisoners said they felt unsafe at the time of the inspection;
  - levels of self-harm remained very high and had increased since the last inspection in February 2016. In a survey, 30% of prisoners said that they had been subject to case management interventions (ACCT) at some point during their stay, but too many prisoners felt the support and engagement offered was either insufficient or inconsistent;
  - levels of violence overall were higher than in comparable prisons and had not reduced since the last inspection in February 2016; and

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

### **Independent Monitoring Board**

19. 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 annual report, published in July 2017, the IMB were very concerned about the levels of self-harm and violence and believed that staff shortages and the availability of illicit drugs were a factor in this. The IMB noted that the restricted regime meant all landings were unlocked for domestic activity in either the morning or afternoon, but those prisoners not allocated a regime activity were locked in their cell for the rest of the day.

### **Previous deaths at Nottingham**

20. Mr Capewell's was the eighth death to occur at Nottingham since 1 January 2016. Six of the previous deaths were self-inflicted and one was due to natural causes. Between 13 September 2017 and 7 February 2018, six prisoners died at Nottingham, including Mr Capewell.

### **Assessment, Care in Custody and Teamwork (ACCT)**

21. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held. 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 prisons at risk of harm to self, to others and from others (Safer Custody)*.

## Key Events

22. Mr Darren Capewell had a custodial history dating back 20 years. He had served numerous sentences at HMP Nottingham. He suffered from cerebral palsy, had a history of alcohol and illicit drug use, and had a significant history of self-harm. Since 2010, Mr Capewell had been monitored under ACCT over 40 times during his time in prison. He had been released from his last sentence at Nottingham on 29 November 2017.
23. On 5 February 2018, Mr Capewell appeared at Magistrates Court and was remanded into custody charged with indecent exposure and racially threatening behaviour. He was due to appear at Crown Court on 26 February.
24. A Prison Custody Officer (PCO) completed a Person Escort Report (PER) and a Suicide and Self-Harm Warning (SSHW) form. These documents are intended to alert staff in all criminal justice agencies who come into contact with a prisoner about his or her risk of suicide and self-harm. The PCO noted on the forms that Mr Capewell had banged his head on the floor in the dock, had attempted to ligature using his shirt when in the cell, and had banged his head against the cell door until the glass broke. He noted that Mr Capewell had a significant history of self-harm. The escort record and the SSHW form accompanied Mr Capewell to Nottingham.
25. A Supervising Officer (SO) saw Mr Capewell when he arrived in reception at 12.45pm. He signed the PER and SSHW forms and immediately opened an ACCT. He assessed Mr Capewell as being at high risk of suicide or self-harm. His level of observations was set at hourly throughout the day and night until the first case review. Mr Capewell was allocated a single cell on D Wing.
26. A nurse saw Mr Capewell in reception. He recorded that Mr Capewell was on an ACCT, had a history of self-harm but had no current suicidal thoughts. He recorded that Mr Capewell suffered from cerebral palsy, had previously been prescribed fluoxetine (used in the treatment of depression) and had a history of alcohol and illicit drug use. He referred Mr Capewell to the doctor. The SSHW form was not signed by a member of healthcare.
27. The nurse told the investigator that he had known Mr Capewell since 2011. He said that he had neither seen, nor was aware of, the SSHW form. If he had, he would have entered the information in Mr Capewell's medical records and would have requested an urgent mental health assessment.
28. That evening, a prison GP saw Mr Capewell as a result of the referral made by the nurse. Mr Capewell said he had been drinking up to eight litres of white cider a day, and that he last drank alcohol two days before entering prison. He said that before his arrest he had smoked a psychoactive substance (PS) which he thought was a cigarette. Mr Capewell said he had not taken fluoxetine for several weeks.
29. The prison GP recorded that Mr Capewell showed little evidence of alcohol withdrawal. He prescribed a five-day alcohol detoxification programme of chlordiazepoxide, thiamine, midazolam and vitamin B (all for alcohol withdrawal). He recorded that Mr Capewell should be reviewed by the mental health team

- after the alcohol detoxification was completed. He told the investigator that he knew Mr Capewell very well as he had been seeing him over a 14-year period.
30. On 6 February, at 9.46am, a nurse recorded that Mr Capewell had refused to take his alcohol detoxification medication. At 11.11am, a substance misuse team assistant recorded that Mr Capewell had agreed to take his medication. He also recorded that Mr Capewell was agitated, and his blood pressure and pulse were high.
  31. At 3.10pm, an officer assessed Mr Capewell as part of ACCT procedures. (It is mandatory for the ACCT assessment to be held within 24 hours of an ACCT being opened; this assessment should have taken place before 12.45pm.) Mr Capewell said he had consumed a lot of alcohol and smoked PS before his arrest. He said he had self-harmed and made a ligature while at court out of frustration at being returned to prison. Mr Capewell said that he had attempted to take his own life on several occasions in the past by using a ligature. He said he had no contact with his family nor did he have any plans to contact them. The officer recorded that Mr Capewell was on an alcohol detoxification programme and that he wanted to contact his solicitor and probation officer.
  32. At 5.00pm, a SO held the first ACCT case review with Mr Capewell. No one else was present or provided any input into the review. (It is mandatory for first case reviews to be held within 24 hours of an ACCT being opened; this first case review should have taken place before 12.45pm.) Mr Capewell said he was upset at being back in prison as he had managed to stay out of prison for two months. He said he would need help to find accommodation on his release.
  33. The SO assessed Mr Capewell as being at low risk of suicide and self-harm, and reduced the level of observations to two conversations during the day and hourly observations during the night. He completed the ACCT caremap which contained one action: for Mr Capewell to have a contact with resettlement services about accommodation. The next case review was set for 8 February.
  34. The SO told the investigator that he was aware that the ACCT review should have been done much earlier in the day. He said that no one from healthcare was available and mental health nurses only work up to 5.00pm, Monday to Friday. He said that he had known Mr Capewell for 10 years, described him as a "loveable rogue", and that he had been on an ACCT on numerous occasions. He said that Mr Capewell used the ACCT process to get what he wanted.
  35. At 7.00pm, Mr Capewell was found in his cell attempting to tie a piece of clothing around his neck. The SO held another ACCT case review with Mr Capewell. Again, no one else was present and no one from healthcare attended. Mr Capewell said he wanted the phone number of his solicitor put on his prison phone account. The SO recorded that Mr Capewell appeared to be struggling and was more agitated than usual. He assessed Mr Capewell as being at raised risk of suicide and self-harm, and increased the level of observations to hourly. He set the date of the next review for 7 February, but did not update the ACCT caremap.
  36. After the So had increased the level of observations to hourly, the on-going record of the ACCT document shows that Mr Capewell was observed every hour,

at 30 minutes past each hour, up to and including 6.30am on 7 February. There were no observations recorded after 6.30am.

37. CCTV footage of the wing shows that at 10.14am, a resettlement worker saw Mr Capewell in his cell. Mr Capewell said that he would require help with his accommodation on release. He said he had no thoughts of self-harm or suicide. The resettlement worker told the investigator he had known Mr Capewell for some 15 years and he, too, described Mr Capewell as a “lovable rogue”. He was aware that Mr Capewell suffered from cerebral palsy and had a history of alcohol and illicit drug use. He said that Mr Capewell had been allocated a case worker and she would work with him once the outcome of his court appearance on 26 February was known.
38. At 10.24am, a SO took Mr Capewell from his cell to a private area on D Wing and chaired an ACCT case review with a mental health nurse and Mr Capewell present. Mr Capewell said he was embarrassed about his offence and was aware of the support available to him. He said that he wanted to contact his solicitor. The SO and nurse agreed that Mr Capewell’s risk of suicide and self-harm was low. They, and Mr Capewell, agreed to close the ACCT. The SO recorded that he would obtain the number of Mr Capewell’s solicitor. He also recorded that the caremap had been updated, although the action had not been completed. A post-closure review was scheduled for 15 February. No further interactions with Mr Capewell were recorded in his prison computer record or the wing observation book before his death.
39. The SO told the investigator he had known Mr Capewell for some 20 years and described him as a “likeable rogue”. He was aware that Mr Capewell suffered from cerebral palsy. He said Mr Capewell was always on an ACCT each time he came into prison as he used the process to obtain something he wanted. He said that at the ACCT review Mr Capewell was his usual self: very chatty and giving no outward sign that he had any thoughts of self-harm.
40. The mental health nurse told the investigator he had known Mr Capewell for a number of years and had seen him on a few occasions during his previous sentence. He said he had no concerns about the ACCT being closed. He said he could not remember whether he had read the notes of the ACCT case reviews of 6 February.
41. Mr Capewell’s medical records show that the mental health nurse recorded his intervention at the ACCT review on 9 February. The nurse told the investigator that he had conducted several ACCT reviews on 7 February and had forgotten to record his intervention with Mr Capewell.
42. CCTV footage shows the SO returning Mr Capewell to his cell at 10.46am. At 11.27am, an officer unlocked Mr Capewell’s cell to allow him to collect his lunch. A SO locked Mr Capewell back into his cell at 11.37am.
43. At 2.20pm, CCTV footage shows an officer and the substance misuse team assistant arriving at Mr Capewell’s cell. The officer told the investigator he was detailed to assist the assistant to conduct healthcare checks with prisoners. He said he opened Mr Capewell’s cell door. Mr Capewell said nothing and the

assistant took Mr Capewell's blood pressure. He recorded in Mr Capewell's medical record that his blood pressure and pulse were within normal range.

44. The officer told the investigator that the regime on the wing meant that half of the prisoners were allowed association in the morning and the remainder in the afternoon. At all other times, unless unlocked for appointments or visits, prisoners remained in their cells. He said Mr Capewell remained in his cell all afternoon and no concerns were raised.
45. Mr Capewell's prison phone records show that he made no phone calls after he arrived at Nottingham. The investigator has found no evidence or intelligence to suggest that Mr Capewell was in debt, bullied or threatened.
46. At 4.58pm, CCTV footage shows that an officer arrived at Mr Capewell's cell to unlock him so he could collect his evening meal. The officer told the investigator that when he got to Mr Capewell's cell, he opened the observation panel and saw Mr Capewell hanging from the window bars in his cell by a ligature made from bedding. He shouted for staff and immediately entered the cell, followed by another officer. The officers cut the ligature and lowered Mr Capewell to the floor and an officer began cardiopulmonary resuscitation (CPR). Another officer arrived at the cell and immediately radioed a code blue emergency, which indicates a prisoner is unable, or having difficulty breathing.
47. The control room log shows the code blue was called over the radio at 5.00pm and an ambulance was called immediately. East Midlands Ambulance Service records confirm that the 999 call was received at 5.00pm.
48. The offender health paramedic immediately responded to the code blue call. He told the officer to stop the resuscitation and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, and at 5.02pm, he pronounced Mr Capewell dead.

#### **Contact with Mr Capewell's family**

49. Mr Capewell had not had nominated anyone as his next of kin. Nottingham managed to trace the address of one of his brothers. A prison family liaison officer and a prison chaplain visited Mr Capewell's brother at his home address at 8.00pm. They informed him of Mr Capewell's death and offered their condolences and support. In the days that followed, Nottingham maintained contact with Mr Capewell's brother and, in line with Prison Service guidance, the prison contributed to the costs of the funeral.

#### **Support for prisoners and staff**

50. The Acting Head of Safer Custody held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
51. The prison posted notices informing staff and prisoners of Mr Capewell's death, and offering support. Staff reviewed all prisoners assessed as being at risk of

suicide or self-harm in case they had been adversely affected by Mr Capewell's death.

### **Post-mortem report**

52. A post-mortem examination confirmed that the cause of Mr Capewell's death was hanging. The toxicology results confirmed that Mr Capewell was not under the influence of alcohol or any illicit drugs at the time of his death.

# Findings

## Management of risk of suicide and self-harm

53. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. 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. Case reviews should be multi-disciplinary where possible.
54. Staff correctly opened an ACCT on 5 February, immediately on Mr Capewell's arrival at Nottingham. However, national instructions explicitly state that it is mandatory for both the ACCT assessment and first case review to be completed within 24 hours of an ACCT being opened. Neither of these happened on time.
55. On 6 February, after an officer completed the assessment at 3.10pm, a SO conducted the first case review at 5.00pm. No one else was present and there was no input from healthcare staff. The SO assessed that Mr Capewell was at low risk of self-harm, reduced the level of observations and scheduled the next review for the 8 February.
56. At 7.00pm, a further review was correctly conducted after Mr Capewell was found with a ligature around his neck. Again, the SO did this review on his own, without anyone else present and without any input from healthcare staff. The SO assessed that Mr Capewell was at raised risk of self-harm, increased the level of observations to hourly and scheduled the next review for the following day.
57. Mr Capewell was very well known to staff, and this may have influenced the assessment of his risk. In our view, as this was the second time in 48 hours that Mr Capewell had used a ligature, staff should have considered placing him on constant observation until at least the next case review.
58. The ACCT on-going record shows that staff conducted hourly observations at 30 minutes past each hour, up to and including 6.30am on 7 February. There were no further observations recorded before the case review was held at 10.25am. National instructions explicitly state that observations must be conducted as specified in the ACCT document and at unpredictable times. Staff did not do this and we consider this a significant failing.
59. We consider that the decision to close the ACCT on 7 February, was inappropriate. We judge that Mr Capewell should have received effective ongoing support from staff, not least given his well-documented and very recent attempts at self-harm, and at the very least until after he had made contact with his solicitor. The caremap should have been updated with an additional action to address Mr Capewell's request to be able speak to his solicitor.

60. We make the following recommendation:

**The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**

- **conducting ACCT reviews as specified in the national instructions;**
- **assessing the level of risk and recording the reasons for decisions;**
- **setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes; and**
- **conducting observations as specified which must be at unpredictable times.**

### Handling information in reception

61. We are concerned that a nurse had not seen the suicide and self-harm warning form, completed at court on 5 February. He said that the suicide and self-harm warning form was one that was not usually passed to healthcare staff, although he said that if he had seen the form, he would have signed it and documented the detail from it as required. He did not recall having seen the Person Escort Record either, despite this being an essential tool for assessing risk.

62. PSI 7/2015, *Early days in custody, reception in, first night in custody, and induction to custody*, states that staff should examine all forms, including person escort records and suicide and self-harm warning forms, when they are received. It requires that all relevant information about the prisoner should be noted in the appropriate record and forwarded to other staff as necessary and any action taken recorded. The nurse did not see the suicide and self-harm warning form which would have prompted him to explore Mr Capewell's risk of suicide and self-harm further. He did not recall seeing the escort record. We are concerned that reception procedures at Nottingham could inhibit appropriate risk assessment. We make the following recommendation:

**The Governor should ensure that, in line with national instructions, reception staff examine and record all relevant information about newly arrived prisoners, that all relevant staff see person escort records and suicide and self-harm warning forms and that there is a clear audit trail to demonstrate that this happens.**

### Clinical care

63. The clinical reviewer considered that Mr Capewell received appropriate care from healthcare staff at HMP Nottingham and this was equivalent to the care he would have received in the community.

64. The clinical reviewer was also concerned that a nurse had not seen the suicide and self-harm warning form in reception. This meant that important information had not been recorded in Mr Capewell's medical record.

65. Mr Capewell was correctly put on a five-day detoxification programme with medication prescribed to supplement vitamins in his body and medication to relieve anxiety and reduce the likelihood of fits during withdrawal. Mr Capewell was correctly monitored for detoxification during the 48 hours before his death.

66. The clinical reviewer commends the offender health paramedic for his swift and confident response to the emergency response on 7 February 2018, utilising his training, experience and following national guidelines on when it is inappropriate to perform CPR.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations