

**Investigation into the circumstances surrounding
the death of a man
at HMP Lincoln in April 2009**

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

March 2010

This is the report of an investigation into the circumstances surrounding the death of a man. He was 44 years old when he died from natural causes at HMP Lincoln in April 2009.

The man had arrived at Lincoln in December 2008 after receiving a 30 month custodial sentence. He suffered a heart attack in his cell shortly after visiting the gym for the first time in April. The post mortem report confirms that his arteries were blocked, reducing the flow of blood to his heart. His heart disease had not been diagnosed and he had not reported symptoms to a doctor.

I would like to extend my sincere condolences to the man's wife and children, as well as others who have been affected by his death. As well as his family, I think of his cellmate who valued their friendship and was greatly upset by his passing.

The investigation was completed by my colleague. He visited Lincoln and spoke with a number of staff. One of the Family Liaison team contacted the man's wife and invited her contribution to the investigation.

A clinical review of the treatment that the man received in custody was undertaken by the clinical reviewer, appointed by NHS Lincolnshire. She assessed whether the care that he received in custody was of a comparable standard to that he would have been offered in the community. I am grateful to her for her assistance. A copy of her review is annexed to this report.

I would also like to thank the then Governor of Lincoln, his staff and the prisoners for their full cooperation whilst the investigation was carried out. I would particularly like to thank the governor who liaised so effectively with the investigator.

The investigation has demonstrated how the gym induction process at Lincoln can be circumvented. The man was able to obtain a pass and use the gym without apparently being properly inducted or shown how to use the equipment. I also return to the issue of first aid training at Lincoln, something I have touched on during previous investigations. I would like officers who are first aid trained to have more confidence in starting resuscitation when a prisoner collapses. I make five recommendations in total.

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

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Prisons and Probation Ombudsman

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SUMMARY

The man arrived at HMP Lincoln in December 2008, having received a 30 month sentence at Crown Court. He underwent an initial health screening and did not report any significant concerns. The next day a follow-up health screening was completed and once again he did not tell healthcare staff of any health problems. Although he provided details of a doctor's surgery where he was apparently registered, staff contacted the practice and discovered that this was not the case.

Because he suffered from asthma, the man attended a clinic in the prison in January 2009 and was provided with an inhaler. Later that month, he was assessed by the mental health team. No concerns were reported and no follow up appointments were made. He made further court appearances in February and early April in relation to an offence of animal cruelty.

To improve his fitness, the man began exercising in his cell. In April, he obtained a gym pass. It was signed by a Physical Education Officer (PEO). There is no record of him being formally inducted into the gym or being trained in how to use the equipment. No evidence of a Physical Activity Readiness Questionnaire (PAR-Q) being completed has been found since he died.

Three days later, the man used the gym for the first time in the company of his cellmate. Returning to his cell at about 3.00pm, he began to feel unwell and complained of chest pains. At 3.24pm, having left their cell for a few minutes, his cellmate returned to find him collapsed on the bed. He called for assistance and four prison officers responded. An officer helped the cellmate to move the man into the recovery position. A second officer attempted to rouse him. A third officer contacted the control room and reported that an emergency was in progress.

Within about two minutes healthcare staff reached the man's cell and began their efforts to resuscitate him. They had been provided with an incorrect location by the control room but this did not delay them because they had to pass the cell en route. An ambulance was called and paramedics arrived on the wing at 3.39pm. Despite the efforts of staff, the man did not regain consciousness and died at 4.00pm.

THE INVESTIGATION PROCESS

1. The investigator was formally notified of the man's death in April 2009. Notices were subsequently issued to both staff and prisoners at HMP Lincoln, informing them of the investigation process and giving them the opportunity to contact the investigator with any relevant information.
2. The investigator made contact with the person who acted as the liaison officer with the Ombudsman's office throughout the investigation. He was provided with the relevant paperwork relating to the man's time in custody.
3. Having examined the man's prison record and medical file, the investigator visited Lincoln in June. He met the then Governor and interviewed three prisoners, six members of prison staff and a nurse.
4. The investigator wrote to the local Coroner's office to inform them of the nature and scope of my investigation. He obtained a copy of the post mortem report. HM Coroner will be provided with a copy of my report.
5. The investigator also contacted the local Primary Care Trust and asked that a clinical review be carried out with regard to the medical treatment which the man received at Lincoln. The purpose of this review was to establish whether the care that he was offered in prison was comparable with that he would have received in the community. The clinical reviewer completed the review, which is annexed to my report.
6. One of the Family Liaison Officers (FLOs) contacted the man's wife (his named next of kin) in May 2009. The FLO told her about the purpose of my investigation and asked if she had any concerns about the treatment her husband had received.
7. The man's wife expressed concern about the manner in which her husband had been inducted into the gym a few days before he died. She had heard from his cellmate that her husband had not received his gym pass through the usual formal channels. She also wanted to know about the initial response to her husband's collapse and whether the officers involved attempted to resuscitate him. Finally, she wanted to understand how her husband had died and to know that he was appropriately cared for. I hope that this report helps the man's family understand the events leading to his death.

HMP LINCOLN

8. Built in 1872, Lincoln is a category B prison holding male prisoners. As a local prison, the majority of men arrive from nearby courts in Lincolnshire, Nottinghamshire and Humberside. They are either on remand, awaiting sentencing, serving short sentences or waiting to be moved to another prison. The prison accommodates a maximum population of 738 men, which includes a small number of remanded young offenders.
9. Healthcare at Lincoln is commissioned by NHS Lincolnshire and provided by Lincolnshire Community Health Services. Twenty-four hour nursing cover is available and there is a ten bed in-patient facility. The majority of nursing staff work between 7.30am and 9.00pm. Outside of these hours two nurses work overnight. Doctors provided by local practices attend the prison six days a week to hold surgeries. All prisoners arriving at Lincoln undergo a health screening before they spend their first night in reception.
10. HM Chief Inspector of Prisons completed an inspection of Lincoln in December 2007. She found that, following considerable previous difficulties, the prison had 'returned to normality, although there remained plenty of scope for further improvement ... [and the] governor still has plenty of work ahead to develop a fully effective local prison ...'
11. She noted that not all staff had been given training in resuscitation in the previous 12 months and recommended that annual training be implemented. She also found no evidence that resuscitation equipment was being checked on a regular basis. Staff from the Inspectorate had visited the gym and found 'a good range of new machines and facilities for cardiovascular work'. They found that 35 per cent of the prison population used the physical education facilities on offer.
12. The most recent annual report published by the Independent Monitoring Board (IMB) at Lincoln covers the year from 1 February 2008 to 31 January 2009. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The Board recognised that 'the staff in general is well motivated [and] carry out their duties with professionalism and care ...' The IMB commented that the prison is well run and that previous problems had been addressed.
13. Since I assumed responsibility for investigating all deaths in prisons in 2004, I have investigated 12 previous deaths at Lincoln. Of these, 11 were self-inflicted and one was the result of natural causes. Of particular relevance to the current investigation are the deaths of two prisoners in December 2007 and February 2008. As a result of both investigations I made recommendations relating to first aid training at Lincoln. This is a concern that I return to in this report and which the Inspectorate has also highlighted.

KEY FINDINGS

14. The man appeared at Crown Court in December 2008 and received a 30 month custodial sentence in relation to a drug offence committed in April 2008. He arrived at HMP Lincoln at 2.50pm.
15. During the reception process at Lincoln, the man underwent a cell sharing risk assessment and an initial health screening (these are both required when prisoners arrive in prison). He was assessed by a substance misuse nurse who was asked to assist in the reception area because of short-staffing. He said he was a heavy smoker and suffered from asthma but was otherwise fit and well. She made sure that he had a Ventolin inhaler.
16. The man had been prescribed fluoxetine (an anti-depressant) by his doctor in the community to help reduce mood swings, and it was agreed that this prescription would continue in custody. He reported daily cannabis use. He was not considered for detoxification as this is not available to cannabis users.
17. The man did not identify any significant mental or physical health problems, nor did he mention any history of heart disease. On the basis of the information she had available, the nurse deemed the man fit for employment and use of the gym.
18. The next day, another nurse completed the man's follow-up health screening. Once again, he did not raise any significant concerns about his health, although a referral was made to the mental health team because of the reason he gave for being prescribed fluoxetine (mood swings and anger problems). A referral was also made to the asthma nurse.
19. In December, a Healthcare Support Worker rang the surgery where the man had said he was a patient, only to be told that he was not registered with them.
20. After the New Year, the man spoke to a member of healthcare staff to obtain a further Ventolin inhaler in January 2009. Because he did not appear to be registered with a doctor in the community, the member of staff referred him to the asthma clinic and planned to discuss the matter with a doctor. Three days later the man approached another member of nursing staff and again asked for an inhaler. The member of staff decided to ask a doctor to prescribe the inhaler.
21. Later that month the man was assessed at the mental health clinic. Because he did not raise any concerns and did not report any suicidal thoughts or history of self harm, no follow up appointments were scheduled. A few days later he moved cells and started working in the prison's clothing store.
22. At the start of the following month, in February 2009, it was noted in the man's medical record that there was some confusion over applications apparently being made for him to be assessed by healthcare staff. He told staff that he

had not made any such application and he thought that another prisoner must be doing this for him.

23. The man appeared at court via video link in relation to an offence of animal cruelty in February. A week later he was granted enhanced status under the Incentives and Earned Privileges (IEP) scheme. (The IEP scheme allows a prisoner to earn privileges in return for constructive behaviour. Similarly, privileges can be taken away if a prisoner does not comply. Enhanced status is the highest available.) Staff recorded in his wing history sheet that he was a polite and mature prisoner who kept himself to himself, obeyed the rules, had no problems and got on well with other prisoners.
24. In April the man was escorted to Crown Court, received a fine of £2,650 (or three months in custody) and returned to the prison later that day. Three days later he was visited by his wife. She planned to visit him again on 19 April.
25. In the middle of the month a pass allowing the man to use the gym was signed by a Physical Education Officer (PEO). As I discuss more fully in the 'Issues' section of this report, there is some confusion regarding the way in which the man acquired the pass. It was not obtained in the usual manner. There is no record of the man ever being formally inducted into the gym or being shown how to use the equipment. There is also no record of the required medical questionnaire (which every prisoner is supposed to fill out during the induction process) being completed.
26. The man shared cell 16 on the second landing of B wing with another prisoner. (He had moved to B wing earlier in the year when he started working in the clothing store.) On Saturday both men went to the gym in the early afternoon. The cellmate told the investigator that he was a frequent gym user and had been properly inducted. However, this was the first time that the man had ever used the facility. He used the gym pass he had obtained earlier that week to gain entry.
27. A Principal Officer (PO) told the investigator that, very shortly after the man died, the cellmate spoke to him. He apparently said that the man had complained of chest pains that morning and had been advised to report these, but had not done so. However, when he spoke to my colleague, the cellmate was sure that the man had not mentioned feeling unwell until they returned from the gym.
28. During their visit to the gym, the cellmate told my investigator that he and the man had used the stepper, the rowing machine, the treadmill and the exercise bike. He said that the man did not lift any weights and spent about an hour in total using the equipment. He recalled that the man 'took it easy' and was not able to keep pace with him. He remembered that the man had stopped before he had on each machine and had rested whilst waiting for him to finish.
29. The cellmate told the investigator that the man 'did not push himself too hard, took a gradual approach, paced himself and took breaks'. He recalled that his friend spent about ten minutes on the stepper, selected the slow setting on

the treadmill and completed a 'steady' bike ride. The cellmate said that the man had not complained to him of any pain, but he subsequently discovered that he was said to have mentioned having chest pains to a couple of other prisoners who were in the gym at the same time.

30. Both men returned to their cell from the gym at about 3.00pm. As soon as they got back, the man complained that his chest hurt and his cellmate advised him to use his inhaler. The cellmate told him to sit in a chair and poured him a drink of juice. The cellmate asked another prisoner, who was in a neighbouring cell, to come in. Both men recalled in interview that they all shared a joke and teased the man, presuming that his condition was not serious. The cellmate thought that his friend had 'overdone it' in the gym and was just out of breath.
31. The man complained to the cellmate that he was feeling hot and sweaty. He lay down on the bed with a towel on his forehead. He complained that his arms ached and then sat up, saying that his chest hurt. The other prisoner had gone back into his own cell and the cellmate stepped out of the cell for two or three minutes. The cellmate returned shortly after 3.20pm and found the man collapsed on his back on the bottom bunk bed with blood around his mouth. He tried to rouse the man, who was lying motionless and did not respond. He immediately raised the alarm, shouting for assistance.
32. Three officers responded to the cellmate's shouts and arrived at the cell at about the same instant.
33. The first officer contacted the control room by radio at 3.24pm, asked for immediate medical assistance and stated that a 'code 1' emergency was in progress. ('Code 1' indicates that the prisoner is not breathing.)
34. The second officer helped the cellmate to move the man into the recovery position whilst he lay on the bunk. The third officer walked past both men to where the man's head was and gently rolled his shoulders, trying to elicit a response. He asked the man to answer, saying, 'Come on.' However, other than an occasional slight cough, he did not respond at all. The third officer noticed that there was blood around the man's lips.
35. The three officers stayed with the man until members of healthcare staff arrived. They did not administer any first aid or attempt resuscitation. (Only the first officer had an up to date first aid certificate.) In the meantime, another officer (a member of the prison's care team) removed the cellmate from the cell and took him to the staff tea room as he was distressed by the man's collapse. Before he left the cell, the cellmate was asked by staff if the man had been taking any medication. In reply, he mentioned his friend's asthma. A Senior Officer (SO), who was in charge of B wing at the time, arrived at the cell and took charge of the unfolding emergency.
36. When the investigator spoke to the PO, he confirmed that, when the emergency was initially communicated over the radio by control room staff, the instruction had been to attend A2 landing rather than B2 landing.

However, the PO remembered that the control room had corrected their original instruction over the radio. He thought that the miscommunication had delayed his arrival at the cell by about a minute.

37. However, the PO and other staff to whom my colleague spoke confirmed that healthcare staff heading in the direction of A2 landing had to pass through B2 landing when proceeding from the healthcare centre. In the event, staff congregating around the man's cell stopped the nurses as they were running along the landing and no time was lost in treating him.
38. By the time the PO arrived at the cell, the nurses were already attempting to resuscitate the man. The third officer felt that the response from the healthcare team was very quick and could be measured in seconds rather than minutes. The first officer also recalled that the nurses arrived very quickly. After he made the initial emergency call on the radio, he stepped out of the cell to usher away prisoners who had started to gather, and it was at this point that he recalled the healthcare staff arriving on the landing.
39. It is not clear precisely who on B2 landing requested over the radio net that an emergency response 'blue light' ambulance be called. When he spoke to my colleague, the first officer said that he had not made the call but he thought that one of the nurses had instructed for this to be done after they reached the cell. A call was placed with the emergency services by control room staff at 3.26pm. Two minutes had passed since the initial 'code 1' had been called over the radio, indicating that it took the healthcare staff less time than that to make their way to the cell, to assess the man, and to decide that an ambulance was required.
40. Two nurses began cardio-pulmonary resuscitation. However, the man did not respond and they could not detect a pulse. He was still not breathing and his pupils were fixed and dilated. The nurses asked the third officer to help them move him onto the floor to allow them easier access. The officer supported the man's head and shoulders whilst the nurses lowered him on his back onto the floor from the bunk bed.
41. The defibrillator indicated that the man should receive an electrical shock to try to restart his heart. This was done but he did not respond. A third nurse inserted a plastic airway into his throat and started to administer oxygen. She also helped to give chest compressions.
42. In her clinical review, the clinical reviewer notes that the nurses tried but were unable to administer medication intravenously when they arrived in the man's cell. When the paramedics arrived, they also failed to gain intravenous access and had to use a reinforced needle to deliver medication directly into his bone marrow cavity.
43. The ambulance entered the prison at 3.35pm and arrived outside B wing a minute later. By 3.39pm, the SO and his staff had locked away all of the other prisoners who had been out on the wing on association. At exactly the same time, paramedics arrived on the landing and began overseeing the man's

treatment. They assisted staff in attempting to resuscitate him but were sadly unsuccessful. He did not regain consciousness.

44. At 4.00pm, the paramedics advised staff that attempts at resuscitation should stop and the man was declared dead. The cell was sealed prior to the arrival of the police and the coroner's officer. In order to do this, the duty governor gave permission for staff to move his body approximately two feet so that the door could be closed.
45. The cellmate had been sitting with an officer and a friend. He was told of the man's death at about 4.10pm. He was very upset and was placed in a different cell with another friend, who was also a Listener. (Listeners are prisoners trained by the Samaritans to offer support to others who might need to talk in times of difficulty.) The cellmate returned to the cell he shared with the man on 23 April.
46. The paramedics left the prison at 4.45pm. The police arrived at 5.00pm, and by 7.00pm the coroner's officer had removed the man's body. A 'hot debrief', attended by staff involved in the response to the man's collapse, was held the same day. (The debrief gives staff the chance to have an initial discussion about the emergency and reflect on how the response was handled.)
47. The prison's designated Family Liaison Officer (FLO contacted the local police before deciding on the best way to notify the family of the man's death. On their advice, and because of offences of animal cruelty committed at the property recently, it was deemed inappropriate that she visit the next of kin. The police visited the home address at about 6.30pm, broke the news to the family and provided the FLO's contact details at the prison.
48. A memorial service for the man was held on Sunday in the main prison chapel. The service was advertised on the wing where he had died and on the chaplaincy notice board. His funeral service took place near the end of April. The prison met the full cost of the service. Prisoners who had known him were able to attend a prayer service at the time the funeral was being held.

ISSUES

Clinical care

49. The man did not inform either prison or healthcare staff that he was experiencing symptoms of heart disease. He did not report any significant health problems, aside from asthma (for which he had an inhaler) and some mood swings (for which he was prescribed an anti-depressant). The nurse therefore reasonably assessed him as being a suitable candidate for both employment and the gym when she completed an initial health screening in December 2008. However, as the clinical reviewer notes in her clinical review, no measurement of blood pressure was recorded in his notes either in December or in the days that followed. I therefore endorse her recommendation:

The Head of Healthcare should ensure that a prisoner's blood pressure is taken and recorded during their secondary health screening.

50. The man's medical record indicates that he did not have many dealings with healthcare staff after his initial assessment upon arrival at Lincoln. Wing staff described him as a polite and mature prisoner who kept himself to himself and did not complain or draw attention to himself. He carried out a job that involved some lifting and manual labour in the clothing store. The doctor's surgery he had said he was registered with in the community turned out not to know anything about him.

51. The first officer told my investigator that he subsequently learnt from other prisoners that the man may have complained of chest pains to them. However, he said that the man had never voiced these complaints to staff. The cellmate said that his friend had not mentioned experiencing chest pains to him, but may have told a couple of prisoners that he was feeling unwell whilst he used the gym in April.

52. The cellmate told the investigator that the man never complained of pains that might be linked to heart disease. He said that he was always cheerful and did not complain. Until April, he apparently never looked unwell or appeared to be struggling to cope.

53. The man's collapse was both sudden and unexpected. Neither prison officers nor healthcare staff could reasonably have anticipated the heart attack that caused his death. The clinical reviewer has confirmed that he had been suffering from severe coronary artery disease that blocked the flow of blood to his heart. She concludes that he could have collapsed at any time. In the event, she finds that a 'significant and acute' heart attack caused 'massive damage' to his heart. I am satisfied that staff could not have taken any steps to address the man's heart disease because they were not aware that he was experiencing symptoms.

Gym induction

54. As I have said, the clinical reviewer has found that the man 'could have suffered a heart attack at any time', such was the severity of his heart disease and the extent of the blocking in his arteries. Nevertheless, it is a simple statement of fact that he died very shortly after using the gym for the first time, and seems to have circumvented the formal gym induction process. This investigation has highlighted failings in the gym induction process that seem to have allowed the man to obtain a gym pass informally.
55. The investigator was told by both the PO and the cellmate that the man had started doing some exercises (such as sit ups and press ups) in his cell about six weeks before he died. He had been trying to improve his fitness. In the middle of April, it seems that he decided to obtain a gym pass.
56. Both the cellmate and another prisoner told my investigator that they were sure the man did not obtain his gym pass through the usual channels. The cellmate said that his friend had essentially bypassed the induction process. He asked the investigator to speak to a prisoner who had been a gym orderly at the time.
57. The gym orderly said that the man had asked for his help in obtaining a gym pass whilst they were both in the clothing store one morning shortly before he died. The man's work commitments in the store made it difficult for him to attend the regular gym induction sessions.
58. The gym orderly said that he had approached the PEO and told him that the man wanted a gym pass. He told my investigator that the PEO had then spoken to the man in the store and asked him some questions about his health. The gym orderly said that the PEO had then instructed him to make up a blue gym pass for the man and to ask a second PEO to sign it.
59. The gym orderly recollected that he told the second PEO that one extra gym pass needed signing because the prisoner was working and could not attend the induction session. He remembered telling the second PEO that the first PEO 'had had a word and said it was OK'. The gym orderly recalled that the second PEO had signed the gym pass, which he then took back to the man on B wing. This prisoner has since been removed from his role as a gym orderly.
60. The investigator spoke to Physical Education Senior Officer (SO), who runs the gym, and the two PEOs named by the gym orderly. He also obtained a copy of the man's gym pass, which shows that it was signed by the second PEO in April 2009.
61. The SO said that, after prisoners have applied to join the gym, they are normally collected by staff for an induction and assessment session on either a Tuesday or a Friday. Every prisoner who applies is entitled to be assessed. The induction process involves a one to one interview with a PEO, during which the prisoner is introduced to the equipment and shown how to lift

weights safely. The rules are explained and a Physical Activity Readiness Questionnaire (PAR-Q) is completed, as per Prison Service Order (PSO) 4250. Prisoners are asked about their medical history and if they are taking any medication. The PSO states:

‘All prisoners may participate in PE activities. Prisoners will not be restricted unless otherwise authorised by the Governor and/or a Healthcare professional. All PE departments must deliver a comprehensive induction programme, which must include as a minimum requirement:

‘Explanation of PE rules and regulations...

‘Instruction on basic weight training, safe use of PE equipment and machinery...

‘A Physical Activity Readiness Questionnaire (PAR-Q) must be completed for all prisoners on PE induction prior to participating in PE activity and signed by both the prisoner and a member of PE staff...

Elements of first aid, safe handling and lifting.’

62. I understand that there is not a locally adapted version of the PSO. The SO told the investigator that his staff adhere to the national instructions. My colleague was provided with a copy of the PAR-Q used by PE staff at Lincoln. The form requires prisoners to acknowledge that they have been shown how to warm up properly before they exercise. Prisoners are asked to declare whether they have a history of nine different medical complaints, one of which is a ‘heart condition’. They are required to state if they are taking any medication and whether there is any other reason they should not use the gym.
63. The PAR-Q is taken to the healthcare department and a member of medical staff confirms whether the prisoner is fit to use the gym, completing the final section of the form. (This procedure allows comparison between the PAR-Q and the prisoner’s medical record.) Once the healthcare team return the PAR-Q to the gym staff and confirm that the prisoner can use the gym, a blue gym pass is issued within about 24 hours. From then on, prisoners are entitled to use the gym as long as they present their gym pass and ID card.
64. During interview, the SO confirmed that he has been unable to locate any paperwork relating to the man’s gym induction. He could not say who might have inducted him or when he might have been inducted. There is no evidence of a PAR-Q being completed. There is no record to show how he came by his gym pass.
65. When the investigator described the gym orderly’s version of events to the second PEO, he said that he ‘had no recollection of it at all’. He said that he had never signed a gym pass for a prisoner without first going through the proper procedures. He confirmed that it was possible that he might have

signed a gym pass if he had been asked to do so by another member of staff who had seen the relevant documentation. He said that he would not sign a pass if asked to do so by a gym orderly.

66. The first PEO said that he used to speak to the man five or six times a week because he would take gym kit to the clothing store where the man worked. He told the investigator that the physical education staff keep an Induction Register (a blue hardback book) in which the name of every prisoner who is inducted into the gym is recorded alphabetically. (This book acts as a back up if a prisoner's induction paperwork goes missing.) The first PEO said that the man's name is not listed in this book either. He therefore thought it certain that he was never formally inducted to the gym. The investigator has been provided with copies of the Register which confirm the man's name is not recorded.
67. When he spoke to my investigator, the first PEO said that he would not have 'pushed [the man] forward without doing the proper paperwork'. He speculated that, because the gym passes are prepared and printed on sheets of eight, it was possible for a gym orderly such as the prisoner to add a prisoner's name to the batch of passes which a PEO was due to sign. Essentially, the first PEO thought that the volume of passes being issued and the involvement of prisoners in administering the process left it open to some element of potential error or mischief.
68. The SO provided my investigator with a breakdown of the number of prisoners being inducted into the gym each month. In April 2009, 124 men were inducted. Between January and November 2009, the average number was 149 each month. These figures indicate that up to 15 men are interviewed and inducted on each induction day. The figures for April fell below the average and thus staff would not seem to have been under unreasonable pressure to process applications around the time the man died.
69. In the absence of any documentation demonstrating that the man was formally inducted into the gym, I have to give some credence to the gym orderly's version of events. I note that the gym pass was signed by the second PEO in April, which certainly tallies with the gym orderly's account. As the SO noted, it is regrettable that the staff are unable to produce any paperwork or adequately explain how the man came by the gym pass.
70. The man collapsed and died after using the gym for the first time and had not been shown how to use the equipment during a formal induction session. However, I note that he had been exercising by himself in his cell in the last few weeks of his life. He had not reported any chest pains to staff and had not asked to be assessed by a member of the healthcare team in recent months. His heart disease remained undiagnosed. The clinical reviewer considers that, even if the man had completed a PAR-Q with gym staff and this had then been passed onto the healthcare department, he would very likely have been assessed as fit to use the gym because his medical record contained no evidence to the contrary.

71. The clinical reviewer confirms that the type of heart disease the man suffered from meant that a sudden, massive heart attack could not necessarily be anticipated and, once it had occurred, there was very little chance of a recovery. She notes that a heart attack could have struck at any time.
72. Although the failure properly to induct the man to the gym did not, in all likelihood, affect his chances of survival, it is of evident concern that a prisoner was able to obtain a gym pass without going through the induction process. I therefore make the following recommendation:

The Governor should ensure that the gym induction process is reviewed. Consideration should be given to the involvement of gym orderlies, the scheduling and frequency of induction sessions and the preparation of the passes themselves. Prisoners should not be able to circumvent the process.

Resuscitation

73. The officers who initially attended the emergency on B wing did not attempt to resuscitate the man. The second officer helped the cellmate to place him in the recovery position. The third officer tried to obtain a response from him. The fourth officer took the cellmate aside and the first officer advised the control room of the emergency over the radio.
74. Of the four staff, I gather that only one had a current first aid certificate. The training received by the other three officers had lapsed and their certificates were not currently valid. The officer who was qualified confirmed to my investigator that he did not attempt to resuscitate the man.
75. I note that nursing staff arrived on the wing very quickly (within at most two minutes). The clinical reviewer has found that the resuscitation attempt by the healthcare staff was 'timely'. She has also found that the man's heart attack was both significant and acute, resulting in cardiac arrest that did not respond to either cardio-pulmonary resuscitation or the use of a defibrillator.
76. In these circumstances, it does not appear that the delay of a minute or two whilst the nursing staff made their way to the wing affected the chances of the man's survival. However, one member of staff was first aid trained. Ideally, I would have hoped that the officer might have felt confident in trying to start a resuscitation attempt with the assistance of his colleagues. I make two recommendations to improve access to first aid training and to ensure that those who are trained feel able to involve themselves immediately if a prisoner needs to be resuscitated.

The Governor should ensure that discipline staff who would like to gain or renew a first aid qualification are afforded the opportunity.

The Governor should remind discipline staff with current first aid training that they should start resuscitation as soon as a prisoner is found collapsed without waiting for healthcare staff to arrive.

77. The clinical reviewer makes a further recommendation regarding the need for healthcare staff to receive first aid training on an annual basis. She stresses the need for this training to include the use of both intravenous and intraosseous (into the bone marrow cavity) needle insertion. She notes that healthcare staff were unable to give the man drugs intravenously in the first ten minutes after they arrived in his cell. When the paramedics arrived, they also failed to gain intravenous access and had to use a reinforced needle to deliver medication directly into his bone marrow cavity. I endorse her recommendation.

Resuscitation training for healthcare staff should be reviewed and refresher training delivered on an annual basis. Basic and advanced life support training should follow Research Councils UK 2005 guidelines and should include the use of intravenous and intraosseous needle insertion.

The cellmate

78. The man's cellmate told my investigator that he had been disappointed by some aspects of the support he was offered. He was particularly affected by the man's death because they had been friends in the community and he had known the family personally.

79. When the man collapsed, he was taken aside and supported by an officer (a member of the prison's care team). She took him to a separate, quiet room to calm him down and then break the sad news of his friend's death a short while later. Staff relocated him to another cell which he shared with a friend who also worked as a Listener. The man's cellmate has praised the support that the officers showed him on the day the man died. In particular, he has described the officer who took him aside as 'very sympathetic'.

80. However, the man's cellmate has expressed concern that he returned to the cell he shared with the man too quickly. I understand that he went back into the cell a few days later. Although it may be that five days was not sufficient time to allow him to feel comfortable returning to the cell, I am conscious of the pressures on prison places generally. I am satisfied that staff did not move the man's cellmate back to the cell with undue haste.

81. The man's cellmate also told the investigator that he had to request counselling after his friend died, despite having been told by a governor that he would be offered aftercare. He said that he had to approach a counsellor on the wing.

82. My investigator spoke to the counsellor on the telephone. She said that she had returned to work on Monday. The man had died at the weekend. She remembered being notified of his death and being asked to offer the cellmate counselling. She knew the cellmate from a previous course she had run.

83. Before the counsellor had the chance to speak to the man's cellmate later that same day, he approached her as she was passing through B wing. He was visibly upset so she immediately took him aside and provided an initial counselling session.
84. She told the investigator that the cellmate was offered and attended two further counselling sessions. She thought that he had needed some support and time to talk, rather than in depth counselling. Because she did not consider there to be a long term need, she did not continue to see him after the third session was completed. He did not ask for any further sessions. She also recalled trying to organise a family visit for him to offer him additional comfort. However, for reasons beyond the prison's control, this did not take place.
85. From the information the counsellor provided, I am satisfied that the man's cellmate was provided with appropriate aftercare. Although he did approach her on the wing, this happened on her first day back at work after the man died, and she had planned to speak to him the same day. She could not reasonably have been expected to have acted more quickly.
86. On balance, I consider that appropriate measures were taken to care for the cellmate after his friend died. He was not left on his own and consideration was given to sharing with a Listener and access to counselling.

Memorial service

87. When the investigator spoke to the man's cellmate and another prisoner, they voiced concern that a prayer service held for the man had been relocated to a much smaller multi-faith room from the main chapel. Both expressed disappointment and felt that this decision had been inappropriate.
88. My investigator has confirmed that the actual memorial service was held in the main chapel. I understand that it was advertised on the wing and on the chaplaincy notice board. Forty-seven prisoners were due to attend but only 14 went to the service. (A 'partial lock down' was in place on C wing which inevitably reduced the number of prisoners who could go to the chapel. However, the men on the man's wing were not affected by the lock down and were able to attend.)
89. I gather that the cellmate asked for some private prayers to be said at the time of the man's funeral. On that morning, the prison's staffing profile meant that the prayer service could not be held in the main chapel so prayers were held in the multi-faith room. I consider this to have been a reasonable decision, given that the memorial service itself had been held in the chapel. Although the multi-faith room is smaller than the chapel, the number of the man's friends who wished to attend could be accommodated.

Communication

90. One of the officers contacted the control room via the radio net to inform them that a 'code 1' emergency was underway. He told the investigator that he gave the correct location. When the control room relayed the information to healthcare staff over the radio net, the location given was A2 (the second landing on A wing) instead of B2 (the second landing on B wing), where the man's cell was. The officer did not correct them. However, there does not appear to have been a delay in healthcare staff reaching the man's cell because they had to pass through B wing to reach A wing, and staff were able to stop them as they came past.

Notification of next of kin

91. The man's cellmate expressed concern to my investigator regarding the length of time it took prison staff to inform the man's wife of his death. (His wife has not raised this as an issue personally.) The investigator asked the prison to provide a copy of the Family Liaison Log relating to the man's death. This document indicates that the FLO contacted the local police before deciding on the best way to notify the family. On their advice, and because of offences of animal cruelty committed at the property recently, it was deemed inappropriate that she visit the home address. The police told her that they would visit the home address, break the news to the family and provide her contact details at the prison.

92. Prison Service Order 2710 recommends that a member of Prison Service staff visits the family if at all possible to break news of a death. However, in this case I consider that the FLO acted entirely sensibly on the advice of the police. There was a slight delay in consequence, but I am satisfied that arranging for the police to visit the family home was the right decision.

93. The police attended the home address at about 6.30pm. The man's wife telephoned the FLO at 6.40pm whilst officers were still with her. The FLO expressed her condolences and arranged for the family to visit the prison and the hospital mortuary the next day.

94. The FLO had asked the man's cellmate to delay telephoning his sister (who knew the family personally) so that the news could be broken properly and in person. After she had spoken to the man's wife, she visited the man's cellmate to thank him for cooperating and immediately organised for him to make a telephone call. I consider that this decision was both sensitive and considerate to the family.

95. The following day the FLO organised for the man's wife and relatives to visit the prison. They were given his possessions and could speak with the cellmate. She escorted the family to the hospital. The man's wife visited the prison again and spoke to the cellmate as well as visiting the cell he and her husband shared. Subsequently, the FLO forwarded contributions made by the man's friends and a card they had signed to his wife. I am satisfied that

all of these decisions were taken to support and assist the family. At the request of the man's relatives, no prison staff were present at his funeral.

CONCLUSION

96. The man's death was sudden and unexpected. Although he had just returned from his first visit to the gym, the clinical reviewer concludes that he could have suffered the heart attack which caused his death at any time. The clinical reviewer has also found that there was nothing in the man's medical history to indicate that he would have been refused use of the gym had he completed the appropriate medical questionnaire. However, the investigation has highlighted concerns about the way the man was able to gain access to the gym facilities.
97. The clinical reviewer finds that the man suffered a significant and acute heart attack. Such was the damage caused that he did not respond to any of the attempts to revive him. Whilst the officers who were initially called to his cell did not begin resuscitation, it does not appear that the short delay in treatment before healthcare staff arrived would have made a difference to the outcome. The clinical reviewer has described the resuscitation attempt as 'timely'. Nonetheless, I draw attention to the importance of first aid training at Lincoln and the need for staff to use the skills they have gained.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that a prisoner's blood pressure is taken and recorded during their secondary health screening.

The prison accepted the recommendation and gave the following response:

'Due to the majority of our client group being fit and healthy, blood pressure was only historically obtained if clinically indicated. However Healthcare now accepts that it should be obtained as part of the secondary health screening process to identify any undiagnosed abnormality. Initial email and follow up audit to identify compliance.'

2. The Governor should ensure that the gym induction process is reviewed. Consideration should be given to the involvement of gym orderlies, the scheduling and frequency of induction sessions and the preparation of the passes themselves. Prisoners should not be able to circumvent the process.

The prison accepted the recommendation and gave the following response:

'The gymnasium induction process was reviewed immediately following the death of the man. New processes were implemented which ensure that attendees' names are cross-referenced against the induction records, which prevents non-inducted prisoners accessing the sessions. This is carried out by a member of staff on all occasions to avoid any recurrence of prisoners circumnavigating the process.'

3. The Governor should ensure that discipline staff who would like to gain or renew a first aid qualification are afforded the opportunity.

The prison accepted the recommendation and gave the following response:

'Initial courses are advertised via email to line managers and via the weekly bulletin and/or a local notice to staff for expressions of interest/line managers to discuss with their staff and forward names. Refresher courses are arranged on demand, according to the first aid register and expiry dates. A plan to introduce basic resuscitation training for staff working in key areas is in progress, with first sessions planned for Feb / March 2010.'

4. The Governor should remind discipline staff with current first aid training that they should start resuscitation as soon as a prisoner is found collapsed without waiting for healthcare staff to arrive.

The prison accepted the recommendation and gave the following response:

'Staff holding in date first aid certificates will be written to individually reminding them of the requirements and expectations of a trained first aider regarding resuscitation.'

5. Resuscitation training for healthcare staff should be reviewed and refresher training delivered on an annual basis. Basic and advanced life support training should follow Resuscitation Councils UK 2005 guidelines and should include the use of intravenous and intraosseous needle insertion.

The prison partially accepted the recommendation and gave the following response:

‘All Healthcare staff are trained to Immediate Life Support (ILS) standard, training is mandatory and provided by the Primary Care Trust on a yearly basis. All staff are trained to the Resuscitation Council (UK) 2006 Standard Guidelines. The use of intravenous and intraosseous needle insertion is an extended role for nurses who carry out this procedure on a regular basis. Our staff do not carry out this role on a regular basis. The use of intravenous or Intraosseous medication is not covered in ILS training therefore this skill is not indicated.’

THE FAMILY’S RESPONSE TO THE DRAFT REPORT

The man’s wife received and read the draft report, but did not wish to make any comments about the Ombudsman’s findings.