Investigation into the circumstances surrounding the death of a man at HMP Lindholme in April 2007

Report by the Prisons and Probation Ombudsman for England and Wales

January 2009

This is the report of an investigation into the circumstances of the unexpected death of a man on 29 April 2007, whilst serving a sentence at HMP Lindholme. A post mortem found that the cause of his death was heart disease. The man was 38 years old. My colleagues and I would like to extend our condolences to the man's family and all those touched by his death.

The investigation was led by one of my investigators. I would like to thank the management and staff at HMP Lindholme for their assistance and co-operation during the course of the investigation. An independent review of the man's medical care in prison was commissioned from Doncaster Primary Care Trust. The report, which was received in February 2008, was subject to a further, comprehensive review by the Assistant Director of Clinical Effectiveness. I am grateful for their assistance.

On reception to prison in April 2006, the man appeared to be in good health. As his sentence progressed, he had thoughts of self-harm (and was subject to monitoring procedures), but there is no evidence that this contributed to his death. Two days before his death, the man reported sick. He was treated for a minor ailment but later complained of a pain in his left shoulder and pins and needles in his arm. Early on the morning of his death he again mentioned the pain and was offered the opportunity to go to the prison healthcare unit immediately. The man elected to wait until later. Unfortunately, before he was able to do so, he was found collapsed in his cell by staff who, with the help of other prisoners, made prolonged and strenuous but ultimately unsuccessful, attempts to resuscitate him.

I am satisfied that the man's death could not have been foreseen. I make three recommendations, two concerning recordkeeping and one about the availability of radios to staff working in accommodation wings. I apologise for the delay in publishing this report which was, in part, due to the delay in receiving the clinical review.

Jane Webb
Deputy Prisons and Probation Ombudsman **January 2009**

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SUMMARY

The man died on the morning of 29 April 2007, in his cell at HMP Lindholme. He had been serving a sentence of two and a half years and had transferred to Lindholme in February 2007, having spent time in other prisons. The man died from a blockage in a coronary artery. He was 38 years old.

The man was a smoker who had used both drugs and alcohol. His health assessment, on first entering prison, indicated that he had no mental health or heart problems. However, in prison he was emotional and said that he felt like self-harming. The man also felt under threat from other prisoners, having cooperated with police after witnessing a murder in Jamaica some years before. Between 1 June 2006 and 10 January 2007, the man was subject to periods of monitoring under the Assessment, Care in Custody and Teamwork (ACCT) procedures. This process identifies and cares for prisoners at risk of self-harm. He also had consultations with the psychiatrist and was prescribed medication for anxiety and mental health problems.

During the morning of Friday 27 April, the man reported sick and was treated for a mouth ulcer. Later that evening, he told one of his friends, a fellow prisoner, that he had a pain in his left shoulder and pins and needles in his arm. The man said that he had reported sick. He had been told that it was muscle strain, given paracetamol and advised to stay in his cell. The following morning, he mentioned to the same prisoner and an officer that he still had the pain in his shoulder. The officer offered the opportunity to go to the healthcare unit (HCU) immediately, but the man elected to wait until the sick parade at around 10.30am.

At around10.20am, an officer went to the man's cell to tell him that the sick parade had been called and saw him laying across the bed facing the door. He realised that something was wrong and tried to find a pulse. Having failed to do so, the officer started cardio pulmonary resuscitation (CPR) chest compressions, with the assistance of a prisoner, and called for urgent medical assistance. In spite of considerable attempts at resuscitation by discipline and nursing staff, as well as paramedics, the man was pronounced dead at 11.09am.

The Head of Residence and Healthcare implemented the Lindholme death in custody contingency plan. The police were informed and initially treated the man's death as suspicious. Because of their suspicions, the police wanted to break the news to the family, but they were not able to make contact until the next morning. Support was provided for prisoners and staff and all open ACCT documents were reviewed. A hot debrief for the staff involved was conducted. The acting deputy governor wrote a letter of condolence to the man's partner in which assistance was offered for travel expenses, but no offer of assistance with funeral expenses was made. The Coroner raised the issue of funeral expenses which was passed on to the Governor. A memorial service for the man was held at Lindholme later the same day which was well attended by staff and prisoners.

I have made three recommendations two relating to recordkeeping and the third relating to the adequate provision of radios. I am pleased to record that the recommendations relating to record keeping have been accepted and an action plan put into place. The third recommendation which was included in response to representations made by solicitors acting for the man's partner was added after the original draft was issued and the Prison

Service has yet to respond.

INVESTIGATION PROCESS

1. My investigator visited HMP Lindholme on 14 May 2007. He met the nominated liaison governor who gave him a full briefing about the circumstances surrounding the man's death. The Governor was subsequently briefed by my investigator on later visits. Offers to meet representatives of the Prison Officers' Association and the Independent Monitoring Board were accepted.

2. Notices to staff and prisoners were published inviting anyone who might have information relating to the man to make themselves known to the investigator. Three prisoners spoke to the investigator. The investigator met with relevant prison staff, including members of the chaplaincy and medical departments. Initially, the police treated this death as one that was suspicious and were investigating it as such. They re-assessed the evidence following a post mortem examination later on the day of the man's death and decided that it was no longer considered suspicious.

3. Copies of the man's prison and medical records were provided. The Head of Commissioning, at the Doncaster Primary Care Trust commissioned a clinical review which was carried out by the Assistant Director of Strategic Support, and the Head of Clinical Governance. This was subject to a further review by the Assistant Director of Clinical Effectiveness, which was received on 22 February 2008.

4. One of my family liaison officers offered to visit the man's partner and mother. The family chose not have a home visit.

HMP LINDHOLME

5. HMP Lindholme is a purpose built prison outside Doncaster, South Yorkshire, which was opened in 1985. It is a split site, part category C Training Prison and part Immigration Removal Centre. The category C site holds convicted adult male prisoners. Category C prisons are for those who cannot be trusted in open conditions but who would not have the ability or resources to make a determined escape. Lindholme has an operational capacity of 839.

6. Since April 2004, healthcare at Lindholme has been provided by the Doncaster Primary Care Trust. There are no inpatient beds and medical services are provided by a doctor from a local practice who visits daily and sees prisoners who have applied for an appointment. The clinical staff provide a day time service, and are all appropriately qualified. Sickness and treatments are managed by nursing staff.

KEY EVENTS

7. The man was first received into prison at HMP Pentonville on 27 April 2006 when he was remanded into custody by Newham Magistrates' Court. On 18 July, he was convicted at Snaresbrook Crown Court. He was subsequently sentenced on 15 August 2006 to a total of two years and six months' imprisonment and recommended for deportation at the end of his sentence.

8. At his initial reception interview in Pentonville, the man named his partner as his next of kin. He said they lived together with their small children in London.

9. The man's First Reception Health Screen document indicates that he had asthma but was taking no medication. It also shows that he used both heroin and crack cocaine and was an occasional user of alcohol. He said that he had no suicidal thoughts or intent. The man was prescribed no medication but was referred to a doctor for detoxification. The clinical record shows that on the following day, 28 April, the man refused to see the doctor and that he appeared well, stating that he had no withdrawal symptoms.

10. After a conversation on 1 June between the man and a staff member during which he said that he felt like self-harming, an Assessment, Care in Custody and Teamwork (ACCT) document was opened, it remained open until 5.25pm on16 June. (The ACCT process is used to provide additional support and monitoring for prisoners at risk of self-harm.) On 10 June, during his Secondary Health Assessment, it was recorded that the man had chronic back pains and that he was "depressed, tearful and at times feels suicidal". An additional note indicated, "Patient very low in mood", however, this assessment of the man's mood was not reflected in the ACCT ongoing record. He was referred to a mental health doctor. The ACCT document shows that the man progressively improved during the period that this additional support was provided. It was noted on 16 June that he had no further thoughts of self-harm due to improved contact with his family. A post closure interview was planned for 26 June, but there is no evidence that this took place.

11. The man's clinical record notes that on 26 June he complained of pain in his left shoulder and that on examination there was a "full range of movement of left shoulder. Old injury at left acromial clavicular joint. Well healed."

Transfer to HMP Belmarsh

12. On 15 August, the man was sentenced and sent to Belmarsh, where he told staff that he used both drugs and alcohol. The Cell Sharing Risk Assessment indicates that, from documents available, staff thought the man had not previously been subject to self-harm monitoring procedures. He said he did not feel suicidal and was assessed as a low risk. Staff deemed him suitable to share a cell.

13. An undated and unsigned Secondary Healthcare Assessment was completed in which the man was recorded as having "osteoporosis bad back shoulder". He also said he was depressed. During the assessment, it was also noted

that he had asthma but was not using a pump and that he did not have diabetes, heart disease, cerebrovascular accident (CVA), high blood pressure or epilepsy and accordingly was not referred for assessment in any of these areas.

14. During his induction interview on 16 August, the man was noted as being tearful. As a result, he spoke to a chaplain and a Listener (a prisoner trained by the Samaritans to provide confidential emotional support to other prisoners in distress). Afterwards, he said he felt better and was no longer feeling suicidal or at risk of self-harm. Once the induction interview was concluded, an ACCT document was opened as a precaution. During the ACCT assessment interview the man was again tearful and low in mood. He told the interviewer that he missed his family but was not suicidal. He also said that he had previously suffered from depression. A referral was made to the Community Psychiatric Nurse (CPN) because the man "Has issues in his head and would like to speak about it."

15. The following day, it was noted in the man's ACCT document that he had been threatened by other unnamed prisoners and that sometimes he heard voices telling him to kill himself. On 22 August, he saw the Community Mental Health Team who recorded that he was distressed during the interview. He denied any previous mental health problems but refused to grant consent to contact his doctor. In the note of the meeting, it is recorded that the man had been suffering from flashbacks, having witnessed a murder in Jamaica and as he had co-operated with police, he feared reprisals from those who had carried out the murder. The outcome of the meeting was that he should remain subject to the ACCT procedure, receive further exploration of his mental health status and attend the CASS Unit (occupational health) to help relieve his anxiety and provide support. A note made on 23 August in his record of events similarly records that he was experiencing flashbacks as a result of the murder and the perceived risk of reprisals.

16. During an ACCT review on 25 August, the man repeated what he had previously said about the murder and said he had come to the UK because the people involved were out to get him. He was able to name the people only by their street names. The man's third ACCT case review took place on 29 August, when he was reported to be very tearful and focussing on suicide. His level of risk was identified as raised.

17. During the morning of 1 September, the man was seen by an occupational therapist in the CASS Unit who felt that he required further assessment by a psychiatrist. The psychiatrist interviewed him that day and concluded that he should be admitted to the healthcare centre for assessment. He was admitted immediately to Ward 1 and was described as anxious and agitated. A care plan was formulated with the aims of minimising the risk of self-harm, elevation of his mood and to reduce his agitation and anxiety. The care plan shows that nursing reviews took place on 8 and 15 September.

18. The fear of reprisals from other prisoners figured large in the man's mind and on 2 September he told medical staff about the murder and that some of the

people involved were in Belmarsh. Again, he could only give their aliases. In spite of this, he settled well and had contact with his family by telephone and in social visits. An ACCT case review took place on 6 September when he was reportedly settled in mood but claimed to have occasional thoughts of self-harm. A note of a further interview with the psychiatrist on 7 September records that he was to stay in the healthcare centre where his mood was consistently reported to be good with no indications of intent to self-harm. During this period he attended the CASS Unit, for art and other sessions, and the gymnasium where he interacted well with other prisoners.

19. The man's fourth ACCT case review took place on 12 September when it was reported that he continued to experience some thoughts of self-harm, but his risk level was, nevertheless, seen as low. He also said that he wished to return to Pentonville because it was closer for his family to visit.

20. The man saw the psychiatrist again on 14 September, who recorded that he was settled in healthcare and was not low in mood. The psychiatrist also noted that he was considering discharging him from Healthcare to facilitate a transfer to another prison. The man's clinical record shows that he wanted to return to Pentonville to be near his family but was still concerned about his personal safety if he transferred back to the accommodation blocks at Belmarsh. On 19 September, he was transferred to Houseblock 1. His review prior to discharge concluded that he remained settled and had no existing thoughts of self-harm. He appeared to settle well on the Houseblock but again expressed a wish for a transfer to Pentonville.

21. The man attended an ACCT case review meeting on 21 September. During the meeting, he became upset and said that he was suicidal. He was, nevertheless, recorded as at low risk of self-harm.

22. On 24 September, the man's personal officer introduced himself and briefly discussed his depression. Just after midday, the man reported that he was feeling depressed and at 7.40pm he asked to speak to a Listener. He had a psychiatrist's appointment scheduled for 25 September but did not attend and was offered another appointment on 16 October. He was reported to be low in mood on 27 September. His sixth ACCT case review took place on the following day when he said that little had changed and he was reported to be uncommunicative. His risk level was again recorded as low.

23. The man was reported to be in a low mood on both 30 September and 1 October. On 4 October, he requested and used the dedicated Samaritans telephone (a phone with a direct line to the Samaritans which can be used by prisoners in distress). The following morning, in response to a question from a staff member, he said that he was "good and had no thoughts of self-harm". He asked the same staff member later that day about a transfer out of Belmarsh and was reportedly in good spirits. However, by early evening, staff again reported that his mood had declined. He was said to be in better spirits on the morning of 6 October. However, by 2.00pm during an ACCT case review, he had become emotional because he was missing his family and wanted to return to Pentonville. He also said he had been threatened by other

prisoners on Houseblock 2. His recorded self-harm risk level remained low. On 7 October, his personal officer reported that he was much more cheerful than he had been in the previous few weeks and that he had suggested to him on several occasions that he should see the doctor if his depression continued. He agreed to this.

24. On the morning of 10 October, a member of the education staff submitted a security information report regarding the man's depression and possible bullying. The report said he had been very depressed and crying. Also, that he was concerned about being in a cell with two other prisoners. He had said, "It can be dangerous for three in a cell – two can turn on one". During the afternoon, a further security information report was submitted from the CASS Unit. The man had reported that he had been threatened by another prisoner in a corridor on the way back from a social visit the previous day and that it was related to the murder he had witnessed many years before. Records show that he spoke to two members of staff, an hour apart, during evening association, telling them that other prisoners in Belmarsh were trying to kill him.

25. On the morning of 13 October, members of the security staff discussed with the man how he felt about being under threat. They recorded that the man was happy, his situation was improving and he wanted to remain where he was. He agreed that if the situation altered he would speak to staff immediately and signed the entry. Immediately after this meeting, his eighth ACCT case review was conducted. It was recorded that the man was feeling depressed and not sleeping well. He remained at low risk of self-harm.

26. The man had an assessment with the psychiatrist on 16 October. He said that he was finding it a little difficult on Houseblock 1 and that some bullying had taken place that he had discussed with staff. The psychiatrist observed that he was dishevelled and showed other signs of self neglect. He requested sleeping tablets and the psychiatrist noted that antidepressant drugs might be appropriate depending on the man's clinical presentation. On 17 October, a Mental Health Team referrals meeting advised that he should continue with Occupational Therapy and attend the CASS Unit. The following day, the man transferred to Houseblock 2. During the evening, he asked to see a Listener on the following day and said that he would be alright for that night. At lunchtime on 19 October, he complained to wing staff that he was no longer feeling alright because he had not spoken to his children for a long time and would like to make a telephone call to them. The man's ninth ACCT case review on 20 October confirmed that his self-harm risk level remained low.

27. The man's tenth ACCT case review took place on 27 October. He said that he did not feel too bad because he had spoken to his partner but had not seen his children because it was too far for them to travel and this upset him. He said at the review that he had heard voices telling him to kill himself or his cellmates. His risk of self-harm was recorded as raised. On 3 and 14 November, The man's ACCT case reviews confirmed that his self-harm risk level had returned to low, although he was still emotional about his lack of contact with his family. Staff put in place procedures to ensure that he was

able to telephone his family outside of normal wing regime times. His ACCT case review on 20 November records that he was much more stable, communicative and confident. His risk level remained low.

28. On the same day, the man saw the psychiatrist who noted that he was feeling better as he had received a letter accepting him for transfer to HMP Coldingley. He also noted that the man had been tearful and said that he had been threatened again by other prisoners. His fourteenth ACCT case review on 24 November records that he had been seen by the psychiatrist and had been placed on antidepressant drugs. He had said that he did not feel too bad but wanted more contact with his family, if possible via the telephone. His risk level remained low.

29. On 29 November, a post traumatic stress (PTS) counsellor noted in the man's clinical record that he had been very distressed about events in his life and arrangements had been made for him to have six weekly counselling sessions, after which a review of his needs would be made. The same day, the duty senior officer (SO) noted that the man had misled him regarding recent contact with his family and that communication played a large part in the man's ACCT care map. The duty senior officer also suggested that a log be kept of the man's family contacts to ensure that he did not manipulate staff. Later in the evening, an officer noted that the man had expressed a desire to come off the ACCT process.

30. An entry in the ACCT case review the next day, records that the man was still a low risk. It was noted that he was still taking medication, occasionally had concerns about self-harm and had spoken about wanting a transfer. The man saw the PTS counsellor on 6 and 7 December. He was recorded as being much more positive and expected to transfer shortly to Coldingley shortly, having been allocated a place. He was looking forward to attending several courses, including an industrial cleaning course. His main problem was noted as the difficulty in accessing a telephone to speak to his family as he never managed to get to the front of the queue during the association periods. Access to a telephone call was given to him after the review.

31. The man attended a third PTS counselling session on 13 December in which he was reported to be tearful and fearful for his life. His next two ACCT reviews on 14 and 21 December were at variance with this, indicating that he had no problems and that his risk of self-harm remained low. On 20 December, the man underwent a psychiatric review which recommended that he remain in shared accommodation in view of his self-harm risk, that he should continue with his medication, attend CASS and counselling and that the transfer to Coldingley be expedited.

32. The man's ACCT review on 28 December noted that although his risk remained low he had raised the matter of other prisoners at Belmarsh being "after him" and that he feared for his safety. He also voiced his concern that he had not yet moved to Coldingley. At his next review on 4 January 2007, the risk remained low and the reviewer explained to the man that a move to Coldingley had been delayed as he remained subject to the ACCT process.

The reviewer noted that he intended to close the ACCT on 10 January if no further concerns were raised. It was duly closed on that date and a post closure interview was scheduled for 12 January. During the post closure interview, the man was described as being much more settled and relaxed and he felt confident that he would be alright. On 24 January, the man attended a fourth PTS counselling session and was recorded in the continuous clinical record as being more settled but still fearful for his life.

33. On 26 January, the man transferred from Belmarsh to HMP Bedford. On reception, an anti depressant, mirtazapine, was prescribed 15mg nightly for 14 days and E45 cream for a skin condition. The mirtazapine prescription was repeated on 8 February, again for 14 days. The man transferred to HMP Doncaster on 16 February. During his initial health assessment, he reported that he had tried to self-harm in the past but no details were recorded. He was recorded as having no current thoughts of self-harm. He also said that he was on an elevated level (30mg) of mirtazapine to that recorded at Bedford. He was referred to the doctor for an assessment of his physical health.

HMP Lindholme

34. Just under a month later, on 23 February, the man transferred to HMP Lindholme. On arrival, medical staff conducted an assessment in which he asked to see a doctor about his medication and raised an issue about his skin condition. He also told them that he had been a crack and cocaine user until six months before and was a smoker who refused help with cessation of smoking.

35. On 27 February, a note in the clinical record indicates that the man was prescribed mirtazapine 15mg nightly for 28 days. A further note dated 5 March says “Rx – signed prescription card for Mirtazapine” but the Prescription and Administration Chart does not support these entries. Neither entry is endorsed by a clear signature.

36. A Registered Mental Nurse (RMN) saw the man in the healthcare centre on 8 March. The nurse recorded that he was quite emotional and that he missed his children and family. He also expressed concerns about his personal safety after his release. The man denied any current thoughts of self-harm but said that he suffered flashbacks related to witnessing a murder. He requested that the mirtazapine dosage be doubled to 30mg.

37. On 12 March, an entry in the Prescription and Administration Record Chart appears to indicate that the man was given 16 paracetamol tablets in possession for a headache. On 20 March, a note in the medical record indicates that the doctor had reviewed his medication.

38. A staff nurse noted in the clinical record records that the man failed to attend a doctor’s clinic on 3 April. Between 4 and 23 April, the mirtazapine 15mg prescription for depression was repeated for a further 28 days and other medications were prescribed.

39. On Friday 27 April, at around 11.30am, the man reported sick. He was seen by the staff nurse who recorded on the form for prisoners attending healthcare for sick/treatments that he had administered treatment to the man but not that he attended as a result of being sick. The Prescription and Administration Record Chart indicates that the staff nurse gave the man Bonjela for a mouth ulcer. No other treatment is recorded and the staff nurse does not recall whether he had discussed any other matter with the man. The second member of staff, a Registered General Nurse and healthcare officer on duty at that time, did not see the man at all during that day.

40. A prisoner who was a friend of the man and lived in a neighbouring cell on E wing said that on the evening of Friday 27 April he had spoken to the man who had complained of a pain in his left shoulder and pins and needles in his arm. The prisoner told him to report sick and the man said that he had done so. He had been given paracetamol and told that it was a muscle strain and to stay in his cell. The man then shut himself into his cell which the prisoner said was not out of the ordinary because he was studying for his parenting exam. The prisoner said he next saw the man briefly in the toilet area of spur 2 on the evening of Saturday 28 April between 4.30 to 5.00pm and had not seen him during the course of the day.

41. Another fellow prisoner and friend of the man, was also located in E wing. On the evening of 28 April, the prisoner helped the man with his parenting coursework. At interview, he said that he did not remember the man complaining of any illness or pain and that he last saw him at around 3.00am on the morning of 29 April when he went to bed.

42. On Sunday mornings at Lindholme prisoners are allowed to lie in. An officer came on duty at 7.15am on 29 April. He checked the E wing roll as soon as he arrived and confirmed it was correct at 7.30am. He remembers seeing the man during the roll check and described him as laying on the bed to the right of the door with his head to the rear of the cell. He was on his side facing into the room, asleep.

43. The prisoner who was friends with the man, and who he had previously complained to, got up at around 8.00am on 29 April and met the man in the corridor. He was holding his shoulder again and said that it hurt. The prisoner told the man to tell the duty officers and went to the servery to serve breakfast.

44. At 8.15am, the main shift staff arrived. On Sundays there is one additional member of staff. A second officer arrived on E wing and the first officer collected the breakfast meal, returning to the wing ten minutes later. The spurs were then unlocked for prisoners to collect their breakfast.

45. Another resident of spur 2 was serving breakfast with the second officer on the morning of 29 April. The man had told him earlier that he had a pain in his shoulder. He recalled that the second officer had said that it was probably the way the man had slept and offered to put him on the list for sick if he couldn't wait until the sick parade. The man agreed to wait. The resident of spur 2

and the second officer then went to the food servery. The man did not get up for breakfast which was served until 8.45am.

46. By 8.50am, the two officers were supervising the running of the wing. At around 10.20am, a radio message was broadcast ordering gate 22 to be staffed. This gate is the muster point for prisoners wishing to report sick and for routine medical treatments.

47. In his initial note of events dated 29 April, the first officer said that he went to the man's cell, E202, at 10.18am to tell him that the sick parade had been called. The officer used his pass key to enter the cell, looking through the door hatch at the same time. He saw the man lying across the bed on his left side with his feet touching the floor. His face was looking directly at the door and his eyes were open. Realising that something was wrong, the officer went directly to the man and tried to find a pulse in the exposed left side of his neck, whilst at the same time looking around the cell for a ligature. The man was warm to the touch but the officer could not find a pulse. The man's arm was trapped by the bed and would not come free. After several seconds the officer moved him onto the bed from the position he had found him in. He laid the man on his back and his legs remained over the side of the bed. The officer then started cardio pulmonary resuscitation (CPR) chest compressions and realised that he needed help to carry on. The officer did not have a radio. There is only one radio on each wing and it is held in the wing office. He went out of the cell and shouted to three prisoners to go and tell the second officer that he needed urgent medical assistance on spur 2. One of the three prisoners ran to the wing office where he relayed the message to the second officer.

48. The first officer returned to the cell to continue CPR with the prisoner who was the man's friend following closely behind. At interview, the first officer said that he needed to get the man lying flat on the bed and the prisoner assisted him to do so. The prisoner noticed the man's hands were cold but that there was no stiffness in his body. The first officer said that he had real difficulty clearing the man's airway. There was a lot of mucous in his mouth and he could not move his tongue out of the way. The first officer resumed CPR and was doing chest compressions to try to get some air into the man's lungs. The prisoner realised that the first officer was having difficulty. When the officer stopped chest compressions to give a breath, the prisoner stepped in and took over the chest compressions for about five minutes. During this time, the first officer believed he found a pulse but this subsequently disappeared. They continued with CPR. Initially the breathing lifted the man's chest wall but after a while the airway became blocked again. The first officer cleared the man's mouth of mucous again and restarted the breaths.

49. At about 10.30am, as soon as the other resident had told him that medical help was required, the second officer telephoned the healthcare unit to call for assistance. He locked the office door and ran to spur 2 where he saw the first officer and the prisoner performing CPR on the man. He then left the cell and broadcast a "code blue" radio message to the communications room. (A code blue is the Lindholme coded message for a patient who is having respiratory

problems or has a compromised airway and an emergency response is required.) Nursing staff at the HCU received the telephone message and at 10.33am had also received the "code blue" radio message. A staff nurse took the emergency response bag from the healthcare centre. The bag contains an oxygen cylinder, airway, blood pressure machine, blood monitoring machine, suction machine and basic medication. Accompanied by a second staff nurse, she took it down the stairs, out through Gate 22 and towards E wing.

50. As the two nurses approached A wing they were met by two prisoners. They were distressed and shouting that "he isn't breathing" and that "an officer is working on him". The first staff nurse then asked one of the prisoners to help carry the emergency bag. The two prisoners took the bag and the nurses followed them to E wing. As they crossed the yard, by their account alternately walking and jogging, some prisoners shouted at them to run faster which the staff nurse found intimidating. They arrived at E wing at about 10.35am. On arrival, the nurses shouted that the defibrillator, located in the Care and Separation Unit (CASU), should be brought over and an ambulance called. The staff nurse said at interview that she believed that there were three defibrillators at Lindholme, at that time located in CASU, J and K wings.

51. The second officer had returned to the cell where prisoners were beginning to congregate to watch what was going on. He moved the prisoners away from the cell to allow the prisoner and the first officer to carry on CPR uninterrupted and to allow the medical staff to have unimpeded access when they arrived.

52. The two nurses followed the two prisoners to cell E202. When they arrived, the second staff nurse saw the first officer performing cardio pulmonary resuscitation (CPR) on a prisoner who was laying on the bed. She said that the bed was firm and suitable to be used for CPR.

53. The two staff nurses established that the man was not breathing and had no detectable pulse. The second staff nurse believes that the first staff nurse said that the man's airway was compromised and that they needed to get an airway into his throat. The first staff nurse put an airway into the man's throat to establish an open airway and whilst doing so, noticed that his tongue and lips were slightly swollen and had a bluish tinge to them. She connected the oxygen to a face mask and put it over the man's face. She then repositioned his head backwards to maintain the airway and used both hands to ensure a good seal around the mask. Whilst the first staff nurse was working at the man's head end, the second staff nurse had started chest compressions at a rate of 30 compressions to two breaths. The first officer continued with this rhythm.

54. Soon afterwards, the orderly officer arrived at cell E202 bringing with him the defibrillator from CASU. The three people working on the man had completed about three cycles of CPR when the defibrillator arrived. The second staff nurse shaved a small area of the man's chest to allow the defibrillator pads to be in secure contact. The first staff nurse stopped compressions for a short while to allow the attachment of the defibrillator pads and to allow the

defibrillator to go through its automated functions. The defibrillator found no shockable rhythm in the man's heart and gave instructions to continue CPR.

55. At about 10.40am, having heard the "code blue" radio message, the head of residence and healthcare, went to E wing. At the same time, he heard an ambulance arriving at the main gate. The Communication log records that at 10.42am staff were moving prisoners from outside D, E and F wings to allow ambulance vehicles access to the front of E wing via gates 6, 8 and 24. A paramedic car arrived at the main gate at 10.43am and, at 10.51am, an ambulance was en route to E wing.

56. A third staff nurse had now joined the other nurses and the first officer in the room. She describes the first officer as being at the head of the bed with his back to the window and looking exhausted. The nursing staff swapped positions so that the second staff nurse compressed the bag, the third staff nurse the seal on the man's face and the first staff nurse the compressions. The defibrillator went through its routine several times, interspersed by CPR, until the first response paramedic arrived at about 10.47am.

57. On arrival, the paramedic asked for the man to be moved off the bed and onto the floor. The prison defibrillator was disconnected and he was placed on the floor by the first officer and the paramedic. The paramedic then replaced the prison defibrillator and airway with ambulance service equipment, using a portable suction device to help him do so. Shortly afterwards, two more emergency ambulance crew members arrived to assist the first paramedic with the CPR and administration of intravenous drugs. The prison staff then handed the resuscitation attempts over to the paramedics and waited outside the cell.

58. The second staff nurse went back to the HCC to collect the man's medical record (IMR) to check it for any medical conditions or relevant treatment of which the paramedics would need to be aware. She noticed that his reception screening indicated that he had attempted suicide some months before. When she got back to the cell she told the paramedic about the suicide attempt and the paramedic asked if anyone had seen a ligature. A small piece of material from a tee shirt with the hem cut to form an apron shape was recovered from around the man's upper left leg. The first officer described the material as being about six inches square with six inch tapes on either side. The paramedic removed it and put it to one side on the floor.

59. The first officer remembers one of the paramedics saying that there was blood in the mucous in the man's mouth. The third staff nurse noticed that the paramedic had difficulty inserting the replacement airway into the man's throat and that a lot of bloody mucous was being removed by the suction device. She had also noticed that the man's tongue was swollen.

60. When the Orderly Officer arrived on E wing, the head of residence and healthcare briefed him and left him in charge of the wing and prison regime. The head of residence and healthcare went to open the Command Suite at around 10.55am. As he did so, the emergency ambulance arrived outside E

wing. On opening the Command Suite he took possession of the man's prison record.

61. Once it was attached to the man, the paramedics' defibrillator went through several automatic cycles but was ultimately unsuccessful. At 11.09am, paramedics pronounced the man dead and stopped the resuscitation attempts.

62. At 11.09am, on receipt of a telephone call informing him that the man had died, the head of residence and healthcare implemented the Lindholme death in custody contingency plan and noted the action times. He informed the police at 11.14am and issued an instruction to the orderly officer to relocate all the other prisoners on E2 spur to other spurs on the wing.

63. Soon after the man died, the orderly officer became aware that a possible ligature had been found in the cell by staff engaged in trying to resuscitate him. At about the same time, a police constable arrived at the cell. After briefing, the police constable went into the cell for a few minutes. He was unhappy about the scene in the cell and wanted to discuss the matter with his senior officer, which he did by telephone from the Command Suite.

64. The orderly officer ordered that the spur be cleared of people, the metal grille door to be chained shut and the solid outer door locked. An officer did so and remained outside the outer door to ensure that there was no unauthorised access to the spur.

65. At around 11.30am, the head of residence and healthcare spoke with the Area Manager to discuss informing the man's next of kin. He was unable to send Lindholme staff to break the news because of the distance to his partner's home in London. It was initially proposed that staff from a prison local to her home should undertake the duty, but because of the possible suspicious nature of the death, police indicated that they wished to break the news. They attempted to do so that afternoon but there was no one at home. They eventually contacted her on the morning of 30 April.

66. A Detective Sergeant (DS) arrived at Lindholme at around 11.45am and went to E202. He then went to the Command Suite and told the head of residence and healthcare that because there appeared to be blood in the man's throat he was treating it as a suspicious death. He also called out his senior officer a Detective Inspector and Scenes of Crime Officers (SOCO). E2 spur was sealed.

67. Two members of the Lindholme Independent Monitoring Board (IMB) arrived at about 12.25pm and went immediately to E wing. On arrival at E wing, they went upstairs to an office to see the deputy head of offender management. The deputy head was trying to calm down the prisoner who had helped in the initial attempt to resuscitate the man.

68. The head of residence and healthcare restricted the prison regime throughout the afternoon and evening of 29 April. Prisoners on wings G, K and J were all

confined to their wings and the exercise yard. Wings A – F were restricted to their wings and all movement of prisoners on and off E wing was stopped.

69. Five prisoners from E wing had scheduled social visits for that afternoon. The visits were allowed to go ahead after the prisoners involved had changed their clothing to preserve any evidence. Because of the disruption to their visits, the prisoners' visiting orders were reissued for use on another day.

70. The chapel is in the same compound as E wing and for that reason the normal Sunday afternoon service was cancelled. Two of the chaplains provided pastoral care to prisoners especially those on E wing. Support for prisoners was also provided by the IMB and Listeners. A member of the care team was released from his duties to provide support for staff for the rest of that day.

71. At around 1.00pm, the head of residence and healthcare asked for a review of all open Assessment, Care in Custody and Teamwork (ACCT) documents. However, the Death in Custody Contingency plan checklist indicates that the orderly officer was supposed to have undertaken this task at 10.55am. At 1.45pm, the detective inspector and the SOCO arrived at E wing and began their investigation of the scene which they indicated would take up most of the afternoon.

72. Funeral directors took the man's body to Sheffield Medico-Legal Centre at 4.30pm for a post mortem examination later in the evening. A hot debrief for the staff involved was conducted at around 5.45pm.

73. The detective inspector rang the head of residence and healthcare at home at around midnight to tell him that the police no longer regarded the death as suspicious. The head of residence and healthcare informed the prison of this development and instructed that the clothing removed from prisoners should be returned the next morning.

74. One of the members of the chaplaincy team spoke to the man's partner on Monday 30 April when she telephoned. They were in contact on four further occasions between his death and 10 May. The chaplaincy member said that she was very emotional during the calls and they spoke about a memorial to the man which was something she found comfort in. They also spoke about the possibility of her visiting Lindholme. Initially, she didn't want to visit but during a call on 10 May she said that she would wait until the man's mother arrived from Jamaica, then she would call again. The acting deputy governor wrote a letter of condolence to the man's partner on 30 April in which assistance was offered for travel expenses, but no offer of assistance with funeral expenses was made.

75. On Thursday 3 May, a principal officer from Lindholme attended the local Coroner's Court where an inquest, attended by the man's father, was opened and adjourned. The Coroner raised the issue of funeral expenses and the matter was referred to the Governor. A memorial service for the man was held at Lindholme later the same day, which was well attended by staff and prisoners.

Post mortem examination

76. On the instructions of the Coroner, a forensic pathologist carried out a post mortem examination at Sheffield Medico–Legal Centre between 6.45pm and 8.10pm on 29 April 2007. Samples were taken for further examination.

77. The pathologist's conclusion, outlined in his witness statement dated 9 July, was that the man had evidence of heart disease and died as a result of a blockage of the left coronary artery. Following further toxicological examination, no significant drugs were found from the samples taken, although paracetamol in an amount consistent with therapeutic use was evident.

ISSUES CONSIDERED DURING THE INVESTIGATION

Medical care

78. A clinical review of the care provided for the man by the prison's healthcare team was commissioned from the Head of Commissioning at Doncaster PCT.

A further review was conducted by the Assistant Director of Clinical Effectiveness. I received the comprehensive report on 22 February 2008.

79. The man had no reported history of heart disease. However, the pathologist mentioned evidence of ischaemic heart disease to which his history of smoking and drug use would have been contributing factors. He concluded that the man had died as the result of a fatal thrombotic occlusion of the left coronary artery following symptoms of left shoulder pain in the preceding few hours. The pathologist confirmed this was in keeping with referred pain from myocardial ischaemia. The clinical reviewer judges that the man received comprehensive care for his mental health problems throughout his time at various establishments.

Attendance at treatment clinic on 27 April 2007

80. On the morning of Friday 27 April, the man attended a sick/treatment clinic. One of the two nurses on duty saw the man and recorded that he had administered treatment. However, he did not record that the man had attended for sick, as opposed to routine or ongoing treatment. The Prescription and Administration Record Chart shows in the sick section that medication was given for a mouth ulcer. No other treatment is recorded and the nurse said that he did not recall discussing any other matter with the man.

81. A fellow prisoner and friend of the man said that on the evening of 27 April he had spoken to the man who complained of a pain in his left shoulder and pins and needles in his arm. He advised the man to report sick and the man said that he had done so. The man also told him it had been diagnosed as muscle strain for which he had been given paracetamol and told to stay in his cell.

82. The last recorded issue of paracetamol to the man is outlined in an entry on a Prescription and Administration Record Chart dated 12 March and relates to a headache. (The clinical reviewers comment that the entry is unclear.) However the toxicological results, reported in the post mortem examination report, indicate that on 29 April concentrations of paracetamol were present in the man's body. He considered these were likely to represent therapeutic use but added that he could not fully exclude the possibility of a previous overdose.

83. I have found no evidence that the man obtained paracetamol outside of the legitimate channels. It is not known whether he had saved the drug from the supply given to him on 12 March and used it just before his death or whether he took an overdose of the drug. According to the staff nurse who saw him on 27 April, he was not given paracetamol. However, the prisoner who was the man's friend reported at interview that the man had told him that he had been given the drug by healthcare staff. The clinical reviewers note that "From the statements and evidence available it has not been possible to reach any conclusion about whether the man did discuss shoulder pain with Healthcare on 27 April 2007 or exactly when he first developed this symptom." They also note that "The medical records are variable and, in some cases, very difficult to read. The lack of any entry in the IMR to match attendances at sickness

clinics at HMP Lindholme has added to uncertainty about events." The lack of clarity in the healthcare record keeping leaves doubt surrounding the truth of this potentially significant event and in common with the clinical reviewers, I am unable to reach a conclusion on this aspect.

The Governor and PCT should ensure that the standard of record keeping meets Royal College of Nursing guidelines and is consistent with all current professional guidance. This should include keeping a record of all consultations, recording symptoms, investigations, treatment given or planned and any non attendance for treatment. The record should also include a chronology of all appointments and sick arrangements.

Staff training on record keeping should be mandatory. Regular audits of records should take place, with action plans to address deficiencies. The audits should be reviewed by the PCT.

Delivery of emergency care on 29 April

84. Between 10.18am and 10.20am on the morning of Sunday 29 April, The first officer went to the man's cell (E202) to tell him that the sick parade had been called. He found the man collapsed and realised that something was seriously wrong. He therefore went directly to him and tried to find a pulse in the left side of his neck but was unable to do so. He did note, however, that the man was warm to the touch. In order to start CPR, he had to move the man from the position in which he found him. By the first officer's account, this took several seconds. He also realised that he needed help so he went out of the cell, shouted to three prisoners to tell the second officer in the wing office that he needed urgent medical assistance and then returned to the cell. The prisoner referred to earlier in the report, assisted the first officer.

85. On receiving the message from another prisoner, the second officer telephoned the healthcare unit for that assistance and then ran to spur 2 taking the E wing radio with him. On arrival, he saw the first officer and the prisoner performing CPR. He then left the cell and broadcast a "code blue" radio message to the communications room.

86. Two staff nurses received the radio message from the communications room at 10.30am. There is a discrepancy in that the second officer's recollection is that he had telephoned HCU with that request. The first record of radio traffic regarding this incident is noted at 10.33am, a delay of about ten minutes from the man's discovery by the officer.

The Governor should consider whether the number of radios issued for the use of accommodation wing staff is adequate.

87. As the two staff nurses left HCU at 10.33am, they received another radio message that the incident was now designated a "code blue" emergency. The first staff nurse carried the emergency response bag from HCU. This contained an oxygen cylinder, airway, blood pressure machine, blood

monitoring machine, suction machine and basic medication. Accompanied by the second staff nurse, she took it downstairs and out towards E wing. They estimate that the journey took them about two minutes and this is supported by the communications room log. Two prisoners from E wing assisted them with the bag. The communications room log also records that the orderly officer, was also en route to E wing.

88. At 10.36am, as they entered E wing but before arriving at cell E202, the two nurses requested that an emergency ambulance be called and the defibrillator be collected from CASU. On arrival at E202, they took over the attempts to resuscitate the man. The communications log records that an ambulance had been called at 10.37am.

89. On his way to E wing, the orderly officer met an officer who gave him a shoulder bag containing the defibrillator. At around 10.40am, the third staff nurse received a telephone call requesting her help. She postponed the sick parade, left the main healthcare building and arrived on E wing some two minutes later.

90. On arrival at the cell, the orderly officer saw the three nurses and the officer administering CPR to the man. The defibrillator was then used to assist in the resuscitation attempts. When the defibrillator was connected there was no detectable sign of life from the man. CPR was continued manually and six or seven further defibrillator cycles were attempted.

91. The communications log records that at 10.43am a first response paramedic arrived by car. On arrival at the cell, the paramedic instructed that the man was to be moved from the bed to the floor. The paramedic then removed the airway that was in place, used a suction machine to remove any obstruction from the man's airway and inserted an ambulance service airway. The first staff nurse continued with the chest compressions.

92. At 10.51am, an emergency ambulance arrived with two crew members. The first response paramedic maintained the man's airway while the second paramedic began administering drugs intravenously through the man's right arm. The third paramedic took over the chest compressions. At 11.09am, the lead paramedic declared that the man had died.

93. It is apparent to me that every effort was made by prisoners, prison officers and prison medical staff in the attempt to sustain the man's life until the paramedics arrived. They, in turn, made every effort to resuscitate him but ultimately the attempts to do so were unsuccessful. I believe that the prison officers involved that morning acted in a timely manner in recognising the seriousness of the situation, summoning appropriate help and rendering what assistance they could personally.

94. However, there was a perception by prisoners that nursing staff had not attended E wing quickly enough, which led to some unfortunate exchanges between staff and prisoners. The issue was addressed with prisoner representatives later in the week by the chaplaincy and the IMB Chairman.

95. Nursing staff who responded initially attended the incident, several hundreds of yards away from the HCU, and within two minutes of receiving messages from the wing staff and communications room. It was fortunate that two prisoners met them to carry the heavy emergency bag for most of the distance. Had they not done so, the nursing staff would have taken longer to arrive. They might also have suffered from the effects of carrying the bag and their effectiveness in trying to resuscitate the man might well have been impaired.

96. As a consequence, there are plans for some of the heavier items, principally the oxygen bottle, to be located strategically throughout the prison. This will obviate the need for staff to carry heavy equipment for long distances.

97. Special mention should be made of the prisoner who was the man's friend's involvement. It was especially traumatic for him as it occurred on the first anniversary of his father's death in similar circumstances and, sadly, with the same outcome. His actions were commendable.

98. The first officer made strenuous attempts to resuscitate the man for an extended period until he was relieved by the nurses and paramedics. He should also be commended for his actions. I concur with the clinical reviewers' recommendation that everyone involved in the attempt to resuscitate the man should be commended.

Provision of defibrillators

99. Following a previous death in custody at Lindholme, an action plan dated December 2006 identified the need for extra defibrillators and oxygen bottles and by the end of January 2007 they had been provided. The healthcare manager, who took up post in January 2006, said that her department had difficulty sourcing suitable cabinets to be installed on the wings. By 29 March 2007, the cabinets had been delivered along with appropriate oxygen signage. The Works Department were contacted at the beginning of April 2007 to arrange installation of the cabinets, but for various reasons they were not installed until after my investigator visited Lindholme on 14 May. Following the man's death, the healthcare manager indicated that three further defibrillators were required for installation on B and E wings and in the Industrial complex. These were delivered on 15 June and cabinets were ordered.

100. On the day of the man's death, the single operational defibrillator in the main prison was located quickly, collected and brought into use within a very few minutes of the first calls regarding the emergency. The defibrillator found no shockable rhythm in his heart so CPR was advised and continued manually by the staff present. Further attempts to use the Prison Service and Ambulance Service defibrillators had the same outcome. The provision and use of defibrillators was therefore not a factor in the man's death.

101. It is unfortunate that following a previous fatal incident at Lindholme, the resultant recommendation and action plan to provide more defibrillators was delayed. It was evident to my investigator that managers and other staff were unaware that the defibrillators were not in place. The situation was addressed soon after the investigator visited and to Lindholme's credit, further steps have been taken since the man's death to provide more defibrillators and emergency equipment at strategic points in the prison.

Self-harm and personal safety

102. Following his reception into prison, the man sometimes felt as if he might harm himself. He missed his family greatly. He also had flashbacks relating to a murder he had witnessed in Jamaica some years previously and had expressed fears that his life was in danger because of the assistance he had given to the police. Those fears continued during his time in prison as he was apparently threatened by Jamaican gang members at HMP Belmarsh. Appropriate actions were taken by all of the prisons within which he was located to prevent reprisals. He had also spent extended periods subject to ACCT monitoring because of the risk of self-harm. The man was seen frequently by a psychiatrist in the early part of his sentence and was comprehensively supported by staff.

103. The man's fears and worries were, for the most part, resolved by the time he arrived at Lindholme although he still missed his family. There was no suggestion that self-harm played any part in his death and, what appeared to be a ligature was later found to be a piece of cloth used as a bandana. Although his death was initially considered by the police to be suspicious, their investigation revealed no evidence of any criminal act.

RECOMMENDATIONS

I make three recommendations:

1. The Governor and PCT should ensure that the standard of record keeping meets Royal College of Nursing guidelines and is consistent with all current professional guidance. This should include keeping a record of all consultations, recording symptoms, investigations, treatment given or planned and any non attendance for treatment. The record should also include a chronology of all appointments and sick arrangements.

The Prison Service accepted this recommendation and in an action plan received from them on 31 July 2008 responded that:

"All staff conform to the current guidelines on record/ record keeping and records are maintained when patients attend for any appointment treatment or for special sick .We also record when patients fail to attend.

Royal College of Nursing guidelines will be given to all staff and a record of this will be maintained as evidence."

This action was completed in September 2008

2. Staff training on record keeping should be mandatory. Regular audits of records should take place, with action plans to address deficiencies. The audits should be reviewed by the PCT.

The Prison Service accepted this recommendation and in an action plan received from them on 31 July 2008 responded that:

"Royal College of Nursing guidelines will be given to all staff and a record of this will be maintained as evidence

Medical records are currently audited by our GP provider. An Audit tool for record keeping is in place and is monitored on a monthly basis."

This action was completed in September 2008.

3. The Governor should consider whether the number of radios issued for the use of accommodation wing staff is adequate.

The Prison Service has yet to respond to this recommendation.