

**Investigation into the death of a man  
whilst in the custody of HMP Lindholme  
in July 2009**

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

**July 2010**

This is the report of an investigation into the circumstances of the death, through natural causes, of a 45 year old man in the gymnasium at HMP Lindholme.

I extend my sincere condolences to his family and all those affected by his loss. I apologise for the delay in the issue of this report.

The investigation was conducted by my investigator. A clinical review was carried out by Doncaster Primary Care Trust. I should like to thank the Governor of Lindholme, and his staff for their co-operation.

The man's death was both sudden and unexpected. The clinical reviewer found that it would not have been possible to anticipate or prevent the man's death.

The man's death was not the first that this office has investigated where the death occurred during or shortly after an exercise session. I am not aware of any other such deaths at Lindholme, however.

I make two recommendations. One is about record keeping and the other is about notification to families following a death in custody. There are two further recommendations made by the clinical reviewer.

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

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**July 2010**

## **CONTENTS**

|                           |    |
|---------------------------|----|
| Summary                   | 4  |
| The Investigation Process | 5  |
| HMP Lindholme             | 6  |
| Key Findings              | 7  |
| Issues                    | 11 |
| Conclusions               | 14 |
| Recommendations           | 15 |

## **SUMMARY**

The man arrived at HMP Lindholme on 26 January 2009, on transfer from HMP Leeds. He was a licence recall prisoner, having returned into custody on 3 November 2008.

During healthcare reception screening at Lindholme, the man was assessed as appearing fit and well. He was deemed fit for work and fit to use the gymnasium. The only health condition he reported was asthma, for which he was receiving medication.

The man settled down very well at Lindholme. He obtained a job working on the servery and all the entries in his records about his behaviour were positive ones. He used the prison gymnasium regularly, normally two or three times a week. The evidence of the physical education staff indicates that he understood what he was doing and that he exercised within his capabilities.

The man attended the gymnasium on the morning of 2 July 2009. He had finished exercising when he collapsed to the floor. At first, staff thought that he had fainted as it was a hot day. He vomited some clear fluid. Staff put him in the recovery position and telephoned healthcare.

When healthcare staff arrived a few minutes later and examined the man they were sufficiently concerned to call an ambulance. A nurse tried to give the man oxygen but he was agitated and pushed the oxygen mask away. His condition deteriorated and staff commenced cardio-pulmonary resuscitation (CPR).

When ambulance paramedics arrived around 15 minutes later they took over efforts at CPR and then took the man to hospital. Unfortunately, all the efforts to resuscitate him proved unsuccessful and he was pronounced dead at hospital at 10.36am. At post mortem, the man's cause of death was found to be pulmonary oedema as a consequence of sudden cardiac dysrhythmia (an explanation of this condition is contained on page 11 of this report).

## THE INVESTIGATION PROCESS

1. My investigator obtained the man's prison records from HMP Lindholme and identified a number of staff that he wished to interview.
2. A clinical reviewer from Doncaster Primary Care Trust carried out a review of the man's clinical care. My investigator visited Lindholme on 7 August 2009 and in company with the clinical reviewer interviewed four members of staff. I am grateful to the clinical reviewer for undertaking this review and for agreeing to carry out joint interviews with my investigator.
3. Notices were posted to inform staff and prisoners about the investigation but no additional staff or prisoners came forward to ask to be interviewed.
4. One of my family liaison officers contacted the man's family to inform them of the investigation and to ask whether they had any specific issues that they wished to be considered during the investigation. The man's sister, on behalf of herself, her mother and the man's other sister, raised the issue of contact following the brother's death. He had named his daughter as next-of-kin and she and her mother were informed in person by prison staff about his death. However, his mother and two sisters were not in contact with the ex-partner so heard the news from neighbours. The man's sister said that staff from the prison treated them very well once they realised there was a separate branch of the family.

## 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.
6. Since April 2004, healthcare at Lindholme has been provided by NHS Doncaster. Lindholme has no inpatient beds. Nursing cover is provided daily from 7.45am to 8.00pm. Sickness and treatments are managed by nursing staff. Medical cover is provided through a local GP practice which sees prisoners who have applied for an appointment.
7. The last inspection of Lindholme by Her Majesty's Chief Inspector of Prisons was an announced inspection in October and November 2007. In her report on the inspection Her Majesty's Chief Inspector of Prisons wrote:

“... The physical education department provided a good quality service ...

“The PE department operated from a well-equipped sports centre, with a large sports hall. There were opportunities to gain accredited qualifications. There were special classes for prisoners over the age of 50. Referrals from the healthcare department were made for remedial PE. Prisoner peer mentors were used to help individuals achieve their goals.”
8. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is run properly and that prisoners are treated decently. In its last annual report for the period 1 February 2008 to 31 January 2009, the IMB at Lindholme made no comment on any issues relating to the man's circumstances. It was a positive report that concluded:

“The management of a prison is highly complex and challenging and as with all establishments problems arise. The response of the staff at Lindholme prison has been one of committed professionalism and bodes well for the future.”
9. The man's death was the fifth at Lindholme since the Ombudsman gained responsibility for investigating deaths in prison custody in April 2004. Three out of the four previous deaths were from natural causes. No issues of concern raised in the investigations into those deaths are directly relevant to the man's circumstances.

## KEY FINDINGS

10. The man was born in Yorkshire on 9 April 1964. He left school at the age of 16 and subsequently worked at a number of labouring jobs. He had been in a long term relationship of around 20 years, although the relationship had ended. The man had four children with his ex-partner.
11. On 2 February 2007, the man was convicted for an offence of assault occasioning actual bodily harm. He was sentenced to 16 months imprisonment with an added period of 18 months on extended licence. He was released on licence on 1 September 2008.
12. The man's licence was revoked on 3 November 2008 after he breached his licence conditions by failing to return to the hostel where he was staying. He was taken first to HMP Leeds before being transferred to HMP Lindholme on 26 January 2009.
13. During a reception health screening assessment on arrival at Lindholme, one of the prison nurses noted that the man was fit for work and fit to use the gymnasium. The man's height was noted as 5' 10" (1.78 metres) and his weight was recorded as 106 kilograms (16 stones and nine pounds). At a follow-up health assessment with a different nurse five days later, the man reported smoking 20 cigarettes per day. He also reported some serious illness within his family. (I understand that the man's father had had cardiac problems.) As far as the man's own health was concerned, he denied a personal history of heart disease. The only condition he reported was asthma, for which he was receiving medication. The nurse noted that he appeared fit and well.
14. The man's records show that he settled down quickly on his arrival into Lindholme and he soon started a job on the servery. All of the entries made in his wing records were positive ones. For instance, an entry made on 14 May 2009 reported that the man was: "Polite, respectful and a good servery worker." That was a typical entry for him.
15. The man was a regular user (two or three times a week) of the prison gymnasium. Prison Service Order (PSO) 4250 provides guidance and instruction of the provision of physical education (PE) in prisons. Some of the instruction in PSO 4250 includes that:

"All prisoners may participate in PE activities. Prisoners will not be restricted unless otherwise authorised by the Governor and/or a Healthcare professional.

"Physical Activity Readiness Questionnaires (PAR-Qs) 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."

16. My investigator in company with the clinical reviewer interviewed a number of Lindholme's gymnasium staff. The Gymnasium Manager explained that the PAR-Q form asks the prisoner a number of closed questions (questions requiring a yes or no answer). Aspects covered include asking if their doctor has ever told them they have a heart condition and whether there is any reason they should avoid physical activity. The form also asks the prisoner whether they have a number of clinical conditions such as epilepsy or diabetes. If a PAR-Q indicates any reasons why the prisoner should not use the gymnasium, he will be referred to a prison doctor. The Gymnasium Manager said that he had not been able to find the man's PAR-Q form. Having said that, he was able to confirm that the man's name was not in the book holding details of prisoners with medical restrictions. He explained that some prisoners will have underlying health conditions which mean that they are not allowed to use the gymnasium at all. Others will be on a list for remedial (therapeutic) exercise. (My investigator was given copies of gymnasium lists showing there were usually around ten prisoners on the remedial exercise list. The man's name was not on any of these lists)
17. My investigator asked the Gymnasium Manager about the man's weight. The Gymnasium Manager said that while the man was burly, he was not excessively overweight. He attended the gymnasium regularly and understood about training programmes. The Gymnasium Manager said that a minimum of two physical education instructors (PEIs) supervise gymnasium sessions and they will advise prisoners about exercise programmes. They could also speak to prisoners who they think might be putting themselves at risk by over-training. Having said that, the Gymnasium Manager pointed out that many gymnasium users in the community will push themselves hard during gymnasium sessions and that is no different to many prisoners too. He said that working hard in the gymnasium gives a feeling of wellbeing and when prisoners attend the gymnasium, it is as near as they can get to being back in the community.
18. The first Physical Education Instructor (PEI) told the investigators that the man seemed a competent gymnasium user who appeared to know what he was doing. He said that prisoners will ask for advice about training programmes and he recalled having advised the group of prisoners with whom the man generally trained. He said that when supervising a gymnasium session he will take note of anyone he thinks is pushing himself too hard. He will speak to the person to gauge whether they have trained that way before. If appropriate, he will suggest to the person that he might ease down a bit. He said he never had to do that with the man as he always seemed to exercise within his capabilities.
19. A second PEI also considered the man to have been a competent gymnasium user who appeared to exercise within the limits of his capabilities. The second PEI said that he would intervene if he thought a person was misusing the equipment or was looking seriously uncomfortable. He stressed, however, that many people do "push themselves hard" in the gymnasium and unless there appears to be a problem, they are allowed to do that.
20. Around once a month from February to June 2009, the man reported 'special sick' and was prescribed painkillers (Ibuprofen or paracetamol). ('Special sick'

is the term used for a daily slot when prisoners can see a nurse to report minor ailments. The nurse can dispense up to three days supply of medication.) Toothache and earache were both listed as reasons why the man was seeking medication. On other occasions, no explanation was recorded by the dispensing nurse. In addition, the man was being prescribed regular medication for asthma and on one occasion was prescribed olive oil to deal with a build up of ear wax.

21. The second PEI told the investigators that 2 July 2009 seemed a normal day with no apparent problems. The man was concluding a session in the weights room and at about 9.25am went to get a drink from the water fountain. The second PEI was sitting at the weights room desk and heard a loud bang. He saw that the man had collapsed to the floor. The second PEI said he went to him while another PEI telephoned healthcare. It was quite warm that day and the second PEI thought that the man had fainted as his face was very red. His eyes were flickering open and he was retching. The second PEI turned the man onto his side and told him that if he needed to vomit, that was okay. The man vomited two or three times but it seemed to be just clear fluid that was coming up. The man then lost control of his bowels. The second PEI still thought that the man was recovering from a faint and he tried to reassure him while waiting for the nurses to arrive.
22. The first nurse on scene told my investigator and the clinical reviewer that she was in healthcare when there was a radio call to announce a Code Blue emergency in the gymnasium (a Code Blue call indicates that a person has breathing difficulties requiring healthcare assistance). The nurse said she and a healthcare assistant went to the gymnasium taking emergency equipment with them. When they arrived several minutes later the man was lying on his side in the 'recovery position'. He was conscious however and wanted to sit up. The nurse allowed him to sit up with his back against a door for support. The man was a little cyanosed<sup>1</sup> so the nurse tried to give him oxygen. The man was quite agitated, he was flaying his arms and said that he did not want the oxygen mask placed on him. The nurse checked the man's eyes and saw that his pupils were dilated (enlarged) so she moved him back into the recovery position and asked the healthcare assistant to call an ambulance.
23. The telephone call to ask for an ambulance was made from the prison control room at 9.40am. The man's condition appeared to have deteriorated rapidly from this point. The nurse checked for a pulse but found none. The man was then checked with a defibrillator<sup>2</sup> which instructed that cardio pulmonary resuscitation (CPR) should be carried out. The nurse attempted to give chest compressions but she found it difficult to apply sufficient force due to the man's heavy build. Two officers took over giving chest compressions and mouth to mouth breathing. In the meantime, the other prisoners were moved away from the area.

---

<sup>1</sup> Cyanosis describes the condition when the bodily extremities turn blue due to lack of oxygen.

<sup>2</sup> A defibrillator measures electrical activity in the heart and issues audible instructions about management of the patient.

24. A fast response paramedic arrived at 9.47am and checked the man with his own defibrillator which instructed that CPR should continue. Six minutes later, ambulance paramedics arrived. At that point, the paramedics took over the efforts to try to resuscitate the man. They continued to treat him at the scene for almost 30 minutes before taking him to Doncaster Royal Infirmary. They arrived at the infirmary at around 10.30am. Unfortunately, all efforts to try to resuscitate the man proved unsuccessful and he was pronounced dead at 10.36am.

### **After the man's death**

25. The man had named one of his daughters as his next-of-kin. On making further enquiries, Lindholme discovered that the man's daughter was a minor (she was 14 or 15 years of age) and that she lived with her mother, the man's ex-partner. Staff from Lindholme visited the family home. The man's ex-partner was at home but their daughter was at school. The staff broke the news about the man's death to his ex-partner and she requested that the staff also break the news to her daughter. The prison staff travelled to the school in company with the man's ex-partner in order to inform his daughter.
26. The man's records contained no details of any other of his blood relatives. His mother and his two sisters subsequently heard about the death from neighbours and they contacted the prison. Prison staff visited these family members and all three went to visit Lindholme. During the visit they had the opportunity to speak to some of the man's friends and to see his cell.
27. The man's family were informed about assistance with funeral expenses in line with Prison Service Order 2710, "Follow Up to Deaths In Custody". A number of staff from Lindholme attended the man's funeral.
28. A staff debrief was held after the man's death and the prison care team spoke the staff directly involved in trying to save him.

## ISSUES

### The man's fitness to use the gymnasium

29. Before prisoners are permitted to use the gymnasium at Lindholme, they must be passed as fit to do so by a healthcare professional. The man was assessed as fit to use the gymnasium by a nurse when undergoing a healthcare reception assessment on the day of his arrival at the prison.
30. In addition, all prisoners are required to complete a PAR-Q form in which they answer a number of questions exploring aspects of their health that might indicate that their access to the gymnasium should be restricted. It has not been possible to locate the man's PAR-Q form. It might be the case that the form was completed, but was subsequently mislaid. Alternatively, it might be that a PAR-Q was never completed in the man's case.

### **I recommend that the Governor review procedures for ensuring both completion and safeguarding of PAR-Q forms.**

31. Despite the absence of a PAR-Q form for the man, I have no doubt that he was fit to use the gymnasium. I have reached this conclusion based on a number of factors. First, the man had been assessed by a nurse as being fit to use the gymnasium and his clinical records contain nothing to suggest that he had any significant medical problems. Next, it appears that the man used the gymnasium without any difficulty on a regular basis for around five months. Finally, none of the PE department staff noticed the man having any problems in the gymnasium prior to his collapse on 2 July.

### Clinical care

32. Following a post mortem examination, the man's cause of death was found to be: "pulmonary oedema as a consequence of sudden cardiac dysrhythmia following a bout of heavy exercise with no contributing factors." The clinical reviewer has explained that the rhythm, or beating, of the heart is controlled by impulses through the network of nerves supplying it and within it and these may not work as they should. There are a variety of reasons why this might happen and the term cardiac dysrhythmia covers these various conditions.
33. Because of the range of different conditions, treatments can vary if the problem is detected. Treatment will depend on the symptoms and reasons for the problems. In some cases it may be appropriate to use medication to improve the function of the heart. Surgical options to try to improve the rhythm of the heart would generally be considered as an option if appropriate and if other medically options have been considered or tried. If the patient dies, the exact reason for them developing the condition might remain unidentified even following a post mortem examination.
34. The clinical reviewer has found no evidence that the man experienced previous symptoms of cardiac dysrhythmia, nor has he found any evidence to indicate that the man was at any greater risk of developing the condition compared to

other people of a similar age. The clinical reviewer concluded that the man's death could not have been foreseen or prevented. The clinical reviewer found that the healthcare response after the man's collapse appears to have been appropriate.

35. The clinical reviewer was critical of certain aspects of record keeping. This included that the man was given pain killers (special sick) on a few occasions with no clear indication of the reasons in the records. The clinical reviewer made the following two recommendations:

**It is recommended that HMP Lindholme ensure that all healthcare staff are trained and kept updated in record keeping including the medical staff to ensure that all documentation is completed appropriately. Consideration should also be given to how the prescription of special sick medication is documented more thoroughly.**

**It is recommended that an audit plan is in place to support any changes in practice particularly around standards of documentation and that assurance about results of audits and subsequent improvement plans are submitted into the local prison governance structure.**

### **Breaking the news to the man's family**

36. The man had named one of his daughters as his next-of-kin. It was only after his death that Lindholme discovered that this daughter was a minor (his three other children are adults). Lindholme obtained details of the man's ex-partner, the mother of his children, and visited her at her home to break the news. The man's daughter was at school and her mother asked for staff to visit the school and for the staff to break the news. The man's ex-partner travelled to the school with them.
37. The following day, a separate branch of the man's family were identified they were the man's mother and his two sisters. This side of the family were not in contact with the man's ex-partner and had heard the news from neighbours. They contacted Lindholme for confirmation and staff from the prison subsequently visited them at one of their homes.
38. Prison Service Order 2710 provides guidance on contact with families following the death of a prisoner. PSO 2710 explains that:

“The family may be large [and] at odds amongst themselves. Many modern families are split by divorce or separation and there may be several branches all with equal rights to information. ... The Family Liaison Officer should be prepared to deal with different sections of one family if necessary ...”
39. It is clear that staff at Lindholme were prepared to deal with the different branches of the man's family once they discovered that there was more than one. Unfortunately, the only family member that the man listed as next-of-kin was his youngest daughter. I do not know whether Lindholme asked the man's

ex-partner about other family members, but it would have been good practice for them to have done so.

**I recommend that the Governor remind his Family Liaison Officers that it is a matter of good practice when visiting relatives to ask about other branches of the family.**

40. The other issue identified in this case was that it was only after the man's death that Lindholme discovered that the daughter listed as next-of-kin was a minor. I understand that Lindholme has changed its practice so prisoners are now asked whether their nominated next-of-kin is an adult. As Lindholme have already acted on this matter I make no recommendation.

## **CONCLUSION**

41. The man's death was both sudden and unexpected. He died following a training session in the gymnasium. He was a regular user of that facility and was said by staff to understand training programmes. Following the man's initial collapse, he deteriorated rapidly. The clinical reviewer found that staff responded appropriately, but unfortunately he could not be saved. I make two recommendations and the clinical reviewer has made two of his own.

## RECOMMENDATIONS

In my draft report I made the following recommendations. The service response to each is now included in italics following each recommendation:

1. I recommend that the Governor review procedures for ensuring both completion and safeguarding of PAR-Q forms.

*Recommendation accepted. Gym staff attach PAR-Q form to the F2055D for all offenders attending the gymnasium. Any problems on the PAR-Q are flagged up and the prisoner is referred to the doctor prior to any physical education taking place. All PAR-Q entries are duplicated into the Induction log book for the gym. This only applies to offenders attending the gym via Induction. This has been in place since August 2009. At review on 10 June 2010 no alterations were made.*

*In the event of an offender attending gym on a add hoc basis who has missed induction this person will be seen by Healthcare on reception and any concerns will be referred to the PE staff. The target date for completion of this is June 2010.*

2. I recommend that the Governor remind his Family Liaison Officers that it is a matter of good practice when visiting relatives to ask about other branches of the family.

*Recommendation accepted. An e-mail will be forwarded to the four family liaison officers explaining the matter of good practise when visiting relatives to ask about other branches of the family. The target date for completion is 15 June 2010.*

## RECOMMENDATIONS FROM THE CLINICAL REVIEW

3. It is recommended that HMP Lindholme ensure all healthcare staff, including medical staff are trained and kept updated in record keeping to ensure that all documentation is completed appropriately. Consideration should also be given to how the prescription of special sick medication is documented more thoroughly.

*Recommendation accepted. HMP Lindholme healthcare staff now make clinical entries on the 'system1' electronic patient medical record. This records the name of the person making the entry and the date and time. In addition all nursing staff will receive documentation training as part of their annual training. A Standard Operating Procedure (SOP) is now in place for the dispensing and documenting of 'special sick' medication. Documentation training to be completed by June 2011.*

4. It is recommended that an audit plan is in place to support any changes in practice particularly around standards of documentation and that assurance about results of audits and subsequent improvement plans are submitted into the local prison governance structure.

*Recommendation accepted. Regular audits of medication issue, record keeping and documentation will be undertaken by the Healthcare manager under the new contract provision. This assurance programme will be overseen by the offender health governance team. The new contract will start shortly.*