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

Report by the Prisons and Probation Ombudsman for England and Wales

July 2010

This is a report into the death of a man at HMP Lincoln on 16 August 2009. He died of natural causes.

I offer my sincere condolences to the man's family and friends.

The investigation was conducted on my behalf by my colleague. In addition, a clinical review into the care of the man received whilst he was in prison was undertaken by the local PCT. I am most grateful to the clinical reviewer for her contribution. I am also grateful to the Governor and staff of Lincoln for their assistance during the investigation.

The man had been arrested for a breach of his licence conditions and was returned to custody on 18 April. Not being his first time in prison, he quickly settled into prison life and staff had no concerns about him. He had very little contact with healthcare until the day of his death four months later.

Despite taking unprescribed drugs hours before his death, the post mortem and the clinical reviewer confirm that coronary artery disease was the cause of his death.

Overall the man's stay in Lincoln was uneventful and I have identified no particular issues until the day before his death. Regrettably nearly two hours elapsed between the first call to help the man and healthcare staff responding. The clinical reviewer believes that earlier treatment might have detected his heart condition so that appropriate care could have been given.

As a result I make six recommendations regarding events on the day of his death. Since the draft report was issued, I have become Acting Prisons and Probation Ombudsman. I endorse these recommendations. They relate to recording and passing on medical information, staff response in emergency situations and breaking news to families.

Jane Webb
Acting Prisons and Probation Ombudsman **July 2010**

CONTENTS

SUMMARY

The man was received into custody at HMP Lincoln on 18 April 2009 following a revocation of his licence. He was screened at the prison reception and said that he did not have any history of physical or mental health problems. He was not taking any medication and denied any drug misuse. He quickly settled into the prison regime and staff did not report any concerns about his health. Further to this, he only consulted healthcare once during his four month period in custody, when he complained of a headache.

During the evening of 16 August, the man's cell mate witnessed him taking some Subutex (a semi-synthetic opiate, often used recreationally) and cannabis. He allegedly obtained the drugs from another prisoner. After taking the drugs, he watched television with his cellmate and started to feel unwell. Believing the drugs had started to have an effect on him, the man remained lying on his bed in his cell. As his breathing became louder, his cell mate became concerned and pressed the cell bell alarm at 7.59pm to alert staff.

The Operation Support Grade (OSG) immediately responded to the cell alarm. He was told by the cell mate that the man felt unwell. At this time, he was standing up against his bed. The OSG advised him to open the window and to remain on his bed. He then rang the healthcare centre and spoke to a healthcare support worker (HSW), who was about to conclude her duties for the evening. The OSG told the HSW that a prisoner on C wing had taken Subutex and felt unwell.

The information was passed on to the registered general nurse (RGN) who was receiving a handover from the day staff before starting his night shift. There was no log of this call and the HSW did not identify any additional information from the OSG about the nature of the man's complaint. Shortly afterwards, the RGN attended an emergency call on another wing.

Nearly two hours after the OSG went to the man's cell, he again answered the cell bell alarm. When he arrived at the cell, his cell mate said that the man was dead. Despite the OSG shouting his name, he failed to respond. The OSG immediately used his radio and requested healthcare and the orderly officer (in charge of the prison at night) to attend C wing. Another OSG who was on the wing at the time quickly ran to assist.

The staff entered the cell and examined the man but no signs of life were found. A Code 1 emergency call (indicates a life threatening emergency) was radioed through whilst the OSG began cardio pulmonary resuscitation (CPR). The healthcare staff and paramedics arrived quickly and continued with CPR. Despite their attempts, he was pronounced dead at 10.32pm.

I make six recommendations in my report. They relate to recording and passing on medical information, staff response in emergencies and breaking bad news to families.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of the Ombudsman's investigators on 20 August 2009 when he met the Governor and some of his staff. Notices of the investigation and terms of reference had already been sent inviting anyone with any information to contact the investigator. The investigator encountered a number of delays due to staff unavailability for interview, which has been acknowledged by the Governor.

2. The investigator also met the Head of Healthcare, representatives of the Prison Officers' Association and a representative of the Independent Monitoring Board. He visited all parts of the prison including the wing where the man lived, and met the prison's liaison officer (the Head of Performance).

3. The man's prison records, including his medical record, were made available to the investigator during his initial visit to the prison. Additional documents were made available when he returned to conduct interviews. The investigator also met a Detective Sergeant (DS) of the local police. The DS shared a number of police statements that he obtained during the police investigation with the investigator. I am grateful to the DS for his help and assistance.

4. A clinical review of the man's medical care was commissioned from the local NHS. I am grateful to the clinical reviewer for her review. As part of her review, she conducted some interviews jointly with the investigator. She also had sight of some of the interview transcripts and the man's medical records.

5. One of the Ombudsman's Family Liaison Officers contacted the man's family to inform them of the investigation and give them the opportunity to raise any questions about the care he received. The man's next of kin wished to share the following information about the care he received. I hope this reports provides his family with a better understanding of the events leading to his death.

    - They had heard rumours that another prisoner had been "dishing out tablets".

    - The man's daughter had visited the prison and seen her father's cell. She asked to meet his cell mate, however this was not possible at the time due to his ill health. The man's cell mate was subsequently released earlier from prison than expected and before the investigator was able to speak with him. The investigator attempted to contact his cell mate by letter and telephone, but did not receive a response.

    - When the man's daughter visited the prison, she was surprised to see a carpet runner and vase of flowers in her father's cell. She believed the prison may have been trying to hide something. The prison explained to the investigator that the carpet was placed on the floor so that his family did not see marks left as a result of the resuscitation attempt.

- His brother said the man was rarely ill and never went to the doctor. He therefore felt something must have been very wrong for healthcare staff to have become involved. His brother was also concerned about the time it took for staff to respond to his brother and questioned why this was.

6. Having received a copy of the draft report, the man's brother commented upon the time lapse that had occurred between his ill health being reported and the staff responding to this and his feeling that this could have been quicker. The man's daughter, who also was provided with a copy of the draft report, had made no further comments on its content at the time of issuing this final version of the report.

HMP LINCOLN

7. HMP Lincoln is a category B local adult male prison. Built in 1872, it receives prisoners remanded from courts across the East Midlands. It also receives serving prisoners transferred from other establishments, and has the capacity to hold a maximum of 738.

8. There are four main residential units. A wing incorporates the First Night Centre (FNC) and holds prisoners on induction and those participating in detoxification programmes. Prisoners new to Lincoln are usually allocated to A wing/First Night Centre. B wing holds sentenced and convicted prisoners, and C wing holds remand and convicted prisoners. D wing is the segregation unit, E wing is designated for vulnerable prisoners and J wing has accommodation for prisoners participating in short duration drug treatment programmes. The healthcare centre has in-patient accommodation.

Her Majesty's Chief Inspector of Prisons' report

9. HM Chief Inspector of Prisons carried out an announced inspection of HMP Lincoln from 3 to 7 December 2007. With regard to new prisoners, the Chief Inspector commented as follows:

> "Fortunately caring staff – well supported by prison Insiders [prisoners trained to provide information for newly-arrived prisoners] – made good efforts to help prisoners through their difficult early days and a new first night centre had just opened. Suicide and self-harm arrangements were sound, as was clinical support for detoxification."

10. The Chief Inspector 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 checked regularly.

Independent Monitoring Board (IMB)

11. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are independent of the Prison Service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and any areas of concern.

12. The IMB's latest report covers the period 1 February 2008 to 31 January 2009. The Board noted that "Drugs and mobile phones continue to enter the prison but the proactive regime has resulted in a significant number of finds". When referring to safer custody, the Board noted that there were two deaths during the reporting year and 195 reported incidents of self harm. The IMB said that the Listeners scheme was well used and there was a well regulated violence reduction policy.

Assessment, Care in Custody and Teamwork (ACCT)

13. ACCT has been introduced at all prisons to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is observed at intervals determined by their perceived level of risk. The observations continue during the day and the night.

14. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner within a prison.

Emergency code and medical bags

15. Lincoln operates a two code emergency system to help staff alert their colleagues through the radio network. Code 1 indicates a life threatening emergency (for example, heart attack or hanging). Code 2 indicates a non life threatening act of self-harm.

16. When a Code 1 is used, it is broadcasted to healthcare as “Hotel 1” and healthcare staff must attend with their blue and orange emergency bags. Amongst other equipment, the bags contains observation equipment, a blood pressure machine, pulse meter, minor dressings, oxygen masks, ambi-bag (to assist with breathing), and some emergency medication such as adrenaline. Other equipment brought to a Code 1 emergency includes an oxygen cylinder and a defibrillator (which monitors a heart’s activity).

Incentives and Earned Privileges (IEP)

17. The IEP scheme was introduced in 1996 to encourage and reward good behaviour by prisoners. There are three levels: Basic, Standard and Enhanced. Incentives include access to in-cell television, more private cash to spend, being able to wear their own clothes, more time out of cell and access to extra and enhanced visits. Each prison sets its own criteria to obtain each level.

Personal officer scheme

18. A personal officer is a prisoner’s first port of call if they have any questions, complaints or need any advice. On C wing, prisoners are assigned a primary and secondary personal officer. The secondary personal officer covers when the primary personal officer is absent.

Reception and induction

19. A Cell Sharing Risk Assessment (CSRA) is opened by a reception officer who completes the basic details. Reception staff do not have access to a prisoner’s past records and so the prisoner is the main source of information. The form is handed to the First Night Centre staff where a confidential interview is conducted. The document is then passed to healthcare staff. The

CSRA is intended to provide consistent and continuing risk assessment regarding sharing cells.

20. The initial healthcare screen concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.

21. All new prisoners are located on the induction wing. Prisoners are asked about any immediate concerns, such as disability, their offence and general well being. The induction includes a further assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack, telephone pin numbers and visiting arrangements are explained.

Sealed key pouch

22. Sealed key pouches containing a cell key are distributed to all night staff patrolling units holding prisoners. They are to be used to gain entry into cells in an emergency (at night) to attend to a prisoner whose life is in danger. On discovering a life threatening incident, staff must raise the alarm by contacting the Control Room. The night patrol officer must decide whether aid is required immediately, or whether any delay may result in a very serious harm or death. If the latter is the case, the officer should break open the sealed pouch and use the key to open and enter the cell.

Police investigations of deaths in custody

23. With all deaths in prison custody, the police are notified by the prison as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that the Ombudsman's investigators begin their own investigation.

Previous deaths in HMP Lincoln

24. Since the Ombudsman assumed responsibility for investigating all deaths in prisons in 2004, 13 deaths have been investigated at Lincoln. Of these, 11 were self-inflicted and two were 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, the Ombudsman 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 previously.

KEY FINDINGS

25. The man was arrested for a serious offence committed in March 2008. On 18 August, Nottingham Crown Court sentenced him to 15 months imprisonment. He commenced his sentence at HMP Lincoln.

26. On 9 October, the man transferred to HMP Ranby where he spent five months before being released in February 2009. Two months later (on 18 April), the man was recalled to prison because he had breached conditions on his licence. He was arrested by the police and returned to Lincoln arriving at around 1.10pm.

27. He went through the normal prison reception process. The Prisoner Escort Record (PER), which accompanied him from the police, noted that he had no known risks. Reception staff completed the cell sharing risk assessment (which decides whether a prisoner is a risk to others he may share a cell with) and noted that he was a "Low" risk. The cell sharing risk assessment (CSRA) noted that he had no alcohol or drug problems and was a smoker. Staff noted on the front of his wing history sheet "staff be aware licence revoke increased risk of self harm".

28. As part of his assessment, the man was interviewed by a member of the healthcare team. No concerns, including any relating to harming himself or suicide, were noted.

29. He was duly located onto A wing (cell A1 -13) to commence his prison induction, which he received over the next few days. No concerns were raised by staff as he settled into the prison regime.

30. Having completed his induction, the man was moved onto C wing on 21 April. He was placed in a double cell with another prisoner. His CSRA remained "Low" and no concerns were noted by staff. On 23 May his personal officer met with him. His personal officer told the investigator that he noted the man's wing history sheet to the effect of **"**He remains quiet and polite works in textiles no concerns".

31. On 26 May, the man was seen by the healthcare nurse as a result of a complaint of headaches. He was examined and said that he had drunk ten pints of beer a day for 30 years. His blood pressure was considered normal and he was prescribed paracetamol, ibuprofen and thiamine.

32. The man had also been appointed a second personal officer who knew him from his previous sentence. His second personal officer told the investigator that he met the man on 1, 14 and 28 June and noted in his wing history sheet that he had no concerns about him.

33. The officer described him as someone who had a good rapport with staff and prisoners. He had settled well on the wing and was not afraid to ask for anything he needed or to raise concerns he might have.

34. During their last meeting on 28 June, the man asked his second personal officer if it would be possible for him to speak to his daughter, who was in custody in another prison. This was subsequently arranged and staff facilitated an inter-prison telephone call to his daughter on 2 July.

35. His first personal officer described him as "always polite and whose mood was generally jovial". The man had submitted an application for enhanced status under the Incentives and Earned Privileges (IEP) scheme on 8 July, which was fully supported by his first personal officer. (At the time of the man's death, his enhanced IEP had not been approved.)

36. The man was aware that he would have to undertake a drugs test before enhanced status could be approved. He told his first personal officer that he did not take drugs, although he had been a drinker in the past. The officer said that he came into contact with him fairly often and had seen no reason to believe he was taking any drugs. It was also around this time that he asked to share a cell with another prisoner. This was later risk assessed and approved.

37. The man's first personal officer last saw the man around the beginning of August after which he took annual leave and changed his duties. He had no concerns about him.

38. Around 3 August a seconded probation officer interviewed the man in response to his application to see someone from the probation unit.

39. At interview with the investigator the seconded probation officer said that the man was working in the textiles workshop when he went to see him. During their discussions the seconded probation officer said that he there was nothing in the man's demeanour which alerted him to any concerns. Their meeting lasted about an hour and concerned the man's uncertainty about how the licence recall process worked. He had never been recalled to prison before and explained the circumstances of his recall to the probation officer.

40. The man was aggrieved at what he perceived to be a poor level of service that he received from the Probation Service in the community. He said he had reported to the Probation Office around five times and was seen by a different probation officer on each occasion. In all, he said his five visits amounted to about 15 minutes at the office. The probation staff told him that as he had no drug or alcohol related problems and was not required to attend any rehabilitation programmes to address his offending behaviour, there was little that could be done with him. He said that he subsequently obtained employment and accommodation but did not notify the probation office. He then failed to attend the Probation Office on a number of occasions which led to his recall to prison.

Events on Sunday 16 August

41. Until this time, no concerns had been raised about the man who died. He had shared a cell (number C2 – 17) with another prisoner that he had requested for around five weeks. During this time, his cell mate said (in his police statement) that the man had taken Subutex (by snorting it) around once a week and occasionally smoked cannabis.

42. The man's cell mate said that he and the man woke up around 8.30am on 16 August. They had some coffee and talked until about 9.30am, when their cell was unlocked. They proceeded to obtain their canteen, which included buying tobacco. Having returned to their cell, the man later went out on exercise before returning for the lunch time break. Sometime during the morning, the man's cell mate said that another prisoner had come to their cell and offered the man some cannabis. Both prisoners collected their lunch, returned to their cell and watched television for the afternoon.

43. At sometime between 2.15pm and 3.15pm, the cells were unlocked and prisoners were allowed a period of association (time out of cell). The man's cell mate said that during this time, another prisoner came to their cell and offered the man some Subutex, which he accepted in exchange for tobacco.

44. Following the period of association and the evening meal, all cells were locked again around 5.00pm. Both prisoners resumed watching the television. The man's cell mate said that it was very soon after this that the man snorted some Subutex and rolled a cannabis cigarette. He offered some to his cell mate but he refused.

45. An hour later, the man said that the drugs had started to have an effect on him. As he got up from sitting on the bottom bunk, he became unsteady on his feet and eventually fell over. His cell mate said he repeatedly asked if he was okay. The man responded and said he "would be alright" and that his cell mate should leave him alone.

46. Having returned to his bed to lie down, his cell mate said he could hear the man's breathing becoming louder. Shortly afterwards, the man got up and tried to walk around the cell. His cell mate repeated to the man that he thought something was wrong with him and decided to alert staff by pressing the cell alarm bell.

47. An Operation Support Grade (OSG) arrived for his night duty shift at around 7.05pm and received a briefing from the officer in charge. At interview he told the investigator that there were 186 prisoners on C wing. He carried out a roll check, and checked all locks and bolts on the wing, which included checking J wing's 15 prisoners. He had no concerns as a result of these checks. The OSG then began his normal duties which include pegging on the landing (walking the wing from one end to the other, using an electronic pegging device to record his movements), every 30 minutes, answering cell bells and checking ACCT and escape list prisoners.

48. At approximately 7.55pm, The OSG said he responded to a cell bell alarm from C2-17, the man's cell. (It is recorded on the prison electronic cell bell recording system as being pressed at 7.59pm and responded to 53 seconds later). He opened the cell observation flap to see the man's cell mate at the door and the man standing by his bed. The man turned around and looked to be standing casually with his arm on the top bunk. Although he appeared to look fine, he said he "could do with some air". The man's cell mate said in his police statement that the man could not breathe properly. He repeated the words on his behalf and added that a doctor was needed.

49. The OSG described the evening as hot and advised the cell mate to fully open the cell window. The cell mate told the OSG that the man had taken Subutex. On learning this information, the OSG said he told the man to lie down if he needed to and he would contact the healthcare centre. The OSG did not suggest that the cell mate referred to the man having breathing difficulties or needing a doctor in either his police statement or in his interview with the investigator.

50. The OSG went to the wing office and telephoned the healthcare centre. The telephone was answered by a healthcare support worker (HSW). He told the HSW that the man was in his cell, said he needed some air and had apparently taken Subutex. The HSW did not ask for any further details about the man's condition. The OSG continued his duties of patrolling the landing and answering any cell bells that went off on C and J wings, expecting that someone from healthcare would deal with the man soon.

51. At interview with the investigator, one of the Registered General Nurse's (RGN) said that he normally worked nights in the prison. He was assisted by an HSW who was not medically qualified. Although he was not rostered to be on duty this night, he was asked to work the shift so that another RGN who was rostered to work could shadow him because it was her first night duty shift.

52. The RGN arrived at the prison that evening around 7.45pm. (His official hours of work were 8.45pm until 7.45am.) As routine, the night duty staff received a handover from the evening duty (ED) staff whose shifts normally end at 8.45pm. The handover comprises of information on all the individual prisoners that were in healthcare, an update on any particular events that had occurred during the day, and a general discussion about other issues such as the distribution of medication that might be required during the evening and night. Once the handover is completed, it is normal for the ED staff to finish their shift.

53. The ED staff on duty were the HSW who answered the telephone in healthcare and a RGN. During their handover talk to the night shift RGN, a telephone call was received in the healthcare centre which was answered by the HSW. The RGN told the investigator that the telephone was located across the room so he did not hear any of the conversation between the caller and the HSW. The HSW however returned and said that she had been

informed that a prisoner on C wing had taken Subutex and was not feeling very well. The RGN said he told her “don’t worry about it I’ll sort it”. He told the investigator that there was no indication that this was an emergency. Their handover meeting concluded soon afterwards and the HSW and the evening duty RGN left the prison.

54. Within minutes of the ED staff leaving the healthcare centre, the RGN said he responded to a Hotel 1 emergency call to attend an incident on E wing. Over on C wing, the OSG confirmed that he was aware of the emergency call broadcast over the radio.

55. The RGN immediately went downstairs into the treatment room and collected the grab bag (a medical bag containing dressings, suturing and other equipment). He proceeded to the gate of A wing which was locked. Healthcare staff do not carry keys at night and so he returned to the office to ring for an officer to open the gates. However, as he was doing this, the HSW arrived in the healthcare centre to start her night duty. As she had been escorted to the unit by an officer, the same officer then led the RGN and HSW to E wing.

56. The RGN said the prisoner had had an epileptic fit and fallen out of his bed. The prisoner was conscious but appeared to have incurred a serious head injury with blood over his bed. Having cleaned and attended to the prisoner’s wound, the RGN said he spent a further ten to 15 minutes with the prisoner talking about his medical health and how frequently he had fits.

57. The Night Orderly Officer (the officer in charge of the prison) told the investigator that he began his duty at around 8.00pm. He also had attended E wing as a result of the emergency. On leaving the cell, the RGN told the night orderly officer that the prisoner was okay and, if any further problems arose, he should be contacted. The RGN then made his way to the E wing office to update the prisoner’s medical record before returning to the healthcare centre.

58. At interview with the investigator, another OSG said that he had telephoned the OSG that responded to the man’s cell bell on C wing about 8.15pm. The OSG that responded to the cell bell told him that at about 8.00pm he had contacted healthcare and reported the man’s condition. No one from healthcare had yet come to the wing. The OSG that responded to the cell bell was aware that healthcare had responded to an incident on E wing, and expected the nurses to come straight from there to C wing, which was next door.

59. The RGN that was shadowing arrived to start her shift on night duty around 8.30pm. The other RGN and HSW informed her that she had just missed an incident where a prisoner had had an epileptic fit. After updating her on this and other issues for the night, the RGN and HSW proceeded to carry out their normal duties. The RGN that had just arrived shadowed the other RGN which involved doing the medication round in the healthcare centre, followed by a

visit to E wing, and then a visit to B wing to administer a controlled drug to a prisoner. All the healthcare team on the night duty shift carry a radio.

60. In the cell mates police statement, he said that at about 9.00pm he got out of bed to use the toilet. He realised that the man was in the same position as when he had last checked him. He touched the man and discovered he was cold. The cell mate also checked for a pulse but could not find one. He immediately pressed the cell alarm bell and said the OSG responded a short time afterwards.

61. At 9.50pm, the OSG said he again responded to a cell bell alarm from the man's cell. (It is recorded on the electronic cell bell record as being pressed at 9.52pm and responded to 41 seconds later.) On this occasion, the cell mate said he thought that the man was dead. The OSG said he immediately tried to get a response from him (who he could see lying on his bed and appeared to be asleep) by calling his name. He failed to respond. The cell mate become very distressed. He was crying and then collapsed on the floor behind the cell door.

62. The OSG failed to gain a response from the man. He was satisfied that the situation was a genuine emergency and carried out a risk assessment to consider entering the cell. The OSG immediately called for support from another OSG, who had recently arrived on C wing. He then radioed through to the Control Room to request the healthcare team and the orderly officer to attend C wing.

63. The other OSG said that he was in the C wing tea room on the first landing. He was aware that his colleague had gone to respond to a cell bell on the second landing and within seconds heard him shouting "Are you alright mate, move". The OSG responded to shouts of assistance from his colleague and ran to the man's cell, arriving within five seconds. As he got there, his colleague was in the process of the breaking the seal on his emergency key pouch and alerting the Control Room to request healthcare and the orderly officer.

64. As the two staff members pushed open the cell door it initially jammed as the cell mate was behind it. They managed to push it wide enough to go inside and found his cell mate still crying and in a hysterical state.

65. The OSG who responded to the cell bell went to attend to the man and checked for any signs of life. No pulse could be found. On seeing this, the other OSG also checked the man for signs of life but could not find any. The OSG who responded to the cell bell immediately radioed through a Code 1 emergency, whilst the other OSG removed the cell mate from the cell.

66. The OSG who responded to the cell bell begun cardio pulmonary resuscitation (CPR) on the man. Although he told the investigator that he had not had any recent first aid training, he felt confident about carrying it out.

67. The night orderly officer said that at around 9.50pm, he received a message via the Control Room to attend C wing with healthcare. Around 20 to 30 seconds later this message was changed to a "Code 1, Level 2, Charlie wing". Along with an officer, the night orderly officer quickly made his way to C wing, arriving in about 30 seconds. When they arrived, the OSG who had recently started his shift on C wing was on the landing trying to console the man's cell mate.

68. The night orderly officer looked into the man's cell, and saw the OSG who responded to the cell bell carrying out CPR on the man, who was lying on his bed. Despite not having received any recent first aid training, he offered to assist the OSG try to resuscitate the man. However the healthcare team arrived at this point.

69. Like the night orderly officer, the two RGN's had heard the initial request for healthcare and the Orderly Officer to attend C wing. As the incident was not initially broadcasted as an emergency, they intended to finish giving out a controlled drug, before making their way to the incident on C wing. However, within 30 seconds, an emergency Code 1, Hotel 1 was broadcast over the radio net. The RGN who was first on duty immediately made his way to the C wing whilst the RGN that was shadowing him locked away the controlled drugs that they were dispensing. She then made her way to C wing.

70. The RGN who was first on duty arrived at the man's cell seconds after the night orderly officer. The night orderly officer contacted the Control Room and requested an ambulance, recorded on the prison incident log as occurring at 9.54pm. When the RGN arrived in the man's cell, along with the OSG who responded to the cell bell and the night orderly officer, he placed the man on the floor.

71. The RGN examined the man for any signs of life. He could find no pulse and his eyes were dilated. He continued with CPR, doing chest compressions. The HSW, who had also responded to the emergency call, arrived at the man's cell seconds after the RGN. She described the man as "cold to touch, very cold".

72. The HSW said that as the RGN had asked whether the RGN that was shadowing him was coming with any of the emergency bags, she left the cell to look out for her. As the RGN that was shadowing approached the cell, it was obvious that she did not have the emergency bags in her possession. The HSW asked where they were. The RGN that was shadowing said she thought that as she had been locking up the medication room, the HSW would have collected the emergency bag.

73. The HSW quickly ran to collect the emergency equipment from the E wing treatment room, which is on the same landing as the C wing landing. She returned back to the cell less than two minutes later with the orange emergency bag. The officer that attended with the night orderly officer, who was on the landing when the RGN who was shadowing arrived, assisted the HSW by carrying the blue emergency bag, defibrillator and the oxygen.

74. The two RGN's continued with CPR whilst they waited for the emergency equipment. When it arrived, oxygen and the defibrillator were used to assess and try to revive the man. Despite this, he still failed to show any signs of life. The defibrillator advised not to shock, which indicated that the man's heart showed no electrical activity at that time.

75. The paramedics arrived at the prison at 9.56pm and were escorted through to C wing cell by the officer that had attended with the night orderly officer. He remained outside the cell and offered support to the cell mate, who was still in a distressed state. The paramedics used their equipment and continued to try and resuscitate the man but he remained unresponsive despite their efforts. his death was subsequently declared at 10.32pm.

Events after the man's death

76. On confirmation of the man's death, the night orderly officer immediately informed the duty Governor. The death in custody contingency plans were instigated and the relevant agencies were informed of the man's death. They included contacting the prison care team and the IMB. The cell was sealed to await the arrival of the police and the undertakers. The man's cell mate was placed on ACCT, taken to the healthcare centre and offered further support.

77. A hot de-brief meeting (held immediately after a serious incident) was conducted by the Governor. Staff were given the opportunity to discuss the events of the night and further support was given. The care team offered support to staff. Throughout the remainder of the night, the night orderly officer said he made frequent visits to all the staff involved in the attempt to resuscitate the man who died, to ensure they were okay.

78. A family liaison officer was appointed and she immediately attended the prison arriving around 11.30pm. She checked the man's prison records and confirmed his next of kin details and that they were located in Nottinghamshire. Following discussions with the duty governor and the police, the decision was made that it would be more appropriate for Nottinghamshire Police to notify his next of kin of his death. This was subsequently done around 8.00am the next day.

79. The prison's family liaison officer spoke with members of the man's family throughout the morning and provided further information about his death. The family were invited to visit the prison and provided with all the necessary contact numbers, including that of the coroner. In line with prison procedures, they were also offered financial assistance towards the funeral.

80. During the day on 17 August, all prisoners on an open ACCT were reviewed including the man's cell mate. From prison security intelligence and subsequent police investigations, two other prisoners were later arrested and charged with supplying drugs to the man who died.

Post mortem

81. The post mortem report confirmed that the cause of the man's death was coronary artery disease. The report comments that coronary artery disease is a known cause of sudden death and its presence was consistent with the symptoms suffered by him prior to his death. Rapid medical intervention is crucial to improve the outcome in cases of coronary thrombosis. In this case no fresh thrombus was identified and death may have resulted from a fatal cardiac arrhythmia. As such, the pathologist has reported that it is not possible to say whether earlier medical intervention would have made a difference to the outcome.

82. The toxicological analysis confirmed the presence of traces of buprenorphine, which is consistent with the information provided that the man had taken Subutex prior to his death. (Subutex contains buprenorphine.) The post mortem report concludes that whilst Subutex has been known to produce side effects such as changes in blood pressure and heart rate which may have the potential to precipitate a cardiac event, it is not possible to say whether this was a contributory factor to his death.

ISSUES

83. The clinical review makes seven recommendations. I refer in my report to those which I believe are the most pertinent to my investigation, and have made the Primary Care Trust aware of the remainder.

Assessing the man's condition

84. The OSG who responded to the cell bell contacted healthcare by telephone and reported that the man had taken Subutex and was unwell. This information was received by the HSW and passed on verbally to the nurse who was on duty for the night and who was receiving a "handover" at the time of the call. Very soon after this limited piece of information was passed over the nurse was called away to an emergency on another wing. The information about the man appears to have been forgotten.

85. At the time, the man's illness was thought to be because he had taken Subutex. His symptoms and condition had not been medically assessed at this stage. The OSG who responded to the cell bell was not medically trained and there appeared to be no sense of urgency for the man to be seen by healthcare staff. There was also no record of this telephone call. The HSW did not recall being given, nor did she request, any details of the nature or severity of his symptoms.

86. The clinical reviewer notes that if the man had received medical attention when he complained of breathing difficulties, it is possible that his acute heart problem and any rhythm abnormality would have been detected and appropriate emergency care provided.

87. It is the usual practice within the Prison Service that prisoners with an acute health problem at night are assessed by officers who pass this information to healthcare staff. There is no formal system to gather information about the healthcare needs of a prisoner with an acute medical problem. Responsibility for assessing the urgency of a prisoners symptoms lies with healthcare and not discipline staff.

88. At the time of this incident, there was no system in place to document the handover of prisoners with health problems between staff shifts. I am pleased to note that since the man's death, the Primary Care Trust have introduced a system whereby reports to healthcare are recorded for handover between officers. The clinical reviewer, however, makes the following recommendations to the Head of Healthcare, about reporting prisoner's health issues.

The process for assessing and communicating the details of prisoners who develop acute health care problems should be completely reviewed.

There should be a system which allows assessment and documentation of the nature of any acute medical complaint, including time of call,

presenting complaint, the effect that this complaint is having in terms of breathing, circulation, conscious level and general condition.

There should be a triage or assessment system in place to enable prisoners who develop acute, potentially life threatening problems to receive prompt, skilled assistance within an equivalent time frame to the 999 emergency response provided by the Ambulance Service within the community. Less urgent problems should be reviewed by the most senior member of health care staff available to decide on the type and speed of response.

First aid training

89. Three of the officers who responded to the emergency had not had recent first aid training. I have previously recommended in investigations that first aid training is provided for all staff in contact with prisoners. I suggest that basic life support or first aid training should be reviewed for frontline staff to ensure that their knowledge of resuscitation procedures is up to date. I acknowledge however that it is doubtful that it would have made a difference in this case, as healthcare staff arrived promptly.

The Governor should review the need for first aid or basic life support training for staff on frontline duties.

Emergency response

90. The emergency response from healthcare staff was timely. The clinical review noted that every effort was made to resuscitate the man. However, when staff responded to the emergency Code 1 call, they did not bring a defibrillator and the emergency bag which resulted in a minimal delay. The clinical reviewer notes that because CPR was carried out during this time, it was unlikely that the equipment would have made a difference to his chance of survival. It is essential however that all necessary equipment is immediately taken to a life threatening situation.

All emergency equipment should be brought to the scene as soon as a Code 1 call is made.

Family concerns

91. When the man's daughter visited the prison, she was surprised to see a carpet runner and vase of flowers in her father's cell. The prison explained to the investigator that the carpet was placed on the floor to avoid the family having to see marks left as a result of the resuscitation attempt. I am content that this was done with the best of intentions, although I have suggested the prison consider the impact of making such decisions without talking to the family beforehand.

Access to illegal drugs

92. I have come across the supply of unprescribed drugs in many investigations I have conducted following the death of a prisoner. I am aware that the Prison Service work hard to combat this illegal trade within their establishments and Lincoln is no different. I am pleased therefore that Lincoln security department and the police shared intelligence which resulted in prisoners being charged with supplying drugs to the man who died.

Breaking the news of the man's death to his family

93. In the supplementary guidance to chapter four of the Prison Service Order 2710 (entitled "Follow Up to Deaths in Custody"), prison governors are given advice as to how news of a death should be broken to relatives. A "recommended option" is given:

> 4.9 The family should be informed face to face as soon as possible after the death. Wherever possible, this should be done by a dedicated Family Liaison Officer working alongside the Chaplain, or Governor or most senior individual available together with the Chaplain. No member of staff should be deployed alone. The police should be told that the visit is to be made and, if judged necessary, should be asked to escort the team or remain nearby. If a dedicated Family Liaison Officer is available for deployment, the duty governor can remain in charge at the scene. This option is recommended because it is what families and agencies that work closely with them say they prefer and expect; it shows that the death is being taken seriously by the prison; and it may help prevent the case running for many years at great cost. If face-to-face prison notification is not possible, there should be swift face-to-face follow-up."

94. Of the previous four reports I have issued concerning deaths in custody at Lincoln, all have noted that news of the death was not broken to family members by a member of prison staff. On three occasions, this was because of information given by the police; the fourth was because of the distance from the prison to the family's home (a distance of 75 miles). While there may have been good reasons for not visiting each family, I am concerned that Lincoln have not followed (or thought they were in a position to follow) the PSO's recommended option on so many occasions. Given that, once again, the news of a death at Lincoln was not broken by staff from the prison, I feel that it is appropriate that the Governor examines FLO procedures at Lincoln and assures himself that staff are confident about undertaking this crucial role.

The Governor should assure himself that the provisions of PSO 2710 are followed when breaking bad news to families, and that the appointed staff are confident about the role.

CONCLUSION

95. The man who died had been recalled to prison after breaching the terms of an earlier licence. On arriving at Lincoln, he told staff that he had no health problems. During his time in custody, he gave little concern to staff at Lincoln.

96. On the evening of 16 August 2009, he used both Subutex and cannabis. Shortly afterwards, he told his cell mate that he felt unwell. His cell mate alerted staff who, in turn, informed healthcare staff. Unfortunately, it seems that, because of a staff handover, no one from healthcare visited him at this time. The clinical reviewer believes that had assistance been provided to him at this time, his chances of survival would have been much improved.

97. A little later, the man's cell mate found him apparently dead. Although resuscitation was attempted, it was unsuccessful and he was pronounced dead at 10.32pm.

98. This investigation has found that systems in healthcare need to be reviewed so that information is passed effectively between staff. Other recommendations have been made concerning first aid training for frontline staff, and about visiting families to break bad news.

RECOMMENDATIONS

To the Head of Healthcare:

1. The process for assessing and communicating the details of prisoners who develop acute health care problems should be completely reviewed.

   The Prison Service has accepted this recommendation

2. There should be a system which allows assessment and documentation of the nature of any acute medical complaint, including time of call, presenting complaint, the effect that this complaint is having in terms of breathing, circulation, conscious level and general condition.

   The Prison Service has accepted this recommendation

3. There should be a triage or assessment system in place to enable prisoners who develop acute, potentially life threatening problems to receive prompt, skilled assistance within an equivalent time frame to the 999 emergency response provided by the Ambulance Service within the community. Less urgent problems should be reviewed by the most senior member of health care staff available to decide on the type and speed of response.

   The Prison Service has partially accepted this recommendation

4. All emergency equipment should be brought to the scene as soon as a Code 1 call is made.

   The Prison Service has accepted this recommendation

To the Governor:

5. The Governor should review the need for first aid or basic life support training for staff on frontline duties.

   The Prison Service has accepted this recommendation

6. The Governor should assure himself that the provisions of PSO 2710 are followed when breaking bad news to families, and that the appointed staff are confident about the role.

   The Prison Service has partially accepted this recommendation