

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in January 2013
at HMP Lincoln**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, a prisoner at HMP Lincoln. He died of a heart attack in January. He was 60 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer conducted a review of the man's clinical care in custody.

The man already had a number of chronic medical conditions when he first arrived in prison in March 2011. He was an insulin dependent diabetic, took medication for high cholesterol and had hearing and mobility problems. He did not manage his diabetes well, but nurses encouraged him to make better lifestyle choices. In January 2013, he was found unconscious by another prisoner. Resuscitation efforts by staff and paramedics were unsuccessful.

The man had long-standing diabetes and other related factors, such as high cholesterol and raised blood pressure, which placed him at significant risk of a heart attack. These conditions were managed satisfactorily, although on one occasion a recommendation for a specialist referral was not actioned. Similarly, while it did not affect the outcome for him and has since been addressed by the prison, the emergency code system used to alert staff to his collapse was inadequate and did not ensure that an ambulance was called immediately. Overall, however, I am satisfied that he received satisfactory care at Lincoln and his death could not have been foreseen or prevented.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was remanded into custody at HMP Wormwood Scrubs on 11 March 2011. He was sentenced to 12 years imprisonment for sexual offences on 25 August 2011 and transferred to HMP Lincoln on 9 November 2011. He had mobility problems and used a walking stick when he came to prison. He was prescribed medication for joint pain and high cholesterol. He was type 1 diabetic and self-administered daily insulin injections. There was no indication that he had heart disease, although he had borderline high blood pressure which, together with raised cholesterol, indicated an increased risk of heart problems.
2. The man had suffered from diabetes for over 30 years and the illness had affected his eyesight. He did not manage his diabetes well, was overweight and, partly because of his mobility problems, took little exercise. He was routinely monitored at the diabetic and older prisoner clinics at Lincoln.
3. In late January 2013, another prisoner noticed the man was slumped and unresponsive in a chair in his cell. He alerted prison staff, and nurses attended who tried to resuscitate him. Paramedics arrived shortly afterwards, but despite their efforts, he was pronounced dead.
4. The man had nominated a solicitor as the point of contact in an emergency, who was told of his death. His aunt was identified as his next of kin the next day and prison staff then visited her to explain what had happened and offer support.
5. The clinical reviewer concludes that the man received a satisfactory level of care at Lincoln. We make two recommendations, about checking emergency equipment and about referrals to specialist clinics.

THE INVESTIGATION PROCESS

6. The Ombudsman was notified of the man's death on 27 January 2013. The investigator issued notices informing staff and prisoners at HMP Lincoln of the investigation and asking them to contact her with any relevant information. No one responded.
7. The investigator visited HMP Lincoln on 1 February. She met the Governor and other relevant staff, and obtained copies of the man's medical and prison records. She visited the wing where he lived and the healthcare unit. She spoke to staff who knew him, as well as prisoners who worked and socialised with him.
8. The local PCT appointed a clinical reviewer to review the man's clinical care. She was given his medical records.
9. The investigator returned to Lincoln on 19 and 20 February and interviewed four members of staff and one prisoner. She conducted a telephone interview with another member of staff on 18 February. She fed back to the Governor throughout the investigation and confirmed her feedback in writing on 22 February.
10. The investigator contacted Lincolnshire Ambulance Service, who provided details of the contact they had with the prison on 27 January.
11. HM Coroner for Lincolnshire was informed of the investigation and a copy of the report has been sent to him.
12. One of this office's family liaison officers contacted the man's next of kin on 18 February, to explain the purpose of the investigation. His next of kin had no specific issues for the investigation to consider.
13. As part of the consultation period the man's family received a copy of the draft report. They commented on the importance of exercise for him and other prisoners in a similar situation to him and agree with the recommendations made. The family said overall they feel the treatment he received was fairly good.

HMP LINCOLN

14. HMP Lincoln is a Victorian prison which holds over 700 remand and convicted prisoners. It consists of four main residential wings, one of which holds vulnerable prisoners (usually due to the nature of the offences). This is where the man lived at Lincoln. Healthcare is commissioned by the NHS and provided by a private company.

HM Chief Inspector of Prisons (HMCIIP)

15. HM Chief Inspector of Prisons' most recent inspection of Lincoln was in August 2012. HMIP were concerned that Lincoln had deteriorated sharply since the last inspection in 2010. Despite the negative findings of this inspection, staff prisoner relationships were found to be good, with good care for older prisoners. HMIP found that chronic disease management was developing, with the input of suitably trained designated lead nurses.

Independent Monitoring Board (IMB)

16. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The last report published by the IMB for Lincoln for the period 1 February 2011 to 31 January 2012, noted that in the Board's view, the prison had made positive progress.

Previous deaths at Lincoln

17. The man's death was one of three deaths in the past year at HMP Lincoln. There were no common areas of concern. The issue of using a clear emergency code has arisen before and we are pleased to see that a new emergency code system has been introduced.

KEY EVENTS

18. The man was born in February 1952 and lived in Essex. He was remanded into custody on 11 March 2011 and was taken to HMP Wormwood Scrubs. On 25 August 2011, he was sentenced to 12 years imprisonment. He had not been to prison before.

HMP Wormwood Scrubs

19. At his initial health screen, the man told a nurse that he had been diagnosed 30 years previously with type 1 (mellitus) diabetes and was insulin dependent. He said that he had high cholesterol and suffered from back and joint pain for which he was prescribed pain relief. He had hearing difficulties and had hearing aids for both ears, although he did not always use them. He was referred to a prison doctor, who prescribed metformin and lantus (for diabetes), gabapentin and co-dydramol for pain relief, and simvastatin (to reduce cholesterol). He told the doctor he felt depressed and was prescribed citalopram (antidepressant medication). His blood pressure was normal 115/80 (the normal range for blood pressure is 100/70 to 140/90), his pulse high at 90 bpm (beats per minute – the normal range is 60-80) and he was overweight at 123kg. He did not smoke and had no history of drug or alcohol misuse. He declined to be located on the vulnerable prisoner unit.
20. Throughout his time at Wormwood Scrubs, the man was seen twice daily by healthcare staff when his blood glucose was measured and he self-administered insulin. His weight and blood pressure were monitored regularly. He was referred to a podiatrist, optician and dentist. He had regular blood tests and reviews in the prison diabetic clinic, to ensure that his diabetes was being managed and he was not developing other known complications associated with diabetes. He was given health education advice about his diet and exercise. On 15 August, he weighed 112.3kg, his blood pressure was recorded as normal 144/87 and his pulse was within normal range (78bpm).

HMP Wandsworth

21. After he was sentenced the man transferred to Wandsworth on 1 September. A prison doctor examined him and his medication was continued, although he did not receive his insulin until 3 September. (The clinical reviewer has commented on this delay and a copy of her review has been sent to the Head of Healthcare at Wandsworth). On 6 September, he attended the prison diabetic clinic for a routine review when he was supplied a machine for testing his blood sugar level. His blood pressure and pulse were normal. He asked to be located on the vulnerable prisoner unit.
22. On 9 September, another prison doctor examined the man as he was feeling dizzy and had vomited. Healthcare staff monitored him closely to ensure that his blood sugar was within normal range. After a few days he said that he was feeling better.

HMP Lincoln

23. The man transferred to HMP Lincoln on 9 November 2011. When he arrived, his medication for diabetes, high cholesterol and pain relief were continued. He was referred to the prison doctor for a review of his physical health and medication, which was completed on 25 November. He was located on E wing for vulnerable prisoners and lived in a single cell on the ground floor because of his reduced mobility.
24. On 9 February 2012, a prison pharmacist reviewed the man's medication. He recorded that the man had a good understanding of his medications and reported no side effects. His pain was now managed by codeine phosphate and paracetamol and not gabapentin as at previous prisons (although not a controlled substance, gabapentin is often restricted in prisons because of the possibility of misuse and to reduce the potential for bullying for medication). He told the pharmacist that he was having problems with his eyesight. He was told to make an application to see the optician whom he saw on 21 March and was prescribed two pairs of glasses.
25. A nurse assessed the man on 7 March at the prison diabetic clinic. He completed routine blood tests and gave advice on foot care. The nurse recorded his blood pressure as borderline high (146/87) and his pulse was high (105bpm). He remained overweight at 124kg and he had reduced sensation on the underside of his feet (which is common in those with diabetes). He was given an adapted chair for his cell.
26. The man's blood pressure was monitored regularly and he was also reviewed monthly at the older prisoners' clinic when he was given advice on personal care. He was also seen by a podiatrist and dentist. On 30 July, a nurse created an older persons' care plan and gave him advice on foot care and healthy eating. Dietary advice was reinforced by a nurse practitioner during his monthly review on 3 September. A nurse saw him on 19 September, as his blood tests showed raised glucose levels due to his poor diet. She gave him advice on healthy eating and requested that he kept a food diary. She told him he would be referred to the prison doctor for a review of his medication if his blood results did not improve.
27. On 9 October a nurse was alerted by prison officers that the man's empty medication bags had been found on the wing and there were concerns that he was being bullied for his medication. She spoke to him, who said that he was not being bullied. He said he sometimes forgot to take his lunchtime medication and the nurse referred him to the prison doctor. On 16 October, a prison doctor reviewed his medication and altered the prescription so that he did not miss his lunchtime dose. She queried the combination of his diabetic medication and wrote to a diabetic specialist for advice. On 27 November, a letter from the diabetic consultant was received stating he needed to be referred to the Intermediate Diabetic Team. Although there is a note on the medical record from the prison doctor asking how this referral should be made, it was never completed.

28. The man's annual care plan was reviewed on 14 December, and he was given ongoing advice about foot care. On 14 January 2013, he saw an eye specialist at the hospital and was given an appointment for a routine follow up on 18 July 2013.

The day of the incident

29. One Sunday in January the man did not go to work as it was a weekend. The regime on E wing meant that all prisoners were unlocked and able to socialise in the morning and afternoon. Prisoner A, a friend of the man, told the investigator that he had seen him in the morning, but he had not come out of his cell in the afternoon. He told the investigator that he did not find that unusual as he often preferred to stay in his cell. The man had not mentioned feeling unwell. Nurse A visited him in the afternoon, around 2.00pm, to check on him as normal. She told the investigator that he had not appeared unwell and that he did not mention feeling ill.
30. At about 4.25pm, E wing prisoners were out of their cells and collecting their meals from the servery on the ground floor. Prisoner A walked past the man's cell and saw that he was slumped over in his chair. Initially he thought he was picking something up from the floor and that he did not respond when he called his name because of his poor hearing. He went into the cell but got no response from him, and so went to tell prison staff. He told a Senior Officer (SO) that the man was unresponsive. The SO and an officer went to the cell. The SO said that she did not think he was breathing and asked the officer to get healthcare assistance. The officer went up one flight of stairs to the treatment room on E wing and asked Nurse A for help.
31. Nurse A went straight to the cell. She took an emergency medical bag but, as she had not heard an emergency "code one" (a code used to alert staff to a potentially life threatening situation and the need for urgent assistance) and was not summoned with urgency, did not take a defibrillator. She described the man as warm but cyanosed (when the skin turns blue due to a lack of oxygen) and she could not feel a pulse. Nurse B, who had been dispensing medication on C wing was alerted to the emergency by the officer (at Nurse A's request) and joined her shortly afterwards.
32. At 4.26pm, the SO radioed the control room (the area in the prison that co-ordinates all radio requests) for more healthcare staff to attend and for emergency equipment to be brought to the cell. At 4.27pm, the officer radioed a code one emergency. The nurses had moved the man to the floor and Nurse A began CPR while Nurse B went to get a defibrillator (a portable electronic device that diagnoses heart rhythms and can administer a shock to restart the heart) from the nurses' room on E wing.
33. When he returned Nurse B attached the defibrillator to the man and inserted a tube into his airway. The defibrillator's reading indicated that his heart was not in a shockable state. Staff found the oxygen cylinder in the emergency bag too tight to open so an officer got another emergency bag from nearby C wing. This

oxygen was attached to the airway tube, while CPR continued. Another nurse joined her colleagues and assisted in the resuscitation attempt.

34. An ambulance was requested by the duty governor at 4.29pm. Lincolnshire Ambulance Service sent two paramedic teams, who arrived at 4.34pm at the prison gate and were at the man's cell by 4.40pm. They assessed him, continued with resuscitation, but at 5.09pm he was pronounced dead.

Support for prisoners

35. The Governor issued a notice announcing the man's death, and expressing his condolences. The notice reminded prisoners of the available support from officers, the prison chaplaincy and Listeners (prisoners trained by the Samaritans to provide confidential support other prisoners). All those subject to suicide prevention monitoring were reviewed and offered additional support, in case the death had affected them.
36. A memorial service was held at the prison on 28 January, for prisoners who wished to pay their respects.

Liaison with the man's next of kin

37. A family liaison officer was appointed. When the man first went to prison he did not give details of a next of kin but asked for his solicitor to be contacted in an emergency. The prison informed the duty solicitor immediately after his death. According to pin phone records, he made regular contact with somebody he described as a friend. The family liaison officer contacted this friend in order to establish if there were any family contacts, and discovered that this friend was in fact his aunt. She therefore broke the news of his death to his aunt over the telephone, but she and a prison manager went to meet her in person later that day to explain the circumstances of his death and provide support.
38. The man's family visited the prison on 6 February and the prison arranged the funeral, which was held on 13 February. The family liaison officer and her deputy maintained contact with the family over the next few weeks to provide support.

Support for staff

39. The duty governor held a hot debrief for officers who were with the man when he died (a hot debrief is a meeting immediately after an incident, designed to reassure staff, and provide them with support). Healthcare staff did not attend as the debrief was arranged while they were still with the paramedics. The Governor met them shortly afterwards and held a second meeting. Officers and healthcare staff told the investigator that they had felt generally well supported.

Post-mortem report

40. A post-mortem examination was undertaken on 28 January 2013. The coroner stated the man died of ischaemic heart disease (damage to the heart caused by poor blood flow) resulting in a sudden fatal heart attack, as a result of coronary

artery atheroma (narrowing of the heart arteries) and diabetes mellitus (known to increase the rate at which atheroma develops) was an indirect contributory factor.

ISSUES

Clinical care

Management of diabetes

41. On 16 October 2012, the prison doctor sought advice from a diabetic specialist about the man's insulin medication. A letter was received at Lincoln on 27 November advising that a referral should be made to the Intermediate Diabetes Team. This was never done. The clinical reviewer concludes that, despite the lack of referral, it was unlikely that any change in medication would have significantly improved his diabetes control before his death.
42. While it would appear that the lack of referral and specialist review was not a causal factor in the man's death, we consider that referrals for specialist consultation should be timely.

The Head of Healthcare should ensure that consultants' recommendations for referral to specialist services are acted on promptly.

Emergency response

43. Because the nature of the incident she was attending was unclear Nurse A did not originally take a defibrillator with her. This had to be requested and collected by another nurse from a nearby treatment room. The nurses could not switch on the oxygen cylinder in the emergency bag, and a second emergency bag had to be brought. The oxygen cylinder was not faulty, but the design of the cylinder made a firm grip difficult, especially if it has been over tightened. The clinical reviewer notes:

"There was a delay of a few minutes in the provision of an AED [automatic external defibrillator] at the man's cell following the discovery of his collapse. There was also a delay in providing oxygen supplementation to the bag valve mask used to deliver rescue ventilation during CPR. It is unlikely that these delays had an adverse effect on the outcome of CPR as Post Mortem examination suggests that he had been dead for some time prior to his discovery and the chances of successful resuscitation following cardiac arrest diminish rapidly within 6 to 8 minutes following collapse. His lungs were congested and fluid filled which would have made ventilation difficult and further reduced the chances of successful resuscitation."

44. We are concerned that, although not faulty, the oxygen cylinder in the first emergency bag was not able to be used. We make the following recommendation:

The Head of Healthcare should ensure that emergency equipment is checked regularly and is ready to use at all times.

45. Healthcare staff were alerted to the man's collapse in person by an officer, although they were not given specific information about the nature of the incident. In many prisons a specific 'red' (for emergency blood injuries) or 'blue' (for emergency breathing difficulties) code system via radio is used when requesting healthcare assistance. The advantage of a code system is that each code can alert staff to the specific type of emergency, enabling the appropriate equipment to be brought to the emergency and prompt calling of an ambulance. We are satisfied that in the case of the man there was no undue delay in obtaining medical assistance because of the close proximity of the treatment room to his cell. We consider an ambulance should have been called at the same time that healthcare staff were alerted to his collapse. As it appears he would have been dead for some time, it does not appear that this would have made a difference to the outcome in his case, but this could make a significant difference in future medical emergencies.
46. Following the investigator's initial feedback on 1 February, the Governor introduced a new radio code system at a full staff meeting on 20 February. Two codes were introduced, red and blue as outlined, and a Notice to Staff (NTS 049/13) was also issued on 22 February clarifying procedures and in what situations an emergency code should be used. The new instruction requires an emergency ambulance to be called immediately a code red or blue is called.
47. In view of this change in practice, we do not make a formal recommendation.

Informing the next of kin

48. The news of the man's death was broken to his next of kin over the telephone. PSI 64/2011 states in Chapter 13:

"Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.

Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison.

If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable."

49. The family liaison officer had no details of a next of kin and used her initiative to try and track down any family members. Unfortunately the man had described his aunt as a friend and it was because of this that the news of his death was broken to her over the telephone. Nevertheless prison staff went immediately to the man's aunt's home to talk to her in person. We consider this was appropriate

in the circumstances, and family liaison following the man's death was well managed.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that consultants' recommendations for referral to specialist services are acted on promptly.

Accepted: *In this case, the GP had made the referral but it was not received. The system now in place is that the Healthcare administration staff manage all referrals to external clinics and monitor replies etc to ensure appointments are received in a timely manner. Target date: Completed and ongoing.*

2. The Head of Healthcare should ensure that emergency equipment is checked regularly and is ready to use at all times.

Accepted: *All emergency equipment is checked on a daily basis and after every use. On this occasion the nurse had experienced difficulty opening the oxygen cylinder valve however, this was due to over zealous tightening on the last check. All records are up to date and evidence that the checks took place as per policy. All staff have been advised however, to be mindful of how tight they turn the valves. Target date: Completed and ongoing.*