PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP Lindholme in March 2011

Report by the Prisons and Probation Ombudsman for England and Wales

June 2012

This is the report of an investigation into the death of a man at HMP Lindholme. The man died in March 2011. The cause of death was a myocardial infarction (heart attack) caused by damaged arteries I offer my condolences to his family and those affected by his death.

The investigation was carried out by one of my investigators. I am grateful to Doncaster Primary Care Trust for the appointment of the clinical reviewer. HMP Lindholme fully co-operated with the investigation. I apologise for the delay in issuing this report.

The man was remanded into custody in 1988 and sentenced to life imprisonment. He was released on license on 17 January 2006 but this was revoked three months later and he returned to prison. His health was satisfactory until early 2011 when he suffered symptoms consistent with a number of mini strokes. He was quickly referred to hospital when this happened and the clinical review of his care found that he received a good standard of medical care while in Lindholme.

There are no concerns about the quality of healthcare the man received in prison indeed aspects of it were considered best practice by the clinical reviewer. The man's next of kin also spoke highly of the support they received. However, it is disappointing that, despite a recommendation in a previous report that a deceased's family should be notified in person of the death by prison staff, this did not happen. Matters were left to the police. Although this was expeditious, a recommendation is made that best practice is adhered to in future.

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 **June 2012**

CONTENTS

SUMMARY

1. In July 1988, the man was convicted of manslaughter and sentenced to life imprisonment. He was sent to HMP Wormwood Scrubs. The man was released on license on 17 January 2006. However, on 13 April 2006, the man's license was revoked and he was sent to HMP Lincoln. On 19 April, he transferred to HMP Lindholme.

2. The man remained in good health until 27 January 2011, when he was seen by prison doctor A having bitten his tongue as he woke. He also complained of pain and weakness in his left arm, and dysarthria.[1] In view of the man's symptoms that morning, the doctor suspected that he might have had a transient ischemic attack or mini stroke (TIA), and sent him by emergency ambulance to Doncaster Royal Infirmary.

3. The man was sent out to hospital again on 21 February having bitten his tongue while asleep again. On this occasion, he was referred to the TIA clinic in the outpatients department. No specific treatment was given at the hospital and he was returned to prison on the same day. The man attended the TIA clinic on 8 March.

4. On 11 March at 6.45am, Officer A started the roll count[2] on the man's wing. Officer A opened the man's door and, believing him to be asleep, shut the door and continued on with his duties. Concern was raised when a friend of the man's asked one of the officers to check on him because he had not come out of his room. Officer B went to the man's cell and found him unresponsive, face down in his bed.

5. The alarm was raised and Nurse A attended. After examination, the nurse advised prison staff that resuscitation attempts would not be successful because rigor mortis[3] had already set in. Nurse A believed that the man had been dead for some time. The paramedics arrived and confirmed that the man was dead at 9.19am. His next of kin was identified and staff from Derbyshire police notified them of the man's death.

6. The results of the post mortem showed the cause of death as myocardial infarction[4] caused by coronary artery atheroma[5].

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[1] Dysarthria is a condition that occurs when problems with the muscles that help you talk make it difficult to pronounce words.

[2] A roll count is a physical count of all the prisoners on the wing.

[3] Rigor mortis is the stiffening of the joints which occurs after death.

[4] A myocardial infarction is more commonly known as a heart attack. Myocardial infarction (MI) means that part of the heart muscle suddenly loses its blood supply.

[5] Coronary artery atheroma is a disease of arteries which restricts the blood flow to the heart. An atheroma is a condition marked by deposits of small fatty nodules on the inner walls of the arteries

THE INVESTIGATION PROCESS

7. The investigation was opened on 18 March 2011, when my investigator visited Lindholme. She issued notices inviting staff and prisoners with information relating to the investigation to come forward. There was no response to the notices.

8. My investigator collected copies of the man's prison files, including his medical records. She visited his cell on A wing and the healthcare unit. My investigator also met the Governor of Lindholme and discussed the scope of the investigation with him. My investigator wrote to the Governor of Lindholme on 22 April 2011 to provide initial feedback on the investigation.

9. A clinical review of the man's healthcare in prison was carried out by the clinical reviewer on behalf of Doncaster Primary Care Trust. The clinical review is attached in full as the first annex to this report. The draft report has been delayed in part by the length of time taken to complete the clinical review into the man's care, which was not received in the Ombudsman's office until February 2012. We are sorry that pressures of work in the office led to further delays after that.

10. One of the Ombudsman's family liaison officers contacted the man's next of kin, his cousin, to inform him of the investigation and to provide an opportunity to raise any issues for consideration as part of this. No issues were highlighted at the outset of the investigation. The man's cousin spoke very positively about the care and support he received from staff at Lindholme following the man's death. He said he could not fault their professionalism or thoughtfulness. He mentioned that the man's funeral was carried out with dignity and that he was grateful to staff for their assistance.

11. The man's cousin received a copy of the draft report. He was satisfied that the man was treated well by all of the staff at Lindholme and said the funeral arranged by the prison was of the highest quality. The man's cousin agreed with the recommendation that news of a prisoner's death should be broken in person by someone from the prison.

12. With regard to the medical care the man received at Doncaster Royal Infirmary, the man's cousin said he was aware it was outside the remit of this office but wished for it to be recorded that he was not happy with the care the hospital provided.

13. The National Offender Management Service responded to the draft report. They identified no factual inaccuracies and we include their response to the recommendation at the end of the report.

HMP LINDHOLME

14. HMP Lindholme is located approximately 10 miles north of Doncaster on the site of a former Royal Air Force base. Lindholme is a split site consisting of a category C and category D prison.[6] The category C site consists of 11 residential units. The man was located on A wing. Nottingham NHS Trust took over healthcare provisions from Serco in 2010. The services provided include a daily GP clinic and a limited range of specialist clinics.

Her Majesty's Chief Inspector of Prisons

15. The most recent report by Her Majesty's Chief Inspector of Prisons (HMCIP) on Lindholme was published in January 2011 following an unannounced short follow up inspection. In this report, the Chief Inspector wrote:

> "Healthcare was delivered in a separate building, which had been refurbished in the previous year. The building was clean and spacious and provided a good environment for the treatment and care of patients. Prisoners had access to primary care, mental health, dental and specialist clinics. Prisoners' access to a GP was satisfactory, with clinics available each weekday and acceptable waiting times."

Independent Monitoring Board

16. The Independent Monitoring Board[7] published their most recent report in January 2011. In this report, the Board commented: "A much needed refurbishment programme of the Health Care building was completed and opened in September 2010 thereby providing modern facilities for both medical staff and prisoners."

Previous deaths at HMP Lindholme

17. There have been nine deaths at Lindholme since the Ombudsman's office took on the responsibility for investigating deaths in custody in 2004. Seven of these deaths were due to natural causes. The last two deaths caused by a heart attack occurred in the prison gymnasium. Despite the cause of death being the same, there are no other direct similarities with the man's death. However, a previous investigation by this office found that Lindholme had not acted in accordance with Prison Service Order 2710 (Follow up to a death in custody)[8], when they broke the news of a prisoner's death to their family. A recommendation was made to ensure that staff acted in accordance with the PSO. We repeat the recommendation in this report.

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[6] A category C prison holds adult male prisoners who cannot be trusted in an open prison but are unlikely to try to escape. A category D prison holds adult male prisoners who are a low risk and are unlikely to escape.

[7] Members of the Independent Monitoring Boards (IMB) are appointed to each prison from members of the community by the Secretary of State for Justice to ensure that the prisons are run humanely. They are required to produce an annual report to the Secretary of State on the prison, highlighting good practice and flagging up areas of concern.

[8] PSO 2710 provides instructions on actions to be taken following a death in custody.

KEY EVENTS

18. In July 1988, the man was convicted of manslaughter and sentenced to life imprisonment. In July 1998, he was transferred from HMP Wormwood Scrubs to Rampton Hospital, a high security psychiatric hospital. The man returned to prison custody in 2002. In June 2004, while at HMP Kingston, the parole board recommended that the man be transferred to open conditions. He moved to HMP Sudbury before being released on license on 17 January 2006.

19. On 13 April 2006, the man's license was revoked after an incident at the approved premises he was staying at. He returned to custody at HMP Lincoln before moving to HMP Lindholme on 19 April.

20. On arrival at Lindholme, the man underwent a reception healthscreen to assess his immediate medical needs. The man mentioned an incident of self-harm while at HMP Maidstone in 1992, and his previous psychiatric treatment at Rampton hospital in 1998. The man raised no concerns about his physical health and, after assessment by the reception nurse, it was noted in his medical file that he was fit for normal location and cell occupancy. At this time, the only medical intervention he received were creams and lotions for psoriasis and eczema.

21. On 21 May 2007, the man was seen by a consultant psychiatrist for the purpose of producing a psychiatric report for the Parole Board. The man said he wished to remain in prison due to his feelings of remorse about his offence.

22. The man's medical record does not include any significant events until January 2011. (His interactions with healthcare staff during this time concerned dental appointments and treatment for his skin conditions.) On 27 January, he was seen by prison doctor A, after he woke up having bitten his tongue. He also complained of left sided pain and said he had weakness in his arm. He also suffered from dysarthria. A note was made in the man's medical record to say that he had previously suffered from two transient ischemic attacks.[9] It is unclear when the man suffered the previous mini strokes because they were not detailed in his medical notes.

23. In view of the man's medical history and his symptoms that morning, Dr A suspected that the man might have had another mini stroke. The man was sent by emergency ambulance to Doncaster Royal Infirmary. On route to the hospital, ambulance staff assessed the man's condition. His blood pressure was recorded as high (170/105). Ambulance service records show that the man said that he had experienced facial droop before the event, and suffered from headaches and pain in his limbs for roughly three weeks. He did not

[9] A transient ischemic attack (TIA) is when blood flow to a part of the brain stops for a brief period of time. A person will have stroke-like symptoms for up to 1-2 hours. It is often known as a mini stroke.

have chest pain or nausea, had normal vision, and no limb weakness although he had a slight limp in his left leg. An electrocardiogram was carried out which showed a first degree heart block and ventricular standstill. This reading was given to doctors at the accident and emergency department on his arrival at hospital.

24. The man was assessed for his slurred speech and left sided weakness at Doncaster Royal Infirmary. He demonstrated a degree of recovery. His blood pressure was recorded as 124/88. Hospital staff assessed the man and diagnosed him with the onset of a viral infection. The man was advised to take pain relief for muscular pain and was discharged back to prison.

25. The man attended healthcare on 13 February complaining of headaches and nausea, and said that he felt similar to how he had felt before the events of 27 January. He also described muscle seizures where he said he was unable to move his limbs. His blood pressure was raised (142/94). Due to his family history of diabetes, blood and urine samples were taken to see if the man was diabetic. The results showed nothing abnormal.

26. On 21 February, the man saw prison doctor B. The man had bitten his tongue again while asleep and reported left sided facial weakness. The doctor noted the facial weakness and slurred speech. No limb weakness or numbness was observed. The doctor recorded that the man suffered from nocturnal fits and progressive dysphasia. His blood pressure was recorded as high (170/89). The doctor prescribed aspirin to thin the blood and simvastatin[10]. The man was sent for assessment at Doncaster Royal Infirmary accident and emergency department.

27. On arrival at hospital, the man informed the doctor that he had experienced increasing dysarthria, memory loss, intermittent arm and leg pains and regular incidents of biting his tongue during the night. Hospital records show that the man's reflexes were sluggish, with reduced co-ordination in his left hand. The man was referred to the TIA clinic in the outpatients department before he returned to prison.

28. The following day, the man returned to Doncaster Royal Infirmary for further assessment because he had woken after biting his tongue again. No specific treatment was given at the hospital and no discharge letter was issued.

29. On 8 March, the man attended the TIA clinic. His blood pressure was taken, which was within normal limits (120/70). An ECG showed his heart was beating normally and his heart had not been damaged by the reduced blood flow. It was explained to the man that epileptic seizures may have caused him to bite his tongue while asleep. A CT scan was booked for the man on 23 March.

30. At 6.30pm on 10 March, while beginning the evening roll check, Officer C saw the man stood in the doorway to his cell wearing his headphones. Officer C

[10] Simvastatin used for lowering cholesterol and other lipids (fats) in the blood.

said in his police statement that they had briefly chatted and the man appeared well.

31. On 11 March at 6.45am, Officer A started the morning roll check on A wing. During a telephone interview with the investigator, Officer A said that, because the observation panel in the man's cell door was covered, he unlocked the cell and went inside. He saw the man lying on his bed covered by a blanket. Officer A said he believed that the man was asleep and, for this reason, did not attempt to get a response from him. He was aware that the man had felt unwell and assumed that he was tired that morning. He closed and locked the door when he left the cell.

32. Officer D and Officer B arrived for duty at 8.00am, and received a handover from the night staff. At 8.25am, Officer B received a call over his prison radio asking him to open the entrance to the wing landings to allow the prisoners to go to work. After opening the landings, Officer B stood at the entrance with the list of names detailing which prisoners were to leave the wing. He commented that he waited for the man to come because he was always first off the list. The man did not arrive and Officer B was asked by another prisoner to check the man's cell because he had not been seen that morning.

33. Officer B went to the man's cell and knocked on the door. Having got no response, he unlocked the cell to find the man lying face down in bed. He touched the man but was unable to gain a response. Officer B commented in his police statement that the man's skin felt cold to the touch and he thought that he was dead. Officer B left the cell and told Senior Officer (SO) A what he had found. The SO called a code blue[11] over the radio to ask for medical assistance.

34. The SO said in his statement that, after requesting assistance over the radio, he went to the man's cell. He explained that he found the man on the bed, covered by his blanket. He removed the blanket and checked for signs of life. The SO was unable to find a pulse or any signs of breathing. He described the man to be cold to the touch. He said he was about to turn the man over onto his back to attempt CPR (cardiopulmonary resuscitation) when Nurse A and Nurse B arrived with the emergency bag.

35. In her statement, Nurse A said that the man's face and torso were discoloured and rigor mortis had set in. She explained that they were unable to open his mouth to insert an airway due to the stiffness in his jaw. Nurse A told SO A that resuscitation attempts would not be successful as she believed the man had been dead for some time.

36. After being alerted by the code blue call, prison managers, A and B arrived at the man's cell. An ambulance was called and the paramedics arrived at the man's cell and at 9.19am confirmed that he had died.

[11] A code blue call indicates a medical emergency related to breathing.

Contact with the man's family

37. The man's next of kin was his cousin. Derbyshire police officers went to the man's cousin's house to tell him of the man's death. The prison's family liaison officer (FLO) contacted the man's cousin by telephone at 3.00pm to introduce herself. She also offered to visit the man's family at their home. The man's cousin said that he was due to be out of the country for two weeks, so a home visit was arranged for 31 March. Lindholme met the costs of the man's funeral expenses, which took place on 11 April.

38. The investigator spoke to the Head of Safer Custody, about the prison's decision to ask the police to break the news of the man's death to his family. The Head of Safer Custody said that, while the prison, were aware of the requirements of Prison Service Order 2710, they decided that the police should visit the man's family because they were able to do so quickly. He explained that the man's family were informed of his death within half an hour.

Support for prisoners

39. SO A informed prisoners on A wing about the man's death. Prisoners were reminded that support was available from prison Listeners,[12] the chaplaincy team and the Samaritans[13].

Support for staff

40. Following the man's death, a hot debrief[14] was held by a prison manager which was attended by uniformed and healthcare staff. Staff were offered access to the prison's staff care and welfare team.

Post mortem report

41. The results of the post mortem examination showed that the cause of death was a myocardial infarction caused by coronary artery atheroma.

[12] The Listener Support Scheme is a peer support scheme where selected prisoners are trained to listen to prisoners who might be experiencing feelings of distress, including those which might lead to self harm or suicide.
[13] The Samaritans provide confidential emotional support on a 24 hour basis and are most commonly contacted via the telephone.
[14] A hot debrief should be held as soon as possible after the incident. The purpose of the hot debrief is to allow those involved to discuss any issues or concerns. The hot debrief should focus on reassurance, information sharing and how staff can support each other.

ISSUES

Clinical care

42. The clinical reviewer does not express any concerns regarding the level of care provided to the man by prison doctors. She comments that it is not possible to say definitely whether the man experienced transient ischemic attacks (TIAs) before his death. The prison doctor considered this a likely explanation as the man's symptoms were consistent with TIAs. On each occasion when the man presented with symptoms of a possible TIA, the prison doctor acted swiftly and appropriately by ensuring he was transferred for an assessment in hospital. The clinical reviewer considers that this was best practice.

43. The clinical reviewer expresses some concern about the care and treatment provided to the man at Doncaster Royal Infirmary. The care provided by the hospital staff is outside the remit of this investigation.

The discovery of the man

44. Shortly after 6.45am on the morning of 11 March, Officer A unlocked the man's cell and, having checked that he was present, he left the cell. At the time of the man's death Lindholme's operational instructions for staff carrying out the morning roll check stated that: "Any blocked observation panels must be cleared immediately to verify the occupant of the cell is present. Staff are accountable for any prisoners they check and sign for." The roll check Officer A completed was simply for security purposes and although he opened the cell door to check the man's presence he believed him to be asleep. Staff are expected to check the well-being of prisoners later in the morning from about 8.15 when they assemble for activities. It was at that point that officers went to check on the man.

45. Following an investigation by this office into another death at Lindholme, further operational instructions to staff carrying out the morning roll check were issued in August 2011. These state that if a prisoner has blocked their observation panel a response must be obtained from the prisoner in the cell.

46. The nurses did not attempt resuscitation when they arrived at the man's cell. Nurse A and Nurse B attended the man's cell and carried out an assessment of his physical condition. They believed he had been dead too long for resuscitation to be effective. The clinical reviewer comments that both nurses called to the scene of the man's death acted appropriately given the lack of signs of life.

Breaking the news of the man's death

47. There is specific guidance in Prison Service Order (PSO) 2710 (Follow up to a death in custody) on how the news of a prisoner's death should be passed on to their next of kin. The PSO says that Governors must:

> "Arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened."

48. The accompanying Family Liaison Officer (FLO) guidance recommends that:

> "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. If face-to-face prison notification is not possible, there should be swift face-to-face follow-up. Asking the police to inform the family may sometimes be necessary but the decision to do so should be based on an assessment of the factors listed above and not chosen as an easy option (which is how it can be and has been perceived by families)."

49. The investigator was told that Lindholme asked the police to break the news because they wished the family to be told as soon as possible. While speed is important, there are other factors to be taken into consideration when making a decision such as this, including sensitivity and using staff who can provide the family with information about the prison. There were no specific reasons in the case of the man that meant using a family liaison officer would be unsuitable.

50. This is not a criticism of the way in which the family liaison role was later carried out. The man's cousin spoke very positively about the help and support he received from the prison once contact had been initiated and commended them for the professionalism and thoughtfulness.

51. Despite the positive account from the man's cousin, it is disappointing that Lindholme asked the police to break the news. We have previously made a recommendation to Lindholme that the news of a prisoner's death should be broken to their family in accordance with PSO 2710. We are therefore concerned that, despite the previous recommendation, the man's family was told of his death by the police, rather than a dedicated family liaison officer. We therefore recommend the following:

The Governor should make every effort to ensure that the news of a prisoner's death is given to the next of kin promptly and in person by someone from the prison. When this is impractical, staff from a nearby prison should be used and failing that, the police.

CONCLUSION

52. The man raised no concerns about his physical health on his arrival at HMP Lindholme on 19 April 2006. He remained in good health until January 2011 when he began to complain of symptoms that prison doctors and the clinical reviewer considered consistent with mini strokes. Each time he complained of such symptoms, he was quickly transferred to hospital and the clinical reviewer does not raise any concerns about the standard of care the man received at Lindholme. The man's family were informed of his death by the police – a task we consider should have been carried out by the prison.

RECOMMENDATIONS

1. The Governor should make every effort to ensure that the news of a prisoner's death is given to the next of kin promptly and in person by someone from the prison. When this is impractical, staff from a nearby prison should be used and failing that, the police.

   The National Offender Management Service accepted this recommendation:

   "The establishment will ensure that the news of a prisoner's death is given to the next of kin promptly and in person by someone from the prison."

   "Since the death of the man, the establishment has unfortunately experienced a further two deaths in custody. In both instances the family have been notified by the establishment's Family Liaison Officer. Contingency plans have been amended to address this issue."

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