



**Investigation into the death of a man in September
2010 in Doncaster Royal Infirmary whilst in the
custody of HMP Lindholme**

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

June 2012

This is the report of an investigation into the death from heart disease of a man, who was only 40 years old when he died. The man collapsed whilst in the gym at HMP Lindholme in September 2010. Although staff provided first aid, his condition deteriorated and he was taken to Doncaster Hospital. He was pronounced dead shortly after arriving there. I offer my condolences to his family.

The investigation was undertaken by one of my senior investigators. I would like to thank the Governor of HMP Lindholme and his staff for their participation. Doncaster Primary Care Trust (PCT) commissioned the clinical reviewer to undertake a review of the man's clinical care. The clinical reviewer's report is attached as an annex to this report. One of my office's family liaison officers contacted the man's brother-in-law to explain the process and the purpose of our investigation. I apologise for the delay in issuing this report.

The man had completed a prison sentence, and was detained pending action by the immigration authorities. In September he went to the prison gymnasium, where he collapsed. Staff provided first aid, nursing staff attended, and an ambulance was summoned. Whilst awaiting the ambulance, the man stopped breathing. Staff performed resuscitation until ambulance staff arrived and took over, and he was taken to hospital. Sadly, he did not improve, and had died by the time he arrived at the hospital. The post mortem showed that he had been suffering from heart disease, and could have died at any time.

Until his collapse, the man presented few physical health issues but he was being treated in custody for mental ill health. The clinical reviewer identifies a number of weaknesses in this provision. While it is not evident that these deficiencies contributed to his death or that his death was predictable, the care he received was not of the standard he would have received in the community. Accordingly, a number of recommendations are made to address these issues.

In response to the draft report, the National Offender Management Service accepted five recommendations. The other two were partially accepted, remedial action already having been put underway to address the issues involved.

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.

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SUMMARY

1. The man had been in prison since July 2008, serving a sentence of four years imprisonment. He arrived at HMP Lindholme in January 2010. The man was a Pakistani national. His custodial sentence ended on 6 August 2010, and he was being held in Lindholme under immigration powers, with deportation papers having been served.
2. The man suffered with his mental health. He received medication, and was in regular contact with healthcare staff. The clinical review identifies a number of issues relating to the man's mental health care. Aside from complaining of chest pain on one occasion in August 2009, he did not present with any serious physical health problems.
3. On the afternoon of the day the man died, at approximately 3.00pm, prisoners from K wing, including the man, were at the wing's outer gate waiting to go through to the prison gymnasium. When the gate was opened, the prisoners surged forward and the man was knocked against the fence, causing him to fall to one knee. He did not seem to suffer any ill effects from this, although it was observed that he did limp slightly as he continued towards the gym.
4. Once in the gym, the man was using a piece of bench equipment to perform sit-ups, when he said he felt unwell. He got off the bench, and collapsed onto the floor. A fellow prisoner alerted staff, and put the man into the recovery position. Staff, who were first-aid trained, noted that although unconscious, he was still breathing. They asked for healthcare staff to attend, and when nurses arrived they requested an ambulance.
5. When the ambulance arrived, one of the nurses was briefing the paramedics when the man stopped breathing. The nurses and paramedics worked to resuscitate him, and he was moved to the ambulance and taken to hospital. Sadly, despite attempts at resuscitation he was pronounced dead in hospital at 4.05pm.
6. The man was subsequently found to have been suffering from heart disease. His heart could have stopped working at any time. The doctor who conducted the post mortem also noted that this could have been made more likely by exercise.
7. This report contains seven recommendations. These concern prisoner movement within the establishment, funeral costs, prisoners' understanding of their medication, the system to monitor prisoners taking anti-psychotic medication, the timeliness of mental health assessments, and the maintenance of medical records. The seventh recommendation asks the Head of Healthcare to address those recommendations contained in the clinical review which are not specifically addressed in this report. Five of these recommendations were accepted, and the remaining two partially accepted with remedial action already being undertaken.

THE INVESTIGATION PROCESS

8. HMP Lindholme provided the Ombudsman's Investigator with the man's prison record. The Ombudsman's Investigator also obtained the man's medical records. He visited the prison to formally open the investigation on 1 October 2010 and met with the Governor and Deputy Governor, representatives from the Prison Officers Association, and members of the chaplaincy. He spoke to staff and prisoners who knew the man, including the Imam and the man's personal officers.
9. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact the investigator. No further information was received.
10. Doncaster Primary Care Trust (PCT) conducted a clinical review of the man's care and treatment. This was undertaken by the clinical reviewer. The Ombudsman's Investigator discussed the report with the clinical reviewer. Unfortunately, the clinical reviewer had some problems in obtaining some information relating to mental health standards that she needed, and this substantially delayed her review. This in turn has led to a delay in publishing this report, and we apologise for any additional distress this has caused the man's family.
11. The Ombudsman's Investigator interviewed five members of staff and two prisoners. Notes of these interviews were forwarded to the interviewees, which they were invited to sign to confirm their accuracy. The notes of these interviews are attached as annexes to this report. The Ombudsman's Investigator provided interim feedback to the Governor at Lindholme during the investigation.
12. One of the Ombudsman's Family Liaison officers made telephone contact with the man's brother-in-law to explain the purpose and remit of our investigation and offer him the opportunity to raise any questions or concerns the family might have had. The Ombudsman's Family Liaison Officer followed up the telephone call with a letter summarising the call and reiterating the investigation process. The man's family made no response to the letter or further attempts to contact them by telephone. Therefore, it has not been possible to involve the man's family in the investigation process.
13. The Ombudsman's Investigator wrote to HM Coroner to inform her of the nature and scope of the investigation and to request a copy of the post mortem report. Throughout the course of the investigation, the Ombudsman's Investigator remained in contact with the Coroner's office. Upon completion, this report will be sent to the Coroner to assist her enquiries into the man's death.

The man

14. The man was born in January 1970. He was 40 years old when he died.
15. The man was born in Kashmir and was a Pakistani national. He was married to a UK citizen, and had lived here since the age of 23. There were five children from the marriage.
16. The man had been diagnosed as suffering from a mental illness. Since 2004 he had been suffering from psychotic symptoms (such as hearing or seeing things, or believing implausible things to be true). He was in regular contact with healthcare services in prison, and was receiving medication. He did not have any apparent physical health problems.
17. Having been convicted of a serious offence, immigration authorities had served the man with papers notifying him that he was to be deported. His prison sentence expired on 6 August 2010, and he continued to be detained in Lindholme under immigration powers awaiting deportation.

HMP LINDHOLME

18. HMP Lindholme is a purpose built category C training prison for adult males. (Category C prisons are for prisoners who are not suitable for open conditions, but for whom higher levels of security are not judged necessary.) It is on the site of a former Royal Air Force airfield and opened as a prison in November 1985. The accommodation has been converted from dormitory conditions into single occupancy rooms on lockable spurs. Within the last 9 years purpose built cellular accommodation has been erected. It has an operational capacity of 1010.
19. In addition to giving prisoners training for resettlement back into the community, HMP Lindholme is the Yorkshire and Humberside base for Foreign National Prisoners held under immigration powers. The man was housed in the main prison.
20. Nottingham NHS Trust took over healthcare provisions from an independent provider, SERCO, in 2010. A refurbishment of the healthcare centre was completed in September 2010, providing modern facilities for both medical staff and prisoners.
21. There is a general doctor's clinic every weekday and an out of hours service is also provided by the same primary care doctors. A limited range of nurse-led and specialist clinics are provided.
22. The mental health team consists of two community psychiatric nurses, one support worker and one administrator. A visiting psychiatrist provides a weekly clinic. Prisoners do not have access to professional counselling services. Mental health awareness training is provided for all prison staff.
23. The last inspection of Lindholme by Her Majesty's Inspectorate of Prisons, in January 2011, noted that a previous inspection in 2007 had reported significant shortfalls in a number of aspects of safety. During the latest unannounced inspection, Lindholme was found to be a much safer establishment, but still with a number of areas requiring further development. The Chief Inspector said:

"Commendably, staff and managers had addressed most of the weaknesses in safety that had concerned us on our previous inspection. Lindholme also remained an appropriately busy and purposeful training prison. However, there remained plenty of scope for further improvements."
24. Each prison in England and Wales is monitored by an Independent Monitoring Board of unpaid people drawn from the local community and appointed by the Secretary of State for Justice. Board members have full access to every part of the prison and all prisoners held there. The Board said in their annual report for 2010-2011:

“Despite the confident assertion by the present Healthcare provider Nottingham Health Care Trust that it could fulfil its contractual obligations, in practise this has not been the case. An inability to recruit a sufficient number of medical staff has prevented the Trust from delivering services promised and paid for by the Establishment. Under the present arrangements the prison has no redress.”

25. There have been five previous deaths at Lindholme due to natural causes since 2004, when the Ombudsman’s office took responsibility for investigating deaths in custody. The last death before the man’s also occurred in the prison gymnasium. The report on that investigation included a recommendation about ensuring that physical activity screening forms, known as PAR Q forms, were completed and safeguarded. In the early stages of this investigation, the prison was initially unable to locate the man’s PAR Q form. It later became apparent that the police had taken it, and the prison successfully obtained copies. Despite these similarities though, there are no other circumstances to compare the two deaths or the other previous deaths.

KEY ISSUES

26. The man was a Pakistani national and had lived in the United Kingdom since the age of 23. He had been in prison since July 2008, serving a sentence of four years imprisonment. After spending some time in HMP Hull and HMP Durham, he was transferred to HMP Acklington on 17 April 2009. During his induction and health screening, he told staff that he had mental health problems. Records note that his English was not good, and that he might have had learning disabilities. He was referred to the mental health team and he saw a Community Psychiatric Nurse (CPN) the following week. He said that he had in the past been in hospital for psychotic depression and reported hearing voices. He said that he felt lonely and isolated. He was placed on special measures to support those thought to be at risk of harming themselves (Assessment, Care in Custody and Teamwork, known as ACCT), and was no longer to have his medication in his possession.
27. A consultant psychiatrist assessed the man on 5 May 2009. The doctor noted that the man could be suffering from psychotic depression, and prescribed antidepressant medication. The man was speaking to his wife daily on the telephone, and she was in regular contact with the man's CPN.
28. During early August, the man complained of chest pain. Through an interpreter, he told staff that he had a dull ache on the left side of his chest. He did not have any other symptoms which might have indicated a more serious problem, such as the pain radiating (spreading outward) of shortness of breath. He was reported to have been tearful as he was struggling with not being understood. Paracetamol and ibuprofen (anti-inflammatory) were issued to help relieve the pain.
29. On 26 August, the man was seen by his CPN. His wife was contacted by phone to act as an interpreter for this consultation. She confirmed that the man had been served deportation papers, however she felt his mood had slightly improved despite obviously being worried about the deportation issue. The nurse noticed that he had a slight tremor during the meeting and discussed this with the prison pharmacist. The pharmacist said that the man's psychiatric medications, aripiprizole¹ and mirtazapine² could be the cause.
30. The man attended an appointment with a psychiatrist on 1 September. Following the meeting, the dose of his mirtazapine was doubled. Despite the dosage increase, his CPN noticed that he continued to show tremors as a possible side effect from his medication.
31. The man's mirtazapine was increased again on 22 September. A week later he reported that his mood had improved, but when he was seen by

¹ A mood stabiliser

² Used to treat major depression and anxiety

the CPN on 19 October, he said that the noises in his head were very loud and he was noticeably agitated. He was also suffering from akathasia³ in his legs. The akathasia had stopped by the time she saw him again at the end of November.

32. A doctor assessed the man's mental health on 10 November. Following the assessment, it was decided to stop the aripiprazole as it was not having a significant effect and it was thought it was causing the akathasia. Alternatively he was prescribed quetiapine (anti-psychotic medication). The doctor wrote to the prison GP to let him know of the change in medication and advised him on how the dosage should be issued.
33. At the end of December the man's CPN created a detailed care plan for him. She noted that he was on an enhanced level Care Programme Approach (CPA)⁴.
34. On 5 January 2010, the man was seen by his CPN. He told her that overall, he felt a little better, however his CPN noticed a slight restlessness in his legs. She completed the Barnes Akathasia rating scale⁵, which indicated that he was suffering from "clinically significant akathasia". A follow up appointment was then made for three weeks time.
35. The man was transferred to HMP Lindholme on 12 January. During his reception health screen, he appeared anxious and it was noted that he potentially had learning disabilities. It was recorded in his medical record that he was suffering from a mental illness and his current prescription was also recorded. He was referred to the Mental Health Team and a note was made that his first language was Punjabi, but that he understood some English.
36. As part of his induction, he completed a physical activity screening form to allow him to use the gymnasium⁶. He confirmed that he did not suffer from asthma, diabetes, epilepsy or low back problems and stated that he exercised three times a week. He did not detail any other information he thought might be relevant.
37. On 8 March, he was seen on the wing by a Mental Health Nurse and a support worker from the Mental Health In-Reach team (MHIT, those coming into the prison to help provide mental health services). An interpreter service was used to help conduct the interview and it was noted that his akathasia was evident throughout the meeting. He told the nurse that he was struggling to cope with the voices in his head and he felt

³ Also known as restless leg syndrome, whereby there is an urge or need to move the legs to stop unpleasant sensations.

⁴ A whole systems approach to mental health care, including a framework for the provision of coordinated care for people with complex mental health needs.

⁵ A series of observations during which the patient is scored on the severity of the symptoms they present. The higher the score, the more severe the akathasia.

⁶ Known as a PAR Q form.

frightened and lonely. He said that his medication was only effective for a short time after he had taken it.

38. The man also said to the nurse that he was having difficulty eating and reported vomiting after every meal. As a consequence, he was throwing his meals away. He said he would be happy to see a psychiatrist and it was planned to book an appointment to continue to monitor his mental state and well being.
39. On 10 March, one of the prison's mental health nurses contacted the Probation Service. They had been in touch with his wife, and she thought his mood had deteriorated. She spoke of his bizarre behaviour at the time of his offence, and wondered if his mental health had played a part in his offending. The nurse discussed the man with her team manager, and it was agreed that he might have been suffering from a psychotic illness. An assessment was arranged for 12 March. There is, however, no evidence that the assessment took place. It was noted in his next care plan review that medication to help reduce the symptoms of akathisia had still not been prescribed.
40. During March, an officer was allocated as his personal officer. This involved formal contact once a week, less formal day-to-day contact, and being his first port of call for any queries or problems, such as helping him deal with his deportation papers. In interview with the investigator, the personal officer described the man as a man of routine, who was naturally shy.
41. A Risk Management Panel, including medical and discipline staff, discussed the man's ongoing care on 29 March. That afternoon the visiting psychiatrist assessed the man. His quetiapine was increased to 200mgs twice a day and he was also prescribed procyclidine "as required". The prison regime and medication cards were not suitable to accommodate the "as required" prescription, so it was agreed that a GP review should take place. The psychiatrist felt that the man might have a learning disability and required an IQ⁷ test to ascertain this. He also requested blood tests and an electrical reading of the heart, known as an electrocardiogram.
42. On 4 April, a note was added to the man's medical record asking staff to ensure that he received his medications. Staff had reported concerns that he hadn't been collecting all his medication. This might have been due to language problems and the man possibly not being aware that he was due to collect them.
43. The man was reviewed by the visiting psychiatrist and a mental health nurse on 12 April. The man said that he felt his mental state and sleeping pattern had improved and he was having fewer side effects from his medication. His quetiapine was increased to 250mgs twice a day and a

⁷ Intelligence Quotient – standardised tests to assess intelligence

follow up appointment was booked for four weeks time. There is no evidence within his medical record that this appointment occurred. The man had also refused to have a blood test and there is also no evidence to suggest that this was reported to the psychiatrist or followed up.

44. On 9 June, one of the prison's mental health nurses noted that the man appeared downcast and was lethargic. She assessed him using Language Line⁸ and found him to be in a low mood. He said he was hearing voices and had thoughts of harming himself. She agreed to make an urgent appointment for him to see a psychiatrist.
45. The man was seen by the psychiatrist on 21 June. He said that the voices were getting worse and that they were telling him to harm himself and others, to damage his television and to set things on fire. He said he had a mixed appetite and sleep pattern and that he was giving some of his food away. He told the psychiatrist that he did not have any active thoughts of self harm. His refusal to have a blood test was recorded in his medical record. The psychiatrist made a plan for him, which included an increase in medication, ongoing nursing review, and an assessment for a transfer to a secure hospital.
46. The man was assessed on 5 July, with the help of Language Line. He said that the voices were getting worse and he appeared introverted and timid. He told staff that he wasn't sleeping and that his legs felt stiff. A plan was made for the psychiatrist to review his medication during his next appointment, and that any further appointments should take place with additional representatives from the health services present so the assessment could be made as to whether he should be transferred to a secure hospital. The psychiatrist wrote to the commissioners to request a transfer to a Learning Disability Forensic Unit⁹.
47. As a consequence, the low-security Newhaven Unit arranged an assessment on 28 July, with the assistance of Language Line, to gauge whether he would be suitable for transfer there to treat his learning disability. It was noted that he attended the appointment wearing dirty clothes, spoke quietly, and made limited eye contact. Following the assessment, the assessor felt that the man might require admission to allow a full assessment to be made. It was difficult to assess him properly in the prison environment because of language issues and his reluctance to engage on a one-to-one basis.
48. Staff from the Newhaven Unit contacted the prison on 30 July suggesting that the man would be better to be treated in a mental health unit. They explained that his mental health problems needed treatment before his learning disability could be fully assessed. A referral was subsequently

⁸ An interpreter service

⁹ An inpatient facility for offenders with a learning disability whose offending behaviour and mental health needs require that they are detained under the Mental Health Act in secure conditions. Treatment, care, and advice is provided by skilled multidisciplinary teams, conforming to the CPA.

sent to the Bretton Centre, a mental health treatment unit in Wakefield, for the man to be assessed.

49. The man's prison sentence ended on 6 August. Deportation papers had been served, and as planned, with his knowledge, he was being held in Lindholme under immigration powers.
50. On 1 September, the man was examined by one of the prison doctors. He was complaining of itchiness and skin tags¹⁰ on his back. He also asked to start attending the gym.
51. A doctor from the Bretton Centre telephoned Lindholme on 14 September to cancel the man's assessment. This was because he wanted to bring an interpreter with him, whereas the Centre wanted to use their own interpreter. The man was told that the appointment had been cancelled and would be rearranged. This was subsequently arranged for 27 September.

The day the man died

52. At approximately 3.00pm on the day the man died, prisoners from K wing who wished to use the gymnasium were waiting at the wing's outer gate. Among these were the man and his friend who were waiting by the edge of the gate. When staff unlocked the gates, there was a surge as the prisoners all rushed forwards. One of the prisoners saw the man and his friend being knocked aside as other prisoners rushed by, and the man fell back against the fence. He dropped to one knee before getting back up. He did not seem particularly distressed and the man's friend told the investigator that it was not a serious knock. The prisoner who saw the man fall did, however, notice the man limping slightly as he made his way to the gym.
53. A Physical Education Senior Officer (PESO) was on duty in the gymnasium. He said that the prisoners, including the man, had come into the gym just after 3.00pm.
54. The man's friend said that it was not the man's habit to lift weights in the gym. While the man's friend and other prisoners began to use the gym equipment, the man started to perform sit-ups on a gym bench. He then suddenly, without warning, got off the bench, said he felt unwell, and collapsed. The man's friend went to help his friend and called for help. The man was breathing, and man's friend was putting him in the recovery position when staff arrived.
55. The PESO and the Physical Education Officer (PEO) had heard the man's friend shout and went to see what the problem was. Both officers are trained first-aiders. They confirmed that the man was breathing, and the

¹⁰ A small benign growth that can appear where there is friction or creases on the skin.

man's friend had already put him in the recovery position, which was the correct thing to do with someone breathing but unconscious.

56. The PESO then used his radio to alert the communications centre and requested healthcare staff to attend. He used the radio term Code Blue, which indicates to healthcare staff that there is a serious medical emergency, involving a prisoner unconscious or not breathing, and they are required to attend with the appropriate emergency bags. Between them, the two officers then removed other prisoners from the area, and monitored the man to ensure that he continued breathing.
57. Nurse A and Nurse B were on duty in the healthcare centre. The call for healthcare staff to attend the gymnasium came over the radio, but the member of healthcare staff who was designated as the emergency responder that day was already attending another call. Nurse A telephoned the gymnasium to obtain more information about the situation they were to deal with while Nurse B collected the emergency medical bag. They then went directly to the gymnasium, arriving some three minutes later.
58. When the nurses arrived at the gym, they found the man still in the recovery position. Nurse A said in interview that she was familiar with the man, as she had sometimes dispensed his medication to him. He was breathing and had a pulse, but was unresponsive. Concerned that his breathing was becoming difficult, Nurse A inserted an airway into the man's mouth to provide oxygen and help him to breathe. Nurse B radioed to the communications centre and asked for an ambulance. An ambulance was requested at 3.19pm. Nurse B then asked the PESO to use the telephone to provide fuller details to the communications centre to pass on to the ambulance service.
59. The ambulance arrived at 3.24pm. While Nurse A was briefing the ambulance staff on what had happened, the man stopped breathing. Nurse A and one of the paramedics immediately began to perform cardiopulmonary resuscitation (CPR)¹¹. The nurses were familiar with the man and knew that he was taking medication for his mental health problems. Nurse B therefore ran to the healthcare centre to obtain the man's medical file so that it could accompany him to hospital. Nurse A continued to perform CPR until told to stop by the paramedics. The man was then taken to the ambulance and transferred to Doncaster hospital.
60. When prisoners have to go to outside hospital, they remain subject to security measures appropriate to their situation. Officer A was one of the prison officers who were on the daily rota to provide escorts to prisoners

¹¹ CPR, or cardio-pulmonary resuscitation, is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.

who required treatment in hospital. He was on G wing when he heard the Code Blue emergency in the gymnasium called over the radio network. He told his colleagues on G wing that he was responding to the call in case a prisoner needed to go to hospital, and made his way to the gymnasium. He arrived at the gym whilst Nurse A and the paramedic were performing CPR on the man. When the man was transferred to the ambulance, Officer A went with him. No physical restraints were used.

61. Paramedics continued to provide first aid to the man during the journey to hospital. However, on arrival the doctor examined him and, at 4.05pm, confirmed that he had died. Officer A waited with the man until the police arrived, whereupon he returned to the prison.

Informing the family

62. South Yorkshire Police went to the man's wife's home that evening to inform her of her husband's death. One of the prison's family liaison officers subsequently made contact with the man's wife. The family asked if the man's brother-in-law could be the single point of contact, and this was agreed. The Governor met the family at the Royal Doncaster Infirmary the following morning.

Debrief

63. It is usual following the death of a prisoner to hold a debriefing session with staff involved in his or her care. This ensures that staff have an opportunity to discuss any issues arising, and for support to be made available.
64. A debrief was held at 4.55pm, chaired by the Governor. This included all staff who had been involved in caring for the man that afternoon, including medical staff and Officer A. Members of the Staff Care and Welfare Team attended and offered support to all staff should they feel that they needed it, either at the time or subsequently.
65. In addition, the man's personal officer said that she was approached by the staff care and welfare team in case she felt that she needed any support.

Support for prisoners

66. The man's friend said that he found out that the man had died later that afternoon when he overheard people talking. He was not officially told until after he had heard the news via rumours on the wing. Prisoners on K wing, where the man had resided, were all spoken to individually by staff to ensure that they were supported if required. All prisoners who were subject to special measures for those thought to be at risk of harming themselves were reviewed in light of the man's death. Prison staff also reviewed prisoners who had recently been taken off such measures, to consider whether they needed additional support.

67. The man's friend said that some members of staff had been "looking out for" him. He was aware that support was there if he needed it, and knew that in particular certain members of staff would be sensitive to how he was feeling if he sought help.

Post Mortem

68. A post mortem was carried out on behalf of HM Coroner on 28 September. The doctor concluded that the man's death was due to ischaemic heart disease. In layman's terms, the arteries around the man's heart had narrowed. It was possible that his heart could have become unable to operate fully at any time. The doctor noted that taking part in exercise can exacerbate the possibility of this happening.

Funeral

69. Once the Coroner had released the man's body to his family, a service was held in Dewsbury on 28 September. He was then flown immediately to Pakistan and the funeral was held on 30 September.

ISSUES

The man's use of the gymnasium

70. In order to be allowed to take part in gym activities, prisoners are required to fill out a physical activity screening form. These are known as PAR Q forms. The man completed his screening form on 13 January 2010. He confirmed that he did not suffer from asthma, diabetes, epilepsy or low back problems. He stated that he exercised three times a week, and did not detail any other information he thought might be relevant.
71. From the information that the man had provided, he was deemed as fit to use the gym and was given an induction on how to use the equipment appropriately.
72. Using the gymnasium is a popular activity in prison. Large numbers of prisoners attend, and it would not be feasible to give an individual health test to each one. The man stated on his PAR Q form that he had no physical problem which would affect his ability to use the gym. Despite having complained of chest pain in August 2009, he had no known physical ailment. Reception health screening did not indicate any problems that might have prompted staff to consider in greater depth whether he should be allowed to use the gym. It would appear, therefore, that the man being allowed to use the gymnasium was reasonable given the circumstances and the information available. The clinical reviewer agrees.

Supervision of prisoners as they were escorted to the gym

73. Whilst waiting to be escorted to the gym, the man and his fellow prisoners congregated behind a gate. When the gate was opened, the prisoners surged forward and the man (among others) was knocked. This was a minor physical event, and he did not sustain any major injuries. Nor is there any suggestion that the prisoners were unsupervised. However, although this incident is unlikely to have played a part in his death, prisoners should be able to move around the establishment safely. The Governor should remind all staff of maintaining prisoners' health and safety during moves.

The Governor should ensure that prisoners moving around the establishment are sufficiently supervised to ensure they do so safely.

The emergency response

74. The man's friend was the first person to offer him first aid support. As the man was still breathing, the man's friend put him into the recovery position, which was the correct procedure in those circumstances. When staff arrived they kept him in the recovery position under observation and called for assistance of healthcare staff over the radio. They acted as they should.

75. When the nurses arrived at the gym with the emergency bag, Nurse A became concerned that his breathing was becoming difficult, so inserted an airway into his mouth to provide oxygen and help him to breathe. This shows good awareness and care. The communications centre was contacted and an ambulance was requested.
76. When the man stopped breathing, nurses and paramedics were by his side. Assistance could not have been provided more quickly. A nurse and one of the paramedics immediately began to perform CPR, and an ambulance was already on hand to transfer him to hospital. Unfortunately, despite attempts to resuscitate him, he was pronounced dead on arrival at hospital.
77. Given the available evidence, the emergency response appears to have been timely and appropriate.

Funeral

78. Prison Service Order (PSO) 2710 offers guidance on procedures following a death in custody. The PSO says that Governors “must offer to pay reasonable funeral expenses”. In this case, once the Coroner had released the man’s body to his family, after a short local service the family had the body flown to Pakistan for the funeral. Because of the speed with which this happened, the prison did not offer to contribute to the cost of the funeral. Nevertheless, the prison should have made efforts to ensure that they offered to assist the family with funeral costs at some stage.

The Governor should ensure that bereaved families are offered reasonable funeral costs in line with PSO 2710.

Medical care

79. The man did not present to staff with any significant physical health problems during his time in custody. He had complained of chest pain in August 2009, but had not apparently suffered any further bouts of such pain since. He had been diagnosed with a mental illness and suffered from symptoms of psychosis. He was prescribed medication to help control the symptoms and was assessed and reviewed by psychiatrists and members of the mental health in-reach team.
80. The clinical reviewer has identified a number of aspects of the man’s care in relation to his mental health diagnosis and the treatment that he received that require comment. This report does not repeat them all in full, but specifically reiterates three. It also recommends that the Head of Healthcare draws up an action plan to address the remaining recommendations in the clinical review.
81. The clinical reviewer raises questions around the man’s understanding of the medications he was required to take, their dosages and the effects

they would have. When it was noted that he was not collecting all his medication, staff were instructed to ensure that he did receive his medication. Nevertheless, records indicate that there were issues around his understanding, and the clinical reviewer notes that it is unclear how much the man understood the need for his medication, the side effects, and the dosages. She could not find any evidence that attempts were made to provide information to him in his first language, or that his understanding was assessed. The clinical reviewer makes a recommendation regarding this, and we concur.

The Head of Healthcare should ensure the process for language interpretation is effective and that prisoners are able to understand the reasons for and the effects and correct dosages of their medication.

82. Although the dose of his medications was increased quite significantly, it does not appear that the effects were reviewed appropriately. The clinical reviewer says that it is not possible for her to state whether his medication had an effect on his physical health which might have contributed to his death. She recommends that the system for monitoring prisoners taking anti-psychotic medication is audited. This report echoes that recommendation.

The Head of Healthcare should ensure that an audit of the system for monitoring prisoners taking anti-psychotic medication is undertaken.

83. Although the man's mental health condition worsened during the summer months of 2010, the assessment of his needs, and the referral for the possible transfer to a secure inpatient facility was not timely and was not in line with the Mental Health Act Code of Practice (guidance for mental health professionals). The clinical reviewer says that the treatment he received is likely to have fallen below the level he might have received had he been in the community. She makes a recommendation that processes are put in place to ensure that prisoners requiring mental health assessments receive them within the same timeframe that non-prisoners would be expected to receive them. Again, this report agrees.

The Head of Healthcare should introduce systems to ensure that prisoners requiring mental health assessment receive these in a timely manner and in line with the Mental Health Act Code of Practice.

84. The clinical reviewer met with difficulty in conducting the clinical review due to gaps in the man's medical records. Electronic and paper records were being kept simultaneously, and there was not a complete single record. Again, this report concurs with the clinical reviewer's recommendation that this needs to be addressed.

The Head of Healthcare should ensure that prisoners' medical records are properly maintained.

85. The clinical reviewer makes a number of additional recommendations in relation to the man's mental health care. Amongst other things, she addresses the use of his wife as an interpreter, the lack of evidence that he received proper care under the Care Programme Approach, the lack of support that he was offered. Whilst she acknowledges that these might not have contributed to his death, his care was "not necessarily comparable to that which he would have received in the community". It is of concern that issues like the man throwing his meals away because he felt sick were not picked up on. This report does not repeat all the clinical reviewer's recommendations, but asks that the Head of Healthcare produces an action plan to address the remaining points that the clinical reviewer raises, which are not repeated as recommendations in this report.

The Head of Healthcare should produce an action plan addressing the remaining points raised in the clinical review.

CONCLUSION

86. The man was a 40 year old man who had lived in the UK since he was 23. He had displayed psychotic symptoms since 2004 and had been diagnosed with mental health problems. He had been in prison since 2008, and once his sentence had been completed he was being detained under immigration powers, pending deportation.
87. On the afternoon of the day the man died, he attended the prison's gymnasium. He had barely begun to exercise, when he said that he felt unwell. Almost immediately, he collapsed. Still breathing but unconscious, he was put in the recovery position by a fellow prisoner, then received first aid from prison staff. An ambulance was called, but while nursing staff from the prison were briefing paramedics, he stopped breathing. Medical staff instantly began to attempt resuscitation, and he was taken in the waiting ambulance to hospital. Sadly, he was dead on arrival. The post mortem report found that he had been suffering from heart disease, and his heart may have stopped working at any time. This could have been made more likely by exercise.
88. During his imprisonment, the man did not present with any significant physical health problems. He did complain of chest pain on one occasion in August 2009, but this was not followed up. He did, though, have ongoing contact with mental health services. The clinical reviewer identifies a range of care delivery problems. However, it is also acknowledged that these might not have contributed to his death although without physical health monitoring with regard to the effects of his medication, this is impossible to rule out. Overall, the clinical review concludes that the man's care was "not necessarily comparable to that which he would have received in the community".
89. As a result of the investigation, we make seven recommendations. The first six of these address prisoner movement within the establishment, funeral costs, prisoners' understanding their medication, an audit of the system to monitor prisoners taking anti-psychotic medication, the timeliness of mental health assessments, and the maintenance of medical records. The seventh recommendation refers to the clinical review. The clinical reviewer makes 13 recommendations in relation to the man's care. Whilst some of these are reflected in the recommendations in this report, the final recommendation here is that the Head of Healthcare should address the reviewer's remaining recommendations in full.

RECOMMENDATIONS

1. The Governor should ensure that prisoners moving around the establishment are sufficiently supervised to ensure they do so safely.

The National Offender Management Service (NOMS) partially accepted this recommendation, commenting:

“The incident ... was due to unlocking procedures on K Wing. This has now been rectified as a Gymnasium list is taken, therefore limiting prisoner movement from the Wing. This is now standardised throughout the Establishment”.

2. The Governor should ensure that bereaved families are offered reasonable funeral costs in line with PSO 2710.

NOMS accepted this recommendation, with the comment:

“The man was of Muslim faith and upon his body being released from the coroner, his family immediately had a burial service and then repatriated his body back to Pakistan where he was buried. This was all completed without the Establishments knowledge and therefore an offer of payment prior to the funeral couldn't be made. In future, an offer of payment will be made upon being informed of similar information. Contingency plans to be amended”.

3. The Head of Healthcare should ensure the process for language interpretation is effective and that prisoners are able to understand the reasons for and the effects and correct dosages of their medication.

This recommendation was accepted, with the comments:

“All staff are aware of how to access interpreting/translation services via telephone. A process is almost complete for staff to follow to ensure that medications are discussed in 1:1 appointments with patients. GPs are also to be made aware of their responsibilities with this as their prescribers”.

4. The Head of Healthcare should ensure that an audit of the system for monitoring prisoners taking anti-psychotic medication is undertaken.

This recommendation was accepted with the following comments:

“An audit was recently undertaken, evidencing the need for a more robust structure to monitor. This process is being produced and will ensure continual review of patients taking antipsychotic medications and their engagement with the service”.

5. The Head of Healthcare should introduce systems to ensure that prisoners requiring mental health assessment receive these in a timely manner and in line with the Mental Health Act Code of Practice.

This recommendation was partially accepted. NOMS said:
“The patient had been referred to services, it was these services that took a lengthy time to arrange assessments. A process is now in place however for the Clinical Matron to monitor the timescales and to escalate issues if external agencies delay the assessment process”.

6. The Head of Healthcare must ensure that prisoners’ medical records are properly maintained.

This recommendation was accepted. NOMS explained that:

“Since this period of time, all Medical records are held on SystemOne, therefore there is one single continuous record for each patient”.

7. The Head of Healthcare should produce an action plan addressing the remaining points raised in the clinical review.

This recommendation was accepted. NOMS said:

“This action plan has been completed, and sits on the Action Plan tracker monitored by Nottinghamshire Healthcare Trust”.