Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Zahid Iqbal a prisoner at HMP Lindholme on 29 August 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Zahid Iqbal died on 29 August 2016 of heart disease at HMP Lindholme. Mr Iqbal was 48 years old. I offer my condolences to Mr Iqbal's family and friends.

The investigation found that the clinical care Mr Iqbal received at HMP Lindholme, notably for raised blood pressure, was not equivalent to that he could have expected to receive in the community. I am also concerned that prison staff did not seek to gain a response from Mr Iqbal when they unlocked his cell and that. once he was discovered unresponsive, an emergency code was not used.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2017**

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Summary

Events

1. On 10 December 1999, Mr Zahid Iqbal was sentenced to life imprisonment for murder. He was moved between various prisons and, in June 2016, was transferred to HMP Lindholme.

2. When Mr Iqbal arrived at Lindholme, a nurse completed a healthcare induction, and recorded that he had asthma, which was managed by medication. She also noted that he was a smoker and offered smoking cessation advice. As part of his induction, the nurse took Mr Iqbal's blood pressure, which was raised. There was no follow up appointment made to find out why.

3. On 29 August at 3.30am, a prisoner reported hearing Mr Iqbal shouting from his cell. He said he witnessed officers attend Mr Iqbal's cell and that then he heard no further noise.

4. An officer unlocked Mr Iqbal's cell at approximately 9.10am, she did not communicate with him.

5. At 10.45am a group of prisoners reported to an officer that they were concerned that Mr Iqbal had not moved since unlock. The officer went to Mr Iqbal's cell and found him on his bed, cold to touch. The prison officer called for support from the healthcare team, but did not call a code blue (indicating an emergency situation) which would result in the control room immediately requesting an ambulance.

6. Both healthcare staff and prison staff attempted to resuscitate Mr Iqbal, however attempts were futile. Paramedics arrived at Mr Iqbal's cell at 11.03am. They confirmed his death at 11.05am

Findings

7. The clinical reviewer concluded that the clinical care that Mr Iqbal received at HMP Lindholme, notably for raised blood pressure, was not equivalent to that he could have expected to receive in the community.

8. We were unable to clarify if Mr Iqbal had pressed his cell bell, as the records provided were unreadable. The prison could not provide a clearer version of the records or an account of events that night.

9. We found that staff were not unlocking prisoners in line with the Prison Officer Entry Level Training (POELT) manual which states that, "Prior to unlock, staff should physically check the presence of the occupants of every cell and that you must ensure that you receive a positive response". Mr Iqbal's door was unlocked at approximately 9.10am but he was not found in his cell until 10.45pm.

10. When an officer found Mr Iqbal unresponsive in his cell, he did not call the appropriate emergency code.

11. We found that, although the emergency response from healthcare staff was timely and sustained, the decision to start CPR was inappropriate. Mr Iqbal was

clearly already dead, and resuscitation attempts were distressing for staff and undignified for Mr Iqbal.

Recommendations

- The Head of Healthcare should ensure that the reception screening process triggers appropriate review and referral where there is doubt about a prisoner's health.
- The Governor should ensure that staff unlocking prisoners satisfy themselves that the prisoner is alive and breathing.
- The Governor should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that staff use the appropriate code to communicate a medical emergency immediately.
- The Governor and Head of Healthcare should ensure that prison and healthcare staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners came forward.

13. The investigator obtained copies of relevant extracts from Mr Iqbal's prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Iqbal's clinical care at the prison.

15. The investigator interviewed six members of staff and two prisoners, jointly with the clinical reviewer at Lindholme on 27 September 2016. She conducted a further telephone interview with one member of prison staff on 12 October 2016.

16. We informed HM Coroner for South Yorkshire East District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

18. Mr Iqbal's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Lindholme

19. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Nottinghamshire Healthcare Foundation NHS Trust provides healthcare services. These include a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Lindholme was in March 2016. Inspectors found the reception health screening was undertaken by a registered nurse, and appropriate follow-up was completed. However the waiting time to see a GP was too long.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published report for the year to January 2016, the IMB commented that it was satisfied that prisoners receive adequate medical care at HMP Lindholme. Daily clinics attended by a GP and dentist are held at the health centre, and nursing staff visit all wings to deliver medication to prisoners twice daily.

Previous deaths at HMP Lindholme

22. There have been six previous deaths at HMP Lindholme since 2015, of which two died of natural causes. We have made a previous recommendation about the need for effective emergency responses.

Key Events

23. On 10 December 1999, Mr Zahid Iqbal was sentenced to life imprisonment for murder. As part of his sentence progression, Mr Iqbal was moved between a number of prisons and, on 1 June 2016, he was transferred to HMP Lindholme.

24. A nurse completed Mr Iqbal's healthcare induction on 9 June 2016. His prison medical records document that he had a history of asthma which was managed with medication. He was recorded as being a light smoker of cigarettes and the nurse offered smoking cessation advice. The nurse took Mr Iqbal's blood pressure and recorded it as high at 145/92. The normal range for blood pressure is between 90/60 and 120/80. There is no record of his blood pressure being taken after this screening.

25. There are no significant entries in Mr Iqbal's healthcare record until 29 August 2016.

26. **Events on 29 August 2016 (Bank Holiday Monday)**

27. A prisoner who was located in the cell opposite Mr Iqbal, told the investigator that, at 3.30am, he heard Mr Iqbal kicking and screaming at his cell door, and pressing his cell bell. He explained that he saw officers go in to Mr Iqbal's cell and that his cell bell was turned off and the officers left. He then heard nothing more.

28. Later that morning, an officer was on duty on K wing. She unlocked Mr Iqbal's cell at approximately 9.10am. She looked through the flap on his door and saw that he was in bed. She did not communicate with him or check on his well-being.

29. At 10:45pm, some prisoners told an officer, who was located on K wing, that they were concerned for a man in cell K1-50 as he had not moved since unlock.

30. The officer went to the cell and saw Mr Iqbal lying on his bed on his right hand side. He shouted to Mr Iqbal and shook him, but got no response. He noticed that he was cold to touch, and he used his radio and asked for nurses and staff to attend his cell as soon as possible. He did not call a medical emergency response code (a code blue indicates difficulties in breathing and code red indicates a loss of blood. Calling a code should automatically trigger the control room to call an ambulance, and enables healthcare staff to bring the correct equipment to the scene).

31. A senior officer heard the request on the radio, and went straight to the cell. He then entered the cell, moved Mr Iqbal onto the floor and immediately started chest compressions, instructing the officer to start mouth to mouth resuscitation (CPR – cardiopulmonary resuscitation).

32. In interview, the nurse who was Hotel 1 (first response radio) told the investigator a call came through to attend K wing, but with no emergency code given to highlight the urgency. As she was administering medications at this time, she asked another nurse and a pharmacy technician to go to K Wing.

33. The nurse who was Hotel 2 (second response radio) then made his way to K wing to provide additional support. He said he walked across to K wing because

there was no urgency as no emergency code had been called. He said that approximately five minutes after the first call to K wing, a call came over the radio for emergency equipment.

34. The Yorkshire ambulance service records show that the call from HMP Lindholme's control room was received at 10.49am requesting an ambulance.

35. When Hotel 2 arrived at the cell, healthcare staff continued CPR. Hotel 1 told the investigator that she attached the defibrillator, which advised to continue CPR and not shock. She described inserting a guedal airway (a plastic curved tube to help maintain an airway) into Mr Iqbal's mouth.

36. Staff continued to giving CPR until the paramedics arrived at Mr Iqbal's cell at 11.03am. Paramedics confirmed Mr Iqbal's death at 11.05am.

Contact with Mr Iqbal's family

37. At 1.20pm on 29 August, following Mr Iqbal's death, the officer appointed as the family liaison officer visited Mr Iqbal's brother in law at their family home. She informed the family of Mr Iqbal's death, and offered both practical and emotional support. She remained in contact with Mr Iqbal's family, assisting with the arrangements so that Mr Iqbal could be returned to Pakistan for burial.

38. The prison contributed towards the funeral costs in line with national policy.

Support for prisoners and staff

39. After Mr Iqbal's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

40. The prison posted notices informing other prisoners of Mr Iqbal's death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Iqbal's death

Post-mortem report

41. The post mortem gave the cause of death as ischemic heart disease.

Findings

Medical care

42. When Mr Iqbal arrived at HMP Lindholme, his blood pressure was taken as part of his healthcare induction. The readings taken were outside the normal range. While the clinical reviewer comments that this could have been triggered by anxiety, given that Mr Iqbal was asthmatic, a smoker and of an age and ethnicity that could predispose cardiovascular disease, his blood pressure should have been reviewed to exclude any underlying heart condition. For men aged over 40 years, there should either be a routine secondary health assessment or an invitation to an NHS Health Check, which did not happen for Mr Iqbal. She concluded that some of his care, notably for raised blood pressure, was not equivalent to that he could have expected to receive in the community. We make the following recommendation:

    The Head of Healthcare should ensure that the reception screening process triggers appropriate review and referrals where there is doubt about a prisoner's health.

Cell bell records

43. On 29 August at 3.30am a prisoner reported hearing Mr Iqbal kicking and screaming at his cell door, and then pressing his cell bell. The investigator interviewed the prisoner, who alleged that officers entered the cell, but took little action. The investigator requested a copy of the cell bell records, but the copy provided by the prison was not legible. Although an alternative copy was requested, the prison was unable to provide one. The investigator also requested CCTV of the wing for the 29 August, however we were not able to view the recordings due to an incompatibility with our I.T. A member of the safer custody team viewed all the CCTV from 12.00am to 6.00am, except for the hours between 3.50am and 04.45am, which would not play. For the hours that she was able to view, she confirmed that no staff were on the side of the landing that Mr Iqbal lived, or were anywhere near his cell. There is no evidence in the wing observation book dated 29 August that any staff went into Mr Iqbal's cell in the early hours of the morning. We therefore cannot draw any conclusions as to exactly what happened that night.

Unlock procedures

44. An officer unlocked Mr Iqbal's cell at around 9.10am on 29 August. She did not check on his wellbeing. She told the investigator that at the point of unlock she is not required to gain a response from prisoners, and that she just needs to be able to see that there is an individual in each cell. She states that she would usually communicate with a prisoner at the point of locking them back up. However, as it was a Bank Holiday, prisoners were on extended association, so she would not have returned to his cell until approximately two hours after unlock. Two other officers also stated in interview that at the point of unlock, they were only required to look in the cell.

45. When officers unlock cells they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that,

"Prior to unlock, staff should physically check the presence of the occupants of every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner had not escaped, is ill or dead."

46. An officer found Mr Iqbal in his cell around one hour and 30 minutes after the first officer had unlocked it. It is impossible to determine whether Mr Iqbal's death could have been prevented if he had been checked earlier, but failure to get a response from a prisoner and check their wellbeing when unlocking a cell could prevent an effective emergency response.

The Governor should ensure that staff unlocking prisoners satisfy themselves that the prisoner is alive and breathing.

Emergency response

47. The clinical reviewer commented that the emergency response for Mr Iqbal from healthcare staff was timely and sustained. However the failure by prison staff to use an emergency code meant that healthcare staff did not respond to the request as an emergency. Healthcare staff told the investigator that it is common for prison staff not to use a code when requesting assistance from healthcare.

48. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, contains mandatory instructions that prisons should have a protocol with guidance to staff about efficiently communicating the nature of a medical emergency that provides guidance to staff on efficiently communicating the nature of a medical emergency and ensures staff called to the scene bring the relevant equipment, and triggers the control room to call an ambulance.

49. Lindholme do have a protocol in line with the PSI. Although we do not think that the delay in calling a code affected the outcome for Mr Iqbal, in other cases, even a short delay can have a significant impact on a person's chance of survival in an emergency. We make the following recommendation:

The Governor should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that staff use the appropriate code to communicate a medical emergency immediately.

50. Two nurses said that they had not seen any indication that Mr Iqbal was alive when they entered the cell. The paramedics' report stated that Mr Iqbal's conditions were 'unequivocally associated with death' - (rigor mortis to jaw and neck).

51. The joint guidance issued by NOMS, RCGP and the RCN in March 2016 cites the European Resuscitation Council Guidelines for Resuscitation 2015 "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile" in the presence of rigor mortis (stiffening of the body following death). The local policy for Nottinghamshire NHS Trust also states that CPR should not be started in instances where patients have rigor mortis. The clinical reviewer comments that the decision to not start CPR or to cease CPR must always rest with the individual health professional, but in all the

circumstances described regarding Mr Iqbal, there seems to be reasonable evidence that attempts to resuscitate him were futile. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that prison and healthcare staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

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