

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neil Linkhorn a prisoner at HMP Ashfield on 1 February 2017

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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.

Our 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 Neil Linkhorn died on 1 February 2017 after choking in his cell at HMP Ashfield. He was 41 years old. I offer my condolences to Mr Linkhorn's family and friends.

Mr Linkhorn was in good health and had no underlying conditions that might have made him prone to choking. When Mr Linkhorn was discovered choking in his cell, staff responded quickly and made commendable efforts to assist him, as well as immediately calling an ambulance. I am satisfied that staff did all they could to try to prevent Mr Linkhorn's tragic and untimely death.

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

October 2017

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Summary

Events

1. On 3 May 2013, Mr Neil Linkhorn was sentenced to 10 years in prison for sexual offences. He was transferred to HMP Ashfield on 31 January 2017.
2. At his initial health screen at Ashfield, Mr Linkhorn told the nurse that he did not have any medical conditions. He appeared fit and well.
3. At around 11.45pm on 31 January, Mr Linkhorn pressed his cell bell. When an officer arrived at his cell, he realised that Mr Linkhorn was choking and called a medical emergency code. The officer entered the cell and administered back slaps and abdominal thrusts, but Mr Linkhorn fell unconscious. When two other officers arrived, they started cardiopulmonary resuscitation.
4. Paramedics arrived around 15 minutes later and removed food debris from Mr Linkhorn's larynx with forceps. They managed to stabilise Mr Linkhorn and took him to hospital, but he did not regain consciousness. He died at 12.53pm on 1 February with his family present.

Findings

5. The clinical reviewer concluded that the standard of care Mr Linkhorn received at the prison was equivalent to that which he might have expected to receive in the community. Staff responded well to the medical emergency and we are satisfied that there is nothing more they could have done to prevent Mr Linkhorn's tragic and untimely death. We do not make any recommendations.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Ashfield informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
7. The investigator obtained copies of relevant extracts from Mr Linkhorn's prison and medical records.
8. The investigator interviewed three members of staff and a prisoner at HMP Ashfield on 9 March 2017.
9. NHS England commissioned a clinical reviewer to review Mr Linkhorn's clinical care at the prison. He conducted joint interviews with the investigator.
10. We informed HM Coroner for Avon District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. The investigator contacted Mr Linkhorn's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked for information on the following:
 - what happened when Mr Linkhorn arrived at Ashfield;
 - why he was eating late at night and whether he had eaten any food that could have caused an allergic reaction; and
 - how many times he had pressed his cell bell, how quickly staff had responded and details of the emergency response.
12. Mr Linkhorn's parents received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Ashfield

14. Until June 2013, HMP Ashfield was a Young Offenders' Institution. In July 2013, it reopened as a specialist medium secure adult male prison for sex offenders. It accommodates approximately 400 men and is managed by Serco.
15. Healthcare is provided by an amalgamation of Hanham Health, Bristol Community Health and Avon and Wiltshire Partnership Mental Health Trust. The healthcare unit provides on-site chronic disease management including diabetes, respiratory and cardiovascular disease screening.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Ashfield was in August 2015. Inspectors found that health services were effective and responsive, long-term conditions were identified and care was good. The inspection report noted the appointment system for internal and external referrals was very good and comparable to the best community GP practices.

Independent Monitoring Board

17. 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 latest annual report, for the year to June 2016, the IMB reported that the prisoners were overwhelmingly positive about the quality of care they receive from nurses, GPs and others. They noted that a nurse triage facility ensured that prisoners received prompt assessments of their needs and that prisoners benefited from 15 minute appointments, longer than in the community.

Previous deaths at HMP Ashfield

18. Mr Linkhorn was the fourth prisoner at Ashfield to die since January 2015. There were no similarities with the circumstances of the previous deaths.

Key Events

19. On 3 May 2013, Mr Neil Linkhorn was sentenced to 10 years in prison for sexual offences and sent to HMP Winchester. He progressed through his sentence and, after spending three and a half years at HMP Isle of Wight, he was transferred to HMP Ashfield on 31 January 2017. At Isle of Wight, Mr Linkhorn was very overweight and had high blood pressure. He joined the gym and began exercising and dieting, which resulted in him losing a lot of weight. He was a non-smoker and had not used drugs.
20. Mr Linkhorn had his reception health screen at Ashfield at approximately 4.15pm. During the assessment, he told a nurse that he was happy to be at Ashfield and did not have any medical conditions. She checked his height, weight, pulse, temperature, blood pressure, heart and respiratory rate. All were within normal range.
21. Prison staff completed a first night induction book. They noted that Mr Linkhorn was a non-smoker and healthcare staff had completed the healthcare assessment. Prison staff completed a risk assessment and noted that staff should complete observations every four hours. Prison staff allocated Mr Linkhorn a single cell in the First Night Centre and they took him to his cell at approximately 5.30pm.
22. Prisoners on the unit collected an evening meal at approximately 5.50pm. The menu options for that day included a vegetarian meal of vegetable samosas, new potatoes, peas and sweetcorn, with melon for dessert (which was the default meal for new arrivals). There was a beef and mushroom stroganoff on the menu for other prisoners but there is no record showing what Mr Linkhorn selected.
23. Mr Linkhorn collected his evening meal, sat with other prisoners and a Prison Custody Officer (PCO) said she saw him eat his meal. He then went to his cell and began unpacking his possessions. We have been unable to confirm what food Mr Linkhorn took into his cell.
24. At approximately 11.45pm, Mr Linkhorn pressed his cell bell. A PCO attended. He saw Mr Linkhorn sticking his fingers down his throat and realised he was choking. At 11.47pm, he used his radio to call a “code blue” medical emergency (indicating a life threatening incident involving breathing difficulties) and to tell the duty manager that he was entering the cell. Staff in the communications room immediately rang for an ambulance. He gave a combination of back slaps and abdominal thrusts, but Mr Linkhorn fell unconscious. He laid him on the floor in the recovery position. When two other officers came to the cell, they started cardiopulmonary resuscitation (CPR).
25. A PCO heard the emergency radio code. He collected the emergency defibrillator from the office of a nearby unit and passed it to the officers in the cell. The reading from the defibrillator said no shockable rhythm was advised, so they continued with CPR. The PCO noted that Mr Linkhorn was bringing up blood and vomit through his mouth and nose. In order to keep his airways clear she wiped his nose and mouth clear of liquid. A PCO asked for oxygen. Another PCO ran back to the office and returned to the cell with the oxygen tank. Staff continued with CPR.

26. A PCO went to the gate to escort the paramedics and ambulance to the cell. The first of three ambulances arrived at 11.59pm, the second at 12.07am and the third at 12.17am. The paramedics asked the prison staff to continue with the resuscitation attempts as they set up their equipment. The paramedics found that Mr Linkhorn's airway was blocked and that vomit/fluid was filling his airway. They used forceps to remove possible food debris from his larynx. Paramedics managed to stabilise Mr Linkhorn and took him to hospital at 12.58am. Two officers escorted him and did not restrain him.
27. The hospital admitted Mr Linkhorn and continued with CPR. A CT scan showed he was unresponsive. Prison staff contacted his family who came to the hospital. Mr Linkhorn died on 1 February at 12.53pm with his family present.

Contact with Mr Linkhorn's family

28. The prison appointed an officer as the family liaison officer. Mr Linkhorn's nominated next of kin were his parents. When he was admitted to hospital a prison manager rang Mr Linkhorn's parents and told them that Mr Linkhorn was seriously ill in hospital. His family travelled to the hospital. The officer met them there and offered support.
29. After he died, the officer contacted Mr Linkhorn's parents and offered condolences and support. He remained in contact with Mr Linkhorn's family until after his funeral, which was held on 14 March 2017. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

30. After Mr Linkhorn's death, a prison manager debriefed the escort staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
31. Staff at Isle of Wight and Ashfield posted notices informing other prisoners of Mr Linkhorn's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Linkhorn's death.

Post-mortem report

32. The pathologist gave the cause of death as a hypoxic ischaemic brain injury (caused by lack of oxygen to the brain), cardiac arrest and choking. The pathologist noted there were small fragments of food material in Mr Linkhorn's windpipe and a possible rice grain in his lower bronchus (a passage airway in the respiratory tract). Blood and pieces of vegetable matter were in his lungs.
33. The pathologist found no evidence of any significant pre-existing natural disease that would have caused or contributed to Mr Linkhorn's death. There was no evidence of any allergic/anaphylactic reaction. The pathologist concluded that, although it was unclear what started the choking episode, this had led to the cardiac arrest.

Findings

Clinical review

34. The clinical reviewer concluded that Mr Linkhorn's care was equivalent to that which he could have expected to receive in the community. He commended the PCO's attempts to help Mr Linkhorn.
35. The clinical reviewer found that, although prison staff accessed a defibrillator with minimal delay, there should be a defibrillator in the First Night Centre. We understand that prison managers have now rectified this.
36. Mr Linkhorn had spent only 10 hours at Ashfield when he collapsed following a choking episode. Staff recognised the seriousness of the situation and responded immediately. We agree with the clinical reviewer's conclusions and commend the staff for their efforts in attempting to help Mr Linkhorn.

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