Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ahmed Omar, a prisoner at HMP Lindholme, on 13 August 2020

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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

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 Ahmed Omar was found unresponsive in his cell on 13 August 2020 at HMP Lindholme. He died in hospital a few hours later from the effects of psychoactive substances (PS). He was 29 years old. I offer my condolences Mr Omar's family and friends.

In the two days before his death, Mr Omar's behaviour became increasingly bizarre and staff, other prisoners and his aunt expressed concerns about him. He admitted that he had been using PS and staff considered that his behaviour was drug-related. I am concerned that, despite this, he was not seen by healthcare staff or referred to the substance misuse team. Although Mr Omar was the seventh prisoner to die as result of PS use at Lindholme since December 2017, staff do not appear to have appreciated that Mr Omar's drug use put him at significant risk of dying.

The apparent ease with which Mr Omar was able to obtain drugs despite the COVID-19 restrictions suggests that more needs to be done to stop the flow of drugs into the prison.

I am also concerned that although a custodial manager asked for Mr Omar to be checked every two hours the day before he died, this was not recorded and was not communicated to the night staff. There was also a short delay before a medical emergency code was called when Mr Omar was found unresponsive in his cell.

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

Sue McAllister CB
Prisons and Probation Ombudsman **June 2021**

Contents

Summary

Events

1. In October 2015, Mr Ahmed Omar was sentenced to 19 years in prison for wounding with intent and firearm offences.

2. In February 2019, Mr Omar transferred to HMP Lindholme. Mr Omar had no significant health concerns and no known mental health concerns and he had no problems with illicit substances or excessive alcohol use.

3. In March 2020, a severely restricted regime was introduced in response to the COVID-19 pandemic. Prisoners spent around 23 hours a day in their cell. However, staff had no concerns about Mr Omar.

4. On 11 August, Mr Omar's behaviour was described as bizarre and he appeared to be having paranoid thoughts. Staff, family and other prisoners were concerned that his mental health was deteriorating. A mental health nurse assessed him as stable and showing no signs of decline in mental health. Mr Omar admitted having used psychoactive substances and staff considered it likely that his behaviour was drug-related.

5. On 12 August, Mr Omar continued to display bizarre behaviour. He was referred to the mental health team again and a mental health assessment was arranged for 13 August.

6. At about 9.30pm, an operational support grade (OSG) found Mr Omar in an extremely agitated state, throwing furniture around in his cell and talking unintelligibly. The OSG called for assistance and was told that Mr Omar had been behaving oddly during the day and would probably calm down.

7. At about 11.00pm, the OSG called for assistance again as Mr Omar's behaviour was still the same. A number of officers responded and consulted the Night Orderly Officer for advice. They decided not to enter Mr Omar's cell because he had become calm and appeared to be going to sleep on the floor. Half hourly monitoring checks were put in place. Mr Omar continued to lie on the floor, apparently asleep.

8. At about 1.00am on 13 August, the OSG called for assistance because he could no longer see Mr Omar breathing. Prison officers responded. They called an emergency medical code and started cardiopulmonary resuscitation (CPR). Ambulance staff arrived and Mr Omar was taken to hospital. At 3.18am, it was confirmed that Mr Omar had died.

Findings

9. For the two days before he died, Mr Omar displayed bizarre behaviour and was thought to be under the influence of psychoactive substances (PS). Prison staff, other prisoners and Mr Omar's aunt repeatedly expressed concerns about him. Although he was seen by a mental health nurse, who assessed him as mentally stable, we are concerned that he was not seen by healthcare staff or referred to the substance misuse team.

10. We remain concerned about the availability of PS in Lindholme. The prison has a comprehensive drug strategy but, despite this, Mr Omar is the seventh prisoner to die at Lindholme as a result of PS use since December 2017.

11. The Orderly Officer, a custodial manager (CM), told us that he asked staff to carry out two-hourly monitoring checks on Mr Omar on the afternoon of 12 August. However, there is no record of this or that staff carried out such checks, and this information was not handed over to the night staff.

12. We consider that the staff who first found Mr Omar unresponsive in the early hours of 13 August should have called an emergency medical code even though they were not sure if Mr Omar was breathing or not.

13. The clinical reviewer concluded that the clinical and mental healthcare Mr Omar received at Lindholme was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that all staff understand that drug use, including PS use, carries a significant risk to health and should always be taken seriously.
- The Governor should ensure that when a prisoner is suspected to be under the influence of illicit substances, staff:
    - record the incident;
    - inform healthcare staff; and
    - make a referral to the substance misuse team.
- The Governor should ensure that there is a formal system in place for recording welfare monitoring checks when a prisoner is suspected to be under the influence of drugs or alcohol.
- The Governor should ensure that the prison's revised drugs strategy takes account of the findings of this report and the Ombudsman's previous reports on drug-related deaths at Lindholme.
- The Governor should ensure that all staff understand the importance of calling a medical emergency code promptly in a medical emergency.
- The Head of Healthcare should share this report with Nurse A and ensure that he is aware of the Ombudsman's findings.
- The Governor should share this report with CM A, CM B, Officer A, Officer B, Officer C and the OSG to ensure they are aware of the Ombudsman's findings.

The Investigation Process

14. The investigator issued notices to staff and prisoners at Lindholme informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

15. Due to the COVID-19 pandemic, the investigator was unable to visit Lindholme. She obtained copies of relevant extracts from Mr Omar's prison and medical records by email and post.

16. NHS England commissioned an independent clinical reviewer to review Mr Omar's clinical care at the prison. The investigator and clinical reviewer jointly interviewed 11 staff on 25 and 29 September and 23 October 2020. All the interviews were conducted by telephone because of the COVID-19 restrictions.

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

18. The Ombudsman's family liaison officer contacted Mr Omar's next of kin to explain the investigation and to ask if she had any matters they wanted the investigation to consider. They did not respond.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified one factual inaccuracy, which has been amended. A copy of the HMPPS action plan is annexed to this report.

Background Information

HMP Lindholme

20. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Care UK provides healthcare services, with healthcare staff on duty between 7.30am and 7.30pm every day.

HM Inspectorate of Prisons

21. The most recent full inspection of HMP Lindholme took place in October 2017. Inspectors found that safety had been significantly compromised by the ready availability of drugs. The prison environment and the nature of its population (which included a high proportion of organised gang members) presented challenges in preventing the flow of drugs. Over two-thirds of prisoners said that it was easy to get illicit drugs and, when PS was included in mandatory drug testing data, 41% of tests were positive. Over a quarter of prisoners said that they had developed a drug problem while at Lindholme, which was higher than at similar establishments. Substance misuse services were reasonably good, with prompt psychosocial assessments.

22. Inspectors noted that the number of violent incidents was higher than at similar prisons and victimisation was mostly due to drugs and/or debt. While there had been significant investment and focus on reducing violence, this lacked coordination between all key stakeholders and there was no detailed supply reduction action plan. The substance misuse meeting was infrequent, and attendance was poor, with no representation from the security department.

23. Healthcare staff had dealt with a large number of emergencies related to drug intoxication, which had put a significant strain on health resources.

24. HMIP also conducted a scrutiny visit (a shortened inspection due to the coronavirus pandemic) in October 2020. Inspectors found that staff generally had limited individual contact with prisoners and held themselves apart. A third of prisoners said it was easy to access drugs in the prison.

Independent Monitoring Board

25. 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 31 January 2020, the IMB found that substance misuse and the availability of illicit drugs remained a significant problem, even though the prison had introduced several measures to improve security.

26. The Board noted that the key worker system had been introduced during the reporting year. However, although 80% prisoners surveyed in October 2019 knew they had a key worker, only half knew their name and only a quarter had spoken to their key worker in the previous seven days. The Board found that significant improvements had been made towards the end of the year.

Previous deaths at HMP Lindholme

27. Mr Omar was the 17th prisoner to die at Lindholme since February 2017. Four of the previous deaths were from natural causes, five were self-inflicted and seven were drug-related.

28. In a previous investigation into a death from PS toxicity at Lindholme in September 2019, we expressed concern about the availability of drugs at the prison and recommended the Governor ensure that the key drug issues were identified and that the prison's local drugs strategy was reviewed regularly to ensure that key issues were being addressed.

The key worker scheme

29. The HMPPS key worker scheme is intended to be an important means of reducing violence and self-harm in prisons. Under the Offender Management in Custody model each prison officer is the named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations with each prisoner.

30. From March 2020, the key worker scheme was suspended across the prison estate because of the COVID-19 restrictions, but wing staff at Lindholme were required to make a weekly welfare check on all prisoners.

Psychoactive substances (PS)

31. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

32. The effects of PS are unpredictable, and prisoners do not know what exactly they are using. In the course of our investigations we see numerous examples of apparently fit young men dying as a result of the effects of PS.

Key Events

33. On 21 October 2015, Mr Ahmed Omar was sentenced to 19 years in prison for wounding with intent and firearms offences. He was sent to HMP Doncaster. This was his first custodial sentence.

34. Mr Omar had a history of drug misuse in the community, but during his time in prison he denied having any current drug misuse issues and declined support offered to him from the drug intervention teams.

HMP Lindholme

35. On 8 February 2019, Mr Omar transferred to Lindholme. When he arrived, he was assessed by a nurse as having no mental and physical healthcare issues and deemed low risk of suicide or self-harm.

36. Mr Omar settled at Lindholme, obtaining employment in the bike repair shop. Mr Omar's key worker, an officer, saw him regularly from August 2019 to 19 March 2020, and recorded each time that he said he was happy and had no issues.

37. In common with other prisons in England and Wales, Lindholme introduced a very restricted regime from 24 March, designed to restrict the spread of COVID-19. As a result, prisoners were locked in their cells for around 23 hours a day and only allowed out for essential purposes such as exercise, showers and collecting meals and medication.

38. On 6 July, staff searched Mr Omar's cell. They found a number of unauthorised items, including SIM cards, a charger and other items for mobile phones, a hypodermic needle, and an improvised weapon. Staff downgraded Mr Omar to the basic regime as part of the prison's zero tolerance policy. On 9 July, he was upgraded to the standard IEP level after completing 72 hours on the basic regime, in line with the prison's COVID-19 interim IEP policy.

39. Although the key worker scheme had been suspended because of the COVID-19 restrictions, a member of wing staff spoke to Mr Omar roughly once a week to check on his welfare (known as a 'decency check'). On each occasion, staff recorded that Mr Omar said that he had no issues, did not need any support from staff and was happy with the regime.

Events of 11 August

40. On 11 August, an officer raised concerns with the safer custody team about a change in Mr Omar's behaviour. He was not coming out of his cell to collect his meals or take part in the regime and other prisoners had expressed concerns about him. The officer told the investigator that Mr Omar was 'hyper' in his behaviour, he was fixated with issues with his cell key and irrational in conversation when he spoke to him, saying that other prisoners had been coming into his cell all night.

41. Mr Omar's aunt called the prison that morning to express concerns about his mental state.

42. At 9.30am, Nurse A, a senior mental health nurse, and a safer custody officer saw Mr Omar in his cell. It was a hot day and they noted that Mr Omar was extremely hot and was lying on his bed with a wet towel on his forehead and two fans on. The safer custody officer told Mr Omar that there were concerns for his welfare. Mr Omar said that he had been poorly and that he believed he had flu as he had a sore throat, headaches, and a blocked nose, but he felt better and hoped to be back to his normal self in a few days. Mr Omar said he was eating and socialising normally and denied any drug use.

43. Nurse A assessed that Mr Omar did not need any mental health intervention. He told the investigator that that Mr Omar showed no indicators of low mood, anxiousness, psychosis or thought disorder and that he was able to concentrate, make eye contact and hold a conversation.

44. The safer custody officer recorded that Mr Omar was coherent, polite and spoke normally throughout their conversation and did not show any signs of mental ill health or drug use.

45. After seeing Mr Omar, the safer custody officer went to speak to two of the prisoners who had raised concerns with an officer. One said that he had only noticed that morning that Mr Omar was "acting out of character", although he also said Mr Omar had not eaten "for a while". The other said that Mr Omar had been taking 'Spice' (a form of PS) for "a few weeks solid" but had not taken any for two or three days. He said Mr Omar had been up for much of the night recently and that he and other prisoners had been trying to calm him down. He said Mr Omar had packed his belongings that morning and told other prisoners he was moving into a flat. The safer custody officer also recorded that other prisoners had told staff that Mr Omar had shown signs of deteriorating after two of his friends had moved to another wing in mid-July.

46. At 1.45pm, an officer went to see Mr Omar to conduct a routine decency check. He recorded that he was aware that Mr Omar was having "some issues" but that he asked him to close his door as he said he did not want to talk.

47. That afternoon, Mr Omar's aunt telephoned the prison as Mr Omar had called her on the phone and told her that someone was threatening to kill him, that he was being held against his will and someone was coming into his cell taking his things. Mr Omar's aunt said that she was concerned that his mental health was deteriorating and asked staff to check on him.

48. At about 6.00pm, the safer custody officer went to see Mr Omar again in his cell. She recorded that he was out of his bed and dressed. She told him that his aunt had telephoned the prison as she was concerned for his welfare. Mr Omar said that he had called his aunt as he wanted to move cells and he thought it would help to get him moved. The safer custody officer told Mr Omar that cell moves only took place when necessary and it was unlikely that he would be moved.

49. The safer custody officer recorded that Mr Omar told her that his cell courtesy key (a key prisoners can use to lock their cells when they leave them) had broken so he could not lock his door and that his key was being hung up outside his cell at night so other prisoners could enter his cell. Mr Omar said that he thought other prisoners were coming into his cell at night to smoke 'weed'. The safer custody officer checked the key and it was working properly.

50. Mr Omar then said that he knew he was hallucinating from using PS the previous week. He said that he had heard all the 'hype' about PS and wanted to see for himself, but it had made him feel unwell, so he had given it to another prisoner. He said he had not been sleeping so he had taken some unprescribed sleeping tablets, which had also made him unwell. Mr Omar refused to disclose how he had obtained the sleeping tablets and denied being under threat from other prisoners. He also said that he had lied earlier and that he had not been eating and was not really drinking. The safer custody officer advised him to eat and to keep himself hydrated. Mr Omar said he would be alright in a few days once the drugs were out of his system. The safer custody officer submitted an intelligence report about Mr Omar's drug taking.

Events of 12 August

51. The following morning, on 12 August, other prisoners told staff that they had concerns about Mr Omar's behaviour and said he had been banging around in his cell during the night and was drinking the water from his cell toilet. Staff found Mr Omar was talking fast and erratically. They encouraged him to tidy his cell and take a shower and allowed him extra time out of cell to do this. Mr Omar was offered support by other prisoners who tidied his cell while he showered.

52. Wing staff contacted a nurse in the mental health team and said that they continued to be concerned about Mr Omar. The nurse responded that Nurse A had seen Mr Omar the previous day and had thought his behaviour was likely to be drug-related. Later that day, Custodial Manager (CM) A, who was the Orderly Officer, spoke to the nurse and it was agreed that there was little that could be done until the drugs had passed through Mr Omar's system.

53. At 3.09pm, an officer rang healthcare staff and asked for a mental health nurse to see Mr Omar because staff had concerns that his mental health was deteriorating further. A mental health nurse said Mr Omar would be seen on 13 August.

54. That afternoon, CM A instructed staff to search Mr Omar's cell for drugs. A number of white tablets were found. CM A told the investigator that Mr Omar was not placed on a disciplinary charge as the tablets had not been identified as unauthorised and he considered the deterioration in Mr Omar's mental health meant it was not appropriate to place him on report at that time.

55. CM A said that he did not consider it was necessary to open suicide and self-harm monitoring procedures (known as ACCT) because Mr Omar had no history of self-harm and it appeared that the deterioration in his mental health was drug-related. He told the investigator that he considered that Mr Omar could be supported by staff on the wing until his mental health assessment on 13 August. He said he therefore placed Mr Omar on two-hourly welfare monitoring checks while the cause of the decline in his mental health was confirmed. He said this decision was not recorded as, from his point of view, "it was about keeping an eye on him, rather than the documentation side of it, but documenting any changes in behaviour or changes in risk".

56. An Operational Support Grade (OSG) was on duty on Mr Omar's wing that night. He said he had not been told to make checks on Mr Omar. At about 9.30pm, he heard banging noises coming from Mr Omar's cell and went to check on him. He

told the investigator that as he looked into Mr Omar's cell, he saw him throwing items around his cell, smashing his fan against the wall, jumping onto the furniture and appearing extremely agitated. The OSG said he attempted to speak to Mr Omar, but he did not respond and appeared to be speaking in a foreign language.

57. The OSG said that he told Mr Omar to drink some water and he then returned to the wing office and telephoned the Assistant Night Orderly Officer, Officer A, for assistance. He said Officer A told him that they knew Mr Omar had been behaving like that at times and that he would calm down. The OSG therefore carried on with his other duties.

58. At around 11.00pm, the prisoner in the cell next to Mr Omar's rang his cell bell and asked the OSG to check Mr Omar because he was making a lot of noise. The OSG looked through the observation panel and saw Mr Omar rolling around on the floor of his cell with a table on top of him. The OSG called for assistance again.

59. Officer B responded. She told the investigator that she knew Mr Omar well because she worked on his wing. When she looked through the observation panel in the cell door, she saw Mr Omar waving his arms and legs around and screaming and throwing his furniture around as though in a tantrum. She attempted to get his attention by banging on the cell door, but he did not acknowledge or speak to her.

60. Officer B called for assistance from other staff. Officer A arrived, together with Officer C and two other officers. Officer B said they watched Mr Omar through the observation panel in his door for 10 to 15 minutes and Officer A went to ask CM B, the Night Orderly Officer, for advice. As staff considered that Mr Omar's behaviour was due to possible drug use and as he appeared to be calmer and to be going to sleep on the floor, CM B decided that staff should not enter his cell but that he should instead be checked every half hour.

Events of 13 August

61. At 1.05am on 13 August, the OSG went to check Mr Omar as part of his half hourly welfare checks. He told the investigator that Mr Omar had been asleep on the floor when he had conducted the previous checks and he had clearly seen him breathing. On this occasion, when he looked through the observation panel in the door, he saw Mr Omar lying on the floor by the door and was unable to see whether he was breathing, so he called for assistance from staff nearby.

62. Officer B and Officer C responded. They shouted and kicked the door but Mr Omar did not respond. They thought he was breathing but were not sure because of the position he was in, so the OSG radioed "a possible code blue". (A code blue is an emergency medical code which indicates that a prisoner is unresponsive or not breathing and alerts the control room to call an ambulance immediately.)

63. More staff arrived, including Officer A who entered the cell and immediately radioed a code blue and began CPR. Staff applied the defibrillator, but no shocks were advised.

64. Staff continued to give CPR to Mr Omar and at 1.25am an ambulance arrived at the prison. At 2.23am, Mr Omar was taken to hospital, where at 3.18am, it was confirmed that he had died.

Contact with Mr Omar's family

65. Mr Omar's family were informed by unofficial means (presumably by another prisoner) that he had been taken to hospital and made their way there. In the early hours of 13 August, a prison Family Liaison Officer (FLO) met Mr Omar's relatives at the hospital. The FLO spoke with Mr Omar's brother who said he would pass on information to Mr Omar's mother, his named next of kin.

66. When Mr Omar died, the FLO contacted Mr Omar's mother by telephone due to COVID-19 restrictions, instead of visiting her in person. She remained the point of contact for the family, providing support.

67. The prison contributed to the cost of Mr Omar's funeral in line with prison policy.

Support for prisoners and staff

68. A duty governor conducted a debrief with staff closely involved in the care and emergency response for Mr Omar, and the staff care team offered support.

69. The prison posted notices informing prisoners of Mr Omar'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 Omar's death.

Post-mortem report

70. The pathologist concluded that Mr Omar died from synthetic cannabinoid (PS) toxicity.

71. The toxicology tests detected a synthetic cannabinoid of a type commonly referred to as 'Spice' in Mr Omar's blood, as well as a low concentration of the antidepressant mirtazapine. A mirtazapine tablet was found in Mr Omar's cell, although it had not been prescribed to him. The level of mirtazapine in his blood was low and would not have contributed to his death.

Findings

Mr Omar's PS use

72. Mr Omar died as a result of using PS and we have therefore considered whether staff were aware that he was using drugs and whether they responded appropriately.

73. Staff told us that Mr Omar was a polite prisoner who caused few problems. They said he was always keen to spend time socialising with other prisoners, and he appeared to have lots of friends on the wing. He was suspected of dealing in illicit items but they had no suspicion that he was using drugs himself.

74. Some staff and prisoners suggested that Mr Omar's behaviour had begun to change a couple of weeks before he died and he had stopped socialising. One prisoner told staff Mr Omar had been taking PS "for a few weeks solid" before he died and attributed his changed behaviour to this.

75. All staff agreed that Mr Omar's behaviour changed dramatically in the two days before his death when he stopped eating, began to express irrational ideas about other prisoners entering his cell at night and started behaving bizarrely. A mental health nurse saw him and thought his behaviour was likely to be drug-induced.

76. From March 2020 onwards, the regime at Lindholme was very restricted in response to the COVID-19 pandemic and prisoners were only allowed out of their cells for an hour a day, plus time to collect meals. This meant that Mr Omar's contact with prison staff was significantly more limited than before the pandemic. Although regular 'decency checks' had replaced the key worker meetings, these appear to have been very routine and an officer (who carried out most of the checks) simply recorded that Mr Omar said he was happy and had no issues. This continued to be the case even during the weeks before Mr Omar's death when some staff and prisoners said his behaviour had changed, that his mental health was deteriorating and that he was using PS on a daily basis. This suggests that the decency checks did not involve any meaningful conversation and may have been a missed opportunity to identify concerns, including signs of drug use or deteriorating mental health.

77. We also note that testing for illicit drug misuse was not carried out at Lindholme because of the restrictions in response to the COVID-19 pandemic. We consider that there might have been missed opportunities to notice early signs of his illicit drug use.

78. However, on 11 and 12 August there was plenty of evidence from other prisoners that Mr Omar was using PS and he admitted this himself to the safer custody officer. We share the clinical reviewer's concern that staff failed to refer Mr Omar to the substance misuse team at this point, especially as they considered his worrying behaviour was drug-related.

79. In addition, although staff acted appropriately in asking a member of the mental health team to review Mr Omar, we consider that they should also have asked a nurse to see him to check his physical health after he admitted that he had been using drugs. Mr Omar's behaviour was very out of character and had continued

over two days; staff, prisoners and his aunt were expressing concerns about him; and the weather was very hot and Mr Omar was described as being dehydrated.

80. CM A told us that his primary concern was whether Mr Omar was at risk of suicide or self-harm. We agree that there was no reason to open ACCT procedures. However, we have seen many cases where have prisoners have died as a result of PS use and, although staff were rightly concerned about Mr Omar's mental state, we consider that they did not take the risks to his physical health seriously enough. If healthcare staff had seen Mr Omar, it is likely that they would have taken his observations, arranged for him to be checked regularly and given prison staff guidance on what warning signs to watch for. We cannot say if this would have altered the outcome for Mr Omar, but it may have done.

81. We make the following recommendation:

The Governor should ensure that all staff understand that drug use, including PS use, carries a significant risk to health and should always be taken seriously.

The Governor should ensure that when a prisoner is suspected to be under the influence of illicit substances, staff always:

- **record the incident;**
- **inform healthcare staff; and**
- **make a referral to the substance misuse team.**

Drug strategy at HMP Lindholme

82. Mr Omar's death is an example of the dangers of PS and illustrates why prisons must do all they can to eradicate its use.

83. Inspections of Lindholme in 2017 and 2020 found that the availability and use of drugs, including PS, was a serious problem linked to debt and violence. Inspectors found that there was no detailed supply reduction plan; drug strategy meetings were infrequent and poorly attended; and there was a lack of coordination across prison departments.

84. In a previous investigation into the death of a prisoner who died as a result of PS use at Lindholme in September 2019, we recommended that the Governor should ensure that prison's local drugs strategy included specific plans to help reduce the availability of PS, and that staff should record all instances of prisoners under the influence of illicit substances and pass the information to the healthcare department and substances misuse service.

85. Lindholme accepted our recommendation and said that they would review the local drug strategy. They also said that they would collate all instances of prisoners being under the influence of drugs which would be shared with the senior management team and the Head of Healthcare. This would allow the substance misuse team to make early contact with each prisoner to offer intervention support. The record of the contact would then be logged on the prisoner's SystmOne healthcare record. The prison said that they would also re- issue a 'notice to staff'

to remind them of the importance of submitting an incident report when a prisoner is believed to be under the influence of illicit drugs.

86. We are concerned that although the prison has taken steps to review its local drugs strategy regularly, Mr Omar was still able to obtain illicit drugs during the pandemic with apparent ease. The prison told us that its drugs strategy is currently being revised, with a planned completion date of August 2021. We make the following recommendation:

The Governor should ensure that the prison's revised drugs strategy takes account of the findings of this report and the Ombudsman's previous reports on drug-related deaths at Lindholme.

Welfare checks

87. Although we agree that it was appropriate for CM A to ask staff to carry out two-hourly checks on the afternoon of 13 August, we are concerned that he did not record this decision, beyond recording at about 5.00pm that staff "will continue to monitor and support Ahmed further while we establish the cause for his current issues and presentation".

88. We are also concerned that there is no record that staff carried out these checks and that CM B (the Night Orderly Officer) and the OSG both told us that they did not know that Mr Omar was subject to these welfare checks. Officer A (who was the Assistant Night Orderly Officer) said they had a handover that Mr Omar had been "under the influence for a couple of days" and was displaying erratic behaviour, but they were not told he was on welfare checks.

89. Some staff told us that they were aware that these checks sometimes took place when a prisoner was suspected of being under the influence of drugs, but that there was no formal means of recording them and that, if they were recorded, it would be done on a loose sheet of paper.

90. It was only after the OSG had alerted staff to Mr Omar's very bizarre behaviour for the second time at about 11.00pm, that CM B asked that Mr Omar should be checked every half-hour. Although we are satisfied that the OSG carried out these checks, there is no record that he did so.

91. We recommend:

The Governor should ensure that there is a formal system in place for recording welfare monitoring checks when a prisoner is suspected to be under the influence of drugs or alcohol.

Emergency response

92. When staff left Mr Omar's cell for the second time on the night of 12 August, he had appeared to calm down and to be going to sleep on the floor. Officer A said that it was a very hot night and that it was not unusual for prisoners to sleep on the floor where it was cooler.

93. The OSG carried out a welfare check on Mr Omar at 12.30am on 13 August. He looked through the observation panel in the door and observed Mr Omar for a few

seconds. He told us that he could see Mr Omar was breathing, and he thought he was asleep and so he did not try to wake him. Prison officers had been content to leave Mr Omar asleep on the floor, CM B had been aware of the situation, and the OSG had been given no instructions to the contrary. In these circumstances we consider it was reasonable for the OSG to accept this situation and not to raise any concerns.

94. When the OSG carried out a further welfare check at 01.05am and thought that Mr Omar was not breathing, he called for help from staff he knew were nearby. We consider that it would have been preferable for him to have called a code blue medical emergency if he thought Mr Omar was not breathing. Even a few minutes delay can make a critical difference in such a situation and Prison Service Instruction (PSI) 3/2013, *Medical Emergency Response Codes*, says, "It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required." This is especially the case in a prison like Lindholme where there are no healthcare staff on duty overnight and it is therefore vital that seriously ill prisoners are seen by ambulance paramedics as quickly as possible.

95. When Officer B and Officer C arrived, they were not sure if Mr Omar was breathing or not and the OSG called "a possible code blue". We are concerned that this was a misleading call. The point of calling an emergency medical code is to alert control room staff to call an ambulance immediately. The urgency of the emergency code is lost if it is used incorrectly. Again, we consider that staff should have called a code blue, even if the ambulance later had to be cancelled.

96. We recommend:

The Governor should ensure that all staff understand the importance of calling a medical emergency code promptly in a medical emergency.

Clinical care

97. The clinical reviewer found that the clinical and mental healthcare Mr Omar received at Lindholme was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

Mental Health Care

98. When Nurse A saw Mr Omar on 11 August, he assessed that Mr Omar had no immediate mental health concerns. He told the investigator that Mr Omar showed no signs of decline in his mental health or drug use, that he spoke normally, was coherent in speech and polite. The safer custody officer, who saw Mr Omar with Nurse A also told us that Mr Omar showed no signs of mental ill health or drug use when they spoke to him.

99. Prison staff continued to raise concerns about Mr Omar's behaviour with the mental health team on 12 August, but suggested that he was under the influence of drugs. It was agreed that a mental health nurse would see him on 13 August.

100. The clinical reviewer is satisfied that the mental health care Mr Omar received was of a reasonable standard and equivalent to that he could have expected in the

community. She said Mr Omar was seen on the day he was first referred and that an appropriate action plan and follow up was agreed.

101. However, we share the clinical reviewer's concern that although Mr Omar reported flu-like symptoms on 11 August, Nurse A did not consider whether he might have symptoms of COVID-19 and did not record a NEWS2 score (a tool for monitoring clinical deterioration). We agree that both should have been done given the COVID-19 situation.

102. We recommend:

The Head of Healthcare should share this report with Nurse A and ensure that he is aware of the Ombudsman's findings.

Learning lessons

103. It is important that staff learn from the Ombudsman's investigations. We therefore recommend:

The Governor should share this report with CM A, CM B, Officer A, Officer B, Officer C and the OSG to ensure they are aware of the Ombudsman's findings.

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