Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Cameron, a prisoner at HMP Lindholme, on 1 October 2022

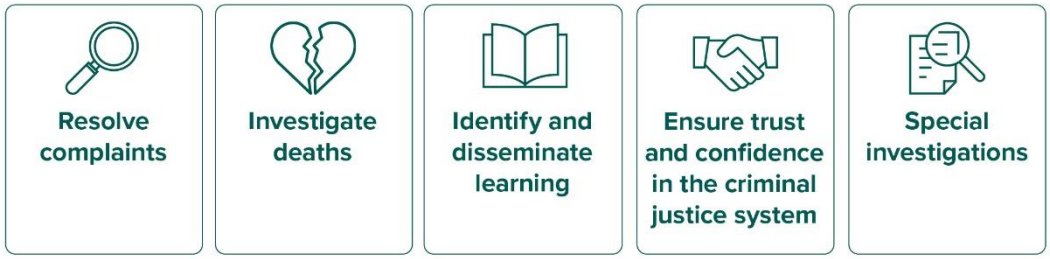
A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Kevin Cameron died in hospital from a spontaneous intracranial haemorrhage (bleeding within the skull) on 1 October 2022, while a prisoner at HMP Lindholme. He was 50 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the care that Mr Cameron received at Lindholme was of a variable standard, and despite a number of areas of good practice, there were some areas of clinical care that were not equivalent to that which he could have expected to receive in the community. I am particularly concerned that prison officers did not call a medical emergency code blue for Mr Cameron in line with national instructions on 25 September 2022, when they found him unresponsive.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **July 2023**

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Summary

Events

1. On 4 February 2002, Mr Cameron was sentenced to life in prison for wounding. He was last released on licence in 2018.

2. On 8 September 2022, Mr Cameron was recalled to prison after breaching his licence conditions. He was sent to HMP Lindholme on 14 September.

3. On the morning of 16 September, a prison officer found Mr Cameron on the floor of his cell. Healthcare staff attended to him, and later that day, placed him on twice hourly welfare checks for the next 48 hours.

4. At 3.20pm, a prison officer took Mr Cameron to the shower. While taking a shower, Mr Cameron fell. Healthcare staff assessed him and asked staff to continue welfare checks. He was also added to the daily healthcare welfare checks.

5. On the morning of 25 September, Mr Cameron did not attend the medication hatch to collect his daily medication. A prison officer went to get him and found that he was unrousable. He asked another officer to check on him and went to tell healthcare staff at the medication hatch. The second officer and healthcare staff advised him to call a medical emergency code blue. (There is no CCTV footage to confirm the timings of these events.)

6. At 9.57am, the officer radioed a code blue. The control room requested an emergency ambulance. Healthcare staff attended and administered medical treatment until the ambulance paramedics arrived.

7. At 10.51am, Mr Cameron was sent to hospital by emergency ambulance.

8. On 30 September, the hospital diagnosed that Mr Cameron had suffered a brain haemorrhage and was brain dead. He died the next day.

Findings

9. We are concerned that a prison officer did not recognise that Mr Cameron was extremely unwell on 25 September and failed to call a medical emergency code blue immediately when he found Mr Cameron unresponsive. While we cannot say if this would have affected the outcome for Mr Cameron, in other emergencies, it could be critical.

10. Lindholme did not provide the CCTV for 25 September, which meant that we could not confirm the order of events when Mr Cameron was found unresponsive.

Recommendations

- The Governor should ensure that prison staff understand when to use medical emergency codes, in line with Prison Service Instruction (PSI) 03/2013.

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

- The Governor should ensure that all evidence about a death in custody, including statements and electronic evidence, is retained and promptly made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.

The Investigation Process

11. 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. No one responded.

12. The investigator visited Lindholme on 14 November 2022. She obtained copies of relevant extracts from Mr Cameron's prison and medical records.

13. NHS England and NHS Improvement commissioned a clinical reviewer to review Mr Cameron's clinical care at the prison.

14. The investigator and clinical reviewer interviewed nine members of staff at Lindholme on 14 November. They also interviewed three members of staff virtually on 22 December.

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

16. The Ombudsman's family liaison officer contacted Mr Cameron's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She asked:

    - about Mr Cameron's medical care at Lindholme;
    - when and how Mr Cameron sustained a head injury;
    - how severe his head injury was;
    - whether any prison officers were supervising Mr Cameron at the time he sustained a head injury; and
    - why Mr Cameron was not taken to hospital following the head injury.

    This report and Appendix A of the clinical review addresses these questions.

17. Mr Cameron's sister received a copy of the draft report. She did not make any comments.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Lindholme

19. HMP Lindholme is a medium security prison near Doncaster. It holds approximately 1,000 prisoners. Practice Plus Group provides healthcare services, with healthcare staff on duty between 7.30am and 7.30pm every day.

HM Inspectorate of Prisons

20. The most recent inspection of Lindholme was in October 2017. A scrutiny visit took place in October 2021. In both reports, inspectors reported no concerns which are significant to the findings of this report.

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 latest annual report for the year to the end of January 2022, the IMB raised no concerns which are significant to the findings of this report.

22. The IMB was pleased that there were no deaths in custody during the reporting year.

Previous deaths at HMP Lindholme

23. There was one self-inflicted death at Lindholme in the two years before Mr Cameron's death. There are no significant similarities between our findings in the investigation into Mr Cameron's death and our investigation findings about the previous death.

Key Events

24. On 4 February 2002, Mr Cameron was sentenced to life in prison for wounding. He was last released on licence in 2018.

25. On 8 September 2022, Mr Cameron was recalled to prison after breaching his licence conditions. He was sent to HMP Lindholme on 14 September.

26. When he arrived, a nursing associate carried out an initial health screen to assess Mr Cameron's health and care needs. She noted that officers were concerned that he appeared under the influence of drugs or alcohol and that his speech was slurred. Mr Cameron reported that he had epilepsy from a previous head injury and was undergoing cancer investigations.

27. On 15 September, an HCA carried out a second health screen. Mr Cameron told her that he had been hit on the head with a crowbar years ago and had been in a coma for two years.

28. On 16 September, Officer A went to Mr Cameron's cell to take him to the medication hatch. She found him on the floor of the cell, unable to speak coherently. She radioed for healthcare staff to attend because Mr Cameron appeared under the influence of substances. She noted that Mr Cameron had banged his head as he fell.

29. At approximately 8.50am, a nurse went to see Mr Cameron, who was still with Officer A. She noted that he was talking but his speech was slurred and that he said he had bad migraines. She also noted a head injury from the 1990s which had resulted in Mr Cameron being in a coma for two years. She completed his physical observations and calculated a National Early Warning Score (NEWS2) of 0. (NEWS2 is a tool to detect and respond to clinical deterioration. A score above 7 indicates the need for an emergency response.)

30. The nurse completed the Glasgow Coma score assessment of Mr Cameron's level of consciousness. She scored him 15 out of 15 because she felt he was conscious, alert, fully oriented and obeying commands. She asked the prison officers to carry out welfare checks on Mr Cameron twice hourly for 48 hours. Officer A completed the welfare check paperwork, and the first check was completed at 8.50am.

31. At around 3.00pm, a nurse saw Mr Cameron to assess whether Lindholme could meet his needs and to find out his history due to reports that he had slurred speech, mobility problems and that he had possibly been under the influence of substances. She noted that he had reported a previous head injury, that he had been in a coma in the past and had had constant migraines for the last three years.

32. At 3.20pm, Officer A took Mr Cameron to the shower. Another officer remained outside the shower room. He regularly knocked on the door and checked on Mr Cameron during the shower. While Mr Cameron was showering, the officer heard noise from the bathroom. He opened the door and found Mr Cameron on the floor. He noted that Mr Cameron was rubbing his head and assumed that he had hit his head. He asked Officer A to call healthcare staff to check on Mr Cameron.

33. A nurse responded. Mr Cameron declined a full assessment and denied having any injuries. He said that he had lost his balance due to the heat of the shower. She asked staff to continue twice hourly welfare checks and she also put Mr Cameron on the list for healthcare daily welfare checks. She noted that he already had an GP appointment scheduled for 20 September.

34. On 20 September, a prison GP reviewed Mr Cameron. She noted that he had reported having a severe headache for three months despite no recent trauma. She completed a brief cognitive impairment test and calculated a score of 15. (A score of 8 or above suggests a significant cognitive impairment). She sent a task (an electronic message) to the healthcare team for Mr Cameron to have an urgent blood test.

35. On 22 September, Lindholme held a healthcare multi-professional meeting to discuss Mr Cameron's ongoing complex health needs. A decision was made at this meeting to monitor and assess Mr Cameron's progress and review him in two weeks' time.

36. On 23 September, a nurse reviewed the list of healthcare tasks and found the task for the blood test. She booked Mr Cameron into the next available blood clinic on 26 September.

Events of 25 September to 1 October 2022

37. At approximately 6.30am on 25 September, an officer completed a routine check of all prisoners on the wing, including Mr Cameron, and identified no concerns.

38. At around 9.50am, Officer B unlocked Mr Cameron's door but did not see or speak to him.

39. Mr Cameron was due to attend the medication hatch to collect his morning medication. A pharmacy technician told Officer C that Mr Cameron had not attended.

40. Officer C went into Mr Cameron's cell and made several unsuccessful attempts to wake him. (There is no CCTV footage available to confirm when this took place.) He then returned to the medication hatch and told them he could not wake him. On the way there, he had also seen Officer B, and told her that he could not wake Mr Cameron. He said that he asked her to try to wake him.

41. Officer B went into the cell and called to Mr Cameron. She said that she shouted his name but he did not respond. She said that his breathing appeared abnormal. She said she left the cell and told Officer C that she could not wake him, and he should call a code blue medical emergency (indicating a prisoner is unconscious or not breathing and initiating a request for an ambulance).

42. A nurse said that she was at the medication hatch when Officer C approached to say that he could not wake Mr Cameron. She said that she asked him if he was asleep or not waking, and that he left to go back to check on Mr Cameron, then returned again to say that he would not wake up. She said she then told him to radio a medical emergency code blue and went to Mr Cameron's cell.

43. At 9.57am, Officer C radioed a medical emergency code blue. The control room requested an emergency ambulance. Healthcare staff attended and found that Mr Cameron was unresponsive. They took his physical observations and recorded a NEWS2 of 12, then monitored Mr Cameron and administered medical treatment until the ambulance paramedics arrived.

44. At 10.51am, ambulance paramedics took Mr Cameron to hospital.

45. On 30 September, the hospital confirmed that Mr Cameron was brain dead.

46. On 1 October, Mr Cameron died.

Contact with Mr Cameron's family

47. On 25 September, when Mr Cameron was taken to hospital, a Custodial Manager was nominated as the family liaison officer (FLO). She asked the police to visit the person listed as the next of kin who then contacted Mr Cameron's sister to tell her that Mr Cameron was in hospital.

48. Mr Cameron's sister contacted the prison, and, on 27 September, the FLO telephoned her to discuss his condition and remained in contact with her. Mr Cameron's sister asked the FLO only to contact her during the day if Mr Cameron died.

49. On the morning of 1 October, the FLO rang Mr Cameron's sister to inform her that he had died.

50. Mr Cameron's funeral took place on Friday 11 November 2022. Lindholme contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

51. After Mr Cameron's death, a senior 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.

52. The prison posted notices informing other prisoners of Mr Cameron'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 Cameron's death.

Post-mortem report

53. The post-mortem report concluded that Mr Cameron died of spontaneous intracranial haemorrhage (a brain haemorrhage described as bleeding within the skull). The post-mortem states that this is likely to reflect an underlying vascular (circulatory systems or blood vessels) abnormality rather than a consequence of either epilepsy, previous cranial trauma (head injury) or drug misuse.

Findings

Clinical care

54. The clinical reviewer concluded that the care that Mr Cameron received at Lindholme was of a variable standard. She said that there were some areas of clinical care that were not equivalent to that which he could have expected to receive in the community. She identified a number of areas of good practice, including good systems for identifying medical appointments for newly arrived prisoners, appropriate use of the complex care register to coordinate care needs and vulnerabilities, and the healthcare team ensured ongoing assessment and monitoring of Mr Cameron following his falls on 16 September. However, she identified a number of concerns about Mr Cameron's clinical care. She made a recommendation about the emergency response and three further recommendations which were not directly relevant to Mr Cameron's death but which the Head of Healthcare will need to address.

Emergency response

55. PSI 03/2013 states that a medical emergency code blue should be called when a patient is found unconscious. All prison staff should be aware of and understand the PSI and their responsibilities during medical emergencies.

56. When Officer C went into Mr Cameron's cell to wake him for medication, he could not get a response from him. At interview, he described him as 'snoring' and 'breathing away quite merrily'. He reported that he left the cell once and asked Officer B to check on Mr Cameron and that he called the code blue within 60-90 seconds of first going into Mr Cameron's cell.

57. A nurse noted at the time that she was asked to review Mr Cameron because the officer was concerned that he was not waking up and that she told the officer to call a code blue. She repeated this at interview and reported that Officer C went back into the cell a second time and could not wake him.

58. The investigator was unable to view any CCTV footage of the incident on 25 September, as Lindholme was unable to locate it, and therefore could not confirm the exact order of events. It is not clear from the reports of the incident how many times Officer C went into the cell to check on Mr Cameron. However, it is clear that he could not immediately wake him. It is also clear that moments later, when healthcare went into the cell, they found him unresponsive and very unwell.

59. Neither Officers B nor C called a code blue when they could not rouse Mr Cameron, though Officer B reported that she told Officer C to do so. We are concerned that Officer C did not recognise that Mr Cameron was extremely unwell. We would expect officers to call a medical emergency code blue immediately when they are concerned that a prisoner is unresponsive. While we cannot say if this would have affected the outcome for Mr Cameron, in other emergencies, it could be critical. We make the following recommendations:

The Governor should ensure that prison staff understand when to use medical emergency codes, in line with Prison Service Instruction (PSI) 03/2013.

The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Providing the PPO with the relevant documents

60. PSI 58/2010 requires prisons to provide evidence to the Ombudsman's office for the purpose of our investigation. Lindholme did not supply the CCTV from the 25 September, as they were unable to locate it. This adversely affected our investigation as we were unable to confirm the order of events during the emergency response. We make the following recommendation:

The Governor should ensure that all evidence about a death in custody, including statements and electronic evidence, is retained and promptly made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.

Inquest

61. The inquest into Mr Cameron's death concluded on the 10 October 2023. The coroner confirmed that Mr Cameron died of natural causes.

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