

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Lindley, a prisoner at HMP Ranby, on 9 August 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

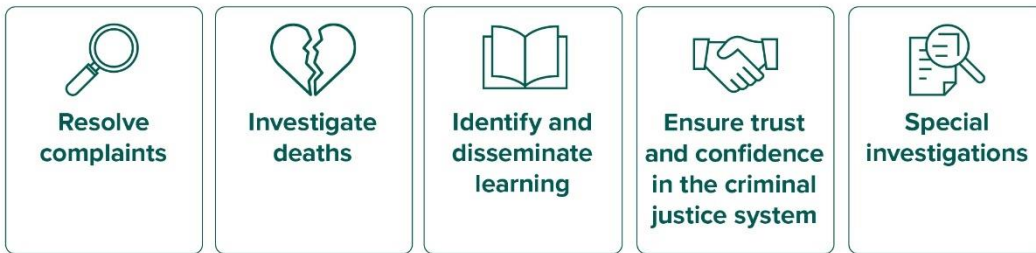
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 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



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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those in prison is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Ian Lindley died of dihydrocodeine (an opioid painkiller) toxicity on 9 August 2022, at HMP Ranby. He was 44 years old. I offer my condolences to Mr Lindley's family and friends.

Mr Lindley had a history of substance misuse and was on a methadone (opioid substitute) programme in prison. He also obtained drugs illicitly from other prisoners.

Mr Lindley was found unresponsive on the morning of 9 August and could not be resuscitated. After his death, a prisoner reported that Mr Lindley had stolen a bottle of dihydrocodeine from the medications hatch. A review of CCTV confirmed this.

Both the prison and the healthcare provider carried out investigations into how Mr Lindley was able to steal dihydrocodeine from the medications hatch. Various actions have been taken as a result and so I make no recommendations in connection with that incident.

The clinical reviewer found that the care Mr Lindley received at Ranby was equivalent to that which he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman

October 2023

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Summary

Events

1. Mr Ian Lindley was recalled to prison on 30 August 2021. He was moved to HMP Ranby on 24 September 2021.
2. Mr Lindley had a history of substance misuse and was on a methadone (opioid substitute) programme in prison. He admitted to using other drugs, including dihydrocodeine (an opioid painkiller), which he obtained illicitly from other prisoners. He got into debt as a result and told staff he was under threat. Staff supported him using violence reduction procedures.
3. During the night of 7/8 August 2022, prison staff reported that Mr Lindley appeared to have had an epileptic seizure. A nurse saw Mr Lindley in his cell and noted that he was shaking. The nurse was concerned that Mr Lindley had not collected his epilepsy medication for the past two days as he was too scared to leave his cell. Staff monitored Mr Lindley for the rest of the night and he appeared much better in the morning, though he continued to refuse to leave his cell.
4. A nurse went to see Mr Lindley on 8 August, but he refused to let her assess him. He said he did not want his door opened while other prisoners were unlocked. He refused to have his door opened even slightly to allow the nurse to pass him his medication.
5. Mr Lindley pressed his cell bell twice during the early hours of 9 August. The staff who responded said he was behaving strangely and refused to engage with them, however, they did not think he appeared to be under the influence of drugs. Staff checked him every 15 minutes for two hours, up to 2.30am.
6. When staff next checked Mr Lindley at 3.25am, he was lying on his cell floor and was unresponsive. Staff and paramedics tried to resuscitate him but were unsuccessful. Paramedics pronounced his death at 4.31am.
7. After Mr Lindley's death, a prisoner told staff that Mr Lindley had stolen some dihydrocodeine from the medications hatch on 6 August. CCTV confirmed this and showed that no officers were in the vicinity at the time.
8. The post-mortem report found that Mr Lindley died from dihydrocodeine toxicity.

Findings

9. Both the prison and healthcare provider carried out investigations into how Mr Lindley had been able to steal the dihydrocodeine. As investigations were initiated and various actions taken, we make no recommendation.
10. We found Mr Lindley was able to trade in illicit drugs and was found to be under their influence on a number of occasions. Staff did not always submit intelligence reports as they should have done. This was a missed opportunity to log incidents of substance misuse and build an intelligence picture. The Governor will want to

consider whether current processes to log and investigate illicit substance use are sufficiently robust.

11. Mr Lindley was bullied by prisoners and assaulted on 3 July. Although staff had agreed that Mr Lindley should be moved to another part of the prison, this had not happened when he died.
12. The clinical reviewer found that the care Mr Lindley received at Ranby was equivalent to that which he could have expected to receive in the community. She found that he received good support with his substance misuse and mental health, though he did not have a mental health care plan as he should have done.
13. The staff who responded initially when Mr Lindley was found unresponsive, said that they entered the cell and started CPR. However, an officer who arrived a few minutes later, said that the staff had not started CPR as they said they did not know how to do it. It is not possible to say which account is correct as there was no body worn video camera footage available to show what staff did once they entered the cell. The Governor will wish to consider the learning from this incident and whether further CPR training is needed for wing staff.
14. We have highlighted several other areas for learning but make no recommendations.

The Investigation Process

15. HMPPS notified us of Mr Lindley's death on 9 August 2022.
16. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
17. The investigator obtained copies of relevant extracts from Mr Lindley's prison and medical records.
18. NHS England commissioned an independent clinical reviewer to review Mr Lindley's clinical care at the prison.
19. The investigator and clinical reviewer jointly interviewed 13 members of staff and a prisoner on 26 and 27 September, and 17 October.
20. We informed HM Coroner for Nottinghamshire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
21. The Ombudsman's family liaison officer contacted Mr Lindley's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Lindley's mother asked whether Mr Lindley was checked when he should have been and why he was not housed in the healthcare inpatients' department. We have addressed these issues in this report and in the clinical review.
22. We shared our initial report with HMPPS. They found no factual inaccuracies.
23. We sent a copy of our initial report to Mr Lindley's mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Ranby

24. HMP Ranby is a Category C prison in Nottinghamshire, holding over 1,000 men. Nottinghamshire Healthcare NHS Foundation Trust provides primary healthcare services.

HM Inspectorate of Prisons

25. The most recent full inspection of HMP Ranby was in March and April 2022. Inspectors reported prisoner on prisoner assaults had increased since their last inspection in 2018. The prison held weekly violence reduction meetings, a forum for dynamic action. Twice weekly Safety Intervention Meetings (SIMs) focused on prisoners who needed most action and support. The Challenge, Support, Intervention Plan process (CSIP, the violence reduction process) was reasonably good, and most investigations were completed swiftly.
26. The prison had taken steps to address its previous drugs culture. Fewer prisoners could obtain illicit drugs or alcohol and target led searches yielded a large amount of alcohol. In January 2023, HMIP reported on Ranby's progress against the 2022 report.

Independent Monitoring Board

27. 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 March 2022, the IMB reported that violence and assaults had reduced, possibly as a result of the restricted regime because of COVID-19 restrictions. There had been 152 prisoner assaults.

Previous deaths at HMP Ranby

28. Mr Lindley was the sixth prisoner to die at Ranby since August 2019. Of the previous deaths, three were self-inflicted and two were from natural causes. There were no similarities between the findings from our investigation into Mr Lindley's death and our investigation findings from the previous deaths.

Key Events

29. On 7 February 2020, Mr Ian Lindley was sentenced to three years in prison for robbery and possession of an offensive weapon. He was released on 6 July 2021, but was recalled on 30 August, after breaching his licence conditions.
30. Mr Lindley was moved to HMP Ranby on 24 September 2021. He had a history of substance misuse and was on a methadone (opioid substitute) programme. He was also on medication for epilepsy, asthma and depression.
31. On 27 September, Mr Lindley told a nurse that the 30ml of methadone he had been prescribed was not enough and that he had been buying dihydrocodeine (an opioid painkiller) from other prisoners. He said he was taking approximately 150mg in the mornings and 180mg in the evenings. Mr Lindley said he was concerned that he would get into debt. The nurse asked for Mr Lindley's methadone prescription to be reviewed and later that day, it was increased to 35ml.
32. On 1 October, Mr Lindley told staff that he had taken an overdose of his medication and that he was being forced to sell psychoactive substances (PS) on the houseblock. Staff started suicide and self-harm prevention procedures (known as ACCT) and opened a Challenge, Support and Intervention Plan (CSIP). (CSIP is used to manage prisoners who are violent or at increased risk of being violent. It can also be used to support victims of violence.). Staff took Mr Lindley to hospital where he stayed overnight. When he returned to Ranby, staff changed his medication from in-possession to supervised daily, meaning he had to collect it from the medication hatch each day and take it while supervised by the nurses. Staff stopped ACCT monitoring on 7 October.
33. Mr Lindley's allegations were investigated as part of the CSIP process. The investigation found that staff were sceptical about Mr Lindley's account, and noted that they should monitor him. The CSIP was closed.
34. On 21 October, a nurse saw Mr Lindley for an epilepsy review. He told her that he was having one seizure a week but had been taking his epilepsy medication and thought his epilepsy was well controlled. The nurse was concerned that one seizure a week was not good control and she referred him to a GP to consider a neurology referral.
35. On 23 October, the nurse saw Mr Lindley in his cell after he had refused to go to the medication hatch to collect his medication. He told her he did not want to leave his cell as he was under threat from other prisoners. She gave him his medication and noted that she would ask wing staff whether Mr Lindley could be brought out first to collect his medication before other prisoners. Staff opened a CSIP, and safer custody staff were tasked to investigate.
36. A nurse met with Mr Lindley on 28 October, as part of a monthly drug monitoring review. Mr Lindley said he had accrued debt on the wing, and he had been paying it off "by getting a beating". Mr Lindley said he had not bought any more dihydrocodeine but was struggling without it (and taking other illicit drugs instead). The nurse arranged for Mr Lindley's methadone prescription to be reviewed. It was

increased from 35ml to 45ml for 2 and 3 November, and 50ml from then on, to be reviewed.

37. Staff searched Mr Lindley's cell on 22 December. They found seven litres of fermenting liquid and charged Mr Lindley with a disciplinary offence. Mr Lindley was found guilty of having an unauthorised article in his possession and as punishment was prevented from spending his private cash (for example to buy canteen items) for 21 days.
38. A nurse saw Mr Lindley again on 23 December, for a drug monitoring review. Mr Lindley said he was coping well on 50ml of methadone. However, he said that other prisoners had found out that he had received a compensation payment and were bullying him to pay a £1,000 debt. Mr Lindley told the nurse that he had been bullied into holding the fermenting liquid. The nurse told wing staff she was concerned about Mr Lindley and they made a CSIP referral which safer custody recorded and staff investigated. Staff told the nurse that Mr Lindley had been offered a move to another houseblock the day before, but he had refused. However, on 29 December, he was moved from Houseblock Three to Houseblock Two.

2022

39. A substance misuse nurse reviewed Mr Lindley on 11 January 2022. Mr Lindley said he was coping well on 50ml of methadone and had not taken any illicit substances. It was agreed he would remain on 50ml.
40. Less than a week later, on 17 January, Mr Lindley told a nurse that he was not coping on 50ml of methadone and had been so stressed he had been getting Seroquel (an antipsychotic medication) for the past two weeks from a prisoner. The nurse noted that she would find out which prisoners on the wing were using Seroquel and submit an intelligence report. Mr Lindley said he had no other issues, was not in debt or being bullied and was happy to be in contact with his mother and brother.
41. On 1 February, Mr Lindley told a nurse that his epileptic seizures were becoming more frequent. He said he had no debt, was not being threatened by other prisoners and had no thoughts of self-harm. The nurse referred Mr Lindley for an epilepsy review.
42. Mr Lindley met with his key worker on 11 February. Mr Lindley said he was under threat from another prisoner, so the key worker noted in Mr Lindley's prison record that he had made a CSIP referral. Staff investigated this, but Mr Lindley told them he was no longer under threat.
43. Mr Lindley reported a seizure on 28 March. This was not witnessed, but he said he had become incontinent and bitten his tongue. Healthcare staff were asked to review Mr Lindley's epilepsy care plan. He refused to see a nurse on 31 March, as he did not think it would help. The nurse saw Mr Lindley on 8 April. He appeared pale and groggy and said he had had a seizure the day before, where he had broken a tooth and cut his lip. Mr Lindley reported another seizure on 11 April.

44. On 22 April, a GP at Ranby saw Mr Lindley and increased his epilepsy medication. Mr Lindley reported another seizure on 5 May. He did not require any medical attention. Mr Lindley did not attend a GP appointment on 19 May.
45. On 16 June, Mr Lindley went to collect his medication at the hatch. He appeared to be under the influence and healthcare staff refused to dispense it. A nurse saw Mr Lindley the next day. Mr Lindley said he had been very stressed, which increased his seizures, but denied any illicit drug use. The nurse said there had been a recent discovery of PS on Houseblock Two and advised Mr Lindley not to share his vape equipment. Staff opened a UTI (under the influence) log and monitored Mr Lindley.
46. Mr Lindley appeared under the influence again five days later, on 21 June. He had spent a lot of time in the workshop toilet, where he worked when he felt well enough, so was taken back to his cell. Mr Lindley appeared to be in the same state the next day, as his speech was slurred and he was incoherent. Healthcare staff were asked to assess him, but could not confirm he had taken illicit drugs as he would present similarly following a seizure. Staff made an entry in the UTI log.
47. Healthcare staff were asked to check Mr Lindley again the next day, as he appeared under the influence again. Mr Lindley was incoherent and slurred his words. In line with the medication protocol, Mr Lindley was not given his non-essential medication, but was given his epilepsy medication. Healthcare staff made an entry in the UTI log.
48. The next day, 23 June, wing staff thought Mr Lindley still appeared to be under the influence. A nurse assessed him and recorded that all his clinical observations were normal. Mr Lindley's new key worker met with him on 23 June. She asked whether he was in debt because of drugs. He said he was not.
49. A substance misuse psychosocial practitioner saw Mr Lindley on 29 June, to discuss drug addiction and harm minimisation following the various reports that Mr Lindley had taken illicit drugs. Mr Lindley said he was in debt for £500 and was being threatened. Mr Lindley said he had told wing officers and asked the practitioner if she could tell the safer custody department, which she did. Staff opened a CSIP and it was agreed that Mr Lindley would move to Houseblock One when a space became available. The next day, Mr Lindley appeared under the influence again. He was not given his non-essential medication.
50. While collecting his medication on 3 July, a prisoner tried to punch Mr Lindley. Mr Lindley said he was in debt for cannabis and alcohol. Staff reported the incident. Staff reviewed his CSIP and reiterated that Mr Lindley should move to Houseblock One as soon as possible (for various reasons, Mr Lindley could not move to any of the other houseblocks).
51. On 4 July, Mr Lindley refused to leave his cell because he was in debt and under threat. He said that he owed prisoners money for buying illicit drugs. This meant he did not take any medication, including his epilepsy medication. On 5 July, staff again noted that Mr Lindley should move to Houseblock One when a space became available (this did not happen before he died).
52. The substance misuse psychosocial practitioner saw Mr Lindley in his cell on 19 July. Mr Lindley said he could not leave his cell because he was being threatened,

following a previous incident in May, when he was holding fermenting liquid for another prisoner. Mr Lindley said prisoners were coming to his cell door, and that he had been assaulted in his cell and at the medication hatch. Mr Lindley said he was being supported by wing and safer custody staff and would only leave his cell when other prisoners were locked in.

53. Mr Lindley seemed to have a seizure at 1.15am on 8 August. A nurse attended and saw Mr Lindley shaking. Mr Lindley was conscious and breathing, but was incoherent and disorientated. Mr Lindley said he had not used any illicit substances. The nurse noted that Mr Lindley had epilepsy, but had refused to leave his cell to collect his medication for the past two days. It was agreed staff would monitor Mr Lindley every 15 minutes for an hour, then every 30 minutes throughout the rest of the night.
54. Later that morning, Mr Lindley seemed much better, but he refused to leave his cell to collect his medication, even with the arrangement that he could collect his medication last, when no other prisoners were around.
55. The substance misuse psychosocial practitioner went to Mr Lindley's cell to speak to him. Initially his observation panel was obscured but he took the covering down, although his mattress remained pushed up against the door. Mr Lindley asked officers not to unlock the door, so she was not able to assess Mr Lindley properly, although she saw he had a stock of food he had bought from the canteen. Mr Lindley told her that he was scared prisoners would get to him if his door was unlocked, due to drug debt. She told Mr Lindley that she was concerned he had not been collecting his prescribed medication and the importance of taking these. She asked if staff could open his door slightly to allow her to pass his medication, but he refused. Mr Lindley said he would only allow his door to be opened during patrol state, but she said she would not be able to deliver his medication then. She noted that despite not taking methadone for two days, Mr Lindley showed no signs of withdrawal. Staff told Mr Lindley to press his cell bell if he needed them.
56. The SMS manager emailed the safer custody team to alert them to the risk for Mr Lindley if he did not take his epilepsy medication. Safer custody staff responded that the plan was to move Mr Lindley to Houseblock One, but they were still waiting for a space to become available.

Events of 9 August 2022

57. On 9 August, an operational support grade (OSG) responded to Mr Lindley's cell bell at 12.10am. Mr Lindley was looking out of the window. It took a while to gain a response from him, then Mr Lindley said he did not want to talk to her, and said he was "okay".
58. Three minutes later, Mr Lindley pressed his cell bell again. The OSG responded and saw Mr Lindley talking and singing, but he did not engage with her. She was concerned about Mr Lindley's behaviour, so contacted a Custodial Manager (CM) the night orderly officer (the operational manager in charge at night), who went to Mr Lindley's cell. The CM did not think Mr Lindley was under the influence of drugs. They agreed that the OSG would check Mr Lindley every 15 minutes for two hours, and then, if his behaviour had not changed, to check him hourly. She checked Mr

Lindley every 15 minutes up to 2.30am. Mr Lindley was still awake. She had heard him shouting and singing off and on between these checks.

59. The OSG next checked Mr Lindley at 3.25am. She looked into the cell and saw Mr Lindley lying on the floor. She was unable to get a response so radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). She waited outside the cell until two officers arrived. According to these three members of staff, they then went into the cell and an officer started cardiopulmonary resuscitation (CPR). The night orderly assistant (an officer) arrived at the cell, followed by the CM. The officer told the investigator that staff were standing outside the door and that they said they did not know how to give CPR. She said that she entered the cell and started CPR.
60. A nurse responded to the code blue and arrived at Mr Lindley's cell at 3.30am. He had brought healthcare's emergency bag and defibrillator. He noted Mr Lindley had some blood on his left hand, although it was not obvious where this had come from, he felt warm, was not breathing and had no pulse. The nurse and prison staff continued CPR until paramedics arrived at 3.59am. The nurse also administered Mr Lindley with naloxone, a drug that can reverse the effects of an opioid overdose.
61. At 4.31am, paramedics declared that Mr Lindley had died.

Information received after Mr Lindley's death

62. After Mr Lindley's death, a prisoner told an officer that Mr Lindley had stolen dihydrocodeine from the medication hatch on 6 August. Wing CCTV shows that when Mr Lindley was waiting for his medication, there were no officers in the immediate area. CCTV from inside the pharmacy shows that when the pharmacy technician turned his back, Mr Lindley's arm reached through the dispensing hatch to pick up a bottle of medication. The missing dihydrocodeine was not reported until a different pharmacy technician returned to duty on Monday 8 August.

Contact with Mr Lindley's family

63. An SO and an officer were appointed as family liaison officers. They, accompanied by a prison manager, visited Mr Lindley's next of kin to break the news of his death.
64. The prison contributed to the cost of Mr Lindley's funeral in line with national instructions.

Support for prisoners and staff

65. After Mr Lindley's death, the Governor and 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.
66. The prison posted notices informing other prisoners of Mr Lindley'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 Lindley's death.

Post-mortem report

67. The post-mortem report concluded that Mr Lindley died from dihydrocodeine toxicity.

Findings

Theft of dihydrocodeine

68. Mr Lindley died from dihydrocodeine toxicity. He was not prescribed dihydrocodeine but had previously admitted that he had been obtaining it (and other medications) illicitly from other prisoners. This had caused him to get into debt.
69. On 6 August, Mr Lindley stole a bottle of dihydrocodeine from the medications hatch on the wing. Both the prison and the healthcare department carried out investigations.
70. The Head of Healthcare raised an incident direction that no medication was to be prepared at the front of the medication hatch, nor stored on the front desk at any time. A completed incident management review has triggered an internal investigation by the Trust. This is ongoing.
71. CCTV showed that no prison officers were in the immediate vicinity of the medications hatch at the time Mr Lindley was able to steal the dihydrocodeine. It is standard prison policy to ensure the medications queue and dispensing of medications is supervised by prison officers. This is to help ensure that there is no bullying or violence between prisoners to obtain medication illicitly, and to provide additional support to healthcare staff.
72. The prison staff who should have supervised prisoners receiving their medication on 6 August were issued with written warnings, and briefings were held to remind staff about supervising prisoners at the medication hatch.
73. Given that investigations have been initiated and appropriate action taken, we make no recommendation.

Ranby's drug strategy

74. Mr Lindley had a history of substance misuse and on at least three occasions in June 2022, staff suspected he had taken illicit drugs.
75. Less than a month after Mr Lindley arrived at Ranby, he told staff he was being threatened to sell PS. He admitted to staff that he had bought illicit medication from other prisoners.
76. Ranby's Substance Misuse Strategy is based on national guidance. The strategy says that the prison's three objectives are to minimise the supply of substances into the prison through effective searching strategies and technologies, discover and recover illicit substances using robust searching, intelligence and drug testing procedures, and disrupt the illicit economy, working with partner agencies, sharing information and tackling vulnerabilities.
77. If prisoners are suspected of being under the influence of illicit substances, healthcare staff are asked to assess the prisoner and, if necessary, put them on observations for a period of time. Staff open an Under the Influence (UTI) log which is held in a prisoner's core record and on their computerised record. Staff should

submit an intelligence report and non-essential medication may be withheld. Staff opened a UTI log for Mr Lindley in June 2022, however there is no evidence that they submitted intelligence reports or that any particular action was taken to consider the information in the broader context of the prison's drug strategy. This was a missed opportunity, and the Governor will want to consider whether current processes to log and investigate illicit substance use are sufficiently robust.

Bullying

78. Ranby has a Violence Reduction/CSIP policy 2022/2023, based on national guidance. The CSIP policy says "Any member of staff can submit a CSIP referral. CSIP referrals must be raised if there is any allegation or evidenced violence or anti-social behaviour, isolation, vulnerability and safeguarding concerns." It goes on to describe the process once a CSIP is raised, including investigating the circumstances of the referral, and supporting the alleged victim. It says that CSIPs should be reviewed at least monthly.
79. Mr Lindley said he was involved in buying, taking and holding illicit substances (including alcohol) for prisoners. He accrued debts and was threatened as a result. Staff raised six CSIPs involving Mr Lindley between October 2021 and July 2022, with actions for the safer custody team to investigate. These were managed within CSIP guidance.
80. Staff noted in Mr Lindley's CSIP on 29 June, that he should move from Houseblock Two as soon as possible. This was reviewed on 5 July, with the action still outstanding. Staff chased Mr Lindley's move, by email, on 8 August, as Mr Lindley had refused to leave his cell or allow staff to unlock the door. There were still no spaces available on Houseblock One, the only houseblock Mr Lindley could reasonably move to, as he had a relative on Houseblock Three, and other houseblocks were for enhanced or drug free prisoners. It seems that no space had become available on Houseblock One before Mr Lindley died. The Governor will want to consider whether there is anything more that could have been done to facilitate a move more quickly.

Clinical care

81. The clinical reviewer was satisfied that Mr Lindley's clinical, substance misuse and mental health care was of a reasonable standard and was equivalent to the care he could have expected to receive in the community. The clinical reviewer noted, however, that Mr Lindley did not have a mental health care plan in his records. The Head of Healthcare will want to consider this.

Emergency response

82. The first two officers who arrived at Mr Lindley's cell said that they entered the cell and started CPR before other staff arrived. This account was supported by the OSG who raised the alarm, but who remained outside the cell. However, the night orderly assistant who arrived a few minutes later, said that she found staff waiting outside the cell and that she was the first to start CPR. She said that one of the officers told her that he did not know how to do CPR. In interview, the officer said he immediately started CPR.

83. CCTV shows that the two officers entered the cell while the OSG waited outside. However, it does not cover the inside of the cell. There is no body worn video camera footage to show what happened once the officers were inside the cell. Without objective evidence in the form of video footage, we cannot reach a conclusion on whether or not staff had begun CPR before the night orderly assistant arrived. The prison was unable to tell us whether any of the staff involved were equipped with body worn cameras at the time (if they had been, guidance instructs that they should have turned the cameras on when responding to the incident). The Governor will want to consider this aspect of our investigation and identify any learning.

Inquest

84. The inquest, held from 27 November to 5 December 2023, concluded that Mr Lindley's death was drug related.

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100