INVESTIGATION INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF A MAN AT

HMP LINDHOLME IN AUGUST 2006

Report by the Prisons and Probation Ombudsman for England and Wales

April 2007

This report considers the circumstances surrounding the death of a man on 26 August 2006. The man died on arrival at the hospital having suffered a cardiac arrest in his cell at HMP Lindholme. The post mortem concludes this was a result of coronary artery thrombosis (a blood clot in the artery). He was 30 years of age.

I would like to extend my personal condolences to his family and to all those touched by his death.

One of my investigators undertook the investigation with the assistance of another colleague. I would like to thank the Governor of Lindholme and his staff for the assistance they offered to my investigators during the course of their enquiry.

I am also grateful to the clinical reviewer of the Primary Care Trust who carried out a first-rate clinical review of the care the man received during his time in custody.

The man seems to have had an unremarkable medical history whilst in custody. He was an enthusiastic body builder and had made good use of the prison's gymnasium. There was no indication that he might suffer heart problems. His death was a great shock both to his family and to staff and prisoners at Lindholme.

This report makes five recommendations, including two in recognition of good practice on the part of healthcare staff and of two prisoners. My office has also raised a number of other matters directly with the Governor.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2007**

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SUMMARY

The man was convicted in January 2004 and remanded into custody at HMP Birmingham. During a standard medical check on arriving at prison, he stated that he had a history of fits and a family history of blackouts.

The man spent a month at Birmingham before being sentenced and transferred to HMP Leicester on 27 February 2004. He remained at Leicester for one week before moving to HMP Stocken, where he stayed for two years and two months. During this period, he never referred to his previous medical history and did not have contact with any healthcare staff apart from standard medical checks on reception.

On 20 April 2006, he transferred to HMP Lindholme. Again, he did not refer to his previous medical history on reception. During his years in prison, he spent a great deal of time weight training and keeping fit in the gym. He was regarded as a very healthy young man with no medical concerns.

On the evening of 25 August 2006, the man experienced strange pains in his neck that prevented him from being able to speak. He was with two friends at this time and they witnessed his discomfort. As he appeared to recover quickly, and did not refer to the pain again, the episode was not mentioned to any member of staff. The man seemed fit and well for the rest of the night.

The following morning whilst training in the gym with his friend A, the man experienced breathlessness and had to stop weight training. They moved into a quieter area of the gym for him to sit down and catch his breath. Again, he quickly recovered and they went into another part of the gym to continue their workout. The man sat on an exercise bike (but did not use it), whilst his friend spent five minutes on the running machine. His friend asked him how he was feeling and he said that he felt much better. They returned to the weights room and continued to train for a further 25 minutes.

At the end of the gym session (approximately 11:30am), the man and his friend returned to prison wing. The man went back to his room whilst his friend went to shower. At this time, another friend (friend B) came to speak to him. The man was lying on his bed and said that his pain and breathlessness had returned. He said he could not speak as it was hurting, so his friend returned to his own cell.

Approximately five to ten minutes later (11:45am), his friend A walked passed the man’s cell on the way back from his shower. He noticed that the man appeared to be reaching for something under his bed. Friend A returned to his room. At this time, friend B returned to the man’s room to call him for lunch. The man was still underneath his bed. As friend B entered the room he noticed that there was something wrong. He bent down to look at him and saw that he was unconscious and his body had tensed. He believed that the man was having a fit and shouted for friend A to come and help.

Both prisoners turned him over into the recovery position and shouted to a fellow prisoner to call an officer for assistance. A wing officer immediately came to the

room. Friend B told the officer that the man was having a fit. The officer told them to remain with the man whilst he called for medical assistance.

Healthcare staff were alerted, and within two minutes two nurses arrived at the man's room with an emergency response bag. On arrival they quickly assessed that he was experiencing a cardiac arrest and began cardio pulmonary resuscitation (CPR). The paramedics were called at 11:52am and an automatic defibrillator was brought. The man was shocked around six times but remained unresponsive. A third nurse arrived at 11:59am to help with CPR.

The first paramedic arrived in a rapid response vehicle at 12:00pm. His initial assessment was that the man had suffered a heart attack. On attaching his own defibrillator and obtaining an electrocardiogram (ECG), he was able to confirm that the man was in cardiac arrest. Two further shocks were administered and CPR continued.

The ambulance followed shortly after at 12:07 and took him to the hospital at 12:20pm. Sadly, he was pronounced dead shortly after arrival.

My report includes five recommendations.

THE INVESTIGATION PROCESS

The investigation was opened on 29 September 2006 by my investigator. The Governor briefed my investigator on what had occurred. My investigator arranged to have notices of my investigation displayed around the prison and asked for all documentation relating to the man to be sent to my office for her consideration.

The investigator asked the clinical reviewer of the Primary Care Trust (PCT) to conduct a clinical review of the care the man received at Lindholme.

The man's family were contacted by one of my family liaison officers. The family was grateful for contact being made but declined a visit at this time, saying they may wish to meet once the draft report is issued.

My investigator nad the clinical reviewer agreed to hold joint interviews with staff and prisoners who knew and attended to the man. These took place on 3 October and 18 October 2006. Another colleague from my office assisted with the interviews. On concluding the interviews, the investigation team provided verbal feedback to the Governor on their findings.

The inquest is to be held on 7 December 2006 in the hospital. This report will be issued to the Coroner in draft form in advance of the hearing. The Coroner has been made aware that the draft will not incorporate responses from either the family or Prison Service at this time, and may therefore be subject to change.

HMP LINDHOLME

HMP Lindholme is based on a former RAF airfield. It opened as a training prison for category C adult male prisoners in 1985 and has an operational capacity of 839.

The site is split between the category C prison and an immigration removal centre. The latter is managed under a service level agreement with the Home Office's Immigration and Nationality Directorate. The category C section of the prison has nine wings. Wings A - F are based on dormitories around the old parade square and have accommodation in spurs holding 7 to 10 single or double rooms. G, J and K are new residential units of cells.

Healthcare cover is provided every day from 7:45am to 8pm. There are nurses on duty daily, and a GP from the Primary Care Trust is at the prison on weekdays. Over the weekend there are at least two to three nurses on duty. There are no in-patient facilities at the establishment.

All nursing staff have current cardiopulmonary resuscitation (CPR) and first aid training. In addition, they are trained to use an automatic defibrillator. There are three defibrillators in the main part of the prison and one in the immigration removal centre. All discipline staff are able to access the defibrillators, but none is currently trained to use them. In addition, not all discipline staff have current first aid training, although all will have received basic training on first becoming prison officers. There is no system in place for ensuring that a minimum number of first aid trained discipline staff are on duty (particularly out of healthcare hours). However, this is not an issue particular to Lindholme.

Lindholme was the subject of an unannounced inspection by Her Majesty's Chief Inspector of Prisons in June 2004. The report was mixed. One concern was that a number of the recommendations made in the 2003 inspection report had not been implemented. One recommendation in particular, "with the introduction of wing-based care, there should be more than one nurse on duty during the evening shift and consideration given to the introduction of a 'twilight' service", remained pertinent to a death in custody at Lindholme in November 2004. The subsequent investigation undertaken by my office echoed the need to review on-site and out of hours clinical cover.

Although it was not an issue in this man's case, the lack of 24-hour healthcare was raised as a concern by both healthcare and discipline staff during the course of this investigation. Had the man collapsed during the night, discipline staff would have been unable to use a defibrillator and they would have had to wait for the paramedics to arrive.

KEY FINDINGS

Events leading up to the man's death

The man was seen by healthcare staff on his admission to HMP Birmingham on 30 January 2004. This is normal procedure for any person entering the prison system. At this stage he was on remand and awaiting sentencing. During his health check, The man told the nurse that he had a history of fits and had been admitted to hospital for three days in 2003. This was recorded on a first reception health screen form and kept with his prison medical record.

On 27 February 2004, the man was sentenced to six years and six months imprisonment by Coventry Crown Court. He was transferred from Birmingham to HMP Leicester. On seeing the healthcare nurse on reception at Leicester, he did not mention his history of fits. Accordingly, he was considered to be fit and well and was not required to see the doctor. No account was taken of the medical history noted on his previous first reception health screen form.

The man remained at Leicester for one week before moving to HMP Stocken to begin his sentence. Once again, he did not mention his medical history on reception. During his two years at Stocken he had no reason to see or be seen by healthcare staff.

On 20 April 2006, the man was transferred to HMP Lindholme. (During a long-term prison sentence it is not unusual for a person to move prisons several times.) Again, the health screen on reception makes no reference to his previous statement of a history of fits. The man was noted as being healthy. He was initially located to J wing, but later moved to spur 4 on F wing. Here he was allocated a room next door to the shower block. The spur was a small one holding only seven prisoners.

The man established a good friendship with two fellow prisoners, who shared a double room on the spur. During interviews, both friends said that the man was a very fit man who trained hard in the gym. He concentrated on lifting weights, rather than cardiovascular exercises, and was capable of long and strenuous sessions.

On the evening of 25 August, the man was sitting talking with both friends when he complained of a "weird pain" down the side of his neck. During interview, the man's friends commented that this was unusual as the man had never previously complained of feeling unwell. The pain was so uncomfortable that he motioned that he was unable to speak and wrote down on a piece of paper, "I don't want to talk, my throat is hurting." This pain only lasted for a short period of time. As he carried on as if nothing had happened and did not refer to the pain again, neither he nor the others found it necessary to tell any members of staff.

At approximately 9:00am the following day (26 August), the man accompanied friend A to the gym for the morning activities session. The man began his workout with weight training, but after 40 minutes he had to stop. He had become breathless and went to lean against the wall near an exercise machine that friend A was using. The man said that he did not feel very well and was having difficulty breathing due to pains in his chest. Friend A suggested that they went into the corridor where there

were fewer people. They sat down for two minutes to allow him to catch his breath. Friend A rubbed his back and asked him if he was feeling better. The man said that he was and they both went into the fitness room (next to the weights area). The man sat on an exercise bike and continued to rest whilst Friend A used a running machine. After five minutes, Friend A asked him if he was feeling better. As he had "returned to his normal self", they went back to the weights room and resumed training. Approximately 25 minutes later, the gym session ended and all prisoners were required to return to their wings.

On returning to their spur at 11:30am, friend A went for a shower in the room next door to the man's cell. Friend B went to the man's room and saw that he was lying on his bed. He started to joke with him about not calling him to come to the gym with them earlier that morning. The man joined in with the joking, but said that it was hurting him to talk again so friend B left the room and went back to his cell.

Five to ten minutes later, after finishing his shower, friend A walked passed the door to the man's room and noticed that he was lying on the floor under his bed. It looked like he was reaching for something underneath his bed, and he did not think anything more of it at this time. As friend A entered his own room, friend B was leaving to go and call the man for lunch. On entering his room, he saw that he was lying underneath his bed. He initially thought that the man was "messing around", but quickly realised that this was not the case and moved to the floor to see what was wrong. He turned him on his side, saw that he was unconscious, and shouted to friend A for help. Friend A ran to the room and saw that the man was on the floor and that his body was tensed up. Friend B said, "I think he's having a fit" (friend B has experience of dealing with seizures as his father suffers with them). The man's face was expressionless and he was lying on his stomach with his hand in a clenched position. Both of them turned him over and placed him in the recovery position. They shouted to a fellow prisoner on the spur, to get an officer to come quickly.

The wing officer was supervising the lunchtime movement at this time. He was on the second flight of stairs on F wing, in the front foyer area, when at 11:45am a prisoner shouted "emergency, emergency". The officer immediately ran down the stairs onto spur 4 and into the man's cell. He saw that he was on the floor in the recovery position with two prisoners by his side. The man was convulsing. Friend B told the officer that he believed the man was having a fit. The officer told both of them to stay with the man whilst he called for medical assistance.

The wing officer was not carrying a radio (only one officer on each of the smaller wings carries a radio), so he went into the office just outside the entrance to the spur to use the phone. The senior officer (SO) was in the office at this time, signing the observation books. The wing officer told the SO that, "the man [was] lying on his back" and fitting. The SO immediately used his radio to call the communications room to request healthcare assistance. It was then 11:46am. The SO said that a prisoner was fitting and required immediate attention. An officer in the communications room sent a message over the radio asking 'Hotel 1' to attend F wing. ('Hotel 1' is the code used to identify the healthcare person on duty to respond to a medical emergency. 'Hotel 2' is used for the second healthcare person on duty.)

At the time of the message, Nurse (Hotel 1) was on J wing with Nurse (Hotel 2) distributing medications. Nurse Hotel 1 was actually in the middle of giving out medications at the time of the call, so Nurse Hotel 2 said that she would respond. Nurse Hotel 2 immediately telephoned the healthcare unit to ask a third nurse to come to F wing and bring the response bag. The third nurse left the healthcare unit bringing the 'code blue' emergency response bag. ('Code blue' refers to breathing difficulties and this bag contains oxygen, other breathing apparatus and a blood pressure machine.) The third nurse decided it was best to arrive fully prepared, although the incident had not been referred to as 'code blue'.

The wing officer returned to the man's room as soon as he had informed the SO, and assured friends A and B that help was on its way. As there were prisoners still moving around the wing for lunchtime, the wing officer left the room to continue supervising the movement and direct people away from the entrance to spur 4. He wanted to ensure that prisoners collected their lunch and moved back to their rooms as quickly as possible to clear the area. The SO entered the man's room as the wing officer left.

It took the nurses Hotel 2 and the third nurse no more than two minutes to arrive at the man's room (approximately 11:50am). At this time friends A and B were still with the man. His breathing was laboured. Friend B described him as taking a "struggled" breath every few seconds. The third nurse asked the two men to vacate the room so the nurses could attend to him. Nurse Hotel 2 told my investigator that on seeing the man she knew that they were dealing with a serious situation. His chest was not rising; he was unconscious and his eyes were half opened and rolled back in his head. Nurse Hotel 2 moved him on to his back and checked for a pulse. On finding he had no pulse and was not responding, they attached a pulse-oximeter (a device used to detect a pulse) and the third nurse inserted an airway whilst nurse Hotel 2 commenced cardiopulmonary resuscitation (CPR). Nurse Hotel 2 had very recently received her updated CPR training and was therefore able to use the newer and most effective technique for cardiac massage.

The SO remained in the room with healthcare staff whilst they performed CPR. He stood with his back to the door so that nobody else could get in, and took instructions from the healthcare staff. At 11:52, Nurse Hotel 2 asked for an automatic defibrillator to be brought and for paramedics to be called. The SO immediately instructed a second officer to collect a defibrillator from the Care and Separation Unit (this was the closest machine to hand), and radioed the communications room for an ambulance to be summoned. A further call was also issued for 'Hotel 2' to attend and for the orderly officer and duty governor to come to the wing. On hearing this, nurse Hotel 1 understood the situation to be serious and packed up the medications on J wing to join her colleagues on F wing.

Around this time, the principal officer (PO) arrived on the wing. He was the orderly officer on duty. The SO handed over command of the situation and left the room. The remaining prisoners had been moved to the communal area at the end of the spur to clear the way for the paramedics. The PO went to speak to them as they were all quite distressed.

The duty governor was doing her rounds in the Care and Separation Unit when the second officer and a fellow officer arrived to collect the defibrillator. She followed them both back to F wing.

Nurse Hotel 2 and the third nurse continued with CPR until the defibrillator was brought. On attaching the defibrillator, the automatic instruction was to administer a shock. This was done six times and cardiac massage continued between each shock. Nurse Hotel 1 arrived at 11:59am and began to assist with CPR. At one stage the nurses had to roll the man over to clear his airway. Nurse Hotel 2 checked again for a pulse, but there was none so they continued with CPR.

The duty governor asked the communications room to instruct the deputy duty governor to attend. On arriving, both the duty and the deputy governors assisted the PO in managing the situation and reassuring the other prisoners on the spur that everything was being done to help the man. The duty governor radioed the control room and asked them to make sure that all gateways were on standby to allow the ambulance to come through. Escorting officers were arranged to accompany the man to the hospital. Standard cuffs and restraints were prepared in case they were required at a later stage, but they were not to be applied on the way to the hospital.

The first paramedic arrived in a fast response vehicle at 12:00pm. His initial thought was that the man had suffered a myocardial infarction (heart attack). The paramedic asked the nurses to detach their defibrillator and he attached his own. The electrocardiogram (ECG) reading given by the machine confirmed that he was in cardiac arrest. Two further shocks were given and CPR continued. The ambulance with two other paramedics arrived at 12:07pm. The man was then transferred from the wing to the ambulance by means of a wheelchair (to negotiate the narrow passage from the spur) and taken to hospital. The ambulance left the prison at 12:20pm.

At 12:21pm, the deputy governor telephoned the Independent Monitoring Board representative on duty that day, and asked her to come to the prison as a prisoner had suffered a cardiac arrest. The duty governor obtained details of the man's next of kin, and attempted to telephone his mother to tell the family that he was seriously ill and on his way to hospital. Unfortunately, his mother was unavailable on all three numbers given and the governor had to contact the man's former partner, the other contact name given, to get details of a family member. The duty governor obtained a number for the man's sister. It was whilst on the phone to his sister that a member of staff gave the governor a message that the man had died shortly after arriving at DRI. She then had to explain to his sister that he had just passed away.

Events after the man's death

On the news that the man had died, the prison's death in custody contingency plan was put into practice. The duty governor notified the Coroner's office and police, whilst the deputy governor arranged for the spur to be cleared and sealed.

The deputy governor relocated the six prisoners from the spur to other areas in the prison. The man's friends were moved to spur 2 on F wing, but the other four

prisoners were moved to different wings. Where possible, they were located together to lessen the distress rather than being split up. The prisoners were told they would be kept informed as to what would happen next. The duty governor briefed the chaplain and asked him to return in the evening to follow up with the several prisoners who were close friends of the man who died.

The IMB member was given the news of the man's death at 1:15pm. She then went to speak with, and offer support to the senior officer, prisoners and other staff on F wing.

After the lunchtime period, Listeners (prisoners who are trained to offer peer support) were informed of the man's death and asked to prepare to provide emotional support to those affected by the news. The Staff Care and Welfare team was also contacted to provide support to those involved. This support has been ongoing.

A hot debrief took place that afternoon. All staff involved were present for the meeting. There were no emerging issues from the discussion. The general feeling was that nothing could have been done differently and everyone acted swiftly and with professionalism.

The duty governor received a phone call from the man's current girlfriend that afternoon as she had heard the news through his family. The man's brother also called and told her that he would take matters forward on behalf of the family. The deputy governor gave him the contact details for the hospital so that he could speak to them directly. She added that the chaplain would be in touch to advise on how the prison could help with the funeral, if the family wished.

The following morning, the deputy governor asked the chaplain to hold a memorial service. This took place on Sunday 27 August. Staff and prisoners were given the opportunity to attend. A collection was raised to give to the man's family.

After 27 September, a second PO assumed the role of family liaison officer. The second PO and the chaplain contacted the family on several occasions and the PO also met them at the interim inquest held by the Coroner. The chaplain, with the assistance of the prison's imam, informed the man's family that he had been a practicing Muslim.

After the interim inquest, the PO tried to contact the family with regard to returning the man's belongings.

The man's funeral was arranged privately in accordance with the family's wishes.

ISSUES

Clinical Review

The clinical review was undertaken by the Head of Clinical Governance at the Primary Care Trust. My investigator has summarised his findings:

Comments on the prisoner's medical record

As the man had little contact with prison healthcare staff, his prisoner medical record is limited. It is interesting to note that the first health screening documents on entry to each prison appear to vary. The first indicates his disclosed medical history of fits, but this is not mentioned in subsequent documents. Information may change over time, however it is important to demonstrate that the medical history referred to in previous documents is reviewed and taken into consideration when a prisoner transfers between establishments.

The head of healthcare should remind staff conducting first health screens to refer to and consider previous medical records if they are made available on reception.

Although there are few entries in the man's medical records, some of them are difficult to read and signatures difficult to interpret. Every effort should be made to ensure good standards of recordkeeping. All entries should be contemporaneous, legible, signed, dated and name printed. It is good practice to regularly undertake a recordkeeping audit to ensure that all standards are met and maintained (Nursing and Midwifery Council, 2005; Guidelines for Records and Record Keeping, Department of Health, 2006; National Health Service Code of Practice Records Management).

The head of healthcare should remind staff to maintain legible and signed medical records for prisoners.

Reception screening suggests that the man was healthy, apart from a reported history of fits and cannabis usage. He was described as physically and mentally well.

Immediately following induction to Birmingham prison, he was prescribed Zopiclone 7.5mg to be taken at night. This drug is prescribed for short-term insomnia. As the drug was only given on two occasions, this would seem reasonable. However, there is no reason given in his medical record for prescribing the medication. All actions stated within a medical record must include a rationale and be followed up with a documented review.

Conclusion

Overall, the deceased was an apparently fit and healthy man about whom there was no significant cause for concern. On that basis and the fact that prison staff were not alerted to the pains he experienced on 25 and 26 August 2006, it is unreasonable to have expected anything to have been done to predict the medical emergency.

A Consultant Pathologist carried out a post mortem examination on the man on 29 August 2006 at the hospital. He confirmed the condition directly leading to death was acute cardiac failure due to coronary artery thrombosis. On this basis, his death was due to natural causes (toxicology was negative).

The fact that the man had had so few signs of the emerging cardiovascular emergency meant it gave little warning. It thus neither prompted him nor his friends to alert anyone before his acute cardiac failure. However, perhaps this serves as a reminder of the importance of health education and raising awareness of the signs of heart disease and of the significance in seeking help and advice.

In terms of the way in which the emergency was handled, everyone involved acted promptly and accordingly. They did everything they could to help the man.

Findings relating to policy and procedures

During interview, the wing officer raised a concern about the number of radios available on each wing. He thought that there should be two, no matter the size of the wing. Current policy is that there is one officer with a radio on each of the smaller wings, and two on the larger wings. However, in the event the fact that the wing officer did not have a radio did not affect the response to the emergency. The man's room was very close to the office on the spur and the officer was able to call for help quickly. However, it has been noted that if the emergency had occurred in a further area of the wing, the time taken to get to the office to summon help may have been critical. In view of this, I recommend that the governor reviews the prison's policy on radio allocation and considers increasing the number of radios available.

The governor should review the prison's policy on radio allocation and consider increasing the number of radios available.

The response to the man's medical emergency was undertaken with speed and professionalism. Staff at all levels reacted appropriately and did everything they could to ensure he was given the best possible chance of survival.

In addition, both the clinical reviewer and I would like to commend the man's two friends for their response on finding him collapsed, placing him in the recovery position, raising the alarm and staying with him whilst help arrived. I appreciate that it must have been very distressing to see their friend suffering.

Friend A and friend B should be thanked and commended for their actions.

The prison's healthcare staff also deserve special commendation for the way in which they undertook his CPR. They demonstrated up to date clinical practice and dedication and clearly worked very hard to save the man.

The governor and head of healthcare should commend healthcare staff for their dedication and professionalism in attending to the man.

Despite the excellent response to the man's needs, I am surprised that the discipline staff did not assess his condition before or after alerting the need for healthcare. Both officers saw that the man was in the recovery position and, as he appeared to be having a fit or seizure, they felt it was appropriate to wait for healthcare intervention. However, I would have been more comfortable if the officers had physically assessed the situation, using their basic first aid training, before determining the situation was in hand. Whereas the absence of these actions had no adverse impact on his care, it is something to consider in view of any possible future incidents.

With regard to aftercare, both friend A and friend B said that they were pleased with the level of support they have received from the prison after the man's death. Staff involved also said they were generally content with the level of support available to them, apart from one officer who was left on his own for the first hour after the man was discovered. Whilst he said that this did not immediately bother him, he had consequently thought more about it and felt that more timely support might have been beneficial. He did receive support from the Staff Care and Welfare team when he came back to work on the Sunday and follow up support was provided.

Observations

A few minor points arose from my investigator's interviews with discipline and healthcare staff.

When healthcare was alerted to the man's collapse, the message over the radio said that someone was 'fitting' on F wing. No 'code blue' was issued. From speaking with the officers involved, it seems that there may be a lack of confidence in their first aid training and their ability to assess appropriately when a 'code blue' should be called. Making this assessment was thought to be something that a member of healthcare was better qualified to do. However, this rather negates the point of having codes which, after all, are supposed to be used to inform healthcare staff what level of emergency response is required and what type of equipment to bring. This is particularly pertinent when healthcare staff need to bring an emergency response bag or defibrillator. It is important that, whenever possible, discipline staff should try and correctly assess the type of emergency and response required. Knowing what to expect on arrival could save someone's life. In light of this, my investigator has separately written to the Governor asking him to consider, in conjunction with the head of healthcare, the issuing (or reissuing) of guidance on the use of codes in calling a medical emergency.

It is clear from my investigator's conversations with the healthcare staff who responded that this was indeed a 'code blue' incident. Fortunately, they did arrive appropriately equipped to deal with the situation and the lack of calling a 'code blue' did not have any adverse impact. The third nurse had brought the emergency response bag containing apparatus to aid breathing difficulties. A defibrillator was quickly accessed and brought to the room. (At this time, response bags were not strategically allocated around the prison, but I am pleased to record that this has since been addressed.)

From interviews with prison staff, the investigation team ascertained that automatic defibrillator machines are kept in strategic points around the prison and that all staff can easily access them. However, both healthcare and discipline staff seemed a little unsure of the exact number and location. Whilst having a number of defibrillators is good practice, it is important to ensure that staff know precisely where they are and that they are in the best possible locations. In correspondence, my office has asked the governor to consider issuing a notice to all staff informing them precisely where all defibrillators are located.

My final observation relates to a point raised by the PO and orderly officer on 26 August. The PO said that, whilst no issues or concerns had emerged during the hot debrief, he feels that in general the prison would benefit from introducing a further ‘cold’ debrief session two to three weeks after a tragedy or other incident. He believes that a more informed and considered discussion could take place at this stage, and it might be easier to identify areas of concern or celebrate good practice. It would also bring a sense of closure for all concerned and deal with any residual issues. I endorse this suggestion and I hope that the governor will consider taking it forward.

RECOMMENDATIONS

The head of healthcare should remind staff conducting first health screens to refer to and consider previous medical records if they are made available on reception.

The head of healthcare should remind staff to maintain legible and signed medical records for prisoners.

The governor should review the prison's policy on radio allocation and consider increasing the number of radios available.

The two man's prison friends should also be thanked and commended for their actions.

The governor and head of healthcare should commend healthcare staff for their dedication and professionalism in attending to the man.

The Prison Service have accepted recommendations 1, 2, 4 and 5 and partially accepted recommendation 3. The number of radios issued on larger wings has increased to three. The number of radios on small wings operated by two members of staff during the core day remains the same. One officer carries a radio.

Of the clinical review recommendations, numbers 1, 2, 5 and 6 were fully accepted. Recommendation 3 (regarding using coded call signs on alerting staff to an emergency) was accepted in principle. There is an operational order for code usage in place for 'life threatening' situations. Using this code will remain discretionary depending on individual assessment, but the operational order will be reviewed and reissued to ensure that all staff are aware of the procedure.

Recommendation 4, relating to first aid training for staff, was partially accepted. Lindholme already has 41 out of a pool of 46 staff first aid trained. The Prison Service response states that it would not be realistic or sustainable to train every member of staff in first aid. However a staff awareness training event for calling 'code blue/code red' in the event of an emergency will take place to underpin the existing operational order referred to above. This training session was to be completed by end of March 2007.