Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Luke Ashcroft, a prisoner at HMP Lincoln, on 1 July 2020

A report by the Prisons and Probation Ombudsman

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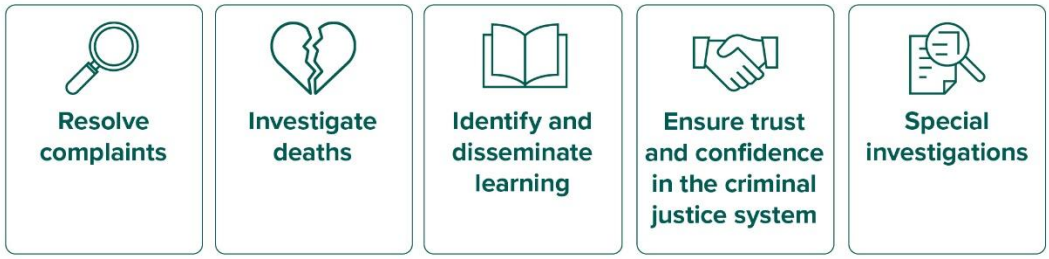
OUR VISION

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 Luke Ashcroft died in hospital on 1 July 2020 after being found with a ligature around his neck in the segregation unit at HMP Lincoln on 24 June. He was 33 years old. I offer my condolences to Mr Ashcroft's family and friends.

Mr Ashcroft had only been at Lincoln for five weeks when he was found unresponsive in his cell with the ligature. He had schizophrenia and bipolar disorder and was suffering from delusions that he had spiders living inside him. The day before he was found unresponsive with a ligature around his neck, a psychiatrist had assessed that he was suffering an acute psychotic episode and a nurse started suicide and self-harm monitoring (known as ACCT) after Mr Ashcroft said he had had enough of the spiders and was ready to die.

My investigation found that healthcare staff did not properly assess whether Mr Ashcroft was fit to be segregated. It appears there were healthcare reasons not to segregate Mr Ashcroft from 23 June, but this was not highlighted to prison managers.

Mr Ashcroft should have been checked five times an hour overnight on 23/24 June. CCTV shows that many of these checks were not carried out and records were falsified to show they had. Following a trial, the officer was convicted of misconduct in a public office.

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 **February 2024**

Contents

Summary

Events

1. Mr Luke Ashcroft was recalled to prison on 23 May 2020 and sent to HMP Lincoln.

2. Mr Ashcroft had a long history of substance misuse and tested positive for opiates and cocaine when he arrived at Lincoln. He was already on a methadone (heroin substitute) programme, which was continued at Lincoln.

3. Mr Ashcroft had schizophrenia and bipolar disorder. Shortly after arriving at Lincoln, he told healthcare staff that he had spiders living inside his body. He was prescribed antidepressant and antipsychotic medication but continued to have delusions.

4. On 22 June, Mr Ashcroft became more distressed about the spiders and barricaded himself in his cell. He was subsequently moved to the segregation unit (known as the Care and Separation Unit (CSU)). A nurse assessed that he was medically fit to be segregated.

5. On 23 June, a psychiatrist assessed Mr Ashcroft and diagnosed delusional parasitosis (a fixed but false belief that the body is infested with insects). He found that Mr Ashcroft was having 'an acute psychotic episode'. He wanted to run some tests to ensure there was no physical cause, but he considered it likely that Mr Ashcroft would require further assessment and treatment in a secure psychiatric hospital.

6. Later that day, a nurse started suicide and self-harm procedures (known as ACCT) after Mr Ashcroft told her that he had spiders in his body and was ready to kill himself. He remained in the CSU.

7. Mr Ashcroft was on five checks an hour. The officer responsible for the checks during the night of 23 June into the early hours of 24 June, failed to carry out numerous checks and falsified the ACCT log to say he had. His last entry in the ACCT log was at 6.50am which said that Mr Ashcroft was pacing in his cell. However, CCTV shows that his last check was at 6.36am.

8. At 6.54am, the day shift officer checked Mr Ashcroft. He saw him lying on the cell floor and thought he saw a ligature around his neck. The officer called for assistance. As soon as he heard colleagues arrive on the unit, he entered the cell and cut the ligature from Mr Ashcroft's neck. Another member of staff called a medical emergency code and healthcare staff arrived quickly.

9. Mr Ashcroft was taken to hospital, but he died on 1 July.

Findings

10. Healthcare staff did not make it sufficiently clear to prison staff that Mr Ashcroft was acutely mentally unwell.

11. Nurses did not complete the Initial Segregation Health Screens correctly. The nurse who completed the second health screen on 23 June, wrongly concluded that Mr

Ashcroft was medically fit to be segregated, when in fact she should have concluded that there were healthcare reasons not to segregate him.

12. We question whether Mr Ashcroft should have been located in the segregation unit given he was so mentally unwell and was being managed under ACCT procedures.

13. Mr Ashcroft was on five ACCT checks an hour on the night of 23/24 June. An officer falsified the ACCT record to show that he had completed checks when he had not. The officer was charged and convicted of misconduct in a public office.

14. The officer who found Mr Ashcroft unresponsive did not call a medical emergency code.

15. The clinical reviewer found that the healthcare Mr Ashcroft received at Lincoln was equivalent to that he could have expected to receive in the community.

16. The prison completed a fact-finding report after Mr Ashcroft's death which noted that Mr Ashcroft was suspected of taking illicit substances on 18 June. There is nothing about this in the records provided to the PPO and no intelligence report.

Recommendations

- The Head of Healthcare should ensure that healthcare staff share information about a prisoner's mental or physical health with prison staff where this is necessary to keep a prisoner safe.
- The Governor and Head of Healthcare should ensure that:
    - healthcare staff are trained in the completion and importance of Initial Segregation Health Screens;
    - staff complete Initial Segregation Health Screens fully and accurately and arrive at a clear conclusion; and
    - authorising managers understand how the Initial Segregation Health Screen should be completed and query it if it appears incorrect or incomplete.
- The Governor should ensure staff record incidents of suspected substance misuse and submit intelligence reports.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact her.

18. The investigator obtained copies of relevant extracts from Mr Ashcroft's prison and medical records.

19. NHS England commissioned a clinical reviewer to review Mr Ashcroft's clinical care at the prison.

20. We suspended our investigation in July 2020 at the request of the police while they carried out a criminal investigation. We were able to reactivate our investigation in July 2021.

21. The investigator interviewed four members of staff in September 2021. She and the clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted remotely because of the COVID-19 restrictions.

22. We informed HM Coroner for Lincolnshire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

23. The Ombudsman's family liaison officer contacted Mr Ashcroft's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had no questions, but she asked to see our report.

24. The family received our initial report, and their solicitor raised a number of queries. We have made some amendments to this report and answered their other questions via separate correspondence. The clinical review has also been slightly amended. However, at the police's request, we delayed finalising this report while they pursued criminal charges against an officer.

25. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Lincoln

26. HMP Lincoln holds up to 729 remanded and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, including a Vulnerable Prisoners Unit. Nottinghamshire Healthcare NHS Foundation Trust provides health services and there is 24-hour nursing cover. 'We are with you' provide substance misuse services.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Lincoln was in December 2019/January 2020. Inspectors reported that Lincoln was a much safer prison since their last inspection in 2017, though there had been two self-inflicted deaths since then. Inspectors said that the prison's approach to prisoners in crisis was good, and they had implemented previous PPO recommendations. The inspectors found that prisoners and staff had a good relationship, which was a real strength.

28. Inspectors reported that health services were generally good. Despite a high level of need, the integrated mental health team provided a very good and accessible service, which delivered a wide range of evidence-based therapies. Drug- and alcohol-dependent prisoners were very positive about the care they received. Their treatment was prompt and met individual need.

29. The level of target searching following the receipt of drugs intelligence had increased substantially since the previous inspection, but nearly a third of requested suspicion drugs tests were not carried out. Work to reduce the supply of drugs into the prison was considered good. In the six months before the inspection, 10% of mandatory drug tests had been positive, which was low compared with other local prisons.

Independent Monitoring Board

30. 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 2021, the IMB reported that self-harm and drug use had decreased but that despite best local efforts, prisoners in need of transfer to a mental health setting sometimes waited far too long for an appropriate placement. On balance, they considered the CSU to be well run.

Previous deaths at HMP Lincoln

31. Mr Ashcroft was the fifth prisoner to die at Lincoln since July 2018. Two of the previous deaths were self-inflicted and two were from natural causes. We have previously made recommendations about the use of medical emergency codes. The prison told us that a notice to staff was reissued in May 2020, setting out the expectations around calling medical emergency codes, and staff had been issued with code red and blue prompt cards between May and July 2020.

Assessment, Care in Custody and Teamwork

32. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT until all the actions are completed.

Segregation units

33. Segregation units (sometimes called Care and Separation Units) are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.

34. Segregation unit regimes are usually restricted, and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A manager, a member of the chaplaincy team and a member of the healthcare team should visit the segregation unit daily and speak to each segregated prisoner to check their welfare. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental wellbeing of the prisoners and whether there are any apparent clinical reasons to advise against continuing segregation.

Psychoactive substances (PS)

35. Psychoactive substances (PS), 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 many 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. There is emerging evidence to link PS use to endangering physical health, precipitating or exacerbating the deterioration of mental health and the risk of suicide or self-harm.

36. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for staff and prisoners to be more aware of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

Key Events

37. On 20 December 2018, Mr Luke Ashcroft was sentenced to 40 months in prison for burglary. On 21 May 2020, he was released on licence, but was recalled on 23 May after taking drugs. He was sent to HMP Lincoln.

38. When he arrived at Lincoln, Mr Ashcroft's urine tested positive for opiates, cocaine and methadone (used to treat heroin addiction). Mr Ashcroft said he was on a methadone prescription of 62mls a day but had recently been told to reduce his dose. The nurse noted that Mr Ashcroft had epilepsy, schizophrenia and bipolar disorder. She referred him for a mental health assessment. A prison GP saw Mr Ashcroft and prescribed medication including methadone. The GP noted that Mr Ashcroft had issues with his heart rate and would need to have an electrocardiogram (ECG) to check whether his methadone should be reduced.

39. Mr Ashcroft was located in a single cell as he was assessed as high risk for cell sharing because of his mental health issues and because he had taken a cellmate hostage in 2016.

40. That evening, officers asked a nurse to see Mr Ashcroft as he appeared to be under the influence of illicit substances. He let the nurse start to take his observations but objected part way through and refused to continue. On 24 May, staff carried out a cell search but found nothing.

41. On 27 May, a nurse carried out Mr Ashcroft's mental health assessment. Mr Ashcroft told him he had been diagnosed with bipolar disorder and schizophrenia in early adulthood and attention deficit hyperactivity disorder (ADHD) as a child. He said he heard internal voices – one that was derogatory and negative and another weaker voice which tried to rationalise with the former. Mr Ashcroft also said he believed there were spiders inside his body which had entered him through an open wound over a year ago. Mr Ashcroft said he had attempted suicide in October 2019 when he tied a ligature around his neck and cut his inner arm. The nurse assessed that Mr Ashcroft was not currently at risk of suicide or self-harm and noted he would be discussed at a multi-disciplinary team (MDT) meeting.

42. On 5 June, Mr Ashcroft was introduced to his offender supervisor. They discussed his recall and Mr Ashcroft said probation staff had not helped him to get to his Approved Premises when he was released. He said he was dyslexic and had needed special directions printed for him, but this was never done. Mr Ashcroft said he had ended up in Doncaster, when he needed to be in Lincoln and would be appealing his recall.

43. On 8 June, a nurse noted that Mr Ashcroft had reduced his methadone from 50mls to 45mls and that this was a big recent reduction. Mr Ashcroft was adamant he wanted to reduce even further, and she sent a task for a doctor to review him.

44. On 10 June, a substance misuse specialist had a telephone appointment with Mr Ashcroft. He had the results of an ECG scan, carried out the day before, and he agreed Mr Ashcroft could continue to reduce his methadone dose. He booked a further review appointment for two weeks' time.

45. On the same day, a nurse saw Mr Ashcroft for a mental health review. He noted that Mr Ashcroft was stable, orientated to time and place and appropriate. Mr Ashcroft said he had spoken to his community probation officer about executive release. The nurse noted that he would follow this up as, if Mr Ashcroft was not going to be imminently released, he wanted to place him on the mental health team's caseload.

46. On 14 June, Mr Ashcroft told nurses at the medication hatch that there were spiders in his body trying to eat their way out. The nurses noted that he did not seem to be under the influence of illicit substances.

47. A nurse saw Mr Ashcroft that afternoon. He repeated his belief that there were spiders living inside of him and said they were becoming more aggressive. He said he was 'Spiderman' and that he believed he was linked to the COVID-19 outbreak in the UK. She discussed the conversation with another nurse, and they wondered if the rapid reduction in Mr Ashcroft's methadone could have caused worsening delusions. She sent a task for Mr Ashcroft to be reviewed by the MDT, including a psychiatrist.

48. On 15 June, a Healthcare Assistant (HCA) saw Mr Ashcroft. He asked to switch from methadone to Espranor (buprenorphine – another opioid drug used as a heroin substitute). She sent a task to the prison GP.

49. The same day, an officer noted that a nurse had spoken to her and asked her to book an urgent appointment for Mr Ashcroft with a psychiatrist as he appeared to be acutely unwell. The entry indicates that the MDT should have happened but did not. The nurse also saw Mr Ashcroft who again told him about the spiders and said they were trying to kill him. He said that he was always told this was a mental health problem, but it was real, and he wanted to go to hospital to verify that the spiders were in him. She told Mr Ashcroft the team were trying to make a psychiatrist's appointment for him.

50. On 17 June, the substance misuse specialist noted that his plan was to reduce Mr Ashcroft's methadone one final time to 30mls and then he would switch him to Espranor on 20 June with a review in nine days' time.

51. On 18 June, the MDT discussed Mr Ashcroft. They agreed that an urgent appointment should be made for him to be assessed by a consultant psychiatrist. An appointment was arranged for 23 June.

52. The same day, prison staff thought Mr Ashcroft was under the influence of illicit substances. (This information was recorded in a fact-finding document the prison completed after Mr Ashcroft's death, but we have found no evidence that any record was made at the time.)

53. On 19 June, an officer noted that another prisoner had threatened Mr Ashcroft through his door, calling him a liar and saying that he would see him at dinner. Staff understood this was over a debt that Mr Ashcroft owed for vapes. The two were unlocked separately for dinner. The next day another officer noted that the situation between the two had calmed down.

22 June

54. At around lunchtime on 22 June, Mr Ashcroft's mother telephoned the prison because she was worried about Mr Ashcroft and thought he was having a psychotic episode. In response, an officer went to see Mr Ashcroft and he said he was okay. She said she would speak to him again after lunch. When she returned, Mr Ashcroft told her he had been bitten by a spider 20 months before and that spiders were growing inside him, and he feared he would die. He said that healthcare staff knew about this, but no one had taken him for a scan to have the spiders removed. He said he had had enough and wanted to go to hospital. She noted that she had contacted healthcare staff who told her that Mr Ashcroft would not be going to hospital that day, but they knew about his issues. There is no record that anyone contacted Mr Ashcroft's mother.

55. At around 2.10pm, an officer noted Mr Ashcroft had used his emergency cell bell and demanded he [the officer] turn on his body-worn camera to record him demanding to be taken to hospital. The officer told Mr Ashcroft that he could not demand to be recorded or to be taken to hospital. He noted that Mr Ashcroft was trying to manipulate staff into getting him to hospital for an unknown reason. (The officer did not make her entry on Mr Ashcroft's prison record until 3.25pm, so another officer did not know what Mr Ashcroft and healthcare had told her.)

56. An hour later, Mr Ashcroft barricaded himself in his cell and covered his observation panel. After staff gained access, they restrained Mr Ashcroft and took him to the Care and Separation Unit (CSU – the segregation unit) at around 3.00pm.

57. At 5.10pm, a nurse noted he had seen Mr Ashcroft in the CSU and considered him medically fit to be held there. The nurse completed the Initial Segregation Health Screen, which contains a flow chart known as the Health Algorithm. In answer to Question 3, 'Does the prisoner show signs of being acutely unwell?', the nurse ticked 'Yes', which then led to the outcome 'There are healthcare reasons not to segregate at this time'. In answer to the final question on the flow chart, 'Do you think that the prisoner will be able to 'cope' with a period of segregation?', the nurse ringed both 'Yes' and 'No'. An answer of 'Yes' leads to a box that says, 'No healthcare intervention at this time' and 'No' leads to a box that says, 'There are reasons not to segregate at this time – discuss with healthcare.' The nurse did not select either conclusion.

58. At 6.00pm, the Head of Security signed the form to say she had seen the Initial Segregation Health Screen. She did not query the lack of conclusion on the Health Algorithm.

23 June

59. On the morning of 23 June, a nurse took Mr Ashcroft's medication to him in the CSU. Mr Ashcroft spat out the water as he thought spiders' webs had fallen into the cup but still took the medication.

60. At midday, the consultant psychologist, who was escorted by a nurse, assessed Mr Ashcroft in the CSU. At interview he said he had not met Mr Ashcroft before and it was a difficult assessment as Mr Ashcroft refused to leave his cell and it had to be conducted at the open cell door with two prison officers in attendance.

61. The consultant psychiatrist noted that Mr Ashcroft was preoccupied, staring at the prison wall and then pointing at his cheek. Mr Ashcroft told them that there was a spider on his cheek, and he believed that there were several spiders in his body which were moving. He lifted his t-shirt and showed some old, healed marks on his chest which he attributed to spiders. He told them that he had first started to worry about spiders after lying down in the loading bay area of a local shop. He woke up feeling that a spider had entered his body. Mr Ashcroft said that he had been taken to Watford Infirmary but rather than investigating him they had sectioned him under the Mental Health Act. He became very agitated when talking about this.

62. Mr Ashcroft offered to show the doctor and nurse the spiders but when the consultant psychiatrist said he could not see anything, Mr Ashcroft became very agitated and started to shout loudly. He became more hostile, and the interview was suspended and continued through the observation panel with the cell door closed.

63. The consultant psychiatrist assessed that Mr Ashcroft knew he was in prison, but he appeared to be paranoid and revealed persecutory delusions and delusional misinterpretation. He recorded that Mr Ashcroft was 'vividly hallucinating', his concentration was poor and his insight very poor. He concluded that Mr Ashcroft was experiencing an acute psychotic episode with a diagnosis of delusional parasitosis (a rare mental health condition in which a person has an unshakable, false belief that they are infested with insects) which required further assessment and treatment in a secure psychiatric hospital. He did not want to prescribe any medication until any physical causes had been eliminated and he ordered blood tests and an ECG.

64. The consultant psychiatrist also noted he asked the nurse for an urgent 'IMPACT' referral form to be completed with a view to further assessment and possible transfer to a medium secure mental health unit, and for psychiatric observation and regular follow up from the mental health team to review risk issues. He noted that if baseline observations were normal, then oral antipsychotic medication should be considered.

65. At interview, the consultant psychiatrist said his SystmOne entry made at the time did not save and it was entered again just after 9.00am on 24 June (after Mr Ashcroft had been taken to hospital).

66. The nurse said at interview that her role was to escort the consultant psychiatrist and she took no part in the assessment and made no notes of her own. She said she could not remember the details of the assessment, although she remembered that Mr Ashcroft had been 'very distressed'.

67. At 1.47pm, a nurse noted she had carried out Mr Ashcroft's CSU assessment. She noted he was calm and relaxed and did not express any thoughts of self-harm or suicide and she had no concerns for his health at that time. There is no paperwork to suggest she completed a Segregation Assessment Screen.

68. At 2.45pm, an unknown staff member made an entry in the CSU wing observation book that Mr Ashcroft had to be moved to another cell after damaging the one he was in.

69. At about 3.30pm, the Head of Residence emailed a member of the prison's psychology department, the Clinical Matron for Mental Health and the Head of Healthcare to ask for information to assist CSU staff in supporting Mr Ashcroft's mental health and understanding the best way to communicate and engage with him. She said she understood that the psychiatrist had been to see him and that it would be helpful for prison staff to receive feedback from him.

70. The Clinical Matron for Mental Health responded and said Mr Ashcroft's mental health worker would be visiting him the next day to get a better understanding of his needs.

ACCT Opened

71. At around 4.00pm, a nurse started suicide and self-harm procedures (known as ACCT) after Mr Ashcroft told her that there were spiders in his body, and he was ready to kill himself. At interview she described Mr Ashcroft as 'acutely unwell' and said she '100% believed he would make an attempt [to kill himself]'.

72. An officer completed the Immediate ACCT Action Plan and set observations at five an hour.

73. As an ACCT had been opened, a nurse completed another Initial Segregation Health Screen and Health Algorithm. In answer to the question, 'Does the prisoner show signs of being acutely unwell … at the present time?', she circled 'Yes'. This leads to the box that says, 'There are healthcare reasons not to segregate at this time – discuss with health team.' Despite this, the nurse marked the other box that says, 'No healthcare intervention at this time'. She also answered both 'Yes' and 'No' to the question, 'Do you think that the prisoner will be able to 'cope' with a period of segregation?' (as a previous nurse had done). At interview she told us she felt Mr Ashcroft would be better off in the CSU 'due to the quieter environment and … more engagement from staff'.

74. The Head of Security and Intelligence signed the form to say he had read the Initial Segregation Health Screen. There is no evidence he queried the nurse's conclusion. He authorised the decision to segregate. He recorded that he had read the ACCT plan and considered other options to segregation.

75. The Head of Security also completed a defensible decision log. He noted he had spoken to Mr Ashcroft at length that day and considered his needs could be met in the CSU, and that he would be vulnerable on the wings. The nurse had agreed with him. He did not consider Mr Ashcroft needed distraction material or anti- ligature clothing and bedding as he was not actively self-harming.

24 June

76. The ACCT observation log shows that Mr Ashcroft was checked five times an hour during the morning of 24 June. However, the police reviewed the CCTV footage from midnight to 7.00am and found that many of the recorded checks were not carried out.

77. Officer A documented five checks between midnight and 1.00am, but only carried out two of them. Another officer relieved him when he went on his break between

1.00am and 2.00am and completed four checks (as he had documented that he had completed one just before 1.00am, although he had not done so).

78. Officer A returned from his break and documented five checks between 2.00am and 3.00am, but CCTV shows he only approached the cell once in that time. From this point until 6.00am, CCTV shows that he made only one check an hour, but documented four or five an hour. At 3.53am, Mr Ashcroft pressed his emergency cell bell and he did not respond until 4.17am.

79. Between 6.00am and 6.50am, Officer A made five log entries compared to two actual checks (which occurred at 6.06am and 6.36am). At 6.38am, he documented that Mr Ashcroft was sitting on the floor and making no sense. This was the last time he checked Mr Ashcroft.

80. At 6.50am, Officer A made his last log entry, which says that Mr Ashcroft was 'stood in cell pacing around'. CCTV shows that he did not carry out this check.

Emergency response

81. At 6.47am, Officer B came on duty and made his way to the CSU, where he received a handover from Officer A. Officer B had been detailed to cover video-link duties, but the rota had changed to put him in the CSU.

82. At 6.54am, Officer B checked on Mr Ashcroft. He described the cell as 'trashed' with items on the floor and the mattress on the floor. Mr Ashcroft was on the floor between the mattress and his sink. He was on his front with his head turned towards the sink. The officer said he was confused as, according to the ACCT book, Mr Ashcroft had been fine only minutes earlier.

83. Officer B thought he could see a small piece of green material above Mr Ashcroft's collar, which he thought might be a ligature. He called out to Mr Ashcroft but got no response. He went to the CSU office to use the radio to call for assistance (as his own radio was turned off and assigned to him for video-link duties and would take time to load up). An Operational Support Grade (OSG), who was the duty communications controller, heard his call, 'Staff assistance required. Prisoner under ligature'.

84. The OSG sounded the prison's emergency alarm, called over the radio for staff assistance and asked for Oscar 1 (the call sign for the Night Orderly Officer in charge of the prison overnight) and Hotel 1 (the healthcare first responder) to acknowledge the message.

85. Officer B said he did not know Mr Ashcroft and so was not comfortable going into the cell alone. He told the investigator he had also experienced a fake self-harm incident the day before. Mr Ashcroft's cell was the furthest from the CSU gate, but as soon as he heard the gate being unlocked by other staff, he entered the cell, at 6.56am.

86. Officer B cut the ligature from Mr Ashcroft's neck using his fish knife. The ligature appeared to have been made from a thin piece of bedding and was not attached to anything. He told the investigator he was focused on removing the ligature and that it did not enter his mind to call a medical emergency code. There was blood around

Mr Ashcroft's nose and mouth, and he started chest compressions. Officer C arrived first and helped with cardiopulmonary resuscitation. Other staff also attended. At 6.58am, a CM called a code blue and confirmed an ambulance was required. A prison manager also arrived.

87. At 7.00am, two nurses arrived. Prison staff were doing compressions and Mr Ashcroft was warm to the touch. One nurse applied a defibrillator, but it advised 'no shock'. Staff continued with CPR. Two more nurses arrived and assisted with efforts. Two ambulances arrived at 7.10am, followed by a third at 7.16am and an air ambulance carrying a doctor at 7.36am.

88. A CM completed the escort risk assessment and decided that Mr Ashcroft should be escorted to hospital by two officers but with no handcuffs. Paramedics said that the prognosis was not good. However, they detected a rhythm and took Mr Ashcroft to hospital at 7.48am.

89. Mr Ashcroft was put on a ventilator, and the prison healthcare team contacted the hospital regularly about his condition. On 1 July at 7.47am, treatment was withdrawn, and Mr Ashcroft died at 8.10am.

Contact with Mr Ashcroft's family

90. On 24 June, the prison appointed a family liaison officer. He contacted Mr Ashcroft's mother to tell her Mr Ashcroft had been taken to hospital and maintained contact with her.

91. Mr Ashcroft's funeral was on 23 July. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

92. After Mr Ashcroft was taken to hospital, a prison manager debriefed the staff involved in the emergency response to signpost staff to support and initiate any required further actions. On 3 July, the manager held a cold debrief to discuss any potential learning points.

93. The prison posted notices informing other prisoners of Mr Ashcroft's death and offering support. Staff reviewed all CSU prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by the incident.

Post-mortem report

94. The post-mortem report concluded that Mr Ashcroft died of hypoxic brain injury (lack of oxygen to the brain) consistent with ligature application.

95. Toxicology tests showed therapeutic levels of quetiapine (an anti-psychotic), mirtazapine (an antidepressant), metoclopramide (an anti-emetic) and methadone in Mr Ashcroft's system at the time of his death, together with a high level of buprenorphine and the presence of psychoactive substances (PS). There has likely been therapeutic range use of metoclopramide, mirtazapine, methadone and quetiapine. The mirtazapine and quetiapine may be artefactually raised in post-

mortem blood due to redistribution. Mr Ashcroft was not prescribed metoclopramide or methadone at the time of his death. The pathologist said that although the use of PS and the high level of buprenorphine may have impacted on Mr Ashcroft's thought processes and awareness at the time of his death, he did not consider they contributed to his death in a toxicological sense.

Findings

Clinical care

96. Mr Ashcroft had been at Lincoln for only five weeks when he died and had received substantial input from healthcare services during this time. The clinical reviewer concluded that the clinical care Mr Ashcroft received was of a reasonable standard and equivalent to that he could have expected to receive in the community, despite it being during the difficult early days of the COVID-19 pandemic.

97. The clinical reviewer said that Mr Ashcroft was quickly and appropriately referred to a psychiatrist who diagnosed delusional parasitosis and had planned to refer him for more specialised assessment by secure mental health services, but he died before this could be actioned.

98. The clinical reviewer noted that Mr Ashcroft also had a long history of substance and alcohol misuse and had regularly been under the care of substance misuse services in the community and in prison. Despite the many courses of treatment given to him, he had continued to use illicit substances.

99. The clinical reviewer noted that Mr Ashcroft had decided to reduce his methadone dose rapidly while he was at Lincoln. She asked the substance misuse specialist if a rapid reduction of methadone may cause an increase in mental health symptoms, such as Mr Ashcroft's delusional parasitosis. He said that in his experience it was very rare for a rapid reduction to trigger psychosis. He also said that Mr Ashcroft had instigated rapid reductions before with no known mental health impact.

Communication with prison staff

100. Although Mr Ashcroft received a good level of healthcare, we are concerned that healthcare staff did not make it clear to prison staff that he had serious mental health problems.

101. For example, although healthcare staff recognised that Mr Ashcroft appeared to be acutely mentally unwell from at least 15 June (when it was agreed he needed an urgent appointment with the psychiatrist), the officer who recorded that Mr Ashcroft appeared to be trying to manipulate a transfer to hospital on 22 June appeared to be completely unaware of this or of Mr Ashcroft's delusions about being infested with spiders.

102. We are also concerned that there is no evidence that healthcare staff made prison staff aware that the consultant psychiatrist had assessed that Mr Ashcroft was having an acute psychotic episode on 23 June. When the Head of Residence asked for feedback on the psychiatrist's visit later that day, she was simply told that Mr Ashcroft's mental health worker would see him the following day.

103. If prison staff had had a better understanding of how unwell Mr Ashcroft was, it is possible they would have managed him differently and may have concluded that segregation was inappropriate or that he should be placed on constant watch.

We recommend:

The Head of Healthcare should ensure that healthcare staff share information about a prisoner's mental or physical health with prison staff where this is necessary to keep a prisoner safe

Fitness for segregation

104. We are concerned that the Initial Segregation Health Screens, which are used to assess whether a prisoner is medically fit to be segregated, were completed incorrectly.

105. The first, completed by a nurse on 22 June, answered 'Yes' and 'No' to the same question and had no conclusion marked. We consider that the second, completed by another nurse on 23 June, reached the wrong conclusion as, according to the answers given, she should have concluded that there were healthcare reasons not to segregate Mr Ashcroft. We are particularly concerned about this because she had recorded on the health screen that Mr Ashcroft was 'acutely unwell' and because she told us at interview that she believed Mr Ashcroft was serious about attempting to kill himself.

106. The nurse told us that she had not been trained in completing the Segregation Health Screen and she found it confusing. The Clinical Matron for Mental Health told us that the form is very simple to follow and although healthcare staff are given no specific training in completing it, they are mentored for four to six weeks before they attend CSU or ACCT reviews on their own. We consider that the fact that two nurses made similar errors in completing this very important form suggests that training is required. In addition, it is important that healthcare staff understand that they are not simply completing a form for the sake of it – they are contributing to a key decision about whether a prisoner can be segregated safely.

107. We are also concerned that there is no evidence that another nurse completed a Segregation Health Screen on 23 June. Her assessment that Mr Ashcroft was calm and relaxed was completely at odds with his presentation less than two hours previously when the consultant psychiatrist had concluded he was having an acute psychotic episode, and with his presentation two hours later when another nurse opened an ACCT and recorded that he was acutely unwell. Unfortunately, this nurse was not available for interview to explain her assessment.

108. We are also concerned that despite the managers who authorised segregation both signing to say they had read the Initial Segregation Health Screen, neither queried the conclusion, or lack of conclusion, or whether the segregation unit was an appropriate location for an acutely unwell prisoner.

109. It is well known that segregation can have a detrimental effect on prisoners' mental health, and it is important that every prisoner is properly assessed before being held in segregation. If there are healthcare reasons not to segregate, this needs to be highlighted and then managers need to assess carefully whether there are alternatives available.

110. This is particularly important in the case of prisoners who are subject to ACCT monitoring. Such prisoners are, by definition, particularly vulnerable and locating

them in segregation units should be avoided wherever possible. Prison Service Instruction (PSI) 64/2011 on safer custody and Prison Service Order (PSO) 1700 on segregation both make this clear. PSI 64/2011 says:

> 'Prisoners on open ACCT plans must only be located or retained in Segregation Units only in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include other options that were considered but discounted.'

111. Given the errors in completing the Segregation Health Screen and the apparent lack of scrutiny or challenge by the prison managers who authorised Mr Ashcroft's segregation, we are not satisfied that the CSU was the most appropriate location for a man who was described as 'acutely unwell'.

112. We recommend:

The Governor and Head of Healthcare should ensure that:

- **healthcare staff are trained in the completion and importance of Initial Segregation Health Screens;**
- **healthcare staff complete Initial Segregation Health Screens fully and accurately and arrive at a clear conclusion; and**
- **authorising managers understand how the Initial Segregation Health Screen should be completed and query it if it appears incorrect or incomplete.**

ACCT observations

113. Mr Ashcroft should have been checked five times an hour on the night of 23/24 June. We are very concerned that Officer A failed to carry out many of the checks and falsified the ACCT log to make it look as though they had been completed when they had not, and that Mr Ashcroft was not observed at all for the 18 minutes before he was found unresponsive.

114. When he was interviewed by the police, Officer A said that as long as he could hear Mr Ashcroft shouting or banging, he knew he was still alive, and he did not therefore always need to check him visually. This displays a worrying misunderstanding of the purpose of the ACCT observations. Mr Ashcroft was on five observations an hour and the officer should have realised this meant he was considered to be at high risk of suicide or self-harm. If he had checked him frequently, the officer might have noticed signs that Mr Ashcroft was preparing to self-harm or use a ligature, or signs that he was becoming increasingly distressed.

115. Officer A has since been convicted of misconduct in a public office.

116. It is not uncommon for our investigations into deaths in prisons to reveal that ACCT checks have not been completed as they should have been. In such cases, it is always difficult for us to know whether what we are seeing are the failures of a single officer, or whether there is a general culture among staff at the prison that ACCT checks do not need to be done. We are pleased to see that managers at Lincoln have introduced an additional assurance process using CCTV to check if

recorded ACCT observations have actually been carried out. We, therefore, make no recommendation.

Emergency response

117. Prison Service Instruction (PSI) 24/2011 on the management of prisons at night says that staff should not normally enter a cell at night unless there are at least two or three staff present and entry has been authorised by the Night Orderly Officer (NOO). However, it also says that where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the NOO and an individual member of staff may enter the cell on their own after first conducting a dynamic risk assessment. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.

118. PSI 3/2013 says that prisons must have a medical emergency response code protocol in place to ensure a timely, appropriate and effective response to medical emergencies. A code blue is called when a prisoner is unconscious or having breathing difficulties and a code red is called for serious blood loss or burns. When a medical emergency code is called it should automatically trigger the prison's communications room to call an ambulance and prison healthcare staff to attend the emergency immediately with the appropriate equipment.

119. In a medical emergency minutes may make the difference between life and death. The PSI says that if staff are in any doubt about the nature of the situation, they must call a code and that 'it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required'.

120. When Officer B saw Mr Ashcroft lying on his cell floor with what looked like a ligature around his neck, he called for staff assistance. He then waited at the cell door until he heard other officers arriving on the unit, and then he went into the cell and cut the ligature around Mr Ashcroft's neck. It was not until two minutes later - four minutes after he saw Mr Ashcroft unresponsive on the floor - that a CM called a code blue. The officer said he was focused on cutting the ligature rather than calling a code, which did not enter his mind.

121. We understand why Officer A considered it may not be safe to go into the cell alone and we recognise that he went in as soon as he heard other staff arriving. We do not criticise him for this.

122. However, we are concerned that he did not call an emergency medical code straightaway, given that Mr Ashcroft was not responding, and he thought he could see a ligature. He subsequently radioed, 'Staff assistance required. Prisoner under ligature' but did not call a code.

123. Officer A has since been reminded about the use of medical emergency codes and he showed a good understanding when interviewed by the PPO investigator. We do not therefore make a recommendation.

Illicit substances at Lincoln

124. Toxicology tests showed that Mr Ashcroft had taken psychoactive substances (PS) shortly before he was found unresponsive. We know that PS can have a detrimental effect on mental health and can increase the risk of suicide and self-harm. However, we cannot say how much impact the use of PS had on Mr Ashcroft's death.

125. He had also used methadone and metoclopramide (prescription-only drugs that he had not been prescribed). He had presumably obtained these drugs and the PS illicitly within the prison.

126. The most recent HMIP inspection in 2020 found that work done to limit the supply of substances into the prison was good, as was the prison's drug strategy. In terms of target searching following receipt of intelligence, it said searches had increased substantially, but nearly a third of suspicion drug tests were not carried out.

127. We are concerned that the post-mortem toxicology tests suggest that Mr Ashcroft had been using illicit substances more than staff were aware of. We are also concerned that although a fact-finding report conducted by the prison after Mr Ashcroft's death said that he was suspected of being under the influence of illicit substances on 18 June, we have seen no evidence that staff recorded this at the time or that they submitted an intelligence report. It is important that incidents of suspected drug use are recorded and acted upon. We recommend:

The Governor should ensure staff record incidents of suspected substance misuse and submit intelligence reports.

Inquest

128. At the inquest, held from 2 to 17 March 2026, the jury concluded that based on the evidence they heard, they were satisfied that Mr Ashcroft did not intend to take his life and died by misadventure.

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