Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Glenn, a prisoner at HMP Lincoln, on 12 September 2022

A report by the Prisons and Probation Ombudsman

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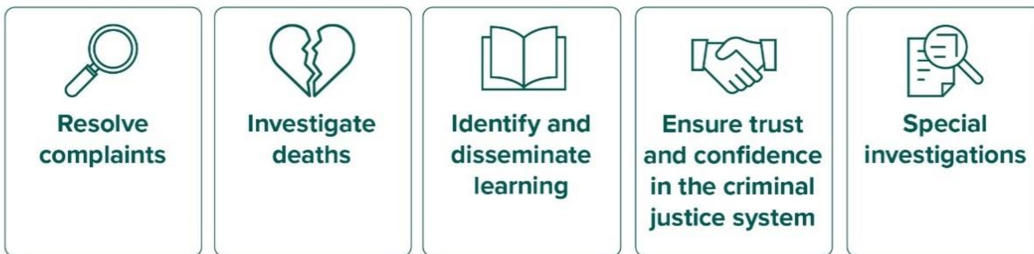
OUR VISION

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

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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 HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Richard Glenn died of a self-inflicted incised wound to the neck on 12 September 2022, while a prisoner at HMP Lincoln. He was 53 years old. I offer my condolences to Mr Glenn's family and friends. Mr Glenn was the tenth prisoner to die at Lincoln in three years.

Mr Glenn harmed himself on 2 August and staff rightly started suicide and self-harm prevention procedures (known as ACCT) to manage the risks. The ACCT procedures were generally well-managed, but when they were stopped on 9 September, healthcare staff did not consider a psychiatry assessment completed earlier the same day which raised concerns about Mr Glenn's presentation. While we cannot measure the impact on Mr Glenn, it is important that staff consider all relevant information when assessing suicide and self-harm risks.

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 **May 2024**

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Summary

Events

1. On 8 June 2022, Mr Richard Glenn was released from prison on licence. He was recalled to HMP Lincoln shortly afterwards, arriving at the prison on 13 June.

2. Mr Glenn had attempted suicide on several occasions, most recently in October 2018. Staff at Lincoln started Prison Service suicide and self-harm prevention procedures (ACCT) on 2 August 2022, after he harmed himself and shared suicidal thoughts.

3. On 9 September, staff stopped monitoring Mr Glenn because they were satisfied that he no longer posed an immediate risk to himself. However, notes from a psychiatric appointment earlier that day were not shared with staff for their consideration. The psychiatrist recorded concerns about Mr Glenn, who had presented as run down and low in mood.

4. At 5.13am on 12 September, an officer checked Mr Glenn through his cell observation panel and saw him lying on the floor in a considerable amount of blood. She immediately radioed a medical emergency code, indicating a serious injury and triggering a call for an ambulance.

5. Around one minute later, other officers and healthcare staff responded to the code and opened the door immediately. They could not find a pulse and noted that rigor mortis was present. When the nurse examined Mr Glenn, she noted a deep laceration to the right side of his neck. She decided not to start cardiopulmonary resuscitation (CPR). Paramedics later confirmed that Mr Glenn had died.

Findings

Management of risk of suicide and self-harm

6. Prison staff appropriately started ACCT procedures when Mr Glenn reported thoughts of harming himself. The ACCT procedures were generally managed well, including use of constant supervision at times of crisis, consistent contribution from the mental health team, and the use of ad hoc case reviews to review risk when necessary.

7. The decision to stop ACCT monitoring was reasonable based on the progress Mr Glenn appeared to have made, including his plans for his impending release. However, staff did not have access to the outcome of a psychiatrist's assessment, which took place earlier the same day, and which identified concerns about Mr Glenn. The psychiatrist's record should have been considered as part of the suicide and self-harm risk assessment process.

Recommendations

- The Head of Healthcare should ensure that healthcare staff check clinical records in preparation for ACCT review discussions, to ensure all available risk information is considered.

The Investigation Process

8. We were notified of Mr Glenn’s death on 12 September 2022.

9. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator visited HMP Lincoln on 1 November 2022. He obtained copies of relevant extracts from Mr Glenn’s prison and medical records.

11. The investigator interviewed 11 members of staff at HMP Lincoln during November 2022.

12. NHS England commissioned a clinical reviewer to review Mr Glenn’s clinical care at the prison. She conducted all staff interviews jointly with the investigator.

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

14. The Ombudsman’s family liaison officer contacted Mr Glenn’s mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Glenn’s family asked about the level of mental healthcare received by Mr Glenn at Lincoln. They were also concerned that Mr Glenn had been released without his medication on 8 June 2022, before being recalled to prison shortly afterwards.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

16. Mr Glenn’s family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Lincoln

17. HMP Lincoln is a Category B prison, which predominantly serves the courts of Lincolnshire. It holds up to 600 remanded and convicted adult/young adult male prisoners. Nottingham Healthcare NHS Foundation Trust provides health services and there is 24-hour nursing cover.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Lincoln was in December 2019 to 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.

Independent Monitoring Board

19. 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 2022, the IMB reported that a range of safety measures were in place, including behaviour management, frequent reviews of and responses to incidents of violence and self-harm, and sharing of information among all relevant departments within the prison. The report stated that there had been a reduction in self-harm and that staff/prisoner relationships continued to be generally positive and supportive.

Previous deaths at HMP Lincoln

20. Mr Glenn was the tenth prisoner to die at Lincoln since September 2019. Of the previous deaths, four were self-inflicted and five were from natural causes. There are no notable similarities in our findings across recent investigations.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

22. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should

be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

23. Following the closure of an ACCT, ‘post-closure’ monitoring must take place for a minimum period of seven days, to ensure closure is appropriate and risks can be managed without additional monitoring.

24. As soon as possible following this seven-day monitoring period, the ACCT Case Coordinator must chair a post-closure review, reviewing the progress made since the ACCT was closed. During the post-closure review, consideration should be given to the current feelings of the prisoner, access to support (both formal and informal), and progress since closure. At the end of the review, the Case Coordinator and any other members of the case review team present will decide whether there needs to be any further post-closure reviews (and, if so, their frequency), or whether the ACCT needs to be re-opened.

Key Events

Background

25. On 28 February 2022, Mr Richard Glenn was released on licence from HMP Lincoln. On 2 March, he was recalled to Lincoln after being charged with assaulting an emergency worker on the day of his release.

26. Mr Glenn had been to prison several times. He had been diagnosed with depression, anxiety, and mixed personality disorder, for which he was prescribed medication. Mr Glenn had a long history of self-harm. He attempted suicide on several occasions, most recently in October 2018.

27. On 4 March, Mr Glenn asked officers for a razor to cut his wrist. Staff started ACCT procedures, which they closed the following day when they were satisfied that Mr Glenn was no longer a risk to himself.

28. On 8 May, staff started ACCT procedures again, when Mr Glenn threatened to kill himself with a razor blade. Staff closed the ACCT on 20 May.

29. On 8 June, Mr Glenn received a 20-week sentence of imprisonment. He had served more than half of the sentence already, on remand, and so was released straight from court into the community. (Offenders sentenced to sentences of less than two years in prison serve half of their sentence in prison and half in the community on licence.) Mr Glenn was required to report to his local probation office on the day of his release, but he failed to attend, and probation made a decision to recall him to custody. The next day, Mr Glenn was arrested by police as part of the recall. He assaulted a police officer during the arrest which resulted in further charges.

Recall to HMP Lincoln

30. On 13 June, Mr Glenn arrived at Lincoln and the reception nurse assessed his mental and physical health. Mr Glenn said that he had not taken any medication since his release from prison on 8 June, and that he had drunk a lot of cider. Based on Mr Glenn’s medical history, the nurse referred him to the mental health team for further assessment. He remained under the care of the mental health team until his death.

31. Mr Glenn applied for vulnerable prisoner (VP) status (for prisoners who would be at risk of attack if kept in the mainstream prison population), which was granted. He applied for VP status because he had previous convictions for sexual offences. He was allocated a single occupancy cell.

32. On 14 June, a GP prescribed Mr Glenn venlafaxine (an antidepressant) and olanzapine (an antipsychotic).

33. On 15 June, a mental health nurse assessed Mr Glenn to ascertain his mental health needs. Mr Glenn told her that he had been through “a rough time” after being granted immediate release from court without any medication or a discharge grant.

34. On 20 July, after refusing to work and littering, staff placed Mr Glenn on the ‘basic’ level of privileges, meaning that he would only have basic entitlements such as telephone calls, visits, access to books and education. Mr Glenn remained on the basic privileges level until 16 August, when staff were satisfied that his behaviour had improved.

35. On 28 July, Mr Glenn was sentenced to 26 weeks in prison for assaulting an emergency services worker during his recall arrest.

36. On 2 August, in the early hours of the morning, staff started ACCT procedures after Mr Glenn told the night patrol officer that he was going to harm himself. He showed the officer some razor blades he was holding in his cell and said he was struggling with his mental health. Staff initially decided to monitor Mr Glenn through hourly observations.

37. The ACCT case co-ordinator chaired an ACCT case review later that day, which included a representative of the mental health team and Mr Glenn’s prison offender manager (POM). Mr Glenn said that he felt low and had thought about harming himself but chose to seek the help of the night officer rather than “suffering in silence”. The case co-ordinator recorded a support action for Mr Glenn to work with the mental health team. He set ACCT observations at three during the day and four during the night, after Mr Glenn cited protective factors and said he had no current thoughts of suicide or self-harm. (From this point onwards, Mr Glenn was only allowed a razor blade for the period in which he wanted to shave. He would immediately hand it back to staff when finished.)

38. On 6 August, the mental health team added Mr Glenn to the Red RAG (‘Red Amber Green’) rating of intervention and input from the team, due to the deterioration of his mental health which was leading to thoughts of self-harm. (The RAG rating is a tool used to assess the risk levels for patients. Individuals rated red receive at least weekly intervention from the mental health team.)

39. At around 6.20am on 8 August, Mr Glenn made small cuts to his arm with a razor obtained illicitly from a prisoner on the wing. He told staff that his mental health was deteriorating. A Supervising Officer (SO) led an ad hoc ACCT case review afterwards, and recorded that Mr Glenn gave no reason for harming himself other than that it was “quiet”. He arranged a full ACCT case review for the following day.

40. On 9 August, the ACCT case co-ordinator chaired the ACCT case review, which included a mental health nurse and the POM. Mr Glenn said that his “head was full” and requested that the mental health team arrange hospital admission. The nurse explained that Mr Glenn would be able to speak to a psychiatrist about this.

41. On 11 August, Mr Glenn self-harmed by cutting his left wrist with another razor blade he had obtained illicitly. Again, he said he was struggling with his mental health. The ACCT case co-ordinator chaired an ad hoc ACCT review, recording that Mr Glenn said that his mental health concerned him and that at the time he felt like he wanted to kill himself. A mental health nurse present recorded that she would try to arrange for his appointment with the psychiatrist (which was set for 26 August) to be brought forward. The co-ordinator added this as a support action and increased the level of observations to a minimum of two per hour.

42. On 16 August, Mr Glenn cut his neck and arm with an illicitly obtained razor and told staff he was depressed. Due to the severity of Mr Glenn's injuries, he was admitted to hospital for an operation. While in hospital, Mr Glenn told escorting staff that he would cut himself again at the first opportunity when he got hold of a razor. As a result, when Mr Glenn was released from hospital on 20 August, staff decided to place him under constant supervision, with a review booked for 22 August.

43. On 22 August, Mr Glenn's ACCT review took place. As constant supervision was in place, a Custodial Manager (CM) chaired the review and was now the case coordinator. Other attendees included the ACCT case co-ordinator, the POM and a nurse from the mental health team. Mr Glenn told staff that he felt he had recovered physically after his operation but not mentally. He said he felt his olanzapine medication was not helping him, and that this was the main cause of his mental deterioration. The CM noted that Mr Glenn had an appointment with the psychiatrist later that day, where his medication would be reviewed. Mr Glenn did not want to return to the cell that he had occupied up until 16 August, so staff relocated him to a cell in a different part of the VP Wing. Mr Glenn did not object to his new location but said he would like to return to a section of the VP Wing where he had resided while previously in custody, as he had felt settled there. Staff agreed to facilitate this for him once a cell became available. The case review team chose to keep constant supervision in place.

44. After the ACCT review, a SO met Mr Glenn in her capacity as his key worker. (She was a prison officer at the time that she worked with Mr Glenn. She has since been promoted to SO.) Mr Glenn told her that he had been struggling recently and had self-harmed. Mr Glenn told her that part of the reason for his self-harm was his olanzapine medication not working for him. He told her that he was going to request a change in his medication from olanzapine to quetiapine (an alternative antipsychotic).

45. Later the same day, Mr Glenn met with a psychiatrist, who reduced his daily olanzapine medication in preparation for stopping all together and switching to quetiapine. The psychiatrist booked a follow-up appointment for 9 September, with a view to increasing the dose of quetiapine should Mr Glenn be tolerating it well.

46. On 23 August, the next ACCT constant watch review for Mr Glenn took place, chaired by a CM and attended by a nurse, the POM, and a wing SO. The nurse told the group that the psychiatrist would not support a move to a secure mental hospital because Mr Glenn did not meet the criteria. Mr Glenn appeared shocked and disappointed by this news, but was pleased that he had another review with the psychiatrist booked in. The nurse recommended that Mr Glenn should be kept under constant supervision because his risk of further self-harm was high, which the group agreed was the correct approach.

47. On 26 August, the next ACCT constant supervision review took place, chaired by a CM and attended by a nurse, the POM and others. Mr Glenn told the group that he was "a bit better" than at the last review but still recovering. He said that he had been sleeping better since his medication had been changed to quetiapine and he felt good about it. Mr Glenn presented well and said his thoughts of self-harm were still there but less intrusive than before. The group agreed that Mr Glenn should no longer be under constant supervision, but that his ACCT should remain open with three observations per hour and three conversations per day.

48. On 29 August, a CM chaired the next ACCT case review, with a SO and a member of the mental health team also present. Mr Glenn talked a lot about how his new medication had improved his mood and sleep. He said he was looking forward to his appointments with the mental health team and psychiatrist. Staff reported that Mr Glenn was still waiting for a space in his preferred section of the VP Wing.

49. On 31 August, the mental health team completed the Colombia Suicide Severity Rating Scale (C-SSRC - a suicide risk assessment tool designed to assess the severity and immediacy of that risk and the level of support a person needs) for Mr Glenn. They assessed him as at high risk and he remained on the red RAG rating.

September 2022

50. On 2 September, a SO chaired an ACCT review, with a nurse, and a CM. Mr Glenn told the group that he felt okay and looked forward to his upcoming appointment with the psychiatrist. He said that he sometimes thought about self-harming but used television and books to distract himself. Mr Glenn told the group that he had ordered a razor from the canteen, which they flagged as a concern and removed from his delivery. Staff agreed that Mr Glenn should be monitored and supervised while shaving, which he understood. In interview, the nurse told us that Mr Glenn appeared fixated on his canteen delivery for the week, which he said was because he wanted to repay vapes to two other prisoners. She had concerns about Mr Glenn's fixation on his canteen delivery and felt his level of observations should remain the same. However, the CM and the SO felt that Mr Glenn was going in the right direction and chose to lower the observations to once every two hours, with three conversations a day.

51. The next ACCT review took place on 6 September, chaired by the ACCT case co-ordinator and attended by the POM and a nurse. Mr Glenn told the group that he was looking forward to his release on 26 October, and that he kept himself busy by watching television, reading, and occasionally meditating. The co-ordinator and POM considered this to be a positive sign and agreed to reduce Mr Glenn's level of observations to three per day (plus three conversations) and four observations overnight.

52. At around 9.20am on 9 September, Mr Glenn attended a review with the psychiatrist. Mr Glenn told him that did not feel brilliant but felt better than he did when taking olanzapine. They agreed to increase his quetiapine dose gradually. The psychiatrist recorded on Mr Glenn's medical record that he still struggled with low mood and was "very run down". Mr Glenn told her that he had struggled with thoughts of self-harm in the past few weeks but did not currently experience such thoughts. He also expressed some concerns about his lack of accommodation on release from prison.

53. At around 10.30am, the ACCT case co-ordinator chaired the next ACCT case review, attended by a nurse and a CM from the Safer Custody Team. Mr Glenn told the group that he was looking forward to his release from prison (on 26 October) and wanted a period of stability after this. To assist Mr Glenn with his accommodation concerns, the co-ordinator contacted the Lincolnshire Action Trust (LAST) to see if they could assist. Although a transfer to his preferred section of the VP Wing was still not possible, Mr Glenn was told that this may change in the

coming days. He said that since his change in medication, he had only fleeting thoughts of self-harm and no plans or intention to harm himself. The information from Mr Glenn's psychiatric appointment that morning was not shared with the ACCT review group. Staff agreed to close the ACCT and put it into 'post-closure' state (during which time it could be reopened if additional concerns arose). They scheduled a post-closure interview, where final closure of the ACCT would be discussed, for 16 September.

54. At 4.45pm on 11 September, Mr Glenn left his cell to collect his dinner. He returned to his cell and closed the door at 4.48pm. CCTV footage shows that staff completed visual checks on Mr Glenn through his cell observation panel at 4.50pm, 5.01pm and 5.38pm. They raised no concerns. At 8.23pm, an Operational Support Grade (OSG) observed Mr Glenn through his cell observation panel as part of her evening routine check. She raised no concerns. Mr Glenn was not subject to any other checks during the night.

Events of 12 September

55. At 5.13am, the OSG checked Mr Glenn through his cell observation panel as part of the early morning routine check. She saw him lying on the floor of his cell in a lot of blood and immediately radioed a medical emergency 'code red', indicating a serious injury and triggering a call for an ambulance. She attempted to open the door with her key but inadvertently failed to unlock the bolt at the bottom of the door, so was unable to open it.

56. Around one minute later, prison and healthcare staff arrived at the cell and opened the door immediately. A nurse could not find a pulse and noted that rigor mortis was present. She noted a deep laceration to the right side of Mr Glenn's neck. Due to the rigor mortis and laceration, she decided not to start cardiopulmonary resuscitation (CPR).

57. Paramedics did not attend the prison immediately as it was clear that Mr Glenn showed no signs of life. At 7.20am, they attended and confirmed Mr Glenn's death.

58. After Mr Glenn's death, an officer told us that two prisoners said that Mr Glenn had asked them for a razor the previous night, but both had not given him one. Police found a blade on the floor of Mr Glenn's cell which they believe he used to make the laceration. However, investigations have not established where or from whom he obtained it.

Contact with Mr Glenn's family

59. At around 11.00am on 12 September, the prison family liaison officer and a prison chaplain arrived at the home of Mr Glenn's next of kin, his mother, to inform her of the death.

60. Lincoln contributed to the costs of Mr Glenn's funeral, in line with Prison Service policy.

Support for prisoners and staff

61. After Mr Glenn’s death, an operational 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.

62. The prison posted notices informing other prisoners of Mr Glenn’s death and offering support.

63. On 24 September, the Head of Residence and Services held a ‘cold de-brief’ with staff, to discuss the emergency response and what could have been done differently. No specific learning was identified.

Post-mortem report

64. A post-mortem examination concluded that Mr Glenn died due to an incised wound to the neck. The toxicology examination showed no evidence to suggest drugs or alcohol caused or contributed to Mr Glenn’s death.

Findings

Management of suicide and self-harm risk

65. Prison Service Instruction (PSI) 64/2011, Safer Custody, contains requirements for the management of suicide and self-harm prevention procedures. It requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.

66. Prison staff appropriately started ACCT procedures on 2 August. The case reviews were multidisciplinary, including consistent input from the mental health team, and case management was broadly consistent. Constant supervision was used appropriately when Mr Glenn’s risk was judged to be very high, and ad hoc case reviews were held when he harmed himself. The ACCT procedures were closed on 9 September, three days before he died. We have considered whether monitoring was ended prematurely.

67. Much of Mr Glenn’s risk revolved around his mental health and his thoughts of harming himself were seemingly linked to deteriorations in mental health. He worked with the mental health team and psychiatrist and, over time, said that he was feeling the positive effects of his new medication, was sleeping better and that his thoughts of harming himself had reduced. Mr Glenn also spoke positively about the future, including his upcoming release, and staff agreed that his outward presentation had improved.

68. Mr Glenn had an appointment with a psychiatrist on the morning of 9 September. The psychiatrist recorded that Mr Glenn presented as run down and low in mood. A nurse attended Mr Glenn’s next ACCT review, but did not check his records, so was unaware of the psychiatrist’s notes. She told us that there was a lot of “future focus” in Mr Glenn’s final ACCT review, and that she “did not see any immediate concerns with his safety”.

69. We consider that the decision to close Mr Glenn’s ACCT was, on the surface, reasonable, based on staff’s assessment of his progress and forward thinking. However, healthcare staff should have checked Mr Glenn’s medical notes before the review, to ensure all relevant and up to date information was shared with the ACCT review. The psychiatrist’s assessment record might have impacted the decisions made. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff check clinical records in preparation for ACCT review discussions, to ensure all available risk information is considered.

Clinical care

70. The clinical reviewer concluded that the clinical care provided to Mr Glenn was equivalent to that which he could have expected to receive in the community. The mental healthcare provided to Mr Glenn was of a good standard and he received regular input from the mental health team, including the psychiatrist.

Head of Healthcare to note

Release on 8 June 2022 prior to recall

71. In addressing concerns raised by Mr Glenn's family, we found that Mr Glenn was released from prison following a court appearance on 8 June without his prescribed medication, which appears to have impacted on his mental health. We found that healthcare staff did not receive any prior notice of Mr Glenn's release from prison, so when he was released directly from court after his hearing, there had not been an opportunity to provide him with take home medications.

72. Although this matter did not impact directly on Mr Glenn's death, it is important that prisoners are released with essential medication to ensure continuity of treatment while awaiting access to community services.

Inquest

73. The inquest into Mr Glenn's death concluded on 23 March 2026, and recorded that Mr Glenn intended to take his own life. The jury concluded that insufficient sharing of risk information between healthcare and prison staff possibly contributed to his actions.

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Independent Investigations

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