Investigation into the circumstances surrounding the death of a man at HMP Lincoln in April 2009

Report by the Prisons and Probation Ombudsman for England and Wales

February 2010

The man was 27 years old when he died in April 2009, in his healthcare cell at HMP Lincoln. He was found hanging. The Senior Investigator and Family Liaison Officer (FLO) join me in offering our sincere condolences to his family and friends for their sad loss. I must apologise to the Coroner and the man's family for the delay in issuing this report.

I wish to thank the Governor of Lincoln for making the necessary facilities and information available to the investigator. I also wish to pay particular thanks to the prison Liaison Officer for her invaluable assistance. Her support to the Ombudsman's office and dedication to the investigation process is worthy of special mention.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment the man received in custody. I am grateful to the clinical reviewer, who was appointed by NHS Lincolnshire, for her assistance and report.

My report shows that the man had been received into prison custody just three days before his death. Concerns about his mental health were raised almost immediately by both prison and healthcare staff. Due to the level of concern, he was admitted into the prison hospital for a mental health assessment.

During the course of the investigation, I was made aware that an allegation of improper conduct by a nurse had been made to the local Primary Care Trust (PCT). Although I comment on the issue in this report, the matter is the subject of a separate investigation by the PCT.

Since the Ombudsman took responsibility in April 2004 for the investigation of all deaths in custody, there have been 11 deaths at Lincoln. Sadly, within the space of a few hours of the man's death, there was another death at the prison. That investigation is being carried out separately by the Ombudsman's office.

I make one recommendation as a result of this investigation, which relates to the monitoring of mail and telephone calls for those prisoners who are subject to public protection. That said, I am satisfied that the lack of monitoring had no bearing on his death. Additionally, despite dying in healthcare and whilst being monitored, I am satisfied that everything possible was done to keep him safe.

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

Jane Webb
Deputy Prisons and Probation Ombudsman **February 2010**

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SUMMARY

In 2009, the man was remanded into prison custody after being charged with "grievous bodily harm with intent". When he arrived at Lincoln Prison, a reception manager was told by a member of the escort staff that he had some mental health problems. The manager decided to keep him apart from other prisoners and under his observation.

Shortly after, following what was described as a commotion, the man was discovered crouched in the toilet area of the room. A nurse was asked to see him, and she decided to admit him into healthcare for observation. He kept referring to hearing a man's voice telling him that his children would be taken away.

The following day, due to continuing concerns about his mental health, the man was monitored under the prisons self harm monitoring procedure. Additionally, a member of the prison public protection team met him. This was because of a previous offence for which he had been placed on the Sex Offenders Register meaning that his telephone calls and mail would be monitored.

In April, due to concerns about his mental health, the man was assessed by a consultant psychiatrist. The doctor assessed him as psychotic, paranoid, with delusion and auditory hallucinations.

The next evening during a routine monitoring check, the man was discovered hanged in his cell. Despite a prompt response from the officer and nursing staff, neither they, nor paramedics were able to safe him. Sadly, at 10.42pm, it was confirmed by doctors at the hospital that he had died.

There was one recommendation made as a result of this investigation. This concerned adequate public protection measures being in place

THE INVESTIGATION PROCESS

1. After receiving notification from the National Offender Management Service (NOMS) of the man's death, the investigation was allocated to a senior investigator. He contacted the Governor, and arranged to travel to the prison to meet him and his team for the purpose of opening the investigation.

2. In April, the investigator met the governor as arranged. Also at that meeting was the liaison officer, the Chairman of the local Independent Monitoring Board, the prison Head of Healthcare, a Detective Constable and an Officer, representing the local Prison Officers Association.

3. The governor gave the meeting an overview of what had occurred in April. His briefing helped the investigator identify a number of people that he wished to interview. In addition, others attending the meeting gave background information about the man and the prison. After the meeting, the investigator went to the cell where he had been found. He was able to view the cell and identify where the ligature had been attached.

4. Before leaving the prison, the investigator arranged to return at a later date to begin his investigation. He had identified a number of prison staff that he wanted to speak to, and arranged to return to the prison in May to begin his work.

5. Following any death in prison, notices to staff and prisoners are published, inviting anyone with information to make themselves known to the investigator. The notices were displayed around the prison and were available to prisoners and prison staff. At the time of writing this report, no prisoners have asked to speak to him.

6. In May, the investigator returned to the prison to continue the investigation. Over the next four days, he interviewed a number of staff, with some, but not all, of the interviews being recorded. One member of staff was adversely affected by his discovery of the man and was still off work as a result. I have accepted his written statement in preference to causing him further distress.

7. The investigator also met the clinical reviewer and discussed the man's medical care. The investigator has shared with the clinical reviewer a copy of the interview transcripts and the man's prison record. As well as interviewing staff, the investigator met the prison Family Liaison Officer.

8. Three days later, the investigator gave feedback to the prison liaison officer as the Governor was not available. He followed up the feedback by writing to the Governor. In that letter, the investigator referred to what he was told was a separate investigation by the PCT into the actions of a nurse, who had apparently destroyed part of the man's medical record.

9. In the meantime, one of the Ombudsman's Family Liaison Officers (FLO) contacted the man's family. She explained the Ombudsman's role and offered his family the opportunity to meet her and the investigator. The purpose of offering the meeting was for his family to contribute towards the report and ask any questions they would like examined.

10. The man's brother said that, when he went to the cell, he had noticed the beds were not bolted down. Additionally he questioned whether it was possible for anyone to hang themselves from a "picture hook". He asked whether the man had been placed on "suicide watch" and whether more could be done to make healthcare cells safer. Finally, he asked whether the man's mail was being monitored, as he felt this would have given an indication as to how distressed he was.

11. The man's mother complimented the way the prison family liaison officers had looked after them. She described their support as "brilliant".

12. She said her family had been upset to learn that her son's death had been reported on the news. She said one member of the family, who was unaware of the death, heard about it as she was driving her car. The family were also upset that his name was spelt incorrectly on teletext. I hope that the report has answered the majority of their questions.

13. The investigator returned to the prison in November. He spoke informally to the officer who found the man and ensured the officer's written statement had been correctly recorded in this report. The officer, accompanied by a member of the local care team, confirmed that it was, and was able to add some further detail to his report. He told the investigator he had returned to work, but was still receiving counselling and support.

14. As well as speaking to the officer, the investigator was able to listen to the man's last five telephone calls and view a closed circuit video recording of what occurred in healthcare in April. After completing this piece of investigation work, he met the new Governor of the prison who took over in October. The investigator fed back his findings, advising him there was likely to be one recommendation relating to public protection and a failure to correctly monitor the man's telephone calls. The Governor accepted the feedback.

HMP LINCOLN

15. The prison is situated close to the city centre of Lincoln. Originally built in the Victorian era, it has undergone extensive refurbishment. The establishment is what is commonly referred to as a local prison which generally means it is used to accommodate prisoners remanded by local courts, although there are a number of sentenced prisoners.

Her Majesty's Chief Inspector of Prisons

16. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments. In December 2007, the Chief Inspector carried out an announced inspection of the prison. In the introduction to her report, she said that on her last visit, the fabric of the prison and morale of the staff remained damaged by the effects of a serious disturbance in 2002. However, on her return to carry out the latest inspection, she was pleased to find that the damaged accommodation had been repaired and that the prison had returned to normality.

17. In her final paragraph, she said the prison had gone through a difficult period adding that staff morale had been repaired following the disturbance. She concluded that "In effect, the prison had successfully turned a particularly unfortunate page in its history".

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB). Their role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.

19. In their latest report covering the period 1 February 2008 to 31 January 2009, the Board Chairman highlighted a variety of concerns and good practice. He said the staff were well motivated and carried out their duties with professionalism and care. The overall conclusion of the Board was that the prison was well run, with many of previous deficiencies identified by them being successfully remedied.

Assessment, Care in Custody and Teamwork (ACCT)

20. ACCT has been in place in every prison since April 2007 and requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document is available to all staff where the prisoner is located. Within 24 hours of the document being opened, the at-risk prisoner will be interviewed by a trained ACCT assessor. The assessor's role is to explore eight specific areas and record their comments in the ACCT document. Following the assessment a case review meeting is held, which is a multi disciplinary meeting. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers act as case managers, oversee the management of the ACCT document and attend case reviews.

Anti ligature knives

21. Staff who deal with prisoners issued with specially designed anti ligature knives, commonly referred to as “fish knives” because of their shape, which are used in an emergency to remove a ligature. The knives have a concealed blade which is placed against a ligature and which can be pushed forward to cut it without harming the prisoner.

Care team

22. Each prison has its own care team. Care team staff are drawn from all areas of the prison and trained specifically to help and support prison staff. Following any serious incident, they provide an invaluable role to any member of staff who requires support.

Listeners

23. The prison has a “Listener Scheme”, which is a system where the Samaritans train selected prisoners to be the first contact for any prisoner who is feeling vulnerable and at risk. The scheme is confidential and any prisoner can request to speak to a Listener at any time of the day or night. Prisoners can access a Listener by speaking to a member of staff, who will then make the arrangements for a trained Listener to speak to them. If a prisoner is locked in their cell and wishes to speak to a Listener, they can ask a member of staff. The night orderly officer (who is in charge of the prison at night) has the authority to unlock a Listener and to escort him to the cell of the prisoner who is requesting assistance.

Police investigations of deaths in custody

24. With all deaths in prison custody, the police are notified by the prison as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that the Ombudsman’s investigators are allowed to begin their own investigations.

Prison officer grades

25. There are three levels of uniformed prison officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

26. Senior Officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day

management of their area, supervising staff and dealing with issues raised by prisoners.

27. Principal Officers (POs) are the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

28. In addition to prison officer grades, there are a group of staff known as Officer Support Grades (OSGs). OSGs wear prison uniform and carry keys but do not carry out the same function as prison officers. Their role is to support the areas of the prison that have little or no prisoner contact, for example, the gate.

FINDINGS

April

29. In April, the man was remanded into prison custody by magistrates sitting at the Magistrates' Court, having been charged with grievous bodily harm with intent. He was remanded until the end of April, when he was due to appear at Crown Court for trial. His prison record shows that imprisonment was not a new experience for him

30. Later that day, the man was taken to Lincoln by staff employed by the private escort company, Global Solutions Ltd (GSL). When he arrived there, he was taken into the reception department to be received into prison custody.

31. The reception manager on duty that day was an Senior Officer (SO). He told the investigator that, when the escort vehicle carrying the man arrived, a member of GSL spoke to him and said that he had some mental health problems. The SO decided to keep him separated from other prisoners and placed him in an interview room. He said the main reason was so that he could sit quietly. As well the position of the room allowed the SO to keep an eye on him.

32. After a short while, the SO heard a loud commotion coming from the room where the man was being held. When he went to see what the problem was, he found him crouched in the toilet area. The man repeatedly said "get him away from me" and pointed towards the door. Because there was no one at the door, the SO asked him if he was hearing voices, to which he said no. Due to concerns about his behaviour, the SO asked the Mental Health Nurse to see him, which she agreed to do.

33. At interview, the nurse said she met the man in one of the reception interview rooms. She described him as distressed, crying and holding his head in his hands. She said he kept referring to hearing a man's voice which was telling him he would take his children away. She said that, although she could see him, he was sitting in the toilet cubicle with the door closed. He told the nurse it was safer to have two doors between him and the man. He repeatedly said the man was laughing at him.

34. The nurse told the investigator that she wanted the man to provide a sample of urine so she could eliminate drugs as the cause of what she believed might be delusional psychotic thoughts. However, he was unable to concentrate on what she wanted him to do and so she decided he should be admitted into healthcare. The nurse said that the reason for admitting him was to enable a comprehensive mental health assessment to be carried out.

35. Despite there being no beds available, the nurse created a space and the man was admitted. She said he appeared to her to be in an acute

psychotic state, which means that his perceptions were not normal. The nurse added that because he was hearing voices and due to his level of distress, it made her think he was experiencing a psychotic episode.

36. At some point during the nurse's meeting with the man in the reception area, he left the toilet cubicle and entered the interview room. As he appeared to have calmed down, she started the normal healthcare screening for newly arrived prisoners. However, within a short space of time, he became agitated and began pacing up and down the room. She said his pacing became faster and faster and she could see he was clenching his fists. He began shouting and the nurse noticed that his hands were so tightly clenched that his knuckles were white. At this point, she left the room.

37. The investigator asked the nurse if she had any concerns at that point for the man's safety. She said that she did not, although she added that he had shown her a number of old scars on his arms where he had hurt himself in the past. She said he told her the cutting had not made things any better and would not do it again.

38. In her clinical review, the clinical reviewer said when the man first arrived into the prison, he did not tell healthcare staff about any physical or mental health problems, or that he was taking any medication. (The reception health screening had been shortened because of his agitation and distress.) However, the reviewer adds that further information revealed that he had a history of having suicidal thoughts and difficulty controlling his emotions. She said there was also some evidence that on one occasion, some months before he was imprisoned, he had been found with a noose and a bottle of paracetamol. He also told staff that he had once laid in a hot bath and cut his wrists. She said there was evidence of self harm, with superficial scarring on his arms.

39. The following day, an officer, from the prison's public protection team went to interview the man as he had a past conviction for a sexual offence. Because of the offence, which was against a person under the age of 16, he had been placed on the Sex Offender Register.

40. The officer told the investigator that when she went to speak to him she took with her two forms for him to sign. One form, entitled "Notification to prisoner of monitoring", told him that he could not contact anyone under the age of 18, or the victim of his crime. This meant that arrangements would be put in place to monitor his mail and telephone calls. He refused to sign the form. The second form, "Safeguarding Children", told him that, should he want to have any contact with a child, he would have to make an application to do so. Although he did not sign the form, he told the officer he would not be making an application to see a child.

41. The investigator asked the officer how the man was when she went to speak to him. She told him that it was not unusual for prisoners to refuse

to sign the forms. She said his behaviour was normal and that he understood what was being asked of him. The officer went on to say she was certain that he understood, because he referred to being on the sex offender register until January 2010.

42. After speaking to him, the officer made a note of her meeting in the contact record. This said: "Interviewed by PPO [Public Protection Officer]. Refused to sign any paperwork and would not interact at all, just kept saying he didn't want to talk about it."

43. Prison telephone monitoring records show that at 2.21pm, the man made the first of five telephone calls. However, when downloaded, the time shown on the CD was 6.21pm. Unfortunately, I am unable to say with any certainty what the correct time was, as the computer record has since been deleted, which is done automatically by the system. The time discrepancies apply to all those calls referred to later in this report. For consistency, I quote the printout time as normal with the CD time in brackets. The call was made to a mobile telephone number, lasted just three seconds, and was not answered.

44. Later that same day, a worker from Lincolnshire Action Trust went to interview the man. Part of the work of the Trust is to help offenders deal with any immediate housing or employment issues that may arise after imprisonment. The purpose of the interview was to help the man with any issues relating to housing or employment.

45. The investigator spoke to the worker and she said the man would not speak to her. She said his body posture was closed and that he refused to engage with her, telling her to "fuck off; I don't trust any of you". Before leaving his cell, she reminded him that he could speak to her at a later date if he wanted to. She said she had no concerns about his safety and was surprised to learn that he had died.

46. At about 6.15pm, a nurse was working in the reception department. She received a telephone call from a Healthcare Support Worker (HSW), who was in the healthcare department. The HSW asked her to return to healthcare, as she was concerned about the man's behaviour. She told the nurse that he was sitting on his cell floor and would not communicate.

47. At interview, the nurse said when she went to his cell, he kept talking about a man, who he referred to as an "agent" and who was speaking to him. Although the nurse did not know what the man was saying to him, it would appear to have been about his children. Concerned about his mental health, the nurse asked another nurse to assist her. (This nurse is a mental health nurse and also a substance misuse nurse.)

48. In the meantime, while waiting for the second nurse to arrive, the man looked out of his cell window. The first nurse said he talked to her but did not make eye contact. She thought he was experiencing auditory

hallucinations (hearing voices) and was possibly paranoid. The nurse said she asked him if he had any thoughts of hurting himself, and he said that he did not. As a precaution, she discussed his behaviour with a prison officer, with a view to having an ACCT document opened. However, she could have opened one herself.

49. At the request of the first nurse, a second nurse went to speak to the man in his cell. At interview, this nurse said that when she got to the cell she saw that he was distressed and sobbing, adding that he would not make eye contact. She told the investigator that the lack of eye contact was a significant factor in her assessment of how he was behaving. The nurse went on to say that he kept referring to a man being behind "the door". He said that the voice was taunting him, saying he would lose someone. She said she tried to establish if the man was someone from his past, but he would not say.

50. As a substance misuse nurse, her qualifications allow her to advise on certain medications that can be prescribed. (The authority for this is known as a Patient Group Directive. Patient Group Directives are a set of instructions that allows a nurse to prescribe specific drugs depending on the clinical presentation.)

51. She told the investigator that she recommended that if the man became distressed again, 5mg of diazepam, (a tranquilizer used to reduce anxiety) would be advisable. She said that at the time she saw him, the medication was not necessary, but it was available to nursing staff during the night if required. In the event, he slept well that evening and did not require any medication.

52. Due to his continued unpredictable behaviour, an officer opened an ACCT document at 6.45pm. In the Concern and Keep Safe section, the officer noted the following:

> "An immature individual, very emotional and agitated. Believes a man is outside his door trying to take him. Thus resulting in his mood and manner indicating he is in danger to self and others, as he has no concept of actual reality at this time, making him unpredictable in a confined area. Delusional and bizarre behaviour noted …"

53. At interview, the officer said the man's behaviour had been odd. She said he sat at the rear of the cell and told her that a man was at his door. He was crying and kept referring to a girlfriend and his offence. She added that he appeared to be somewhat distant and unaware of what was happening around him. Although she could not recall exactly when it happened, she remembered seeing him stroking a single strand of hair and him telling her that it belonged to his partner.

54. The investigator asked the officer if she thought he had understood what was happening. The officer said he did understand and had told her he

did not want to be monitored and was not suicidal. She added that he told her to leave him alone. Having opened the ACCT, the officer passed the document to the PO.

55. At 8.00pm, the PO went to the man's cell to complete the Immediate Action Plan section of the ACCT document. At interview she said that when she arrived at the cell, he was sitting in a corner, in the dark. The PO said he spoke calmly and asked to be left alone, saying he was not suicidal. Having spoken to him, the PO wrote instructions for staff to monitor him on an hourly basis, pending completion of the ACCT assessment, which would take place later. As well as asking for him to be monitored hourly, she noted that she had explained to him that the Samaritans telephone was available and also told him about the Listeners. Additionally, the PO noted that the second nurse had authorised medication to help him sleep.

56. After completing the Immediate Action Plan section, the PO passed the ACCT document to an officer, for her to make the ACCT assessment. When the officer went to speak to the man he refused to engage with her. The ACCT ongoing record shows the officer made a note to say that he would not answer questions and that he was sitting behind his bed, looking anxious. Because he would not speak to the officer, the assessment was deferred to a later time.

57. The following day at 10.40am, an officer, one of the prison ACCT assessors, went to speak to the man with the intention of completing the ACCT assessment. The officer noted in the ACCT "record", that the man would not answer questions, sat behind his bed, and was anxious and uncooperative. As a result, the ACCT assessment could not take place that day and monitoring continued.

58. In the meantime, a Registered Mental Nurse (RMN) went to speak to the man. She told the investigator that, when she introduced herself to him, he said he did not want any contact with mental health services. She said he had sat in the corner of his cell, looking out of the window. She said that although his behaviour was unpredictable and, in her view, manipulative, she did not detect any sign of psychosis. She went on to say that she had observed him over a period of time, and saw that he behaved normally when in his cell and on occasions had joked with prison staff. In her opinion, he was not mentally unwell.

59. In order to ensure that staff were observing the man regularly, the RMN recommended that the level of observations be increased to every 30 minutes, which was done from 11.30am onwards. One of the reasons for the recommendation was that he had, in the past, had suicidal thoughts and planned his death. She stressed that he did not display similar thoughts on this occasion, but did want to ensure that he was monitored more frequently until he could be seen by a consultant psychiatrist.

60. A short time after cancelling the ACCT assessment, the RMN went to speak to the man, as she wanted further information which would assist the doctor.

61. At 1.58pm [5.58pm] the man made a second telephone call to the same number he had dialled the previous day. On this occasion, the call was answered by his mother and terminated after 39 seconds. In that call, the man, who spoke very quietly, said to his mother "they are all mad in here, they all need doctors". He then went on to say "they keep staring at me". From what can be heard from his mother, that comment appears to have caused her some concern. She asked him to send a visiting order, but he said no. The call ended soon afterwards.

62. Later that afternoon, at 2.30pm, the SO went to the man's cell to complete the induction documents for newly arrived prisoners. (They had not been completed during the reception process due to his behaviour.) When the SO arrived at the cell, the man was sat on the floor. The SO said he became agitated when he saw him and told him to leave. Unable to complete the document, he left the cell with the intention of returning after the weekend to complete it.

63. In her clinical review, the clinical reviewer said as well as being seen by the nurse, the man was assessed by a consultant psychiatrist. She said the consultant psychiatrist described him as paranoid, disturbed and deluded. She said when the consultant psychiatrist went to the cell he was curled up in the corner but did leave his cell and accompanied the doctor to a clinical room. He said the man appeared suspicious of prison and healthcare staff, describing them as "being in league with police". He went on to say that the man appeared terrified. At one stage he "physically jumped" at the sound of footsteps outside his cell and believed everyone was out to get him.

64. The consultant psychiatrist's assessment was that the man was psychotic and paranoid, with evidence of delusion and auditory hallucinations. The doctor prescribed olanzapine, an anti psychotic medication, and lorazepam, which is a tranquilizer. (Although the consultant psychiatrist did not see him again, he gave his medical opinion to the clinical reviewer. He said the man's actions were likely to have been spontaneous.) At the end of the meeting with him, the man returned to his cell. The clinical reviewer said in her clinical review that he was apparently distressed and not interacting with staff. However, she said he later accepted his evening meal and appeared settled.

65. In her clinical review, the clinical reviewer said the nurse had recorded in the man's medical notes that he had refused to accept his medication. However, she added that the prescription chart shows that he accepted it at 5.00pm. The prescription was for 10mg olanzapine and 1mg lorazepam.

66. The man continued to be observed regularly as part of the ACCT monitoring arrangements, but would not engage with staff. At 8.00am, he was given 1mg lorazepam and later in the day accepted his lunch.

67. At 2.14pm [6.14pm] the man made the third telephone call. On this occasion he dialled a landline number. The call lasted 14 seconds and was answered by a man. He is heard to ask for a woman by name. The person answering the telephone said “no chance” and terminated the call.

68. Seven minutes later at 2.21pm [6.21pm], the man made a further call to the same number. The call lasted 16 seconds and on this occasion was answered by a woman. He asked her for a photograph, after which the call was terminated by her.

69. The final telephone call was made just six minutes later at 2.27pm [6.27pm]. It was to the same landline number and lasted seven seconds. The call was answered by the same woman and again he asked her for a photograph. She terminated the call.

70. An officer, who was also an ACCT assessor, returned to the man’s cell, as he had agreed to let the ACCT assessment take place. When she arrived he had been using a telephone. After completing his telephone call, both she and the man went to his cell to talk.

71. At interview, the officer said she sat at the entrance to the cell, as the man was uncomfortable having someone in his cell. She said he sat about half way inside the cell. The officer said he was tearful and said he could not remember what he had done to cause him to be in prison. She added that, although he spoke normally, there were occasions when his voice was quiet. However, at one point, he raised his voice and pointed towards her.

72. At first, the officer thought that he was shouting at her and so offered to leave. He told her he was shouting at the person stood at the door. The officer said that although he was shouting, she did not understand what he was saying, as he was not making sense. After a while, he ended the interview saying he did not want to talk any longer as there were too many questions.

73. At 3.20pm, the man was given a second prescription of lorazepam (1mg) after initially refusing it. Fifteen minutes later, at 3.35pm, the first ACCT case review meeting was held and was chaired by a Registered General Nurse. Also at that meeting were the man and an officer. In the case summary record, she wrote:

> “Appears very paranoid. Sat in corner of cell on chair. At times smiled, interacted and held conversation, then said he’d had enough and didn’t want to talk anymore. Refused to take offered

medication. States no ideas of suicide or DSH [deliberate self harm], but also said would not tell us if he had."

The nurse recorded the likelihood of further risk as "raised" and asked for an urgent mental health assessment to be made.

74. As well as completing the case review section, the nurse made a number of recommendations which she listed in the CAREMAP section of the ACCT document. The recommendations were for the man to be encouraged to mix with other prisoners and take exercise, be referred to the mental health in reach team, assessed daily and for prison staff to contact the public protection department for advice about how he could maintain contact with his family. The meeting ended with another case review scheduled.

75. After the meeting had ended, the man accepted his evening meal, and later took extra food offered to him. He also made enquiries about having personal items brought into the prison.

76. At about 5.00pm, prisoners were locked into their cells for the night. An officer locked the man into his cell. At interview, the officer said he knew that the man was being monitored on ACCT and had spoken to him. He said he appeared to be cheerful and spoke to him about the future, telling the officer of things he was hoping to do. For example, he talked about seeing his family at his next court appearance, and was looking forward to having a television in his cell.

77. The investigator asked the officer if he had any concerns about the man's safety. The officer said the man's conversation with him was all positive and that he had given no indication that he was going to harm himself.

78. The officer told the investigator that before leaving healthcare for the evening, he handed over to the night patrol officer. He said that as part of the handover he told the night patrol officer that the man was being monitored under ACCT.

79. At about 8.30pm, an RGN took over healthcare duty for the night. Before starting her night duty, she received a handover from one of the day nurses. At interview, the RGN confirmed she had been told that the man was being monitored by the ACCT procedures and that he had asked for his prescribed medication to be given to him later. The medication was 10mg olanzapine.

80. She said she had not seen him before that evening, as it was the first night of her one week night duties. She said she had gone to his cell to introduce herself and to tell him and other patients that she would be the nurse on duty that night. When she saw him, he asked her for his medication.

81. In the meantime, the night patrol officer had arrived at the prison to begin his night duty in the healthcare unit. In his written statement to the Governor, the officer said he had received a handover from the day officer who had told him that the man was being monitored under ACCT every 30 minutes.

82. At about 8.30pm the night patrol officer carried out a security check, which meant he ensured that all the cell doors were locked and that he saw every prisoner who he was responsible for. He said he spoke to the man, who he described as being "normal". He had spoken to him on each of the three nights he had been on duty and that he had not given him any cause for concern. The officer noted his conversation in the man's ACCT document.

83. About 30 minutes later, at 9.00pm, the officer carried out a further security patrol. As he did so, he said he saw a nurse at the man's door. He stopped with the nurse while she gave him his medication (15mg olanzapine). He spoke to him to ask if he was "okay" and he said he was.

84. The Ombudsman's investigator has obtained a copy of the video recording for the corridor outside the man's cell. As with the telephone records, I can not be certain that the times shown on the video image are correct and, as before, I show the CD image time in brackets.

85. At about 9.30pm [9.15pm], the officer went to the man's cell to carry out a further ACCT monitoring. In his report, he wrote that he saw him suspended from the left wall of his cell. He said the man was in a kneeling position. Unsure about what he had seen, he called to the nurse for urgent assistance. He also used his prison radio and asked for urgent assistance and permission to break the seal on his key pouch. (Unlike the officers on duty during the day time periods, night patrol officers are not issued with any security keys. Instead, they are issued with a cell key, which is kept secure in a sealed leather pouch, secured to the officer and only opened in the event of an urgent need to enter a cell. The officer must first of all be satisfied that it is safe to unlock the door and enter the cell. If they judge that it is not safe, then they must wait for assistance to arrive.)

86. The nurse was in an office just a few feet away from the officer when she heard him call for assistance. She went to the cell and saw that the officer was trying to break the seal on his key pouch, but was having difficulty. At interview the nurse said she heard the officer asking the prison radio control room operator for permission to open the cell. She said permission was granted straight away.

87. Having broken the seal, both the nurse and the officer went into the cell. The nurse said the man was facing the wall with a ligature around his neck. The ligature, which was the torn edge of a green bedding sheet, was attached to a hook which had been secured into the cell wall to

support the picture board. (The hook used is a standard fitting for holding picture boards.) The officer lifted him to the ground and, using his anti ligature knife, cut the ligature from around his neck.

88. The officer said the man's body was warm to touch and, because his eyes were open, the officer thought he was still alive. He said he cut the ligature and, as he did so, he fell into his arms. When he placed him on the floor, the officer realised that the ligature he had cut had not relieved the pressure from his neck. This is because the ligature around his neck was tied separately to that secured to the hook. Once again, he used his anti ligature knife and cut the one around his neck. As he did so, he heard the sound of air and again thought him to be alive. The officer said the ligature appeared to be strands of bedding sheet, twined together.

89. In the meantime, and in response to the request for assistance, a Healthcare Support Worker (HSW), who was also on duty in healthcare, collected bags containing emergency resuscitation equipment and took them to the cell. The bags contained oxygen, a defibrillator, airways and other emergency equipment.

90. The nurse checked the man's condition but could not detect any sign of life. Both she and the HSW began cardio pulmonary resuscitation (CPR). The nurse attached the defibrillator to his body. The automated system advised not to administer an electric shock and to continue with chest compressions instead. (The clinical reviewer said in her clinical review that this suggests there was no electrical activity in his heart. She adds that this can occur immediately or within eight minutes following asphyxia.)

91. In response to the radio call for assistance, an officer arrived. At interview she said that when she arrived, she saw both nurses carrying out CPR. The officer offered to assist and took over from the HSW.

92. As he was affected by what he had seen, the officer was escorted away from the area by the night manager. Unable to return to the area and distressed, he went to the prison gate and assisted the gate staff instead.

93. At about 9.40pm [9.29pm], paramedics arrived and took over the man's care. Further tests were carried out and, on at least one occasion, their defibrillator advised them to administer a shock to him, which they did. The paramedics continued with CPR, administered adrenalin and followed the standard life support protocol for cardiac arrest before transferring him to hospital by ambulance at 10.26pm. (The video recording ended at 9.40pm and does not show what occurred after that time.)

94. Accompanying the man in the ambulance were two escort officers. The first officer told the investigator that CPR continued in the ambulance and at least one further shock was advised and given. When they arrived at the hospital, which is situated directly opposite the prison, the man was transferred into a resuscitation bay in the accident and emergency

department. Sadly at 10.42pm, hospital medical staff confirmed that he had died.

Following the man's death

95. The officer telephoned the prison to tell the night manager that the man had died. After seeking advice, both escort officers were asked to return to the prison.

96. Having received confirmation that the man had died, his prison record was examined to identify his next of kin details. One of the prison's family liaison officers and her deputy began making plans to travel to his home address to break the news. However, the police dealing with the death decided they would be the ones to tell his family and at 4.30am, a police officer telephoned the prison to confirm that his family had been told.

97. Later that day, the family liaison officer telephoned the man's family to introduce herself and explain her role. As well as this, she offered his family the opportunity to visit the prison and to view his cell, which they accepted. She accompanied his family to his cell where they were able to leave flowers and say prayers. His family returned to the prison the following day to attend a chapel service.

98. The family liaison officer told the investigator that the man's family had invited her and her deputy to his funeral, which they accepted. I understand that the Governor offered assistance with the cost of his funeral.

99. As well as considering the care of the person who died, I also take a view on how well prison staff and prisoners have been cared for after the event. It is important to recognise that tragic events such as this affect people in different ways.

100. I understand that following the man's death that all those prisoners who had been identified as being at risk of self harm were spoken to and offered support. Additionally, prison staff were offered the support of the prison care team and had the opportunity to attend a critical incident de-brief meeting.

101. The officer who discovered the man hanging was disturbed by what he found. In his report to the investigator, he said he had received counselling and had been taking medication. He went on to say the effect of what had occurred had caused his relationship to break down. That said, the officer said the support from Lincoln Staff Care and Welfare had been "fantastic". I welcome his comments.

ISSUES

When the man arrived at HMP Lincoln

102. It soon became apparent to reception staff that the man's behaviour was a cause for concern. The result was that a nurse was quickly asked to assess him, which was done. Although there were no beds spaces available in healthcare, one was found for him, and from then on his care was overseen by medical staff.

103. I am satisfied that his needs were identified quickly by prison staff and that the appropriate action was taken to alert medical staff. Additionally, despite being full, I am pleased to learn that he was prioritised and a bed space created for him.

Assessment Care in Custody and Treatment

104. Following concern about his behaviour, an ACCT document was opened by an officer. The officer wrote an informative report detailing her concerns, which was then used to assess his needs. I am pleased to confirm that her report, the assessment and first case review ensured that he was appropriately monitored.

Public Protection

105. In April 2009, the man was informed that his mail and telephone calls would be routinely monitored. The reason was a previous offence against a child under the age of 16, for which he was placed on the Sex Offender Register. This meant that he would have to submit the names and addresses of those he wanted to write to, and the telephone numbers of those who he wanted to telephone.

106. The investigator has listened to the final five telephone calls made by the man. It is clear that the last three calls were made to a woman. She may well have felt intimidated at receiving the calls. It is also clear that despite being told his calls and mail would be monitored, this did not happen.

107. As the woman ended the telephone calls abruptly, the calls were short, and the content restricted to him asking for a photograph of her. Nonetheless, the mere fact that he was able to make the calls may well have been upsetting. The lack of a proper robust monitoring system could lead to victims being vulnerable and it is important that the public have full confidence in the procedures in place for their protection.

The Governor should satisfy himself that public protection procedures are in place and are monitored robustly

Cell picture board

108. To enable prisoners' to display pictures in their cells, picture boards have been fitted to the walls. The boards are not screwed flat to the wall, but can be lifted down from the bracket to ensure that nothing is secreted behind them. However, the hook used to hold the board is secured permanently into the wall and can only be removed using proper tools.

109. The main question to consider is whether the fitting causes an increased risk. Clearly, the man was considered at risk of self harm and was being monitored under the ACCT procedure. Sadly he used the fixture to attach the ligature. That said, there was no suggestion that he should have been placed into a cell without any ligature points.

110. It is important that prisoners are treated as normally as possible and, unless absolutely necessary, they should be allowed to display photographs and personal items. I am satisfied that there was nothing to suggest that he should be placed in a cell where he could not personalise his surroundings, should he choose to.

111. However, I have since learned that following his death, a nurse took the decision to have the board fittings in healthcare cells removed. She told the investigator that her reason was the high number of suicidal prisoners in the cells and the reduction of possible ligature points. The nurse added that the removal of the fittings applied only to healthcare and not the wider prison. Although I make no formal recommendation I do wonder whether the fittings have to be so robustly attached to the wall. The Governor may wish to consider the point.

Family contact and support

112. Following the man's death, and once the details of his next of kin were identified, arrangements were made for the prison family liaison officer and her deputy to travel to his home to break the news. However, as we now know, the police decided that they would tell his family and confirmed early the next morning that they had done so.

113. The Prison Family Liaison Officer subsequently telephoned the man's mother to introduce herself and explain her role. During that conversation, she told the Prison Family Liaison Officer that her family were convinced that he would kill himself at some stage.

114. I have been pleased to learn that the man's family were offered the opportunity to visit the place where he had died and to be allowed to place flowers in the cell. Additionally, they were given the opportunity to attend a chapel service at the prison on the following day, which they accepted. This was a kind and compassionate gesture.

115. At the request of his family, the two family liaison staff attended his funeral and left a bouquet of flowers at his graveside. I understand that following the funeral, his mother presented both members of staff with a bunch of flowers as a way of thanking them for their help and support. Additionally, they were both given a card to thank them. At such a difficult time for his family, their generosity demonstrates the importance of the work of a prison family liaison officer and of the strong bonds that can be achieved when bereaved families are supported well, as was the case here.

116. In addition to the family liaison support, I am aware that the Governor offered to assist with the cost of the man's funeral. Although this is now normal practice for Governors, it must not be underestimated that the offer of assistance undoubtedly helps bereaved families cope not only with a death, but with the financial responsibility. It pleases me that I am able to comment positively on the level of care and support offered to his family by the prison Family Liaison Officer and her deputy. Although I make no formal recommendation, the Governor may wish to share my comments with his family liaison officers.

Clinical review

117. In her clinical review, the clinical reviewer has listed her key findings, opinion and recommendations. In summary, she says that:

> ”During his short stay in the healthcare centre, the man received prompt and appropriate care from healthcare staff, mental health nurses and the consultant psychiatrist who assessed and treated him.”

118. In her clinical review she has drawn the following conclusions:

> “The presence of psychosis with paranoid thoughts and behaviour, anxiety and agitation are all key indicators of suicidal behaviour and result in a high incidence of successful suicide in the general population.
>
> ”He displayed many features of acute psychosis, a condition that is known to have a high incidence of successful suicide. If he had been a patient in the community, it is unlikely that he would have received such prompt and supportive care.
>
> ”Olanzepine has been implicated as being associated with a higher incidence of suicide in patients with acute schizophrenia and affective disorder compared to other anti-psychotic medication. However, he had only received one dose the day before his suicide and a second dose shortly before his death. It is therefore extremely unlikely that the prescription of olanzepine contributed to his suicide.

”Other risk factors that have been identified for suicide in prisons include male gender, single cell accommodation, being on remand, being married and employed and previous attempts at suicide.

”The ACCT record shows that he was regularly observed and offered support. His act of hanging himself appears to have been impulsive and deliberate.”

119. In her review, the clinical reviewer makes two recommendations which I note below. I have considered the recommendations and am satisfied that I do not need to endorse them. The reason for this is that NOMS has well embedded systems in place to protect those at risk of suicide or self harm, and that Lincoln are aware of the instructions. That said, her recommendations are:

- “Self-hanging is a common method of suicide in prisons and can be carried out within a short space of time. Prisoners who are considered at high risk of suicide because of their voiced intent or, as in the man’s case, their mental health status, should be considered for continuous observation.”

- “Accommodation within single cells for prisoners considered at risk of self harm and suicide should be reviewed.”

Allegation of improper conduct

120. During the investigation, the investigator was made aware of a rumour circulating within the prison concerning allegations that after the man’s death a nurse had apparently destroyed medical documents relating to him. In order to clarify whether the rumour was in fact correct, the investigator contacted the prison liaison officer, and she in turn asked the Head of Healthcare to meet the investigator.

121. In May, the investigator met the Head of Healthcare who confirmed that the PCT were investigating complaints made against the nurse. She said that one of the allegations was that the nurse had destroyed an urgent mental health assessment referral form after his death. The assessment had been asked for by another nurse in April.

122. Although I am aware that the man was seen in April by a nurse, it was not as a result of the application submitted by this particular nurse. The reason for the other nurse seeing him was because yet another nurse was concerned about him and wanted a mental health assessment.

123. I am satisfied that the allegation is being dealt with by the proper authority and will be subject to scrutiny by the PCT. The investigator has, as part of his written feedback to the Governor, raised the matter with him. At the time of issuing this report, I have not been informed by the PCT of the outcome of that investigation. I understand the Governor has been unable to obtain the investigation report from the PCT, as this nurse is no longer employed within the prison.

Liaison Officer

124. Whenever there is a death in custody, NOMS requires the prison Governor to appoint a member of staff to act as the liaison officer to the investigator. Liaison officers form the link between the investigator and the prison. It is an important task and I fully recognise the additional work that this causes.

125. In this case, I wish to pay particular thanks to the prison liaison officer for the way she has assisted the investigator and the Ombudsman's office. She responded and managed the needs of the investigator professionally and delivered a high level of support for which I am extremely grateful. It is her attention to detail that has made her work stand out.

126. Although I make no formal recommendation, I invite the Governor to share my comments with her. I also invite NOMS to consider inviting those Governors with little or no experience of the role of death in custody liaison officer, to seek her guidance and advice.

CONCLUSION

127. When the man arrived into prison, he was soon identified as being distressed and agitated. Although there were no beds available in healthcare, one was found for him and he was quickly admitted. Whilst in healthcare, his mental health was assessed, with the result that medication was prescribed to help alleviate his symptoms.

128. The clinical reviewer said that, had the man been a patient in the community, it is unlikely that he would have received such prompt and supportive care. I welcome her opinion and endorse her judgement that his health needs were promptly and properly dealt with.

129. Due to concerns about his safety, an ACCT document was opened in April and remained open until his death. The immediate action plan, assessment and care plan are all well documented and contain appropriate support. I am satisfied that his safety was given due consideration and proper support was made available to him. He made it clear that he would not tell staff if he were thinking of suicide and, sadly, he did not.

130. There was a lot of information to suggest the man was at risk. Indeed, his family said they believed he would take his own life at some stage. I am regularly told that once a ligature is placed around the neck and tightened, it takes just a few seconds to become unconscious. Unless the person is discovered very quickly, the outcome is usually inevitable. In this case, he used what some would say was an unlikely place to secure the ligature. Unfortunately, the hook was so well embedded into the wall that it made a more than suitable anchorage point to support his weight.

131. It would appear, from what the officer said, that the ligature had been twined together, which suggests a degree of planning. However, we do not know and it may well have been a spontaneous act.

132. Although I make a recommendation about the lack of monitoring relating to the man's telephone calls, I am satisfied he did not give a direct indication of what he may well have been planning to do. The only real indication that something was amiss was when he told his mother that people were staring at him, and even that was obscure. Therefore I conclude that, even had his telephone calls been monitored, they would not have revealed anything specific to suggest he was planning to end his life, or harm himself.

RECOMMENDATIONS

1. The Governor should satisfy himself that public protection procedures are in place and are monitored robustly.

   The Governor has accepted the recommendation and introduced a system to ensure calls are listened to within 72 hours.