The death in custody of a male prisoner

at HM Prison Lincoln in May 2004

Report by the Prisons and Probation Ombudsman for England and Wales

February 2006

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HM Prison Lincoln in May 2004. The prisoner was found hanging in his cell at approximately 11:40am that day and was pronounced dead at 12:07pm. A post mortem examination showed that the prisoner died of the effects of pressure to the neck due to hanging.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service which came into effect on 1 April 2004. In keeping with that agreement, a Senior Investigating Officer (SIO), who was appointed by the Prison Service, carried out the bulk of the investigation on my behalf under the guidance of my own investigator. The SIO was assisted by a Prison Service Investigating Officer (IO). The SIO's examination of the circumstances that preceded the prisoner's death, together with his findings, are recorded in Part Two of this report.

I also commissioned an independent clinical review (not published) into the management of the prisoner's health needs while he was in custody. This was carried out by a representative of the West Lincolnshire Primary Care Trust.

My thanks go to the SIO and his assistant, as well as to the West Lincolnshire Primary Care Trust, for their work. I am also grateful to the Governors and staff of Lincoln and Stocken prisons for their ready co-operation with the investigation. My report reveals shortcomings in Lincoln's suicide and self-harm procedures which should be remedied urgently. The report also shows that the prisoner had serious mental health problems and was vulnerable throughout his time in custody. That vulnerability may have been increased by the prisoner's failure to take the powerful anti-psychotic medication he had been prescribed. The tragedy of his death raises questions about the demands currently placed upon the Prison Service in caring for people with serious mental disturbance. Prisons are not psychiatric hospitals, yet it seems that they are often expected to operate as if they were.

At consultation stage, the prisoner's uncle expressed his dissatisfaction with aspects of the report. He was especially concerned that my investigator had not sufficiently addressed his concerns about the fact that his nephew did not go to work on the morning he died. The uncle felt that, had he gone to work, his nephew would not have died. Although the draft report was amended to include more information about the system in place at Lincoln for accounting for prisoners who do not appear for work, the uncle has remained dissatisfied with this, final, report. I respect his views. I have therefore included as an appendix a full copy of a letter he wrote to me on 29 January 2006 and a copy of my reply.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2006**

Contents

2. Summary

The prisoner was arrested on 19 August 2003 for drugs-related offences. He appeared at Mansfield Magistrates' Court the next day and was remanded in custody at Lincoln prison.

On arrival at Lincoln, although assessed as not being at risk of self-harm or suicide, the prisoner was immediately admitted to the healthcare centre for observation because of concerns about his mental health. A week later, he was discharged to a wing. On 30 August, he asked to be transferred to the Vulnerable Prisoners Unit (VPU). This request was granted. On 2 September, he deliberately cut his arm. Form F2052SH - a document used for the monitoring of prisoners considered to be at risk of self harm or suicide - was opened. The prisoner was also re-admitted to the healthcare centre, where he remained until 6 October. He was discharged on that date to the VPU. The F2052SH remained open until 29 October.

During his time in custody, the prisoner wrote letters to his children in which he talked of suicide. Their mothers separately took the view that he was using suicide as a veiled threat to persuade them to visit him in prison. On 16 October 2003, the mother of his two sons instructed solicitors to write to the prison to make it clear that she wanted no further contact between them while he was in custody. This was a source of deep anxiety for the prisoner.

In January 2004, the prisoner was sentenced to four years imprisonment. He was allocated to Stocken prison and transferred there on 12 February 2004. At Stocken he became depressed, and a form F2052SH was opened on 16 February. He asked to be returned to Lincoln and was transferred on 20 February, with the F2052SH still open. The prisoner returned to the Vulnerable Prisoners Unit. The next day, he was admitted to the healthcare centre after behaving strangely. He remained there until 25 February when he was discharged to the VPU. On 3 March, after staff had noticed an improvement in his demeanour, the F2052SH was closed.

In April, the prisoner wrote to the mother of his daughter telling her that he was having difficulty coping and asking her to pass a request to their daughter to write to him before he did "anything silly". No return letter was forthcoming.

A few days before he died, the prisoner was seen by the Chaplain after she had noticed that he seemed low. He told her that he was very depressed, that he was hearing voices and that he believed that a riot was going to take place in the prison. The Chaplain did not feel that the prisoner was suicidal, but arranged for him to be allocated a Prison Visitor.

The day before he died, the prisoner was given back two unopened letters that he had sent to his sons a week earlier.

At 8:30am the next day, the prisoner's cell mate left to go to work, leaving the prisoner in the cell on his own. The cell mate noticed nothing out of the ordinary in the prisoner's demeanour. A member of staff saw him at about 9:45am and noticed nothing wrong. At 11:45am, that same member of staff unlocked his cell door to let the cell mate in after work. He discovered the prisoner hanging from the cell window bars. Despite the fact

that he appeared to have been dead for some time, staff made strenuous attempts to revive him. He was pronounced dead in his cell at 12:07pm.
The investigation has found that some aspects of the management of the prisoner's risk of self-harm at Lincoln were less than satisfactory.

I am particularly concerned about the manner in which F2052SH case reviews were conducted, the standard of record keeping, the arrangements made for a visit to the prison by the prisoner's relatives the day after he died, and the use of specialist drugs and equipment in emergencies

I make eight local recommendations.

3. Investigation methodology

The investigation was opened when my investigator met with the acting Governor, a representative of the Independent Monitoring Board and representatives of the local branch of the Prison Officers' Association. My investigator explained the nature and scope of the investigation, and briefed the meeting on the transitional arrangements that had been agreed between my office and the Prison Service for the conduct of investigations.

On the same day, notices were issued to staff and to prisoners at Lincoln announcing the investigation and inviting anyone who wished to do so to submit information to the investigating team.

The Senior Investigating Officer (SIO) began his work on 24 June 2004. A number of staff at Lincoln prison were formally interviewed.

The SIO visited the prisoner's uncle, his former partner and his daughter. This was in part to give them all an opportunity to raise any concerns they had about the prisoner's treatment while he was in custody.

A representative of West Lincolnshire Primary Care Trust carried out an independent clinical review of the management of the prisoner's health needs while he was in custody.

4. Lincoln Prison

Lincoln is a local prison that was built in 1872. It serves courts in Lincolnshire and Nottinghamshire. At the time of the investigation it was able to hold up to 510 prisoners, 192 below its normal accommodation level of 702. This shortfall was due to the fact that one wing was still being refurbished after a major disturbance in 2002.

The prison was last inspected by Her Majesty's Chief Inspector of Prisons in October 2003. The report of that inspection contained positive comments about the prevention of suicide and self-harm at the establishment but recommended that there should be more trained Listeners (prisoners trained by the Samaritans to listen to other prisoners in distress). The report also highlighted an area of good practice in the combination of the management of self-harm and anti-bullying into one function.

A Prison Service Standards audit of the establishment in March 2003 judged the suicide awareness function as being of an acceptable standard.

5. Consideration of emergent issues

The SIO has drawn attention to a number of issues that arose during the investigation. These concern:

- the management of the prisoner's risk of self-harm;
- courtesies not shown to his relatives;
- the response to the discovery of the prisoner hanging;
- the management of the prisoner's health needs.

At consultation stage, the prisoner's uncle expressed his concern about the fact that his nephew did not go to work during the morning of the last day of his life, and was of the opinion that a check by staff as to why he had not attended for work would almost certainly have saved his life. The uncle therefore asked for this matter to be investigated further. He also commented that my report should include recommendations for appropriate procedures to be implemented in relation to accounting for work absences.

These issues are considered below.

The management of the prisoner's risk of self-harm

The following significant events related to self-harm that took place during the prisoner's time at Lincoln and Stocken prisons:

2 September 2003	deliberately cut his arm
23 September 2003	found carrying a ligature made of shoe-laces
29 September 2003	overheard talking to other prisoners about methods of suicide
8 October 2003	ligature found under his pillow
15 October 2003	attempted to hang himself in reception holding room
28 October 2003	attempted to hang himself in a secure vehicle on his way to court
February 2004	told his cellmate at Stocken that he would try to commit suicide before he was released.

- This catalogue of events spans nearly the whole of the prisoner's period in custody. During that time there were two occasions when he was made subject to self-harm monitoring procedures through the use of the F2052SH system. I have concerns about some aspects of the self-harm monitoring procedures applied to the prisoner, especially during the first episode.

- This began on 2 September 2003 when the prisoner cut his arm. I consider that the initial response to this incident was appropriate. Not only was a

F2052SH opened, but the prisoner was also admitted to the healthcare centre where his mental state could be monitored. He was given anti-depressant medication, and was seen by the mental health in-reach team and by a psychiatrist.

- During this period, staff at Lincoln conducted a number of F2052SH case reviews. There are numerous instances either of poor record keeping or of poor care. In some instances, wrong dates are inserted in the daily supervision and support record of the prisoner's F2052SH. Nowhere in the case review documentation does the record make clear whether the prisoner was present. Some of the comments made in the case review summaries imply that he was, but the reader has to guess. If the prisoner did attend, as he should have done, the record should have made this clear. His absence would have largely invalidated the process.

  I also criticise other aspects of the management of the prisoner's case reviews:

- The record of a case review that is believed to have taken place on 4 September 2003 is not signed or dated.

- The record of the case review held on 25 September 2003 makes no reference to the fact that, two days earlier, it had been discovered that the prisoner had been found carrying a ligature made of shoe laces.

- The record of the case review held on 2 October 2003 makes no reference to the fact that, three days earlier, the prisoner had been discussing methods of suicide with other prisoners. However, it does record very clearly that he said he would commit suicide if he were to be returned to a wing.

- The record of the case review held on 9 October 2003 makes no reference to the fact that, 24 hours earlier, a ligature had been found under the prisoner's pillow. The officer who found the ligature did not attend the review.

- The record of the case review held on 16 October 2003 makes no reference to the fact that, 24 hours earlier, the prisoner had tried to hang himself in the reception holding room.

- The record of the case review held on 29 October 2003 makes no reference to the fact that, 24 hours earlier, the prisoner had tried to hang himself in a vehicle whilst in transit to court. It is difficult to comprehend why at this case review a decision was made to close the F2052SH. Although the prisoner's death was not related to this decision, it was entirely inappropriate to terminate the self-harm monitoring procedures so soon after a series of self-harm incidents or events had taken place. No staff who had made significant entries in the prisoner's F2052SH in September and October 2003 attended any of the case reviews so that they could have a role in the decision making process.

- The locally produced Annex 10 that is designed to structure post-closure F2052SH reviews was used in only one of the two F2052SH forms opened for the prisoner. There was no evidence that a post-closure review took place. The idea behind the annex is a good one. It should be used properly.

Courtesies not shown to the prisoner's relatives

- The prisoner's family did not know of the self-harm incidents that had occurred or of his admission to the healthcare centre. It is important for staff either to encourage prisoners to tell their families about significant events, or to offer to do so on their behalf with consent.

- It is unfortunate that, despite the fact that fresh flowers had been placed in the prisoner's cell for the visit by his relatives the day after he died, the cell was otherwise not in a fit state to be seen by them. I appreciate that, at the time of the visit, the police had not given their authority for the contents of the cell to be removed, but I believe that more care could have been taken about the timing of, and preparation for, the relatives' visit.

- I am also concerned that the prisoner's relatives were left alone to speak with his cellmate on that day. Staff could not have predicted that the cellmate would be critical of the family, but I can understand why the family were upset. It might have been more appropriate had a member of staff been present.

- The SIO points out that Lincoln's contingency plans for the management of a death in custody make no mention of the arrangements for informing the next of kin. I understand that, in the case of this prisoner, because no clear procedures were in place, it was the police who informed the next of kin of his death. Prison Service Order 2710 makes clear that, unless there are very good reasons not to do so, notification should be made in person by a visit to the next of kin by the Governor (or in his/her absence the deputy) and chaplain or other religious leader.

Response to the discovery of the prisoner hanging

- After the prisoner was discovered hanging, routine communications were allowed to continue on the prison's UHF radio net. This had the effect of impeding those messages relating to the emergency. Consequently, the healthcare staff who attended the incident had difficulty in contacting their colleagues elsewhere in the prison. This situation should not be repeated.

- It is a matter of concern that, of the two defibrillators available in the prison at the time of the prisoner's death, only one was serviceable. I am also concerned that few staff were trained in its use. Although these were not factors in the prisoner's death, both machines ought to have been serviceable and an appropriate number of staff should be authorised and trained to use them. The clinical review makes the same point.

- The Primary Care Trust comments that, although a medical bag containing drugs is normally taken to emergencies, the staff who take it are not authorised to use it. The clinical review says that under this policy, unless or until a medical officer or a paramedic arrive at the scene of an incident, the potentially vital drugs within the bag cannot be used. It goes on to recommend that appropriate staff should be trained and authorised to administer such drugs in a resuscitation attempt. The review also draws attention to the need for regular training of appropriate staff in resuscitation techniques.

- It is clear that those staff who attended the cell made strenuous efforts to revive the prisoner even though he appeared to them to have been dead for some time. I commend those efforts. It takes little imagination to understand how harrowing the circumstances must have been.

The management of the prisoner's health needs

The clinical review draws attention to the fact that, by failing to take about half the anti-psychotic medication he was prescribed, the prisoner may have received a sub-therapeutic dose. The review suggests that this was an indicator of worsening mental health. The review recommends that, when a prisoner refuses to take prescribed anti-psychotic medication, the medical officer should be notified and the details recorded in the nursing and medical case notes, together with details of any proposed follow-up action.

The review also highlights the fact that, despite the prisoner's long history of vulnerability and his clear potential for self-harm evidenced within his case notes, no entries were made in his medical record between 28 April 2004 and his death. The review proposes that criteria should be developed to identify those prisoners who are not within the healthcare centre but who require regular reviews by a medical officer.

The prisoner's absence from work during the morning of his death 2004

The concerns expressed by the prisoner's uncle about his nephew's absence from work during the morning of the day he died are entirely understandable.

However, the further investigative work undertaken by my investigator has found that:

- The prisoner was employed in the Charity workshop which normally employed 45 prisoners.
- During the week preceding his death, there was a staff shortage in that workshop which resulted in a reduction in the number of prisoners who could attend for work from 45 to 30. The prisoner was among those who were not required to attend for work that week. Wing staff had been notified to tell him this each day.
- On the day he died, the workshop staff complement returned to normal. As a result, the prisoner roll increased to its former capacity of 45. The prisoner was therefore required to attend for work.
- The prisoner did not report for work that morning. The workshop staff contacted the wings to ascertain the reasons for any absences. In the case of the prisoner, the workshop instructor thought that he had probably not appeared for work because he was not sure whether he was required, given the events of the previous week. The instructor told the wing staff to make clear to him that he was required to report for work that afternoon. At 9:45am, an officer communicated this to the prisoner personally. At that time, the officer saw no evidence that there was anything wrong with him.

I am satisfied that the arrangements in place at Lincoln to account for the movement of prisoners between wings and workshops, and those for accounting for absences, were satisfactory at the time of the investigation. Reasonable steps were taken to taken to account for the prisoner's absence form the workshop: he was seen by a wing officer at

9:45am, only 45 minutes after he should have reported for work, and told of his requirement to attend for work that afternoon. At that time, the officer saw nothing in the prisoner's demeanour that might have suggested that he was contemplating suicide.

Whilst I sympathise with the views expressed by the prisoner's uncle, I can find no grounds on which to base any recommendations for change in the manner in which prisoners' whereabouts are checked at Lincoln.

6. Recommendations

I make the following recommendations:

F2052SH procedures

Local recommendation 1:

The Governor should remind all staff that:

- F2052SH case reviews should not take place in the absence of the prisoner under review, unless the prisoner refuses to attend;
- records of F2052SH case reviews must make clear whether the prisoner under review was present, and the record must faithfully describe his involvement in the review process;
- whenever F2052SH case reviews follow an act of self-harm, a member of staff involved in the management of the incident should be invited to attend the review;
- they sign, and accurately date, all entries made in F2052SH documents;
- post-closure F2052SH reviews must take place in line with local policy for the use of Annex 10;
- care should be taken by those who may chair F2052SH case reviews to take into account the recent history of prisoners under review, as well as their current demeanour, before decisions are made to close the document.

Record keeping and information sharing

Local recommendation 2:

The Governor should remind all staff of their responsibility for recording and sharing information about meetings or interviews with prisoners who present a risk of self-harm.

Communicating with families

Local recommendation 3:

The Governor should review local contingency plans for the management of a death in custody to ensure they include clear procedures for informing the next of kin.

Local recommendation 4

The Governor should remind staff to encourage prisoners to tell their families of any significant event such as the opening of a F2052SH, an act of self-harm or an admission to the healthcare centre or hospital, or to offer to do so on their behalf provided they give their consent.

Contingency planning

Local recommendation 5

The Governor should review local contingency plans to ensure they include clear guidance about the arrangements that need to be made prior to any visit to the scene of a prisoner's death by his relatives.

Local recommendation 6

The Governor should remind staff about the need to give precedence to emergency communications over the radio net during an incident.

Emergency equipment

Local recommendation 7

The Governor should ensure that an appropriate number of serviceable defibrillators are available and easily accessible and that appropriate staff are trained in their use.

Medical issues

Local recommendation 8

Consideration should be given to the implementation of the following recommendations made by the Primary Care Trust in the clinical review:

- **Anti-psychotic medication**

Where a prisoner is on anti-psychotic medication, and refuses to take this medication, this should be reported to the medical officer, and recorded within both the nursing and medical casenotes. The medical officer should state within the medical casenotes what action they propose to take.

- **Medical review of prisoners**

Criteria should be developed to determine those prisoners who are not within the healthcare centre but who require regular review by a medical officer on at least a weekly frequency. This should include all patients on olanzapine or similar medication. The medical officer should record his or her findings and decisions in the medical casenotes following such assessments.

- **Resuscitation**

Sufficient numbers of staff should be trained in basic life support, laryngeal mask airway insertion and use of the defibrillator such that at least one member of staff trained in these techniques can be expected to be present at every attempted resuscitation.

Written protocols for resuscitation should be produced and disseminated to all relevant staff. These protocols should mirror those used at John Coupland Hospital.

Regular practice resuscitation drills should take place.

Consideration should be given to the introduction of a practice group direction to allow suitably trained healthcare staff to administer appropriate drugs during resuscitation attempts.

At consultation stage, the prisoner's uncle expressed the following concern about resources:

> "I am concerned that the Prison Service have in place generally (and specifically locally in Lincoln) the resources to deliver the staff training, equipment and staffing levels required for the processes recommended. It is clear that the Prisons and Probation Ombudsman has the resources to pursue and produce the required investigation reports, and no doubt to do so in all cases of deaths in prison. But unless the Prison Service has the resources to deliver due process (and many of the Ombudsman's recommendations in the draft refer to current due process rather than new process) then the recommendations are not likely to become reality. The need is clearly for the Prison Service generally (and specifically Lincoln Prison) to be in receipt of the (additional?) resources in order to deliver the service as recommended in the report."

I replied to the prisoner's uncle as follows:

> "On the question of resources, I take the view that this is a matter for the Prison Service to decide how it can best implement my recommendations. I expect the Prison Service to act on my recommendations, but I do not consider it is my task to tell them how to do this. I would not, therefore, expect to deal with the question of resources in my final report, although I am very willing to include your comments in my report."

PART TWO

SENIOR INVESTIGATING OFFICER'S REPORT

Contents:

SECTION 1

TERMS OF REFERENCE

The investigation was conducted under the following terms of reference:

From: Stephen Shaw

To: The SIO and the Ombudsman's investigator

Date May 2004

FATAL INCIDENT INVESTIGATION UNDER THE TERMS OF THE TRANSITIONAL ARRANGEMENTS AGREED WITH THE PRISON SERVICE

You are requested to investigate the circumstances surrounding the death of a male prisoner at HMP Lincoln in May 2004.

You and other members of the investigating team act on my behalf in conducting the investigation.

The investigators appointed by the Prison Service will be responsible for:

- gathering and analysing evidence and information;
- conducting interviews;
- carrying out necessary audits of policy and procedures;
- presenting my investigator by 16 July 2004 a report of their findings and conclusions together with supporting documentary evidence, and details of the time and other costs incurred in the investigation.

My investigator will liaise with you. I have asked him, in conjunction with you, to:

- initiate the investigation on the Ombudsman's behalf;
- meet the Governor;
- meet representatives of the appropriate Trade Union;
- meet representatives of the Independent Monitoring Board;
- make himself known to the Police and Coroner's office;
- secure clinical advice through the appropriate NHS Trust as necessary
- inform the bereaved family of the investigation and seek to involve them in the investigation process;
- issue appropriate notices to staff and to prisoners;
- prepare a summary of the Prison Service investigators' report and any observations and recommendations for my consideration by 2 August 2004, together with a statement of the time and other costs incurred in the investigation.

Families

You should ensure that the bereaved relatives are kept informed of the progress of the investigation and that they have an opportunity to raise any questions during it.

Timescale

If you anticipate any difficulty in completing the investigation and report within timescales please let me know as soon as possible.

Stephen Shaw
Prisons and Probation Ombudsman

SECTION 2

CHRONOLOGICAL ORDER OF EVENTS

Time in police custody

The prisoner was arrested on 19 August 2003 and taken to Mansfield Police station for questioning. He was subsequently charged with carrying an offensive weapon, burglary and possession of drugs. Whilst in police custody he stated to the police that he was hearing voices and it was reported that he seemed agitated. At 1:40am on 20 August he was seen by the police surgeon who prescribed him 5 milligrams of nitrazepam. Later the same day he appeared at Mansfield Magistrates' Court where he was remanded into custody at HMP Lincoln until 29 August.

Reception at HMP Lincoln

As soon as he arrived at Lincoln, the prisoner underwent normal reception procedures. A nurse completed a first reception health screen during which the prisoner said that he had been an inpatient in a psychiatric hospital following an attempted suicide by taking an overdose and had been subsequently treated for depression. The nurse also noted that even though the prisoner was not feeling suicidal he did seem excessively withdrawn, depressed and overly anxious. However the nurse felt there was no need to open an F2052SH at that point but did decide to admit him to the healthcare centre for a period of observation. He was also referred to a Registered Mental Nurse (RMN) for further assessment. Once in the healthcare centre, the prisoner was seen by a doctor. During the interview with the doctor, the prisoner was quite tearful when talking of his family and stated that he was hearing voices. The doctor made an entry in the prisoner's medical record that he was not actively suicidal but that he was vulnerable.

First period in the healthcare centre: 20-27 August 2004

The prisoner was admitted to the healthcare centre from reception on 20 August and placed in a single cell. At the same time, he was given a night sedative and it is recorded that he slept throughout the night. On 22 August, he was reviewed by nursing staff and he was also seen by the Medical Officer. It was noted that he had stopped taking his medication when discharged from the psychiatric hospital but he did not know what medication he had been taking. The Medical Officer prescribed venlafaxine and referred him to the Community Psychiatric Nurse (CPN). On 26 August, he was seen by a member of healthcare staff who referred him to a member of the Mental Health in-reach team to assess his mental state. A further review was scheduled for the following day.

On 27 August, a comprehensive psychiatric nursing assessment was carried out by the in-reach team and the following points were noted during this assessment: The prisoner seemed agitated, anxious and paranoid. Whilst he co-operated with the assessment he stated that he was suspicious of other people knowing about him, particularly his connections between himself, the secret services and the IRA.

He was also displaying signs of anxiety, continually wringing his hands and showing exaggerated hand movements. He was referred for further assessments but there was insufficient evidence that his mental state was such that he needed to remain in the healthcare centre. He was subsequently moved to C Wing (Cell 2-28) on 27 August.

C Wing 27 - 30 August 2003

There seems to be very little or no record pertaining to the prisoner's period in C Wing, other than an application to be relocated onto the Vulnerable Prisoners Unit (VPU) on 30 August. He made a request to be segregated for his own protection under Prison Rule 45 because he believed that there was going to be a riot and that other prisoners were targeting him. We found no evidence to support this claim. The prisoner was moved from C Wing to the VPU the same afternoon.

First period in the VPU: 30 August - 2 September 2003

In the VPU, the prisoner shared a cell. He was allocated work in the Charity shop. Although he was described by wing staff as lacking motivation to attend work and quite often had to be chased up when others had gone, once there he was regarded as a good worker, although the shop instructor stated that he was quiet and a bit of a loner.

On 2 September 2003, the prisoner presented himself at the treatments room at approximately 4:30pm. It was at this point that he informed a nurse that he had cut himself during the previous night, claiming that he had been told to do it by the voices in his head. On examination, it was noted that he had what appeared to be a superficial cut, some 5cm in length to his mid left arm, slightly below the elbow. The prisoner refused to allow the nurse to dress the wound. Owing to his distressed state, it was decided to admit him to the healthcare centre. A F213SH form was completed and he was placed on a F2052SH self harm booklet (on which he was to remain until 29 October). Following his admission to the healthcare centre, the prisoner was again referred to the mental health in-reach team. It was noted that he seemed more settled.

Second period in the healthcare centre: 2 September - 6 October 2003

Between his admission on 2 September and 15 September, the prisoner was seen on a daily basis by members of the healthcare team, who noted that he continued to hear voices telling him to kill himself. He still believed that people were going to get him, still appeared to be anxious and fearful but stated that he felt safe in the healthcare centre. On 4 September a (72hr) F2052SH review took place. It was decided that he should remain in the healthcare centre for the time being. This document was not signed or dated and there is no evidence that the prisoner attended the review. A further F2052SH case review took place on 12 September, when it was noted that he was focussing on things that he had lost - his children etc. The review concluded that he should remain in the healthcare centre and that he should seek support from the chaplaincy.

On 17 September, the prisoner was seen by a visiting psychiatrist who recommended that he should remain in the healthcare centre, and that he should

be reviewed after two weeks. The psychiatrist prescribed Olanzapine (10mg) to be taken at night.

Another F2052SH case review was carried out on 18 September. This review recommended that the prisoner should remain on his medication and should seek support from the Mental Health in-reach team. Again, there is no evidence to show whether the prisoner attended this review.

On 23 September, during a routine rubdown search, the prisoner was found with a bootlace made into a noose, hidden in the back pocket of his trousers. When questioned about this, he stated that he had thought about using it but there was no intention now to use it and he was not having any suicidal thoughts. On 25 September there was a further F2052SH case review. It was noted at this review that his mental state was improving and that he seemed much more settled. Once again, there is no evidence to indicate the prisoner's attendance at this review. There is no evidence that the events of 23 September were considered.

For the next few days there seems to be very little of note. However, on 29 September the prisoner was overheard by a member of staff having a discussion with other prisoners about ways in which he could commit suicide. During this conversation he referred to the use of explosives strapped to his chest or crashing a speeding car. When challenged about this, he said he was not suicidal but concerned about returning to normal location.

On 2 October, a F2052SH case review was held. The review concluded that the prisoner should now be able to return to the VPU. There was no cell available in the unit at that time. It was therefore decided that he should remain in the healthcare centre until one became available. A cell did become available on 6 October and, following a further F2052SH case review, it was decided to relocate the prisoner to this cell. Again, there is no evidence that he attended this review. Neither is there any evidence that the conversation overheard on 29 September was considered.

Second period in the VPU: 6 October 2003 - 12 February 2004

On his arrival in the VPU on 6 October, the prisoner was allocated a shared cell. He was also reallocated to employment in the prison charity workshop. Two days later, an Officer found a ligature under the prisoner's pillow. He was immediately referred to the Mental Health in-reach team and was seen by a Registered Mental Nurse. When questioned about the ligature, the prisoner said that he was concerned that his cellmate was soon to be discharged and he did not know with whom he would end up sharing a cell. There is no mention of this incident in the notes of the subsequent F2052SH case review carried out on 9 October. Arrangements were then made for the prisoner to share a cell with another prisoner. This move took place on 19 October. The deceased prisoner remained in this cell until his new cell mate was discharged in late December 2003.

Whilst being held in a reception holding room following a court appearance on 15 October, the prisoner attempted to hang himself. No documentary evidence was presented to the investigation team to clarify precisely what had happened. The prisoner was immediately seen in Reception by a nurse. He told her that he would

be safe until he had seen the doctor. The doctor recommended that he continue to be managed in the VPU. A F2052SH case review was carried out on 16 October. There is no mention of the events of the previous day in the record of this case review.

Whilst in transit to Mansfield Magistrates Court with Group 4 escort services on 28 October, a Prison Custody Officer (PCO) saw that the prisoner was standing on the seat in the cell, had tied his belt around his neck and was attempting to hook the other end over the cell door. When the PCO spoke to the prisoner about this, he stated that he was finding it hard, had problems coping and had issues outside. The prisoner was placed on a constant watch for the remainder of the journey. This meant that the PCO was standing outside the cell door observing the prisoner for the whole time until their arrival at court.

A F2052SH case review was carried out on 29 October. There is no mention at this review of the events of the previous day in the cellular vehicle. The findings of the review were that the prisoner should be removed from the F2052SH process and the document was subsequently closed. The prisoner was not mentioned as having been present at this meeting. An entry regarding this review was made in the IMR on 29 October stating that he had been reminded to pick up his medication in the evenings. A document entitled “Annex 10” was completed at the end of this review, stating that further F2052SH case reviews should take place within the four week period following its closure. There is no record that any reviews took place in that period.

On 14 November, the prisoner was seen by a member of healthcare staff who restarted him on his Olanzapine prescription, as he had not been taking it on a regular basis. The dose was set at 5mg daily but, on 24 November, his condition seemed to have deteriorated, so the dose was increased to 10mg daily. As a result, the prisoner’s condition seemed to improve. A doctor saw him on 3 December. The prisoner told the doctor that he was not sleeping very well and he was still hearing the voices that were telling him to harm himself. The doctor noted that he was psychotic and at risk of unpredictable self-injury and increased the dosage from 10mg daily to 10mg twice daily. No consideration seems to have been given by either the doctor or any other member of the healthcare staff to opening a fresh F2052SH.

On 11 December, the prisoner attended Nottingham Crown Court and was found guilty of possession of controlled drugs with intent to supply. He was remanded for sentencing at a later date on this charge.

On 19 December, the prisoner’s cell mate was discharged. The prisoner was then given a new cell mate. They remained together until 12 February 2004.

A doctor saw the prisoner again on 7 January 2004 and varied his dosage of Olanzapine from 10mg twice per day to 20mg once per day. This was because the prisoner was not attending for the morning surgery but was attending for the evening one. The doctor was of the opinion that the prisoner could have the medication at one dose in the evenings.

On 8 January, the prisoner attended Nottingham Crown Court and was sentenced to four years imprisonment. There is no evidence that a health screen was completed on him following his court appearance and change of status.

Contact with family: August - December 2003

During this period in custody, the prisoner had been writing to his former partner. However, she did not want contact with him. On 16 October 2003, she instructed solicitors to write to the prison asking them to stop all contact. In the letters he was sending her he was making veiled threats of suicide if she did not allow his sons to visit or write. His partner had no objections to his having contact with his sons when he was not in custody, but she did object to allowing contact through letters or visits whilst he was in prison.

The prisoner made several attempts to contact his partner by phone but she had changed her telephone number in December 2003, again following veiled threats towards her. This lack of contact seems to have frustrated the prisoner and he became quite depressed about it. He also made contact with his daughter through another former partner, asking her to get his daughter to write to him. The prisoner had talked of suicide and self-harm but the prison was not informed. He had said this on many previous occasions and they viewed this as nothing more than empty threats.

HMP Stocken: 12 - 20 February 2004

On 12 February 2004, the prisoner was transferred to HMP Stocken. There he was allocated to D Wing where he shared a cell with another prisoner who described him as being fearful, anxious and paranoid. The prisoner had told his cell mate that other prisoners were out to get him and that there was going to be a riot. He was also making bizarre comments such as, “I am the anti Christ and cannot be killed that’s why my suicide attempt failed” and “I can be badly beaten but I’ll never die”. The cell mate also stated that the prisoner had said “that he will try to commit suicide again some time before he gets released. He did not want to go on the streets again as he had no-one out there.” The cell mate said that he was making these comments in his sleep. He also said that he had intended to write to the Governor of Lincoln but had not done so.

The prisoner made an application to be returned to Lincoln within days of his arrival at Stocken. He was unhappy and depressed at being there and was placed on a F2052SH on 16 January. He was described by staff as extremely paranoid and fearful with a possible persecution complex. On 17 January, he was seen by a RMN who noted that he seemed extremely paranoid, fearful and talking about a possible riot. The prisoner was also seen by the Medical Officer who recommended that he be returned to Lincoln as soon as possible. On 18 January, a 72 hour F2052SH review was carried out which the prisoner attended. It was recommended that he remain on D Wing, in a double cell with his cell mate until a transfer could be arranged.

Return to Lincoln: 20 February - May 2004

The prisoner was subsequently returned to E Wing at Lincoln on 20 February. He was allocated a cell with a former cell mate. There is no evidence that a health screen was carried out on the prisoner's return. Section 3 of the Cell Sharing Risk Assessment was not completed. As staff were concerned about his mental state, the prisoner was admitted to the healthcare centre on the morning of 21 February for observation. Whilst in the healthcare centre, his medication was started again. He had not been given any at Stocken but there was a note in his medical notes that his medication needed reviewing. This does not appear to have happened. The prisoner seemed to have settled down since his return from Stocken.

On the afternoon of 25 February, he was discharged to E Wing and moved into a double cell.

A F2052SH case review was carried out on 28 February in which it was recommended that the prisoner should try to mix more and talk to staff. He was also referred to a RMN. He was seen that same day and he stated that he needed to see a doctor because he thought that the medication was not working. It was noted that he had not been attending to collect his medication.

A F2052SH case review took place on 3 March. The prisoner may or may not have attended as there is no record that he did. However, he had made a request to come off the booklet and wanted a job. In closing the F2052SH, staff at Lincoln noted that he was a lot more settled back on E Wing and was mixing with others. He was seen by a doctor for the third time on 24 March. He told the doctor that he did not think his medication was working. The doctor changed his dose of Olanzapine to 10mg twice daily and also started him on 75mg of Amitriptyline at night.

On 28 March, the prisoner was allocated work in the charity shop and seemed to have settled down on the wing. There are no records of staff having any major concerns about his behaviour

A few days before his death, the Chaplain saw the prisoner standing in the dinner queue on E Wing. She asked him how he was and, because he seemed low, she arranged to see him later that afternoon. At 2pm that day, the Chaplain collected him from his cell and took him to her office. During their meeting, the prisoner made various statements to her in which he indicated that he was very depressed, was hearing voices and that he believed there was going to be another riot. The Chaplain had known him since his first reception into the prison and in her opinion, even though he seemed depressed and low, he did not indicate any signs of self-harm. Based on this observation, she decided not to open a F2052SH. The prisoner agreed to have a prison visitor reassigned to him having had one previously.

A record that the meeting between the prisoner and the Chaplain had taken place was documented in the Chaplain's Journal. However, no details of the interview were written down and no entries were made in any other documents such as the Staff Observation Book in E Wing or in the prisoner's wing file. Nor did the Chaplain mention her meeting with the prisoner to any other member of staff.

Contact with family: January - May 2004

During his second period at Lincoln, the prisoner had written to his former partner and daughter. On interview, his daughter told the investigator that in the letter to her mother the prisoner had stated that he was having difficulty and could she make contact, asking her to write to him "before he does something silly". The daughter said that she was quite angry about the context of this letter, as her father was in the habit of making threats to kill himself whenever he was feeling low. Her reaction to these threats was not to write back to him. She also indicated that she was not surprised to hear of her father's apparent suicide, because as she stated, "he would have his down times", during which he would call her saying things like "I am so down, I can't handle it all". She indicated that this had happened quite a few times over a number of years.

The prisoner's cell mate told the investigator that, on the day before he died, the prisoner had two letters that he might have sent out to his sons returned to him unopened and unread. The cell mate remembered seeing the two letters in the waste paper bin in the cell with '*return to sender'* stamped on them. He also stated that the prisoner had written to the two boys the week before. The letters, if written, would have been returned without having left the prison, in line with the family's solicitors' request that the prisoner should not be allowed to communicate with her. As these letters cannot be found, it is believed they went into the rubbish disposal system.

Events on the day of the prisoner's death 2004

At 8:15am, the wing was unlocked so that prisoners could go to work.

The prisoner's cell mate left the cell at 8:30am to go to his place of work. Unlike the prisoner, the cell mate did not work in the charity workshop. According to the cell mate, the prisoner seemed his usual self and he did not notice anything different about him.

When prisoners are given a job in a prison workshop, they are given a slip of paper saying that they have been allocated a 'permanent job' in that particular place of work. They are then added to that workshop roll, which is a chart with a list of all the names of prisoners allocated to work there. It is the responsibility of the prisoner with a 'permanent job' to leave his wing at the appropriate time each morning and afternoon and to make his way to his allocated workplace. The only reason why a prisoner should not turn up for work each weekday is if he has been told not to because of workshop staff shortages or because he has another appointment to attend somewhere else, for example, a medical or dental appointment, a legal or domestic visit. Unless prisoners are told explicitly that they are not required for work they are expected to report for work as normal.

The prisoner had a 'permanent job' in the charity shop. During the previous week, the charity shop had been one member of staff short. This meant that the workshop took only 30 prisoners, instead of its usual number of 45. The workshop officer rang the wing each morning in order to inform one of the wing staff which prisoners out of the workshop roll were not required each day. The prisoner was

not required during that week and wing staff had been notified to tell him this each day.

On the day the prisoner died, the workshop staff were back up to their normal complement which meant that all 45 prisoners on the workshop roll were expected for work. The workshop officer told my investigator that prisoners who have a 'permanent job' slip are expected to make their own way off the wing when work is called, inform the officer at the exit of the wing where they are going and then to make their way to their place of work via the free flow movement system. On arrival at their place of work, the prisoners' names are ticked off on the workshop roll sheet. The prisoner did not make his way to the charity shop on that Monday. When movements had finished, the workshop officer counted up the number of prisoners that had arrived for work and identified the names of those who had not turned up. Movements finish about 9am.

The workshop officer then set about contacting the wing in order to find out what reason there was for each 'no show' prisoner not arriving. Some prisoners may have refused to work (and would then face a disciplinary adjudication), some may have had a medical appointment, were on sick absence (called rest in cell) or may have had a legal visit. The reason for a person's absence would be clarified with wing staff. Other prisoners may have been unaware that they were needed for work and this appears to have been the case with the prisoner on that day. He should have made his way to the workshop that morning but he did not do so. The reasons for this are not clear, but they may be linked to the fact that he had not been at work at all during the previous week.

The workshop officer told my investigator that the prisoner, whilst never refusing to work, was not 'proactive' or keen about going to work. He therefore assumed that on that Monday morning the prisoner was not certain that he was required, and had not turned up at the workshop because of this uncertainty. The instructor told the wing staff to ensure that he knew that he was required for work in the afternoon.

At 9:45am, an Officer informed the prisoner that he was required to go to work that afternoon. His reply was "OK." The officer did not notice anything unusual or odd, and he stated that the prisoner seemed his normal self.

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At about 11:45am, the same Officer unlocked the prisoner's cell to let in the cell mate who had come back from work for his lunch. As he did so he saw the prisoner with a ligature made of bedding round his neck. The other end was secured to the cell window by means of a knot. This knot was jammed into the gap between the window casement and the window frame. The Officer immediately went into the cell and lifted the prisoner's weight off the ligature and the cell mate called for assistance from officers on the wing.

A Senior Officer and another Officer managed to cut the prisoner down. They placed him onto the floor and were about to start resuscitation when medical staff arrived and took over. At the time, there was only one defibrillator in the prison which was held in the healthcare centre. There was a delay of about three minutes before the machine arrived on E Wing. This was due to the difficulty of staff in the cell contacting the healthcare centre over the radio. Normal radio transmissions

were still taking place. This delay did not have any effect on the outcome, as the prisoner had apparently been dead for some time before he was found. The prison doctor has confirmed this.
The communications room called for an ambulance at 11:53am and the crew attended the prison at 11:59am.

An airway was inserted and CPR commenced. This continued until the arrival of the paramedics some five to ten minutes later. The paramedics inserted a cannula for administering drugs and connected the prisoner to an ECG machine by which time the prison doctor arrived. Resuscitation was continued with the aid of drugs and defibrillator for another five minutes without success. The doctor pronounced death at 12:07pm.

No suicide note was found.

All relevant agencies within the prison and headquarters were informed as per instructions within Lincoln's contingency plans.

The cell was sealed and the police informed at 12:20pm. A police officer attended and confirmed that there were no suspicious circumstances.

A hot de-brief was held in the Governor's office at 1:30pm for all those members of staff who had attended. Care-team support was offered to all those who were identified as being involved.

The police informed the next of kin, the prisoner's uncle, of the death. A visit was arranged for the family to attend the prison the next day at 2:00pm. There was some disquiet raised by the family about the visit. They had asked if they could speak to the prisoner's cell mate and visit the cell. The cell had not been prepared, as the police had not handed it back to the Governor. Apart from putting some flowers in the cell, it was still in the same condition it had been in at the time of the death. The cell mate was left alone in the room with the family without any member of staff being present. During the course of this meeting, he accused the family of being responsible for the prisoner's death because they had not written or visited him.

SECTION 3

FINDINGS

Despite the fact that upon his reception at Lincoln on 20 August 2003 it was known that, a year earlier, the prisoner had taken an overdose of drugs, no F2052SH was opened. However, the prisoner was admitted to the Healthcare Centre for observation. During his time in custody, he became frustrated and depressed at his lack of contact with his children.

He was prescribed anti-psychotic drugs but would often miss treatment times and therefore only took half the prescribed medication.

The prisoner deliberately cut his arm on 2 September 2003. A F2052SH was raised as a result. There was also a report that he had tried to hang himself in the reception area on 15 October, but there are no details recorded in his file nor was there a F213SH opened. At the time he was already on a F2052SH. There was also one occasion when he was found with a ligature around his neck. This was on 28 October in the Group 4 cellular vehicle on the way to court. The following day the F2052SH was closed without any reference to this or previous incidents.

F2052SH case reviews took place as follows:

2 September 2003 HMP Lincoln Book opened
4 September 2003 HMP Lincoln 72 hours review
12 September 2003 HMP Lincoln
18 September 2003 HMP Lincoln
25 September 2003 HMP Lincoln
2 October 2003 HMP Lincoln
9 October 2003 HMP Lincoln
16 October 2003 HMP Lincoln
29 October 2003 HMP Lincoln Book closed

16 February 2004 HMP Stocken Book opened
18 February 2004 HMP Stocken 72 hour review
28 February 2004 HMP Lincoln
3 March 2004 HMP Lincoln Book closed

Whilst regular reviews took place at both prisons, there is no evidence to show whether the prisoner attended any of them at Lincoln.

Even though significant entries referring to self-harm incidents were recorded in the F2052SH, no mention of them appears in the case review record.

In some instances, the wrong dates were inserted in the records in the prisoner's F2052SH.

In one instance there was no date or signature recorded on the F2052SH case review.

There was no written record of the interview between the prisoner and the chaplain.

The prisoner's cell was ill-prepared for the family visit.

The family were left alone to speak to the prisoner's hostile cell mate.

No arrangements for informing the next of kin of a death in custody were included in the prison's contingency plans.

The healthcare staff who attended had difficulty contacting other health care staff in the prison. This seems to have been due to a lack of control of the radio net. Other messages, i.e. normal radio net traffic, were allowed to continue even though there was an emergency going on at the time.

The prisoner had been the subject of two periods under observation of an F2052SH. No family members were aware of this.

There is a locally produced form "ANNEX 10 HMP LINCOLN PRISONER SUPPORT PLAN AND NO SELF-HARM AGREEMENT" that has been inserted into the first 2052SH. This form indicates that a review should take place within the four-week period following closure of the document. There is no record that any reviews took place. There is no Annex 10 in the second F2052SH.

There was only one operational defibrillator available in the prison, which was located in the hospital. Another machine located in E Wing Treatment Room was being repaired.

Staff response on discovering the prisoner hanging was quick and appropriate. They tried to do all they could to resuscitate him and did not give up until all hope had gone.

SECTION 4

CONCLUSIONS

The prisoner had suffered from bouts of depression over a number of years and, when his mood was low, he would often talk of suicide. He had taken an overdose in the past and whilst in prison he had deliberately harmed himself. His depressive mood would not have been helped by the lack of contact with his sons.

The Chaplain saw him five days before he died. Her opinion at the time was that he seemed low in mood but not suicidal. This information should have been recorded in the wing observation book and in the prisoner's wing file.

The decision not to open a 2052SH following the interview with the prisoner a few days before his death may appear to have been wrong in hindsight. However, staff are called upon every day to make judgements as to the state of mind of prisoners, and in this case there were no indications that the prisoner was going to harm himself. He was making positive responses to suggestions about work and having a prison visitor. However, the Chaplain should have made an entry in the Staff Observation Book in the VPU and, perhaps, in the prisoner's wing file.

The way in which the family visit took place should have been more carefully thought through.

The meeting between the cell mate and the prisoner's relatives should have been attended by a member of staff.

The lack of control over the radio net had no impact on the outcome of this particular incident but could, if not addressed, have serious repercussions in any future incidents.

A post closure F2052SH review should have taken place and a record of the outcome should have been made.

Appendix A : Copy of a letter from the prisoner's uncle to the Ombudsman 29 July 2006

Dear Stephen Shaw,

Death in custody of my nephew at HM Prison, Lincoln 25.5.04

Further to my earlier letter to you of 9 October 05, I enclose a copy of my letter of today's date to your investigator, following receipt of the revised draft report enclosed with his letter of 4 January 06.

You will see from this letter that I am significantly dissatisfied with this revised report and somewhat disheartened that I can write at such length on a number of occasions both to your investigator and have concerns (which should be as much the concerns of the investigating Ombudsman as myself) simply disregarded or sidelined.

I believe that a careful reading of the text of my enclosed letter to your investigator will serve to confirm that relevant questions remain to be asked, answered and reported upon, and that important issues remain to be addressed.

I ask you again to accept this letter as a formal request that you investigate all the circumstances in respect of work as outlined in my letters of 18 June 05 and today's date (29 January) and include in your final report (and appendices) details of this investigation, together with recommendations for appropriate procedures in future.

Once again, please advise if you will do this. And once again, if you are not prepared to do so, please advise of procedures – outside of a request form myself to my Member of Parliament to ask a Parliamentary Question in respect of the treatment of next of kin by yourself and by the Prison Service to deaths in custody – to appeal in respect of reports from yourself.

29 January 2006.

Appendix B: Copy of letter to my investigator from the prisoner's uncle.

Dear Investigator,

Death in custody of my nephew at HM Prison Lincoln, 25. 5. 04

I am writing to the Prisons and Probation Ombudsman's revised draft report enclosed with your letter of 4 January.

The fact that issues in relation to my nephew's work commitments on the day of his death - issues previously ignored in the earlier draft - have now been raised is clearly a step forward. However, the revise text leaves more questions unanswered (and apparently unasked) than answered.

Who was due to tell my nephew that he was required for work on the day he died? Was he told? And if so, by whom and when? And is this a matter of record? (Note: If a matter of record, can these records be included in the appendices to the report, and may I receive copies).

Is attending for work, when due to attend for work, entirely a matter which is left to a prisoner's discretion? Are the Prison Officers who will need to open cells to enable prisoners to go work provided with advance information as to which prisoners are to go to work, including where and when? Do these Prison Officers the have a duty of responsibility to ensure that prisoners are released appropriately from their cells in order to attend for work?

These specific questions go unaddressed in the revised report. Relevant facts are reported but NOT investigated. To take 2 examples:-

1) The revised report stated that "On…… May, the workshop complement returned to normal. As a result, the prisoner roll increased to its former capacity of 45. [My nephew] was therefore **required** to attend for work."

I have highlighted the word 'required'. Given that my nephew was 'required' for work, then who among the Prison Officers was/were responsible for ensuring that this requirement was met? Had this requirement been met on the morning of ….. May then my nephew would not have died that morning.

2) The revised report states that "the workshop instructor thought that my nephew had probably not appeared for work because he was not sure whether he was required." This observation in respect of the workshop instructor's 'thoughts' goes unqualified and unquestioned in the revised report, and it therefore emerges that the Ombudsman is implicitly accepting that arrangements for prisoners required to attend for work are generally a desultory - rather than organised - affair. But if the requirement for my nephew to attend for work on the morning of…… May had been known to - and acted upon - by all appropriate Prison Officers then my nephew would not have died that morning.

Given all of the above, it is surely imperative that procedures and processes in place in relation to requiring prisoners to attend for work (both in general and specifically to my

nephew's situation) should have been and still remain to be fully investigated and reported upon together with any appropriate recommendations for the future.

The impression given to any reader of the revised report - in relation to issues relating to the requirement to attend for work - is that this is an issue which has only been reluctantly addressed by the author in the revised report solely because of my concerns and that it has been something of a pointless exercise. Given the questions which I have raised in this letter, the conclusion of the revised draft - "I can find no grounds on which to base any recommendations for change in the manner in which prisoners' whereabouts are checked in Lincoln" – is bland, not to the point in relation to the specific issues to be investigated, and patronising in relation to myself as next of kin.

In contrast to the care which has gone in addressing other issues in the report (around self harm, for example, which is carefully explored with details and dates of events and meetings, etc) the investigation of issues around work (if investigation is the appropriate word) is cursory to say the least, and I repeat my earlier request for it to be properly, appropriately and carefully investigated.

26 January 2006.

Appendix C: Copy of my reply to the prisoner's uncle

2 February 2006

Dear Sir,

Thank you for your letter of 29 January (received here yesterday). I have carefully considered the further points you raise and discussed them with colleagues here.

I am sorry that you remain significantly dissatisfied with my revised report into your nephew's death. However, my view is that further investigation of the matters raised in your letter would not be justified. For that reason I have asked my investigator to issue the report as a final document. It should be with you and the other parties in a few days.

That said, I recognise the strength of your disagreement with the report. I have, therefore, also asked my investigator to amend the final report to refer explicitly to your dissatisfaction with the way we have dealt with the issue of your nephew's work commitments. I have also asked him to append your letter as an annex to the report so that all recipients have a chance to judge what we have done against your criticisms. This is not standard practice on my part, and I hope you will feel it goes some way to meeting your concerns.

Other than by application for Judicial Review, or by drawing matters to the attention of the Coroner, there is no appeal against my reports. However, should you remain dissatisfied and judge that my actions constitute maladministration, you could ask your Member of Parliament to draw your complaint to the attention of the Parliamentary Commissioner for Administration. This is of course a matter for you to decide, but I have to say that I am entirely content both as to the propriety of our correspondence with you and as to the substantive matter at issue.

On a more personal note, I understand from my investigator that you have been in hospital recently. I wish you a happy and successful recovery.

With kind regards,

Yours sincerely,

Stephen Shaw
Prisons and Probation Ombudsman