

**Investigation into the circumstances surrounding the
death of a male prisoner at HMP Lindholme
in November 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2010

This is the report of an investigation into the death of a man who was found in his cell with a ligature around his neck at HMP Lindholme on 16 November 2008. The man was in custody for burglary.

I wish to offer my sincere sympathy and condolences to the man's family and friends for their loss.

This investigation was conducted by a senior investigator from my office. I would like to thank the Governor of HMP Lindholme and his staff for their help and co-operation during this investigation. I also wish to thank the prisoners who agreed to be interviewed.

I must apologise for the delay in issuing this report. This has been due in part to the delay in obtaining an accurate copy of the man's medical record from the prison.

The man had suffered the loss of his grandmother shortly before the anniversary of his mother's death. At the same time his relationship with his partner appeared to be breaking down. Unfortunately, not all of that information was available to the staff before his death and his apparent suicide shocked staff and prisoners alike.

I make two recommendations as the result of this investigation referring to issuing staff with resuscitation face masks and the integrity of healthcare records.

Jane Webb
Acting Prisons and Probation Ombudsman
March 2010

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SUMMARY

The man was sent to HMP Lincoln on 4 February 2008 having pleaded guilty to a charge of burglary on 1 February and been remanded for sentence to a local Crown Court. In March, the man was sentenced to two years imprisonment for burglary.

The man was made a category D prisoner and on 10 April he was transferred to HMP Moorland (open). Two days later he absconded and went to see his girlfriend. He was arrested the following morning and returned to Lincoln. On 21 July, he was sentenced to an additional 28 days imprisonment for absconding.

The man began to have some problems with other prisoners, alleging that he had been hit whilst at work. He applied to be moved to the vulnerable prisoners section of the prison on 1 August. On 4 August, he transferred to HMP Lindholme. There is no evidence that he had any further problems with other prisoners after the transfer.

On 3 September, staff searched the cell which the man shared with another prisoner in order to find a mobile telephone. The man volunteered an improvised tattoo gun and some battery packs. He pleaded guilty at adjudication and received two days in the Care and Separation Unit as punishment. Subsequent to that search the man informed staff that his former cell mate had the mobile phone and he was using it to send text messages to his girlfriend.

On 15 November, the man's Personal Officer saw that he was upset and spoke with him. The man told him that his grandmother had died recently but assured the officer that he was alright. The following day the man's Personal Officer spoke with him in the morning and he again confirmed that he was alright. In the afternoon the man was upset again and this time he told the officer that it was also the anniversary of his mother's death the coming Thursday. The officer spent some time talking with him and the man said that he was not feeling suicidal or at risk of harming himself. He just wanted to talk with the chaplain the next morning.

The Personal Officer wrote the details of his conversation with the man in the wing observation book and also mentioned it to a fellow Officer who also went to speak with the man. Again the man assured the officer that he was okay and just wanted to see the chaplain in the morning. The man did not tell the officers that he had had several telephone conversations with his partner that day and that they were likely to separate.

At 8.16pm, shortly before he went off duty, the fellow Officer returned to the man's cell and found him hanging by means of a strip of bed sheet attached to the cell window. He immediately entered the cell and cut the ligature. After raising the alarm he started resuscitation and was soon joined by other staff. Paramedics and an ambulance arrived but the efforts to revive the man were not successful and he was pronounced dead at 9.00pm.

As the result of my investigation into the man's death I make two recommendations relating to the issue of face masks and an investigation into how the man's medical record was mixed with that of another prisoner.

THE INVESTIGATION PROCESS

1. The investigation was opened by one of the Ombudsman's Senior Investigators on 21 November 2008. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were displayed around the prison to inform both staff and prisoners of the investigation.
2. The Investigator formally interviewed a number of members of staff and prisoners regarding the man's death. The transcripts of those interviews are attached at the end of this report.
3. One of the Ombudsman's family liaison officers contacted the man's sister who was his next of kin. She offered the family the opportunity to meet with her and the Investigator to discuss the purpose of the investigation, and to enable the family to raise any concerns or questions they would like explored. The Family Liaison Officer and the Investigator met with the man's sister and her main concern was why the man was not on a 'suicide watch' at the time of his death. I believe that this report addresses that question and provides an answer.
4. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in preparing for the inquest into the man's death.
5. NHS Doncaster was asked to prepare a clinical review of the care that the man received whilst in custody. The Head of Quality and Vulnerable Adults for NHS Doncaster was appointed to undertake the review.

HMP LINDHOLME

6. HMP Lindholme is situated outside Doncaster, South Yorkshire. It is on the site of a former RAF airfield. It opened as a prison in 1985. The accommodation has been converted from dormitory conditions to single and multiple occupancy rooms on lockable wings. It is a category C prison holding adult male prisoners. Category C prisons are for those who cannot be trusted in open conditions but who would not have the ability or resources to make a determined escape.
7. Since April 2004, healthcare at Lindholme has been provided by NHS Doncaster. There are no inpatient beds and medical services are provided by a doctor from a local practice who visits daily and sees prisoners who have applied for an appointment. The clinical staff provide a day time service, and are all appropriately qualified. Sickness and treatments are managed by nursing staff.
8. Her Majesty's Chief Inspector of Prisons writes in the foreword to her January 2008 announced inspection report of Lindholme:

“... Like many similar prisons, it has had to manage increasing numbers of prisoners with relatively few staff. Population pressures have also led to a high churn of prisoners (a high turnover) and an influx of some who, previously, might have been held for longer in prisons with a higher security category. As a result, this full announced inspection found an establishment struggling with an increased number of violent incidents and a serious drugs problem, not helped by a huge perimeter which was hard to secure. On the positive side, both purposeful activity and resettlement were reasonable, but Lindholme badly needed a period of stability and a robust focus on safety, if these assets are to be maximised.

“Lindholme faces an array of challenges, foremost among which are the need to improve safety, reduce the number of incidents of violence and stem the flow of illegal drugs into the prison. It is suffering the effects of its increased size and the population pressures in the prison system in general. There are shortfalls in a number of other areas, but there are also considerable strengths to build on, including some good quality purposeful activity and effective resettlement services. This is a demanding agenda, but with a new governor fully aware of the challenges, it is one which can, and indeed must, be addressed.”

9. Since the Ombudsman was given responsibility for investigating all deaths in prisons in April 2004, there have been three deaths at Lindholme prior to that of the man. All three were from natural causes and no issues were raised in the investigations into the earlier deaths which are relevant to this one.

10. Each prison has an Independent Monitoring Board (IMB). IMB members are lay members of the public and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. In the latest annual report published in February 2009 the Board does not make any comment regarding matters raised in this investigation. The overall assesment concludes,

“The management of a prison is highly complex and challenging and as with all establishments problems arise. The response of the staff at Lindholme prison has been one of committed professionalism and bodes well for the future.”

KEY FINDINGS

11. On 31st January 2008 the man was arrested for burglary. The following day he pleaded guilty and was remanded into custody and committed to a local Crown Court for sentencing.
12. The man was held in police cells due to lack of space in the local prisons before moving to HMP Lincoln on 4 February 2008. Upon arrival in reception he was taken through the standard induction regime which included a First Reception Health Screen (FRHS) with a nurse. The man told the Nurse that he had last been in prison in 2006 when he was at Lincoln. He said that he had been to see his doctor in January 2008 and been given a prescription for 16mg of subutex which he collected weekly from his local pharmacy. The man told the nurse that he only drank alcohol socially, but admitted to using benzodiazepines daily. When his urine was tested the result was positive for benzodiazepines and heroin.
13. The man was asked if he had any medical or mental health problems and he replied that he did not. He also said that he had never tried to harm himself, nor did he feel like doing so at that time, although he did reveal that he had accidentally overdosed five years previously. It was decided, with his agreement, that the man should detoxify from both subutex and benzodiazepines. (Subutex is used to control symptoms when withdrawing from heroin and benzodiazepines are tranquillisers, such as valium or Librium.)
14. The man was given 10mg of diazepam and symptomatic relief medication that night. He began the detoxification regimes the following day and had completed both by 15 February.
15. On 17 February, a Officer made an entry in the man's history sheet. The man had asked to speak with a particular Listener, but when he was told that another Listener was on the rota he declined and became abusive. The Officer added that the same thing had happened previously on a number of occasions. (A Listener is a prisoner who volunteers to be trained by the Samaritans to carry out a similar role within the prison.)
16. The Ombudsman's Investigator has spoken with the Officer who cannot recall the interaction so long after the event. However, there is no indication from the documentation that the man was feeling low or thinking about harming himself.
17. The man was sentenced to two years imprisonment for burglary at a local Crown Court on 17 March.
18. A categorisation algorithm (a flowchart used to determine a prisoners category) was completed by a Senior Officer (SO) on 21 March and it was decided that the man was suitable for a category D prison. The recommended allocation was HMP Moorland (open). (There are four security categories for adult male prisoners: A, B, C, and D. Category A

is for prisoners whose escape would be considered highly dangerous to the public, or a threat to national security. Category B is for prisoners for whom escape must be made very difficult. Category C applies to prisoners who cannot be trusted in open conditions and Category D prisoners can be reasonably trusted in open conditions.)

19. On 23 March, an entry was made in the history sheet stating that the man had been recommended to become an enhanced prisoner as he was polite, co-operative and helpful when asked to do anything. (The Incentives and Earned Privileges Scheme was introduced in 1995 to “to encourage responsible behaviour by prisoners; to encourage hard work and other constructive activity by prisoners; to encourage sentenced prisoners to progress through the prison system; and to create a more disciplined, better controlled and safer environment for prisoners and staff.” There are three levels, basic, standard and enhanced.)
20. The man had been working as a reception orderly which is a position of trust. Unfortunately, on 2 April, just as his enhanced status was confirmed, the man was removed from his job for helping himself to his own clothes from the property boxes in Reception. He was returned to standard regime as a result.
21. The man transferred to Moorland (open) on 10 April. He was not happy about being transferred and continued to talk to staff about returning to Lincoln afterwards. The man spoke with a Nurse and complained of having sciatica (pain caused by pressure on the sciatic nerve) in his left leg for the previous ten days. An appointment was arranged for him to see a doctor on 16 April. There is no record of the man previously having complained about the sciatica.
22. On 12 April, the man absconded from Moorland (open) and made his way on foot to see his partner in Worksop. He later told a probation officer, that he knew his girlfriend was having problems with her pregnancy and he wanted to see her. He believed that he would simply be returned to a closed prison, rather than receive an additional sentence.
23. The man was arrested by the police the following morning and returned to Lincoln on 14 April. He was seen in reception and a FRHS was completed. The man told the nurse that he had no thoughts of self-harm and no concerns about his mental or physical health. He tested positive for opiates and was given symptomatic relief for any withdrawal symptoms.
24. The man went to the morning healthcare treatment session on 17 April complaining about painful and bleeding haemorrhoids. He was given some Anusol cream.
25. On 23 April, the man complained to staff that he was being intimidated by other prisoners on C wing, and claimed that he had been hit whilst on the exercise yard the previous Saturday. A SO recorded that the

bullying related to an 'out of prison' problem. The man was moved to A wing as part of the support plan.

26. It was noted in the man's medical record that he declined to attend healthcare treatment sessions on 29 April and 20 May, though it is unclear what they were for.
27. The man appeared at a local magistrates' court on 12 June and was sentenced to seven days imprisonment for non payment of outstanding fines. The sentence was to run concurrently with his existing sentence.
28. On 23 June, the man saw a Nurse and complained of pain in his back, left side and radiating down to his left knee. He also said that he had occasional tingling in his left foot. He told the nurse that he was particularly concerned as both his father and his uncle had arterial disease and his father had to have an amputation as a result. The man was referred to the smoking cessation clinic and for blood tests. The following day the man was seen by the smoking cessation nurse who prescribed 21mg nicotine patches. Blood samples were taken and sent for analysis on 26 June.
29. At a local Crown Court on 21 July, the man pleaded guilty to absconding from prison on 12 April and was sentenced to serve 28 days imprisonment consecutive to his current sentence.
30. On Friday 1 August, the man wrote an application for Rule 45. (Prisoners can apply to be treated as vulnerable prisoners and moved to a separate area of the prison so as not to mix with the general population. This action may be taken out of fear of physical attack or after incurring debts with other inmates.) The man wrote that he had problems (not specified) which followed him from C wing. He also claimed that he had been hit at work the previous Tuesday and named one of the prisoners involved. The man was moved to E wing. The prison's anti-bullying procedures were started, but the man was assessed as fit for transfer on 3 August. No further incidents were reported and there is no evidence that anything similar happened after the man's transfer to Lindholme.
31. The man moved to Lindholme on 4 August. During his reception health screen at Lindholme he told the nurse that he did not have any physical or mental illnesses. He admitted to last using heroin six months previously. He also told the nurse that, although he was a smoker, he did not want any help to give up.
32. On 1 September, a Operational Support Grade (OSG) was passing the cell occupied by the man and another prisoner at 9.00pm. He saw that the prisoner on the top bunk was using a black mobile telephone. He duly reported the matter and the cell was searched two days later. The officer who later checked on him (after the man's Personal Officer mentioned that he was upset) was one of the members of staff involved and described in his interview what happened,

“... there was myself, one of the officers I can't remember and the SO at the time and we opened the door and went, 'Right where is it'? Before we even entered the cell, before we even started, the man turned round and went 'it's up there boss'. I've never had that before, I don't think I'll ever have it again which I was quite shocked ...”

33. When the shelf indicated by the man was searched, an improvised tattoo gun, various wires and two battery packs were found. The officers did not find the mobile telephone. It was noted that the other prisoner claimed to be unable to squat down due to a leg injury, and so he was not fully searched. The man admitted possession of the tattoo gun and received two days in the Care and Separation Unit as punishment.
34. On 6 September, the man spoke with the officer involved in the search (who later checked on him after the man's personal officer mentioned the man to him) and complained that his former cell mate had taken a lot of his toiletries when he had moved to D wing. He also told the officer that the prisoner had a Samsung mobile telephone which he kept 'plugged'. (prisoners sometimes 'plug' (insert into their bottoms) drugs, phones and other objects which can drop out when they are asked to squat.)
35. A few days later, on 10 September, the man approached the officer again and asked if the telephone had been found. The officer asked the man why he was enquiring and he replied it was because the prisoner was using it to send texts to his girlfriend. During his interview with the investigator, the officer said that, a couple of days later, the man told him that his girlfriend had contacted the mobile provider and blocked the telephone.
36. The man's Personal Officer during his interview with the investigator explained how the scheme worked and how he became a personal officer. The officer was assigned to work primarily on the Blue 3's landing and became the personal officer to those prisoners residing there. He introduced himself to those prisoners and explained that if they had any problems or needed anything they should speak to him.
37. The man's Personal Officer described the man as a quiet, friendly and polite prisoner who never really came to his attention for any major issues. He made a number of entries on the man's wing history sheet.

“5 October - Drags his heels at bang up, apart from that, no concerns.”

“19 October - Given a verbal warning this week about being late behind his door, appears to have taken it on board.”
38. On 15 November, the man's Personal Officer was locking the cells after teatime and saw the man sitting in his cell looking upset:

"I asked him if he'd had his dinner he said yes boss. I looked at him and asked if he was okay and he explained to me that he'd had some bad news recently in that his grandma had passed away. Obviously I stepped into the cell and started a conversation with him, asking are you okay, are you coping fine. He said yes I'm fine. Obviously he was a bit upset but he said he was fine at that time."

39. The man's Personal Officer made an entry in the wing observation book as follows:

"Spoke to the man ref his grandmother's death. [He] was upset. Asked if he was ok. He said, "Yes". Asked if he needed anyone to talk to about it, he said, "no I'm fine."

The man's Personal Officer confirmed during his interview that he had received the Assessment, Care in Custody and Teamwork (ACCT) training but that nothing about the man or the conversation held made him consider opening an ACCT document. The ACCT encourages staff to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

40. The following day, Sunday 16 November, the man's Personal Officer completed the entries in the Behaviour Monitoring Sheets (BMS) which are used to document any concerns about prisoners on the wing. He recorded that the man had been given some bad news but was fine and he continued to be a very good, well behaved prisoner. At 11.15am, the officer saw the man whilst patrolling the wing. The man was cleaning out his cell, as he regularly did at weekends. The officer asked how the man was feeling and he replied that he was fine.
41. At about 5.00pm, the man's Personal Officer spoke with the man again:

"The next time I spoke to him was in the evening. I was on the servery again and I had a call from the Blue 3's landing, third landing up, saying that a prisoner wanted to speak to me. I didn't know who it was but the call came down and said that it's the prisoner in room 56 so obviously I knew that was the man. I went up there to speak to him. Again he did seem upset. I asked him what was wrong. He said he's just got a lot of things going on at the minute. I said okay do you feel comfortable talking to me about it. He said yes. I believe it was the anniversary of his mother's death the Thursday coming up. Obviously I listened to this, I didn't know that, due to the conversation I had with him the previous night I felt it was important to ask him if he was also upset because of his grandma's passing away recently. I thought that was an important question to ask. He said no, that's not the case he's just worried about this anniversary coming up for his mum. So I said what would you like me to do, what can I do for you. In response to this he asked if he could see the chaplain on Monday morning. So I

said yes that's no problem, is there anything else I can do for you. He said, no that's all so I said okay I'll go downstairs and book that for you now."

42. The officer returned to the wing office and recorded the conversation in the observation book. He also mentioned the situation to the other wing staff. At the end of his shift at 5.30pm, the officer decided to return to the man's cell. The officer described his reasons and the conversation as follows:

"I wanted to go back upstairs, so the man knew I wasn't fobbing him off, that I'd actually done that for him, that I'd actually booked him in to see the chaplain the following day. On my way up I saw a fellow officer I told him about the conversation I'd had with the man. I informed him that I was going back up to speak to him again to tell him I'd booked the chaplain for him. He said he was just going to check on another prisoner and that he'd meet me on the Blue 3's landing, the third landing, we'd have a talk there as well, so I said fine.

"That's when I proceeded to walk back up to the man's cell and I obviously looked through the obs panel to see he was still sat at his chair. I walked in and said to the man I've booked that for you mate, I've booked the chaplain for you, you are down to see him tomorrow morning. He said fine boss. It was at this point that there was tears in his eyes and I could see that he was more upset than when I left him. So I crouched down so that we were at eye level, so that I could properly speak to him so I'm not towering over him. I asked him if he was okay and he said yes I'm fine, obviously I could see he was upset. I asked him whether he had any thoughts, not the best use of words. I said have you any thoughts of doing anything stupid? Have you any thoughts of harming yourself? He said no boss, I just want to see the chaplain. So I took that onboard and from there I decided to offer him, if he would like a Listener in his cell. A Listener is another prisoner that's been trained to listen to the problems of other prisoner and they can go in their cell with them and talk. Mainly just to be there with them to help them through. He said no, he didn't feel comfortable talking about it to anyone, especially another prisoner. Obviously I took that onboard as well, obviously I knew he had friends on the wing, I asked him if he'd like a friend in with him, maybe he could talk to them instead. He said no, he didn't want that. I offered him the use of the Samaritans' phone, if he needed someone to talk to during the night. He said he didn't need that either, he was fine".

"So I said okay, you just want to see the chaplain in the morning. He said yes. I said okay, that's no problem, that is booked for you and I then informed him that I'd keep him back from work and I'd personally walk him over in the morning to see the chaplain. He said thank you and then I said that if he would like I could stay over

at the chaplain with him, and that we could talk as well and have a little conversation. He said I appreciate that boss thanks a lot and then I said okay, I'm going to ask you the question again. Have you any thoughts of harming yourself? And the man said no boss, I have no thoughts at all, I'm going to be fine. I just want to see the chaplain in the morning. And I said yeah, okay that's sorted for you and I'll see you tomorrow and that was the end of my conversation with the man."

43. The man's Personal Officer waited outside the man's cell whilst the fellow officer spoke to the man. At the end of their conversations neither officer was concerned that the man had any thoughts of self-harm. One of the things that eased the fellow officer's concerns was reading the letter that the man was writing and seeing that he was asking for money to be sent to him.
44. The officers returned to the wing office. The man's Personal Officer then went off duty (45 minutes after his shift was due to end). The fellow officer told the Night Duty Senior Officer, about the man being upset stating that he had no thoughts of self-harm. The fellow officer then wrote the following entry in the observation book:

"[with] the man's Personal Officer outside I spoke to the man, who was upset. He stated that he was upset as it is his mother's birthday (deceased) on Thursday. He stated that although upset, he has no intention of self-harm, but appreciated offer of seeing chaplain AM tomorrow."
45. The fellow officer was then alone on the wing until the night duty OSG was due to start just before 9.00pm. He looked in on the man whilst he was patrolling the wing and the man gave him a 'thumbs up' to his enquiry if he was alright.
46. About 8.16pm, the fellow officer went to the man's cell again, this time with the intention of telling him that he would be going off duty shortly but that the night officer would be around if he needed anything. When he arrived at the cell the door flap was open as he had left it but the cell was only dimly lit. He looked into the cell and saw the man apparently sitting on a heating pipe below the window at the rear of the cell. The officer called out "Watty" but got no reply. He repeated his call and kicked the bottom of the cell door to attract his attention. When he still got no response he opened the cell even though it was in contravention of the prison's policy. (Verbal permission to enter a cell must be given by the Night Orderly Officer.) As he did so the extra light illuminated a strip of torn bed sheet running from the window to the back of the man's head. The fellow officer ran to the man and used his anti-ligature knife to cut the sheet strip whilst supporting the man's body. He removed the sheet from around the man's neck. The man was now lying on the floor with his head on the pipe.

47. The fellow officer ran from the cell to the nearest alarm bell and pressed it several times. In his interview he explained that he was aware that there were some radio “dead spots” and so his first choice was to use the alarm bell to summon assistance. Having done that, he also used the radio to issue a ‘code blue’ emergency message. (Like many prisons, Lindholme has a colour emergency code system, with blue reporting prisoners with breathing difficulties. The use of the correct code allows staff to bring the appropriate equipment.)
48. The fellow officer then returned to the cell and immediately began cardio pulmonary resuscitation (CPR), using his own one way valve face mask. The Night Duty Senior Officer and three other officers were in the Care and Separation Unit when they heard the alarm call and immediately began making their way to the man’s cell. It is a distance of about 100 yards and they arrived very quickly. One of the officers entered the cell first and took over the chest compressions, leaving the fellow officer to concentrate on mouth to mouth breaths. The Night Duty Senior Officer checked the man but was unable to detect a pulse.
49. The Night Duty Senior Officer then left the cell to inform the control room of the situation and request an ambulance. An officer and a Principal Officer (PO) arrived at the cell and the officer was sent to get the automatic defibrillator machine. He returned with the machine a couple of minutes later and the officer who previously had been doing chest compressions attached the pads to the man. The machine indicated that staff should stand back whilst it carried out its assessment. A few seconds later the machine indicated that the staff should carry on with CPR, which they did.
50. A paramedic arrived and was taken to the cell at about 8.30pm and, a few minutes later, an ambulance crew arrived. They took over the resuscitation attempts from the prison staff, but at 9.00pm they declared the man dead.
51. A letter to his children and a poem the man had written about heroin and cocaine were found on his bed by the police who attended that night.
52. The man had listed his girlfriend as his next of kin, and was therefore visited personally by the prison chaplain and the Family Liaison Officer to break the news of his death. The man’s girlfriend then told his sister at 10.00am on 17 November.
53. On 17 November two prisoners approached the man’s Personal Officer and the fellow officer. They told the officers that the previous day the man had been on the telephone to his girlfriend and that she had said that she was leaving him. The prisoners thought that he had looked really ‘down’, and that he told them that he did not think his life could get any worse. In his interview with the Ombudsman’s investigator, one of the Prisoners said that they did not think that the man was feeling depressed or likely to harm himself, but was more angry than anything else.

54. As part of the investigation the Investigator was able to listen to recordings of several telephone calls made by the man on 15 and 16 November. At 2.33pm on 15 November, the man spoke with his girlfriend and she said that she wanted a break from him, she wanted some space. The call ended with both of them sounding upset. At 3.38pm on 16 November, the man spoke to his sister about his relationship. She told him that his girlfriend had kissed another man. At 3.47pm, the man was crying and upset but still talking about the future with his girlfriend. Then at 4.24pm, the man had another conversation with his sister, and was again talking about future plans. These telephone conversations were recorded but were not monitored at the time.
55. During the Investigator's interviews with the prisoners, both men said that just before the man's body was taken away they saw staff laughing and joking. They could not identify the staff and one of the prisoners said that it was not staff who worked regularly on the wing.

ISSUES

56. The main concern that the man's sister raised (when the investigator met her) was to find out why he was not thought to be at risk of suicide and being monitored by the ACCT procedures. The two members of staff who spoke with the man on 16 November and the two prisoners said that they did not at any time feel that the man was likely to harm himself. Also, neither the man's sister nor his partner, both of whom spoke with him that afternoon, contacted the prison to inform staff of any concerns that they might have had.
57. The Prison Service Order (PSO) that covers the opening of ACCT documents is PSO 2700. Annex 8G section 4 sets out the circumstances when an ACCT should be opened:

“In the event of any incident of self-harm or whenever a member of staff believes a prisoner is at risk of suicide or self-harm, they must (where there is not one open already) open an ACCT Plan.”

As previously stated, no one felt that the man's mood or presentation that evening suggested that he was at risk.

58. The Night Duty Senior Officer, who is a trained ACCT assessor, was asked what would have happened if an ACCT had been opened that evening. She replied that, in the absence of any further information, the man would have been subject to checks twice an hour until the ACCT assessment was completed the following day. He would also have been offered the opportunity to speak with a Listener or use the Samaritans' phone. In fact although the fellow officer did not think that suicide monitoring was necessary I am pleased that he offered both to the man and had checked on him within a similar time frame.
59. Whether or not to open an ACCT is in many cases a judgement call for staff based upon the information they have been given, and the presentation and responses of the prisoner concerned. It must also be remembered that being on an ACCT does not guarantee a person will not try or be prevented from harming themselves. I believe, as a result of this investigation, the officers' decision not to open an ACCT was reasonable and in line with PSO 2700.

Face Masks

60. The fellow officer was able to swiftly and safely begin CPR when he found the man in his cell as he carried a resuscitation face mask on his uniform belt. I was disappointed to learn that such masks are not issued to all staff.

The Governor should consider issuing all staff with resuscitation face masks and encourage them to carry their masks at all times.

Staff reactions outside the cell

61. The two prisoners sharing a cell opposite the man's told the investigator that they witnessed a small number of staff laughing and joking outside his cell. One of them said that the staff involved were not regular wing staff. There would have been a lot of noise, and radio transmissions at the time, as well as paramedic, ambulance and police personnel. The investigator asked each officer involved at the man's cell if they heard or saw any unprofessional behaviour and all denied it completely.
62. I take this opportunity to draw the matter to the Governor's attention as it seems clear that the two prisoners were offended by staff behaviour though I would be shocked and surprised if the staff intended to give offence. In difficult and highly charged situations, it is very easy for things to be taken out of context and staff should at all times be aware of their surroundings and conduct themselves accordingly.

Clinical care and medical records

63. The Clinical Reviewer conducted a review on behalf of NHS Doncaster into the clinical care that the man received whilst in custody. In general terms the Clinical Reviewer concluded that the health care provided was equitable to that he would have received if not in prison. There are three recommendations in the report, none of which directly relate to the man's death, and I have forwarded them to the Primary Care Trust to consider.
64. There was an issue that became apparent after the man's death which related to his medical record. The investigator was given a copy of the man's record when he opened the investigation at Lindholme. After a copy had been sent to the Clinical Reviewer it became clear that the document contained the records of two prisoners who both shared the same name, although the middle names, dates of birth and prison numbers were different.
65. The prison was notified of the situation and efforts were made to provide a complete copy of the medical records for the deceased. Those records were finally forwarded to the investigator via the Clinical Reviewer in August 2009, some nine months after the man's death.

The Healthcare Manager should investigate how the records of two separate prisoners were mixed and put procedures in place to prevent such a situation recurring.

Actions of the man's Personal Officer and the fellow officer

66. I believe that this investigation has shown that both officers acted in the best traditions of the Prison Service out of concern for the man. The man's Personal Officer remained on duty for three quarters of an hour after the end of his shift talking to the man and the fellow officer against

the local instructions, without hesitation entered the cell alone, cut the man down and started CPR.

CONCLUSION

The man moved to Lindholme in August 2008 after apparently having some problems with other prisoners on his wing at Lincoln. He settled into the routine at Lindholme and generally got on well with the staff and other prisoners. He told staff on 15 November that his grandmother had recently died, and that the anniversary of his mother's death was in a few days' time. Staff were concerned about his mood but he assured them that he was alright. The staff were not aware until after his death that he was also having relationship problems.

Neither the staff nor his prisoner friends could tell that the man's mood was lower than usual, and no one thought that he was at risk of harming himself. The decision that the man's mental state did not require an ACCT to be opened was reasonable in the circumstances. Despite that decision the man's Personal Officer and the fellow officer both spent significant periods of time with him, offering him support as if he was in fact on an open ACCT.

When the man was found hanging in his cell the staff responded swiftly but neither they nor the paramedics were able to revive him. I believe that the issues raised in my investigation, concerning face masks and record keeping, did not contribute to his death in any way.

RECOMMENDATIONS

The Governor should consider issuing all staff with resuscitation face masks and encourage them to carry their masks at all times.

The Healthcare Manager should investigate how the records of two separate prisoners were mixed and put procedures in place to prevent such a situation recurring.

The National Offender Management Service accepted both these recommendations at draft report stage.