

**Investigation into the circumstances surrounding the death
of a man
at HMP Lincoln in October 2007**

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

June 2009

This is the report of an investigation into the death of a man at HMP Lincoln in October 2007. At 1.40pm on the day of his death, the man was found suspended by a ligature in his cell in the prison's segregation unit. A post mortem examination carried out that day confirmed the cause of his death as hanging. A toxicological analysis revealed the presence of a sub-therapeutic level of temazepam (benzodiazepine) in the man's body. However no opiates were present.

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

The investigation was conducted by my colleague.

I also commissioned a clinical review of the management of the man's health needs while he was in custody. This was conducted by a representative of the local Primary Care Trust. I should like to thank the clinical reviewer for her significant contribution to the investigation.

My thanks also go to the Governor and his staff at Lincoln for their help and co-operation during the investigation. I pay particular tribute to the investigation liaison officer whose help was invaluable.

On 14 December 2007, my colleague and one of my Family Liaison Officers met the man's parents in order to ascertain whether there were any matters they wanted the investigation to address. They raised a number of points of concern which I trust have been adequately dealt with in this report.

The investigation found the man's health needs were satisfactorily met while he was in custody. I hope that the recommendations I make will help to prevent similar further tragedies at Lincoln and elsewhere in the Prison Service.

In April 2006, I published the report of my investigation into the death of another prisoner at Lincoln that had occurred 17 months earlier. In that report I made a number of recommendations including three that related to the management of segregated prisoners. The Prison Service accepted all the recommendations. Although similar issues have arisen in this investigation, I am pleased that I have not had to repeat any of my earlier recommendations.

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

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SUMMARY

The man was born in Nottingham in July 1982. As a young boy, he behaved well, and became popular at primary school, where he played football and sang in the choir. He enjoyed family life. Later, he moved to a comprehensive school, but left at age 16 with no qualifications. He worked with his father for a while and later took a job delivering coal. During this time, the man started to use drugs and took to crime to feed his habit. He frequently appeared in court and was given numerous prison sentences.

The man was arrested in June 2007 for interfering with a vehicle and was taken into police custody in Nottingham. He told a doctor he had ingested a large number of wraps of heroin. His police medical notes indicated that he did so as an attempt to kill himself, but he told prison staff he wanted to avoid detection by the police. He was bailed so that he could be admitted to hospital for examination and observation. His records show he passed the wraps naturally and caused himself no harm. The next day the man discharged himself.

As he was leaving the hospital premises the man tried to break into a car in the hospital car park and was caught and arrested. The next day he appeared in court and was sentenced to 14 days imprisonment. The man served this sentence in HMP Nottingham. Here he displayed no signs of being at risk of suicide and was released on 5 July.

A fortnight later the man was arrested for breaching an Anti-Social Behaviour Order. He appeared before Nottingham magistrates and was remanded in custody at Nottingham. Again, during the reception procedures the man was not considered to be at risk of self-harm or suicide. However, he admitted he had used drugs during the previous month. He said he had been placed on a methadone detoxification programme when last in prison and agreed to comply with a methadone treatment plan during his current sentence.

On 23 August the man was sentenced to four months imprisonment for theft from a vehicle and a further consecutive sentence of four months for breach of his Anti-Social Behaviour Order.

In September, evidence came to light that the man was behaving improperly towards a female member of staff. As a result, he was transferred to HMP Lincoln. Upon his arrival there on 27 September, he was not assessed as at risk of self-harm or suicide.

Initially the man settled at Lincoln. He engaged with the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) service and with the Substance Misuse Team, agreeing a care plan to reduce the harm he was incurring by his drug dependency.

On 13 October the man asked for his detoxification medication to be changed from methadone to subutex. It was from this point that his behaviour started to deteriorate. On 19 October, he was found in possession of a drug smoking implement. At a subsequent disciplinary hearing, he was given a punishment of loss of various privileges. On 24 October the man was rude to an officer. That same day, he allegedly assaulted a senior officer. As a result he was taken to the segregation unit.

The next day the man was given three days' cellular confinement for being rude to the officer. During the morning of 26 October, the deputy governor opened an initial hearing in relation to the man's alleged assault on the senior officer. She decided that an independent adjudicator should deal with the case. The man was therefore kept in the segregation unit to complete his period of cellular confinement and to await the hearing by the independent adjudicator. At 1:40pm that day, he was found hanging in his cell.

The investigation found that the man displayed no obvious signs that he was at risk of suicide either at Nottingham or at Lincoln. There were therefore no grounds upon which staff could reasonably have been expected to subject him to formal self-harm monitoring procedures.

The marked deterioration in the man's behaviour in the fortnight before his death could, in my view, be linked to the fact that he may have taken cannabis at the very time he was on a rapid methadone detoxification programme. It may also have been linked to the change from methadone to subutex at this own request. The clinical reviewer points to the fact that rapid detoxification from methadone can result in both physical withdrawal symptoms and the precipitation of psychosis with abnormal behaviour patterns. However, the reviewer draws the conclusion that in the man's case there was no reported evidence of physical withdrawal symptoms during the detoxification process and nothing to suggest the development of a mood disorder or psychosis.

My report shows that, in general terms, the man's mental and physical health needs were adequately met while he was in custody. I believe the decision to segregate him on 24 October was justified by the circumstances of his behaviour. I take the view that the requirements of Prison Service Order 1700 (The Management of Prisoners in Segregation Units) were satisfactorily met.

My report nevertheless makes recommendations about the management of prisoners on detoxification programmes. I also make recommendations about record keeping, the availability of emergency first aid equipment and the need to encourage prisoners to disclose details of their next of kin during the reception process.

I commend the staff who attempted to save the man's life in harrowing circumstances. I also congratulate the establishment's family liaison officer for the fact that she informed the man's family of his death within three and a half hours, despite immense difficulties in tracing them. I draw attention to an example of good practice in healthcare.

INVESTIGATION PROCESS

1. The investigation was conducted by my colleague. On 30 October 2007 my colleague formally opened the investigation at Lincoln by meeting the deputy governor, the chair of the local Independent Monitoring Board and the investigation liaison officer. The local branch of the Prison Officers' Association were invited to the meeting but no-one was able to attend. Notices to staff and prisoners were posted that day inviting anyone with information about the man to make themselves known to my colleague. No-one came forward.
2. Twelve members of staff and two prisoners were formally interviewed at Lincoln. Informal discussions were held with eight other members of staff. My colleague also exchanged correspondence with the Governor of HMP Nottingham about events that occurred while the man was there.
3. I also commissioned a clinical review of the management of the man's health needs while he was in custody. This was undertaken by the clinical reviewer on behalf of the local Primary Care Trust.
4. On 14 December 2007, my colleague and one of my Family Liaison Officers met the man's parents in order to ascertain whether there were any matters they wanted the investigation to address. His parents were particularly concerned to discover whether he had been treated fairly by the Prison Service in relation to suspicions that he had behaved improperly towards a female member of staff at HMP Nottingham. This matter is dealt with in the report.

HMP LINCOLN

5. Lincoln is a local prison of Victorian design, situated about two miles from the city centre. The prison receives convicted and remanded adult male prisoners from Magistrates and Crown Courts in Lincolnshire and Nottinghamshire.
6. The accommodation comprises A, B, C, D and E Wings. A Wing holds prisoners on induction as well as those participating in detoxification programmes. One of its landings is for enhanced remand and convicted prisoners. Another landing is the first night centre. B and C Wings hold sentenced and convicted prisoners. D Wing is the segregation unit. E Wing is for vulnerable prisoners. At the time of the investigation, the prison held nearly 700 prisoners, a number well in excess of its accepted operating capacity.
7. At the time of the investigation, healthcare at Lincoln was provided by the West Lincolnshire Primary Care Trust (PCT). (It is now provided by the Lincolnshire PCT.) The healthcare centre offers 24 hour nursing and medical care and has in-patient facilities.
8. The prison was last visited by Her Majesty's Inspectorate of Prisons in December 2007. The following are relevant extracts from the report of that inspection, published in March 2008:

“On our last visit, we noted that both the fabric of the prison and the morale of staff remained damaged by the effects of a serious riot in 2002. On our return for this full announced inspection, we were pleased to find that not only had the damaged accommodation been repaired and brought back into use, but that in most obvious respects, the prison had returned to normality , although there remained plenty of scope for further improvement.

“Fortunately, caring staff - well supported by prisoner Insiders – made good efforts to help prisoners through their early days and a new first night centre had just opened. Suicide and self-harm arrangements were sound, as was clinical support for detoxification. However, prisoners told us that illegal drugs were readily available. This no doubt added to an evident bullying problem, which was a particular issue on the poorly managed vulnerable prisoner unit. The segregation unit was grubby and badly in need of refurbishment.

“The environment was generally clean and bright, particularly the refurbished A Wing, and access to telephones and showers was good. Staff-prisoner relationships were positive. They were supported by an effective personal officer scheme, which is not something we often find in busy local prisons with transient populations....Health services were good, but

healthcare staff were not sufficiently into the work of the prison.

“Lincoln prison has gone through a difficult period, but this inspection found that normality had returned, with both accommodation and staff morale repaired following the disturbances. In effect, the prison had successfully turned a particularly unfortunate page in its history.”

9. The following are extracts from the annual report by the Independent Monitoring Board for the period 1 February 2007 to 31 January 2008:

“Prisoners can be placed on the Assessment, Care in Custody and Teamwork (ACCT) document that is an effective method of recording and caring for prisoners who may be at risk of suicide or self-harm. During the reporting period, 457 documents were opened and 412 closed. Board members monitor these documents on every rota visit and are satisfied that the procedure works well.

“Sadly, it has to be recorded that there were two deaths in custody during the reporting year. It must however be recorded that a large number of lives are saved due to the diligence of staff of all grades. Records show there were 226 incidents of self-harm reported (which do not include prolific self-harmers).

“The Samaritan led Listener scheme trains some prisoners to provide an essential listening service for other prisoners. There are dedicated Listener suites used for this purpose and the scheme is well used to great effect.

“There is a well-regulated anti-bullying/violence reduction policy.

“Prisoners in segregated conditions are located in D Wing staffed by a professional team of officers. Despite many changes in the personnel working in this area, they continue to achieve a high level of care. IMB members attended 100 Good Order and Discipline reviews in accordance with PSO 1700 that considers circumstances surrounding a prisoner being held in segregated conditions.”

KEY EVENTS

Background

10. On 27 June 2007, the man was arrested for interfering with a vehicle and was taken to Bridewell police station in Nottingham. The police doctor examined the man at 1.25pm that day and made a note of his findings in a Detained Person's Medical Form. He concluded that, although the man was showing signs of the effects of drug abuse, he was not currently withdrawing. The police doctor prescribed anti-nausea medication and advised that the man should undergo "routine observations". He judged the man to be fit for detention and interview in police custody. He recommended that the man should be reviewed again at 9.00pm. Although the man was detained overnight, there is no evidence to show whether the recommended review took place.
11. A second Detained Person's Medical Form shows the man was examined again at 11.05am the next day, this time by a second police doctor, who made the following note:

"D/p is oriented to person place and time sia (sic) well perfused and has no obvious injuries at present. Dp has self discharged from QMC after ingestion of 10 bags of heroin 17 and requires immediate return to A&E for further assessment as dp isn't fit for detention at present. QMC are expecting dp today. Medical advice- half hourly observations and further assessment at QMC today."
12. In spite of the above comments, the form shows that the second police doctor ticked the boxes showing that the man was again considered to be detained and interviewed.
13. The man was bailed by the police so that he could attend the Acute Medicine Unit at the Queen's Medical Centre in Nottingham. A consultant made the following note in his file:

"Yesterday swallowed 10 heroin wraps - intention to kill himself. Self d/c (discharge) -court- returned to complete period of obs. No effects clinically of absorption of opiate. Main diagnosis at discharge: Intentional heroin overdose. Follow up: GP."
14. After having discharged himself, the man tried to break into a car parked near the hospital premises. He was seen and later arrested.

HMP Nottingham: 29 June to 5 July

15. On 29 June 2007, the man appeared at Nottingham Magistrates court charged with interfering with a vehicle. He pleaded guilty and was given a sentence of 14 days imprisonment. He was taken to Nottingham prison that day, arriving

at about 5.50pm. The Prison Custody Officer (PCO) who escorted the man between the court and prison, completed a self-harm warning form. This form is used to draw attention to a perceived risk of self-harm or suicide so that the various agencies involved in managing an offender can take steps to monitor the individual concerned. The PCO wrote on the form, "DP (detained person) swallowed 19 bags of heroin yesterday (28.6.07). Seems in good frame of mind at present."

16. A prison reception officer was on duty in reception at Nottingham when the man arrived. He signed the warning form to acknowledge that he had seen it.

First reception health screen

17. The warning form was also signed by the prison reception nurse who carried out the man's first reception health screen. The man told her his date of birth. He said he had been living in Nottingham and was registered with a doctor in Kirkby-in-Ashfield. The man disclosed that he had been released from HMP Ranby earlier in the year. He also said he had seen a doctor recently after swallowing "large quantities of drugs". He had no outstanding medical appointments and was not receiving any prescribed medication. He said he had sustained no physical injuries in recent days and had no concerns about his physical health. The prison reception nurse recorded that the man was "healthy in appearance". She then turned to the subject of substance misuse. The man told her he did not drink alcohol but had taken heroin at a daily cost of £15. He said he had last used heroin three days earlier and had taken cannabis every day.
18. As far as his mental health was concerned, the man told the prison reception nurse he had received psychiatric treatment in the community because of self-harm issues but had never actually harmed himself. He said he had never been in a psychiatric hospital and did not have a psychiatric nurse or care worker. He had never received any medication for mental health problems. The man told the prison reception nurse he did not feel suicidal. The prison reception nurse recorded that the man's behaviour seemed calm and appropriate. At his own request the prison reception nurse referred the man to a doctor for detoxification and to the CARAT (Counselling, Assessment, Referral, Advice and Throughcare) Service. At 6.00pm, the prison reception nurse made the following entry in the man's medical record:

"Inmate seen on reception. Known drug user. Has just been discharged from Queen's Medical Centre (QMC) after swallowing 10 (sic) of heroin to conceal them from cops. Was given laxatives and says he passed them BD. Appears fit and well. No mental health issues. No self-harm/suicide ideation expressed. For substance misuse team and MO (Medical Officer)."
19. As there were no current concerns about self-harm, the man was not made subject to self-harm monitoring procedures. Following his referral to the doctor, the man was placed on the detoxification regime shown in the following tables.

Stabilisation:

Day				Given by (signed)	
	AM	PM	Date	AM	PM
One	-	20mls	29.6.07	-	Officer
Two	10mls	15mls	30.6.07	Officer	Officer
Three	25mls	-	1.7.07	Officer	-
Four	30mls	-	2.7.07	?	-
Five	30mls	-	3.7.07	?	-

Detoxification:

Day six	25mls	-	4.7.07	UHH
Day seven	25mls	-	5.7.07	?
Signed	Illegible			
Name	Illegible			
Date	29.6.07			

20. At 7:00pm the prison reception nurse made the following further entry in the man's medical record: "Contacted ward B3 to confirm about care given. They will look for the notes and get back to us."
21. The next entry was made by a doctor whose signature is illegible. The doctor wrote, "On examination, withdrawal. Plan: methadone detox."
22. The man was released from Nottingham in July. Arrangements were made for him to be given a 25 ml dose of methadone in the morning prior to his release. He was also advised to contact a Drug Abuse Clinic in Nottingham. However, only a little over a fortnight later, the man was back in prison.

Nottingham: 23 July to 27 September 2007

23. In the early hours of 22 July the man was arrested for breaching an Anti-Social Behaviour Order. He was detained overnight in Bridewell Police Station in Nottingham. Whilst there, he underwent a urine test that showed he had taken a Class A drug. An appointment was made for him to undergo a mandatory initial assessment with a drugs worker from the Criminal Justice Intervention Team (CJIT). The investigation found no evidence to show whether that appointment materialised.
24. The next day, the man appeared before Nottingham Magistrates. He was remanded in custody at HMP Nottingham and ordered to return to court on 30 July via video link. He was taken back to Nottingham later that day, arriving at approximately at 2.40pm.
25. During the reception procedures, the man told staff he was single and had no occupation. He said he had been living in the Radford area of Nottingham prior to his arrest. He gave no details of his next of kin.

First reception health screen

26. The prison reception nurse, who had seen the man when he was last received at Nottingham, carried out his reception health screen. The man told her he was not registered with a doctor, but had consulted one during the previous few months. The man disclosed that he was currently taking prescribed medication but did not have any outstanding medical appointments. He said he had not sustained any physical injuries recently and had no concerns about his physical health. The man said he did not drink alcohol but admitted he had used drugs during the previous month. The table below shows which drugs the man said he had used.

Drug	Frequency	Last used
Heroin	On and off	21 July 07
Methadone	Daily	21 July 07
Benzodiazepine		
Amphetamine		
Cocaine/Crack	On and off	21 July 07
Cannabis	Daily	
Other		

The following table shows the results of a urine test the man underwent the same day.

Heroin	Positive
Methadone	Positive
Benzodiazepine	Not tested
Amphetamine	Negative
Cocaine/Crack	Positive
Other	Positive

27. As far as his mental health was concerned, the man told the prison reception nurse he had never been a psychiatric outpatient or inpatient. He said he did not currently have a psychiatric nurse or care worker and had never received any medication for mental health problems. He said he had never tried to harm himself either in prison or in the community and did not feel like harming himself now that he was in prison again. The man did not wish to see a doctor. The prison reception nurse recorded that she had no concerns of any note about the man's behaviour or his mental state. She gave him a health care services leaflet and referred him to a doctor with regard to his substance misuse. The prison reception nurse also referred the man to CARATs. She considered that he was fit for normal location (i.e. for location in a wing rather than in the healthcare centre). As there were no current concerns about his risk of self-harm, formal self-harm monitoring procedures were not invoked.

Substance misuse assessment

28. On 23 July, the man underwent a full assessment by the joint substance misuse team and CARATs. After giving a urine sample, the man tested as follows:

Drug	Result
Amphetamine	Negative
Cocaine	Positive
Morphine	Positive
Cannabis	Negative
Subutex	Positive (One off)

29. The record of the assessment shows the man presented signs of shivering, aches, back pain, watering eyes and yawning. He disclosed that he was used to smoking or taking heroin intravenously at a daily cost of £30 and crack at a cost of £100 each day. He said he had last taken both drugs on the previous Tuesday. Finally, the man told the assessors he smoked cannabis daily and had taken subutex on one occasion. He said he had been placed on a methadone detoxification programme when last in prison and agreed to comply with a methadone treatment plan during his current sentence.
30. A prison officer conducted a cell-sharing risk assessment in conjunction with the prison reception nurse. After interviewing the man they concluded that there were no indications of any risk of self-harm and that it was safe for him to share a cell.
31. On 30 July, the man appeared before Nottingham Magistrates via video-link. As a consequence of the fact that he had offended whilst on bail the magistrates decided to refuse bail on this occasion. The man was therefore remanded in custody and ordered to return to court on 23 August.
32. At about 11.45am on 2 August, the man's cellmate assaulted him in their cell during a game of backgammon. The man sustained minor bruising to his face and lower lip. He was examined by a nurse who gave him a paracetamol tablet but decided no treatment was required.
33. The Legal Services department for Nottingham City Council applied in August for the man to be produced at Nottingham City Magistrates Court for a hearing at 2.15pm on the next day. The council wished to apply for a further ASBO as the man's current interim order was due to expire that day.
34. The man was taken to Nottingham Magistrates court on 23 August. He was sentenced to four months imprisonment for theft from a vehicle and a further consecutive sentence of four months for breach of his Anti-Social Behaviour Order. He became eligible to be released from custody under the Home Detention Scheme on 23 October 2007. His sentence would have expired on 22 December that year.

Alleged inappropriate behaviour towards a female member of staff

35. On 16 September, the following information was entered into the man's security file by a female CARATs worker at Nottingham:

"Over the past two weeks the man has been making inappropriate comments to me with reference to females of interest to a female member of the CARATs team (sic). Initially I thought it was another member of the team. He did not mention names but he stated that he had feelings for and could change for. This was challenged on several occasions. However, on 10 September, he stated his interest was in me. I feel his comments made to me were inappropriate."

36. A security manager later made the following entry in the man's core prison record: "Spoke to prisoner re inappropriate behaviour with female staff. Warned re this and staff to monitor his behaviour and SIR (security information report) any inappropriate behaviour."

37. A prison Senior Officer recorded the following:

"The man has been put on the risk to females register...as his behaviour is not deemed appropriate. I have also informed the man that he will be moving wings. The man stated he knew he was on the risk to females register. However, did not comment on anything else at this time."

38. On 20 September, the prison Senior Officer wrote:

"On informing prisoner to pack his own kit as he is being allocated to D Wing, he has issues there with two other prisoners. They will end up fighting. States he cannot go to D or E Wings because of following inmates: (names withheld)."

39. The Governor of Nottingham later told my investigator that on 14 September, the CARATs worker reported that the man had kissed her. A meeting was convened later that day to decide how to manage the issue. Present at the meeting were the woman concerned and three members of staff, including the woman's line manager. It was decided the man should be warned about his inappropriate behaviour and a male CARATs worker should be assigned to him. On 19 September, it came to light that the man was still trying to see the member of staff. A further meeting was therefore convened that day at which it became apparent that the man was exploiting every opportunity to make contact with her.

40. On 21 September, the man submitted a formal complaint about being placed on the 'risk to females' register. In her response to the complaint, the Head of Residence justified the decision.

41. It was later decided the man should be transferred to another prison. Initially HMP Ranby was chosen but this was later cancelled for operational reasons. As a result of the cancellation, it was decided to move the man to another wing so that he could not see the woman any more. When staff attempted to move him, he became aggressive. He was therefore re-located to the segregation unit. The next day, 27 September, the man was transferred to Lincoln.

Lincoln: 27 September to 26 October

Reception health screen

42. The only evidence in the man's medical record to show that a health screen took place upon his arrival at Lincoln in September is contained in the following entry made that day: "Transferred in from Nottingham on maintenance methadone. To continue. Referred to detox. No dsh (deliberate self-harm) suicide or mh (mental health) issues. In good humour."

Cell-sharing risk assessment

43. A cell sharing risk assessment was carried out by a prison officer and prison nurse as part of the reception procedures. After interviewing the man they considered that he presented a low risk of harming others and they had no concerns about self-harm.

Induction

44. The Chaplain, a CARATs worker and an officer conducted induction interviews with the man. He admitted to using illegal drugs and said his offending behaviour was linked to his drug addiction. He said he had sought help for his drug abuse by using the CARAT service during previous periods of imprisonment. A referral was therefore made to the CARAT service at Lincoln.
45. As far as his domestic circumstances were concerned, the man said his next of kin was his best friend. It is not clear what, if any, contact details were disclosed about his friend. The man said he had no contact with his family since his arrival at Lincoln but did not want anyone to contact them on his behalf.

Interview with Substance Misuse Team

46. On 28 September a member of the Substance Misuse Team at Lincoln, interviewed the man in order to assess what support he needed in relation to his drug abuse. The member of the Substance Misuse Team decided he should continue with his methadone programme until his release from prison.

Application to become a Listener

47. On 8 October, the man applied to become a Listener. In his application form he wrote, "I would like to be a Listener as I've been one before and was waiting to be one at Nottingham and I'm very interested. Check my wing record. Thank you."

48. The man's wing manager commented upon his application as follows:

"The man arrived at HMP Lincoln on 27.9.2007. Since his arrival he has not come to the attention of staff. He has no adjudications at HMP Lincoln and is always polite to staff and other inmates. He shows a willingness to become a Listener at Lincoln and states he held this position at HMP Notts though this is not confirmed."

49. There is no evidence in the man's record to show what, if any, action was taken in respect of his application. The investigation found no evidence to show whether the man became a Listener.

CARATs interview

50. On 11 October the man's CARATs worker made initial contact with him and opened a Drug Intervention Record. A copy of the record was sent to the Criminal Justice Intervention Team (CJIT). The man told the CARATs worker he liked socialising, football and using the gym. He said his life was "not just about drugs". He had been expelled from school when he was 13 and again at 15. At the age of 16 the man had been employed for 18 months as a coalman. This had been his only experience of employment. He told the CARATs worker he was keen to get a job on release but did not know what type of job he wanted.
51. The man disclosed that his drug use was always out of control. He would worry about the prospect of missing a "fix". He said he wished he could stop taking drugs but knew it would be very difficult. He said he depended on committing crimes to fund his drug use. He lived with friends who were aware of his drug use and who would support him if he stopped. He was intent on returning to live with them on release.
52. The man told the CARATs worker he was fully aware of the risks involved in injecting and sharing needles. However, he said he did not inject himself often and was careful when he did. He said he valued his health and had "just finished detox". He said he was currently drug free (i.e. he was not using illegal drugs) and on a subutex "script" (prescription).
53. The CARATs worker told my investigator the man was keen to give up drugs and wanted to join a short duration drug programme. (This is a month-long course designed to counsel those prisoners whose sentence length is too short to enable them to undertake more comprehensive courses.) The CARATs worker set out a care plan for the man in which his attendance on a short duration programme was the principal aim.

Cell-sharing

54. On 13 October another prisoner was located in the same cell as the man. The two prisoners shared the same cell until 24 October when the man was moved to the segregation unit. At interview the prisoner explained he had not met the

man before they were co-located. He said the man appeared to him to be a happy sort of person. The prisoner was a drug addict and knew the man was addicted to heroin and was struggling to become drug free by the time he was due for release. The prisoner stressed he thought the man was not the sort of person to take his own life.

Conversion from methadone to subutex

55. On the same day, the man asked for his detoxification regime to be changed from methadone to subutex. His request was referred to the duty doctor for approval but the investigation found no evidence that this was documented. The nurse from the Substance Misuse Team who discussed the matter with the man told the clinical reviewer that the man wanted to change to the rapid detoxification programme so that he could “work with his partner to assist other drug abusers and addicts”.
56. The methadone prescription was terminated on 14 October and detoxification with subutex was started the next day. Thereafter, the man was given gradually reducing doses of subutex until 23 October when he was due to receive a final dose of 0.4mg.

Comprehensive Substance Misuse Assessment

57. The man underwent a Comprehensive Substance Misuse Assessment (CSMA) on 18 October. The assessment was carried out by the CARATs worker. On this occasion the man said he had used drugs about one month before going to prison. He had only been able to remain drug free in the community when he was employed and in a stable relationship between the ages of 16 and 17. When asked whether there were any situations made worse by his substance misuse, the man said “crime and going to prison”. He told the CARATs worker he used ecstasy and cannabis when he was 13. At age 16 he used heroin but did not like it. He said he therefore avoided its use for 18 months. When he was 17, he started to use heroin again, at times taking it intravenously. By the time he was 20, the man had begun to take crack cocaine. The CARATs worker wrote in the assessment form,

“Though the man has used a variety of substances, they appear to be more of an outward expression of his aggression, anger and frustration (his youthful rebellion) rather than masking deeper emotional difficulties as is so often the case in this client group.”

Telephone calls

58. On 19 October, the man made two telephone calls to different numbers. These were the only two calls he made while he was at Lincoln. Each call was monitored by a member of staff who reported that he sounded happy while on the phone and optimistic about his future.

Found with drug smoking equipment

59. At approximately 10.00am that day, a wing prison officer carried out a routine cell search of the man's cell. During the search, the officer found an inhaler to which was attached some tin foil. (This is the sort of equipment used by prisoners to smoke illegal drugs.) The officer placed the man on report and charged him under Prison Rules for having an unauthorised article. On the notice of report issued to the man, the officer wrote as follows:

“At approx 10.30 hours on Friday 19 October 07, whilst conducting a routine search, I found an insulin needle, five pieces of burned silver foil, an inhaler with foil stuck on the front and a plastic bottle containing an unidentified liquid.”

Disciplinary hearing

60. The adjudication (disciplinary hearing) in relation to this charge was opened on 20 October by the adjudicating governor. In his evidence to the adjudicating governor, the man admitted that the inhaler was his and that he had used it to smoke cannabis. However, he said his cell mate had told him the liquid was orange juice. The adjudicating governor adjourned the hearing so that he could take evidence from the man's cell mate.
61. On Monday 22 October, the hearing was resumed. A second adjudicating governor on this occasion wrote on the record of the adjudication as follows: “To clarify, you have owned up to using the inhaler to smoke cannabis, that your padmate was aware of the bottle found, but know nothing about the foil or needle”.
62. The man agreed with the second adjudicating governor who then wrote,
- “I will adjourn to consult the Discipline Manual. Reconvened. After referring to PSO (Prison Service Order) 2000 paragraph 6.72, it allows me to delete items from the list of unauthorised articles found in your cell. I am therefore deleting the following items found: an insulin needle, five pieces of burned silver foil and a plastic bottle containing an unidentified liquid. This therefore leaves one item – the inhaler – to which you have pleaded guilty. Have you anything to say or add?”

The man said he did not.

63. The second adjudicating governor found the charge proved and gave the man the following punishment:
- 14 days' stoppage of earnings at 50%
 - 14 days' forfeiture of facilities to use his private cash
 - 7 days' loss of association
 - 7 days' forfeiture of the use of his television.

This punishment meant the man could return to his wing.

64. At interview the second adjudicating governor told my investigator that the drug smoking implement found in the man's cell was not sent for forensic analysis. Thus there is no evidence to show what drugs had been used and when. The second adjudicating officer said the man told him he had used the implement to smoke cannabis earlier in his time at Lincoln. The second adjudicating officer also told my investigator that during the adjudication he saw no signs in the man to suggest he was suffering from drug withdrawal or that he was contemplating suicide. The wing officer also said the man showed no such signs during the cell search and during the ensuing adjudication.

Detoxification programme completed

65. On 23 October an entry made in the man's medical record shows he had completed his detoxification programme. However, he refused his last dose of 0.4mg subutex that day.

Events on 24 October

Altercation with prison officer

66. Shortly after 3.00pm on 24 October a prison officer noticed the man leaning over the railing on A4 landing. Knowing that five days earlier, he had been given a punishment that required him to remain in his cell at certain times of the day, the prison officer asked the man to return to his cell. The man replied, "You've got to remember I'm out soon and I know where Gainsborough is." (This is where the man believed the prison officer lived. The investigation found that this was not the case.)
67. The prison officer placed the man on report for using abusive and threatening language. A Senior Officer made the following entry in the man's core prison record that day:

"Very poor attitude especially to the prison officer. He is arrogant to staff and not a person who should be enhanced (i.e. the enhance level of privileges under the Incentives and Earned Privileges scheme). Poor, poor attitude."

The record does not show what time the entry was made.

Alleged assault on a senior officer and transfer to segregation unit

68. At about 8.00pm that day the man rang his cell bell. The Senior Officer responded and later submitted the following report of what happened thereafter:

"I went into A4-10 and asked him (the man) what he wanted. He said he wanted a shower. I explained it was 20:05hrs and he had time for a shower in the afternoon. He became aggressive towards me and made an aggressive move towards

my direction. Two prison officers then restrained him. A third prison officer had his head. I asked him if he was OK and he would be removed to D Wing (the segregation unit). I received a cut to my left hand which was caused by the man assaulting me.”

69. A form F213 (report of an injury to a prisoner) was completed. Information about how the injury was sustained should be written in sections one and two. Comments should be written by a medically qualified member of staff about the prisoner’s injuries.

70. A fourth prison officer wrote in section two,

“At approx 20:05 hrs on 24.10.07 in cell A4-10, PV9382 the man lunged at the SO and was restrained. When first asked in D Wing if he had any injuries, he replied no but after a few moments pointed to his right wrist.

71. A healthcare nurse, who witnessed this incident from the outset, completed section 3 of the form. He wrote,

“The man relocated to seg under restraint. Patient was not on front for longer than 3 mins. Whilst in cell in seg I asked if he was injured which he replied no then maybe. I asked him if he was in pain he pointed to his right wrist and stated it was a little sore. He refused examination stating he would contact his solicitor. On observation, there was no localised swelling or obvious deformity and he was displaying full range of movement.”

72. My investigator interviewed the nurse about this and other matters. The nurse explained that where possible it was the practice of healthcare staff to attend from the outset any incident involving the restraint of a prisoner so that the event can be monitored from a healthcare point of view.

73. The Senior Officer placed the man on report for assaulting him. The Senior Officer made the following entry in the man’s record:

“Inmate located in D wing after altercation on A wing. Brought down in restraint given a strip search and placed in D1-11 not happy very cocky and surly individual who has no respect for staff.”

Segregation safety algorithm

74. Before a prisoner can be segregated, his ability to cope with the effects of segregation has to be assessed through the use of a segregation safety algorithm. The algorithm requires a number of questions to be answered by the assessor. These are set out below.

Question 1: Is the prisoner awaiting transfer to/being assessed for a bed in an NHS Secure setting?

Question 2: Has the person self-harmed in this period of custody/are they on an open F2052SH/ACCT form? Or is the person currently taking any anti-psychotic medication?

Question 3: Does the prisoner show signs of being acutely unwell (e.g. psychotic/withdrawal from drugs/significant physical injury) at the present time?

Question 4: Do you think that the prisoner will be unable to cope with a period of segregation?

The healthcare nurse marked the “no” box in answer to each of those questions. Thus, he judged that the man could cope in the segregation unit and signed the algorithm to this effect.

75. The duty governor of the day telephoned the segregation unit at 8.55pm provisionally to authorise the man’s segregation. The duty governor countersigned the algorithm at 7.30am the next day, thereby formally confirming his authorisation. He noted on the algorithm that he had read the assessment completed earlier by the healthcare nurse.
76. The Night Patrol officer on duty in the segregation unit, made the following entry in the man’s core prison record: “Blocked cell obs window. I had to remove it due to him refusing. Very bad language towards Night Patrol demanding his stuff to be collected so he can have a smoke. Very rude.”

Events on 25 October

77. During the morning of 25 October, the duty governor conducted an adjudication in relation to the charge brought against the man by the prison officer. The duty governor found the man guilty of the charge and gave him three days’ cellular confinement. This punishment was to be completed in the segregation unit. During that period he could not watch television but could have reading and writing materials and have a daily shower and exercise.
78. After the adjudication, the duty governor spoke to the man in his cell. The duty governor later wrote in the man’s record,

“Seen on rounds after adjudication. Received 3 days cc. Made allegations of assault by staff and requests contact with his solicitor. Seg S/o to allow special letter. I will contact PLO (Police Liaison Officer) and security re allegation.”
79. A second entry was made by a member of the security staff, who wrote, “Advised that the police will not be following up on his complaint. Advised that if he wishes to make a complaint he should write to the Governor. 3 x photos taken.”

80. Another entry was made by a member of staff in the segregation unit. She wrote,

“Started day off at adjudication. A little unsettled but soon advised by staff the choices he can make if he accepts help from staff. He was given guidelines and realised his boundaries. Tries constantly to be THE BIG MAN and if allowed could become demanding both in his nature and of staff’s time. He was given his property on E.D. (evening duty) plus all missing items and medication given by nurse. Does not seem to appreciate anything but has shown his attitude can change when he understands clearly what staff are trying to achieve. Did show smiles throughout afternoon and subsequently keeps a clean and tidy cell which he again likes to be on top of.”

Events on 26 October

81. A second Senior Officer was deployed to manage the segregation unit between 8.00am and 5.00pm on 26 October. The second Senior Officer was normally employed as the Voluntary Sector Co-ordinator at Lincoln. She was not therefore a regular segregation unit manager. The second Senior Officer told my investigator that as soon as she arrived in the unit that day, she was given a handover briefing on the prisoners in the unit by a member of staff in the segregation unit who had been on duty since about 7.15am. Apart from the fact that the man was already in the unit and was awaiting an adjudication for an assault to be conducted that morning, nothing of particular note was mentioned during the briefing.
82. The second Senior Officer explained that prisoners in the segregation unit have to apply for showers, telephone calls and exercise so that the staff can coordinate the activities during the day. She recalled that at about 8.30am, the man asked to be allowed to make a telephone call. The second Senior Officer remembered that he said he needed to ring again later on as the person he rang was not available.
83. The second Senior Officer said she saw the man once or twice later that morning. At one stage the man told the second Senior Officer he “had messed up” since being at Lincoln and wanted a fresh start in another prison. The second Senior Officer asked him which prison he would prefer. The man said he had no preference, saying he simply wanted to move away from Lincoln as he had got into too much trouble. The second Senior Officer said the man was smiling at her as he talked to her on that occasion. She emphasised that she had not come into contact with the man before that day. She therefore knew nothing of his background. She told my investigator that at no stage that day did the man give her any reason to think he was contemplating suicide. She said his demeanour was neither odd, nor subdued, nor pre-occupied. The second Senior Officer said he was not pale, sweating, impulsive or moody (the classic symptoms of opiate withdrawal). She described the man as perfectly normal. My investigator put to her the suggestion that it is not uncommon to find that prisoners who appear to be completely normal before they die may

have been suffering from the effects of withdrawal. In such circumstances, they may not be in charge of their mind. The second Senior Officer said that the man gave no such indication.

84. At 9.00am, in keeping with the provisions of PSO 1700, the prison doctor briefly interviewed the man to assess his ability to cope with segregation as he was about to face a further adjudication. The prison doctor signed a further segregation safety algorithm to confirm his opinion that the man was able to cope with segregation. At interview the prison doctor told my investigator this was the first time he had met the man. He said,

“I remember seeing the man as a person in good mood and he was sensible in his answers. I asked him whether he feels fit for adjudication and asked about previous mental history, history of previous mental disorders but he denied any previous problems. So I didn’t feel any concern about his current physical or mental health in the morning before the incident.”

85. At 9.35am the deputy governor opened an adjudication to hear the charge of assault brought two days earlier by the Senior Officer. The deputy governor remanded the case for hearing by an independent adjudicator.

86. At interview the deputy governor told my investigator that at no stage did the man’s demeanour give her any cause for concern. She said,

“He didn’t seem depressed, he didn’t seem down. The main concern he had was...telling me that he wasn’t guilty of the charge that had been laid before him and that he’d got injuries to his hand and his head. His main concern was telling me about those.”

87. My investigator asked the deputy governor if she saw any injuries. She replied,

“No. He had no injuries and I also asked him if he had been seen by the nurse and he said he had but he hadn’t reported it. I did have a conversation with the nurse at a later stage to say, ‘when you saw him initially, did he have any injuries’ and he said ‘no’. And then when they saw him on the morning of the adjudication, I believe he’d got an injury then and they suspected that he may have done it himself, but at the time of the restraint, when seen immediately afterwards, he didn’t present with any injuries at all.”

88. My investigator reminded the deputy governor of the fact that on 19 October, the man had been found in possession of a drug smoking implement and that during the subsequent adjudication, he had admitted using the implement to smoke cannabis. At the time the man was subject to a detoxification programme. My investigator put to the deputy governor the suggestion that when the man was transferred to the segregation unit, he might have been affected either by his use of cannabis or by a change in his detoxification

programme. He asked the deputy governor to explain whether wing staff would have alerted the segregation unit staff of the details of the man's detoxification regime. The deputy governor replied,

"...It wouldn't necessarily be the wing because the wing staff might not know or wouldn't know the details of what medication they are on. It would be Medical in Confidence. For me as the duty governor or the Governor signing somebody on for good order or discipline or making the decision that they can stay in the segregation unit pending adjudication, my expectation would be that healthcare staff would advise me of any issues...that I'd need to be aware of. That should be in addition to what goes on the algorithm, because obviously we go by the algorithm as to whether there's been any history of self harm, if there any mental health issues, whether it's on this sentence, the last sentence or previously in custody etc."

89. At 11.10am, after completing the adjudication, the deputy governor completed a further segregation safety algorithm. When asked about her reasons for doing so, she replied,

"My practice is that if somebody is in segregation and is going to continue and I've got an algorithm there, the doctor or a mental health nurse has to see all the prisoners before the adjudication and complete their part of an algorithm, regardless of whether they are on one already, because it might have been a week. So on the morning of the adjudication, I'll look at that and make sure they are ok and I'm satisfied that the medical staff are saying to me there is no cause for concern as to why they can't come on adjudication..."

90. The deputy governor confirmed that she saw no signs in the man's behaviour to suggest he was suffering from either the effects of taking drugs or from the effects of withdrawal. She described him as quite cheerful and articulate during the adjudication.
91. A segregation unit officer who was also on duty in the segregation unit that morning, confirmed that throughout the morning the man appeared to be in good spirits, making jokes and interacting well with staff. The segregation unit officer said the man was talking positively to staff about his future.
92. In a statement later provided to my investigator a prisoner employed as a cleaner for the unit, said,

"I spoke to the man at dinner time, 11.20. He was talking to me, saying he was leaving tomorrow from the block. I said you must be buzzing. He said can you please get me some fag papers. I said I promise I will get you some after dinner. After dinner I went to the inmate's cell and looked into the spy hole and saw it was dark. I was going to put the light on but I said to myself, he might be asleep so I left him....."

93. At about 11.30am, the man rang his cell bell. A second segregation unit officer responded. The man asked the second segregation unit officer what would happen now that his period of cellular confinement was about to come to an end and his case had been remanded to be heard by the independent adjudicator. The second segregation unit officer told him he would be assessed for his suitability to be returned to normal location but that it was unlikely that he would be returned to A Wing. The second segregation officer added that if the man could not be returned to any of the wings, he might be kept in the segregation unit for the good order or discipline of the prison.
94. During the morning, the man was visited in his cell by the chaplain who noted no concerns about him.
95. My investigator was presented with no evidence to show that a lunch time roll check was conducted.
96. The final entry made in the man's core record was as follows: "Seen on rounds. No problems. Asking about TV. Wing staff to look into this." It is not clear who made that entry or at what time.

Discovery of the man hanging

97. At about 1.40pm, the second Senior Officer went to the man's cell in order to see him about the matters she had discussed with him earlier. The second Senior Officer opened the observation hatch and noticed the cell was in darkness. On closer examination, she saw the man hanging from the cell window, suspended by a ligature made from his bedclothes. The second Senior Officer called for assistance and then entered the cell with the segregation unit officer. The second Senior Officer lifted the man's legs and tried to support his body. She noticed a mark around his neck from the ligature. The second Senior Officer told my investigator the man's eyes were half open and colourless. She said his skin was grey and he did not appear to be breathing. She asked the segregation unit officer to cut the ligature. At the same time, the segregation unit officer used his radio to call for assistance from the healthcare centre. He did so by using a code system in use for life threatening situations. He and the second Senior Officer then placed the man on the floor and began to administer cardio-pulmonary resuscitation (CPR). The second Senior Officer applied chest compressions while the segregation unit officer breathed into the man's mouth. At one stage, the second Senior Officer heard a noise and thought the man was breathing.
98. Moments later, the Orderly Officer arrived at the cell. The second Senior Officer asked the Orderly Officer to call an ambulance. (The log of events kept by the prison shows that an ambulance was requested at 1.44pm.) At the same time three nurses arrived and relieved the second Senior Officer and the segregation unit officer.
99. The prison doctor also arrived at the cell with emergency first aid equipment at about the same time. He later made the following record of events:

“Arrived approx 13.46 to the cell in the segregation unit and found members of healthcare doing CPR. On examination, pupils fixed dilated no signs of breathing or pulse. Face was cyanosed. I made an effort to cannulate his left hand but unsuccessfully. Cardiac rhythm was assessed with defibrillator and it showed asystole which did not indicate defibrillation. Paramedics arrived 13.57 and took over the resuscitation. After about 27 minutes of resuscitation, with no signs of life, at 14.07 I pronounced him dead.”

Death was also confirmed by one of the paramedics.

100. At interview the prison doctor told my investigator,

“When I entered the cell, there were no signs of life and I could not recollect whether rigor mortis was present, but after assessing him, I could find no pulse. Dilated fixed pupils, cyanotic skin on his face probably due to strangulation more than suspecting other cause, and I remember seeing a mark from strangulation as well. So on entering the room, there were signs of clinical death and it’s difficult to predict about length of it, so most likely it happened within the last half an hour.”

101. The second Senior Officer told my investigator that no-one had brought a defibrillator to the cell. My investigator asked the prison doctor whether the initial absence of a defibrillator might have affected the outcome. He said he did not think so as there were signs of clinical death on his arrival at the cell.

Informing the man’s next of kin

102. As the man gave no details of his next of kin when he was first received in prison, difficulties were experienced in ascertaining who his next of kin was and where they lived.

103. The prison’s Family Liaison Officer (FLO) was the Governor’s secretary. She was on leave at home when the man died. However, at about 2.00pm, she received a call asking her to attend the prison. The FLO arrived at 2.10pm.

104. At about 2.48pm, the FLO telephoned the man’s probation officer and asked if she knew who was the man’s next of kin. The probation officer was able to confirm that the man’s mother lived in a town in Derbyshire but did not know her address. The probation officer said she knew the telephone number of the man’s uncle. She gave the FLO two addresses from the man’s probation file but emphasised that she did not know who lived at either place.

105. The FLO decided to take advice from the Police Liaison Officer (PLO) for the prison as to who occupied the addresses given by the probation officer. The enquiries made by the PLO revealed only the family name of four people who occupied one of the addresses given. However, the PLO could not confirm whether they were related to the man. The FLO therefore rang the man’s

solicitor who gave her the telephone number of a relative. The FLO rang that number but there was no reply. By this time over two hours had elapsed since the man was pronounced dead.

106. The Governor decided that attempts should be made to contact the man's best friend whose mobile telephone number was recorded in his prison file. At about 4.45pm, the FLO rang the friend. She explained that she needed to trace the man's family and asked him if he could help. The man's friend said he was the next of kin and said the man had not had any contact with his family for some time. The FLO therefore broke the news of the man's death to his friend. He became very distressed and asked to be allowed to collect himself and to ring the FLO back. Five minutes later, he rang back. He told the FLO he had received a letter from the man only that morning and had visited him a week earlier. He said the man had given him no indication that anything was wrong. The man's friend suggested to the FLO that she should call two other friends of the man's who might be able to help her trace his family.
107. At 4.54pm, the PLO telephoned the FLO to confirm the correct address and two telephone numbers for the man's uncle. The FLO rang both numbers but again there was no reply. The FLO was then called by the person operating the prison switchboard who told her he had been telephoned by the man's cousin. The FLO called that number and spoke to the man's brother-in-law. The FLO asked him to pass a request to the man's uncle to ring her as soon as he could. At 5.35pm, the man's uncle telephoned the FLO. She broke the news of the man's death to him. He agreed to pass the news to other family members in his own time.
108. Arrangements were made for members of the man's family to visit his cell at their convenience.

Support for staff and prisoners

109. A member of the prison's care team made herself available to speak to the second Senior Officer, the segregation unit officer and all other staff who had been involved in discovering the man hanging and in attempting to save his life.
110. At about 2.30pm the deputy governor convened a meeting of the staff in order to allow them an opportunity to explain what they had done. At the end of the meeting all those present were offered the services of the care team and were reminded of the telephone number of the "Care First" confidential facility. The staff my investigator interviewed expressed their satisfaction with, and gratitude for, the care they were offered.
111. One of the Senior Managers personally informed every prisoner located in the segregation unit of the man's death. All prisoners were offered an opportunity to speak to a Listener or to the Samaritans, or to the Chaplain. The senior manager also arranged for any prisoner currently subject to formal self-harm monitoring procedures to be reviewed that day in light of the man's death.

Funeral arrangements

112. The man was cremated in November 2007. With the agreement of the man's family, representatives from the prison attended the service. Flowers were sent from prisoners and staff. The full costs of the funeral were offered by the Governor.

ISSUES

113. Here I examine the following:

- Whether the man's health needs were properly met whilst he was in custody at Nottingham and at Lincoln
- Whether the decision to transfer the man from Nottingham to Lincoln was appropriate and fair
- Whether the man was appropriately managed while he was in the segregation unit at Lincoln
- Whether the man's risk of suicide was properly assessed at Nottingham and at Lincoln
- Whether the response to the discovery of the man hanging was prompt and effective
- Whether appropriate courtesies were extended to the man's family in the aftermath of his death.

Were the man's health needs properly met while he was in custody at Nottingham and Lincoln prisons?

114. Here I rely heavily upon the findings of the clinical reviewer whose report can be found at Annex 1. The reviewer's key findings and conclusions are:

- The man had a well documented history of multiple drug abuse and was managed for most of his period in custody with methadone maintenance therapy.
- There was no past evidence of self-harm or suicidal ideas and no history of mental health problems.
- Two weeks before his death the man requested and underwent rapid detoxification from methadone using buprenorphine (subutex).
- There is published evidence that rapid detoxification from methadone can result in both physical withdrawal symptoms and the precipitation of psychosis with abnormal behaviour patterns.
- There was no reported evidence of physical withdrawal symptoms during the detoxification period and nothing to suggest the development of a mood disorder or psychosis.
- There was a reported deterioration in the man's behaviour during the detoxification period, culminating in the alleged physical assault of a male Prison Officer and verbal aggression towards a female officer. This behaviour resulted in the man being transferred to a segregation cell.
- The man's aggressive behaviour appeared to be directed towards Prison Officers and not towards other prisoners or members of the substance misuse team.
- It has been suggested that the man's aggressive behaviour was precipitated by frustration relating to his request for a prison transfer.
- Drug smoking equipment was found in the man's cell shortly before his death but there was no evidence of illicit drug use in the toxicology report.
- The standard of documentation in the prison medical records was adequate, with a daily evaluation and report of the man's physical and mental wellbeing.

- All daily contacts with the substance misuse team were recorded and there was repeated reference to the man's contentment with his drug management. There was no documentation of the reason for converting him from maintenance therapy to detoxification.
- The man had little documented contact with the medical and healthcare nursing staff and they were not directly involved in his drug therapy regimens.
- There is no obvious clinical explanation for the man's hanging, with no evidence of mental disturbance, depression or ideation of self-harm prior to the act.
- Comment has been made about the delay in resuscitation equipment arriving at the man's cell. This is unlikely to have contributed to the unsuccessful resuscitation attempt.

The reviewer makes two recommendations, which I endorse:

Prisoners who elect to undergo detoxification should have the reasons for this decision fully documented and reviewed during the detoxification process.

There should be readily available psychological support for prisoners who elect to undergo detoxification, particularly if the process is rapid as in the man's case. Regular review should be undertaken and documented.

Was the decision to transfer the man from Nottingham to Lincoln appropriate?

115. At consultation stage, the man's family expressed their concern that he may not have been treated fairly by being transferred from HMP Nottingham to HMP Lincoln. They thought his transfer had an adverse effect on him.
116. The investigation found that the decision to transfer the man was based entirely on a claim made by his female CARATs worker that he had behaved improperly by making advances towards her. The man was initially warned about this but he continued to exploit every opportunity to see her despite being assigned a male CARATs worker, being sacked from his job as a cleaner and being placed on the 'risk to females' register. On 25 September, an attempt was made to move the man to a different wing. However, he became aggressive and was moved to the segregation unit. Two days later he was transferred to HMP Lincoln as this was the only prison that could offer him a drug misuse programme.
117. The man's family made available to my investigator extracts from a diary the man had kept whilst in prison. In it were some graphic descriptions of alleged lewd activities between him and the woman concerned. The man's family believed these suggested that both were equally guilty of improper behaviour.
118. The investigation conducted by the Governor found no direct evidence of any improper behaviour on the part of the woman. She had acted appropriately in immediately reporting the man for making advances towards her. Although it is not clear to what extent the man was given an opportunity to explain himself, there was plenty of evidence that after initially being warned to stay away from

the woman, he continued in his efforts to see her. In my view, it was not possible for anyone at HMP Nottingham to prove that the claims of lewd behaviour between them as recorded in the man's diary were true.

119. In these circumstances, I am satisfied that the Governor of Nottingham managed this episode appropriately and that his decision to transfer the man was reasonable.

Was the man appropriately managed in the segregation unit at Lincoln?

120. Policy guidelines for the management of prisoners in conditions of segregation are contained in Prison Service Order (PSO)1700. The principal components of that policy are as follows:

- Within two hours of being segregated, an initial segregation safety screen should be completed by a registered nurse or a doctor.
- The Governor must authorise initial segregation for up to 72 hours.
- Prisoners who are held in segregation must be visited by prison management and by others who work in the prison.
- All prisoners who are segregated should have a Segregation History sheet opened for them.
- At least the following people must visit and speak to all staff and prisoners in the segregation unit:
 - a. operational manager
 - b. the person in charge of the prison (at least once per week)
 - c. members of the Independent Monitoring Board
 - d. a member of the chaplaincy team

Segregation safety screen

121. The man's ability to cope with the effects of segregation was assessed on three occasions: once on 24 October when his segregation was initiated, again on the morning of 25 October and finally on the morning of 26 October. On each occasion, the assessor was required to note whether the man was showing any signs of being unwell because of withdrawal from drugs or for other reasons. Each time the assessor judged that the man was showing no such signs. None of the members of staff involved in the assessments was given any reason to doubt the man's ability to cope with segregation or with the punishment of cellular confinement. I am satisfied that staff complied appropriately with PSO 1700 in this regard. I am also satisfied that, in the circumstances, the punishment of cellular confinement was not unduly harsh. The man had been rebuked by an officer for being out of his cell when already under a punishment of loss of association. His response was to make implied threats to her safety.

Authorisation of segregation

122. As the man was initially placed in the segregation unit because he had offended against Prison Rules, no formal authorisation for his segregation was necessary other than through the adjudication process. However, verbal authorisation was given by the duty governor. I am satisfied that the procedures at the two adjudications held on 25 and 26 October respectively were correctly followed and the decisions as to the man's retention in the segregation unit were appropriate.

Segregation reviews

123. PSO 1700 sets out the following policy for segregation reviews:

"The period of initial segregation under Prison Rule 45 (i.e. for the good order of the prison) without a review board is for a maximum of 72 hours."

My investigator was told that had the man not died, a review board would have met on 27 October - the day his period of punishment would have expired - in order to consider whether he should remain in the unit. I consider this to be appropriate in the man's case.

Access to regime facilities

124. The man's status in the segregation unit was that of a prisoner subject to cellular confinement and awaiting a hearing by an independent adjudicator for an alleged offence of assault against a member of staff. PSO 1700 sets out the following requirements for those prisoners subject to cellular confinement:

"The regime to which a prisoner will have access if he is serving a period of cellular confinement as part /all of a disciplinary award under Prison Rule 55(e) will be as laid down in the Prison Discipline Manual (Chapter 7):

"(para 7.21) Prisoners serving a punishment of cellular confinement will be located in an ordinary cell set aside for the purpose. A bed, bedding, a table and a stool or chair must be provided in the cell and there must be access to sanitary facilities at all times. Other furnishing and fittings may be provided at the governor's discretion.

"(para 7.22) Prisoners serving a punishment of cellular confinement will be allowed all normal facilities except those which are incompatible with cellular confinement unless a punishment of forfeiture of those facilities has also been imposed. Facilities which should normally be compatible are a reasonable number of personal possessions, cell hobbies and activities, entering public competitions and own clothes and footwear where these have already been allowed. Facilities which will normally be incompatible are use of

canteen, use of private cash (although exceptions might be needed, for example to send money home or to purchase replacement radio batteries, phone cards or postage stamps) and association.

“(para 7.23) Prisoners entitlements to correspond, to exercise, and to make applications to the governor, seconded probation officer, chaplain and Independent Monitoring Board, are unaffected by cellular confinement. Prisoners will be allowed to attend the main service of their religion unless prevented under Standing Order 7A. Prisoners will be allowed to have books within the limits set out in Standing Orders. Visits and access to a telephone should be allowed unless the prisoner’s behaviour and attitude make removal from cellular confinement impracticable or undesirable. Visits should take place at a time or place away from other prisoners.”

125. As the man was awaiting a hearing by an independent adjudicator, it would have been both impractical and inappropriate to allow him to serve his three day period of cellular confinement in any location other than the segregation unit. My investigator was told that as the man was held in the segregation unit under punishment rather than for the good order of the prison, and as he was only held there for less than 72 hours, no formal history sheet was opened.
126. Scant documentary evidence was available to show what facilities and activities the man could access during that period. The punishment of cellular confinement included the withdrawal of his television. However, it is not clear whether he was given any books to read or whether he had anything in his cell to distract his attention away from his plight. I consider this to be a crucial factor in the management of prisoners undergoing periods of cellular confinement, especially since the absence of such materials can have an adverse effect on their mental health.

The Governor should ensure that in the case of any prisoner located in the segregation unit, proper records are kept to show the full range of activities and facilities afforded.

Visits by officials

127. Paragraph 7. 24 of the Prison Discipline Manual sets out the following further requirement:

“A prisoner serving a punishment of cellular confinement must be observed by an officer at least once an hour and must be visited by the chaplain. The governor or an operational manager above the grade of principal officer must visit all prisoners in cellular confinement daily. Where there are concerns about the potential deterioration of a prisoner’s mental health, they should be drawn to the attention of healthcare staff. A doctor must visit each prisoner as often as their individual needs dictate. Visits must be made to

such prisoners on all other days by a healthcare professional (e.g. qualified nurse). At each visit, the doctor or nurse must assess the prisoner's physical, emotional and mental well being and whether he or she is sufficiently fit for the punishment to continue. A note of each visit must be made in the patient's medical record. If there are concerns about the prisoner's state of health, the issues must be discussed with the rest of the healthcare team. Where the healthcare team considers that there are clinical reasons why the punishment should not continue, they must inform the duty governor/in-charge governor, who must fully consider and act on the advice of the healthcare team."

128. On 24, 25 and 26 October the man was visited, as required, by the duty governor, chaplain, and the doctor or a nurse. No concerns were noted. Although the doctor made comments about the man in the segregation safety algorithms, there is no evidence that he wrote anything in the man's medical record.

The PCT should ensure that contemporaneous entries are made in the medical record of any prisoner subject to cellular confinement following visits by qualified medical practitioners.

129. The investigation found no evidence that the man was observed at least once an hour by an officer, as required by PSO 1700. It is known that on the last day of his life, the man was seen at 11.30am, after his adjudication, by the second segregation unit officer. On that occasion, the second segregation unit officer said the man was not cheerful but was accepting of his situation. The second Senior Officer told my investigator that the man took his lunch that day. A member of staff in the segregation unit confirmed that the meal was served at 11.30am. It is possible that the man was not observed again before he was found hanging at 1.40pm.

The Governor must ensure that, in keeping with the provisions of PSO 1700, all prisoners subject to cellular confinement are observed by an officer at least once an hour and that a record of each observation made is entered into the appropriate history sheet and segregation unit diary.

130. That said, it is clear that the man was seen by different disciplines during his brief time in the segregation unit. I am satisfied that the provisions of PSO 1700 were adequately met and that the management decisions made in respect of the man were appropriate.

Effects of detoxification

131. In her clinical review the clinical reviewer reports as follows:

"During his periods of imprisonment the man's drug addiction was managed by the Substance Misuse Team with methadone maintenance. Two weeks before his death the man requested conversion from maintenance therapy to methadone to detoxification using subutex (buprenorphine). The reason

given by the man for a change from maintenance therapy to a detoxification programme was his stated desire to work with a person whom he described as his partner, who was already involved in work with drug abusers and addicts. He underwent a rapid detoxification programme, shortened to 8 days at his request. During this period, there appears to have been a marked deterioration in the man's behaviour, with two reported incidents of aggression towards Prison Officers. There were no reported physical signs of drug withdrawal during this period. The man was seen daily by a member of the Substance Misuse Team and reported no problems with his rapid detoxification. The key worker from the team confirmed that the man was happy that he had managed to detoxify and there was no evidence of mental disturbance."

132. The clinical reviewer acknowledges the existence of published evidence that rapid detoxification from methadone can result in both physical withdrawal symptoms and the precipitation of psychosis with abnormal behaviour patterns. However, she found no reported evidence of physical withdrawal during the man's detoxification period and nothing to suggest the development of a mood disorder or psychosis.
133. Although I concur with the reviewer's conclusions and therefore make no formal recommendation on this subject, I cannot overstate the importance of ensuring that prisoners who may be detoxifying are carefully assessed before being placed in the segregation unit and are closely monitored once there. My investigations into the deaths of other prisoners in segregation units have often highlighted a link between the fact of their detoxification and their mental health.

Was the man's risk of suicide properly assessed at Nottingham and at Lincoln?

134. Prior to his imprisonment on 29 June 2007, the man swallowed a large number of heroin "wraps". There is some doubt as to his motives for doing so. The medical forms completed while he was in police custody carry the comment that he did so as a deliberate act of self harm. Consequently, a Prisoner Custody Officer raised a self harm warning form to alert prison staff to the possibility that the man was at risk. The decision to raise this form was, in my view, entirely appropriate. However, the man later told a member of prison staff that he swallowed the heroin to avoid detection by police. I am persuaded that this, rather than an attempt to kill himself, was likely to have been his intention.
135. An assessment of his risk of self-harm was carried out when he arrived at Nottingham. No current risk was identified. As a result, there was no need to invoke self-harm monitoring procedures. The man showed no suicidal tendencies during the two week period he spent there prior to his release on 5 July. This was also the case during his second period at Nottingham between 23 July and 27 September.

136. A brief entry made in his medical record when the man arrived at Lincoln shows that there were no concerns about any risk of self-harm or suicide at that stage. On the contrary, he was described as being in good humour, despite having been removed from Nottingham because of his behaviour towards a female member of staff.
137. During the initial stages of his period at Lincoln, the man behaved well and gave no indication that anything was troubling him. However, his behaviour deteriorated significantly two days before he died. He became disrespectful towards a female officer and allegedly assaulted a male senior officer. This led to his transfer to the segregation unit. On the day of his death, he mentioned that he wanted to move to another prison. His only explanation was that he had “messed up” at Lincoln. However, it is clear that even at this stage, the man showed no obvious signs that he was contemplating suicide.
138. I believe the man’s risk of suicide was satisfactorily assessed both at Nottingham and Lincoln. I conclude that there were no grounds upon which staff could reasonably have been expected to initiate formal self-harm monitoring procedures.

Was the response to the discovery of the man hanging prompt and effective?

139. The man was found hanging at approximately 1.40pm on 26 October by a Senior Officer. She entered the cell in the company of a prison officer without hesitation and called for assistance at the same time. Together they supported his body and cut the ligature without delay. Once this had been done, CPR was administered. An ambulance was requested within four minutes and a paramedic crew arrived at the cell within 17 minutes. The Senior Officer, the officer, prison nurses and the prison doctor made determined and sustained efforts to save the man’s life but, sadly, without success. Death was pronounced at 2.07pm.
140. I am satisfied that staff acted promptly once the man was discovered hanging. There was no undue delay in removing the ligature or in administering CPR. An ambulance was called within four minutes of the discovery and the response time achieved by the paramedic crew was in keeping with normal expectations.

I believe the discipline staff, healthcare staff and the paramedic crew did everything possible to try to save the man’s life, in harrowing circumstances. I commend them.

141. My investigator was told that no defibrillator was taken to the cell with the rest of the emergency first aid equipment after the initial alarm had been raised. The prison doctor said he thought the absence of this piece of equipment would not have affected the outcome as there were signs of clinical death on his arrival at the cell.
142. Although I am satisfied with the prison doctor’s judgement, I take the view that the failure to make a defibrillator available at the outset in any future emergency might jeopardise the chances of saving a life.

The Governor should ensure that the full range of emergency equipment, including a defibrillator, is taken to a life threatening emergency as a matter of course. Contingency plans should make this clear and key staff should receive appropriate training.

Were appropriate courtesies extended to the man's family in the aftermath of his death?

Informing his next of kin of his death

143. No details of the man's next of kin were recorded in his prison record at Lincoln because he had refused to disclose them when he was first received in prison. This caused immense difficulties when it became necessary to inform the man's family of his death. However, it was achieved three and a half hours after his death was pronounced. The man's family were most appreciative of this.

I congratulate the Governor's secretary, who acted as Family Liaison Officer, for this achievement.

I nevertheless recommend that the Governor should ensure every effort is made to encourage prisoners to disclose details of their next of kin as part of the reception and induction procedures.

Funeral arrangements

144. The man was cremated at Mansfield Crematorium in November 2007. With the agreement of the man's family, representatives from the prison attended the service. Flowers were sent from prisoners and staff. The full costs of the funeral were offered by the Governor.

RECOMMENDATIONS

At consultation stage, the Prison Service rejected none of the following recommendations:

Management of prisoners in the segregation unit

1. The Governor should ensure that in the case of any prisoner located in the segregation unit, proper records are kept to show the full range of regime activities and facilities afforded.
2. The Governor, in conjunction with the PCT, should ensure that contemporaneous entries are made in the medical record of any prisoner subject to cellular confinement following visits by qualified medical practitioners.
3. The Governor must ensure that, in keeping with the provisions of PSO 1700, all prisoners subject to cellular confinement are observed by an officer at least once an hour and that a record of each observation made is entered into the appropriate history sheet and segregation unit diary.

Emergency first aid equipment

4. The Governor should ensure that the full range of emergency equipment, including a defibrillator, is taken to a life threatening emergency as a matter of course. Contingency plans should make this clear and key staff should receive appropriate training.

Next of kin details

5. The Governor should ensure every effort is made to encourage prisoners to disclose details of their next of kin as part of the reception and induction procedures.

Congratulatory

6. I congratulate the Governor's secretary, who acted as Family Liaison Officer, for tracing and breaking the news of the man's death, within three and a half hours of death being pronounced despite the immense difficulties she encountered.

Commendation

7. I believe the discipline staff, healthcare staff and the paramedic crew did everything possible to try to save the man's life, in harrowing circumstances. I commend them.

Good practice

8. The policy adopted at Lincoln requiring a representative of the healthcare staff to attend from the outset any incident involving the restraint of prisoners is in my view an example of good practice.