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

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

This is a report into the death of a man. The man, who was aged 27, was found hanging in his cell at HMP Lincoln in December 2007. He had been recalled to custody for breach of licence in September 2007 but had only surrendered to police in December. He had thus been in custody for just two days before his death.

I would like to offer my sincere condolences to his family and friends for their loss.

The investigation was undertaken by an investigator. We would both like to thank the Governor of Lincoln and his staff for their participation and assistance. The clinical reviewer conducted a most thorough and helpful clinical review, and also jointly interviewed some prison staff with the investigator.

Given that the man had only been at Lincoln for two days. I cannot see that staff could reasonably have been expected to have done more to have prevented his death. He gave no indication of his feelings or of his intentions. On the contrary, he presented himself well to staff and no-one was concerned about him. However, information had been recorded two years earlier in his OASys report which indicated that he was at risk of harming himself, but this report was not seen, nor acted upon, by anyone at Lincoln.

I make three recommendations to the Governor and the clinical reviewer makes four recommendations which I also endorse. The clinical reviewer also highlights three areas of good practice in his clinical review.

I must apologise for the delay in issuing this report. After completing an earlier draft, my investigator wanted to re-visit issues regarding the man's probation report and this took some time.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2009**

CONTENTS

SUMMARY

The man was 27 years old when he died at Lincoln prison. He had only been there for two days when he was discovered hanging in his cell in December 2007.

The man had been recalled to prison after breaching his licence conditions in September 2007. He was returned to prison the same day.

During the reception process at HMP Lincoln, he gave staff no cause for concern and appeared relaxed. He told staff that he had been in prison before and knew what to expect. Based on his behaviour and the responses he gave, the nurse in reception who carried out the health screening did not assess him as being at risk of harming himself. However, as he had been violent during previous periods of imprisonment, his Cell Sharing Risk Assessment was that he was a high risk to others and he was allocated a single cell. He was placed in J wing, which usually accommodates prisoners on short duration drug treatment programmes. It was the only wing to which he could be allocated as there were no other single cells available in the prison. Despite this he did have an induction, which included information about his canteen, in cell television and race equality at the prison, amongst other things. Also, although undated, his canteen form is stamped to say that he had been 'seen by the First Night Centre'.

During his two days at Lincoln, the man did not come to the attention of staff and appears to have kept himself to himself. He spoke to a couple of prisoners on the wing, and had a conversation the night before he died about how much of his sentence he was likely to serve.

As it was approaching Christmas, the regime was slightly different to usual. Education courses had ended for the Christmas break and the workshops had closed. This meant that prisoners spent longer out of their cells on association on the wing.

On a day in December, prisoners were unlocked at approximately 1.45pm for association after lunch. The man was seen out of his cell only briefly by another prisoner. At approximately 2.50pm, the same prisoner noticed that he had been standing in the same position every time he had walked past his cell. He looked and then went inside and saw that he had tied a ligature around his neck and attached it to the bars of the cell window. The prisoner checked for signs of life but could not find any and immediately alerted staff.

Staff tried to resuscitate the man and continued Cardio Pulmonary Resuscitation (CPR) until the paramedics arrived. They attached a defibrillator and carried out their own checks for signs of life, but found none. The prison doctor arrived almost immediately after the paramedics and pronounced him dead at 3.02pm.

THE INVESTIGATION PROCESS

1. I appointed an investigator to conduct the investigation on my behalf. Notices were issued both to prisoners and staff inviting anyone who had information relating to the man's death to make themselves known to her. However, no additional witnesses came forward.

2. The man's prison records, including his medical records and police statements (taken after he died), were made available to the investigator. All of these documents were forwarded within a week of her initial visit on 4 January 2008.

3. The investigator visited Lincoln to carry out taped interviews with staff on 26 and 27 February 2008. The interviews on 26 February were jointly conducted with the clinical reviewer, a General Practitioner and Clinical Governance Advisor to the local Primary Care Trust (PCT).

4. One of my Family Liaison Officers (FLOs) contacted the man's family to explain the role of the Prisons and Probation Ombudsman and to offer them the opportunity to participate in the investigation process. The man's father told the FLO that he was concerned about the lack of contact his family had received from the prison, and he was not happy with the prison liaison at all. He had been told that the prison chaplain would conduct the man's funeral, but in the event he had been unable to do so. The family also felt let down by the prison, as they were told certain members of staff would go to the funeral but they did not then attend.

5. The man's father also explained to the FLO that the prison told him they would pay funeral costs up to £2,000. However, when he later gave them the invoice from the undertakers, the prison said they would only pay £1,400. The man's father said he was disappointed that he had not been told beforehand that there were specific items, such as wreaths, that the prison would not pay for. The investigator was subsequently given a copy of the Funeral Director's invoice by the prison, which was sent direct to the prison's Family Liaison Officer. The investigator is aware that the prison paid £1,600 of the £1,651.50 invoice. A letter from the Governor to the man's family representatives, dated 10 April 2008, reiterated that the prison's FLO had explained that the prison would pay for the cost of the funeral, up to £2,000, although certain items such as flowers and tributes in the newspaper were excluded. However, the Governor agreed to consider other funeral expenses incurred by the family.

6. The man's family had asked for the last picture of him, taken from his prison records, to be sent to them. The man's father was unhappy about the length of time this took and that he had to make several requests for it.

7. My investigator was also asked to look at how the man was assessed when he arrived at Lincoln and why he was not watched more closely. His father also wanted to know how long association was and how the man was able to take his own life during that time. The man's father told the FLO he felt the Prison Service had let his son down. My investigator agreed to look into these issues.

8. Howells, the firm of solicitors acting on behalf of the man's family, wrote to the investigator asking her to clarify whether he was seen by a nurse on the morning he died. After making enquires to the new Head of Healthcare at Lincoln, the investigator received a letter explaining that normal practice would be not to record if a prisoner is seen by a nurse if they merely ask for advice for symptoms or for general malaise. The investigator passed a copy of this letter to Howells. They replied on 26 June to say that if this was the case, it was evidence of a systematic failure to properly document a prisoner's medical record and a recommendation should be added to suggest this practice is reviewed. The investigator agreed and a further recommendation has been made.

9. The final report was originally issued in October 2008 but as it has now been amended, with another recommendation added, it has been re-issued. All parties were given a further 28 days to respond to the report.

HMP LINCOLN

10. HMP Lincoln is a category B local adult male prison. Built in 1872, it receives prisoners direct from courts across the East Midlands. It also receives serving prisoners transferred in from other establishments and has the capacity to hold a maximum population of 738.

11. There are four residential units. A wing incorporates the First Night Centre and holds prisoners on induction and those participating in detoxification programmes. Prisoners new to Lincoln are usually allocated to A wing/ first night centre. B wing holds sentenced and convicted prisoners, and C wing holds remand and convicted prisoners. D wing is the segregation unit, E wing is designated for vulnerable prisoners and J wing has accommodation for prisoners participating in short duration drug treatment programmes. The healthcare centre has in-patient accommodation.

12. There have been 11 deaths at Lincoln prison since 2004 when I first began investigating all deaths in prison custody. Three deaths have occurred since the man died in December 2007, all of which have been apparently self inflicted.

Anti-ligature knives (fish knives)

13. Anti-ligature knives, also known as ‘fish knives’ (because of the shape of the knife) or ‘cut down tools’, are specially designed to cut ligatures.

Assessment, Care in Custody and Teamwork (ACCT)

14. ACCT requires any member of staff who identifies concerns about a prisoner they believe to be at risk of suicide or self harm to take action and to record those actions. The ACCT document should be available to all staff where the prisoner is located, including workshops and visits. Within 24 hours of an ACCT being opened, the prisoner is seen by an assessor and has a case review meeting. ACCT reviews are held at appropriate intervals and are attended by the prisoner and a case manager, together with other members of staff.

Cell Sharing Risk Assessment (CSRA)

15. In order to ensure that a prisoner who may pose a threat to other prisoners (for example, a violent or racist prisoner) is not located in a shared cell, a risk assessment is carried out. The CSRA form is completed by a reception officer when a prisoner first arrives, and the form is countersigned by a nurse.

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

16. There are drug workers in most prisons from organisations specialising in the treatment of substance abuse. CARATs workers run programmes, and offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATs is voluntary. A Charter of Rights and Responsibilities for prisoners who use the CARATs service is included as an annex to this report.

Her Majesty's Chief Inspector of Prisons' report

17. HM Chief Inspector of Prisons carried out an announced inspection of HMP Lincoln from 3 to 7 December 2007. With regard to new prisoners, she commented as follows:

> "Fortunately caring staff – well supported by prison Insiders made good efforts to help prisoners through their difficult early days and a new first night centre had just opened. Suicide and self-harm arrangements were sound, as was clinical support for detoxification."

Independent Monitoring Board (IMB) report

18. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the Prison Service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and flagging up areas of concern.

19. The Lincoln IMB's latest report covers the period 1 February 2007 to 31 January 2008. When referring to safer custody, the Board noted that 457 ACCT documents were opened during the reporting period and 412 were closed. There had been two deaths during the reporting year (one of which was the death of the man) and 226 reported incidents of self harm. The IMB also said that the Listeners scheme was well used and there was a well regulated violence reduction policy.

Insiders

20. Insiders are experienced prisoners who welcome new prisoners, highlight any concerns they may have and explain the processes they may encounter during the early days of their custody.

J Wing

21. J Wing normally houses prisoners on short duration drug treatment programmes. However, Lincoln sometimes uses this wing to locate new prisoners if there are no available cells elsewhere in the prison.

Licence recall

22. Once released, prisoners can be recalled to prison if they breach the conditions of their licence.

Listeners

23. A number of prisoners at each prison are trained and supported by the Samaritans to be Listeners and to offer peer support. Other prisoners can speak to Listeners in confidence about any issues that affect them. Listeners are bound by confidentiality rules, like the Samaritans, and are unable to disclose any details about conversations they have had (unless it is a matter which affects the security of the prison).

Offender Assessment System (OASys) report

24. OASys reports are assessments completed by the Probation Service in advance or after a court appearance. Each report provides information regarding the offence and personal details (including accommodation, financial status, education, relationships and lifestyle), and includes a risk of harm summary.

Prisoner Escort Form (PER)

25. The Prisoner Escort Form is a record made by the escorting contractors who take prisoners to prison from either courts or police stations. The record contains information regarding the prisoner, such as any concerns with their health, and details of their property.

Reception

26. All prisoners see reception officers and the nurse on duty when first entering prison. During this process, staff obtain address and next of kin details. Prisoners' property is logged, and they are health screened by a nurse, before being allocated a wing.

KEY FINDINGS

27. The man was recalled to prison on 19 September 2007 as he had failed to comply with the terms of his licence. He presented himself to police on 18 December 2007 and was transferred to HMP Lincoln on the same day.

Reception at Lincoln

28. On the evening of 18 December, the man underwent health screening in reception with a Registered General Nurse (RGN). The RGN rarely covered the reception duty and had not assessed a prisoner there for some time. However, on the evening that the man arrived at Lincoln there was only one nurse on duty and 29 new receptions. The RGN could see that the other nurse was very busy and offered to assist.

29. The purpose of the screening was to assess whether the man had any medical complaints, to explore any thoughts he had of harming himself, and to complete a Cell Sharing Risk Assessment (CSRA) which is automatically raised for every prisoner. It was noted on the CSRA that, due to his behaviour at previous prisons which he had declared himself, he should be located in a single cell.

30. The RGN completed a routine First Reception Health Screen document, which is annexed to this report. In interview, the RGN said she remembered the man as he had laughed and joked with her. She said he had seemed relaxed during their meeting and appeared to be familiar with the routine. The RGN said she discussed his medical history with him and talked about his use of alcohol and drugs.

31. Part of the screening involved a discussion about his mental health. The RGN recorded that he had never received medication for mental health problems and had never attempted to harm himself. The RGN did not have any documents (other than a Prisoner Escort Record (PER) form and the CSRA) to provide her with any further information about him, so had to rely on what he told her and how he presented himself.

32. The RGN also carried out a secondary health assessment at the same time. This health screen does not specifically assess mental health issues, but may give the prisoner the opportunity to voice concerns not discussed at the first reception health check. The RGN told my investigator that staffing levels would dictate when this was carried out. As the man did not appear to have any problems, the RGN decided to carry out the second assessment. This assessment recorded his next of kin details, explored any history of serious illness and gave advice on smoking cessation. The RGN did not see him again after 18 December.

33. On 29 June 2009, the prison forwarded a copy of his induction booklet to the investigator. This had not been included in the original paperwork which was passed to her when she began her investigation. The booklet shows that he was seen on 18 December and given information about the prison. He gave information about his employment history and said that he wanted assistance to find a job and accommodation after his release. Other issues included in the booklet were a housing needs assessment, healthcare and disability issues, drug or alcohol problems, and a discussion about his financial status (including a referral to a debt advisor). This appears to be a full and comprehensive induction meeting.

Cell location

34. As the man was assessed as a high risk prisoner on the CSRA (indicating that he was a possible risk to other prisoners), he needed to be located in a single cell. Due to population pressures and a lack of spaces at Lincoln, he had to be located on J wing, the only wing on which there was a single cell available. This wing normally houses prisoners who are undertaking short duration drug treatment programmes.

Routine on J wing

35. On J wing prisoners are unlocked between 7.45am and 8.00am every morning until 9.00am. At 9.00am, the prisoners who are employed or attending courses move off the wing. The other prisoners are locked in their cell until between 11.30am to 11.45am, when they are unlocked to collect their lunch. This is taken back to the cell and all prisoners are then locked in their cell again until approximately 1.45pm. The routine is repeated in the afternoon, with those prisoners who are not employed or on a course remaining in their cell again until association. However, as it was approaching Christmas at the time the man was there, the routine had changed as courses had finished for the Christmas break. Prisoners spent the afternoons on association until approximately 4.00pm.

36. The next day appeared to pass quietly for the man. From statements by prisoners (which were taken by the police) and from prison records, my investigator saw that he was issued with a PIN number so he could use the telephone on the wing and that he made a call to a friend. During this call he expressed regret at being back in prison and said he would call his friend back on Christmas Day.

37. Another prisoner recalled that he spoke to the man through his cell door some time. He gave him a cigarette which he passed under the door, and they spoke about how the man could make telephone calls and get tobacco.

38. At about 7.00pm, another prisoner spoke to the man in the showers. They discussed the man's sentence and the man asked how long he would serve. The second prisoner told him he would probably serve the remainder of his sentence.

39. A prison officer on J wing said in a statement to police that he recalled that the man asked to see a nurse on 19 December. He was told this would be arranged for the following morning. The prison officer said he was aware that the man saw a nurse the next morning (although there is no record of this meeting actually taking place on 20 December, either in the wing or healthcare records).

40. The Head of Healthcare said in a letter to the investigator dated 9 June, that normal practice at that time would have been for prisoners on J wing to be taken to the C wing treatment room. Any medication issued would have been recorded in the treatment chart. However, if a prisoner merely required advice for symptoms or general malaise, then this may not have been recorded anywhere.

41. The routine on J wing continued as the day before and all prisoners were unlocked for an afternoon of association at about 1.45pm. In interview, the second prisoner recalled seeing the man come out of his cell and stand on the landing near a water boiler. He remembered that they nodded to each other and then the man went back into his cell.

42. About five minutes later, the second prisoner walked past the man's cell. As he glanced in, he noticed his silhouette. He appeared to be looking out of his cell window. About 20 minutes later the second prisoner walked back past the man's cell, and thought that he was still looking out of the window. A further 20 minutes passed until the second prisoner was walking back to his cell and saw that the man was in the same position. He thought this was very strange so he pushed open the cell door and saw that he was hanging. The second prisoner felt for the man's pulse but could not find it, so rushed out to alert staff.

43. Two officers were on duty on J wing. Neither held current first aid training certificates. In interview, the second prison officer recalled that a prisoner ran up to the first officer and shouted that somebody was hanging. The first prison officer ran to the man's cell with the prisoner, and then ran into the J wing office where the second prison officer was working. This took only a matter of seconds. The second prison officer followed the first prison officer and the prisoner to the man's cell. When he arrived there, there were four or five prisoners already attempting to support him. The second prison officer could see that he had made a ligature from a green bed sheet which he had tied around the bars of the cell window.

44. The officers and the prisoners lowered the man onto the floor of his cell. By this time, a number of prisoners had gathered around the cell door. The first prison officer used his radio to make a Code One call

for assistance (Code One is the emergency call sign signalling that healthcare staff must attend).

45. The second prison officer checked the man for signs of life. He put his head to the man's mouth and nose to see whether he could feel or hear him breathing. He could not detect any signs that he was. The second prison officer then began Cardio Pulmonary Respiration (CPR) by chest compressions and a third prisoner began to carry out mouth to mouth resuscitation. The third prisoner was unsure what to do, so he and the second prison officer swapped and the third prisoner took over chest compressions while the second prison officer carried out mouth to mouth.

46. A Control and Restraint Officer, who responds to all emergency calls, heard the call over his radio and was the next officer to arrive at the man's cell. He was trained in first aid. As he entered the cell he saw the second prison officer and the third prisoner attempting to resuscitate the man. The Control and Restraint Officer asked the third prisoner to leave the cell and took over the chest compressions. The second prison officer was trying to clear an airway, as he was having difficulty administering mouth to mouth. Every time the man's chest was compressed, vomit came out of his mouth. The second prison officer was not carrying a mask to place over the man's mouth which would prevent vomit from entering his own mouth. The Control and Restraint Officer recalled that the man looked very pale and he could not detect any signs of life.

47. The Principal Officer (PO) was the Orderly Officer that day and held the radio codenamed Victor One. It took him about 20 seconds to arrive at the man's cell. When he arrived he saw the two Officers carrying out CPR on the man. In his role as Orderly Officer, the PO began to manage the emergency. He ensured that an ambulance had been called, and managed the prisoners who had gathered around the cell and those who had entered the cell.

48. The first nurse to arrive was holding the healthcare radio (Hotel One) and had heard the emergency call. It took her about one minute to get to the man's cell from the E wing treatment room. A healthcare worker also heard the call and ran to the cell with the nurse.

49. The nurse quickly assessed the situation and then took over from the second prison officer. She noticed there was strong smell of vomit and looked to see whether the man's airway was clear. The nurse saw that there was a pool of vomit at the back of the man's throat and told the Control and Restraint Officer they needed to turn him on to his side. The nurse also shouted to the healthcare worker that she needed suction (a piece to equipment used to suck out any obstruction in the airway). Both the nurse and the healthcare worker had arrived without any emergency bags because, as the First Response, they were required to get to the cell immediately.

50. The nurse and the Control and Restraint Officer turned the man on to his side and vomit poured out from his mouth. The nurse checked his airway again, which was clear. They rolled him onto his back, but as soon as the Control and Restraint Officer compressed his chest more vomit filled his mouth. This happened four or five times. The nurse told my investigator that she thought the reason why his mouth kept filling with vomit was because he had possibly been dead for some time and the compressions were bringing up the contents of his stomach. (The clinical reviewer confirms that this is an indication that the man had been dead for some time.)

51. An Officer heard the Code One call over his radio, as he was a designated First Response Officer. (This means that the officer is required to attend and the role is designed to ensure that not all staff attend the scene of an emergency.) When he arrived at the man's cell he saw that the Control and Restraint Officer and the nurse were attempting CPR. In interview, the First Response Officer remembered that the nurse was still trying to clear the man's airway. The Orderly Officer asked the First Response Officer to begin a log and to note down everything that was happening and which staff were present.

52. An officer had telephoned healthcare for more assistance, and two more nurses were the next to arrive at the man's cell. It took them just over a minute to get there. The second nurse took over from the Control and Restraint Officer and began chest compressions. It is unclear which nurse brought the healthcare emergency bag with them, but at interview the Orderly Officer recalled seeing both a red and blue emergency bag in the cell. (The bags hold different types of equipment, both used in CPR.)

53. The Control and Restraint Officer recalled that the first nurse was attempting to insert a tube into the man's throat to find an airway and the second nurse continued with chest compressions. The second nurse had only just started the compressions when the paramedics arrived. It had taken them approximately eight minutes to arrive after the ambulance was requested.

54. The paramedics moved the man out onto the landing so they had more room to work on him. They attached a defibrillator to his chest and continued to carry out checks for signs of life. At this point the prison doctor arrived. The doctor carried out his own checks and pronounced him dead at 3.02pm. He was covered with a blanket and carried back in to the cell.

55. The man's family live in Bridlington in East Yorkshire (a distance of about 75 miles by road). For that reason, the prison's Family Liaison Officer (FLO) first contacted three other prisons (Everthorpe, Full Sutton and Hull) to ask whether they had a FLO who could visit the man's family. When this was unsuccessful the FLO rang the Coroner's

Office to ask local police to break the news of his death. The prison's FLO also spoke with the man's family that day.

Aftercare for staff

56. Members of the prison's Care Team came immediately to J wing and spoke to the staff who had been involved in discovering and attempting to resuscitate the man. Senior managers also spoke to staff, and officers told my investigator that, in the main, they felt properly supported. Some vomit from the man's mouth had entered the second prison officer's mouth (when he was attempting to resuscitate him) and, as prison nursing staff are now unable to treat staff, he had to visit the local hospital to ensure there were no medical implications.

57. Later that day, a hot de-brief was held for staff involved. One officer, the First Response Officer, said he was not invited and, during his interview, said he would have found it helpful. Nobody who was interviewed recalled attending a critical incident de-brief at any other time after the man's death, although one was held on 4 January 2008, which 18 members of staff attended..

Aftercare for prisoners

58. A number of prisoners were very upset by the man's death. A counsellor from the chaplaincy and members of the Care Team spoke to every prisoner on the wing, and all open ACCT documents were reviewed. A small service was held for prisoners on the wing on the night of his death.

Family concerns about prison liaison

59. As noted, the prison's FLO spoke to the man's family and arranged and accompanied them during a visit to the prison and also to see his body. The prison FLO also discussed how the prison could contribute to the cost of the funeral. The prison FLO told my investigator that the prison agreed to cover the cost (excluding certain items) and liaised directly with the undertaker. A message of thanks was left on the prison FLO's answer phone by the man's father. His father told my FLO that he was disappointed that the prison had not explained to him more clearly the things they would not pay for, as he had been left with an outstanding bill that he had thought the prison would cover. However, the prison FLO said this had been made clear. The prison FLO was unwell on the day of the funeral so was unable to attend, but another prison representative went in her place.

60. The prison chaplain spoke to the man's family and agreed to carry out the funeral service, as he had known him. However, when the funeral date was set, the chaplain was not able to carry out the service as he

had pre-booked leave. The chaplain suggested that the assistant chaplain could conduct the service instead, but the man's family declined this offer. However, the Prison Service covered the cost of the minister's fees.

61. It took some time for the man's property to be returned to his family and they told my FLO they were unhappy that they had to make several requests, as well as asking for a last photograph of him which had been taken for his prison record. His property was returned his family on 21 January.

Post mortem

62. A post mortem examination was carried out at the local hospital. The toxicology report indicated previous cannabis use and tetrahydrocannabinol (the main active ingredient of cannabis) was detected in the man's blood, suggesting he had used this within four to 12 hours of his death (whilst he was in custody at Lincoln). The conclusion of the post mortem examination was that he died as a result of hanging.

OASys report

63. After the man died, all the prison documentation was forwarded to my investigator. Amongst the documentation was an OASys report which was completed by his probation officer and was printed out by the prison on the day he died.

64. An entry made in the report on 26 July 2006 said that:

> "The man claims that he is not suffering from any current psychological problems or depression, however he claims that he was diagnosed with depression 5-6 years ago and prescribed anti-depressants (which he did not take). The man said during interview that he has never attempted suicide or had suicidal thoughts or feelings; however he did say that he will not ever come back to prison and if he ever had he would commit suicide."

65. The OASys clerk explained to my investigator what she did when she received notification of a prisoner on a recall from licence. She said that each morning she receives a copy of all new receptions to the prison, including all those who are licence recalls. The Discipline Office (the part of the administration department which deals with sentence calculation, warrants and all other processes relating to a prisoner's custody) also contact the Early Release and Recall Section at the Ministry of Justice and requests papers from them, including the decision for the licence recall. Once this has been received, the OASys clerk then passes the information to other departments in the prison.

66. The OASys clerk confirmed that she would have access to the OASys document on her computer and that she would check the Summary Sheet (section ten of the document) to see whether a prisoner was at risk of self harm or suicide. If there was a tick in either box, she would forward the form to wing staff and to the Suicide Prevention Officer. She confirmed that there was no other way in which a prisoner would be 'flagged up' as at risk, other than through reading the Summary Sheet. She said that this would take place a few days after a prisoner had arrived at the prison.

67. The Summary Sheet of the man's OASys report (annex ten) does not refer to his claim (in 2006) that if he ever returned to prison he would take his own life. There are also no ticks in the box next to current concerns about risk of suicide or the risk of self harm. However, the Summary Sheet is slightly misleading as next to 'Current concerns about' there is a 'yes'. It is not clear what this refers to.

68. My investigator also spoke to a worker from the prison's Probation Department. The worker explained that, if a licence recall prisoner arrives at Lincoln, an assessment is carried out by probation as quickly as possible, but not usually within two days. She confirmed that she has access to the OASys report as soon as a prisoner arrives at the prison, but that probation would not normally access the report until an assessment needed to be carried out, usually a week or so later.

ISSUES

Clinical issues and risk assessment

69. Staff had no paperwork available to them when the man first arrived at Lincoln to suggest that they should be concerned about his mental or physical health. On the contrary, he laughed and joked with the nurse who saw him on reception and appeared relaxed and upbeat. When asked if he was likely to harm himself, he told the nurse he had never attempted to do so and was not at risk. An ACCT form was not opened for him as staff did not assess him as being at risk and noted that he had presented himself positively. Staff followed the process and assessed him on the information they had available.

70. The RGN who assessed the man on reception was a registered general nurse and not a mental health nurse. She said at interview that she had conducted about 12 First Reception Health Screen assessments in two years. The RGN helped on the evening that the man arrived because there were 29 new prisoners and only one other nurse working in reception.

71. Despite her relative inexperience, the man's health assessment was completed in full by the RGN and he was specifically asked about depression, self harm and suicidal thoughts. These are standard screening questions and thought to be a generally reliable test. The clinical reviewer concludes that the man was appropriately screened and neither his answers nor his demeanour gave any indication that he was likely to take his own life. I entirely agree. The clinical reviewer also comments that the screening is much more comprehensive than any new patient check in normal primary care.

72. The second health care assessment was carried out at the same time as the first reception health screen. Although the clinical reviewer thinks this would not have made a difference in the man's case, he has made a recommendation that consideration should be given to carrying out the secondary health screen a few days after the first. This would give staff another opportunity to assess a prisoner's mental state.

    Healthcare should consider whether there is a benefit in delaying the secondary healthcare screen for a few days in order to give another opportunity to assess the mental state of a prisoner.

73. Although the first prison officer recalled that the man was taken to see a nurse on the day he died, there is no record of this in any medical records. The Head of Healthcare said that at that time advice for symptoms or general malaise would not necessarily be recorded in the medical records. I think it is important that every time a prisoner is seen by a member of healthcare, that this is recorded properly. I make the following recommendation.

Healthcare should review their practice and make an entry in medical records whenever a prisoner is seen by a member of healthcare, regardless of the reason or whether or not any medication is prescribed.

74. Whilst administering CPR to the man, the second prison officer had some vomit enter his mouth. I endorse the clinical reviewer's recommendation that the provision of airways should be made widely available for use by prison officers and healthcare staff.

Healthcare should consider the wider provision of airways for use in mouth to mouth resuscitation for use by both healthcare staff and prison officers.

75. The first nurse to arrive at the man's cell did not have any equipment with her, which was because she was required to respond immediately. This was the responsibility of other healthcare staff, who arrived subsequently. The clinical reviewer recommends that provision of the resuscitation equipment and where it is placed in the prison should be reviewed. An emergency bag, for example, should be kept on each wing to enable the first healthcare worker arriving at the cell to be fully equipped without delay.

Healthcare should consider the provision of resuscitation equipment. Its siting should be reviewed and changes put in place to allow the first healthcare worker to arrive on scene to be fully equipped without delay.

76. The clinical review notes that that not all of the officers involved in the attempted resuscitation of the man had undergone CPR training, and that it would be useful if this training was more widely available. I agree that this would be helpful and frequently make this observation in my fatal incident reports. I suggest that a first aid training programme for all staff (in particular senior officers as there is always an SO on duty at the prison) is rolled out.

The Governor should consider implementing a first aid training programme for all staff, especially those of senior officer grade.

Checks on the man on the wing

77. There were two officers working on J wing on the afternoon the man died. They were carrying out other duties on the wing whilst prisoners were on afternoon association. During association all prisoners are unlocked and it is up to the individual prisoner whether he spends time out of cell or remains in it.

78. Officers will not usually check on a prisoner unless they are on an ACCT document that specifies they should be observed at particular

intervals. The man was not on an ACCT and therefore was not observed.

Family concerns about prison liaison

79. The man's family has expressed concern about various aspects of the prison's liaison with them. The man's father was unhappy that the prison chaplain was unable to carry out his son's funeral service, despite agreeing that he would. My investigator found that the chaplain was on annual leave and had suggested to the man's family that the assistant chaplain carry out the service instead. The man's family declined this offer. However, the Prison Service covered the cost of the minister's fees. The man's father said he was also upset that the prison's Family Liaison Officer did not attend the funeral as she had said she would. My investigator found that the liaison officer had been unwell and was unable to attend and another representative from the prison had attended in her place. The FLO apologised for this and said she would be thinking of them on the day. In the circumstances, I believe the prison did all they could in this instance. However, while I appreciate that the drive from Lincoln to Bridlington would have taken around two hours, it would have been better had the prison itself personally informed the family of the man's death rather than relying on the police. I have chosen not to make a formal recommendation, but the Governor will wish to review his contingency plans covering a death in custody.

80. The man's father also expressed concern about the lack of clarity surrounding the payment of funeral costs by the prison. He said it was unclear exactly what the prison would pay for. The prison's Family Liaison Officer thought that she had been very clear during their conversations and they had paid £1,400 towards the total cost. I am aware that many prisons would have been more generous (quibbling over the costs of wreaths is not respectful nor consonant with good public service), and once more the Governor will wish to review his contingency plans.

81. The man's father also said that his family had spent some time contacting the prison for his property and a last photograph the prison had taken of him. My investigator spoke to the prison's Liaison Officer who agreed to forward these to his family immediately.

De-brief and aftercare for staff

82. A hot de-brief was held on 20 December for staff to talk about what had happened. On the whole, they told my investigator that this had been useful. A critical incident de-brief was held on 4 January 2008. This is always helpful as staff sometimes do not feel the full impact of a death in custody, until some time after it has happened, and then feel more ready to talk about it.

83. The second prison officer, in particular, was distressed as some vomit from the man's mouth had entered his mouth. Healthcare staff were unable to treat him, and he had to visit the local hospital (opposite the prison) instead. My investigator understands that it is now national policy that healthcare staff cannot treat or assist prison staff (unless it is in an emergency).

Radios

84. On the day that the man died, healthcare staff identified a problem with a lack of radios allocated to them. (This did not ultimately affect their response time to the man's cell, as there were staff who did have a radio and responded immediately). This issue has now been addressed by the prison.

OASys report

85. An entry recorded in the OASys report in July 2006 noted that the man had said that, if he ever returned to prison, he would take his own life. This information was not seen by any member of staff at the prison before he died and so they were unaware of it. His probation officer in the community would not have been aware that he had been recalled to prison and the information contained with the OASys report was 18 months old. The OASys clerk and the Probation Department both had access to the report from the day that he arrived at Lincoln, but the reports are not routinely checked (apart from the Summary Sheet) until an assessment needs to be carried out. Further, the Summary Sheet in the man's case was misleading as it was unclear whether there were concerns about self harm or suicide or not.

86. Although it is not likely that an ACCT document would have been opened for the man had prison staff been aware of the entry in the OASys document, the fact that OASys reports are not checked as soon as possible is a weakness in terms of safer custody. Currently, between 10 and 20 per cent of all deaths in custody occur in the first week after reception. The recommendation below is directed at the Governor of HMP Lincoln. However, the NOMS Safer Custody and Offender Policy Group will wish to consider if there is a case for national guidance.

The Governor should put a system in place to ensure that the entire OASys report is read through when a prisoner first arrives at the prison, to ensure that concerns about risk are identified at the earliest possible stage.

The assistance offered by the third prisoner

87. I do not know what special arrangements were put in place for the third prisoner (the prisoner who first assisted with CPR) following these sad events. Nor do I know if he is still in custody. However, I think that the assistance he gave when the man was first discovered should be recognised. I therefore recommend as follows:

The Governor should write to the third prisoner to thank him for the assistance he gave to staff when the man was first discovered.

RECOMMENDATIONS

To Healthcare:

1. Healthcare should consider whether there is a benefit in delaying the secondary healthcare screen for a few days in order to give another opportunity to assess the mental state of a prisoner.

2. Healthcare should review their practice and make an entry in medical records whenever a prisoner is seen by a member of healthcare, regardless of the reason or whether or not any medication is prescribed.

3. Healthcare should consider the wider provision of airways for use in mouth to mouth resuscitation for use by both healthcare staff and prison officers.

4. Healthcare should consider the provision of resuscitation equipment and its siting should be reviewed and changes put in place to allow the first healthcare worker to arrive on scene to be fully equipped without delay.

To the Governor:

5. The Governor should consider implementing a first aid training programme for all staff, especially those of senior officer grade.

6. The Governor should put a system in place to ensure that the entire OASys report is read through when a prisoner first arrives at the prison, to ensure that concerns about risk of self harm or suicide are picked up at the earliest possible stage.

7. The Governor should write to the third prisoner to thank him for the assistance he gave to staff when the man was first discovered.