

**Investigation into the circumstances surrounding the
death of a man at HMP Lincoln
in February 2008**

**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. He was discovered in his cell on the morning of 24 February 2008 with a ligature tied around his neck. Although it appeared that he had already died, staff tried to resuscitate him but sadly without success. He was pronounced dead at 6.09am.

I would like to offer my sincere condolences to the man's family for their loss.

The investigation was undertaken by two of my senior investigators. We would like to thank the Governor of Lincoln and his staff for their participation and assistance.

I must apologise to the man's family and to the prison for the unacceptable delay in issuing this report. A clinical review, commissioned in February 2008, was not completed and forwarded to my office until 21 January 2009. Nevertheless, I would like to thank the reviewer for his report which has proved very helpful.

There is no doubt that the man was a challenge to the staff who cared for him. He arrived at Lincoln on an open ACCT and spent much of his time being monitored under the ACCT process. The final ACCT document was closed on 21 February, three days before he died.

I believe that staff made every effort to limit the man's risk of harming himself. ACCT reviews were conducted regularly, he had access to Listeners and the Samaritans telephone, and enjoyed frequent contact with members of the Healthcare Department. However, I make four recommendations to the Governor and the Head of Healthcare, and a further two recommendations to the Governor.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man died apparently at his own hand, at HMP Lincoln on 24 February 2008. He had been at Lincoln for ten months and was awaiting trial.

The man had a history of harming himself which was flagged up when he arrived at the prison. He was frequently assessed by both prison and clinical staff using the Assessment, Care in Custody and Teamwork (ACCT) process, and was referred to the prison's Mental Health In-Reach Team for further assessment. During his time at Lincoln, he had periods when he refused food, made cuts to his arms, and told staff he had taken an overdose of tablets and swallowed a razor blade. He was assessed by a GP, who provides primary medical care to the prison on a sessional basis, who agreed with an assessment made at HMP Nottingham that he did not have a psychotic or depressive illness and displayed no symptoms of mental illness. However, staff continued to keep a close eye on him, who frequently spoke to Listeners and had use of the Samaritans telephone.

The man was particularly anxious about his trial, and appeared to alternate between being hopeful that the case against him would be thrown out, to despair at possibly receiving a lengthy sentence. He spoke of his dissatisfaction with his legal team.

The man had great difficulty adjusting to being locked in a cell; he was a keen conservationist and was used to the outdoor life. Some staff tried to alleviate these pressures by allowing him out of his cell to help with cleaning duties on an unofficial basis. He did secure a cleaning job on the wing, but was sacked from the position around January 2008.

An ACCT document had been opened for the man on 9 February 2008. It was reviewed on 14 February and a decision was made to close it on 21 February, three days before he died.

On the morning of 24 February, a member of staff was carrying out a routine roll check before he went off duty. When he arrived at the man's cell, he lifted the observation panel and immediately saw that he was suspended by a ligature. Assistance arrived very quickly and, despite the fact that he appeared already to be dead, staff attempted to resuscitate him until the paramedics arrived. After carrying out their own checks, at 6.05am the paramedics pronounced that he had died.

THE INVESTIGATION PROCESS

1. I appointed one of my senior investigators to conduct the investigation on my behalf. Notices were issued to prisoners and staff inviting anyone who had information relating to the man's death to make themselves known. Two prisoners asked to speak to my investigator. One was spoken to informally while the other was content for a written note to be taken of their conversation. A senior officer from the prison rang my investigator on 16 April 2008 as a prisoner wanted to speak to her about the man's treatment whilst at Lincoln. She spoke to this prisoner, but he did not want a note made of the meeting. In the event, she found his account to be anecdotal and unhelpful as he did not talk about the man.
2. The man's prison records, including his medical records, were made available to my investigator during her initial visit to the prison on 27 February. A full set of documents was given to my investigator, which she found extremely helpful. Additional documents were forwarded a week later.
3. My investigator and her colleague, another of my investigators, visited Lincoln to carry out recorded interviews with staff on 8 April, 15 May and 26 June. The three prisoners were also seen on 15 May.
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 brother said that he had some concerns. First, that approximately six weeks before the man died he had told him that one of the night staff had made a gesture of running his finger across his neck in a cutting throat motion and mouthing "You're gonna die" to him. His brother also said that he had spoken to him about a week before he died when he seemed happy and confident that he would be found not guilty at court and would soon be released. His brother was also concerned that the Coroner had informed him that some anal bleeding had been noted at the post-mortem and that this might have indicated that the man had been assaulted. My FLO agreed to share these concerns with my investigator.
5. The man's brother also requested that my investigator listen to any taped telephone calls between himself and the man, as it would show his state of mind and that he was happy. He also asked for a copy of the tapes. My investigator received transcripts of five telephone conversations (undated) which were forwarded to his brother.
6. A clinical review was carried out by an appointed doctor from the Primary Care Trust (PCT).

HMP LINCOLN

7. 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.
8. There are four main residential units. A wing incorporates the First Night Centre (FNC) 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.
9. There have been 11 deaths at Lincoln since 2004 when I first began investigating all deaths in prison custody. Two deaths have occurred since the man died in February 2008, both of which appear to have been self inflicted. In a report into the death of a prisoner who died at Lincoln in December 2007, I made recommendations regarding first aid training and critical incident debriefs. However, in fairness to the Governor, he would have been unaware of my recommendations at the time the man who is the subject of this report died

Anti-ligature knives (fish knives)

10. 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.

Association

11. Association is a period of time when prisoners are unlocked from their cells and are able to associate with each other.

Assessment, Care in Custody and Teamwork (ACCT)

12. 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 should be seen by an assessor and have a case review meeting. ACCT reviews are held at intervals and should be attended by the prisoner and a case manager, together with other members of staff. After an ACCT is closed, a further review should take place to assess whether the document should remain closed.

Cell Sharing Risk Assessment (CSRA)

13. In order to make sure that unsuitable prisoners do not share cells (for example to prevent the location of a known racist prisoner with someone of the targeted

group or a prisoner with disturbed behaviour or mental illness from cell sharing inappropriately), a cell sharing risk assessment form is completed by reception when a prisoner is first admitted and is a live document which can be reviewed at any point and follows the prisoner on transfers to another establishment.

Her Majesty's Chief Inspector of Prisons' report

14. HM Chief Inspector of Prisons carried out an announced inspection of HMP Lincoln from 3 to 7 December 2007. With regard to new prisoners, the Chief Inspector 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.”

Incentives and Earned Privileges (IEP)

15. The Incentives and Earned Privileges scheme was introduced in 1996 to encourage and reward good behaviour in prisons. There are three levels: Basic, Standard and Enhanced. Incentives include access to in-cell television, more private cash to spend, wearing own clothes, more time out of cell and access to extra and enhanced visits. Each prison sets its own criteria to obtain each level.

Independent Monitoring Board (IMB) report

16. 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 any areas of concern.
17. 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 and 226 reported incidents of self harm. The IMB said that the Listeners scheme was well used and there was a well-regulated violence reduction policy.

Insiders

18. The Insiders scheme involves the training of selected prisoner/under 18s volunteers to provide basic information and reassurance to prisoners new to the prison, shortly after their arrival in prison..

Listeners

19. 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). Samaritans allow exceptions to their principle of confidentiality only on the following very specific circumstances - volunteers will not accept a confidence which contravenes the Prevention of Terrorism (Temporary Provisions) Act 1989, since updated to the Terrorism Act 2000, as amended by the Anti-Terrorism Crime and Security Act 2001. Also, volunteers will call for help, without consent, where a caller has begun to commit suicide and has reached a condition where it is clear that they are unable to make their own decisions. Listeners providing support for prisoners in distress will follow the same practice. Listeners can refuse to see a prisoner if they wish.

Personal Officer scheme

20. Under the Personal Officer scheme, prisoners are given a named officer who they can approach in the first instance for advice or to resolve complaints.

Rule 45

21. Prison Rule 45 relates to the segregation of prisoners for the good order of the prison or for their own protection.

KEY FINDINGS

22. The man was transferred to HMP Lincoln from HMP Nottingham on 19 April 2007, some ten months after being first remanded in custody charged with a very serious offence. He was seen by staff in the First Night Centre (FNC) where he was given an induction talk and risk assessed for sharing a cell. During the Cell Sharing Risk Assessment (CSRA), it was noted that he said he had abused alcohol and drugs but was not currently dependent on alcohol. He also said he was on an open ACCT, and had been in the past. The man was then seen by a nurse. He told her that he had no thoughts of harming himself or of suicide. He again said he was on an open ACCT when he transferred to Lincoln (one had been opened at Nottingham on 2 February 2007, although a copy of this was not included in my investigator's paperwork). He was assessed as a low risk. He made an application for Rule 45 status as, due to the charges he was facing, he was concerned about his safety on a mainstream wing. He was allocated a cell on E wing.
23. The next day the man received a full induction and a prisoner information pack. An officer recorded in the wing history sheet that the man said he had "no problems".
24. On 26 April 2007, an officer introduced himself to the man as his personal officer. The personal officer noted in the wing history sheet that he had explained to the man, "what is expected of him whilst at Lincoln". The personal officer interviewed him using a printed questionnaire to which a prisoner answers questions with a yes or no and where further details can be added. He said that he had suffered from depression, that he had recently felt low in spirits, and that he had tried to harm himself in the past, giving details of when he had cut and stabbed his forearms. The man said that he was aware of the services of the Samaritans and the Listeners, and that he knew what to do if he felt like harming himself again. He said that he intended to spend his association time making telephone calls and playing pool. He also said that he had not yet been allocated a job and did not want to work whilst he was on remand.
25. Later that day, it was noted by the personal officer in the wing observation book that the man had been assessed (as part of the ACCT process) and was to be checked every 30 minutes. (As my investigator was not provided with this first ACCT document, references to its contents come from other paperwork such as the wing observation book and medical records.) He told the personal officer that he did not feel too bad and that it helped to talk to someone.
26. The man was seen by healthcare on 27 April and complained of a painful knee. He said he had jumped off of his bunk bed two weeks earlier and felt his knee "go", but had not reported this to anyone at the time. It was noted that this was unlikely to be a major injury and he was prescribed co-codamol painkillers.
27. On 28 April, the man stopped eating and drinking. The personal officer and a senior officer spoke to him. It was noted on the wing observation sheet that, although he seemed positive, he maintained he would not eat or drink anything.

28. A day later, the man was given access to the Samaritans phone in his cell from 8.45pm until 10.45pm. It is unclear exactly how much time he spent, if any, on the telephone.
29. A nurse in the Mental Health In-Reach Team (MHIT) noted in the medical record that she attended an ACCT review for the man on E wing on 1 May. She recorded that there was no evidence of mental illness and that he had never been prescribed any form of psychiatric medication and never been admitted to a psychiatric hospital. She also noted that he displayed a good sense of humour and was intelligent and articulate. He had told her that he was starving himself to death as he was innocent of all allegations against him, but even if he were to be acquitted he felt that "mud sticks".
30. The man said that he had harmed himself at Nottingham prison by cutting his arm, and described this behaviour as "attention seeking" to get people to listen to him. He said he enjoyed talking about his campaigning and pacifist beliefs. He made an agreement that he would resume eating normally once a telephone call to his solicitor had been arranged. There is no record to indicate whether this was facilitated or not, but it appears that he resumed eating. The half-hourly ACCT observations remained and a review was arranged for a week's time. The MHIT nurse said she would refer the man to the Primary Mental Health Team so they could assess whether they should have some input into his clinical care. No further MHIT input was planned as there was no "severe and enduring mental illness evident".
31. On 8 May, another ACCT review was held. It was decided that the document should be closed but that the man's progress would continue to be monitored.
32. The next day, the man told other prisoners that he was going to hand out a petition and would organise a protest about loss of association for all prisoners on the wing. This information was passed to security. He was seen by a governor the following day about his plan to organise a protest and he agreed to withdraw the threat. No action was taken against him.
33. On 13 May, the man again requested use of the Samaritans phone. It was given to him at 10.30pm, but it is not clear how long he had the telephone for. Three days later on 16 May, he asked for a Listener to be located in his cell. The Listener sat in with him from 12.40am until 02.30am when he returned to his own cell. Later that day, the man spoke to an officer on the wing and asked if he was listed to see a senior officer as he had seen a Listener. He was told that he was not, but that he could see a senior officer if he wished to do so. There is no record of whether he spoke to a senior officer or not.
34. Another ACCT document was opened for the man on 16 May. The trigger was his anxiety about his court case (a plea and directions hearing was due on 30 May) and a change of cell location. He said that he was unsure whether he would harm himself and his mood was low, and he was tearful during parts of the ACCT interview. It was agreed that the man would remain in his current cell with his cell mate, would be observed hourly by staff (both day and night), and

have access to the Samaritans telephone and Listeners when he felt he needed them.

35. A day later, an officer (the signature is illegible) spoke to the man about a telephone call the prison had received from his solicitors. They were concerned as he had told them he was going to commit suicide. He told the officer that it was just a threat to his solicitor because he was “fed up” with his legal team who he thought were not acting in his best interests.
36. An ACCT review was held on 18 May (attended by a senior officer and a nurse). The man spoke about his worry about his court case, and that he did not like to be “enclosed” and could not stand to be “banged up”. It was recorded in the On-Going Record part of the ACCT document that he had had a “bad” telephone call with his solicitor. He said he had been told to “expect the worst at court” and could expect a sentence of 20 years if he pleaded not guilty, or a sentence of six years if he pleaded guilty. The man said he was not prepared to plead guilty as he was innocent. It was noted that he felt very low and he said he had nothing to live for. He also said he would not harm himself at the moment, although he could not guarantee this in the future. Observations were raised to five an hour.
37. The next ACCT review was held on 23 May. It was agreed that the man’s level of risk was high. He appeared very upset and kept saying that his wife (the alleged victim of his offence) had won. He promised that he would not do anything “silly” and agreed to talk to staff. It was arranged for a member of healthcare to see him later that day. However, staff became very concerned for him when he appeared to be “very distressed”. He refused the offer of a bed in healthcare and said he had not slept for days as his “head was a mess”. He was prescribed 5mg of Diazepam for his anxiety and 7.5mg of Zopiclone for one night only to help him sleep. It was noted that he appeared more settled after taking the medication, and he said he would speak to staff if he felt he was deteriorating during the night.
38. The next day, the man made a superficial two inch scratch to his left forearm. A nurse (the signature was unclear) cleaned and covered the wound. He was shaking his leg and told staff that he could not spend 20 years in prison for an offence he had not committed. He also told staff that he might try and harm himself again that night. As a result, he was placed on constant observations. An ACCT constant watch review was held later that day (attended by a prison governor, two officers and a nurse). It was noted that the man continued to behave in a “manipulative way”. He had said that “sleep is a problem” and that he was anxious about his future and upcoming court appearance. It was agreed that he should be prescribed Diazepam for three days and Promethazine (an antihistamine with a sedative effect) for seven days. It was also agreed that he should be introduced to anxiety management techniques.
39. A further ACCT review was held on 25 May, again with a nurse in attendance. It was noted that there was no change and that another review should be carried out after the man’s next court appearance on 30 May.

40. On 1 June, an ACCT review was carried out by two senior officers and two nurses. It was noted that the man seemed more positive following his court appearance (via video link) two days earlier. Observations were reduced from half-hourly to every hour and to four quality conversations a day.
41. Five days later, an officer had a conversation with the man about how he was feeling. This is noted in the On-Going Record of the ACCT. He said he was "so, feeling a bit low but not too bad". He said he had been watching the G8 Summit on television and wished he was there as he was a peace activist. He also said he wanted to train as a Listener. The officer told him that he would need to sort out his own problems before this could be considered. Later that day, another officer spoke to him about his court case. The officer noted that he did not seem concerned about it and had said there was no evidence against him. However, he was worried that a jury mainly comprised of women might be a problem to him. He ended the conversation by saying that he felt he was sliding into a breakdown, but felt alright at that time.
42. Another ACCT review was held on 8 June attended by a senior officer and a nurse. The man said he had a few bad days but felt fine now. He seemed positive and looked forward to being allowed to have a guitar in his cell once he had gained enhanced IEP status. The review panel agreed that his ACCT document could now be closed and a post closure review was set for 22 June (although the entry in the wing history book incorrectly says the review should be held on 22 April 2007).
43. On 14 June, the man again asked for a Listener to be located in his cell with him. The Listener went to his cell at approximately 1.10pm and stayed until 3.00pm.
44. The next day, a senior officer (SO) asked a nurse to see the man who said that he felt anxious and that it was the anniversary of a death in his family. The entry in the medical record shows that the nurse spoke to him at length, and spent time reassuring him and advising on ways to cope with his feelings. The man said that he would like to become a Listener or an Insider and wanted to begin some kind of education. The SO said that the man would need to make an application. The nurse arranged for him to see a GP the following Tuesday (four days later). The nurse went to see him two days later to see how he was feeling. He said he was fine, but declined to speak to her at length on this occasion.
45. The man was assessed by the GP on 19 June. The GP noted in the medical records that it was "a long and aggressive interview". The man said that he wanted anti-depressants and that the nurse had told him he should have them (the nurse says she did not say this). According to the GP's note, he refused to engage in any "useful" conversation and was aggressive in manner, saying that just because he was a prisoner he was still entitled to good care. The GP noted that the man's medical records contained entries regarding his apparently manipulative behaviour. An entry made by a doctor on 23 February 2007 said, "I am not convinced this is a psychotic or depressive illness." A note made by a Community Psychiatric Nurse (CPN) at Nottingham on 12 April 2007 said "no

symptoms of mental illness". The GP recorded that eventually the man stormed out of the room. He made a referral for him to be seen by the Mental Health In-Reach Team. (I may say in passing that I am always cautious about a phrase like 'manipulative behaviour'.)

46. On 21 June, at approximately 6.00pm, the nurse was called to see the man in his cell (he was in a single cell). He appeared quite upset and could not tell her why. The nurse advised him to try to calm down and said she would return to see him. She returned about half an hour later. He still seemed upset but now said that he could hear the voice of his mother singing to him. They spoke at length about ways to ease his anxiety. The man told the nurse that he felt ready to "explode" and felt very anxious, and that his mother's voice was upsetting him. He was given 5mgs of Diazepam and advised to contact Healthcare if he continued to feel the same. He denied that he had thoughts of harming himself or of suicide.
47. The ACCT post closure review was held on 22 June by a single member of staff (the signature is illegible). No problems were reported (suggesting that the member of staff was not aware of the events the day before), and the ACCT remained closed. Later that day a nurse was called to see the man in his cell. He was sitting in a chair shaking, refusing to speak to staff and hitting himself in the head with his hands. He was given another 5mg of Diazepam and the member of staff on night duty agreed to monitor him and inform the nurse of any changes.
48. The following day, the man again asked for a Listener. They went to speak in the Listener Suite and remained there for 15 minutes.
49. A prisoner reported to staff on the same day (23 June) that the man had swallowed a razor blade. The man told staff he had swallowed half a razor blade and that voices in his head were telling him to do it. He was admitted to Healthcare for overnight observations and an ACCT was opened. The nurse on duty noted there were no signs of bleeding or pain. At 8.30pm, he began shouting and banging, demanding tea and tobacco. The senior officer (SO) in healthcare said he would try to get his tobacco for him. Approximately 15 minutes later, the man began to smash his cell with a pole which must have been inside. He shouted that the next person to enter the cell "will get it". He continued to smash his cell until 9.15pm, and attempted to hit an Operational Support Grade (OSG) over the head with the pole. At 9.45pm he was relocated to D wing where a nurse completed some checks on him.
50. An hour and a half later, the man told staff he had swallowed medication (which he had kept from in-possession medication he had been given three weeks earlier) and a razor blade. Staff believed this to be untrue and that he was seeking to be transferred to the Accident and Emergency Department at the local hospital. He then said he had a pain in his groin area, but a nurse said this was unlikely to be from the razor blade or the alleged overdose. He then pointed to his lower abdomen and said that the pain was there. However, he would not let the nurse examine him and crawled around on the floor.

51. At 12.30am on 24 June, an out of hours doctor was contacted so that the man's blood samples could be sent to Accident and Emergency to determine the paracetamol levels. At 1.10am, the blood samples were taken to the outside hospital (opposite the prison) by an officer. At 5.30am, Healthcare were told that the man's paracetamol level was five, salicylate less than ten and all others NAD". This meant that no further action was necessary as his blood results were normal. In the meantime, it had been noted that he had been up and about on the wing and smoking.
52. On 26 June, the man was seen by the GP because of his behaviour three days earlier. It was agreed with the Mental Health In-Reach Team that, in view of his previous psychiatric reports, there would be no further involvement with them.
53. A post closure ACCT review was held on 13 July. The man said that he would kill himself should he receive an indeterminate sentence when he attended court on 6 August. However, he said he had no thoughts of harming himself at that time. Two days later, he spoke to the duty Listener for approximately one hour.
54. There is a note in the Record of Events booklet, made on 17 July, that the man attended a prison disciplinary hearing for "damages/prop". He pleaded guilty and received a punishment of loss of canteen (access to the prison shop) and loss of television for 14 days.
55. The man saw another Listener on 22 July for approximately 40 minutes. Three days later, he was contacted by his solicitor who was concerned that he was not eating or drinking and that during a visit the week before he had spoken of suicide or of harming himself. The officer who made the entry in the man's records (the signature is illegible) said that they had spoken to him and that he had not been eating or drinking because he had not been well and had a sickness bug. (In fact, an entry in the medical records notes that he was seen in his cell by a nurse who said he was suffering nausea and vomiting and that he looked "washed out and pale". It was noted that he was not eating and barely taking fluids. He was given medication and told to allow it time to work and to try to sip water. The man was to see the doctor if he felt no better the next day. However, the next day he said he "felt fine".) The entry also notes that, "the healthcare is well aware of his threats of suicide if found guilty and the trigger points leading up to his trial on 6 August, he says he's feeling no worse and no better."
56. On 6 August, the man had a court appearance at the Crown Court. It was noted on the Prisoner Escort Record (PER) that he had again threatened, "if he is given an indeterminate sentence he will kill himself".
57. The next day, when the man returned from court, he said he had injured his right hand. He told staff that he assaulted his solicitor, but there was no evidence to corroborate this. He was seen by a nurse once he returned to the wing and it was noted in the medical records that his hand and fingers were swollen. He was prescribed analgesia and told to keep his hand elevated.

58. An ACCT was opened for the man on 11 August as he said he was on hunger strike and would kill himself if he were to be convicted. He was seen in Healthcare the next day where he said he intended to end his life by not eating or drinking. He said that he could not manage “sentence and life in future”. He refused any treatment and said he had not eaten or taken fluids since 7 August. It was noted that, although he looked pale and slim, he was not “overly dehydrated”. He was advised of issues regarding mental capacity and told that, whilst he could refuse treatment, if it was judged that he had lost his mental capacity, clinical staff would be obliged to treat him unless he had made an Advance Directive. (This is a legally binding document which gives a person the right to refuse any medical treatment, as long as they are deemed to be of sound mind when making the decision.)
59. An entry in the Record of Events on 12 August (the officer’s signature is again illegible) said that the man had rung his cell bell at 5.50pm and asked to speak to a Listener. The duty Listener said that the man would have to have the Samaritans telephone, as he had spoken to him at length the night before and could do no more for him. He was given the Samaritans telephone to use in his cell, but it was taken out at 6.10pm. He complained that staff were preventing him from talking to Listeners, so an officer again explained to him what the duty Listener had said.
60. On 13 August, it was noted in the medical records that the man had taken some fluids. The next day he told staff that he was awaiting an Advance Directive from his solicitor, and that he intended to starve himself to death. He asked for a mental health referral, but according to the medical records, “the manager states she has already received one and seen this man.” It was noted that he took sips of water and some food during the day.
61. An entry in the prison records dated 4 September says that, “as a result of an ACCT review inmate said that if he didn’t get on with his new cell mate tomorrow he will cut the inmate’s throat.” The Cell Sharing Risk Assessment was re-assessed and raised from low to high. The man was moved to a single cell.
62. On 2 October, it was noted in the medical records that the man had said his legal situation had improved and that he felt more positive. He had started to eat and drink normally and no longer had any plans for starvation or any other forms of self harm or suicide. The ACCT was closed.
63. Two weeks later, a nurse was called to the man’s cell as he was complaining of chest pains and numbness in his fingers. He was examined and did not appear to have any other symptoms. He said he did not require any pain relief as he was not in any great discomfort. He was seen later that day by the doctor and, although the entry in the medical record is difficult to read, it seems that no further action was required.
64. The man attended Healthcare on 28 December because he again had chest pains. The doctor examined him and reassured him that the result of an Echocardiogram (ECG) test was normal. No further action was required.

65. Although the timescale is unclear, an officer recalled in interview that some time in December 2007 he put the man's name forward to a cleaning officer (responsible for employing cleaners on the wing) for consideration as a wing cleaner. The cleaning officer spoke to the man about the suggestion and gave him a copy of the job description for a servery cleaner. The cleaning officer said at interview that the advantages of being employed in such work are that the prisoners are unlocked for longer and have more freedom on the wing. They are also able to use the telephone whenever they want and can decide when to take a shower, as long as the work is done. The cleaning officer recalled that the man worked well, although he had to speak to him about being too vocal and eating food from the servery before it was open.
66. The officer that put his name forward, was aware that the man had got the job as a cleaner, as he saw him out of his cell cleaning the landing. He said he realised the man was no longer a cleaner when he saw that his name had been taken off of the prisoners' pay sheet. He asked another prisoner what had happened and was told that he had been suspended from his job. The officer who put his name forward then heard staff talking about the man being sacked from his job and spoke to him about what had happened. The officer that put his name forward was aware that he hated being locked in his cell, and often left his cell door unlocked (as did other officers) to help him cope better. The officer also used to let him help out unofficially with the cleaning, which other staff were aware of too.
67. In his interview, the cleaning officer recalled why the man had been sacked from his job. He said that one Sunday morning (again, there is no precise date when this occurred), he noticed that all the servery utensils had been left piled up and unwashed. He went to his cell to see why this was, and found him lying in bed. He said he thought that the cleaning officer was covering his job (they had previously agreed that he would do so during the afternoon, as he had a visit arranged). The man told the cleaning officer that he did not want to do the washing up and, as the cleaning officer left the cell, slammed the door shut. The cleaning officer went back to the man's cell after a few minutes to ask whether the wind had blown the door shut, but he said that he had slammed it. The cleaning officer then sacked him from the job.
68. The cleaning officer recalled a conversation with the man a few days later about what had happened. He apologised for his behaviour and asked whether he could have his job back. The cleaning officer had already employed someone else to do the work, but agreed to consider re-employing him when he had another vacancy.
69. A fellow prisoner and friend of the man's, told my investigators that, after the man was sacked from his job, he noticed a deterioration in his mental health as he hated being locked up all of the time. The prisoner said he tried to speak to the cleaning officer about giving him his job back, but was unsuccessful. The prisoner added that he felt the cleaning officer seemed to "target" the man after he sacked him and treated him with "utter discontent (sic) and disregard for his (sic) well being". The prisoner said this contributed towards "the man's

deteriorating state of mind and hopelessness”. (My investigator has found no other evidence to suggest that the cleaning officer targeted the man, although it is manifest that losing his job and not being unlocked as frequently as before might have had a detrimental effect on him. There is also no evidence that he was bullied by the cleaning officer or any other member of staff.) The prisoner confirmed that some staff would allow the man out of his cell to help unofficially with some jobs. This does not indicate that he was targeted or bullied. Quite the contrary.

70. Another ACCT was opened on 9 February 2008. The man had made 16 superficial cuts to his left forearm, and had said that he could not do his “bang up” and needed to be out of his cell. It was recorded that he had been sacked from his job as a cleaner (which had allowed him out of his cell more often), and that he had applied for bail eleven times without success. It was agreed that he should remain in a single cell and be observed by a member of staff every half an hour. The ACCT assessment ended with him saying that he had no thoughts of self harm at that time. A further review was held just over an hour later; the man seemed more positive and remorseful about cutting himself earlier that day. The ACCT review panel discussed the need to find him another job, and he said there was no likelihood of harming himself any more and that he would alert staff if he had any problems. An application for employment was submitted later that day.
71. On 14 February, another ACCT case review was held. The man’s outlook seemed positive and his body language appeared to reinforce this. He was also positive about the possibility of obtaining employment again. It was agreed that the ACCT could be closed, with a post closure review scheduled for 21 February.
72. It is noted in prison records that the man was visited by his brother on 15 February. This visit lasted an hour.
73. Prison records show that the man also had a disciplinary hearing on 14 February. This was adjourned until 19 February so he could obtain legal advice. He had taken a random drugs test and tested positive for Benzodiazepines (a class of psychoactive drugs with varying hypnotic, sedative, anti-anxiety, anti-convulsant, muscle relaxant and amnesic properties, which are mediated by slowing down the central nervous system). He pleaded guilty to the charge, but there is no record of any punishment given to him before he died. He was seen by a member of Healthcare in the segregation unit (before his disciplinary hearing) and he said that he felt well and had no thoughts of harming himself or of suicide.
74. A post closure ACCT review was held by a member of staff on 21 February. (The signature on the record is illegible.) The record says that the man was maintaining a positive attitude and outlook, communicating effectively with staff, and overcoming his problems.
75. At interview, the officer that put his name forward told my investigators that at some point during the man’s time at the prison (he could not be sure when) his

cell mate was attacked by another prisoner and he was threatened by him. The officer could not recall what action, if any, was taken, but said that he thought it was a one-off incident and that the man was well liked on the wing. Another SO discussed the issue of bullying with my investigators and explained that there was a robust Violence and Anti-Bullying Strategy in place at the prison. An officer who worked on E wing, told my investigators that bullying did occur on the wing but that the man was not someone who would get bullied.

76. The prisoner told my investigators that the night before the man died he asked the prisoner if he had done anything to upset him. The prisoner said he had not. He thought that he might have felt this as they had not seen that much of each other since he was sacked from his job. The prisoner told him that he had been quite busy and had other things on his mind.

Events of 23/24 February 2008

77. On the night of 23 February, an operational support grade (OSG) was on night duty on E wing. Following a briefing from an officer, he checked all the cell doors were secure. The OSG then took a radio, signed onto the net (a network for all staff carrying radios), and began carrying out a roll check to ensure that all prisoners were in their cells. The OSG carried out the roll check at about 8.30pm. He was also responsible for checking any prisoner who was on an ACCT at the required frequency and time. In interview, the OSG recalled the times he had checked on the man when he had been on an ACCT. Sometimes the man would chat to him and sometimes he would not. He said that, as he was a high risk prisoner in a single cell, he was not allowed access to a Listener at night but could have access to a Samaritans telephone.
78. The OSG carried a sealed pouch containing a cell key and a gate key for the wing. If any problems were encountered during his duty, he would be able to break the seal in order to enter a cell. The local procedures for opening a cell door at night state that where:

“... there is, or appears to be, immediate danger to life, eg Fire, Attempted Suicide, cells may be unlocked without the authority of the NOO [Night Orderly Officer, a senior member of staff in charge of the prison during night duty] and with only one member of staff. In any event, the NOO must be informed first.”

A member of staff must use their own discretion whether or not to break the seal and enter the cell, depending on the situation. They are also required to radio immediately for help and assistance.

79. The OSG's next roll check was at about 5.45am the next morning (24 February). The OSG arrived at the man's cell (cell 14 on the fourth floor landing) and opened the flap to the observation panel. The light in the cell was on and he immediately saw that he was suspended from a ligature made from a pale green sheet. In interview, the OSG recalled that the man looked grey in colour and appeared to be stiff. He used his radio to call a Code One emergency. (This requests the attendance of Healthcare staff, the NOO and

any other available staff.) As he got his pouch out, ready to break the seal and unlock the door (which took a few seconds as his hands were shaking), an SO and another OSG arrived. The second OSG heard the emergency call on his radio and joined the SO as he was running to E wing.

80. The SO on scene unlocked the cell door and the second OSG went straight in and saw that the man was hanging from a ligature attached to the bars of the window and slumped almost onto a chair. He tried to lift the man to release the pressure around his neck and attempted to cut the ligature with his fish knife. However, the ligature was too tight and the second OSG was unable to cut it, so he tried to undo the knot. The SO on scene was standing at the cell door directing staff up to the cell. The second OSG was still trying to untie the knot when an officer arrived. They both tried to cut the ligature, without success. In interview, the second OSG recalled that a member of staff from Healthcare arrived with a pair of sharp scissors which the officer on scene used to cut the ligature. The officer on scene and the second OSG then laid the man onto the cell floor. The second OSG left the cell and two nurses attended to the man. They had heard the emergency call over the radio and, after the first nurse had picked up the trauma bag from Healthcare (containing an oxygen cylinder, defibrillator and other medical equipment), they ran to E wing. None of the staff who initially responded to the Code One call was currently trained in first aid.
81. The SO on scene used his radio to request an ambulance at 5.58am. Control room staff made the call immediately.
82. The first nurse recalled at interview that the man appeared very grey in colour and there was blood pooling around his stomach area suggesting he had been in the same position a long time. He could see that there were signs of rigor mortis.
83. The first nurse tried to get an airway open, but was unable to tilt the man's head back or open his jaw as his body was too stiff. He then began cardio pulmonary resuscitation (CPR) and asked his colleague to get the defibrillator and oxygen ready. He then attached the defibrillator pads to the man's chest and put the oxygen mask on his mouth. The defibrillator said "no shock advised," meaning that his heart could not be shocked back into a rhythm, so the first nurse continued administering chest compressions.
84. Within ten minutes the paramedics arrived. They advised the first nurse to stop CPR whilst they carried out their checks. After carrying out an echocardiogram, they pronounced that the man was dead at 6.05am.

After the man's death

85. An undated note was found in the man's cell in which he tried to explain the reasons for his actions. He apologised to the officer who would find him and to all who knew him.
86. Following advice and a risk assessment from the local police at 9.30am that morning, the Governor asked the police to inform the man's family of his passing. This they did, reporting back to the prison at 11.50am. The prison's family liaison officer telephoned the man's brother at 12.20pm. As the man was a Buddhist, a short Buddhist meditation was held later that day for prisoners who wished to attend. (he was also remembered in the Church of England service on 2 March.)
87. All prisoners on an ACCT on E wing were spoken to by staff and reminded of the services of Listeners and Samaritans. Members of the chaplaincy spent time on the wing speaking to prisoners and checking on their well being.
88. A post-mortem was carried out on 24 February at an outside hospital. The cause of death was hanging.
89. Members of the man's family visited the prison on 25 February, and spoke with members of the senior management team. The role of my office was explained to them, as was that of the Coroner. The family visited his cell and met with some of his friends to whom they spoke for some time.
90. HMP Lincoln contributed towards the cost of the man's funeral. Although nobody from the prison attended (as they had formed the impression from the family that it was to be a private affair), they did send flowers. Some prisoners held a collection and raised £170 to send to the man's family to enable them to plant a tree in his memory. A cheque was sent to his brother on 21 April. However, the cheque was not cashed and another letter was sent on 10 October 2008. The man's brother is looking into where and how to go about planting a tree, and intends to contact a preservation society the man was involved with.
91. Although there does not appear to have been a hot de-brief on the day the man died (possibly because of the time of day and that night duty staff were going off duty), a critical incident debrief was held some time after (although the date on which it was held is unclear). Those who attended found it helpful and spoke highly of the help and support given by local Care Team members at the prison.

ISSUES

Clinical Care

92. The clinical reviewer notes that:

“A formal clinical assessment of suicide risk should be undertaken by a trained member of the mental health staff after any episode of self harm. No clinical assessment was undertaken after [the man’s] (sic) last episode and this is regrettable, although it seems likely that the decision to take him off ACCT subsequently would probably have been the same.”

However, the clinical reviewer concludes that overall, “the health care provided by the primary care service in Lincoln Prison for the man’s mental health problems was at least of an equivalent standard to the service available in the community.” The clinical reviewer also says that, “a serious suicide attempt at the time of his death was not predictable”.

The Governor and the Head of Healthcare should ensure that a member of the Mental Health In-Reach Team is present or has input into all ACCT assessments, where possible.

93. The clinical reviewer also recommends that a meeting should take place between prison and Healthcare staff to discuss any lessons that could be learnt.

The Governor and the Head of Healthcare should ensure a meeting is held between prison and Healthcare staff to discuss the learning points arising from the man’s death.

94. A further recommendation from the clinical reviewer, which I also endorse, concerns the quality of clinical record keeping. This is a recurrent finding in my investigations. Clinicians should print as well as sign their names in clinical records so that they are more readily identifiable. My investigator also found that many of the notes made in the man’s prison records by prison staff were either not signed or were illegible.

The Governor and the Head of Healthcare should ensure that all staff (both clinical and prison) are aware of the need to make legible entries into prison records and to sign and print their name against any entries.

95. The clinical reviewer comments on the absence of a formal screening questionnaire to assess the degree of the man’s depression, and recommends that a screening tool be integrated into the assessment of a prisoner’s mental health.

The Governor and the Head of Healthcare should ensure that a formal screening tool is available (and used) to assist in assessing a prisoner’s level of depression.

Bullying

96. The man's brother asked my investigators to check records of the man's telephone conversations to look for signs that he was happy and had no plans to take his own life. The calls that my investigators were given copies of (and which were copied to the man's brother) gave no indication to this effect, but neither did they give any signs to the contrary.
97. His brother was concerned that the man might have been bullied or threatened by staff whilst at Lincoln, and referred to when he had told him that an officer had made a cutting gesture across his throat saying, "I'm gonna kill you." My investigators could find no supporting evidence of this from staff or from other prisoners. Although there is evidence from staff that bullying can and does occur on E wing, there was no evidence to suggest that he was ever bullied. He appeared to be a popular and well liked person, and none of his fellow prisoners was aware of his having any trouble with others.

Drug testing

98. The man had a random drug test which tested positive for Benzodiazepines. He pleaded guilty at the subsequent disciplinary hearing. I do not know how he obtained the drugs, and have not sought to discover how prevalent the abuse of Benzodiazepines is at HMP Lincoln. I simply draw the matter to the attention of the Governor, and make no recommendation here.

Resuscitation and first aid training

99. Even though there were clear signs that the man was already dead, the nurses attempted CPR. This speaks well of their dedication, although there comes a point when CPR is respectful neither to the staff concerned nor to the memory of the person who has died. I note that none of the prison staff who attended to him before the nursing staff arrived was first aid trained. I have previously made a recommendation to the Governor that a cross-section of staff should be current first aiders. I repeat my recommendation and 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.

Hot de-brief

100. Although a critical incident de-brief was held in respect of the man's death, a hot de-brief does not appear to have taken place. This may have been because of the time he died and the changeover from night to day staff. However, where possible, a hot de-brief for staff should be held as instructed in Prison Service Order 2700 to allow staff to talk over what has happened and how they are feeling.

The Governor should ensure that a hot de-brief is held as soon as possible after a death or other serious event has occurred.

Anal bleeding

101. His brother was concerned that the man's post-mortem report said that there had been some anal bleeding and was worried that he might have been assaulted. In fact, the relevant section of the post-mortem report reads as follows:

“... bloodstained faecal material was present to the anus. An examination of the buttocks, peri-anal and anal area as well as a complete removal of the anus with the rectum, revealed petechial haemorrhages to the anal-rectal junction.”

These findings were considered by the doctor carrying out the post-mortem to have resulted from the hanging rather than from a penetrative injury. There was no other injury to the anus, the rectum or surrounding areas, which suggests that no assault had taken place.

Conclusion

102. According to the clinical review, the man's clinical care whilst at Lincoln was at least of an equivalent standard to that he would have received in the community.
103. The man was on an ACCT when he arrived at Lincoln (it had been opened on 2 February 2007) and remained on it until 8 May. Another ACCT was opened on 16 May and was regularly reviewed by staff. This ACCT was closed on 8 June with a post closure review on 22 June. Although another ACCT was not opened until 9 February 2008, staff appeared to continue to monitor him closely. He had further episodes of harming himself (by cutting himself or hitting his head) although none of these incidents involved the use of a ligature.
104. I believe that staff at Lincoln managed the man's problems entirely properly. He was seen by members of Healthcare (including a specialist mental health nurse) on a regular basis, and his ACCT reviews were carried out on time, often with a member of Healthcare available, and action plans were followed up.
105. I agree with the clinical reviewer that a serious suicide attempt at the time the man died could not reasonably have been predicted.

RECOMMENDATIONS

To the Governor and Head of Healthcare

1. The Governor and the Head of Healthcare should ensure that a member of the Mental Health In-Reach Team is present or has input into all ACCT assessments, where possible.
2. The Governor and the Head of Healthcare should ensure a meeting is held between prison and Healthcare staff to discuss the learning points arising from the man's death.
3. The Governor and the Head of Healthcare should ensure that all staff (both clinical and prison) are aware of the need to make legible entries into prison records and to sign and print their name against any entries.
4. The Governor and the Head of Healthcare should ensure that a formal screening tool is available (and used) to assist in assessing a prisoner's level of depression.

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 ensure that a hot de-brief is held as soon as possible after a death or other serious event has occurred.