PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Lincoln in August 2012

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man at HMP Lincoln who was found hanging in his cell in August 2012. He was 21 years old. I offer my condolences to his family and friends.

An investigator was appointed and a clinical reviewer carried out a review of the man's clinical care and treatment on behalf of the local Primary Care NHS Trust. Lincoln prison cooperated fully with the investigation.

The man had been released on licence from a previous period in custody, when he was recalled to prison on 5 July 2012 facing fresh charges. He was very briefly subject to self-harm monitoring on 11 July when prison staff discovered that he had cut himself when he returned to prison. The monitoring ended the next day when he assured staff that it had been a rash act which he would not repeat. Later in July, his probation officer passed on her concerns to the prison about his state of mind. Subsequently he stopped attending work, resulting in a withdrawal of privileges and a disciplinary punishment, which furthered his isolation as he was moved to a single cell. In August, he was found hanging from a locker in his cell. Staff tried to resuscitate him, but their attempts were unsuccessful.

The investigation found that there was insufficient enquiry into the reasons the man chose to stop attending work. The response to his non-attendance was too punitive and not consistent with national guidance. His initial monitoring for risk of suicide and self-harm ended prematurely and insufficient attention was given to his probation officer's warnings about his risk. I am concerned that this meant that a key opportunity to provide him with greater support was missed.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2013**

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SUMMARY

1. The man was born in October 1990. He had been sentenced to 36 months imprisonment at the end of 2010 for grievous bodily harm against his girlfriend. He was released from prison on licence in February 2012. On 5 July, he was arrested and charged with new offences. He was recalled to custody and went to HMP Lincoln that day, where he was held in the vulnerable prisoners unit because of the nature of the charges.

2. During a routine health screening the man said he had no thoughts of self-harm, but on 11 July blood stains were noticed on his shirt sleeves and he admitted to having cut his arms. An ACCT[1] was opened. He said he had cut himself a few days earlier, when he had first returned to custody. He said he was angry at the time, but cutting himself had not helped and he indicated he would not harm himself again. Prison staff were satisfied with his assurance and the ACCT was closed the next day.

3. The man's probation officer visited him on 19 July and was concerned about his mood and that he had stopped contact with his family. She spoke to a probation colleague at the prison who passed her concerns to his wing, to the mental health team and to the prison's security department. None of these alerts resulted in any change to his management and no-one spoke to him as a result of these concerns to assess his mood.

4. At a post-closure ACCT review the next day, the senior officer conducting the interview considered there were no grounds to re-open the ACCT. It is not clear that the senior officer was fully aware of the probation officer's concerns.

5. The man refused to go to work on 8 and 9 August. As a result he was placed on the basic level of the incentives and earned privileges (IEP) scheme, his television was taken away and he was moved to a single cell. At a disciplinary hearing on Saturday 11 August he said his reason for refusing work was that he had had a "bad week", but would resume work the following Monday. He was further punished by loss of some of his prison earnings for the next two weeks and a restriction on his opportunity to use the prison shop.

6. During an early morning count of prisoners in August, the man was found hanging in his cell. Staff responded quickly, entered the cell, cut the noose and attempted resuscitation but when paramedics arrived they confirmed that he was dead.

7. The investigation found that the man's ACCT plan was closed prematurely. Insufficient attention was given to his probation officer's concerns about his risk to himself, which were not entered on his individual record and ought to have resulted in an ACCT being opened. We do not consider that aspects of Lincoln's IEP scheme were consistent with national guidance and he was

[1] ACCT (Assessment, Care in Custody and Teamwork) is the process used for monitoring and supporting prisoners at risk of self-harm or suicide.

placed on the basic regime level too quickly and was subject to double jeopardy in relation to his refusal to attend work.

THE INVESTIGATION PROCESS

8. The investigator visited HMP Lincoln on 15 August 2012 and met one of the prison's operational managers, a representative from the Prison Officers' Association and a member of the Independent Monitoring Board.

9. The investigator visited the man's cell and the wing where he lived. He obtained copies of his prison and health records. Notices were issued to staff and prisoners informing them of the investigation and inviting them to contact the investigator if they wished to be involved. Three prisoners came forward in response who the investigator subsequently interviewed, as well as 18 members of staff.

10. The investigator informed the Coroner's office of this investigation and a copy of this report has been sent to the Coroner to assist his enquiries.

11. A clinical reviewer carried out a review of the man's clinical care and treatment at the prison on behalf of the local Primary Care NHS Trust.

12. One of the Ombudsman's family liaison officers contacted the man's mother to inform her of the investigation and to offer the opportunity to raise questions for the investigation to consider. She asked whether her son had harmed himself previously in Lincoln and whether he had been monitored at any time to prevent further acts of self-harm.

HMP LINCOLN

13. HMP Lincoln is a Victorian prison which holds up to 729 remand and convicted prisoners. It consists of four main residential wings, one of which houses vulnerable prisoners. Healthcare is commissioned by a NHS Trust.

HM Inspectorate of Prisons

14. HM Chief Inspector of Prisons' most recent inspection of Lincoln was in August 2012. In the introduction to the report the Chief Inspector said:

> "… This inspection identified some serious concerns about the prison which had deteriorated sharply since our last inspection in 2010. These needed to be vigorously addressed as a matter of urgency …
>
> "The prison was not safe … 24% of prisoners told us they felt unsafe at the time of the inspection compared with 17% in comparable prisons and 14% the last time we inspected Lincoln. This was even higher on the vulnerable prisoner wing. A third of prisoners told us they had been victimised by other prisoners … There was little attempt to investigate either individual incidents or patterns of violence …
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> "A saving grace for the prison was good-staff prisoner relationships – without this, the other problems may have had much more serious consequence … We saw generally good relations and examples where individual staff reacted with care and compassion to prisoner concerns …"

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their annual report for the period 1 February 2011 to 31 January 2012, the IMB noted "Staff make considerable efforts to ensure prisoners at risk of suicide and self-harm are identified and their care is appropriately recorded in the Assessment Care in Custody Treatment documentation (ACCT)".

Previous deaths in custody at Lincoln

16. The Ombudsman investigated another self inflicted death at Lincoln in April 2012. Both prisoners were subject to ACCT procedures during their time in Lincoln but there were no other obvious similarities between the deaths.

KEY EVENTS

17. The man subject to this investigation was born in October 1990. On 27 November 2010, he was arrested and charged with grievous bodily harm against a girlfriend. Two days later he was remanded into custody at Her Majesty's Prison and Young Offenders Institution (HMP & YOI) Hatfield. On 7 January 2011, he was sentenced to 36 months imprisonment.

18. After he had served 14 months of his sentence, the man was released on licence[2] on 9 February 2012.

19. On 5 July 2012, the man was arrested and charged with several offences, including one of sexual assault against a new girlfriend. He was recalled to custody and remanded to HMP Lincoln. During the reception process, he named his mother as his next-of-kin and reported that he had lived at her address before his arrest. His mother was also the carer of his young daughter. He went to the vulnerable prisoners (VP) unit[3] on E wing.

20. At a healthcare assessment on 5 July, a nurse noted that the man had no physical health problems, except he was prescribed medication for acne. He reported no past or present thoughts or acts of self-harm, and no mental health concerns.

21. The first Senior Officer (SO) told the investigator that although she had seen the man on the wing she had no direct dealings with him until 11 July, when another prisoner told her that there were blood stains on the cuffs of his sweatshirt. She asked him to show her his arms, which revealed a number of cuts to both forearms. He said he had done this about five days earlier when he was first recalled to prison, because he was angry at being recalled and had cut himself in a "moment of madness". She arranged for a nurse to examine him, who noted:

> "Seen due to self-harm on both forearms, had made several deep cuts says 5 days ago but did not tell anyone. Remain as deep open wounds but scabbed in places. Dressed [wounds]. Advised as required."

22. The first SO opened an ACCT and explained the process to the man, who said that he did not need such support and was adamant that his actions had been a "one-off" event. She set a support plan pending a full assessment and case review. The support plan included checks every two hours, and three conversations with staff during the day. She told the investigator that owing to annual leave she had no further contact with him.

23. An officer (an ACCT assessor) conducted the full ACCT assessment the next day, 12 July. The man repeated that he had made the cuts a week earlier, in

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[2] When a prisoner is released early on licence they must abide by the conditions of the licence until its expiry. If they fail to comply with the conditions they can be recalled to prison.

[3] Vulnerable prisoners are those who are at potential risk from other prisoners, mostly because of the nature of their offence.

"an hour of madness". He said that he regretted his actions as making the cuts had resolved nothing. He said that he had a supportive family and good circle of friends and had no intention of repeating his actions.

24. The first and only case review followed after the assessment and was chaired by the second SO, with the man and the ACCT assessor also present. There was no healthcare presence or representative from any other prison department. The man reiterated what he had said during the ACCT assessment. The second SO noted in his summary of the review that the man:

> "… is now a lot more settled and has not had any thoughts of self-harm … has received encouragement from his mum and his solicitor … states that if he has thoughts of self-harm in the future he will speak to staff."

25. Both members of staff agreed that the ACCT should be closed. A post-closure interview was set for 19 July. (Post-closure ACCT interviews are held around a week after the closure of an ACCT to identify whether there are any outstanding concerns or problems.)

26. On 13 July, the man started work in the prison's 'charity workshop', which mainly works in textiles, producing items such as clothing and towels. The workshop also embroiders clothing and makes signs.

27. On the morning of 19 July, an officer wrote in the man's electronic prison record (known as P-NOMIS) to say that:

> "[he] is a quiet individual who is polite and respectful to staff and wing visitors, he has gained employment in the charity [workshop] and he tells me he enjoys getting out of his cell and being occupied, no current issues or concerns and he is fully aware of all means and methods of support available to him and how to access these if required."

28. In the afternoon of 19 July, the man was visited by his community probation officer (offender manager), who was accompanied by one of her colleagues. She told the investigator that the purpose of her visit was to carry out a post-prison recall interview. He told her that he was intending to plead not guilty in response to his latest charges. She intended to recommend to the court that he should remain in custody until his trial. She said that he understood that if found guilty he would receive a lengthy sentence. He said he was close to his family, but told her that he intended to break off contact with them as he was remorseful of the effect on them of him being back in prison. He mentioned that he had cut himself when he was recalled to prison and had been subject to ACCT monitoring for a day. She asked him if he would harm himself again but he was adamant that he would not. Despite this, she was concerned about his mood. She described this as "seething anger" and she was concerned he might harm himself. When she returned to her office she telephoned the prison probation officer for advice on what she should do about her concerns.

29. The prison probation officer told the investigator that when she started working at the prison she was briefed about prison procedures such as the ACCT

process, as well as other processes including security information reports[4] (SIRs). She had never met the man, but contacted healthcare who advised her to make a written mental health referral and to inform the wing. She phoned E wing and spoke to a landing officer. She also submitted an SIR saying:

> "Received a telephone call from the Probation Officer who had seen [the man] earlier today … She was concerned as he presented as extremely low. He [is isolating] self from family … Told her he was on ACCT previously … She felt he had underlying anger and [she] was under the impression he was building up to do something to harm himself. Mental health referral made and I have also informed E wing – Officer A."

30. The E wing landing officer acknowledged at interview that he was informed of the probation officer's concerns. He could not recall speaking with the man as a result, but in any case did not consider it necessary to take any action as an ACCT form had already been opened and then closed again when he assured staff that the issues were in the past. He made no entry on P-NOMIS about the concerns raised in the SIR, nor did he make an entry in the wing observation book.

31. Once she had completed the SIR, the probation officer signed it as well as dating and timing it. She noted the time as 4.20pm and she then submitted the form to the prison's security department in keeping with standard procedures.

32. The security department SO told the investigator that she arrived on duty at 7.30am on 20 July and read all SIRs submitted the previous evening. When she read the SIR about the man, she telephoned the E wing senior officer who she thought was the second SO[5]. She said that she did not read out the SIR in full but the gist of the issues highlighted. She understood from the second SO that he would take appropriate action. (She did not record on the SIR the action she had taken.)

33. The second SO saw the man for a post-closure ACCT interview on 20 July (the interview was originally scheduled for 19 July but was postponed by a day). He had chaired the ACCT review of 12 July when the ACCT was closed and he noted on post-closure document that all the issues that led to the ACCT being opened were now resolved. He also noted that the man said he had the full support of his family and friends and would turn to prison staff for further support if needed. The second SO told the investigator it was possible that he was told by the security department that probation staff had raised concerns but he could not remember. He said he had not seen the SIR or known the full contents, but if he had been aware, he would probably have re-opened the ACCT.

34. In response to the mental health referral made by the probation officer on 19 July, the mental health team sent the man a letter on 23 July asking him

[4] Security Information Reports are used to collect information and to manage and prevent incidents that could impact on prison security.
[5] Lincoln has confirmed that SO A was the only senior officer on duty on E wing that morning.

whether he wanted a triage appointment with the mental health team to identify any problems he might be having and to decide what treatment would be best. He declined the offer explaining: “Felt down when I just came in [to Lincoln] – fine now”.

35. The mental health team co-ordinator told the investigator that had the man been displaying clear signs of mental health illness, he would have been assessed by the mental health team within four hours of being alerted. However, in the case that a prisoner’s symptoms are in the range of a more low level depression the process is to invite the prisoner to choose whether or not he wishes to have an appointment, as happened with the man. He acknowledged that an entry should have been made in the clinical records that he had declined an appointment.

36. On 8 August, the man refused to go to work. The personal officer[6] told the investigator that the man was a quiet and polite prisoner who tended to keep himself to himself. At first, he seemed to have been doing well, including getting a prison job but then he stopped going to work. The officer said that he tried to explore with him his reasons, but he just said he did not want to go.

37. Because of his refusal to go to work the man was called to a “basic regime” review with his personal officer and the second SO. (Basic regime is the lowest level of the incentives and earned privileges (IEP) scheme[7]. Lincoln’s scheme stated that a single refusal to attend work would result in immediate demotion to basic regime.) The personal officer told the investigator that he and the second SO “tried every angle” to persuade him to return to work. They told him that if he agreed to return to work that afternoon or the following morning his IEP level would be unaffected. He was adamant, however, that he would not go.

38. The effect on the man being demoted to the basic regime included a reduction in the amount of time he could spend out of his cell associating with other prisoners and the loss of his television. So that the lack of a television would not impact on a cell-mate, he was moved to a cell on his own. The second SO told the investigator that he tried to find him a radio but was unable to as he said there were “not very many radios around”.

39. The man again refused to go to work on the afternoon of 9 August. An officer told him that this refusal would lead to disciplinary charges, but he replied that “he did not care”. The officer wrote a ‘notice of report’ that he had contravened Prison Service rules by disobeying a lawful order and that this was the third time he had refused to attend work since being reduced to basic regime. He was told that an adjudication (disciplinary hearing) would be held on the morning of Saturday 11 August.

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[6] (Prisoners are allocated personal officers to support them and act as their first point of contact for questions, complaints and advice.)

[7] Prison IEP schemes aim to encourage and reward responsible behaviour through the award of greater privileges where a prisoner has been compliant with the prison regime and has engaged in work, education or other constructive activity. Enhanced status is the highest level within the scheme. Standard status is the middle ranking level and basic status the lowest.

40. The man's adjudication was carried out by one of Lincoln's residential managers. He said that as part of the hearing, he read a conduct report that said that apart from his failure to go to work, the man was otherwise a polite person who adhered to the wing regime. The conduct report also explained that an ACCT had been opened at one time following an act of self-harm. He pleaded guilty to the charges and said he had no excuse for not attending work, only that it had been a "bad week". He said, though, that he intended to return to work the following Monday. The residential manager told the investigator that the man did not elaborate on what he meant about it having been a bad week and he did not question him about this. His presentation that day had been quite "upbeat". He stressed that the man did not seem depressed or troubled.

41. The residential manager found the man guilty of the charge and decided that he should lose access to canteen (prison shop) purchases for ten days and have a 50 per cent reduction in earnings for 14 days. He told the investigator that the punishment was at the bottom end of the scale for the offence and the man accepted the punishment without complaint.

42. The investigator spoke to several prisoners from E wing. The first prisoner was the man's cell-mate when he first came to E wing. The man had shown him the cuts he had made to his arms after his recall to prison. He said the man spoke about wanting to die as he felt he had let down his parents. He told the man that he thought that suicide was a very selfish act and he thought that he had convinced him of this. When the man's IEP level was reduced to basic he was moved to a different cell and they had no further conversation after this.

43. The second prisoner told the investigator that he and the man spent a lot of time together. The man told him that the reason he had cut himself when he arrived in Lincoln was because of the difficulties he had created for his family by returning to prison. He spoke about wanting to take his life and the prisoner told him that he should think about the impact on his family if he were to do this. He said the reason the man had stopped going to work was because other prisoners in the workshop were making lewd comments to him. He had told him to report this to staff but he would not, so he said he had told the E wing Principal Officer (PO).

44. The PO told the investigator that one of the officers told her the man had missed work on more than one occasion, so she spoke to him to find out why. He said that he was still trying to come to terms with being recalled to custody. He said that he had started his life again after had had been released on licence and so was struggling with being back in prison. He said that he did not want to be amongst people and needed some time on his own to deal with his recall. She warned him about the consequences if he continued to refuse to go to work and she asked him whether there were any specific problems at the charity workshop. He said there were not and repeated that he wanted time alone. She again told him about consequences and he replied in a matter of fact way that she could do whatever she wanted to do and it would make no difference to him.

45. The E wing PO said that a few days after this conversation, the second prisoner told her that the man was being bullied in the charity workshop and that was why he was not going to work. She said she spoke to the man again, but he was adamant that he was not being bullied. She said that she was confident that there was no substance in what the prisoner had told her. She added that there had been other occasions when this prisoner had reported prisoners being bullied when she believed that was not the case. She thought this conversation had taken place on either 8 or 9 August and it was her last conversation with the man. She made no record of her conversation with him, nor did she complete an SIR.

46. The second prisoner told the investigator that the man had continued to cut himself through his time in Lincoln by cutting his arms and his thighs. He said his grey prison issue sweatshirt and jogging bottoms both had visible bloodstains. Not only should staff have noticed this for themselves, but he said he had reported it to the wing nurse. He said that he asked her what she would do if he were to tell her that the man was harming himself. He said that he understood from the nurse that the matter would be dealt with as a medical matter, but instead the nurse reported it to the third SO. He, in turn, spoke with the man. The man told the third SO that the cuts were old and so no further action was taken.

47. The investigator spoke to the wing nurse and the third SO. The wing nurse said that the second prisoner had not spoken to her about the man harming himself. She said that it had been many months since she had had any conversation at all with the second prisoner. Moreover, she would not give an assurance to a prisoner that a matter of deliberate self-harm would be dealt with as a medical issue, as it is an issue for all staff and must be managed through the ACCT process. The third SO also denied any knowledge of the second prisoner's claims. He said that he had had no one-to-one dealings with the man.

48. The investigator asked several other staff whether they had ever observed the man wearing blood stained clothing. None had done so, apart from the one recorded occasion on 11 July when this had been drawn to their attention by another prisoner.

49. The personal officer told the investigator that he saw the man on the wing on the morning of 12 August, when he appeared to be his usual self. The personal officer had heard from a colleague that the man had agreed to return to work the next day (Monday), so he asked him about this. The man confirmed that that was his intention.

50. That evening the final roll check of the day was carried out by an officer between 7.00pm and 7.20pm. He noticed nothing unusual.

51. An Operational Support Grade[8] (OSG) member of staff who was on duty on E wing that night, carried out a check of all the cells at some time before 9.00pm

[8] Operational Support Grade staff do not receive the same level of training as prison officers staff and have limited direct contact with prisoners.

to make sure that all the prisoners were present. He signed a report that all was okay. As the man was not on an ACCT, the OSG had no reason to make any further checks on him through the night.

52. At about 5.30am the following morning, the OSG started the morning roll check. When he checked the man's cell he saw him hanging from a ligature that was tied to the bed frame and looped over a locker. He called a code one emergency over his radio, which indicates a prisoner with serious breathing difficulties, and that a full staff response is needed. The call was timed at 5.36am. The OSG broke his sealed key pouch[9] and went into the cell. He lifted the man's body to relieve the weight from his neck but was not able at the same time to cut through the noose which had been made from T-shirts. He was joined at 5.38am by a healthcare assistant (HCA), a nurse and the Night Orderly Officer[10].

53. Because the noose was very thick staff were unable to cut the noose with their anti-ligature knives so they used scissors from the emergency bag brought by the nurse. Staff laid the man on the floor and the OSG and HCA started chest compressions. The nurse had already asked the control room staff to call an ambulance. She then checked the man with a defibrillator, which advised that no shock be given. When she attempted to insert an airway into his windpipe to aid delivery of oxygen, she was unable to do so as his jaw was clenched tight. Despite indications that the man was already dead, staff continued delivering chest compressions until ambulance paramedics arrived. The paramedics arrived at just after 5.45am and the man was pronounced dead four minutes later.

54. One of Lincoln's family liaison officers (FLOs) was appointed to liaise with the man's family. At just after 10.00am, the Coroner's officer confirmed that the FLO was no longer needed at the prison and, together with Lincoln's Head of Residence, the FLO visited the man's mother. They arrived at her house at just after 10.30am and broke the news. The FLO asked the mother whether there was anyone he should contact for support. She declined, saying she would call a friend to visit. The FLO gave the mother an information leaflet. Later that day the FLO spoke to the man's father and grandfather, as well as contacting the man's mother again to inform her about financial assistance with the funeral arrangements. The mother was also offered the opportunity to come to the prison and to visit her son's cell.

55. A hot debrief was held for staff involved in the discovery of the man's death (the purpose of a hot debrief is to offer support and reassurance to staff involved in the incident). The E wing PO told the prisoners what had happened and she arranged for staff and Listeners to be available to support other prisoners. Prisoners on open ACCTs were reviewed. E wing prisoners later made a collection to purchase a floral tribute for the funeral.

[9] At night time, most staff carry a cell-key contained in a sealed pouch which should only be opened in the case of an emergency.
[10] The Night Orderly Officer (NOO) is the person in operational charge of a prison at night time.

56. The post-mortem examination revealed that the man had multiple superficial scars and cuts of variable age to many parts of his body.

ISSUES

Opening and closing of the ACCT on 11 and 12 July

57. The man arrived at Lincoln on 5 July. No issues of concern were identified during the reception processes and he said he had no thoughts of self-harm. However, on 11 July, a prisoner drew the first SO's attention to blood stains on the man's sweatshirt sleeves. When she asked him about this he told her that he had cut his arms when he first arrived in Lincoln and had done so because he was angry about being back in prison. When the cuts were examined by a nurse, it was evident that they had been inflicted some days previously as they were in the process of healing. The first SO opened an ACCT.

58. At an ACCT assessment interview the next day, the man said that he had cut himself in an "hour of madness", that he regretted his actions, which had resolved nothing, and that he would not harm himself again. The assessment interview was immediately followed by an ACCT case review when the man and the ACCT assessor were joined by the second SO. He made similar comments at the review and the ACCT was closed.

59. The ACCT had remained open for only a little over 24 hours at its point of closure. The man's act of self-harm had occurred some days earlier, as many as seven days earlier if he did it immediately after he arrived at Lincoln. Despite this, and despite his protestations that he would not repeat such an act, we consider its closure premature. On reception, he had indicated that he had no intention of self-harming yet did so very shortly afterwards. Prison staff therefore already knew that his statements about his intention to self-harm could not be relied on. The staff did not know him and he had other risk factors in addition to his recent incident of self-harm. These were that he was a licence recall prisoner and that the victim of his alleged offences was a partner or ex-partner. It is also a concern that the ACCT was closed so quickly without a multi-disciplinary review – only an SO and an officer were present at the review, while Prison Service instructions require that case review teams "must be multi disciplinary where possible".

60. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. However, too much weight was placed on the man's presentation, rather than a more holistic consideration of all the factors. In the light of the known risk factors and the recent act of self-harm, we consider that it would have been prudent to have kept his ACCT open for a period to allow staff more time to assess whether there was any risk of further acts of self-harm.

The Governor should ensure that multi disciplinary reviews take into account and record all evident risk factors before closing an ACCT.

Concerns raised by the man's offender manager

61. When the man's offender manager visited him on 19 July she was concerned about his mood. He told her that he had cut himself when he first came to Lincoln and had been on an ACCT for a day. Although he said he would not harm himself again she was very concerned about him and was struck by his "seething anger" and how he might act on it to harm himself. She was also concerned that he told her that he was intending to sever relations with his family out of feelings of guilt. When she returned to her office she telephoned a prison probation officer for advice and to pass on her concerns.

62. The probation officer completed a Security Information Report (SIR) detailing all the concerns raised by the offender manager. In addition, she reported the concerns to a wing officer and made a referral to the mental health team.

63. The E wing landing officer recalled being contacted by the probation officer, but he did not consider he needed to take any action as an ACCT form had been closed a week earlier when the man told staff then that he would not harm himself again. Nor did he make any note of the call from her either in the wing observations book or in the man's P-NOMIS record.

64. We consider that the information relayed to the E wing landing officer warranted the re-opening of the ACCT. The probation officer was relaying fresh concerns about the man's current state of mind. In addition, the SIR mentioned that he was isolating himself from his family, which contradicted what he had said at the ACCT case review on 12 July. It is a concern that one officer took this decision without discussing it at least with the wing senior officer.

    The Governor should ensure that staff record and take fully into account significant new information about risk or change in circumstances and refer to managers when considering whether to re-open an ACCT.

65. In addition to considering more carefully whether the information relayed to him by the probation officer warranted the re-opening of the ACCT, the E wing landing officer should have, at the very least, noted the information in the man's P-NOMIS record and in the wing observation book so that other staff would be aware of the concerns raised and could be vigilant for other signs of risk.

    The Governor should ensure that staff note important information about risk received from external agencies in prisoners' P-NOMIS records and wing observation books.

The SIR and the ACCT post-closure interview

66. After contacting wing staff and the mental health team on 19 July to pass on the offender manager's concerns, the probation officer submitted an SIR to the security department, which considered the information on 20 July.

67. The security department SO told the investigator that she telephoned the wing and spoke to a senior officer. She thought this had been the second SO and

the prison has confirmed that he was the only senior officer on duty on E wing on the morning of 20 July. She said that she did not read out the SIR in full, but would have read out the salient points of the concerns.

68. The second SO said he had no clear recollection of whether he had received a call from the security department SO. This is surprising, as it was the same day that he met the man for the ACCT post-closure interview. He did not deny receiving a call yet, if he did, he made no record of it. At the post-closure review he noted that all of the issues that led to the ACCT being opened were resolved and that the man had the full support of his family. This is contradicted by the information in the SIR. He decided that no further action was necessary and that the ACCT should remain closed.

69. When the investigator read out the SIR in full to the second SO, he said that if he had received all of the information he would have challenged the man's answers at the review and he might have reopened the ACCT. We consider that had he been aware of the information the ACCT should have been reopened.

70. While we have no reason to doubt the security department SO's evidence, she acknowledged that she did not record on the SIR the action she had taken.

71. SIRs are normally used to convey information about matters of security, such as a suspicion that a prisoner might be in possession of illicit items or suspicion of bullying by a prisoner. SIRs are managed by the security department who contact the relevant prison wing to convey any information that might compromise safety. However, SIRs are retained in the security department and are not copied to the wing staff. This makes it important that information about a prisoner's risk of harm to himself contained in a SIR is clearly conveyed.

The Governor should ensure that the security department clearly convey to wing staff all relevant information about a prisoner's risk to himself contained in SIRs and record the action they have taken.

Referral to the mental health team

72. In her referral to the mental health team the probation officer used a standard pro-forma referral form. On the form she noted that the man's offender manager was concerned about his mental state, that he appeared to have an underlying anger, that he was isolating himself from his family, that he had previously cut himself and that he was possibly building up towards harming himself again. The referral was submitted on the afternoon of 19 July, the day of the offender manager's visit.

73. In response to the referral, the mental health team wrote to the man on 23 July asking him whether he wanted to be assessed by the team. He wrote back declining the offer explaining that he had "felt down" on his initial return to custody but was "fine now". The mental health team accepted his decision to decline an appointment.

74. The matter of the man's immediate risk of self-harm had been dealt with, as far as the probation officer and healthcare were concerned, through her contact with wing staff. However, the clinical reviewer recommends that the mental health team should develop a process that allows a more in depth risk assessment for dealing with referrals on prisoners considered at risk of self-harm. We agree that handling of this referral about a prisoner's risk of self-harm was unsatisfactory.

The Head of Healthcare should ensure that the prison mental health team implements a process for in depth risk assessment of referrals for prisoners considered at risk of self-harm with a clear triage and prioritisation pathway to facilitate timely face to face assessment.

The IEP scheme and the adjudication on 11 August

75. In April 2011, Lincoln issued a notice on new procedures for dealing with prisoners who refuse to go to work. The previous procedure was that following three occasions of refusing to attend work, a prisoner's IEP level would be reduced to basic. The change in April 2011 was that a prisoner would be reduced to basic after a single refusal to attend work and that the immediate reduction to basic would occur regardless of their current IEP status.

76. The man was noted to have refused to attend work for the first time on 8 August and later that day he was issued with a notice informing him that he had been reduced to basic regime.

77. On 10 August the man was issued with a disciplinary charge for breach of Prison Rules. The details of the charge are that on the afternoon of 9 August he had refused to attend work for a third time since being reduced to basic regime. (There is no record of him having refused work on four separate occasions as the notice would imply.)

78. At the adjudication hearing on 11 August, the man pleaded guilty to the charge. He gave no proper excuse for refusing to go to work but said he would return to work on the following Monday. The evidence of the residential manager who conducted the adjudication hearing indicates that he was untroubled. However, there is little indication on the record that the residential manager questioned what he meant by having had a bad week. We would have expected the adjudicator to make further enquiries about this. It is also a concern that the adjudicator was not given information that he might have been having problems at work so he could investigate that. However, the evidence was consistent with that of the E wing PO, who tried to persuade him to return to work and gained a response from him that he did not want to work at that time and was unconcerned about the consequences.

79. Prison Service Instruction (PSI) 11/2011, issued on 1 March 2011, sets out the framework for prisons in delivering IEP schemes. Advice contained in the PSI includes that:

"… A single incident of misbehaviour or short term failure of performance will not automatically result in a change of [IEP] status, but may be taken into account when considering the prisoner's general suitability to … retain privileges.

"The determination of a prisoner's privilege level must be based on patterns of behaviour rather than a single incident … unless it is especially serious … be separate from the disciplinary system ….

"… The fast-tracking of prisoners from enhanced to basic must be avoided except in the most serious cases of misconduct, e.g. assault …"

80. Regardless of the man's apparent acceptance of the sanctions imposed following his refusal of work, Lincoln's policy on dealing with a single refusal appears at variance with the principles set out in the PSI. It also meant he was punished twice, firstly by a reduction in his IEP level and secondly at the adjudication hearing.

81. When the man was reduced to basic IEP status, he lost his television and was moved to a cell on his own. the second SO attempted to obtain a radio for him, but without success. The man had library books in his cell, but these were his only items of distraction. This would have been a particular concern had he been on an open ACCT but the removal of all items of distraction is likely to increase vulnerability even for those who have not been assessed as at risk of self-harm or suicide.

The Governor should ensure that the local IEP policy is consistent with the principles of PSI 11/2011 and that prisoners on the basic regime have sufficient distraction activities.

Breaking the news to the man's family

82. The man was pronounced dead at 5.45am and his mother, who lived locally, was informed of this news at around 10.30am. Before making the visit, Lincoln's appointed FLO clarified with the Coroner's officer that he was content that all was in order and that his (the FLO's) presence at the prison was not required. There was no great delay in the notification, but the news could have been broken sooner had he been able to concentrate on that important task alone.

The Governor should ensure that families are notified about a death in custody without undue delay.

Information from another prisoner

83. The second prisoner reported two matters of concern to the investigator. One was that other prisoners in the charity workshop were making inappropriate comments to the man. He did not witness this as he worked elsewhere, but he said the man had told him about it. The other matter was that the man was continuing to cut himself and his clothing was visibly blood stained so staff should have noticed. In addition, the prisoner claimed to have brought the matter to the attention of a nurse.

84. The second prisoner spoke to the E wing PO about the alleged victimisation the man was experiencing in the workshop which, according to the prisoner, took the form of unwelcome sexual attention from other prisoners. The E wing PO said she spoke to the man twice about whether he was having any problems in the workshop. The first time was when she was exploring why he was refusing to go to work and the second time after the prisoner had reported his concerns. She said that he was adamant that he was not being bullied and insisted that his reason for not going to work was because he needed time alone as he was still trying to come to terms with being back in prison. He repeated the explanation to other staff. We are concerned that there was inadequate enquiry into the prisoner's allegations. Prison culture is such that many prisoners will inevitably not report having problems with other prisoners for fear of being seen as a 'grass'. We also note that the Inspectorate found that a high proportion of prisoners on the vulnerable prisoner unit reported being victimised by other prisoners. It is not sufficient to dismiss the possibility of victimisation simply because the prisoner involved will not confirm that it is happening. In this case there was sufficient evidence from the prisoner and from the fact that the man had suddenly stopped attending work to warrant further investigation, but this was not done.

The Governor should ensure that all allegations about potential victimisation are recorded and appropriately investigated.

85. The second prisoner suggested that the man continued to cut himself during his time in prison and his clothing was obviously blood stained. The post-mortem report identified that he had signs of multiple scars of variable age to many parts of his body. However, none of the staff interviewed by the investigator could recall observing blood stains on his clothing. (On 11 July when his ACCT was opened the stains on his sweatshirt were pointed out to them by another prisoner.) The investigator explored what would happen if blood stained clothing is found among clothing collected for cleaning. He was told that clothing contaminated by bodily fluids is destroyed, but the laundry orderly had dealt with only one item of blood stained clothing since July which had not come from the man. When the investigator spoke to the wing nurse, she refuted the second prisoner's claim that he had spoken to her about the man, and added that she had not had any conversation with him for many months.

86. The investigator's own observation in the two days he spent on E wing was that prisoners' clothing, which consisted of grey sweatshirts and grey jogging bottoms, appeared generally clean. As a consequence, blood stained clothing

would have been particularly noticeable, but at the time the man had stopped attending work, was on the basic regime and would have spend most of his time in his cell. While the evidence of the post-mortem examination suggests that he could have continued to self-harm in prison we are unable to conclude that this would have been readily visible from his clothing.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Governor should ensure that multi disciplinary reviews take into account and record all evident risk factors before closing an ACCT.

   Recommendation accepted:
   A Staff Information Notice has been issued on the need to ensure that a multi disciplinary review takes place and all risk factors are recorded before closing an ACCT. Target for completion: 30 April 2013.

   New management checks are being put in place to ensure this is being done. Target for completion: 30 April 2013.

2. The Governor should ensure that staff record and take fully into account significant new information about risk or change in circumstances and refer to managers when considering whether to re-open an ACCT.

   Recommendation accepted:
   A Staff Information Notice will be issued reminding staff of their responsibilities under the ACCT process. Target for completion 30 April 2013.

   Refresher ACCT training for all relevant staff is ongoing. Target for completion: work ongoing.

3. The Governor should ensure that staff note important information about risk received from external agencies in prisoners' P-NOMIS records and wing observation books.

   Recommendation accepted:
   A Staff Information Notice reminding staff of their obligation to record all relevant information in P-Nomis and observation books will be issued. Target for completion 30 April 2013.

4. The Governor should ensure that the security department clearly convey to wing staff all relevant information about a prisoner's risk to himself contained in SIRs and record the action they have taken.

   Recommendation accepted:
   Security staff have been reminded to do this. The matter will also be covered in a full staff briefing. Target for completion: 30 April 2013.

5. The Head of Healthcare should ensure that the prison mental health team implements a process for in depth risk assessment of referrals for prisoners considered at risk of self-harm with a clear triage and prioritisation pathway to facilitate timely face to face assessment.

   Recommendation accepted:
   The mental health team now have a 4 hour target for face to face assessment of all urgent referrals and a 2 week face to face assessment for all non urgent/routine

referrals. The team has reviewed and amended their referral process to ensure that all prisoners referred have a face to face initial assessment to determine the level of urgency. Prisoners no longer receive a letter offering them an opt out of the referral process. People telephoning the service to make a referral are supported to complete the referral from over the telephone with key questions being asked to ascertain level of urgency. Target for completion: completed.

6. The Governor should ensure that the local IEP policy is consistent with the principles of PSI 11/2011 and that prisoners on the basic regime have sufficient distraction activities.

Recommendation accepted:
IEP policy now reflects PSI 11/2011. Target for completion: completed.

Activity packs containing colouring books, games, radios etc, are being introduced. Target for completion 1 April 2013.

7. The Governor should ensure that families are notified about a death in custody without undue delay.

Recommendation accepted:
This is current practice

8. The Governor should ensure that all allegations about potential victimisation are recorded and appropriately investigated.

Recommendation accepted:
A new Violence Reduction Strategy is being introduced and will meet this recommendation. Target for completion 30 April 2013.