

**Investigation into the death of a man
at HMP Lindholme in June 2011**

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

April 2012

This is the report of an investigation into the circumstances of the death of a man who was found hanging in his cell in HMP Lindholme. I extend my sincere condolences to his family and friends for their loss. I apologise for the delay in issuing this report.

This investigation was undertaken by one of my senior investigators. I would like to thank the Governor and his staff at HMP Lindholme for their co-operation throughout the course of the investigation. A review of the man's clinical care and treatment was carried out by the Medical Director and Head of Quality of Bassetlaw Primary Care Trust. The review is attached as an annex to this report.

The man was a life-sentenced prisoner who had been in custody since 2003 and who had been in Lindholme for most of the previous five years. He worked, was compliant with prison rules and lived on a wing with other prisoners with long sentences.

Nothing occurred to cause staff any concern that the man might be at risk of harming himself. Nor did his friends recognise any signs, although he told one friend just before his death that he could have his some of his possessions. A letter was found lying on his bed that indicated some inner turmoil but he appears to have taken pains to hide this from others.

While the investigation found that the prison could not have predicted his tragic actions, one significant procedural flaw was identified. At the time of the morning roll check on the day the man died, he was found to have obscured his cell door observation panel. Instead of entering the cell, the officer making the check continued with his count of the other prisoners. This led to an excessive and unacceptable delay in the discovery of the man's death. This failure carried implications both for prison security and prisoner safety. The prison has rightly taken disciplinary action against the member of staff concerned.

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

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Prisons and Probation Ombudsman

April 2012

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SUMMARY

1. The man was found hanging in his single cell in HMP Lindholme in the late morning in June 2011.
2. He had been in prison custody since April 2003 and at Lindholme for most of the previous five years before his death. He was a life-sentenced prisoner with a ten year tariff. (This meant that he would become eligible for parole in April 2013.)
3. As a servery worker, the man was well known to all of the staff and prisoners on his wing. He had, by all accounts, an animated personality and staff spoke about him positively.
4. The man had always denied guilt for his primary index offence of murder. This began to impact on his sentence progression leading to him becoming somewhat disengaged with the parole process in recent years. However, his day-to-day behaviour in and around the prison did not change and he remained positive.
5. None of the staff, or his friends, saw any signs to suggest that the man was troubled or might be at risk of harming himself. The one hint that he might have been planning to harm himself was when he told his closest friend he could have his CDs. This occurred four days before his death. Otherwise, the friend thought that the man was his usual self that day and did not tell staff about their conversation at the time.
6. A substantial delay occurred in the discovery of the man's death. At the time of the morning roll check, he was found to have obscured the observation panel on his door. Instead of going into the cell, the officer making the check continued with his count of the remaining prisoners. The man was only discovered hanging when he was checked properly around four hours later. On examination, it was clear that he had died some time before, so resuscitation was not attempted.
7. While responding to the discovery, staff found a letter on the man's bed addressed to his parents. He asked them to try to take comfort from knowing that he had chosen this outcome.
8. This report makes two recommendations. One concerns the action to be taken when prisoners obscure their cell door observation panels. The other concerns action on discovering an apparent death. A further recommendation on clinical matters can be found in the clinical review.
9. Lindholme took disciplinary action against the officer who conducted the morning check on the day the man died so no recommendation of this type is made in this report.

THE INVESTIGATION PROCESS

10. The investigator in this case first visited HMP Lindholme on 20 June 2011, when he met one of the prison's functional governors, a representative from the Prison Officers' Association and the chair of the Independent Monitoring Board.
11. The investigator was shown around B wing and spur 2, which was where the man lived. He also visited the man's cell. My investigator spoke with the seven prisoners who also lived on spur 2. He was given a copy of the man's prison and health records. Notices were issued to staff and prisoners informing them about the investigation and inviting them to contact the investigator if they wished to be involved in the investigation.
12. The investigator subsequently interviewed ten members of staff and two prisoners. Transcripts of these interviews are attached to this report as annexes. No other prisoners came forward in response to the notices about the man's death.
13. My investigator contacted the Coroner's officer and a copy of this report will be sent to the Coroner to assist his enquiries.
14. The Medical Director and the Head of Quality carried out a review of the man's clinical care and treatment on behalf of Bassetlaw Primary Care Trust. Their review is attached as an annex to this report.
15. One of the Ombudsman's family liaison officers contacted the man's family to inform them of the investigation and to offer them the opportunity to raise any questions or concerns. They were interested in receiving a copy of the investigation report, but raised no particular issues that they wanted included as part of the investigation. The family were very complimentary about the support they received from prison staff following their son's death.
16. We apologise for the delay in issuing this report and for any additional distress this may have caused. The delay was caused through workload pressures.

HMP LINDHOLME

17. HMP Lindholme is located approximately 10 miles north of Doncaster. It opened as a prison in 1985 and is based on the site of a former Royal Air Force base. Lindholme holds over 900 category C prisoners. (There are four security categories for adult male prisoners: A, B, C, and D. Category A is for prisoners whose escape would be considered highly dangerous to the public, or a threat to national security. Category B is for prisoners for whom escape must be made very difficult. Category C applies to prisoners who cannot be trusted in open conditions and Category D prisoners are those who can be reasonably trusted in open conditions.)
18. The accommodation on the category C site at Lindholme includes six wings of a dormitory design. This comprises six single and one double cell on lockable spurs. It was on such a spur on B wing that the man was based. He lived in one of the single cells. Prisoners on the spurs have latch keys to their own cells with the spur itself being secured by a spur gate that is locked with a key only carried by staff. Each spur also contains an association room with seating and a television.
19. The spur accommodation at Lindholme is usually allocated to enhanced prisoners. (Enhanced prisoners are those who have gained access to the highest level of privileges through good behaviour and engagement in work and education¹.) B wing usually houses prisoners serving longer sentences, including life sentences.

Her Majesty's Chief Inspector of Prisons

20. The Chief Inspector of Prisons' last inspection of Lindholme was an unannounced follow-up inspection in January 2011. In the introduction to his report the Chief Inspector wrote:

“... When we last visited [in October/November 2007] we were particularly concerned by significant shortfalls in a number of aspects of safety. On our return [for this] inspection we found a much safer establishment, appropriately focused on its training function ...

“... most aspects of offender management were sound, including sentence planning, public protection and categorisation arrangements ...”

“Commendably, staff and managers had addressed most of the weaknesses in safety [identified] on our previous inspection. Lindholme also remained an appropriately busy and purposeful training prison. However, there remained plenty of scope for further improvement, for example in ... resettlement ...”

¹ This is known as the Incentives and Earned Privileges Scheme (IEP).

Independent Monitoring Board

21. Each prison in England and Wales is monitored by an independent board of volunteers drawn from the local community to help ensure that standards of decency and care are maintained. Members of the Board have access to every part of the prison and all prisoners held there. In its annual report for the year ended 31 January 2011, Lindholme's Independent Monitoring Board raised no matters relevant to the man's death.

Previous deaths at Lindholme

22. This office took on the responsibility for the investigation of every death in prison custody in April 2004. This was the second self-inflicted death at Lindholme since that time. There were no similarities in the circumstances of that previous death and the circumstances surrounding that of the man's.

KEY EVENTS

23. The man was born in Manchester, where he grew up and was educated. He left school at 16. He reported enjoying school, although he also said that his behaviour and attendance deteriorated as time went on. He said that this was due to the peer group with whom he was associating by then, together with his increasing use of alcohol.
24. After leaving school, the man started a training course in cabinet making but, after six months, took up employment as a window fitter. He remained in this job for around a year, before resigning.
25. In April 2003, he was arrested and charged with murder, and a separate offence of wounding against a different victim that had occurred a week earlier. He was remanded into custody at HMP Forest Bank. During a standard healthcare screening assessment at Forest Bank, he disclosed incidents of self-harming behaviour during his adolescence. However, he denied having any thoughts of self-harm at that time.
26. In October 2003, he was convicted for both of the offences with which he had been charged. He was sentenced to life imprisonment for the offence of murder, with a concurrent sentence of five years imprisonment for the offence of wounding. Following his conviction, he returned to Forest Bank where he was assessed by a nurse. The nurse noted that while the man was shocked, he was not suicidal and wanted to return to a standard prison wing "to be with his mates".
27. Where a person has been sentenced to life imprisonment, the courts must determine the minimum time they must spend in prison before becoming eligible for parole. This term is known as the tariff. Taking into account the man's age at the time of the offence, along with other mitigating factors, the courts decided that the appropriate tariff would be ten years.
28. The man remained in Forest Bank until February 2004 when he transferred to HMP Moorland. He spent almost two and a half years there, before moving to HMP Lindholme in July 2006. He remained at Lindholme thereafter, apart from a two month spell at HMP Featherstone at the end of 2008. (This was a temporary move for him to undertake a course not available at Lindholme.)
29. The man's records from his various establishments show that he adjusted well to prison life. It appears that he got on with both staff and other prisoners and was compliant with prison rules and regulations. He made no reports at any time of having thoughts of self-harm or suicide while in custody.
30. When the man returned to Lindholme in December 2008, following his course at Featherstone, he moved to B wing. The manager of B wing told the investigator that life was very steady on that wing as the prisoners were generally more mature prisoners who were serving longer sentences and who had already spent a lot of time in prison.

31. The manager of B wing said that he had spoken with the man at an early point after his return to Lindholme about his tendency of involving himself in discussions with staff about other prisoners' problems. The man settled down after that warning. The manager said that the man worked on the servery and was a good worker. He got on well with staff and other prisoners.
32. The man's personal officer² told the investigator that he had worked on B wing for over three and a half years so had known the man for almost that length of time. The personal officer said that the man was a good worker and he got on well with prisoners and staff. He explained that, as a servery worker, the man would naturally have to engage with a lot of staff in carrying out his duties.
33. One of the duties of the personal officer is to make periodic entries in prisoners' records about their behaviour and progress. The personal officer accepted that his entries in the man's records were generally brief. He explained that, in part, that was because the man's behaviour was so consistent there would be little to write that was different. He said that the man never reported having any concerns, nor was there any alteration in his behaviour.
34. Officer A told the investigator that he had worked on B wing at Lindholme for over four years and knew the man well. He said that the man was a helpful and reliable servery worker who never caused any trouble. He added that the man was well liked by staff and other prisoners.
35. The investigator asked Officer A whether the man had ever reported having any significant issues or problems. The only issue of which the officer was aware was when the man had a knockback³ with his parole. The officer said that he and other staff tried to encourage the man to re-engage with the parole process, but his response was to say that he would not "jump through any more hoops" and would instead "just get on with his time". The officer said that the man did not seem "bothered" and his behaviour around the wing was the same as it had always been.
36. Officer B had also worked on B wing for around four years. He told the investigator that he got on well with the man. They had a similar taste in music and they spoke a lot about various bands and albums. In addition, they had lived in neighbouring roads in Manchester, which had amused the man. Officer B described the man as a "bouncy" character who was always smiling and always chatting.
37. The B wing cleaning officer explained to the investigator that her responsibilities in that role include management of the cleaning and servery workers. The officer told the investigator that she had a son the same age as the man who had the same name as the man. As a result; she had affection for the man. She said that he was very cheeky with staff and other prisoners and she would

² When prisoners arrive at a prison they are usually allocated a personal officer. Among other things, the personal officer is a prisoner's first port of call if they have questions, complaints or need advice.

³ Knockback is the term commonly used when the Parole Board decides that a person is not suitable for release.

tell him off in a motherly way. Officer C agreed there was a time when the man lost interest in the parole process and she tried to encourage him to become re-involved. His response was to say that he would never get out of prison, but said this in a flippant way. She added that on the occasions that the man felt down, it was obvious as he would be quiet and would not engage with staff. She said that it had been a while since there had last been a day like that.

38. A fourth officer from B wing gave similar evidence to that of his colleagues.
39. As previously mentioned, the man's tariff was ten years. It is the duty of the Parole Board to consider whether a person is safe for release into the community upon completion of their tariff. Factors for the Parole Board to consider include whether the person has engaged with their sentence plan. Sentence planning includes assessment of the reasons why the person has offended in the past and what they need to do to stop them re-offending in the future. Various courses are available to help prisoners gain an insight into their previous behaviour, to help them deal with potentially difficult situations they might face in the future, and to help them control how they will react. A parole assessment report written for the man in November 2009, noted that:

“In terms of offence focussed group work, the man has attended the Enhanced Thinking Skills Group ... to look at his decision making skills, the prison based Addressing Substance Related Offending Group and latterly the Controlling Anger and Learning to Manage it Group ...

“Reports from [these] groups ... have generally been good however ... The man has continued to deny his involvement in the [murder] ...

“Release on licence at this stage is not an option ... but consideration may be given to whether to transfer the man to [an open prison] ... Given that [he] has not to date specifically addressed his murder conviction, his progress might usefully be reassessed after his engagement in Victim Awareness work
40. The man's records show that he admitted guilt for the offence of wounding against one individual, but had always denied having murdered another person on a separate occasion. The man's records contain occasional reference to him speaking about an appeal against his conviction, although there is no evidence that he ever in fact submitted an appeal.
41. In March 2010, the Parole Board considered the man's suitability for transfer to a category D open prison. (Life sentenced prisoners are transferred to an open prison for the final stage of their sentence ahead of their release from prison. Open prisons prepare the prisoner for return to the community and also test and assess the prisoner's suitability for release in conditions that are as close to possible as life in the open world. Most life sentenced prisoners spend around two years in an open prison before being considered for release.)
42. The Parole Board decided that the man was not suitable for transfer at that time as the level of risk that he posed to the public had not reduced sufficiently in

their view. In a report covering the background and reason for its decision, the Board explained that:

“The man’s custodial behaviour has been largely acceptable ... He has completed [a number of offender related courses] and is on the waiting list for [one-to-one] psychology work. Some report writers doubt the effectiveness of [some of his coursework] as it will not have been based on an active offence account regarding the murder. There is some concern that the man has used an appeal he says is pending to avoid discussing the murder. No evidence of such an appeal has been found to exist ...

“The Panel gives credit for the coursework completed to date and for the man’s generally constructive attitude to his sentence plan. However, the index offences represent very serious violence ... with no apparent build up ... The Panel is not persuaded that the man has fully explored and addressed the attitudes and beliefs which lie behind his use of violence and supports the proposed [one-to-one] psychology work as a means of carrying that out. This is important risk related work which must be completed in closed conditions before any transfer to open conditions can realistically be considered.”

43. The offender supervisor who was appointed for the man in late October 2010 told the investigator that the man reported to her that he had become disengaged from the parole process because of previous knockbacks. He did not seem particularly concerned when he said this. He acknowledged, instead, that he had become comfortable with an existence that entailed a job on the servery which he found quite easy, after which he could return to his cell.
44. The offender supervisor said that she wanted the man to re-engage and to move forward with his sentence and she had a number of conversations with him to try to re-motivate him. She suggested to him that if he did not wish to concentrate on offence focussed work at that time, he could instead consider education or work related skills, such as a plastering course. The man said that he would be interested in doing something of that nature. The offender supervisor said that her last meeting with the man was on 3 June 2011. He had a video conference that day with his Probation Service community offender manager. The man expressed an interest in a plastering course and he agreed to see a careers advisor.
45. The investigator asked the offender supervisor about the impact on any potential progression for the man given his denial of guilt for the index offence of murder. The offender supervisor said that the Parole Board would probably consider there to be a significant ongoing risk if the man had not addressed specific offence related work.
46. The cleaning officer told the investigator that she supervised the serving of the tea-time meal 17 June, the day before the man’s death. She said that he had been his usual self that afternoon.

47. The investigator spoke with the man's two closest friends at Lindholme. One said that he met the man in 2004 or 2005 when they were both in Moorland. They shared a lot of common interests and were "best friends". They had other mutual friends at Lindholme, but three of these had also recently been transferred to category D prisons. He said that the man had "split-up" with his long-term girlfriend in 2007 and this had been difficult for him. He understood that the man remained friends with his ex-girlfriend.
48. He said that he had previously been based on one of the spurs on B wing. However, following a number of warnings about his behaviour, he lost his enhanced prisoner status and he was transferred to a standard cell on a different wing. He corrected his behaviour and regained enhanced status. The week before his death, the man asked about moving back to B wing. His friend told him that that he would not ask to move back as he was settled on his new wing, and did not wish to risk any disruption as he was about to be transferred to a category D open prison. By contrast, the man had stopped engaging with his sentence plan and this had affected his chance of getting released on parole.
49. The friend told the investigator that, on the Tuesday before his death, the man told him that he could have his CDs. He asked the man why he was doing this, but he did not explain. All that the man's friend could think was that he was becoming bored with the music. He certainly did not consider that he was about to harm himself.
50. The other friend with whom the investigator spoke with was also based on B wing so he said they saw one another every day and would often pop into one another's cell to chat. The friend was aware of the man's ex-girlfriend. The man did not speak of her often but, when he did, it was always with fondness. The friend did not think that the man was concerned about what was happening with his parole, but was prepared, instead, "to do his time".
51. The friend said that he went to the man's cell on the Thursday before his death to have a chat. The man was reading old letters from his ex-girlfriend and he spoke of her. There was nothing about his mood that caused the man's friend to feel any concern. (He said that he found it difficult to believe when he heard later that the man had apparently taken his life. He said that he would have hoped the man would have spoken with him if there was anything troubling him.)
52. The seven other prisoners who lived on spur two told the investigator that they had noticed no changes in the man's behaviour, and were all shocked about what had happened.

The day of the man's death

53. Officer B worked an early shift on the day of the man's death, a Saturday. He told the investigator that he arrived on B wing at just after 7.00am and commenced the morning roll check. (The principal purpose of a roll check is to confirm the numbers of prisoners to ensure that none have escaped since the

time of the last check.) The officer told the investigator that when he reached the man's cell door, he found that the observation panel had been obscured by a piece of cardboard placed from the inside. He said that many prisoners, including the man, would do this on a frequent basis. The officer explained that, in that situation, staff are expected to open the cell door to ensure the prisoner was in the cell. He said he had done this on every previous occasion that the man had obscured his observation panel and could not explain why he failed to do so that morning. He said that he made a mental note that he would speak to the man later on and he then continued with his roll check. On completion, he reported to the prison's communications unit that all prisoners were present and he then carried on with his other duties.

54. Officer B told the investigator that he went to the man's cell at about 10.30am to have a chat. He knocked on the door, but there was no answer. On Saturday mornings, prisoners receive their canteen⁴ orders. Almost all prisoners had collected their orders by around 11.15am, but the man had not yet collected his. Officer A was supervising the distribution of orders and he asked Officer B whether he had seen the man that morning. Having first asked another prisoner to tell the man to get out of bed, Officer B then went to the cell himself. He found that the observation panel on the door was still obscured. He unlocked the door and, on entering the cell, saw the man hanging from a ligature that had been attached to a wall locker. Officer B cut the ligature and radioed the communications room to announce a code blue alarm⁵. The alarm was raised at 11.20am.
55. A number of staff responded, including two healthcare nurses. When the man's body was examined, it was clear he had died as rigor mortis had begun to set in. As a result, staff did not attempt to resuscitate him.
56. The manager of B wing told the investigator that lunchtime was approaching and the news of the man's death was already spreading around the wing. He decided to call together all prisoners from the individual spurs to inform them of the man's death. He asked them for their co-operation with the disruption that would be caused to the prison regime during the remainder of that day and the following day. He also asked the prisoners to support one another and to make use of the other support that was available through speaking with the staff, the Listeners and the chaplains. The other prisoners from the man's spur (spur 2) were moved to other cells.

Liaison with the man's family

57. The man's next-of-kin were his parents. They lived in Manchester and Lindholme's duty governor asked Manchester police to visit the family home to break the news.

⁴ Canteen relates to the prison shop. Prisoners are able to spend their own money on items such as tobacco, toiletries and sweets.

⁵ A code blue alarm means that a prisoner has been discovered with breathing difficulties and healthcare and other staff must attend as an emergency.

58. The duty governor had asked the police to give the family a contact telephone number for the prison and the man's father telephoned early that afternoon. She arranged a visit for later that day and at 6.30pm she and one of Lindholme's family liaison officers went to the family's home. She gave the family as much information as she was aware of at that time. The family were also shown a copy of a letter that the man had left on his bed.
59. In the letter, the man apologised to his parents. He wrote that while he had tried his best to pretend that all was well, all was not well and he had been "on empty for years". He asked his parents to take comfort from knowing that it had been his choice.
60. The prison held a memorial service on 24 June which was attended by the man's family. Lindholme contributed towards the funeral expenses.

Support for staff and other prisoners

61. A hot debrief meeting was held and the prison care team offered support to the staff involved. Support was also offered to the prisoners on B wing and others who knew the man.

Toxicology at post mortem

62. A bottle of hooch (illicit alcohol) was found on spur 2 following the man's death. When the investigator met the other prisoners from the spur, they told him that all the prisoners on the spur, including the man, had been drinking the hooch on the night of 17 June.
63. A Home Office Pathologist carried out a post mortem examination and commented on the toxicological findings.

"Toxicological analysis revealed evidence of previous buprenorphine use. Buprenorphine is an opioid drug which is sometimes used therapeutically to treat opioid dependence, but which may also be abused. Alcohol was detected at a moderate level in the blood. I would expect [the man] to have been experiencing some of the effects of alcohol at the time of his death. However, I do not consider these substances to have directly contributed to [the] death."

ISSUES

The morning roll check in June

64. On the morning the man died, Officer B commenced a roll check of the prisoners on B wing. The purpose of such a check is to ensure that no prisoners have escaped since the time of the previous check.
65. When the officer reached the man's cell he found the observation panel obscured. He told the investigator that the man, along with many other prisoners, did this on a regular basis. He also said that on all previous occasions he had unlocked the man's door to ensure that all was well. He could not properly explain his reasons for failing to do so on this occasion. He acknowledged, though, that a factor had been complacency.
66. The investigator spoke with the manager of B wing about the way in which Lindholme handled the practice among prisoners of obscuring their observation panels. The manager of B wing said that notices are displayed across the prison informing prisoners that they should not obscure observation panels and doing so can lead to a warning being given. Three such warnings can result in a reduction in a prisoner's IEP level. The manager said that some officers are very strict on this matter, while other officers are more lenient. He said that he prefers a more lenient approach with prisoners such as the man, who have longer sentences and who are otherwise well behaved. He said that what he would have expected from Officer B was for him to have gone into the man's cell at the time of the roll check to assure himself that all was well and to remove the obstruction. Whether or not the man should also have been issued a warning would be a matter for Officer B.
67. It is common practice for prisoners to try to gain extra privacy by obscuring their door observation panels. Prisoners know that this is a contravention of the rules and they might face sanctions. It is for each prison to decide how to deal with such contraventions. A category A (high security) prison is likely to take a different line to a prison such as Lindholme, a category C prison. For many prisoners at Lindholme, the next stage for them is likely to be a move to a category D open prison as they prepare to return to the outside community. In light of that, the manager's lenient approach to the issuing of warnings would not seem unreasonable. Much more importantly, however, the manager would have expected Officer B to have gone into the cell without delay. That would have been the appropriate response given the need for the roll check to be accurately completed, and for staff to assure themselves that nothing illicit or dangerous is taking place.
68. The man had been at Lindholme for a number of years and was familiar with the routines, including the time of the morning roll check. The man's death was discovered at 11.20am, and when he was examined it was found that rigor mortis was established. However, that does not assist in determining the man's actual time of death as various factors can influence the length of time for rigor mortis to set in. While there is no evidence to suggest that the man could have been saved had the officer gone into the cell at 7.00am, nor is there any

evidence to say with certainty that the man was already dead that that time. What we can say, is that the officer's failure to carry out the check carried implications both for prison security and prisoner safety.

69. Officer B's actions were subject to local investigation and disciplinary action was taken. For this reason, no recommendation is made about Officer B specifically, but the following general recommendation seeks to avoid any similar oversight in the future:

The Governor should ensure that staff remove any obstruction blocking a cell observation panel without delay and satisfy themselves that the occupant is properly accounted for.

Indications that the man might have been at risk

70. The man had been continuously at Lindholme for almost five years by the time of his death (apart from a two month spell at HMP Featherstone). Staff at Lindholme therefore knew the man well. All spoke about him with fondness and all indicated that he was a friendly, easygoing person, who gave no signs or indications that he was at any risk of harming himself.
71. The man had, of course, received a knockback with his parole. The reason behind this was his apparent failure to engage fully with some of his offender management courses because of his ongoing denial of involvement in the murder for which he had been convicted. He claimed to have submitted an appeal against his conviction but there is no evidence of this. However, when referring to his knockback in conversation with staff, the man seems to have spoken lightly about it. This accords with how the man's friends perceived matters.
72. The man's offender supervisor's plan to re-motivate the man was to encourage an interest in employment-related training and he seems to have responded positively.
73. It is, of course, possible that the man was masking or minimising his frustrations about the parole process, but there is no evidence that the knockback had any bearing on the outcome. However, even if this were a factor, the man managed to successfully deceive not only staff, but also his closest friends.
74. In retrospect, the one clue that the man might have been thinking of harming himself was when he told one of his friend that he could have his CDs. (The giving away of personal possessions has been found to be a factor in some previous suicides in prison.) The man did not give any reason for making this offer and the friend did not find it unduly out of character. Staff were unaware of this conversation at the time so they had no reason for believing that the man was at any risk. When prisoners give no indication of risk it is very hard for staff to put in place measures to protect them. This is particularly true of prisoners such as the man who have settled into prison life well. Given this, no fault is found with the actions of prison staff.

Informing the man's family of his death

75. The man's family lived in Manchester, around 75 miles away from the prison. Lindholme's duty governor that day asked Manchester police to visit the family to break the news. Prison Service Order (PSO) 2710 gives guidance and advice to prisons about contact with families following a death in custody. The guidance in that order states:
- “The family should be informed face to face as soon as possible after the death. Wherever possible, this should be done by a dedicated family liaison officer working alongside the chaplain, or Governor or most senior individual available together with the chaplain ...
- “If distance from the prison presents a problem, a dedicated family liaison officer or chaplain based in the area nearest the family home [can be asked to make the visit] ...
- “Asking the police to inform the family may sometimes be necessary but the decision to do so should be based on an assessment of [factors such as speed, distance from the prison, the possibility of the news being leaked by other prisoners and availability of suitable staff] and not chosen as an easy option ...”
76. The PSO lists a number of reasons why asking the police can be deemed poor practice. One reason is that the police officer deployed to break the news might not be trained in breaking bad news. In addition, the officer might know little about prisons and will have limited information about the death itself.
77. The investigator spoke with the duty governor about her reasons in asking Manchester police to make the visit. The duty governor explained that staffing levels at prisons are reduced at weekends so she did not have spare staff available to make an immediate visit to the family. Moreover, she had to make arrangements for the care of a number of staff who were badly affected by the man's death. She acknowledged that she could have contacted HMP Manchester to ask if they could make the visit, but she was not confident that they would be able to visit as swiftly as the police could.
78. Her primary motivation, therefore, was to ensure there would be no delay in the family being told. In addition, she then followed up the visit by the police by visiting herself later that day and she arranged for one of Lindholme's family liaison officers to accompany her on that visit.
79. As already noted, there are reasons why, in unusual circumstances, asking the police to break the news might be the best option. The duty governor spoke about two of these: the availability of staff and speed of notification. Another factor that should be considered is the possibility of the news being leaked by other prisoners. It was almost midday when the man's death was discovered and news of his death spread quickly – as a server worker, the man was well known and his death impacted on the normal regime. This office has

discovered in other cases families that have heard the news of a death through an acquaintance or neighbour.

80. The duty governor ensured that the police officer gave the family contact details for the prison and, in the company of a prison family liaison officer, visited the family in person that evening. Although varying from the best practice described in the PSO, the investigation found that, due to the particular circumstances outlined above, the duty governor's actions were pragmatic and appropriate to the circumstances.

Issues arising from the clinical review

81. The clinical reviewers appointed by Bassetlaw Primary Care Trust, a Medical Director and the Head of Quality. Their report is attached as an annex. The reviewers find that the man was fit and well, whose only contact with the healthcare department was dental care in the period leading up to his death. They conclude that the man received care equal to that which he would have received in the wider community. Even so, the clinical reviewers identify two matters for comment.
82. The first matter identified by the reviewers was their discovery of an understanding among some staff at Lindholme that resuscitation should always be attempted on discovery of an apparent death regardless of the person's condition. In fact, Lindholme's local policy is compliant with national policy, making it clear that resuscitation should not be attempted where rigor mortis has set in. Staff complied with policy in the man's case and did not attempt resuscitation. Even so, to prevent the possibility of future misjudgements staff should be aware of the policy:

The Governor and head of healthcare should recirculate the local resuscitation policy on discovery of an apparent death to staff.

83. The second matter arising from the clinical review is the recording of clinical histories. When the man first arrived in custody, prison healthcare records were paper based and continuity of clinical care was liable to be affected when prisoners transferred between establishments. In recent years, the prison service has introduced an electronic record keeping system known as SystemOne. The advantage of this system is that the record follows a prisoner as he or she moves between prisons. In addition, SystemOne contains a section for the recording of clinical histories. The clinical review contains a recommendation on the transfer of key clinical history from paper records onto SystemOne. (The clinical reviewers acknowledge that the absence of a clinical history for the man made no difference in this case.)

Other issues

84. Following the man's death, a container of hooch was found in spur 2. The other prisoners on the spur all admitted to drinking hooch on the night of 17 June. When Lindholme investigated the incident, the prisoners on spur 2 alleged that

the man had brought the hooch onto the spur. In the circumstances, Lindholme decided not to pursue the matter any further.

85. It is not just the manufacture of hooch that runs contrary to prison rules, consumption is also a breach. Lindholme would have been able to pursue this breach had they wished. That said, the man's death would have had an impact on the other prisoners from the spur, so letting the matter to lie was a duly sensitive response.

CONCLUSION

86. The man had been at Lindholme for a number of years where he worked on the servery. He was well known to the staff with whom he seems to have enjoyed a cheery and jovial relationship. Although the man's sentence progression had stalled somewhat, this did not seem to have concerned him to any great extent. There were no signs that the man would harm himself when he did, and no fault is found with the prison in this regard. However, the length of time taken to find the man was unacceptable, and Lindholm must ensure that, in the future, staff act on such matters immediately.

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 staff remove any obstruction blocking a cell observation panel without delay and satisfy themselves that the occupant is properly accounted for.

Recommendation accepted: An Operational Order (Number 14/2011) was issued on 3 August 2011 addressing the issues raised in this recommendation.

2. The Governor and head of healthcare should recirculate the local resuscitation policy on discovery of an apparent death to staff.

*Recommendation accepted: Instructions will be provided by the Governor and Head of Healthcare regarding resuscitation on discovery of an apparent death in custody.
Target for completion: May 2012*