

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in March 2013
at Lincoln County Hospital while a prisoner at HMP
Lincoln**

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 Lincoln County Hospital in March, while a prisoner at HMP Lincoln. The man was found hanging in his cell in the segregation unit at Lincoln in the early hours of 4 March. He was 55 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer carried out a review of the man's clinical care at HMP North Sea Camp and Lincoln. Both prisons cooperated with the investigation.

The man was a life sentenced prisoner who had served a number of years beyond his minimum term. He had been at North Sea Camp open prison since 2010 as part of his preparation for release but was returned to closed conditions at Lincoln in July 2012, because he was suspected of trading medication. After a Parole Board review, he returned to North Sea Camp in November 2012. Prison managers returned him to Lincoln again on 1 March 2013 after alleged security concerns, including the possible theft of a jar of coffee from a manager's office. He was serving a punishment of cellular confinement in Lincoln's segregation unit when he was found hanging in his cell after just two days. He was taken to hospital but did not regain consciousness. His life support machine was removed and he died on 6 March with his family present.

The investigation found that allegations against the man were insufficiently investigated to justify his transfer back to closed conditions and this decision, and its implications, received inadequate consideration at North Sea Camp. The man was being treated for depression and had told a nurse that he had felt suicidal when he was last at Lincoln. This information was not flagged up for Lincoln staff to note when he moved. While the man gave staff no obvious indication of being at risk of suicide, an individual's personal presentation is only part of the picture when considering risk and I am concerned that there was no apparent consideration at either prison of the circumstances of his transfer and how this might impact on him, particularly on his chances for release. Nevertheless, even if this risk had been acknowledged, I accept it would have been very difficult to predict the man's action that night and prevent his death.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2014

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SUMMARY

1. The man was sentenced to life imprisonment in July 1995, with a minimum period to serve of nine years (reduced to seven on appeal). In May 2010, he was assessed as suitable for an open prison and moved to HMP North Sea Camp as part of his preparation for release.
2. The man suffered from chronic back pain and had been prescribed tramadol and other pain relief drugs. In 2012, he underwent two periods of therapy for depression. During his time at North Sea Camp, he was found guilty of a number of disciplinary offences, mainly relating to the illicit use of drugs. On 12 July 2012, the man collapsed and staff suspected that this was related to drug use. He was returned to closed conditions again at HMP Lincoln. While at Lincoln, he was treated for depression.
3. In November 2012, he returned to North Sea Camp after a Parole Board recommendation. He was still suspected of illicit drug use and five security information reports were received after he returned.
4. On 21 February 2013 the Head of Reducing Reoffending at North Sea Camp, suspected that the man was responsible for stealing a jar of coffee from his office. A confrontation took place, during which the Head of Reducing Reoffending dismissed the man from his prison job. An officer who witnessed the altercation felt that the Head of Reducing Reoffending's behaviour was inappropriate and unprofessional. He made an entry about this in the unit observation book. The man made a written complaint about his treatment by the Head of Reducing Reoffending and the loss of his job. The Head of Reducing Reoffending did not complete a security information report about the allegation of theft, as would normally be expected.
5. On 27 February, an anonymous note, believed to have been written by another prisoner, said that the man had recently been shoplifting while out of the prison on a visit to the dentist. This information was discussed by senior managers at their morning briefing meeting. The Head of Reducing Reoffending was at the meeting and mentioned the alleged stealing of the coffee. The then deputy governor decided that the man should be returned to closed conditions. On 1 March, the man was taken to reception to be transferred. When he was searched, he was found to have two tablets of tramadol and two ten pound notes (he was not permitted to have money in his possession). He was charged with a disciplinary offence and taken to HMP Lincoln.
6. When he arrived in reception at Lincoln, the man was uncommunicative but reception staff were not concerned about his well being and did not regard him as at risk of suicide and self-harm. The next day, he was found guilty at a disciplinary hearing of the unauthorised possession of the money and tablets he had been found with at North Sea Camp. He received a punishment of seven days cellular confinement. He told the manager conducting the hearing that he had problems with drugs and a routine referral was made to the drug team.

7. The man made three attempts to telephone his niece over the weekend but his telephone account had not been set up since his transfer, so he could not get through.
8. An operational support grade (OSG) was on night duty and checked the man and the other two prisoners in the segregation unit hourly, as the segregation unit routine required. At 1.00am, he discovered the man hanging in his cell from a bed sheet and immediately called for help. An Officer was in the segregation unit at the time and went into the cell with the OSG who cut the sheet from the man's neck. More staff arrived very quickly and started cardiopulmonary resuscitation. Paramedics arrived and resuscitation continued until a pulse was established. The man was taken to hospital but did not regain consciousness and on 6 March the life support machine was switched off. He died shortly afterwards.
9. The investigation found that the man generally received prompt and appropriate care for his physical and mental health needs. However, there were some missed opportunities to identify his history of depression and the risk of suicide and self-harm when he returned to closed conditions. The grounds for returning the man to closed conditions do not appear to have been soundly based at the time the decision was made and was not well managed by senior staff at North Sea Camp.

THE INVESTIGATION PROCESS

10. The investigator issued notices informing staff and prisoners at HMP Lincoln and HMP North Sea Camp of the investigation and asking them to contact her with any relevant information. An officer from North Sea Camp contacted her and she subsequently interviewed him.
11. The investigator visited Lincoln on 13 March. She collected relevant documentation and visited the segregation unit and other areas of the prison. The investigator and another investigator, subsequently went to Lincoln three more times and interviewed 19 members of staff.
12. Both investigators visited North Sea Camp on 2 April and met the Governor and deputy governor. They returned on 30 April to interview other staff.
13. Lincolnshire NHS Foundation appointed a clinical reviewer to review the man's clinical care. She was given the man's medical records and copies of the interview transcripts with healthcare staff.
14. HM Coroner for Lincolnshire was informed of the investigation and a copy of the report has been sent to him. The coroner's officer provided a copy of a note the man left in his cell. The investigator spoke to the investigating police officer.
15. One of this office's family liaison officers contacted the man's niece, his nominated next of kin, to explain the purpose of the investigation. His niece had no specific issues for the investigation to consider, but said that the man had told her that if he was ever returned to closed conditions again he would take his own life.
16. Although she did not say this to our family liaison officer, we have learnt that the man's niece told the prison family liaison officer and the investigating police officer that at one point she had spoken to someone at North Sea Camp about what the man had said about taking his own life if he was returned to closed conditions. She was unable to say when this was or who she had spoken to and we have been unable to find any record of this.
17. One of the other prisoners in the segregation unit on the night of the man's death complained about staff conduct while resuscitation was being attempted. The investigator wrote to the two prisoners who had been in the segregation unit on the night the man died. Both had been released from prison but neither replied to the request to interview them and we have not found any other evidence to indicate poor staff conduct that night.
18. The man's niece received a copy of the draft report. She raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
19. A response to the recommendations in this report can be found at pages 28-30.

HMP LINCOLN

20. HMP Lincoln is a local prison which holds up to 729 unconvicted and convicted prisoners. It had four main residential wings, one of which houses vulnerable prisoners. At the time of the man's death, healthcare was commissioned by Lincolnshire Primary Care NHS Trust.

HM Inspectorate of Prisons

21. HM Inspectorate of Prisons (HMIP) most recently published inspection report of Lincoln followed an inspection in August 2012. The Chief Inspector noted some serious concerns about the prison which had deteriorated sharply since the previous inspection in 2010, but that relationships between staff and prisoners were good. Inspectors were very critical about the segregation unit environment which lacked natural light. Cells were covered in graffiti, poorly furnished and had dirty, scaled toilets. The inspection found that adjudication records were variable and not all demonstrated sufficient enquiries before a finding of guilt, although punishments were broadly fair.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their annual report for the period to January 2012, the IMB considered that the prison had made positive progress.

Previous deaths in custody at Lincoln

23. The Ombudsman investigated another self-inflicted death at Lincoln in April 2012. There were no obvious similarities between the deaths.

HMP North Sea Camp

24. North Sea Camp is an open category D prison in Lincolnshire, which holds up to 420 prisoners.

HM Inspectorate of Prisons

25. The last inspection of North Sea Camp was in April 2012. HMIP concluded that, despite the prison's isolated location and the poor state of its buildings, it continued to fulfil its function as an open prison relatively successfully.

Open prisons

26. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. Prisons with a physically secure wall or

fence are known as closed prisons. Prisons without secure physical barriers are known as open. Open prisons are for the lowest category of prisoner (D) and are used as part of prisoner's sentence progression before a prisoner is released back into the community.

Life sentenced prisoners

27. Prisoners with life sentences are set a minimum period to serve by the trial judge (often known as 'the tariff'). After that, release is determined by the Parole Board for England and Wales, an independent public body. The Parole Board also assesses risk and makes recommendations to the Secretary of State about the suitability of life sentenced prisoners for open conditions. Once the tariff is served the Parole Board can direct release when it is satisfied that the risk is such that it is no longer necessary for the prisoner to be detained for the protection of the public. The Parole Board usually requires life sentenced prisoners to have a period of testing in open conditions before it will direct release.

KEY EVENTS

The man's earlier period in custody

28. On 26 July 1995, the man was sentenced to life imprisonment with a minimum period to serve of nine years (reduced to seven years on appeal) before he could be considered for release. He had been found guilty of three offences of grievous bodily harm (GBH). After 15 years in custody, the Parole Board recommended that the man should be tested in open conditions as preparation for release. He transferred to HMP North Sea Camp from HMP Shepton Mallet in May 2010.
29. The man suffered chronic back pain throughout his time in custody for which he was prescribed analgesics (pain relief) including tramadol, dihydrocodeine and pregabalin. During the man's time at North Sea Camp, there were concerns about abuse of medication and illicit use of prescribed medication belonging to other prisoners. He was found guilty of some disciplinary offences in connection with this. Analgesic medication was stopped for a period because of these concerns and because the man appeared to function well without taking analgesics, but they were restarted in 2012.

Time spent at HMP Lincoln in 2012

30. On 12 July 2012, the man was moved back to closed conditions at HMP Lincoln after collapsing from a suspected misuse of drugs. This followed a number of security reports suggesting that the man was using and selling medication (mainly tramadol). He had also been found not to have medication which he had been prescribed and should have had.
31. On 10 October, the man saw a mental health nurse at Lincoln after an urgent referral from the wing senior officer. He described feeling depressed and anxious but said he had no thoughts of self-harm or suicide. It was recorded that he had a poor motivation for daily living, reported disrupted appetite and sleep and had negative thoughts about his return to closed conditions. The man said he did not think he could improve his mood by himself and requested continued support and antidepressants. The next day, the GP prescribed him citalopram (an antidepressant). On 23 October, he saw the mental health nurse and said he was slightly less anxious.
32. A Parole Board panel considered the man's return to open conditions on 26 October 2012. The panel concluded that:

‘there is nothing further for you to do in the closed estate and that to keep you here is simply to punish you; that it would be far better to return you to open conditions to test you and see if you truly have learned from these events.’

The Parole Board therefore recommended that the man should return to open conditions.

HMP North Sea Camp from November 2012 to March 2013

33. The Parole Board's recommendation was accepted and the man returned to North Sea Camp on 8 November 2012. He worked in the prison as a litter picker. On 17 December, he was tested for illicit drug use in response to a security report suggesting he was using and dealing drugs. The results of the test showed that he was clear of drugs. He was monitored briefly under violence reduction procedures after an alleged incident with another prisoner but this ended when it was noted there was no evidence to support the allegations. On 25 December, an officer who worked on the unit where the man lived, noted in the man's records 'speaking to [the man] on a regular basis around the prison he seems to be getting on well and does not report any problems'.

34. On 18 January, the man saw a mental health nurse who described her role as delivering low intensity cognitive behavioural therapy (CBT) interventions for people with mild to moderate symptoms of anxiety and depression. He had seen her previously for two periods of weekly support in 2011 and again between March and July 2012 to address his low mood. He said the interventions had helped at the time although he continued to relapse into depressive states. The man told the nurse that, while he had been at Lincoln, he had felt suicidal and had seen the mental health team but had been transferred back to North Sea Camp after one session of CBT. The antidepressant medication he was taking was helping to improve his mood but not significantly. He admitted to long term use of illicit drugs during most of his prison sentence and the nurse recorded the following:

"states that he predominantly used to 'mask' his feelings of low mood and feels that it was just part of prison life and helped him to get by and cope better – however states that following his transfer to HMP Lincoln he is now completely "clean" of illicit substances and believes that this is contributing towards his feelings of 'hopelessness and worthlessness' – reporting "I feel flat most days"..."

35. The man told the nurse during their meeting that he was not currently experiencing any suicidal thoughts and that he felt disgusted with himself for having those feelings when he was at Lincoln. He said he would seek help from staff if his thoughts deteriorated to that level again. The nurse noted that the man said that he felt 'lost' most days, was struggling with his sleep pattern and his appetite was reduced.

36. The nurse referred the man to the mental health counsellor who assessed him on 30 January 2013 and noted that the man described having some 'adjustment concerns about what happened last year which caused him some emotional concerns and he feels his depressive symptoms stem from this'. The man said that he had stopped illicitly using prescription drugs and a follow up appointment was scheduled for four weeks later.

37. On 9 January and 19 February, the man went out of the prison, unaccompanied, for dental appointments.

Events on 21 February

38. The Head of Reducing Offending said he had known the man for some time. His office is in the farm area of the prison and he told the investigator that he often left it unlocked as a number of prisoners needed access to it as part of their cleaning duties, including litter pickers such as the man. On 21 February, the Head of Reducing Reoffending realised that a jar of coffee was missing from his office. He told the investigator that he confronted the prisoner cleaner who denied taking it but alleged that the man had taken it. The Head of Reducing Reoffending said he went to the unit where the man lived and, on his way, encountered another prisoner who suggested that he should look in the man's room for the coffee. The Head of Reducing Reoffending said that the man's roommate also told him that the man had stolen the coffee and traded it for tramadol.
39. An officer was in the unit office when the Head of Reducing Reoffending called the man in. The officer described the governor as 'ranting and raving...it was quite embarrassing really...I was shocked at the man's behaviour'. He made the following entry in the unit observation book about the incident:
- 'The man: Heated exchange with [the Head of Reducing Reoffending] who has accused the inmate of stealing a jar of coffee from his office. Although out of sight of other inmates the argument could clearly be heard by others in the unit corridor'
40. The Head of Reducing Reoffending told the investigator that he had confronted the man. He said:
- 'I was annoyed or upset and whilst you're trying not to vent that anger I think it would have been clear for anyone to have known that I was upset about the incident that happened.....'
41. The man denied taking the coffee and said that he would not have done it because he knew the Head of Reducing Reoffending held his future in his hands. The Head of Reducing Reoffending explained to the investigator that he believed the man meant that he could have had him transferred to another prison. The Head of Reducing Reoffending said that he told the man he had no intention of doing that, but wanted him to confess to taking the coffee. The Head of Reducing Reoffending told the man that he was dismissing him from his job as he did not want him working in the farm area. The encounter ended with the man saying that he was going to put in a complaint.
42. The Head of Reducing Reoffending did not document the incident which should have included a security incident report (SIR). He told the investigator that he did not do so:
- 'Mainly because that's what I'd said to him [the man] at the time. I wasn't there to put in an SIR, I wasn't there to put in an adjudication and I wasn't

there to do anything else. I just wanted him to say to me this is what I've done, this is why I've done it and then I can work through that. I wasn't there to try and, as he said, get him transferred, get him kicked out of the jail, knock him back, stop ROTL, stop anything else. All I wanted was yes he'd taken it, no he hadn't and why that happened.'

43. The man completed a complaint form about the incident the next day. He wrote:

'My complaint is about [the Head of Reducing Reoffending]. Yesterday, 21/2/13 the Head of Reducing Reoffending confronted me in North Unit Office, he accused me of entering his office and stealing some coffee, I strenuously denied this. His manner was aggressive and of a bullying, intimidating stance. However, I do not wish to pursue his unprofessional, bullying behaviour. He sacked me from my job (litter picker) without the slightest evidence I had done anything wrong. I feel singled out by [the Head of Reducing Reoffending]'

44. The man indicated on the form that wanted the situation put right by being reinstated in his job and not to lose any pay.
45. The Governor of North Sea Camp responded to the man's complaint on 4 March and wrote 'as you are no longer at HMP NSC this is clearly not now possible'. The response made no reference to the allegation against the Head of Reducing Reoffending, or any investigation into it.

The decision to transfer the man to closed conditions

46. On 27 February a security analyst informed his manager, the Head of Security and Operations, about an anonymous note that had been received in the previous 24 hours. The note alleged that the man had been shoplifting while out on his dental appointments. When interviewed the analyst said he did not provide any further information about the man at that stage. He did not collate a security summary (known as a 'gist') until the next week on 5 March, after the man had been moved to Lincoln. There was no investigation into the allegation at the time.
47. The Head of Security and Operations told the investigator that he mentioned the information about the alleged shoplifting at the senior management meeting on 27 February. He recalled that the Head of Reducing Reoffending then told the meeting about the coffee incident, which the other senior managers had not previously been aware of because the Head of Reducing Reoffending had not reported it. The then deputy governor chaired the meeting. She told the investigator that she was presented with a written summary report which she said was 'the gist that I had which made my decision' to return him to closed conditions. The only security summary that was provided to the investigator was dated 5 March. The deputy governor recalled that, during the senior management meeting, she had been told about the coffee and the allegation of theft from shops in town. She said that the man was already on their radar and that she had seen 'this escalation of

intelligence that linked him to the drug culture etc'. However, the Head of Security and Operations, the security manager, told the investigator that at that time the man was not being monitored because of any security concerns.

48. The deputy governor told the investigator:

'it might seem that it's absolute nonsense to send somebody back to closed [conditions] for a jar of coffee, I absolutely appreciate that. But in the bigger scheme of things, when you have this pattern of behaviour breaking away from someone in open conditions and their potential of causing harm, if you feel it's escalated it's best to hold securely, to protect them from themselves and protect them from others.'

'I don't always need evidence, as harsh as that seems, we don't always need evidence. We have to do and it's a judgement call and it's at that judgement call where we will return people to try and find a way through it. It's not done lightly, absolutely not done lightly'.

49. The deputy governor said that hearing the allegation that the man had stolen the coffee 'did not have any bearing on my decision to return him'. She said her expectation was that the Head of Reducing Reoffending should have completed an SIR about the theft of the coffee.

50. An operational manager was present at the meeting and was tasked with arranging the transfer. He said that the Head of Reducing Reoffending had given a verbal report about the coffee being stolen. The manager told the investigator that he rang the duty manager of Lincoln to arrange the transfer and gave him a brief summary of why the man was being transferred back. The operational manager said that he was not sure why the move was not arranged for the next day, 28 February, as would be the normal procedure. The duty manager recalled taking the phone call and agreeing to accept the man back to Lincoln. He said that he had been told that the man had been shoplifting and had stolen a jar of coffee from a governor. He thought that the man was due to come the next day but he did not arrive.

The man's transfer

51. On 1 March, two officers went to the man's cell to take him to reception. They were accompanied by the duty manager, who said that he had not been briefed about the reasons for the man's transfer. They told the man he was being taken to reception to be transferred to another prison. The officers said the man did not ask why he was going and did not engage in any conversation with them on the way to reception. He was seen trying to put his hands down his trousers and was asked to stop doing this.

52. In reception, the officers strip searched the man, as is usual for all prisoners being taken back to closed conditions. During the search, two tramadol pills (still in their foil) were found and two £10 notes fell out of his trousers. The man said the medication was his but healthcare staff told one officer that he had not been prescribed tramadol. The man then said he had found the

medication. The man was charged with a disciplinary offence for having unauthorised possessions. The staff said that the man did not ask why he was being transferred but asked where he was going. It is not clear whether he was given this information.

53. In preparation for his transfer, the man was assessed as medically fit by the primary healthcare manager. He completed a form indicating that there were no medical concerns about the man in relation to his transfer. The primary healthcare manager did not make an entry in the medical records to say that the man was fit for transfer. He could not remember whether he saw the man in person to complete the assessment.
54. A Senior Officer (SO) completed an escort risk assessment which indicated that the man was on the sex offender register and was rated as a medium risk to the public and a low risk of hostage taking or escaping. There was no previous history of escape but the man's history of drug addiction and violence was noted. The SO noted that there were no medical objections to him being restrained and the assessment concluded that the man should be 'double cuffed'¹ and accompanied by two officers at all times. There was no further explanation for the use of double cuffs. Double cuffing is usual for security category A and B prisoners but is an exceptional procedure for category C and D prisoners for which written reasons should be given.
55. The SO gave the man two copies of a letter which stated that he was being returned to closed conditions 'as you have been deemed unsuitable for open conditions'. It also said that the reasons for this decision would be sent to him at the earliest convenience but did not give any other details of the allegations against him. One copy of the letter was for the man to keep and the other was for his solicitor.
56. The man was taken to Lincoln in a people carrier, sat between two officers. During the journey, one officer said that he had told the man that having unauthorised articles was not going to do him any favours. He said that the man had shrugged and said that he could not live on £7.50 a week. When the officer suggested he could have found better employment, he said the man replied that this was not easy as jobs were rare. For the rest of the journey, an hour and 15 minutes, the man did not speak and appeared to be dozing. The officer did not give any verbal handover to reception staff at Lincoln to brief them about the circumstances of the man's move.

Arrival at Lincoln

57. A Senior Officer (SO), the reception senior officer at Lincoln, said he had been aware that a prisoner was arriving from North Sea Camp that day. He described going through the reception documentation with him but that at first the man would not answer basic questions such as to confirm his name or

¹ Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs.

more detailed questions about drug use, self-harm and suicide. The SO said that he spoke to the man again later and this time the man had said that he had no issues with drugs or suicide and self-harm. There is no record to indicate that the SO had this further conversation with the man after his first attempt to complete the documentation.

58. Another reception officer said he was unable to remember very much about the man. He completed the First Night Officer 'keep safe' form from information provided by the man and from the prisoner escort record (PER) form. The officer said that this form was completed in reception rather than the First Night Centre as reception staff had access to more information about the prisoner. The officer recorded in the 'keep safe' form that the man did not currently use drugs but had in the past, 12 months previously. The man said drugs were not a problem for him and he did not want to be referred to the drug team (known as CARATS²). It was also recorded that he had not previously self-harmed and was not likely to do so. Two other reception officers interacted with the man in reception but could not remember anything significant about him. There is no evidence that any member of staff considered a return to closed conditions for a life sentenced prisoner a significant risk factor for suicide and self-harm.
59. A nurse completed an initial health screen and remembered the man from when he had been at Lincoln before. She was aware he had returned from open conditions but also did not consider this as a potential trigger for suicide or self-harm. She recorded that he had no thoughts of self-harm, was on citalopram, gabapentin (for pain relief) and lansoprazole (for gastric problems). These medications were continued. It was also recorded that he had problems with his knees. In interview, she said she was not concerned about him and said he was slightly grumpy. The nurse recorded that the man had no drug problems because that is what he had told her. She estimated that the consultation took about 15 minutes and told the investigator that she could not remember looking at any previous entries in his medical record. She said that she tended to look at the record only if there were any concerns and she had not had any in the man's case.
60. The man then spent one night in a shared cell on the prison's first night centre. (The prisoner who shared the cell with the man was released from custody before his death and has not been interviewed.) An officer who completed the first night centre documentation could not recall whether he had actually done this with the man in person or whether he had just prepared it for another officer to complete with him. As indicated earlier, the 'keep safe' form had already been completed by the officer in reception. There is no entry in the man's history sheet about his arrival or induction at Lincoln.
61. Later that day, another officer issued the man with the formal written charges in relation to the unauthorised items that had been found on him at North Sea

² CARATS stands for Counselling, Assessment, Referral, Advice and Throughcare. It is a support service for those with problems with substance abuse.

Camp before his transfer. The officer said that the man seemed 'fine' about this.

62. The next morning, 2 March, phone records show the man tried to telephone his niece at 9.48am from the wing but was not able to get connected to her number. It is not clear what message would have come over the phone to the man and whether he would have been aware of what the problem was, but the phone record print out indicates that his phone account had not been transferred from North Sea Camp. As the man transferred on a Friday, his account would not have been activated until the following Monday.

The man's move to the segregation unit

63. That morning, 2 March, the man was taken to the segregation unit for the hearing into the disciplinary charges against him. The man faced two separate charges in relation to the money and medication he had been found with at North Sea Camp. Initially he pleaded not guilty to the charge of possession of unauthorised medication but then changed his plea after the adjudicator, a residential manager, explained that the adjudication would then have to be adjourned for the reporting officer to be present. The duty manager said that the man had said that he 'could not be bothered with that' and changed his plea to guilty, saying that he had found the medication and did not know he was going to be searched. He said that he had had problems with drugs in the past and agreed to a referral to the CARATs team. The duty manager completed a non-urgent referral. The duty manager told the investigator:

'[he did not present] as a drug addict at all...I wasn't sure if he was taking it or dealing it ... He could have seen the nurses in reception when he came through and had all the questions asked and all the assistance'.

64. In relation to the two £10 notes, the man pleaded guilty and explained that he had been out on a town visit and forgot to hand the money in when he got back to the prison. The duty manager asked the man why he had been sent back to Lincoln but he said that he did not know yet. He then asked the man if his transfer would cause him problems with his parole, to which the man said that he was 'kicking himself about it'. The duty manager asked him if he had had setbacks before and if he had got over them. The man said that he had.
65. For possession of the two £10 notes, the duty manager gave a punishment of 14 days cellular confinement (CC) which was to be suspended. He gave the man a punishment of seven days cellular confinement for possession of the medication to begin immediately.
66. The man moved to the segregation unit and a nurse completed the safety algorithm, used to ensure a prisoner is medically suitable for segregation. She explained that a mental health nurse usually completed the safety algorithm but, as a general nurse, she had been asked to do it as there were fewer staff at the weekends. She recorded in the medical records:

'no issues identified. The man states he is fit and well, has not had history of mental health issues, no thoughts of self-harm at this time, stated he is ok for a time in segregation'

67. The nurse explained to the investigator that her practice was to interview the prisoner and then look briefly at their medical records once she was back in the healthcare centre. She said she did not look very far back in the records and her assessment would be based mainly on what the prisoner told her and his presentation. She said she spoke to the man for two or three minutes and he was very chatty and gave her no cause for concern. He told her that he had no mental health issues. The nurse said that, even if she had known that the man was taking citalopram for depression, this would not have precluded him from being held safely in the segregation unit.
68. Cell bell records indicate that the man pressed his bell at 4.27pm that afternoon. There is no record of what he was asking for. He was checked hourly as is routine in the segregation unit and there is nothing of significance in the records.
69. The next morning, 3 March, the man pressed his cell bell at 8.26am. Again there is no record of why. The nurse saw the man again as part of the routine daily healthcare check. She recorded 'no issues or concerns raised' and described him as being communicative and having good eye contact. The duty manager saw him as part of the duty manager's daily checks. He said that he opened the cell door and the man was sitting on the bed and said that he was okay. The duty manager asked him where his possessions were as he had forgotten that the man had come from North Sea Camp that week. He then explained to the man that his property would come early the following week, as was usual for prisoners transferring from other prisons. (We would have expected the man's property to have accompanied him from North Sea Camp.)
70. At 2.00pm, the man went to the segregation unit exercise yard. An officer, who had seen the man in reception when he first arrived, was working in the segregation unit that day. He said that the man took exercise and was quite chatty and 'certainly cheered up a lot from when he came into reception'. He recalled showing him where clean clothes and library books could be found in the segregation unit.
71. The man tried to ring his niece at 2.17pm. He rang his cell bell at 3.01pm and again tried to call his niece at 3.06pm. The officer was also working in the segregation unit that afternoon. He told the investigator that 'we unlocked him for a phone call, used the phone but it was obviously engaged or didn't get an answer so he gave up'. An officer thought that the man's phone account must have been working, otherwise he would not have been able to use the phone at all. Another officer also remembered the man using the phone and recalled him not being able to get through but did not know if this was because of the pin system not being reactivated or because he could not get through.

Neither officer spoke to the man about not being able to use the phone, or offered him an alternative.

72. At 4.00pm, the man was given his tea and seen by a chaplain. The next five entries each hour indicate he was either reading or lying on his bed. At 10.00pm, the prison was in night security state and an operational support grade (OSG) was on duty alone in the segregation unit. There were three prisoners in total on the unit, all of whom were checked hourly. The OSG checked the man at 10.00pm and 11.00pm. He said that both times the man was walking around his cell and said that he was okay when asked.
73. At around 11.00pm, a segregation officer, who was on duty that night as the assistant night manager, went to the segregation unit to complete paperwork for the weekend as there had been no regular segregation officers on duty. Not long after an alarm went off as there was a serious cell fire on E wing. A number of the night staff, including the segregation officer responded to this incident.
74. At the midnight check, the OSG said that the man was:

‘stood in the corner, the near right corner.....I could see the back of him but obviously he’s facing the corner so I thought that he was playing his radio but I don’t know what he was doing. But again I went are you alright and he said yes. He just looked at me and then he just carried on and then I walked off’.
75. The OSG explained that he looked back in the cell briefly twice during the next fifteen minutes and the man was still standing in the corner. He said that he thought the man’s behaviour was a little strange as he was walking around his cell and it was not completely clear what he was doing when he had his back to him. The OSG said he had just looked through the gap in the door frame rather than through the observation flap. The light was on. He recalled this was between 12.00 and 12.15am.
76. The segregation officer returned to the segregation unit at about 12.45am and spoke to the OSG for a few minutes before the OSG began the 1.00am check. When the OSG got to the man’s cell the light was off in the cell and he opened the observation flap. He turned on the cell light and realised the man was hanging from the window from a bed sheet. He immediately shouted to the segregation officer who ran to the cell, unlocked the door and went in. The OSG radioed a medical emergency and followed this up one minute later with a request for an ambulance. The OSG used his anti-ligature knife to cut the sheet while the segregation officer supported the man’s weight and placed him on the bed. A Senior Officer (SO) and another officer then arrived and helped move the man onto the landing floor outside the cell. The SO began chest compressions as part of cardiopulmonary resuscitation (CPR). Two nurses arrived within a few minutes and attached an oxygen bag to the man’s face. The OSG went to the prison’s gate to bring the paramedics to the segregation unit when they arrived.

77. The segregation officer took over chest compressions and the nurses attached a defibrillator³ which indicated that they should continue with chest compressions. They continued CPR until the paramedics arrived at 1.05am. The paramedics' defibrillator indicated some electrical activity in the man's heart and they continued CPR until they got a pulse. The man still did not start breathing spontaneously and showed no sign of response. He was taken to Lincoln County Hospital, accompanied by the segregation officer and another officer. No restraints were used. Officers found a letter in his cell that the man had written to his niece, stating his intention to take his own life.
78. The man had identified his niece as next of kin. The telephone number recorded for her in the man's records was incorrect and it took until 10.05am that morning for the prison's family liaison officer to find the correct number from his phone records and speak to her. The man's niece and his sister went to the hospital and the liaison officer accompanied them at their request. One officer stayed at the hospital with the man but no restraints were applied at any time.
79. The man's family agreed that his life support machine should be turned off. The prison's family liaison officer spent some time with the man's sister and niece. The man did not regain consciousness and he died shortly after his life support machine was switched off at 8.09pm on 6 March. A contribution towards funeral expenses was offered in line with national guidance.

Support for prisoners

80. The duty governor spoke individually to the two prisoners in the segregation unit to explain what had happened and the chaplain offered support. All prisoners being monitored as a risk of suicide or self-harm monitoring were reviewed in case they had been adversely affected by the man's death.

Support for staff

81. A hot debrief was carried out at 7.45am on 4 March to consider both emergencies that night - the man being found hanging and the cell fire on E wing. Some learning points from the response to the cell fire were identified and it was acknowledged that staff had felt that resources had been stretched with the need to respond to two incidents in quick succession. Staff at the debrief were made aware of the support available to them, although not all of the staff who attended to the man were in the prison at the time. One of them told the investigator that they felt they had to seek out support themselves without it being offered.

³ A defibrillator is a piece of medical equipment which detects electrical rhythms in the heart and indicates whether to deliver a shock in order to re-start the heart.

ISSUES

The decision to transfer the man to closed conditions

82. After the investigator informed the Governor of North Sea Camp about the allegations that the Head of Reducing Reoffending had behaved inappropriately towards the man, the Governor arranged an internal investigation. The investigation was carried out by a residential manager from HMP Sudbury, and the subsequent report was given to us. The residential manager concluded:

‘I do not feel there is sufficient evidence to refer to a Code of Conduct Hearing and therefore no further action should be taken’.

83. The Head of Reducing Reoffending did not submit a security information report about the theft of his coffee or that he had confronted the man about it. Both the Governor and the Head of Security said that they would have expected him to have done so. Without the officer’s entry in the observation book and the man’s complaint there would have been no record of the incident. The residential manager concluded that:

‘The Head of Reducing Reoffending stated that he did not do an SIR retrospectively (having been on rest days for a few days post the incident) as he did not wish this to be seen as ‘helping’ to build a case for return to closed.

Having examined the security intelligence I understand the explanation of The Head of Reducing Reoffending in this regard, however for completeness a Security Intelligence Report should have been completed’.

84. We have considered the internal investigation report and do not find its conclusions entirely convincing. The Head of Reducing Reoffending’s conduct towards the man, observed and recorded by a member of staff, appears to have fallen below that which would be expected of a manager. Although the Head of Reducing Reoffending said he did not submit a security information report because he did not want there to be serious repercussions for the man, he later reported the incident at the morning meeting on 27 February and there were serious consequences. The man also lost his job as a result of an uninvestigated and unproven allegation. The Governor’s response of 4 March to the man’s complaint did not address the issue that the man considered he had been victimised by the Head of Reducing Reoffending.
85. The man was discussed at the senior management morning meeting on 27 February, after an anonymous note was submitted by a prisoner alleging that the man had been shoplifting while out at a dental appointment and had been selling the goods in the prison. The Head of Reducing Reoffending then reported his suspicions that the man had stolen his coffee. The deputy governor said she had based her decision not just on these unsubstantiated allegations but also on a “gist” of a range of security information about the

man. However, this account is not backed up by others present at the meeting and the only security “gist” we have seen was dated 5 March. The deputy governor said that she had seen an escalation of intelligence linking the man to drugs but the manager responsible for security said that the man was not being monitored for security concerns at the time. It appears that some security incidents which had led to the man’s first transfer to Lincoln were taken into account.

86. It is evident that the discussion about returning the man to closed conditions was very brief. There appears to have been no discussion involving his offender supervisor or offender manager, no consideration given to his security record since his return from Lincoln or any reference made to the quality of the security information (which had come from other prisoners and would usually be considered low grade).
87. The man was found with unauthorised articles on him when he was being searched, which was later used to justify the decision to transfer him to closed conditions. Although the discovery of these articles reinforced some of the suspicions against the man, the decision had already been made when they were found so this cannot be used as evidence to justify the original decision.
88. Prison Service Instruction (PSI) 40/2011 Categorisation and Recategorisation of adult male prisoners says:

“When deciding upon a transfer for disciplinary reasons, the Governor/Director must base their decision upon proven offences or on the basis of reliable security information, rather than suspicions, and their report laying out the full reasons for the transfer must accompany the [prisoner] on transfer. A copy must also be sent to the Offender Manager for their OASys input. In lifer cases, a copy must be sent to their Home Probation Officer.”
89. Prison Service Order (PSO) 4700 (Indeterminate Sentence Manual) Chapter 4, sets out the criteria for returning an indeterminate sentenced prisoner (which includes life sentenced prisoners) to closed conditions. The PSO requires the prisoner to be notified in writing of the reasons and the evidence. The man was notified in writing about his transfer, but all he was told was that he was “deemed unsuitable for open conditions”. The PSO says that “if being transferred, they must receive this information prior to the transfer and that evidence can only be withheld on security grounds or to protect the safety of a third party.” It was not explicitly stated that it was intended to raise the man’s security category but the statement that he was unsuitable for open conditions would indicate that this was the case. We are not persuaded that there were sufficient security reasons to make it necessary to withhold from the man the full reasons why he was being transferred.
90. We do not consider that the events leading up to the man’s return to closed conditions were sufficiently investigated to justify the decision or that the suspicions about his behaviour were so serious as to justify a return without following the usual procedures. No report was prepared and there were no

minutes of the meeting at which the decision was taken and no supporting documents detailing how the decision was reached. The security information from other prisoners was untested and not proven. It is entirely possible that a fuller investigation and proper consideration at the time would have led to the same outcome but the implications for a life sentenced prisoner of such a move requires that appropriate procedures are followed before such a decision is reached. We make the following recommendations:

The Deputy Director of Custody for East Midlands should re-investigate the events which led to the return of the man to closed conditions, including whether the staff involved acted appropriately.

The Governor of North Sea Camp should ensure that, unless there are immediate and serious public protection implications, an indeterminate sentenced prisoner is not returned to closed conditions without a full evaluation of the circumstances and written reasons, in line with Prison Service instructions.

Clinical care

91. The clinical reviewer concluded that, overall, during the man's time in custody at North Sea Camp and Lincoln he received prompt and appropriate care for both his physical and mental health needs. However, the clinical reviewer was concerned about the assessment of his fitness for transfer to Lincoln.
92. Before the man left North Sea Camp he was 'fitted' for transfer by the primary healthcare manager. The clinical reviewer notes that this assessment was cursory and did not involve the mental health nurse who had seen him regularly for 18 months. Neither did the primary healthcare manager read the medical record and he does not appear to have seen the man in person before he made his assessment. As the mental health nurse was not involved in the assessment, she did not have the opportunity to alert mental health staff at Lincoln that the man's transfer to closed conditions could be a trigger for suicidal thoughts which he had reported having when he had previously been at Lincoln.
93. The clinical reviewer makes a number of recommendations which the Head of Healthcare at North Sea Camp will need to consider. As the implications of a transfer for a life sentenced prisoner and other indeterminate prisoners are so serious we consider it is important that healthcare staff see such prisoners before a move. They are likely to have knowledge of such prisoners and be able to alert healthcare staff at the receiving prison if there are any concerns. We make the following recommendation:

The Governor and Head of Healthcare at North Sea Camp should ensure that a member of healthcare staff assesses an indeterminate sentenced prisoner in person before they are returned to closed conditions and alerts the receiving prison of any concerns.

Assessing risk of suicide

94. When he arrived at Lincoln, the escorting officers gave no handover briefing to reception staff about the circumstances of his return to closed conditions. Little information about the man's position was passed to Lincoln and a summary of the circumstances of his move might have alerted staff at Lincoln by providing them with fuller picture rather than relying on his presentation and what he told them. Had there been a more detailed review of the circumstances before it was decided to transfer him, information could have been collated. This might not always be possible when someone is transferred very quickly but the man remained in North Sea Camp for nearly two days after the decision was made.
95. The man went through the standard reception process which includes an assessment of the risk of suicide and self-harm but none of the staff involved appeared to consider the implications of such a move for the man and how and whether this affected his risk. The SO who dealt with him in reception said he was uncooperative and would not answer questions including about suicide and self-harm. Although the SO said he spoke to the man later when he said he had no self-harm issues, there is no record of this and there is no indication that the SO considered that the man might be at raised risk because of his move. None of the reception officers who dealt with the man seemed to consider this as a risk factor to be taken into account. Neither did the nurse who assessed him in reception. She, along with other reception staff, seems to have relied solely on what the man told her and did not consult his medical record, to the extent that she noted he had no problems with drugs simply on the basis of what he had said. No one in reception noted that he was already being treated for depression.
96. The day after his arrival, a nurse saw the man to complete a segregation safety algorithm. She recorded that the man had no mental health issues even though he had been prescribed citalopram for depression. She does not appear to have checked his medical record. Again she relied on what the man told her and his personal presentation in a two to three minute assessment.
97. In PSI 64/2011 (Safer Custody), Chapter 3 Risks & Triggers, it notes that transfers between establishments can be a trigger and goes on to state:

“The existence of a trigger may not necessarily increase a prisoner's risk. However, it is vital that staff remain alert to the changes in a prisoner's risk and act when appropriate.”
98. We accept that it would have been extremely difficult for prison staff either at North Sea Camp or Lincoln to have predicted or prevented the man's death. However, we are concerned that staff appeared to rely so heavily on his personal presentation and what he said. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make

a judgement of risk. It is not apparent that full account was taken of the likely impact of a life sentenced prisoner being returned to closed conditions or that reception staff at Lincoln were sufficiently briefed about the circumstances of the transfer and its potential implications, particularly as it was the second time in a relatively short period this had happened to the man. The man had disclosed at North Sea Camp that he had felt suicidal the previous time he was at Lincoln yet this information was not passed on.

99. A number of the reception officers described the man as being uncommunicative which they said was not untypical for someone who had been returned from open conditions. At interview none of them identified a return to closed conditions as a risk factor to be considered when assessing risk of suicide and self-harm. We make the following recommendations:

The Governor of North Sea Camp should ensure when transferring an indeterminate sentenced prisoner back to closed conditions that the receiving prison is fully briefed about the reasons for the transfer, the possible impact on the prisoner's sentence progression and the effect this might have on his risk of suicide and self-harm.

The Governor of Lincoln should ensure that all the known risk factors of a newly-arrived prisoner, including a transfer back from open conditions, are fully considered and documented when determining his risk of suicide or self-harm.

Access to telephones

100. The man transferred to Lincoln on a Friday morning. Administration of the phone accounts system at Lincoln meant that he would not have been able to use the system until Monday. In reception, he was offered a routine short phone call but declined to make one. Over the weekend he made three attempts to telephone his niece but was unable to get through. It does not appear that the man was told that his numbers had not yet been transferred to the Lincoln phone system otherwise it seems unlikely he would have attempted to use the phone. None of the staff seem to have realised this. He pressed his cell bell and asked to make a call and the officers in the segregation recalled some problem with the phone. Although the segregation unit officers noticed that the man was having difficulty making a telephone call, neither of them spoke to him about this.
101. The change of circumstances for the man in just a day or so were very significant. He had moved from the relative freedom of open conditions to the extremely confined conditions of cellular confinement in a segregation unit where he had none of his possessions. In such restricted circumstances contact with the outside world is likely to become all the more important. We make the following recommendation:

The Governor of Lincoln should ensure that prisoners have the opportunity to make telephone calls if there is a delay in them accessing

their telephone account and that staff understand the importance of this in relation to safer custody.

Contact with the man's next of kin

102. The contact details for the man's next of kin, his niece, were out of date in his records, which caused a delay of several hours in her being informed about his condition. It does not appear that these details were checked with the man when he arrived at Lincoln. We are surprised that the staff did not check the man's telephone account as soon as it became clear that the telephone number in his records was out of date, as this might have avoided the delay. Although the man's niece was able to spend time with him at the hospital before he died, inaccurate next of kin details could cause a distressing delay to a family.

The Governors of North Sea Camp and Lincoln should ensure that prisoner's next of kin details are kept up to date and checked on reception.

RECOMMENDATIONS

Deputy Director of Custody East of England

1. The Deputy Director of Custody for East Midlands should re-investigate the events which led to the return of the man to closed conditions, including whether the staff involved acted appropriately.

North Sea Camp:

2. The Governor of North Sea Camp should ensure that, unless there are immediate and serious public protection implications, an indeterminate sentenced prisoner is not returned to closed conditions without a full evaluation of the circumstances and written reasons, in line with Prison Service instructions.
3. The Governor and Head of Healthcare at North Sea Camp should ensure that a member of healthcare staff assesses an indeterminate sentenced prisoner in person before they are returned to closed conditions and alerts the receiving prison of any concerns.
4. The Governor of North Sea Camp should ensure when transferring an indeterminate sentenced prisoner back to closed conditions that the receiving prison is fully briefed about the reasons for the transfer, the possible impact on the prisoner's sentence progression and the effect this might have on his risk of suicide and self-harm.

Lincoln:

5. The Governor of Lincoln should ensure that all the known risk factors of a newly-arrived prisoner, including a transfer back from open conditions, are fully considered and documented when determining his risk of suicide or self-harm.
6. The Governor of Lincoln should ensure that prisoners have the opportunity to make telephone calls if there is a delay in them accessing their telephone account and that staff understand the importance in relation to safer custody.

Lincoln and North Sea Camp:

7. The Governors of North Sea Camp and Lincoln should ensure that prisoner's next of kin details are kept up to date and checked on reception.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p>Deputy Director of Custody East Midlands</p> <p>The Deputy Director of Custody for East Midlands should re-investigate the events which led to the return of The man to closed conditions, including whether the staff involved acted appropriately.</p>	Accepted	At the time of the event an investigation was conducted by the then Acting Deputy Governor of North Sea Camp. A new and independent investigation will be commissioned and completed into the events which led to the return of the man to closed conditions, including whether the staff involved acted appropriately.	1 st May 2014	
2	<p>North Sea Camp</p> <p>The Governor of North Sea Camp should ensure that, unless there are immediate and serious public protection implications, an indeterminate sentenced prisoner is not returned to closed conditions without a full evaluation of the circumstances and written reasons, in line with Prison Service instructions.</p>	Accepted	Arrangements will be put in place to ensure that prisoners returned to closed conditions are done so with due regard and compliance with the relevant Prison Service Orders and Prison Service Instructions, alongside a full evaluation of the circumstances available at the time and through later investigation or analysis. The prisoner will be provided with verbal instruction accompanied by written instructions prior to them departing the establishment. This information will be sent with the prisoner to the receiving establishment.	28 th February 2014	

3	North Sea Camp The Governor and Head of Healthcare at North Sea Camp should ensure that a member of healthcare staff assesses an indeterminate sentenced prisoner in person before they are returned to closed conditions and alerts the receiving prison of any concerns.	Accepted	A Healthcare Nurse professional now assesses every prisoner prior to transfer to closed conditions or other establishments. The nurse then records this information in writing and records electronically. Any issues or concerns are forwarded in writing and or verbally to the receiving establishment.	Completed on 1 st February 2014	
4	North Sea Camp The Governor of North Sea Camp should ensure when transferring an indeterminate sentenced prisoner back to closed conditions that the receiving prison is fully briefed about the reasons for the transfer, the possible impact on the prisoner's sentence progression and the effect this might have on his risk of suicide and self-harm.	Accepted	Arrangements will be put in place to ensure that when prisoners returned to closed conditions, the receiving establishment will be informed both verbally and in writing about the reasons for transfer, impact on the risk levels the prisoner presents and in particular the effect this might have on his risk of suicide and self-harm.	28 th February 2014	
5	Lincoln The Governor of Lincoln should ensure that all the known risk factors of a newly-arrived prisoner, including a transfer back from open conditions, are fully considered and documented when determining his risk of suicide or self-harm.	Accepted	A review of the reception risk assessment documentation used at HMP Lincoln will be carried out. The documentation will be revised to ensure that the needs of prisoners who have been transferred from a less secure environment to HMP Lincoln are identified and addressed and an appropriate record made of all relevant details.	June 2014	
6	Lincoln The Governor of Lincoln should	Accepted	All staff will be reminded via a Notice to staff, senior management and safer custody meetings of their	April 2014	

	ensure that prisoners have the opportunity to make telephone calls if there is a delay in them accessing their telephone account and that staff understand the importance in relation to safer custody.		discretion to grant telephone calls in circumstances where there is a delay in them accessing their account.		
7	<p>Lincoln and North Sea Camp</p> <p>The Governors of North Sea Camp and Lincoln should ensure that prisoner's next of kin details are kept up to date and checked on reception.</p>	Accepted (NSC & Lin)	Systems will be improved to ensure that we correctly capture, record and update next of kin details for prisoners received in or departing reception at HMP North Sea Camp.	28 th February 2014	