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

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Lincoln in July 2008. At about 2.00am that day, he was found hanging in his single cell in the Vulnerable Prison Unit by a member of staff. He was 24 years old.

I offer my sincere sympathy and condolences to the man's family and friends for their sad and untimely loss. I also offer them my apologies for the length of time it has taken to produce this report. I recognise that this will have added to their distress.

The investigation was conducted on my behalf by an investigator. I would like to thank the then Governor of Lincoln and his staff for their help and co-operation. I owe especial thanks to the investigation liaison officer, whose contribution was exemplary.

I commissioned a clinical review of the management of the man's health needs while he was in custody at HMP Lincoln. This was conducted by the clinical reviewer on behalf of the local PCT. I am grateful to her for her significant contribution to this report.

I am also grateful to Lincolnshire Police for their invaluable assistance in sharing important information with my investigator.

The man had a long history of harming himself both before he came into prison and in 2006, generally by cutting himself and only once by using a ligature. During 2006 the prison opened their suicide monitoring procedures no less than six times. My investigation was delayed whilst allegations about the conduct of a prison officer were considered. Neither I nor the prison or the police have found any evidence that the officer's misconduct was the cause of the man's untimely death.

In general terms, I believe that the man's health needs were met at Lincoln and that his risk of self-harm was managed satisfactorily. Nevertheless I make 11 recommendations that I hope will help to prevent a similar tragedy occurring at Lincoln or elsewhere in the Prison Service. I also offer two commendations with regard to the actions taken by staff on the night he died.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2012**

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SUMMARY

The man was a 24 year old man. He had a troubled family background and began using cannabis at the age of 14. He left school with no qualifications and spent most of his short life thereafter unemployed. On two occasions in 2000, he attempted to take his own life, once by taking an overdose of pain relief tablets and, on another occasion, by attempting to hang himself. By his own admission, he frequently harmed himself by inflicting multiple minor cuts to his arms as a means of relieving his tension.

In February 2001, the man pleaded guilty to a serious assault on a woman and an attempted theft for which he was sentenced to seven years imprisonment. He was released on parole licence in July 2005 and was required to live at an approved premises (also known as a probation hostel). The licence was revoked the following October after he had returned to the approved premises under the influence of drink or drugs. He returned to custody until he was released in February 2006. Two months later, on 23 April, he attempted to kidnap a young girl. He was arrested during the early hours of the following day and was subsequently recalled to prison.

The man was held in police custody between 24 and 26 April, when he was taken to Magistrates' Court. He was remanded in custody and ordered to appear for trial at Crown Court on 2 August 2006. A Prisoner Custody Officer who escorted him to court completed a suicide/self-harm warning form because he had seen comments on the Prisoner Escort Record (PER) suggesting that he had made threats to take his own life.

After his court appearance on 26 April, the man was taken to Lincoln prison. During the reception procedures, he was not assessed as at current risk of self-harm or suicide. Although he made it clear that he was unhappy at being returned to prison, he told staff that he thought he could cope. However, the day after his arrival, he applied to be separated from other prisoners because of the nature of his offence.

Thereafter, the man's mental state deteriorated and he began to commit frequent, but minor, acts of self-harm by cutting his arms. As a consequence, formal self-harm monitoring procedures were put in place on six occasions during 2006. He was given medication for depression and anxiety. In September of that year, he was sentenced to life imprisonment with a recommendation that he serve not less than six years before he could apply for parole.

In 2007, the man's state of mind seemed to improve. He refrained from deliberate self-harm throughout the year. Although he continued to have frequent mood swings, he was no longer considered to be at risk of self-harm or suicide and so was not subject to any additional monitoring procedures. His medication was regularly reviewed and adjusted where necessary.

However, in June, the man's uncle, who was in the community, was found hanged after having gone missing. He appeared to take this news quite well and also appeared to cope reasonably well when told he would not be allowed to attend the funeral. In October, he began work as a wing cleaner, a job that enabled him to spend longer periods out of his cell.

The year 2008 began well for him. On several occasions during the year, he was reported by staff as having a good attitude and being a good worker on the wing cleaning party. However, on 17 April, he was placed on report for failing a mandatory drugs test. He disputed the charge against him and asked for an independent drugs test. His case was remanded to enable an independent drugs test to take place. The final hearing was eventually scheduled to take place in July, on the day that he died.

Earlier in June and July, information was given by prisoners that a prison officer was trafficking in drugs and mobile telephones with prisoners, including the man, in E wing. The information was taken seriously by managers who took measures to monitor the activities of the officer concerned who was suspended on 16 July. Thereafter, the Prison Service conducted an investigation into the claims of corruption made by various sources and the officer was dismissed the following year. The investigation found strong evidence to suggest that he may have been coerced by the officer. However, no evidence arose from either the internal Prison Service investigation or from the subsequent police investigation to show that there was a provable connection between his conduct and his death.

On 10 July, the man was told by the prison chaplain that his grandmother, to whom he had been especially close, had died. He was so distressed at this news that he cut his arms. Consequently, an Assessment, Care in Custody and Teamwork (ACCT) plan was opened for the first time since November 2006. (The ACCT plan is a process by which prisoners considered to be at risk of self-harm or suicide are monitored and supported with the aim of helping them to reduce the risk they present. It can be initiated by any member of staff working in a prison.) He asked to be allowed to attend his grandmother's funeral but this was refused as she was not considered to be a close relative and had not acted in place of his parents. He was upset at this refusal but told staff he could cope. The ACCT plan remained open until 21 July.

At 11.00pm on 28 July, the man's mother telephoned the prison to say that her son had called a friend and said he wanted to join his uncle and grandmother, both of whom were dead. The night orderly officer took the call and decided to go to see him in his cell. He was surprised to be told of his mother's telephone call but admitted saying that he wanted to be with his uncle and grandmother. However, he told the officer that he "was not going to do anything silly" (meaning harming himself). The officer found nothing in his demeanour to suggest that he was at risk of self-harm or suicide. Nevertheless, as a precautionary measure, he decided to open another ACCT plan there and then. He instructed the operational support grade (OSG) on duty in the wing to observe him at half hourly intervals. These instructions were carried out, but at regular and predictable intervals. At 2.05am the OSG saw him hanging in his cell.

An officer cut the man down and commenced cardio pulmonary resuscitation despite the fact that he believed him to be dead. Further attempts to revive him were made for approximately 30 more minutes by other officers and healthcare staff until an ambulance crew arrived. However, he was pronounced dead at 2.44am.

The investigation found that, overall, the man's general health needs were met at Lincoln and that, with some exceptions, the assessment, monitoring and management of his risk of self-harm and suicide was satisfactory.

The investigation also found that, although an ambulance was requested promptly after the man had been found hanging, the paramedic crew who responded were unaware of the nature of the emergency until they arrived at the prison. As their journey to Lincoln started some 21 miles away, they did not arrive until about 30 minutes after the original request for an ambulance had been made.

There was a delay of about six hours in informing the man's next of kin of his death. I am satisfied that, however unpalatable, the delay was not due to any insensitivity or negligence on the part of the staff involved.

There was no evidence of proper prisoner support in the immediate aftermath of the man's death and no immediate debrief was held for the staff involved in handling the emergency.

I make 11 recommendations to the Governor about ACCT procedures, self-harm reduction measures, record keeping and the management of a death in custody. I offer two commendations with regard to actions taken by staff during the night of 28/29 July 2008.

THE INVESTIGATION PROCESS

1. The investigation was opened by my colleague on 1 August 2008. The Governor and his staff produced the man's core record and a number of other documents for examination. Notices were displayed around the prison to inform both staff and prisoners of the investigation.

2. The investigator conducted the initial stages of the investigation until, unfortunately, he became ill. In February 2010, another investigator assumed responsibility for completing the investigation. Both investigators interviewed a number of staff and prisoners at Lincoln.

3. On 16 September 2008 one of my family liaison officers contacted the man's mother in order to explain the purpose of my investigation and provide her with an opportunity to raise any questions or concerns about the care he received. She raised a number of points of concern with the family liaison officer. These are summarised as follows:

   - Why was he not subject to more frequent observations once the prison staff were aware of the telephone call he made to his friend in which he spoke of wanting to be with his uncle and grandmother, both of whom had recently died?

   - Why was he not placed in a safer cell once he had been put on a 'suicide watch'?

   - Why were there unexplained marks on his body?

   - He had been concerned about a possible transfer to a prison on the Isle of Wight or to a secure hospital in Rampton. Was a transfer being considered and what had been communicated to him?

   - Why was there a delay of over six hours before the family were informed of his death?

   I have done my best to address these issues. I hope the findings of my investigation and report help the family better understand the events leading to his untimely death.

4. The investigator met representatives of Lincolnshire Police to discuss matters of joint interest, with especial reference to the conduct of the officer at Lincoln prison who had allegedly involved the man and other prisoners in trafficking.

5. I commissioned a clinical review of the management of the man's health needs while he was in custody at Lincoln. The review was conducted by the clinical reviewer on behalf of the local PCT.

Final report

6. The circulation of this final report has been significantly delayed and we apologise to the man's family, HM Coroner, the National Offender Management Service (NOMS) and other interested parties.

7. In this report the NOMS has accepted ten of the recommendations and partially accepted a further recommendation. Their responses to those recommendations are noted on pages 63 to 65. The NOMS noted three factual inaccuracies, amendments have been made in paragraphs 34 and 47. An officer's name had been removed from paragraph 53.

8. The family liaison officer spoke to the man's mother following the circulation of the draft report. Some of the responses she made have been dealt within the draft report however, his mother asked this report to note her ongoing concerns. I summarise those in the following paragraphs.

9. On reading the report, the man's mother said that she agreed with the findings and recommendations made and hoped that it would lead to improved practice at the prison in assisting the prevention of further deaths.

10. The man's mother had several points that are still of concern to her. Those points are as follows:

- That the telephone call she made to the prison on the evening of 28 July raising her concerns over her son's mental well being, were not taken seriously. Whilst acknowledging that an officer spoke to her son following the call and he denied any thoughts of self harm, she felt he should have been moved to a safer cell as a precaution.

- The quality of the psychiatric assessment that her son underwent shortly before his death.

- Finally, she wished to know if any further legal action had been taken against the officer dismissed from the Prison Service for corruption, whose actions she believes to be responsible for her son's death.

11. We note the three points raised by the man's mother, but are unable to add any further comment or information. However, we reflect her ongoing anxieties and distress from her son's death.

HMP LINCOLN

12. HMP Lincoln was built in 1872 and is a category B prison holding male prisoners. New prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A prisoners being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult. The prison's design is typical of the times, with galleried wings spreading out from a central core. All cells have integral sanitation. It serves the nearby courts of Lincolnshire, Nottinghamshire and Humberside. The prison holds remand prisoners and those serving short sentences or waiting to be moved to another prison. It holds a maximum of 738 men, which includes a small number of remanded young offenders.

13. There are four main residential units. A wing consists of the first night centre and holds prisoners on induction. B wing holds sentenced prisoners and C wing holds remand and convicted prisoners. D wing is the segregation unit and E wing is the vulnerable persons unit. J wing holds prisoners on short duration drug treatment programmes.

14. Healthcare at Lincoln is commissioned by NHS Lincolnshire and is provided by Lincolnshire Community Health Services. There is inpatient accommodation.

Her Majesty's Inspectorate of Prisons

15. Prior to the man's death, the most recent inspection of Lincoln by Her Majesty's Chief Inspector of Prisons for which a report has been published was in December 2007. In the introduction to that report the former Her Majesty' Chief Inspector wrote:

    > "Lincoln prison has gone through a difficult period, but this inspection found that normality had returned, with both accommodation and staff morale repaired following the disturbances. In effect, the prison had successfully turned a particularly unfortunate page in its history. The new governor still has plenty of work ahead to develop a fully effective local prison, particularly given the poverty of purposeful activity, but there are some solid foundations now in place".

16. In the section of her report headed 'Suicide and Self-harm', the Inspector wrote:

    > "A total of 350 ACCT documents (Assessment, Care in Custody and Teamwork plans, used in the management and monitoring of prisoners considered to be at risk of self-harm or suicide) had been opened in 2007 to date, and there were currently 15 open ACCT documents, the standard of which was good. There had been 183 incidents of self-harm in 2007 to date, although there were a significant number of repeated incidents by the same few prisoners. There had been one death by self-harm that was

still under investigation by the Prisons and Probation Ombudsman. There was a full-time SASH [suicide and self-harm] coordinator. Listener suites had recently been refurbished and introduced. Listeners, who are prisoners trained by the Samaritans to help and support other prisoners in distress, felt supported in their work. A multi-disciplinary committee met regularly to monitor trends."

17. The Inspector wrote about the vulnerable prisoners unit (where the man was located and where he died) as follows:

> "The vulnerable prisoners unit was located on E wing. About 60% of the population of the wing were sex offenders or prisoners who for various reasons were likely to attract adverse attention from other prisoners. The remainder were a mixture of those who had been assaulted or claimed to have been in debt in the main prison. There was evidence that some of the latter group acted in a predatory or aggressive fashion towards the others on the wing. There was no clear protocol on how to decide whether a prisoner could be accepted onto the wing. Prisoners who were sex offenders claimed that there were examples of name calling and kicking of cell doors by others on the wing when they were locked up. There were persistent claims that meals were being adulterated and that alien items had been found in the food. There was no compact to regulate expected behaviour. Between 40% and 50% of the bullying incidents reported each month emanated from E wing, and this had been the case for several months before the inspection. However, at the time of the inspection there were no prisoners on E wing on the basic level of the incentives and earned privileges (IEP) scheme, and none were being monitored under the anti-bullying strategy.
>
> "In group discussions, the vulnerable prisoners were the most negative group in regard to feeling that they were ignored by the establishment. They were the most critical of the personal officer scheme, and wing files examined on this wing showed the least evidence of entries made by staff about prisoners. On some days during the inspection, none of the staff on duty on E wing were regulars".

18. A further inspection took place in May 2010, but the report of that inspection has not yet been published.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB). IMB members are lay members of the public and are unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. In

the IMB annual report which covers the period February 2008 to January 2009, the Chairman wrote in conclusion:

> "This report details a variety of concerns and good practice and recognises that the staff in general are well motivated, carry out their duties with professionalism and care, which augurs well for the future.
>
> "The Board's overall conclusion is that the prison is well run and many of the previous deficiencies reported by this Board and other Statutory Agencies who have a reporting function rather than monitoring, have been successfully remedied".

Investigation of previous deaths at Lincoln

20. I have investigated ten other apparently self-inflicted deaths at Lincoln, the report of one of which has yet to be published. In respect of the other nine, none of the recommendations made are relevant here.

KEY EVENTS

21. On 23 April 2006, two months after the man came out of prison and his licence expired, he attempted to kidnap a young girl. He was arrested during the early hours of the following day and was subsequently recalled to prison for failing to adhere to the conditions of his licence.

22. The man was held in police custody between 24 and 26 April, when he was taken to Magistrates' Court. He was remanded in custody and ordered to appear for trial at Crown Court on 2 August.

23. A Prisoner Custody Officer (PCO), who escorted the man from the police station to court, completed a suicide/self-harm warning form because of the following comments he had seen on the Prisoner Escort Record (PER):

> "DP (detained person) whilst on remand was on suicide watch. Has made threats to his flatmate that he will take his own life."

The PER also indicated that he was considered to present no known medical or security risk. No signature appears on the PER to show who made the above comments.

24. At section 4 of the suicide warning form, the PCO made the following comments:

> "Over 4 years ago. States he is ok. He knows he is going to prison today and is not happy about it. But can deal with it."

Reception at Lincoln

25. The man arrived at Lincoln at approximately 2.30pm on 26 April 2006. The PER was signed by a member of the reception staff at Lincoln but the signature is illegible. Nurse A, who conducted the initial health screen, signed the suicide/self-harm warning form. She ticked a box on the form to indicate that no Assessment, Care in Custody and Teamwork (ACCT) plan was opened at that stage.

Health screen

26. The man told Nurse A that he had no medical problems or concerns and had not seen a doctor within the previous few months. He admitted to binge drinking and using cannabis. When asked about his mental health, he said that he saw a psychiatrist regarding depression in 2004 and had attempted to overdose in 2000. She recorded her impression of his behaviour and mental state as follows:

> "Has a history of self-harm. However, states it was something he did a long time ago, issues now resolved. Previous inmate of Lincoln, states can cope with being here. Good eye contact, cheerful and open in manner."

27. At interview, the nurse was asked why she did not refer the man for a mental health assessment. She said:

> "Because it would have been based on the individual and how he presented at that moment in time, from what I can see of the document. He didn't show any problems to me. He maintained good eye contact. He was cheerful, open in his manner from what I've documented. And we can only go on how the individual presents at the time."

Secondary health assessment

28. The following day, the man was seen for a secondary health assessment. (The purpose of this assessment is to assess a prisoner's longer term physical and mental health needs.) He raised no medical or mental health concerns then, although he did say he had suffered with depression for most of his life but had learned how to cope with it. He said he had not taken any medication for depression since 2004.

Cell sharing risk assessment

29. An officer conducted a cell sharing risk assessment (CSRA – the assessment is made to determine the level of risk a prisoner poses to other prisoners in a locked cell) as part of the normal reception procedures. The officer noted that he had seen the man's PER, his warrant, and a closed F2052SH (the predecessor of the ACCT plan). He told the officer that he had never abused alcohol or drugs and was not currently dependent on these substances. He said he was not currently subject to self-harm monitoring procedures and had never been subject to them. He was not concerned about sharing a cell and the officer concluded that he presented only a low risk of harming others if he shared a cell.

30. The nurse completed the healthcare element of the cell sharing risk assessment. She agreed that the man's risk of harming others if he were to share a cell was low. She noted on the form,

> "Denies any thoughts of suicide or self-harm. Only left Lincoln in February 06."

Request to be separated for own safety

31. That same day, the man asked to be separated from other prisoners for his own safety because of the nature of his offence. He was located in J Wing, a unit that was used as a temporary overspill facility for prisoners in need of separation when there were no spaces in the Vulnerable Prisoner Unit.

Complaint about being depressed

32. On 2 May, the man attended the healthcare centre complaining of depression. He explained that he had previously been prescribed clomipramine, dothiepin and Seroxat (which are types of anti-depressant medication) for three years prior to 2004. He said he had been experiencing broken sleep and difficulty

waking up in the mornings. He denied having any thoughts of harming himself and it was felt that his mood was due to his current situation. He was prescribed fluoxetine, another anti-depressant, which was to be reviewed three weeks later.

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

33. On 17 May, the man asked to speak to a member of the local CARATs team. (CARATs is a community based agency which supports and advises drug or alcohol misusers both in the community and in prisons.) The following day, a CARATs worker interviewed him and completed an initial Drug Intervention Record (DIR) to assess his substance misuse needs. During his interview, he confirmed that he had used alcohol and cannabis since he was 14. He told her that he had taken an overdose of painkillers whilst in the community and had cut his arms four years ago. She noted that further intervention with him was both needed and accepted by him. A further appointment was scheduled for 1 June at which a care plan was to be agreed.

Review of medication

34. The man's fluoxetine prescription was reviewed, as planned, on 23 May. He complained that he was depressed and "stressed out". He admitted to having occasional fleeting thoughts of self-harm but said he had put that behind him. Two weeks later 10mg of buspirone (normally prescribed for the treatment of anxiety) was added to his prescription.

CARATs care plan

35. On 1 June, as planned, the CARATs worker saw the man again and drew up a CARATs care plan. This was as shown in the following table:

Date objective set	Objective	How will progress be measured?	What has to be done to achieve the objective?	Who will do the work?	What is the timescale for the work?
1 June 06	Discuss alcohol related issues	Successfully engage with Alcoholics Anonymous (AA)	Refer to chaplaincy and AA	Chaplaincy The man AA	Two weeks
1 June 06	Community based help and support upon release	Successfully engage with Criminal Justice Intervention Team (CJIT)	Send DIR to CJIT in area of residence	The man CJIT	DIR sent 18 May 06. Letter received 30 May 06. Visit prior to release.

Further review of medication

36. The man complained on 15 June that the fluoxetine was still not working and asked to change to clomipramine (another form of anti-depressant medication). This happened on 23 June when he was seen in the mental health clinic. It was written in his medical record that he "appears to have an underlying depression, exacerbated by situation. Denied any thoughts of self-harm".

Recommendation for enhanced privileges

37. On 27 June, the man was recommended for enhanced privileges under the Incentives and Earned Privileges scheme. (The IEP scheme aims to encourage good and constructive behaviour among prisoners.) This was approved three weeks later, with the result that he could benefit from having more visits, spend more of his private cash and have more of his own property in his cell.

Complaint about being stressed

38. The man complained to a nurse on 14 July that he was feeling stressed. Arrangements were made for a doctor to see him later that day. At 3.00pm, the doctor who saw him made the following note in the medical record:

> "Says he is feeling low and depressed for the last three weeks. Says he is very agitated and angry. Also complains of poor sleep. In court in two weeks to be sentenced. Expecting a long sentence. [In fact he was not sentenced until 29 September.] Trouble getting to sleep and also early morning awakening. Denies self-harm or suicidal ideas. Various options discussed. Increase clomipramine to 100mg tomorrow and 150mg by night. Zopiclone [a mild sleeping tablet] for three days. For mental health review please."

Disengagement with CARATs

39. When The CARATs worker went to see the man on 20 July, he told her that he no longer wished to engage with CARATs. No reasons for his decision were recorded in his CARATs file and he signed a service withdrawal disclaimer.

First Assessment, Care in Custody and Assessment (ACCT) plan opened

40. Two weeks later, on 31 July, a nurse was called to E Wing at about 9.15pm to see the man after he had made several minor cuts to his right arm with a razor blade, some of which required the application of steristrips (adhesive strips which can be used in place of stitches to close wounds). A form F213SH (report of a self-inflicted injury sustained by a prisoner) was completed, indicating that no further treatment was needed. He told the nurse that he had thrown the razor blade he had used out of the window.

41. Prison Service policy is that whenever, a prisoner harms himself, an ACCT (Assessment, Care in Custody and Teamwork) plan must be initiated. At 9.40pm on 31 July, an ACCT plan was opened for the man by Senior Officer (SO) A, who was the night orderly officer at the time.

42. When an ACCT plan is initiated, the following procedures must be carried out:

    - A Concern and Keep Safe form must be completed as soon as possible after the initial risk has been identified.
    - An Immediate Action Plan must be compiled within one hour of the risk being identified.
    - An assessment interview must also be completed within the same time scale.
    - A first case review must be held within the same time scale. At this review a Care and Management Plan (or Care Map) must be agreed with the at-risk prisoner. Subsequent reviews must also be planned if it is decided that the ACCT plan must remain open. When it is considered appropriate to close the ACCT plan, a post closure review must be held within seven days of closure. Case review panels must be multi-disciplinary and must make judgements as to the level of risk the prisoner presents and how often he/she needs to be observed and engaged in conversation.

43. The Concern and Keep Safe form for the man was completed by the SO at 9.40pm on 31 July. He wrote as follows:

    > "He had made numerous cuts to his right upper and lower arm. He was in a calm mood when we opened his cell and he was just sitting patiently. He stated he had no intention of committing suicide and that he had cut himself because he felt low. I offered him the 'phone' [ie the Samaritans telephone] but he said he could and would talk to his cell mate. I told him I would have him observed during the night and that he could ring his bell if he felt upset at any time."

44. The Immediate Action Plan, also compiled by the SO, recorded that the man was happy to remain in his current cell so that he could talk to his cell mate. He did not feel any need to telephone the Samaritans. The SO decided that he should be observed four times during the night.

45. An officer conducted the man's assessment interview at 3.00pm the next day, 1 August. During the interview, he said he had a lot on his mind after speaking to his solicitor about his impending court appearance and about himself. However, he insisted his act of self-harm was not an attempt to take his life. Rather, it was a means he had often used in the past to relieve tension. He told his assessor he had done this since he was 13. Finally, he said his reason for wanting to live was his mother, to whom he was very close.

46. The first case review was held at 4.40pm on 1 August in E wing where the man was living. The panel comprised the Unit Manager, a SO and the officer who had completed the assessment interview with him, and a student on placement.

No-one from the healthcare department was present. The record of the review makes no mention of whether the man was present. The review was summarised as follows:

> "He is punishing himself inside at the moment and needs support. His cell mate is supporting him at the moment whilst in his cell. Listeners, Samaritans, KW, [Key worker] staff, Chaplaincy all offered as support. Positive goals set."

The panel decided that, although his risk of harming himself was thought to be low, he should be observed at hourly intervals during the day and night and that staff should engage in a conversation with him once in the morning, once in the afternoon and once during the evening period. The ACCT plan was to remain open and the next case review was scheduled to take place on 5 August.

47. The panel also set out a Care and Management Plan which included the following goals for the man to achieve:

    - Seeing a mental health nurse
    - Writing to his mother
    - Telephoning his mother to arrange a visit to him in the prison and at court.

48. The record indicates that the second and third goals concerning contact between the man and his mother were achieved on 3 and 4 August respectively. However, the following entry was made in his ACCT ongoing record shortly after 3.00pm on 3 August:

    > "Was expecting a visit from his mother this afternoon but whilst he was waiting on the 1s landing to go, visits called to say the visit had been cancelled by her. Seems disappointed by this in his body language. Spent the conversation picking at arms and old self-harm scabs and not always making eye contact. When asked if he was more anxious and thinking of further self-harm, he replied no. Hopes to call his mother tomorrow."

    No further mention of this matter was made in the ACCT ongoing record.

Court appearance

49. The man appeared at Crown Court on 4 August. The hearing was adjourned so that a Pre-Sentence Report could be compiled. A note in his medical record that day shows that he was considered to be "fit and well" upon his return to prison. Entries made in his ACCT ongoing record while he was out at court also suggest that he managed to cope relatively cheerfully throughout the day.

50. However, at 8.45pm that day, the following entry was made in his medical record by a member of staff whose signature is illegible:

> “Called to see this man who had several cuts to left arm. Steristrip required for only one wound and micropore dressings to arm applied. Said he felt better after cutting but had been promised a mental health nurse last week but still hadn’t seen one. He had also stopped taking citolapram (anti-depressant) tablets a week ago.”

Change of medication

51. An entry made in the medical record the next day, 5 August, by Registered General Nurse (RGN) A shows that a decision was made to change the man’s medication to Cipramil (another anti-depressant) following a review by the mental health team. The record does not make it clear whether this was a formal mental health review with him present.

Mental health review

52. However, two days later, the man saw a member of the mental health in-reach team. The following entry was made in his medical record:

> “Still not sleeping - looks awful. Things have improved slightly - mum visited yesterday. Concern - bored quickly, easily distracted. Some elements of OCD [Obsessive Compulsive Disorder] - straightening things. Gets worse when feels stressed. Would benefit from zoplicone every 3rd night for the next two weeks. To see in clinic in four weeks. He has agreed to approach me sooner if he begins to feel worse.”

First ACCT plan closed

53. On 7 August, a further ACCT case review took place. The review was chaired by a SO and attended by an officer. The man was present but again no members of the healthcare team attended. The review was summarised as follows:

> “More positive now had good visit from mother on 6 August. She is supporting him and will be there for him when he gets out. He aims to live with mother when released.”

The summary does not categorically state that the ACCT was to be closed but the case review form does contain a note showing that a post closure review was to take place on 14 August. This review did not materialise as a further ACCT plan was opened on 12 August.

Further act of self-harm

54. Nurse A went to the man’s cell at 6.30pm on 10 August at the request of wing staff who noticed that he had “old multiple superficial cuts” to both arms from the previous day. The nurse applied gauze to both sites. He told the nurse he was alright and was not thinking about harming himself.

Second ACCT plan opened

55. A second ACCT plan was initiated at 10.40am on 12 August, this time by SO B. In the Concern and Keep Safe form, the SO wrote:

> "Self-harmed on 9 August. Says he has self-harmed because he is stressed out at the moment. Says he has mood swings and he would like to see the doctor."

This act of self-harm is not mentioned in the man's core prison record or in his medical record.

56. The 2006 calendar shows that 9 August, when the man harmed himself, was a Wednesday and that 12 August, when the ACCT was opened, was a Saturday. My investigators were presented with no evidence to show why there was a delay of three days between his act of self-harm and opening the ACCT plan.

57. The SO also compiled an Immediate Action Plan. He recorded that the man was once again content to remain in his current cell with the same cell mate. He was to engage in four conversations with staff during the day and be observed at hourly intervals when locked in his cell during the day. At night, he was to be observed four times. The SO also noted that he had spoken to his mother the previous day. He agreed to use the Listeners if necessary.

58. During the assessment interview the same day, the man said he was feeling low and did not know how to lift his mood. He thought his low morale may have been due to his inability to forgive himself for the offences he had committed in the past. He said he saw his acts of self-harm as a means of punishing himself. Although he said he did not value himself and felt worthless, he reiterated that he did not wish to die. He said he had support from his mother and family. He agreed with the plan for him to be assessed by the mental health review team and for his medication to be reviewed.

59. The first case review for this second ACCT plan was held at 10.10am on 13 August in E wing. SO C chaired the review. The Unit Manager for the day and an officer attended, as did the man, but the healthcare department was not represented. The review was summarised as follows:

> "The man attended the review stating he felt okay at present but did feel a little low in mood earlier. His medication was changed approximately a week and a half ago and he feels his mood has deteriorated since this time. The Board suggested a review of his medication and he will be put forward for this. He has had a contact with a mental health worker and feels comfortable speaking with her. Ongoing support from mental health team is required as per care map. He was advised as to all support mechanisms available. The Board agreed the level of observations and conversations should remain the same at present."

60. The panel judged that the man's risk of self-harm or suicide was raised and scheduled a further review for 21 August. An invitation was to be sent to a Registered Mental Nurse (RMN) of the mental health team to attend.

61. A care and management plan agreed by the panel with the man set two principal goals:

    - His medication was to be reviewed by a doctor.
    - Ongoing support was to be made available by the mental health team.

62. Four days later, on 14 August, the man again told staff that he felt stressed. He was seen by a nurse (whose signature in the medical record is illegible) who decided that he should see a member of the mental health team as well as a psychiatrist. The nurse discussed him with another nurse who had apparently seen him during the previous week. This nurse, who had altered his medication, took the view that the new prescription had not yet been given enough time to take effect. She felt she could not do any more for him until she could assess the success of the medication. She therefore felt no need to see him at that point. It is not clear from his medical record whether he saw a psychiatrist.

63. At 11.00pm that day, another nurse was asked to see the man as he had made a number of fresh cuts in his left arm. The nurse applied steristrips to four cuts and left the other wounds to dry. The nurse made the following entry in his medical record:

    > "States feels stressed. On ACCT already. Declined Samaritans phone." Signed Nurse.

64. A further case review was held at 3.15pm on 15 August, earlier than planned, as a consequence of the man's further act of self-harm the previous day. Once again, SO C chaired the review and was joined by an officer and RMN. The review was summarised as follows:

    > "The man attended the review stating he felt okay today. Case review held due to self-harm incident last night. He has seen the doctor who has referred him to a psychiatrist. A referral to mental health has been made and a nurse will see him next week. He is due back in court on 11th September and has set his mind on the worst case scenario."

    The panel judged that his risk was still raised. No changes were made to the observation levels set previously. A further case review was scheduled for 22 August.

Second ACCT plan closed

65. The next case review was held as planned on 22 August. SO B chaired the review which was attended by an officer and the man. The healthcare

department was not represented. The record of the review does not show what level of risk was assessed but the SO summarised the review thus:

> "States he is okay. Says his medication is working very well. He is less agitated. The nurse says that he has improved a lot since Thursday. He says that if he is feeling down he will speak to a member of staff and not bottle it up."

The record of the review does not explicitly state that a decision was made to close the ACCT or for what reasons, but the form does indicate that a post closure review was scheduled for 5 September. In the event, no post closure review took place as a new ACCT plan was opened on 4 September.

Third ACCT plan opened

66. At 8.40pm on 4 September, the man's cell mate rang his cell bell to alert staff to the fact that the man had inflicted a number of minor cuts to his right arm. His wounds were treated by a nurse both in the cell and in the wing treatment room. No stitches were required. As a result of this act of self-harm, an ACCT plan was opened by the Night Orderly Officer (NOO).

67. The NOO completed a Concern and Keep Safe form shortly after 9.00pm and then drew up an Immediate Action Plan. The man told him that he had cut himself to release pressure and he felt better as a result. He said he had no intention of harming himself again. The NOO decided to remove his razor blades from his cell in order to prevent any further attempts. (Razor blades are issued to prisoners to allow them to shave each day. If a prisoner uses them to self-harm they can be removed.) The NOO also decided that the man should engage in conversations with staff during the morning, afternoon and evening periods and be observed at hourly intervals during the night.

68. At his assessment interview, held at 4.00pm on 5 September, the man reiterated that his acts of self-harm were a means of relieving tension within him and were not related to any desire to kill himself. On this occasion, he said, he had not taken his medication for a week. He told his assessor that he was due to see a mental health nurse but he became frustrated whilst waiting for the appointment to take place. He said he had been experiencing mood swings but did not want to die. He said the main issue was to see a member of the mental health team so that his medication could be reviewed.

69. The initial case review was held at 4.15pm that day. The review was chaired by a SO and attended by an officer who had conducted the assessment interview. The man was present but the healthcare department was not represented. The review was summarised as follows:

> "After speaking to the man, his main issue and reason for cutting himself is that he has stopped taking his medication as it was giving him severe headaches. He becomes easily frustrated and has used cutting his arm since he was 13 as a way of releasing stress and as a coping mechanism. He is

waiting to see mental health team about a review of his tablets."

The care and management plan drawn up at the review included two goals for him to achieve with the support of staff. They were to stabilise his mood with appropriate medication and to re-establish contact with his mother (who had recently moved house). The panel considered that his risk of further self-harm was low and made no changes to the frequency of observation set by the NOO when he opened the ACCT plan. They scheduled a further review for the following day, 6 September.

70. The review took place as planned, at 3.00pm. The panel comprised a SO, the case manager for the day, an officer and a mental health team member referred to only by his first name. The man was present. The review was summarised thus:

> "He appears to be having problems with sleeping and medication. Both are linked. Therefore the medication will be re-assessed with a view to changing it. No other problems."

The panel considered that he presented a low risk of further self-harm and directed that he should be observed at hourly intervals by day and by night and that he should engage in conversations with staff during the morning, afternoon, evening and night time periods. A further case review was scheduled for 13 September.

71. A nurse, whose signature is illegible, made the following entry in the man's medical record on the same day::

> "Seen in ACCT review. Immediately prior to this episode of self-harm, had not been taking his citolapram for one week as was having nausea/vomiting as side effects. States mood very low, anxiety high and sleep poor. To discuss with MO (Medical officer, the prison doctor) re possibility of change to Mirtazapine. No change to ACCT."

72. On 7 September, a member of the healthcare department, whose signature is illegible, noted in the man's medical record that he did not appear for an appointment with the doctor. There is no evidence to show whether anyone checked why this was the case. However, the following two inter-related entries in his ongoing record the next day suggest there may have been a misunderstanding about the timing of the appointment:

> 9.35pm 7 September – "Must see doc in morning to get med script" [prescription].
>
> 9.00am 8 September – "He was under the impression that he was down to see the doctor this morning. Has now been told that nursing staff are sorting his medication with the doctor without the need for him to be present."

Third ACCT plan closed

73. On 13 September, a further ACCT case review took place as planned, chaired by a SO and attended by an officer. The man was present but no-one from the healthcare department attended. The following is the summary of the review:

> "Attended review and stated he felt ok and no problems. Medication now sorted and sleeping a lot better. No thoughts of self-harm and has not attempted it since this book was opened. Stated he feels he can cope on his own and will approach staff members if he becomes frustrated in the future. Aware of Listener scheme and Samaritans scheme and how to access. Happy to close ACCT book at this time."

The panel scheduled a post closure review for 20 September. In the event, this review did not take place as a new ACCT plan was initiated on 15 September.

Nurse called to cell during the night

74. At 2.20am on 15 September, a nurse was called to see the man in his cell because he was feeling stressed. The nurse, whose signature is illegible, made the following entry in his medical record:

> "Complains of feeling stressed and unable to relax. States is feeling the effect of no medication today (to commence fluoxetine tomorrow). Advised that mirtazapine has a long half life and will therefore still be in his system. Given reassurance. Will ask staff to speak to MO re anxiolytic [a drug used for the treatment of anxiety]."

Fourth ACCT plan opened

75. The man made more superficial cuts to his right arm at about 11.30pm on 15 September in his cell. His wounds were cleaned and steristrips applied. No further treatment was necessary. As a consequence of this act of self-harm, the Night Orderly Officer, SO A, initiated a new ACCT plan.

76. The SO completed a Concern and Keep Safe form just before midnight. The man told the SO "his head was in a mess" following an interview with a psychiatrist (for the purpose of compiling a psychiatric report to court). He said that during that interview, "he went over all the events that had happened to him and the offences". He told the SO he would not be "doing anything else" (meaning harming himself) as he felt he now "had it out of his system". He said he wanted to see a doctor as soon as possible. The SO's concluding remarks on the Concern and Keep Safe form were, "After a discussion with the nurse, we felt that he was a low risk for further action".

77. The SO also completed an Immediate Action Plan on 15 September, in which he recorded that the man wanted to see a doctor on the following Saturday (ie the next day, 16 September) if possible. The SO directed that the man should

be observed at hourly intervals by day and night and should engage in four conversations with staff during the day.

Further act of self-harm

78. At 2.30pm on 16 September, the man was found to have inflicted minor cuts to his right forearm. A nurse covered the wound with a dry dressing and steristrips.

79. At 10.30am on Sunday 17 September, Officer A conducted an assessment interview with the man. During the interview, he said he was experiencing anxiety and depression and felt his medication was insufficient for his needs. He told the officer he was “coping with prison life in general”. He reiterated that his act of self-harm had been brought about by talking to a psychiatrist which brought back memories of his childhood. He explained that he used cutting as a release valve. He confirmed that his act of self-harm was not an attempt at suicide and that he had no intention of dying.

80. The officer recorded that the man experienced regular mood swings and disturbed sleep patterns. He communicated in a positive manner throughout the assessment. He said he was close to his mother with whom he had regular contact. He told the officer that he needed to live for his mother because of the support she gave him. His main concern was his need for his medication to be sorted out. A note was made in the record of his assessment interview that he was due to see a doctor later that day. The record of the assessment ended with an agreement that he should try to remain with the same cell mate and with an assurance that he should see a doctor. (There is no evidence that he saw a doctor later that day. See also paragraph 80 below.)

81. The initial ACCT case review was convened at 10.45am on 17 September, immediately after the assessment interview. The review was chaired by a SO and attended by an officer and the man. The healthcare department was not represented. The review was summarised as follows:

> “He is more settled especially now that he is on the right treatment but not strong yet. Awaiting sentence on 29 September at Crown Court. He feels he can now handle his situation especially if we remove razors other than for use.”

82. The panel considered that the man’s risk of further self-harm was low. He was to be observed at hourly intervals during the day and that staff were to have four conversations with him. He was also to be observed at hourly intervals by night. The next ACCT case review was scheduled to take place on 21 September.

83. The review panel set out a care and management plan for the man in which two goals were agreed. His medication was to be improved by seeing a doctor and his razor blade was to be handed back after use.

Appointment with doctor

84. The man's medical record shows that he was due to see doctor during the morning of Monday 18 September, but that he did not keep the appointment. However, an entry made three days later shows that he was seen by a doctor that day. The following information was recorded:

> "Seen on E wing.
>
> "Depression. Says was on fluox 40 on the out. But has not taken it for six months. Advised starting dose is 20mg and will increase as needed after two weeks.
>
> "Stress. Works at the charity shop and is fine at work. But finding association very difficult/stressful. Self - harms on association/nights. F35 done: two weeks no association. Review two weeks regarding fluox." .

(The term 'F35' refers to a Prison Service form used by managers to give written advice or instructions to another person. See also paragraphs 183-185 below.)

ACCT case review

85. The case review scheduled for 21 September took place as planned. The panel comprised a multi-disciplinary team including a healthcare representative and the man. The review was summarised as follows:

> "Appears settled at this time. Gets stressed up after association. Saw doctor 21.9.06 not given medication. Does feel like cutting up now and again. Cuts up on out. Lots of scars on arms done over past two months. At court in next few weeks. Will then be able to cope better possibly."

The panel made no changes to the frequency of observations and recorded that his level of risk was considered to be low. The ACCT form was to remain open. The next case review was scheduled for 28 September. A nurse was to be invited to attend.

86. At that review, it was decided that, although the man felt alright, the ACCT plan should remain open until after his court appearance the following day. The next review was therefore set for 3 October.

Appearance in court

87. On 29 September, the man appeared at Crown Court for sentencing. He was given a sentence of life imprisonment and told that he would have to serve a minimum of six years before he could apply for release on parole. The Prisoner Escort Record (PER) for the journey to and from the court indicated that he was at risk of self-harm or suicide. He was checked regularly during the journeys and whilst in the court cells. He arrived back at Lincoln at about 2.20pm. An entry was made in his core prison record to reflect the fact that he had been

given a life sentence and that he was already subject to ACCT procedures. It is clear from the entries made in the ACCT ongoing record that, in keeping with Prison Service policy, the ACCT plan was taken with him. He told reception staff upon his return that he felt alright. The following entry was made in his ACCT ongoing record at 4.00pm that day by an E wing officer:

> "Had a chat on return to E wing. States that he expected an indeterminate sentence but was hoping for a shorter recommendation but was not surprised with 6 years. Says he has begun to accept it and has no thoughts of self-harm at present. Advised that I am on all weekend if he needs a chat."

Fourth ACCT plan closed

88. At 6.45pm on 29 September, the duty manager noted in the man's ACCT ongoing record the need for staff to watch for any change in his demeanour, in view of his sentence. Thereafter, he appeared to settle to the extent that, on 3 October, his ACCT plan was closed after a final case review that day, at which a representative of the healthcare department was present. A post closure review was scheduled for 16 October. However, that review did not take place as a new ACCT plan was opened on 9 October.

Fifth ACCT plan opened

89. The man only managed to avoid harming himself until 8.20am on 9 October when he made a number of minor cuts to his left arm, none of which required any significant treatment. SO B initiated an ACCT plan immediately. In the Concern and Keep Safe form, the SO recorded that the man had told him that he had thought of self-harm and therefore cut himself. In the Immediate Action Plan, the SO recorded his decision that the man should be observed at hourly intervals during the day and night and should be engaged in conversations with staff four times during each 24 hour period.

90. SO D completed the assessment interview with the man that evening. In the record of the interview, the SO wrote:

> "The life sentence is playing on his mind and he is wondering if it is all worth it. Has a recommendation of 6 years but knows he will do more than that. Says he feels ok at the moment but his mood changes quickly. This happens on a daily basis.
>
> "Mental state fluctuates sometimes quite rapidly. Says he has a poor sleep pattern and some days a poor appetite. Saw a psychiatrist for a pre-sentence report who diagnosed a personality disorder. Says he can't sleep as his mind is racing, lots of thoughts about his past, his current offence and feelings of remorse.

> "States that he does not want to die, but part of him does. Wants to use this sentence as a way of starting afresh."

The box in the form entitled 'agree what is to happen now with the interviewee' was left blank.

91. The first case review was conducted at 7.30pm that evening. Present were two SOs and the man. The healthcare department was not represented. The review was summarised as follows:

    > "Says part of him wishes to be alive but part of him not. Self-harm is a way of coping with life stresses. Wants to stop self-harming. Observations to remain at hourly, 4 x conversations per day (am/pm/evening/night)."

92. The panel judged that the man presented a raised risk of further self-harm. And noted that a routine referral was to be made for a mental health assessment. A further case review was scheduled for 13 October. A mental health nurse was to be invited to attend.

93. The care and management plan included two goals for the man to achieve with the support of staff. The first was for him to explore ways of coping with past problems (i.e. those stemming from his childhood). A referral was to be made via the chaplain for him to see a counsellor to help him achieve this goal. The second was for him to explore any mental health issues or problems with the help of the mental health team. The record does not make clear whether he saw the chaplain or a counsellor.

94. The next case review took place on 13 October as planned. The panel comprised a SO and an officer but a mental health nurse was not present. The review as summarised as follows:

    > "He states he's feeling ok at the moment. He is on medication which is stabilising his depression. However, he is still getting mood swings that he cannot stop. He knows his trigger points but has no coping strategies in place. He is waiting to see Mental Health Team about this and in view of that we feel the document should remain open on same obs."

    The panel judged that his risk of further self-harm was low and scheduled a further case review for 20 October. A mental health nurse was to be invited to attend.

95. That review took place as planned but the mental health nurse was not present. The review was chaired by a SO and attended by an officer, with the man present. The comment was made that he was now unemployed but was hoping to join education classes. The panel judged his risk to be low but kept the ACCT plan open. The next review was to take place on 26 October with a nurse present.

96. The next review took place on 26 October. It was chaired by a SO and attended by an officer. No member of the healthcare team was present. The review was summarised as follows:

> “Medication has been changed, needs a while to take effect. Family ties with mother have improved. Still waiting for education interview. Same obs. No feelings of self-harm.”

The panel considered that his risk was low but kept the ACCT plan open. A further review date was set for 1 November. No comment was made in the record of the review as to whether a member of the mental health team was to be invited to attend.

Fifth ACCT plan closed

97. The review took place as planned but again, no member of the healthcare department was present. The review was summarised as follows:

> “He says he is still wanting to go on education. I have spoken to them and a member of the education department will come and see him on Monday. Family ties with mother is still good. He and the board feel that this booklet can be closed. He says he has no thoughts of self-harm.”

The ACCT plan was closed. A post closure review was scheduled for 15 November but actually took place a day later than planned, on 16 November. The following comments were recorded:

> “His attempt at self-harm was purely an act of frustration because his mother had not turned up for a visit. He now realises that it was a silly thing to do and it will not happen again. He has no thoughts of self-harm.”

Sixth ACCT plan opened

98. During the evening of 11 November, the man cut his left arm in his cell shortly after 10.00 pm. He told the NOO that he had done so because he had been refused his medication. The NOO opened an ACCT plan that evening and recorded his comments in the Concern and Keep Safe form. The NOO also drew up an Immediate Action Plan in which it was agreed that he should remain in shared accommodation and be observed at half hourly intervals through the night and at hourly intervals by day. The NOO reminded him of the availability of Listeners and the Samaritans.

99. The ACCT ongoing record shows that the man was observed at 30 minute intervals in keeping with the NOO’s instructions. My investigator noticed that the observations were carried out on a predictable basis. He managed to achieve a restful night without further incident.

100. At 3.00pm the next day, an assessment interview was conducted by Officer A. The man told the assessor he had become stressed because his mother had not booked a visit the previous day. As a consequence, he had asked the

nurses for extra medication to calm him down. He said the nurses told him his medication could not be changed without first seeing a doctor. He therefore cut his arm later that evening. He emphasised that there were no other reasons for his self-harm and he did not wish to kill himself. He also confirmed that he had since been able to contact his mother and now felt better.

101. The man also told the officer he had regularly self-harmed both in and out of prison and had twice attempted to take his life in the community. He said he had suffered from depression for many years and was currently taking anti-depressant medication. He told the officer that he felt disappointed that he had self-harmed again as he had managed to avoid doing so for nearly two months. He said he wanted to "come off the ACCT book to put this behind him".

102. The assessment interview was followed by an initial ACCT case review, chaired by a SO. Also present were Officer A and the man. The review was summarised as follows:

> "The man admits that he only self-harmed because his mother didn't visit him. He has agreed to ask his mother to contact the prison if she thinks she will not be visiting him when previously agreed. We will then let him know that she is not coming thus preventing al the stress caused. All agreed on closing book. No thoughts of self-harm."

103. The ACCT plan was closed. According to the front cover of the ACCT plan, a post closure review was set for 25 November. However, the record of the initial (and only) case review, signed by the SO, shows the same date and time as the post closure review. This is clearly a mistake on the part of the SO. In the event, a post closure review was held on 29 November. The review was conducted by the SO who recorded the following summary:

> "He has settled down. He is now unemployed but at ease with himself and still in contact with his mother. He has no thoughts of self-harm."

104. The last entry made in the man's medical record in 2006 was on 15 December. It read as follows:

> "Not sleeping and this is making him angry in day. When had mirtazapine was given at 4pm (sic). Was asleep by 6pm but awake from midnight. Would like to try mirtazapine again but nocte [nightly] and reduce fluoxetine to 10mg for five days and then start mirtazapine."

Key events in 2007

105. The man's records show that 2007 was a very different year for him. He refrained from deliberate self-harm throughout the year. Although he continued to manifest frequent mood swings, he was not considered to be at risk of self-harm or suicide and no ACCT plans were opened. His medication was regularly reviewed and adjusted where necessary.

106. In June, the man's uncle, who was in the community, was found hanged after having gone missing. He appeared to take this news quite well. He also appeared to cope reasonably well when told he would not be allowed to attend the funeral. During this period, he had frequent contact with his mother. Nevertheless, as a precaution, his razors were removed from his cell after use. The entries made in his core record show that he was given appropriate care and support by wing and healthcare staff.

107. On 10 October, the man began work as a wing cleaner, a job that enabled him to spend longer periods out of his cell in constructive activity. A week later, his cell sharing risk was reviewed. It was decided that he should remain in a shared cell with the same cellmate.

108. In December, an entry made in his core record shows that the man adhered to wing and prison rules and got on well with other prisoners.

Key events in 2008

109. The year 2008 also began well for the man. On several occasions during the year, he was reported by staff as having a good attitude and as a good worker on the wing cleaning party. Although his record shows that he applied in March to become a Listener although it is not clear what happened to his application.

Failed Mandatory Drug Test (MDT)

110. However, on 17 April, the man was placed on report. It was alleged that he had administered buprenorphine to himself between 24 March and 7 April. (This is a drug used to replace heroin during the treatment of drug addiction.) He disputed the charge and asked for an independent drugs test. His case was adjourned to allow that to happen. On 12 May and again on 10 June, his case was further adjourned to be heard by an independent adjudicator. (This hearing was eventually scheduled to take place in July on the day he died.)

111. As a result of the fact that a drugs related charge had been raised against him, the man was referred back to the local CARATs team. On this occasion, was the CARATs worker assigned to him. The following is an extract from the note the CARATs worker made on 20 May in the man's Drug Intervention Record (DIR):

> "He has no drug issues. He admits to having some cannabis in the past, but never caused problems. This current MDT positive is being challenged by him. He did not/does not take drugs. Signed service withdrawal suspended for now."

No further entries were made in his CARATs file.

112. An entry made in the man's core record in mid-May shows that he was regarded by staff as "mixing with the wrong element on the wing".

Allegations of trafficking by a prison officer

113. In June and July, information was given by prisoners that an officer was trafficking in drugs and mobile telephones with prisoners in E wing, where the man lived. The information was taken seriously by managers and a corruption information log was opened.

114. On 15 June, an entry was made in the man's core record showing that the appropriateness of introducing him to a new cell mate was assessed. The record shows that, as they knew each other, both he and the other prisoner were happy to share the same cell. The new cell mate was interviewed by my investigator. The following are extracts from his interview:

> "As you may be aware, there is an Officer currently suspended for an investigation of corruption of bringing drugs and mobile phones into the prison.
>
> "The man was in a cell with [a prisoner – name withheld] who was due to be released. He asked me to go into his cell with him. One of the first things that he said to me was, 'If you want anyone contacted, let me know and I will sort it for you'. I said, 'What do you mean?' He said, 'I have got an officer in my pocket. I am not going to tell you who but I have got a phone, he has brought me a phone in.'
>
> "On this mobile phone, he rang his mum…He made other calls to his brother … On one phone call to one of his brothers he asked his brother that if he goes to this funeral [that of his grandmother] if he was allowed, to have his brother bring along some cannabis for him. Obviously I heard his brother speak and he was absolutely not going to do that.'
>
> "And then I noticed his state of mind deteriorate rapidly and his use of heroin substitute – subutex – he started to take a lot of that, snorting up his nose. He was taking heroin which I was obviously against."

115. My investigator asked the prisoner whether he knew where the man was getting the drugs from. The prisoner replied:

> "I do know where he was obtaining that from but I am not prepared to tell that at the moment, but he was getting it from an inmate on the wing who I believe was having it supplied by the officer that was suspended.
>
> "Things then came to a head. Obviously I knew a lot about this suspended officer. I knew what he was getting up to … and he was coming into the cell regularly, very distressed, stating that this officer had threatened him because he had apparently owed him money for mobiles but he couldn't get

> any money from anywhere. People that were on the wing that were ordering the mobile phones, he was the go-between basically. They were ordering the phones and he was going to the officer who bought them in but the others weren't paying up and the buck stopped with him. He was getting increasingly distressed that this officer had threatened violence against him if he didn't pay the debt. They knew where his family lived, all that sort of stuff. Like I say, his intake of drugs increased, his self-harming increased. He would not seek any help from the nurses whatsoever because he didn't want to go on the book [the ACCT document].
>
> "So it was about this time [about 10 July] that I thought enough is enough. Drugs were being brought in, he was self-harming, he was scared for his safety, scared for his family and he was in debt with the officer so I then took it upon myself to report the officer."

116. The officer was suspended from duty on 16 July 2008. Thereafter, the Prison Service conducted an investigation into the claims of corruption made by various sources. The officer was dismissed from the Prison Service the following year.

Seventh ACCT plan opened

117. On 10 July, the prison chaplain told the man that his grandmother had died. He asked to be allowed to speak to his mother. At 6.20pm that day, Officer B, seeing how upset he was, opened an ACCT plan. In the Concern and Keep Safe form, he wrote:

> "The man had heard that one of his grandparents had died today. On talking to him to see how he was he informed me he had cut his arms this afternoon."

118. At 6.45pm, a SO completed an Immediate Action Plan. The SO commented that the man felt safe and comfortable with his cell mate and did not wish to move to another cell. The SO decided to place him on hourly observations and instructed that staff should engage in conversations with him four times during the morning, afternoon and evening periods. The record shows that Officer B was to arrange for him to have a telephone call to his mother the next day, 11 July.

119. The officer conducted an assessment interview with the man the following day at 10.30am. He recorded his concern at the news of his grandmother's death and an apparent deterioration in his relationship with his mother with whom, he said, he had not spoken since February. He also told the officer that the last time he saw his mother, she told him she thought more about her boyfriend than about him. He said he had also lost contact with his father. He told the officer he had self-harmed by cutting his arms as a means of stress relief and that he had behaved in this way several times in the previous three months. He

also said he had been self-harming by one means or another over a 12 year period. He told the officer he would most likely cut his arms again if necessary to relieve his stress and would do it secretly. However, he said he did not feel suicidal. The officer recorded his view that the man needed to regain contact with his parents.

120. An initial ACCT case review was held immediately upon the officer's completion of the assessment interview, at 10.45am on 11 July. The review was chaired by a SO and attended by Officer B and the man. No-one from the healthcare department was present and neither was a chaplain. The review was summarised as follows:

> "The man attended his review and actively participated in a constructive and positive manner. Having been advised of his gran's death, he was accepting of this news and states he has now come to terms with it. He uses self-harm as an anger management tool and dresses his own cuts as appropriate. He states he has no intention to take his own life and understands the facilities available to support him. He declined a copy of the care map. Board agreed to reduce obs. To provide support as required."

121. The panel judged the man's risk of further risk behaviours to be low and decided that a further case review should be conducted on 16 July. The panel also decided that he should be observed at hourly intervals and that he should be engaged in conversations with staff once during each of the morning, afternoon, evening and night time periods.

122. The panel also drew up a care and management plan. This set out a number of goals or targets for him to achieve with the help of staff in order to reduce his risk. The targets included reviewing the cell activities in which he could engage, continuing to share a cell, restoring contact with his mother and making use of Listeners and/or the Samaritans if necessary. However, there was no mention of any plan to remove razors from him.

123. The following entry was made in the ACCT ongoing record at 2.15pm on 11 July, by a member of staff whose signature is illegible:

> "The man has been in contact with his mum. Had a long talk to her. This seems to have upset him as his father was there and his dad blanked him and doesn't want anything to do with him. Positive out of this his mum has told him she is going to visit him next week. Learned that his gran's funeral is next Wednesday and he wants to look at the possibility of going. Says he is stressed at present. States he is not suicidal and has no thoughts of suicide. States he feels like cutting his arms to release the stress but is going to try and be strong for his mum."

124. Shortly after 3.00pm the next day, the following further entry was made:

> "Had a long chat with the man about his history of self-harm, his relationships with his parents and his gran dying. Very upset about his gran dying and hopes to go to the funeral to grieve and be of support to his mum. He believes that going to the funeral will help him stop thinking about dying and will also help him grieve for his gran. Also by going he will be able to banish some feelings of helplessness as he will be there to support his mum."

125. On 13 July, the man handed in a formal application to attend his grandmother's funeral. One of the prisoners interviewed by my investigator said that he told him that if he were not allowed to attend the funeral he would kill himself. The investigation found no evidence to show whether that information was passed on to staff. During her interview with my investigator on 30 April 2010, the Deputy Governor said she could not recall whether she personally dealt with his application. However, she explained that the Prison Service's policy for prisoners' attendance at funerals was that they were normally only allowed to attend if the deceased was a close relative such as parent, sibling or son/daughter. In the case of other deceased relatives, including grandparents, a prisoner would only be allowed to attend the funeral if it could be shown that the person concerned had acted as a parent. She said that her understanding was that his grandmother had not acted in this way which would explain why he was not allowed to attend her funeral.

126. The following entry was made in the ACCT ongoing record at 8.30am on 16 July, the day of the funeral of the man's grandmother:

> "Spoken to briefly. Stated no current problems or thoughts of self - harm. Is upset he cannot go to his nan's funeral today. However, states he is coping. All methods of support re-explained and offered to him."

127. My investigator was told by two members of the chaplaincy team that prisoners who had suffered a family bereavement but had not been allowed to attend the funeral could apply for permission to attend a 'parallel funeral' in the prison chapel. The investigation found no evidence that the man applied for this facility.

128. At 7.00pm on 16 July, a further ACCT case review was conducted as planned. The panel comprised two members of staff from E wing together with the man, but without anyone from the healthcare department. The review was summarised as follows:

> "He appears settled and states he no longer wishes to harm himself. Will review on Sunday with a view to closing book. States knows how to ask for help and who to ask. Has made contact with mother and family which he has found reassuring."

The panel considered that he presented a low risk of further self-harm and made no changes to the frequency of observations set at the review held on 11 July.

Seventh ACCT plan closed

129. The same panel met in the man's presence at 9.15am on 21 July, to review his risk. The panel concluded that the ACCT plan could be closed. They summarised the review thus:

> "Is waiting for a move to a therapeutic environment. Has a long history of self-harm. States is on cleaners and can approach staff if feeling low. Is waiting for assessment. Would consider other units. He states if he feels like harming himself will speak to staff."

A post closure review was scheduled for 28 July but there is no evidence that it took place.

130. No entries were made in the man's core prison record or in his medical record between 21 and 28 July. However, one of the prisoners interviewed by my investigator said that on an unspecified date – almost certainly during this period – staff decided to move the cleaners down from the fourth to the ground floor of the wing. According to this prisoner, he was told that he was to move but he said, "I'm not having any pad mate [cell mate] down there." As a result, he moved into a single cell, where he remained until his death. The investigation found no evidence to show whether any assessment was made of his suitability to be in a cell on his own despite the number of times the support of the ACCT procedures was required and the support which his cell mate gave.

131. Another prisoner volunteered the following information to my investigator during an interview:

> "… The next night [the evening of 28 July] he had had his hair cut, which was very unusual for him. He had had a shave, again which was very unusual, he used to have a little beard, very rarely shaved. He had shaved, had had his hair cut, put clean clothes on because normally he wore the same clothes for a few days. He was unusually happy. He was very friendly with people, very chatty.
>
> "This was on the night he took his life. I saw him. He was speaking to an officer. I believe you should talk to her as well because he got on very well with her. (This officer was not interviewed by the first investigator. She resigned from the Prison Service in September 2009 and was not interviewed by the second officer either.)
>
> "Looking back now, and obviously hindsight is a wonderful thing, he seemed to be as though it was an acceptance that

something was going to happen. He just wasn't the person that people were used to. He was totally different."

Events during the night of 28/29 July

132. Among those on duty in the prison during the night of 28/29 July were an Operational Support Grade (OSG) and the NOO. In a statement he later gave to the police, the NOO said that, at about 11.00pm, he was patrolling the prison when he received a message from the Control Room to move to a place where he could take a telephone call. He went to an office in J Wing and took the call which was made by the man's mother. She explained to him that she was concerned about her son's mental state because a member of her family had received calls from him in which he had expressed a wish to be with his grandmother and his uncle (both of whom were dead). He told her that he would go and speak to her son to assess his mood.

133. He and two colleagues went to the man's cell and found him sitting on his chair. The SO told him about the call he had just received from his mother. He appeared to be surprised by what he told him but admitted to making the calls. He said that he had done so at a time when he felt low but now told the NOO that he felt fine. The NOO asked him if he was considering "doing anything silly", meaning harm himself. He replied that he was not. The NOO asked him to remove his t-shirt so that he could check whether he had harmed himself recently. He saw no fresh cuts or blood on his upper torso or on his arms. After replacing his t-shirt, he told the NOO he felt fine. The NOO said he had no reason to believe that he presented any risk to himself.

Eighth and final ACCT plan opened

134. Nevertheless, having consulted his colleagues, the NOO decided to take the precaution of opening an ACCT form and to place the man on half-hourly observations. These commenced at 11.20pm.

135. The ACCT form shows that the OSG checked the man at 30 minute intervals from 11.20pm in keeping with the NOO's instructions. He made the following entries in the ongoing record:

"2320 Stood in cell. Said he was ok."
"2350 Walking round in cell."
"0015 Still up and about in his cell."
"0045 Walking round his cell."
"0115 Stood in his cell."
"0140 Walking in his cell."

136. At interview, the OSG confirmed to my investigator that "most of the time", he did not say anything to the man. The OSG said:

"I looked through the observation flap but didn't say anything, as far as I can remember. The light was on in his cell and I could see him clearly. I could see he was ok. I know I made my first entry in the ACCT form at 11.20pm on 28 July 2008

> but I cannot recall the event. I know I wrote, 'stood in cell, says I'm ok'. I therefore may have spoken to him on that occasion. I next made an entry at 11.50pm and recorded that he was walking around in his cell. The light was on. He did not look agitated or anything. He seemed alright. I made other entries recording that he was stood up in his cell or that he was walking around. I did not regard this sort of behaviour as odd because prisoners often spend long periods during the night moving around their cell. So I didn't think his behaviour was unusual. He gave me no indication he was contemplating taking his own life. An officer on duty and the NOO both thought he was pretty normal when they saw him at about 11.00pm."

137. In a statement he gave to the police, the OSG wrote that at 1.30am on 29 July, he switched on the night light in the man's cell and saw him standing towards the right side of the cell. The OSG thought he was "fine". He therefore switched the night light off. He said he did not engage in any conversation with him as he was not requested to do so. He said he was only expected to "observe that he was ok".

The man found hanging

138. At 2.05am, the OSG approached the man's cell in order to conduct a further check. When he looked through the observation panel in the cell door, he could see his silhouette against the window. He was facing the cell door. The OSG therefore switched the cell light on and could clearly see him hanging from the window frame. He told an officer who was stationed outside another prisoner's cell about 15 feet along the landing that the man was hanging.

139. The officer joined the OSG, took his emergency keys from him and went into the cell. (For security reasons, staff on duty at night carry keys in a sealed pack which they may only open in an emergency.) Meanwhile, the OSG raised the alarm by transmitting a Code One message over the radio. (The code system alerts staff to a life threatening emergency in the prison without the use of language or terminology that could cause distress to other prisoners within earshot.) After raising the alarm, he had no further involvement in the emergency.

140. When the officer went into the cell, he saw that the man appeared lifeless. He described his face as having a "greeny/brown" colour. The officer cut him down from the window from his suspension point with a specially issued knife.

141. As the officer was on his own he could not prevent the man's body dropping to the floor. He positioned him on the cell floor on his back with his head towards the cell door and his feet towards the window. He then cut the ligature away from his neck. The officer felt for a pulse in the neck but found none. He later told the police:

> "The man's teeth were clasped around his tongue and I tried to open his jaw but I was unable to and could not move his

tongue. I then decided to attempt CPR [cardio pulmonary resuscitation] although I was convinced he was dead. I started to apply chest compressions over his t-shirt. I had only been doing this for a short while when another officer entered the cell. He then took over doing chest compressions and I went to the cell door and saw the nurse coming down the stairs. I re-entered the cell with the nurse who had her green medical kit with her. At this time the officer was still applying chest compressions. The nurse then took over the chest compressions and asked me to apply a face mask to the man. I started to do this and the officer took over. At this time, another nurse, a Healthcare Support Worker (HSW), came into the cell and the two nurses took over the medical duties. I then stepped out of the cell and after speaking with the OSG I returned to my previous duty."

142. The NOO made his way to E wing as soon as he heard the Code One message on his radio. In his statement to the police, he wrote:

> "I entered the cell and I could see that a man was laying on his back on the floor with his feet towards the window ad his head towards the cell door. Two officers were in the cell.
>
> "I requested an ambulance over my personal radio."

143. The following are extracts taken from the statement the HSW gave to the police:

> "… At approximately 0200hrs the following morning, Tuesday 29 July 2008, we [HSW and nurse] received a radio message over our personal radios of a 'Code One' … The message gave a location of E Wing but it did not give any indication as to the precise nature of the medical emergency. This is normal practice.
>
> "… I took the green coloured medical bag containing the oxygen and ambu-bag [a device that enables oxygen to be squeezed into a person's lungs from a bag] and the nurse took the orange coloured bag which contains the airways equipment, drugs and medicine. I then opened up my sealed key, which is contained in a pouch that I carry and the seal should only be broken in an emergency situation to allow us to exit the Healthcare Wing. As it happened, my key had not been sealed in the pouch correctly and I had to cut it with a fish knife [an anti-ligature knife] to get it open.
>
> "… I remember that on entering the cell one of the officers, I don't remember who it was, was applying chest compressions to the man lying on the floor and the other officer appeared to be clearing the man's airway. As soon as I had arrived in the

cell she told me to collect the defibrillator machine which is kept in the treatment room in E wing. [A defibrillator is a portable electronic device which automatically diagnoses a life threatening disorder of the heart rhythm.] As a precaution, earlier in the evening I had left the treatment room door unlocked on E wing which houses vulnerable prisoners and poor copers, in case there was a medical emergency on that wing and we had to gain quick access to the treatment room. I went with an officer to the treatment room which is located on the next floor up from the ground floor. After locating the defib machine, the officer ran back down the stairs with the machine as he was quicker than me and he probable returned to the cell in just less than a minute after he had left the cell to collect the machine.

"… Because the work was so exhausting and it was very hot in the cell, myself and the nurse and two other officers…took it in turns to perform chest compressions on the man and attempt to ventilate him using the ambubag but there were no signs of life and the defib machine repeatedly advised not to shock in its analyse phases.

"… We carried on repeating this procedure until two paramedics … arrived at the cell. I think from memory they logged this on the sheet as 0244hrs."

144. Later that day, the HSW wrote a memorandum to the Governor in which she drew attention to the problem she had encountered opening her sealed key pouch. She wrote:

> "At approximately 0205 hrs on 29 July 2008, I arrived on E wing ground floor to a Code One. I was then asked to collect the defib machine from E wing treatment room. I was unable to gain access at first as I was unable to open my key pouch as the key pouch was sealed incorrectly. This put vital minutes on to gaining access to equipment. I feel this could have been avoided if the pouch was correctly sealed."

145. The Lincolnshire police took a statement from one of the paramedics who responded to the prison's request for an ambulance. The following are extracts from that statement:

> "At approximately 0200am on Tuesday 29 July 2008, whilst at Horncastle Ambulance Station, having just finished a break, we received a job via our personal airwaves terminal from the Lincolnshire Control Room ... The job was to attend HMP Lincoln …
>
> "There was no detail at this time as to the nature of the job and I was informed via my airwaves radio that they would attempt to find out more details of the job while we were on

route. It was treated as an emergency response. Having arrived at HMP Lincoln at around 0230am we called up 'on scene'.

"During the journey from Horncastle to Lincoln [a distance of approximately 21 miles] my assistant in the ambulance had attempted to find out more information as to the nature of the job but this information had not been obtained.

"On arrival at the prison and reporting at the main gate, all mobile telephones were taken from us and we were then escorted through the prison in our ambulance by a prison officer to E wing.

"As we approached the wing I actually asked the prison officer why we were there and he replied that it was for a hanging.

"… Having arrived at the cell … my assistant fixed the heart monitoring leads to the man's chest area. While she was doing this, I attempted to cannulate the man on the inside of his left elbow but this was unsuccessful. [A cannula is a tube inserted into the body in order to administer medication or to remove fluid.]

"Whilst my assistant had placed the heart monitoring leads on the chest area she was also engaging in performing chest compressions, alternating with ventilations at the rate of thirty chest compressions to two ventilations. She then informed me that the reading from the heart monitoring machine was asystole, meaning that there were no signs of life. She continued the CPR and ventilations for about another four to five cycles which lasted about five minutes approximately, before stopping. After this time, the reading was still asystole. The medics [the nurse and HSW] had informed me that they had been carrying out CPR on the man for about 30 minutes prior to our arrival and so the decision was made to cease any further action. The man's face had cyanosed [a bluish discolouration of the skin], his lips were blue and his pupils were fixed and dilated. The man's extremities had hypostasis, which indicated that life was extinct. I was able to say that life was extinct and pronounced this at 0244hrs."

146. My investigator asked one of the prisoners he interviewed whether he had an opinion as to why the man might have taken his life. The prisoner replied:

"I believe it was two things. One, the death of his grandmother because he made it quite clear to me that if he couldn't go to the funeral to be there for his mum, not so much for his nan, he would commit suicide, that was what

he told me. I had a discussion with him and he sort of came around a bit and said he was being daft.

"The other one I believe [the corrupt officer - name withheld] had a lot to answer for because he [the man] was very scared of him. [The officer] threatened him a lot. He was in debt with [the officer]. [The officer] knew about him, threatened him and his family."

147. An officer who was in charge of the wing cleaning party of which the man was a member, told my investigator:

> "I cannot speculate as to why the man took his own life. I cannot comment as to whether he did so because on the day of his death he was due to face a disciplinary hearing for failing a Mandatory Drug Test. I know that, had he been found guilty of this charge, he would have lost his job as a cleaner with the result that he would probably have had to spend long periods locked in his single cell."

Letter found in the man's cell

148. After his death, a letter addressed to his mother was found in the man's cell. In it he wrote:

> "I hope you understand why I have had to do this and I'm sorry that it is in close proximity to Nan's … Mum, this has been on the cards for years. I think deep down you know that my head has been f*****d for years and though I've battled through this long I can't do it any longer. Mum, I'm so f***ing depressed. I go to bed every night hoping I will die and feel cheated every morning when I awake. I've got so much pain inside me it hurts every time I close my eyes so this is the answer to my suffering. I don't know why I'm like this. I don't know why I'm so messed up. To be truthful I don't think I can take being away from you as long as I have and I have lost hope of ever seeing anything other than bars and razor wire and in a way it's an escape from prison as well as the demons which plague me."

Informing the next of kin

149. At interview the duty governor explained that he was contacted at home at about 3.00am on 29 July and told that the man had been found hanging. He left for the prison as soon as he could and arrived at about 3.30am. He said he went straight to the orderly officer for a briefing about what had happened. Afterwards he went to E wing. He told my investigator that he considered notifying the man's family of his death immediately but decided not to do so. He said:

> "I was aware that the mother was concerned and I had to think about her feelings and I didn't think that was the sort of news she would want to receive at 3.30am – 4.00am, particularly when I wasn't aware of the situation at home. I also had other matters, operational issues that I was trying to resolve. So I was trying to sort that out. I needed to try and get everything back to normal by 7.30am when the rest of the prison was opened up. I had, as I've mentioned earlier, at least two members of staff that were quite adversely affected by the incident that night. So I was dealing with those issues as well. And I was trying to get the coroner in and trying to establish all the facts and make sure the area was sealed off. But I think the main reason was the feelings of the mother, and I didn't think it was appropriate at that time in the morning, particularly as it was only two to three hours before daybreak anyway, when the family liaison officer would be able to make the contact."

150. My investigator asked the duty governor whether, in similar circumstances, he would do anything differently in the future. He said he felt he made the right decision and would do the same again if the circumstances were to be repeated.

151. A prison family liaison officer was appointed. At her interview she told my investigator that she was called by the prison at around 6.30am to 7.00am. She confirmed that she was initially called by the control room to be told that there had been a death. She could not recall whether she was told that the person who had died was the man. She said she was next called by the Governor just as she was leaving her house for the prison. Again, she could not recall whether the Governor told her who had died.

152. She arrived at the prison at about 8.15am. Upon her arrival she was told by the Governor that the man had been found hanging and had died. The Governor also told her that the man's mother had telephoned the prison at about 8.00am to enquire how her son was following her telephone conversation with the NOO the previous evening. My investigator was unable to ascertain who took the call at 8.00am. That person was unable to confirm to the man's mother that her son had already died. She told my investigator that she was thus aware of the need to inform her of his death as soon as possible.

153. By 8.50am, she was equipped with sufficient information about the details of the man's death to ring the telephone number she had been given for his next of kin. The man's answered and she told her of her son's death.

154. She asked the man's mother if she and any other family members wished to attend the prison in order to receive more detailed information in person. She also offered to send a taxi to collect those who wished to make the journey. This invitation was declined. However, that afternoon, members of the family visited the prison and viewed the body at the mortuary under arrangements made with the help of the family liaison officer. Later, his personal property was handed to his family at different stages.

The man’s funeral

155. The man’s funeral took place on 11 August. The Governor offered to pay the full costs.

Prisoner support

156. My investigator interviewed the prisoner who had been the man’s cell mate. During the interview, the prisoner confirmed that early on the morning of 29 July, the Governor personally told him of the death. However, beyond that, my investigator was presented with no information to show what other support was given to prisoners in the aftermath of the death.

Staff support

157. The duty governor on the day of the man’s death told my investigator that there was no ‘hot debrief’ after he had been pronounced dead. (A ‘hot’ - or immediate - debrief designed to allow staff involved in responding to an emergency to express any distress they may have experienced.) He said:

> “We had a debrief, a cold debrief, some weeks later. There wasn’t actually a hot debrief. I went round and spoke to all the staff that were on. I had some concerns with staff. The Staff Care and Welfare team were in. Some staff had been adversely affected by what had happened and I decided … not to hold a debrief. It had been a long night for those involved in the whole thing.”

158. According to the duty governor, a member of the Staff Care and Welfare Team attended the prison on 29 July and spoke to all those staff who wanted to see her. He believed that follow up contact was made with some staff who had been particularly affected by the events of the previous night.

159. My investigator was told by one member of staff that when the debrief was held, those present were limited in what they could contribute because they were “not allowed to talk about operational matters”. The member of staff concerned said he did not have a chance to discuss “how things might have been done differently”.

ISSUES

160. Here I examine whether:

- The man's health needs were adequately met while he was in custody at Lincoln.
- His risk of self-harm or suicide was properly assessed, monitored and managed prior to the night of 28/29 July 2008.
- His risk of self-harm or suicide was properly assessed, monitored and managed during the night of 28/29 July 2008.
- He was subject to any form of bullying or coercion and, if so, whether this was linked to his death.
- The response to the discovery of him hanging was prompt and effective.
- The family were promptly and sensitively informed of his death and whether they were given appropriate follow up support.
- Prisoners and staff were appropriately supported after the death.

I also provide responses to the additional specific concerns raised by the man's mother.

Were the man's health needs adequately met while he was in custody at Lincoln?

161. Here I rely heavily on the findings of the clinical review conducted by the clinical reviewer on behalf of the local PCT. The following are key extracts from her report.

History of events

162. "The man was received into custody at HMP Lincoln on 24 April 2006. At reception, a history of depression and repeated attempts at self-harm were documented. During his period of custody at HMP Lincoln, he frequently sought help and advice for mental health issues and there were multiple documented episodes of self-harm. During the night of his death on 29 July 2008, he had been placed on 30 minute observations in his cell due to concerns that he may harm himself. At 1.40am he was reported to be walking around in his cell. At 2.05am he was found hanging with a blanket ligature around his neck. He was cut down by prison staff and resuscitation commenced. The attending ambulance paramedics arrived at around 2:40am and he was pronounced dead at 2.44am."

Medical history

163. "The man received a First Reception Health Screen at HMP Lincoln on 26 April 2006. There was no declaration of physical health problems. He declared a family history of type 2 diabetes and heart disease. There was a declared

history of drug abuse with use of cannabis in the past and within the preceding month. He admitted to binge drinking of alcohol and a smoking habit of ten-15 cigarettes a day. He stated that he had received treatment from psychiatric services in 2004 for depression. He admitted to an attempted overdose in 2000 and a history of self-harm. He denied any current feelings of self-harm and was assessed as cheerful and open in manner with good eye contact."

Background information

164. "The man was seen by a Consultant Psychiatrist on 15 and 26 September 2006 at the request of a firm of solicitors. In the report produced following these interviews and taking into account background information, the psychiatrist concluded that he was not suffering from a mental disorder as defined in Part 1 of the Mental Health Act 1983. It was the psychiatrist's view that he was suffering from a personality disorder of antisocial type as defined in International Classification of Diseases 10th Edition. His depressive symptoms were described as dysthymia, a term used to describe low grade depressed mood that is not severe enough to be classified as depressive illness. His dysthymia, put in the context of ongoing personality disorder and offending behaviour was felt to put him at odds with the society in which he lived and in turn made him worthless, hopeless and subjectively helpless."

Recommendations and opinion

165. "There is clear evidence that the man received timely and appropriate response to his physical and mental health needs and the healthcare staff involved in his care should receive recognition for the level of care provided."

166. "Frequent requests for changes of medication by the man were inappropriate but were carefully considered by the medical officers concerned in an appropriate manner with full documentation of any changes made."

167. "There is no documentation of any psychotherapeutic intervention being offered. This may have been helpful in addressing the man's persistent self-harming behaviour and should be considered in any prisoner who presents with mental health issues that are not responding positively to medication."

168. The clinical reviewer concludes that "Overall, the standard of healthcare received by the man during his period of custody was exemplary" and I agree with his judgement.

Was the man's risk of self-harm or suicide properly assessed, monitored and managed prior to the night of 28/29 July 2008?

169. When the man was first received at Lincoln on 26 April 2006 from court, included in the accompanying documentation was a self-harm/ suicide warning form which highlighted concerns about his history of self-harm. However, the nurse who conducted the first reception health screen and who read the comments on the warning form judged that he did not present as being at a current risk of self-harm. Therefore, reception staff did not consider it

necessary to open formal self-harm monitoring (ACCT) procedures at that stage.

170. As it happens no harm befell the man on this occasion. However the Governor will wish to consider whether it would have been a sensible precaution to have opened the ACCT proceedings in the light of the concerns expressed by court staff.

Involving healthcare staff in ACCT case reviews

171. Although the records of the 22 ACCT case reviews held in respect of the man do not always make clear the disciplines of those staff in attendance, it appears that healthcare staff were only present on four occasions. On at least three occasions, no mental health team representative attended despite having been invited to do so.

172. Whilst I acknowledge the demands placed upon staff in busy local prisons such as Lincoln, especially where healthcare staff are concerned, I would urge the Governor and PCT to give due weight to the involvement of healthcare staff in ACCT case reviews, especially where the at risk prisoner is a prolific self-harmer, as was the case with the man, and when healthcare are providing treatment.

The Governor and PCT should remind their respective staff of the need to involve appropriate healthcare staff in ACCT case reviews, where possible, in keeping with the provisions of Annex 8G of PSO2700.

Record keeping

173. The investigation found several examples of poor record keeping:

- No comment was made in the man's medical record or in his core prison record after he had self-harmed on 12 August 2006.
- The record of the ACCT case review that took place on 22 August 2006, does not explicitly state that the ACCT plan was to be closed.
- The record of an assessment interview conducted on 9 October 2006 after he had self-harmed contains no entry in the box entitled 'agree what is to happen now with the interviewee'.
- Not all the signatures of staff who made entries in his ACCT plan or in his medical record were sufficiently legible for the author to be identified.

As minor as these housekeeping points may seem, I believe that it is essential for front line staff to achieve and maintain the highest standards of record keeping, especially in relation to all aspects of self-harm risk monitoring. Where the specific issue of the legibility of signatures is concerned, I make the following recommendation:

The Governor and PCT should take steps to ensure that whenever members of staff make an entry in a prisoner's record, they should

always print their name clearly and legibly against the entry. It is especially important for them to do so when making entries in ACCT plans and medical records.

Prompt opening of ACCT plans

174. The ACCT procedures were initiated on six occasions between July and November 2006 and on two occasions in 2008, on most occasions as a result of the man's infliction of minor cuts and scratches on his arms. On each occasion bar one, they were opened in a timely fashion and appropriate support was put in place.

175. However, it appears that there was a delay of three days between the man's act of self-harm on 9 August 2006 and the subsequent opening of an ACCT plan. I make no formal recommendation on this matter as this was the only delay discovered in a total of eight ACCT plans. However, I cannot overstate the importance of initiating ACCT plans promptly after any act of self-harm by a prisoner.

Closing the ACCT plans

176. The ACCT plan opened at 10.00pm on 11 November 2006 after the man had self-harmed, was closed at 3.20pm the following day. Although a Concern and Keep Safe form, immediate action plan, assessment interview and initial case review were completed, no Care Map was drawn up before the decision to close the ACCT plan was made.

177. PSO 2700 sets out the following provisions for the closure of ACCT plans:

> "The ACCT plan can only be closed once all Care Map actions have been completed and the Case Review Team judges that it is safe to do so, i.e. that the problems that caused the ACCT plan to be opened have been resolved or reduced, the prisoner is able to cope with any remaining difficulties."

It is clear from the record of this particular case review that the staff in attendance did not follow the correct procedures for closing an ACCT plan. As this oversight was an exception, I make no formal recommendation but suggest that the Governor draws the attention of the relevant staff to the policy set out in Annex 8G of PSO 2700 for the closing of ACCT plans and to paragraph 9.14 of his local suicide prevention policy document.

Post-closure ACCT reviews

178. After a decision had been made to close the man's ACCT plan on 21 July 2008, a post closure review was scheduled to take place a week later. However the investigation found no evidence that this review took place. This apparent omission has to be seen in the context of the fact that a further ACCT plan was opened at 11.00pm on 28 July. I therefore make no formal recommendation on the matter. However, I take the view that staff should ensure they schedule and

convene post closure ACCT reviews appropriately and in accordance with guidance.

Predictability of ACCT observations

179. During the evening of 11 November 2006, the man cut his left arm in his cell shortly after 10.00 pm. The NOO opened an ACCT plan shortly after 10.00pm that evening, completed a Concern and Keep Safe form, drew up an Immediate Action Plan in which it was agreed that the man should remain in shared accommodation and should be observed at half hourly intervals through the night and at hourly intervals by day. The ACCT ongoing record shows that he was observed at 30 minute intervals in keeping with the NOO's instructions. However, my investigator noticed that almost all the observations were carried out on a predictable basis.

180. This happened again during the night of 28/29 July 2008 when the night patrol on duty was instructed to observe the man at 30 minute interviews. The list below shows the times of the observations carried out and the comments recorded.

"2320 Stood in cell. Said he was ok."
"2350 Walking round in cell."
"0015 Still up and about in his cell."
"0045 Walking round his cell."
"0115 Stood in his cell."
"0140 Walking in his cell."

181. The fact that the man was awake and pacing or standing still in his cell throughout the period of monitoring suggests that he was likely to have known when he was about to observed. Paragraph 4 of Annex 8HH in PSO 2700 refers to the need for irregular observations. Paragraph 9.23 of the Governor's local suicide prevention policy document also refers to the same issue.

The Governor should remind staff of the need for observations of at-risk prisoners to be carried out at irregular intervals, in keeping with the provisions of paragraph 4 of Annex 8HH in PSO 2700 and of paragraph 9.23 of his local suicide prevention policy document.

182. That said I blame no-one for the fact that the man successfully hanged himself.

Removing razor blades

183. The investigation found that on some occasions, staff reduced the availability of razors after the man had used them to cut himself, but that on many other occasions, no such steps were taken. There was rarely any mention made in the record of his ACCT case reviews of the question of the removal of razors, despite the fact that the local suicide prevention policy directs that this must be done.

184. My investigator was told that the formal removal of razors from the man could at any time be undermined by the fact that he would have been able to borrow or

even steal such items from other prisoners, including cell mates. However, it seems that there was an inconsistent approach by different staff to the difficult task of minimising the man's reliance on cutting himself as a means of relieving his tension.

The Governor should remind his staff of the provisions contained at paragraph 9.25 of his local suicide prevention policy for the removal of items such as razor blades from at risk prisoners. He should ensure that those provisions are followed consistently by all staff, especially where the recording of decisions made in ACCT case reviews and care maps is concerned.

Restriction of association

185. On 18 September 2006, an entry was made in the man's medical record that included the following comment:

> "Stress. Works at the charity shop and is fine at work. But finding association very difficult/stressful. Self-harms on association/nights. F35 done: two weeks no association. Review two weeks regarding fluox."

186. The term 'F35' refers to a form used in the Prison Service by a manager normally to give written advice or an instruction to another person. My investigator was concerned that in this particular case, it seems that an instruction may have been given by a doctor instructing that the man should not be given association, a sanction normally enacted only as part of a punishment awarded after a disciplinary hearing. My investigator was presented with no evidence to clarify whether the comments on the form were to be taken as advice or as an instruction.

187. I am concerned that the apparent restriction of the man's association on this occasion, however well intentioned, was, to say the least, unorthodox. Whilst I make no formal recommendation on the matter, I suggest that the Governor will wish to satisfy himself that decisions to prevent prisoners, especially those considered to be at risk of self-harm or suicide, are made in keeping with current national policy.

The man's suitability to be in a cell on his own

188. One of the prisoners interviewed by my investigator said that on an unspecified date – almost certainly between 21 and 28 July - staff decided to move the cleaners down from the fourth to the ground floor of the wing. According to this prisoner, the man was told that he was to move but he said, "I'm not having any pad mate down there". As a result, he moved into a single cell, where he remained until his death. The investigation found no evidence to show whether any assessment was made of his suitability to be in a cell on his own. It is possible that his apparent refusal to share a cell on the ground floor suggested to staff that there was no value in conducting a formal assessment. However, if staff had studied his previous ACCT plans, they would have seen that central to

his management when at risk of self-harm was the need for him to be with a cellmate.

The Governor should review his local suicide prevention policy so that clear guidance is given to staff with regard to the need for continuous assessment of the appropriateness of at-risk prisoners' relocation from shared to single cell accommodation. This factor, where it applies, should be included on the agenda for post closure ACCT reviews.

189. Following the closure of the man's most recent ACCT plan on 21 July, he was supposed to have been the subject of a post closure review on 28 July but the investigation found no evidence to show that this took place. This is a matter of concern. This was not the first time a post closure review was not held but on all other occasions the opening of a new ACCT plan negated the need for such a review. In my view, there was no good reason for there to be no post closure review in this instance. Had such a review occurred, it is possible that due consideration may have been given to the appropriateness of placing him in a single cell.

The Governor should remind his staff of the requirement for a post closure review to take place whenever an ACCT plan is closed, unless in exceptional circumstances, and should make regular management checks to ensure that this requirement is met.

190. In assessing whether the man's risk of self harm was properly managed, I have found that his frequent acts of self-harm were demanding of healthcare staff and wing officers. Nevertheless, I believe that decisions to open ACCT plans were carefully and thoughtfully made and measures taken to support him were, in the main, appropriate. It became clear to staff that he had developed a propensity, if not a dependence, on cutting his arms as a means of releasing and relieving tension. His risk of harming himself was constantly re-assessed during periods when ACCT plans were in force.

191. Apart from the exceptions on which I comment in paragraphs 165-182 above, I have found that ACCT procedures were carried out as set out in Prison Service Order 2700 – Suicide Prevention and Self - Harm Management. I therefore conclude that the assessment, monitoring and management of the man's risk of self-harm prior to the night of 28/29 July 2008 was satisfactory.

Was the man's risk of self-harm or suicide properly assessed, monitored and managed during the night of 28/29 July 2008?

192. A prisoner told my investigator that he thought the man was different that evening. He had shaved, his hair had been cut, he was unusually happy and talkative, and was wearing clean clothes, something he rarely did. In hindsight, the prisoner wondered whether this was a sign that he had accepted that "something was going to happen". However, he gave no indications to staff that he was actively contemplating suicide at any stage that day and so there were no apparent grounds for any intervention.

193. The first significant event occurred at about 11.00pm that night, when the man's mother called the prison as she had received a telephone call from a third party whom the man had rung to say that he wanted to be with his uncle and grandmother, both of whom were dead.

194. The NOO took the call and reassured the man's mother that he would go and see him to assess his stage of mind. The NOO told the man about the call from his mother and he seemed surprised but admitted making the call to the third party. He said he had done so at a time when he felt low but he now felt fine. The NOO asked him if he was considering "doing anything silly", meaning harm himself and he replied that he was not. The NOO asked him to remove his t-shirt so that he could check whether he had harmed himself recently. He saw no fresh cuts or blood on his upper torso or on his arms. After replacing his shirt, he repeated that he felt fine. The NOO said he had no reason to believe he presented any risk to himself.

195. Nevertheless, the NOO decided to take the precautionary step of opening an ACCT plan there and then. He gave an instruction to the OSG to observe the man at half hourly intervals and recorded this decision in the ACCT plan.

196. The man's death followed very quickly after he had given an indication to a third party outside the prison that he wanted to be with his two deceased relatives. Although, when checked, he said he felt alright, the NOO made an intelligent decision to open an ACCT plan. In keeping with the NOO's instructions, the OSG observed the man at the required intervals but on a predictable basis, as described in paragraphs 173 - 175 above.

197. Prior to the night of 28/29 July 2008, I do not believe that the man gave any indication that he was actively contemplating suicide. However, he gave an indirect indication of suicidal ideas to a third party outside the prison shortly before 11.00pm that night. That person called the man's mother who relayed her concern to the NOO, who checked him and assessed that he was not at risk. Nevertheless, the NOO took the sensible precaution of opening an ACCT plan there and then, and directing that the man should be observed at half-hourly intervals.

198. I conclude that the measures taken by the NOO were in keeping with best practice. Although I draw attention to the predictability of the observations made of the man that night, I blame no-one for the fact that he was able to successfully take his life. He did so using a method which he had not used in prison before. It is generally accepted by pathologists that it possible for unconsciousness to occur within seconds of the brain receiving no oxygen when a prisoner hangs himself, and for death to occur within less than three minutes.

I commend the NOO for having the presence of mind to open an ACCT plan shortly after 11.00pm on 28 July as a precautionary measure, and for deciding that the man should be observed at half hourly intervals.

Was the man subject to any form of bullying or coercion, and, if so, was this linked to his death?

199. With the significant help of senior managers at Lincoln and of Lincolnshire Police, my investigator was able to gather and scrutinise useful intelligence about the claims made by prisoners that an officer in E wing at Lincoln was trafficking mobile telephones and drugs with the man and others in 2008. The claims were investigated by a Governor from another prison between February and May 2009. That Governor recommended that disciplinary charges should be laid against the officer for the following:

    - Trafficking subutex to a prisoner (not the man) in or around May 2008.
    - Trafficking codeine based medication to a prisoner (not the man) on an unknown date in 2008.
    - Trafficking veterinary medication to a prisoner (not the man) on an unknown date in 2008.
    - Conspiracy to undertake the trafficking of contraband to the man on an unknown date in 2008.
    - Entering into an inappropriate relationship with the man on an unknown date in 2008.
    - Assisting two prisoners (not including the man) in damaging prison property namely a mobile telephone detector on an unknown date in 2008.

200. The charges were heard at a Prison Service disciplinary hearing on 16 November 2009. All the charges against the officer were proved and he was subsequently dismissed from the Prison Service.

201. The investigation found evidence to suggest that the man may have been coerced by a corrupt prison officer. However, no evidence arose from either the internal Prison Service investigation or from the police investigation to show that there was a provable connection between the conduct of the officer and his death. In the letter found in his cell after his death, addressed to his mother, he made no reference to these matters. I accept that any misconduct by the officer had no bearing on his decision to take his life.

Was the response to the discovery of the man hanging prompt and effective?

202. The man was found hanging at approximately 2.05am on 29 July by the OSG who immediately called for assistance from an officer, who was about 15 feet away, outside the cell of another prisoner who was on constant observations. The officer went into the cell and, single handedly, cut him down and removed the ligature. At interview, the officer said he found him to be lifeless and his face a greeny/brown colour. He could not find a pulse. The officer later told the police that the man’s teeth were clasped so tightly that he could not move

the tongue. Nevertheless, he decided to attempt CPR, despite his belief that he was dead.

203. The OSG raised the alarm over the radio, as a result of which other staff arrived to give assistance. A request was also made to the emergency services for an ambulance. Amongst those who first responded to the OSG's request for assistance were another officer, a nurse and the HSW. The NOO also responded. The second officer assisted the first officer with the application of chest compressions. The nurse and HSW applied advance resuscitation techniques using emergency first aid equipment brought to the cell. They continued to attempt to revive the man until two paramedics arrived at about 2.30am. Further attempts were made by the paramedics to revive him but he did not respond. In view of the length of time unsuccessful attempts had already been made to revive him prior to their arrival, the paramedics decided, at 2.44am, that he was dead.

I commend the two officers, nurse and HSW for their determined attempts to save the man's life.

<u>Emergency service response</u>

204. One of the two paramedics, who were tasked to respond, logged the time of the incoming call as approximately 2.00am. Although this time is not consistent with that logged by the prison, it is not unusual for slightly different times to be recorded by different agencies in an emergency such as this.

205. The paramedic and her colleague did not arrive at Lincoln prison until approximately 2.30am. In a statement given to the police, she disclosed that when she and her colleague were tasked to respond to the request from the prison for an ambulance, they had just come to the end of a break at Horncastle Ambulance Station, some 21 miles away from the prison. Although I am concerned at the length of time it was bound to take for the ambulance crew to travel such a distance in response to a life threatening emergency at the prison, there is no evidence that the 30 minute response time achieved affected the outcome.

206. However, I am concerned that the ambulance crew were not aware of the nature of the emergency. As a result, the control room staff at the Ambulance Station made attempts, while the ambulance was on its way to the prison, to acquire more details. Nevertheless, the ambulance crew did not discover that they had been asked to respond to a suicide by hanging until they arrived at the prison. (Despite the lack of information given to the crew when they were deployed, they treated the task as an emergency from the outset.)

207. My investigator was unable to clarify whether anyone at the prison failed properly to inform the emergency services of the reason for calling an ambulance. No matter what caused the confusion, and no matter that the lack of information did not seem adversely to affect the outcome, this must not be allowed to happen again. The Governor must be satisfied that his contingency plans for the management of a life-threatening emergency properly legislate for the passage of essential information to the emergency services.

The Governor should review his contingency plans for the management of life-threatening emergencies to ensure that proper information is passed to the emergency services as to the nature of the emergency. If necessary, appropriate staff training should be offered.

Withdrawal of mobile telephones from the ambulance crew

208. One of the paramedics wrote in her statement to the police that, upon their arrival at the gate at Lincoln, she and her colleague were instructed to surrender any mobile telephones in their possession. Although there is no evidence that this delayed their progress into the prison, I am concerned that it could do so in the future. I leave it to the Governor to judge whether, in the circumstances, this was an unnecessary security procedure.

Incorrectly sealed key pouch

209. The HSW told my investigator she had difficulty gaining access to the emergency keys in her sealed pouch when called upon to respond to the emergency. She believed the difficulty occurred because her pouch had been incorrectly sealed. She reported this to the Governor in writing the same day. The Governor will wish to satisfy himself that her complaint has been satisfactorily resolved and that steps have been taken to minimise the risk of it happening again.

210. Notwithstanding the criticisms I have made above, I consider that the response to the emergency was handled well.

Was the support given to the man's family after his death appropriate?

Informing the next of kin

211. The investigation found that there was a lapse of time of about six hours between the discovery of the man hanging and his mother being informed of his death. This was a matter of concern to his family.

212. According to the protocols in place at the time, it fell exclusively to the person appointed as the prison's family liaison officer to inform the next of kin of the death of a prisoner.

213. The duty governor that night was the first manager to be contacted, at about 3.00am, and told that the man had been found hanging. He left for the prison and arrived at about 3.30am. He said he went straight to the orderly officer for a briefing on what had happened. Afterwards he went to E wing. He considered notifying the man's family of his death immediately but chose not to do so, primarily because he believed it would have been inappropriate to break the news of his death at that time of night, especially when the family liaison officer would be on duty within two to three hours. He also had urgent operational duties to perform in the prison as a direct result of the death, as well as gathering accurate information about what had happened.

214. The prison's family liaison officer was called by the prison at around 6.30am to 7.00am, arriving at the prison at about 8.15am. Upon her arrival, she was told by

the Governor that the man had been found hanging and had died. The Governor also told her that the man's mother had telephoned the prison at about 8.00am to enquire about his wellbeing following her telephone conversation with the NOO the previous evening. Whoever took the 8.00am call may not have been aware of the full details of events and may not have been in a position to report that her son had died. She told my investigator that she was thus aware of the need to inform the man's mother of her son's death as soon as possible. By 8.50am, she was equipped with sufficient information about the details of his death to ring the telephone number she had been given for the next of kin. The man's mother answered. She then told her of her son's death.

215. I have considerable sympathy with the concerns expressed by the man's mother in this regard. However, I am satisfied that the delay was not borne out of any negligence or insensitivity on the part of the duty governor or family liaison officer. They had considered other methods of breaking the news of the man's death to his mother. One such option was to ask the police to inform her in person. However, the view of the duty governor and of the family liaison officer was that this method was also likely to incur lengthy delays, such that the news may not have been conveyed to her significantly earlier.

216. That said, I take the view that, following the death of a prisoner, the need to inform the next of kin in an appropriate manner is paramount. I am aware that in previous reports I have drawn the attention of the previous Governor to this issue. The present Governor will wish to satisfy himself that the need to break the news of a prisoner's death promptly and, ideally, on a face to face basis is clearly expressed in his local contingency plans.

The Governor should urgently review his local contingency plans for informing the next of kin of the death of a prisoner so as to ensure that this task is carried out promptly and, ideally, on a face to face basis, by an appropriate person.

Were prisoners and staff appropriately supported after the man's death?

<u>Prisoner support</u>

217. My investigator was told by the prisoner who had been the man's cellmate that, early on the morning of 29 July, the Governor personally told him of the death. However, beyond that, my investigator was presented with no information to show what other support was given to prisoners in the aftermath of the death.

218. Prison Service Order 2710 sets out the following provisions for the support of prisoners following a death in custody:

> "Friends, associates and cellmates of the prisoner who has died or other prisoners who had been offering peer support or acting as Listeners and any friends or relatives in other establishments should also be offered support. Local Samaritans will make themselves available to debrief Listeners. Other peer support schemes can help, such as prisoner group sessions. The Chaplaincy Team and, in

particular, the Chaplain from the particular faith tradition of the prisoner must always offer support to, and to pray with prisoners and staff. This will include holding a memorial service for the deceased's family, prisoners and staff subject to any faith specific considerations and the views of the family, staff and prisoners. Some self-inflicted death in custody statistics may be taken to indicate that there is a potentially heightened risk of suicide and self-injury attempts following a death in custody, with several prisons having experienced "clusters" of deaths, sometimes with "copycat" features. Staff should be alert to this possibility and be vigilant, particularly with other vulnerable prisoners, especially known self-injurers, other high-risk groups or recent "at-risk" prisoners and those on recently closed or open ACCTs, *which must be reviewed and documented as soon as practicable and within 24 hours.* Applied psychology, probation and mental health in reach staff should also be able to offer assistance to individual prisoners."

I consider that the support offered to prisoners and staff in the aftermath of the man's death was not satisfactory.

The Governor should ensure that, following any death in custody, appropriate support is offered to prisoners in keeping with the provisions of PSO 2710.

Staff support

219. The investigation found that there was no debrief of staff after the man had been pronounced dead in his cell. My investigator was also told by one member of staff that when the full debrief was held some time later, those present were limited in what they could contribute because they were "not allowed to talk about operational matters". The member of staff concerned said he did not have a chance to discuss "how things might have been done differently".

220. PSO 2710 also makes it clear that there should always be a 'hot' debrief after a death in custody has occurred.

The Governor should ensure that, in keeping with the provisions of PSO 2710, a 'hot' debrief takes place immediately after any death in custody.

ADDITIONAL FAMILY CONCERNS NOT INCLUDED IN MAIN BODY OF REPORT

Consultation with psychiatrist:

221. The man's mother asked why the psychiatrist who saw her son only spent a short time with him and why he did not arrange a further referral. I am unable to answer this question as there is no evidence in his medical record to clarify this point.

Use of a safer cell

222. The man's mother asked why her son was not put in a safer cell, especially on 28 July 2008. She took the view that had this been done, he would not have been able to use his curtains as a ligature. (The ligature he used was made from a torn piece of green bed-sheet and not from the blue curtain material covering the windows of his cell.)

223. A safer cell is defined as one in which the opportunity for a prisoner to hang himself is minimised. There are no safer cells in the Vulnerable Prisoner Unit where the man died. Had there been any such cells it does not follow that he would necessarily have been located in one during the night of 28/29 July. The NOO took the sensible precaution of opening an ACCT plan and directing that he should be observed at half hourly intervals through the night. I consider that these measures were appropriate, particularly as the man had not harmed himself with a ligature on any previous occasion whilst he was in custody.

Why were there marks on the man's body?

224. The man's mother expressed her concern that there were unexplained marks on her son's body when she viewed him in the mortuary. The pathologist who conducted the post mortem examination listed the following old marks and injuries on the body:

    - A horizontal scar measuring 1.0cm just below the central aspect of the lower lip.
    - Numerous oblique, horizontal and vertical scars to the posterior and anterior aspect of both forearms as well as to the back of both hands and to the anterior aspect of both upper arms measuring up to 15cm.
    - Irregular indistinct scarring to both anterior knees.

225. The pathologist also listed the following fresh marks and changes on the body:

    - A very superficial abrasion measuring 1.5cm, 2.0cm to the left of the midline, to the forehead.
    - Two abrasions measuring 0.1cm to the forehead, 3.0cm right of the midline.
    - A ligature mark to the neck.
    - Fresh and recent cuts to the anterior and posterior aspect of the left forearm. These were measuring up to 8.0cm in length and were of oblique orientation. There were at least 20 such cuts present.

- A longitudinal band-shaped abrasion measuring 6.0 x 0.9cm to the inner aspect of the right forearm.
- An abrasion measuring up to 0.9cm to the back of the left hand.
- A blue to purple bruise measuring 2.9 x 1.0cm to the left inner elbow.

226. The pathologist commented that none of these injuries (other than that caused by the ligature) might have caused or contributed to the man's death.

Transfer to a prison on the Isle of Wight or to Rampton

227. The man's mother thought that her son had been considered for a transfer to a prison on the Isle of Wight or to the secure hospital at Rampton. There is a reference in his life sentence plan to his being "happy at the prospect of a move to HMP Wakefield". On 3 October 2006, a Governor submitted a request to the Population Management Section at Prison Service Headquarters for him to be transferred to HMP Wakefield on the grounds that it was "the only appropriate allocation when considering his offence and length of sentence". The investigation found no evidence that he had been considered for a transfer to a prison on the Isle of Wight.

228. The only reference to Rampton Hospital that my investigator could find was contained in a psychiatric report to court by a doctor dated 28 September 2006. In this report, he wrote:

> "After his sentence it is also worth referring him to the Dangerous and Severe Personality Disorder Unit (DSPDU) in Rampton Hospital. Following his sentencing, if I am informed about his whereabouts, I will be happy to refer him to Rampton Hospital for an assessment and advice."

Conduct of the prison family liaison officer

229. The man's mother said that her son had told her that another prisoner in a nearby cell had taken his own life. When she told the family liaison officer, she said that the family liaison officer became annoyed.

230. At interview, the family liaison officer replied to this claim as follows:

> "I have absolutely no memory of that conversation but I can say 100% categorically that I wouldn't be annoyed. It wouldn't be my place to be annoyed by that. And if that's been mis-communicated to her, then I'm really sorry but I have no memory of that at all."

231. The version of events given by the man's mother differs from that given by the family liaison officer. I consider that there has most likely been a misunderstanding between the two parties but I note the family liaison officer's professionalism in offering her apologies.

CONCLUSIONS

232. In her clinical review of the management of the man's health needs at Lincoln, the clinical reviewer concludes that, overall, the standard of healthcare he received was exemplary. I agree. However, his frequent acts of self-harm were demanding of healthcare staff and officers in E wing. Nevertheless, decisions to open ACCT plans were carefully and thoughtfully made and measures taken to support him were, in the main, appropriate. It became clear to staff that he had developed a propensity, if not a dependence, on cutting his arms as a means of releasing and relieving tension. His risk of harming himself was constantly re-assessed during periods when ACCT plans were in force.

233. Apart from the exceptions on which I comment in paragraphs 167- 179 above, I believe that the ACCT procedures were carried out as set out in Prison Service Order 2700 – Suicide Prevention and Self - Harm Management. I therefore conclude that the assessment, monitoring and management of the man's risk of self-harm prior to the night of 28/29 July 2008 was satisfactory.

234. Prior to the night of 28/29 July 2008, the man gave no indication that he was actively contemplating suicide. However, he gave an indirect indication of suicidal ideation to a third party outside the prison shortly before 11.00pm that night. That person called the man's mother who relayed her concern to the NOO, who checked him and assessed him as being alright. Nevertheless, the NOO took the sensible precaution of opening an ACCT plan there and then, and directed that he should be observed at half-hourly intervals.

235. I conclude that the measures taken by the NOO were in keeping with best practice. Although I draw attention to the predictability of the observations made of the man that night, I blame no-one for the fact that he successfully hanged himself.

236. The investigation found evidence to suggest that the man may have been coerced by a corrupt prison officer. However, no evidence arose from either the internal Prison Service investigation or from the police investigation to show that there was a provable connection between the conduct of the officer and his death. In the letter found in his cell after his death, addressed to his mother, he made no reference to these matters.

237. I consider that the response to the emergency was in the main handled well. However, there was a delay of about six hours before the news of the man's death was conveyed to his mother. I take the view that, following the death of a prisoner, the need to inform the next of kin promptly is paramount. Local contingency plans for informing the next of kin must reflect this.

RECOMMENDATIONS

1. The Governor and PCT should remind their respective staff of the need to involve appropriate healthcare staff in ACCT case reviews, where possible, in keeping with the provisions of Annex 8G of PSO 2700.

Accepted – "There is currently a robust system in place to ensure either Lincolnshire Community Health Services (where general health needs are concerned) or Lincolnshire Partnership Foundation Trust (where mental health needs are concerned) are integral to the ACCT process."

2. The Governor and PCT should take steps to ensure that, whenever members of staff make an entry in a prisoner's record, they should always print their name clearly and legibly against the entry. It is especially important for them to do so when making entries in ACCT plans and medical records.

Accepted – "Accurate and legible completion of records are required under Nursing and Midwifery Code of Conduct and Lincolnshire community Health Services Policy All staff are required to work to this standard and information regarding this has been circulated to all members of the healthcare team to ensure they are up to date and aware of their requirements. A Governor's Order has been issued that informs all staff that anyone who makes entries into ACCT documents should always print their name clearly and legibly against the entry and where applicable add their epaulette number."

3. The Governor should draw the attention of the staff concerned in the case review conducted on 1 November 2006 to the policy set out in Annex 8G of PSO 2700 for the closing of ACCT plans and to paragraph 9.14 of his local suicide prevention policy document.

Accepted – "This is covered through ACCT training and the ACCT books give guidance on how to conduct an ACCT closure."

4. The Governor should remind staff of the need for observations of at-risk prisoners to be carried out at irregular intervals, in keeping with the provisions of paragraph 4 of Annex 8HH in PSO 2700 and of paragraph 9.23 of his local suicide prevention policy document.

Accepted – "ACCT observations are discussed at reviews. The wing managers also carry out daily quality checks of all ACCT books. This is also raised at ACCT training. Residential managers complete weekly management checks on all ACCT books to ensure consistency."

5. The Governor should remind his staff of the provisions contained at paragraph 9.25 of his local suicide prevention policy for the removal of items such as razor blades from at-risk prisoners. He should ensure that those provisions are followed consistently by all staff, especially where the recording of decisions in ACCT plans is concerned.

Accepted – "The policy has been reviewed since 2008; this is covered in 9.32 of the current policy. Staff do not routinely remove items in possession from prisoners at

risk of self harm. Staff are reminded of this at ACCT training sessions. 10% quality checks of closed ACCT books are completed by the Head of Safer Prisons."

6. The Governor should remind his staff of the requirement for a post closure review to take place whenever an ACCT plan is closed and should put in place regular management checks to ensure that this requirement is met.

Accepted – "Regular management checks are carried out by:

- Daily wing SO managers checks
- Weekly Residential Governors checks
- 10% quality checks of closed ACCT books by Head of Safer Prisons, Safer Prisons Admin manages the follow up of Post Closure reviews."

7. The Governor should review his local suicide prevention policy so that clear guidance is given to staff with regard to the need for continuous assessment of the appropriateness of at-risk prisoners' relocation from shared to single cell accommodation. This factor, where it applies, should be included on the agenda for post closure ACCT reviews.

Accepted - "This is covered through paragraphs 9.18 and 9.19 of our local policy. The Post Closure form has been reviewed and this added to the agenda to ensure it is discussed at the post closure review point."

8. The Governor should review his contingency plans for the management of life-threatening emergencies so as to ensure that proper information is passed to the emergency services as to the nature of the emergency. If necessary, appropriate staff training should be offered.

Partially accepted – "Basic life support training for officers is now being provided by staff from Lincolnshire community Health Services as a rolling programme to maintain knowledge and skills. Medical emergencies are notified to healthcare staff via radio (Hotel 1) and healthcare staff communicate required information to external emergency response via Control. It is reported that the ambulance control room requests information that is not readily available at the time that ambulance is requested. A Governor's order will be issued on a annual basis reminding staff of the reporting codes for medical emergency and the mandatory details that are required in order for the control room provide information to the ambulance service."

9. The Governor should urgently review his local contingency plans for informing the next of kin of the death of a prisoner so as to ensure that this task is carried out promptly and, ideally, on a face to face basis, by an appropriate person.

Accepted – "The death in custody contingency plan was reviewed in September 2010 and reiterates the process of who informs the next of kin and the risk assessment process that is applied in considering any issues in informing the next of kin in person."

10. The Governor should ensure that, in keeping with the provisions of PSO 2710, a ‘hot’ debrief takes place immediately after any death in custody.

Accepted – “The death in custody contingency plan was reviewed in September 2010 and highlights the requirement of the Duty Governor to arrange the hot debrief.”

11. The Governor should ensure that, following any death in custody, appropriate support is offered to prisoners, in keeping with the provisions of PSO 2710.

Accepted – “The death in custody contingency plan was reviewed in September 2010 and highlights the requirement of the Duty Governor to arrange appropriate support is offered to prisoners.”

Commendations

1. I commend the NOO for having the presence of mind to open an ACCT plan shortly after 11.00pm on 28 July as a precautionary measure, and for deciding that the man should be observed at half hourly intervals.

The Governor has written to the NOO, drawing attention to the commendation within the report.

2. I commend the two officers, the nurse and HSW for their determined attempts to save the man’s life.

The Governor has written to the staff concerned and drawn attention to the commendation within the report.