PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

# A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

**Investigation into the death of a man in December 2013 at HMP Lindholme**

## *Our Vision*

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

This is the investigation report into the death of a man at HMP Lindholme in December 2013. He was 22 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Lindholme was undertaken. The investigation was suspended during a criminal investigation and subsequent trial. Lindholme cooperated fully with the investigation.

The man had been released from a prison sentence in April 2013 and then recalled to prison in October 2013, after allegedly stabbing his sister. He had been at Lindholme since 6 November 2013. On the afternoon of Saturday 21 December 2013, he went to another prisoner's cell and attacked him with an improvised knife. The other prisoner retaliated and he received a fatal stab wound to his neck. Two prisoners were charged with offences, including murder, but were acquitted at trial.

The fight between the prisoners began in a cell, and only came to the notice of staff once the prisoners involved came back onto the landing. At first, there was some confusion about what was happening, which meant that at least one of the immediate witnesses was not kept separate from the others prisoners, as should have happened. The initial emergency response was not as smooth as it could have been, but there was no significant delay and, sadly, the severity of the man's injury meant that it is unlikely that anyone would have been able to do anything to save him.

Information about the man's history of violence towards other prisoners and staff should have been recorded more effectively, but there was no specific intelligence to suggest that either man posed a particular risk to the other, and they had shared a cell without incident when he first arrived at Lindholme.

Mercifully, deaths in prisons at the hands of other prisoner are relatively rare. However, the availability of home made weapons at Lindholme and the willingness of the prisoners involved to use them, whether as aggressor or in self-defence, is a stark reminder of the need for effective security and violence reduction strategies. Nevertheless, this investigation found no evidence that Lindholme could have anticipated or prevented the incident that led to the man's death.

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** **May 2015**

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## SUMMARY

1. The man was arrested and recalled to prison 11 October 2013, after an allegation that he had stabbed his sister. The next day, he was taken to HMP Nottingham. On 14 October, he assaulted two prison officers during a routine search of his cell. Information about this and previous assaults committed by him was not highlighted and flagged up on his prison record, as it should have been.

2. On 6 November 2013, the man transferred to Lindholme. From 7 November to 8 December, he shared a cell on J Wing with a cellmate, who had been at Lindholme since 13 August 2013. Staff moved him to a different cell, after a probation officer noticed his history of violence and suggested that he should not share a cell because of his level of risk of others. Prison staff reported no concerns with either prisoner.

3. At around 3.30pm one afternoon in December 2013, the man went to his ex-cellmate's cell during an association period, when prisoners are unlocked and able to mix with each other. He questioned him about his offences (one of which was rape) and then attacked him with a shank (a make-shift knife). The ex-cellmate retaliated. During the fight, the ex-cellmate stabbed him in the neck. He stumbled out onto the wing landing before collapsing on the floor.

4. At 3.37pm, a prison officer working on the landing above noticed a commotion between some prisoners below and radioed the prison's control room for help. When officers arrived, they found the man on the floor covered in blood with a serious neck wound, which two prisoners were treating with a towel. Prison staff started to help him. An officer radioed for medical assistance at 3.38pm. When a nurse radioed back, he asked for an ambulance, which the control room called at 3.40pm. At 3.41pm, the officer radioed again and said it was an emergency code red (indicating a significant loss of blood). Despite efforts of officers and healthcare staff, and paramedics when they arrived, it was not possible to save him. At 4.05pm, paramedics pronounced him dead.

5. After the man's death, the ex-cellmate told prison staff that the man had targeted him because of his offence. Although the man had a history of violence in prison, there was no information to suggest that he was a particular risk to his ex-cellmate, or that he had any specific grudge against him. He died as the result of a violent incident, in which he was the principal assailant. We are satisfied that prison staff could not have anticipated or prevented his death.

6. Although these issues would not have affected the outcome for the man, the investigation found that information about his risk of violence to other prisoners was not highlighted as it should have been on his prison record and staff did not initially use the appropriate emergency code. In the aftermath, of the incident, prison staff left the ex-cellmate, who had witnessed the initial attack, unmonitored in a cell with two other prisoners. This might have led to the loss of important evidence. We make four recommendations.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at Lindholme, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

8. The investigator went to Lindholme on 10 January 2014 and met the Governor, other prison staff and the senior police investigating officer. He went to J Wing, where the man had lived, and obtained copies of his prison and medical records, as well as information about the ex-cellmate, the other prisoner involved in the fatal incident.

9. NHS England, West Yorkshire, commissioned a clinical reviewer to review the man's clinical care at Lindholme.

10. In line with the Ombudsman's terms of reference, the investigation was suspended while South Yorkshire Police investigated the circumstances of the man's death and during a subsequent trial. The investigator remained in contact with the police during the investigation and shared information with them.

11. After the conclusion of the trial in late August 2014, the police provided a number of documents, including witness statements and the transcripts of interviews with staff and prisoners. The investigator reissued notices to staff and prisoners at Lindholme on 3 October, but did not receive any responses. The investigator interviewed four members of staff at HMP Lindholme in November 2014 and January 2015.

12. We have sent a copy of this report to HM Coroner for South Yorkshire, East District.

13. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and invite them to identify any relevant issues that they wished the investigation to consider. The family wanted further information about what had happened to him and about the circumstances of his death.

14. The family received a copy of the draft report. They did not make any comments.

## HMP LINDHOLME

15. HMP Lindholme, near Doncaster, is a medium security prison, which holds about 1,000 men. The site includes ten separate wings, comprising six converted RAF dormitories and four new buildings, one of which is a small induction unit. J and K Wings each have space for 209 prisoners in modern cellular accommodation. J Wing is divided into two sides, blue and red. At the time of his death, the man lived on the second landing on the blue side of J Wing. There was no CCTV coverage on the wing.

## HM Inspectorate of Prisons

16. The most recent inspection of Lindholme was in February 2013. Inspectors commented that there were significant problems in parts of the prison. They noted that there was little support for prisoners who were vulnerable and victimised or bullied by other prisoners. The only option offered was to confine them to their cells and many prisoners said this caused their mental health to deteriorate. Drugs and alcohol were easily available and action to address this was poorly co-ordinated. Prisoners said that few staff spoke to them during association periods and inspectors noted that, on the larger wings, staff were usually in wing offices during association periods.

## Previous deaths at HMP Lindholme

17. The man's death was the first homicide that the Ombudsman has investigated at HMP Lindholme.

## KEY EVENTS

18. On 19 October 2009, the man was convicted of grievous bodily harm with intent and sentenced to five years imprisonment. He had served custodial sentences before. He began his sentence at HM Young Offender Institution (YOI) Glen Parva and spent time at several other prisons and YOIs before returning to Glen Parva in December 2010.

19. On 19 January 2011, the man attacked another prisoner at Glen Parva with a sock containing pool balls. In May 2011, at HMP Rochester, he headbutted a prison officer and was later convicted of battery. On 18 July 2012, he was convicted of grievous bodily harm and wounding for the assault at Glen Parva. He received a 24 month sentence to run concurrently with his existing sentence. He had several other disciplinary charges for fighting and assaults.

20. In a pre-sentence report of 21 June 2012, a probation officer noted that the man used violence as a "first resort". The probation officer said that he had anger management problems and portrayed himself as a hard man who was not afraid to use violence. Previous sentence plans had recommended an assessment for the Thinking Skills Programme, but his prison moves had made it difficult for him to complete this. The probation officer noted that he had no mental health or alcohol problems.

21. On 15 April 2013, the man was released from prison on licence. On 11 October 2013, he was arrested for allegedly stabbing his sister in the leg. He had also breached the conditions of his licence by not living at his father's house. His licence was revoked and he was recalled to prison.

### HMP Nottingham

22. On 12 October, the man was taken to HMP Nottingham. His escort record indicated that he had previous convictions for violent offences and drugs. No other concerns were recorded.

23. An officer saw the man when he arrived at Nottingham and noted his offence and that he had been recalled to prison. He recorded his father as his next of kin. An officer completed a cell sharing risk assessment (CSRA, which is designed to assess the risk of violence a prisoner poses to others he might share a cell with). The officer assessed him as a standard risk and suitable to share a cell. A nurse completed a reception health screen and did not record any concerns.

24. On 14 October, the man was charged with assaulting two prison officers during a cell search. The matter was referred to the police and staff moved him to a different cell on the induction wing (the segregation unit was full) to wait for a disciplinary hearing. There is no record of the outcome of the police enquiries or the disciplinary hearing.

25. On 17 October, staff began to manage the man under the prison's violence reduction procedures and reduced him to the basic level of the prison's incentives and earned privileges scheme, designed to encourage good behaviour. Wing staff monitored him each day and reviewed his progress weekly.

26. On 31 October, staff at Nottingham reviewed the man's security category and assessed him as category C. Security category C prisoners are those who cannot be trusted in open prison conditions, but will not necessarily have the intention, the will or the determination to make any real attempt of escape from the prison.

27. At a review on 6 November, a Supervising Officer (SO) recorded that the man should remain on the basic regime level until the police investigation had been completed. Staff did not record any other incidents of violence during his time at Nottingham.

**HMP Lindholme**

28. Later on 6 November 2013, the man transferred to HMP Lindholme. Before he arrived, a reception officer reviewed his NOMIS prison record, which showed in the case note section that he had assaulted two prison officers on 14 October 2013 at Nottingham. NOMIS has an "Alerts" section, which gives a summary of serious incidents to help officers quickly identify and assess what risks a prisoner poses to himself or others. There was no information recorded on the Alert page about the assaults.

29. The officer told the investigator that the man had transferred from Nottingham's segregation unit, which she said she had learnt from his NOMIS record before he arrived. The investigator spoke to the Head of Security at Nottingham, who said that the man had stayed on the induction unit and had not been moved to the segregation unit after the alleged assault. He had not been segregated under Prison Rule 45 on the wing. As the officer believed that he was being transferred directly from the segregation unit, she believed the transfer should have been agreed in advance. Usually, such a move would result in a prisoner from Lindholme's segregation unit moving to Nottingham in return. She telephoned the duty governor for advice.

30. The duty governor told the investigator that the officer had contacted him about a prisoner who would be arriving from Nottingham. He could not recall if he had phoned Nottingham, but the officer said that he had told her that Nottingham had refused to take the prisoner back. He told her that when the man arrived at Lindholme, she should assess the situation and speak to him again if he caused any problems. She recorded this on his NOMIS record.

31. When the man arrived at Lindholme he went through the normal reception screening process. The officer said that he was in a good mood and was happy that he had transferred to Lindholme.

32. The officer at Nottingham had noted the man's risk of violence on his escort record, and that he had assaulted staff. His cell sharing risk assessment also arrived with him, indicating he was a standard risk for cell sharing. The officer said that she had no additional information to warrant a change of his risk level, although the words "Assaulted x 2 members of staff 17/10/3" had been added to the comments section on the CSRA form. (It is not clear who added this note, which presumably refers to the alleged assault of 14 October 2013.) At a healthcare assessment, the day he arrived, a nurse noted on the existing cell sharing risk assessment that there was no change to his risk level.

**J Wing**

33. On 7 November, the man moved to J Wing (cell J-1-222), on the ground floor landing (known as “the ones”). He shared with another prisoner, who had been at Lindholme since 13 August 2013, serving a sentence for attempted robbery, robbery and rape. There was no information to suggest that they would present a risk to each other.

34. On 2 December, an offender manager from Nottingham Probation Trust phoned a probation officer based at Lindholme and discussed the man’s transfer to Lindholme. He asked her to tell him that the Parole Board had not directed his release from prison at a panel hearing on 19 November 2013 to consider his recall.

35. The probation officer told the offender manager that she was concerned about the officer’s entry in the man’s record about assaults at Nottingham and she was concerned that staff at Nottingham had not flagged up the information about the alleged assaults on 14 October, as an alert on NOMIS. She was also concerned that there were no records of the assaults at Glen Parva and his assault on an officer in 2013. They agreed to hold a conference call with him the next day to discuss his sentence plan. The offender manager faxed a copy of the Parole Board notification letter for the probation officer to disclose to the man.

36. The probation officer emailed Lindholme’s security department about the man’s history of violence, and copied the officer’s NOMIS entry. She added that the offender manger had told her that he had been violent in the community and she was surprised that Nottingham had not informed Lindholme of his history. She asked for an alert to be placed on his NOMIS record and she submitted a security information report recommending that his cell sharing risk assessment should be increased from standard to high.

37. On 3 December, the man told the probation officer that he was disappointed to have been recalled and explained the circumstances that led to his arrest. They had a conference call with the offender manager to discuss his sentence plan, and they talked about the potential benefit of anger management courses. She told him that the Parole Board had decided not to release him. He was unhappy about this and said he now expected to remain in prison until his sentence expired on 15 October 2014.

38. After the conference call, the probation officer spoke to the man about his violent behaviour. He agreed that he had anger management problems and she told him that she intended to raise his risk for sharing a cell to high, to safeguard other prisoners. She said she would refer him to an anger management course and asked him to use his time in prison constructively and behave well.

39. Prisoner A was due to be released from prison at the end of his sentence, on 6 December 2013, but he stayed at Lindholme, detained under the Immigration Act 1971 as he was subject to deportation. On 8 December, the man was moved to a single cell, J-2-427, on the first floor landing of J Wing (“the twos”).

Prison staff reported no incidents or concerns about them. From 18 December, the prisoner shared his cell (J-1-222) with Prisoner B.

**Thursday 19 December 2013**

40. At 5.00pm on 19 December, all prisoners on J Wing were unlocked for an association period. During association periods, prisoners are able to socialise with each other, take part in recreational activities, make telephone calls, take showers and complete other domestic tasks. In his police statement, Prisoner B said that he was in another prisoner's cell with three other prisoners, including Prisoners A and C. Prisoner C then started "ranting and raving" at Prisoner A and accused him of being a "wrong un" (because his offences included rape). He denied the accusations. The other prisoners tried to diffuse the situation but Prisoner C attacked him and punched him in the head three times, before the other prisoners stopped him. Prisoner A was upset and had a slight cut on his lip. He went back to his own cell. No one reported the incident to prison staff, who were unaware of it.

**Events leading up to the incident**

41. Afternoon association period for prisoners on the blue side of J Wing began at 1.45pm, for two hours. Prisoners B and C and another prisoner went to the gym together. Prisoner B said Prisoner C told him that he had spoken to a prisoner (later identified as the man) who had agreed to attack Prisoner C and "chop him up like Zorro" that day. Prisoner B thought he was joking and so did not take him seriously. They spent about an hour in the gym.

42. In his police statement, prisoner D said that he went to see the man in his cell that afternoon and they played cards. He showed him two improvised weapons and said that he intended to use to them to "slice" his old cellmate, Prisoner A, implying that this was because of his offence. They played cards for about 25 minutes, and then went down to the ground floor to play pool.

43. The pool table was opposite cells 221 to 223 and Prisoner D said that the man kept looking at Prisoner A's cell, which was 222. Prisoner A came back to his cell about ten minutes later. The man then walked away from the pool table to the other end of the wing landing and spoke to another prisoner. Prisoner B was on the phone at the end of the landing, near the staff office at the time. He told the police that he saw the man, Prisoner A and Prisoner C go into the cell he and Prisoner A shared.

44. Prisoner D went out onto the exercise yard for a few minutes then came back to the pool table. He noticed that Prisoner A was in his cell with another prisoner, later identified as Prisoner C. In his police statement, Prisoner E said that he was playing pool when he saw the man walk into Prisoner A's cell and close the door behind him.

45. Prisoner B told the police that after he finished his phone call, he spoke to Prisoner F and told him that the three prisoners had gone into his cell. He said Prisoner F looked into the cell through the door observation hatch and told him that nothing was happening. He went to another cell and had a cigarette with the prisoner and Prisoner G. Prisoner G asked him what was wrong, and he went to look into the cell. He came back and said that the three prisoners were

not doing anything. He suggested that Prisoner B should go to the cell and get his shower kit.

46. Prisoner B said that he went into his cell, and told the others that he was going for a shower. He collected his towel, and reached behind Prisoner C for his dressing gown. The man was standing behind the door. At this point, he said that the man called Prisoner A a rapist. He kept one of his hands in his pocket, as if he was gripping an object. He then attacked the prisoner with a shank (an improvised bladed weapon) he had taken from his pocket. The two prisoners fought for several minutes, blocking the cell doorway. Prisoner B asked the man why he was trying to stab Prisoner A. He said he saw blood on the cell floor and tried to intervene, but could not stop them fighting.

47. Prisoner B said that he did not notice that Prisoner A also had a shank in his hand, until he saw him swing it at the man and hit him in his neck. The man held his hands to his neck, which had started to bleed. Prisoners B and C were concerned about how serious the situation had become and left the cell and waited on the landing outside.

48. Prisoner B said that 30 seconds later, Prisoner A came out of the cell covered in blood. He held his hands up and looked very shocked. Seconds later, the man staggered out of the cell with his hands on his neck. His hands, face, clothes and the floor were all covered in blood. Prisoners on the landing started to scream and shout.

49. Another prisoner, who had just left his cell (number 1-220), saw the man come out onto the landing. He told the police that he was bleeding profusely from a wound on his neck and he was using his right hand to try and stem the blood. He and another prisoner went to help him and put him on the floor in the recovery position. Someone passed them a towel to use to try and stop the flow of blood from his neck. He appeared to be very weak. Prisoner E then ran to the office at the end of the landing to alert staff. There were over 50 prisoners out on the landing at the time; many of them had gathered around the man.

50. In a prison statement, another prisoner said that after the incident he saw Prisoner A on “the threes” (second floor landing) throwing something out of a window. (Other prisoners, including Prisoner B, recalled that he was on the ground floor until officers took him away.) The police later found a weapon they suspected was the one used to injure the man. Other prisoners alleged that Prisoner C had previously given a weapon to the man, and had also given a weapon to Prisoner A, as he feared for his own safety.

51. Officer A was on the first floor landing, “the twos”, when she heard a disturbance below. She looked over the railing and saw a large group of prisoners huddled together and suspected that something was wrong. She radioed the control room (recorded in the control room log at 3.37pm) and asked that all available staff should attend the blue side of J Wing. She then went to the ground floor. In his police statement, Officer B said that he was on J Wing when he heard prisoners shouting for staff. As he ran to the landing, he pressed the personal alarm on his radio to alert the control room that he needed assistance. A control room operator issued a message over the radio, also at 3.37pm, for all available staff to attend.

52. A SO told the police that she was in the wing office when she heard prisoners shouting from the blue side landing of J Wing. She went to investigate and heard an officer shouting for staff help. When she arrived, she saw the man on the floor covered in blood, with two prisoners at his side. She shouted to Officer C (who had come when he heard the noise) and Officer D to get a nurse, call an ambulance and put prisoners in their cells. Officer C ran to the red side landing of J Wing and asked a nurse, who was issuing medication, to come immediately. Officer D shouted to prisoners to go back to their cells.

53. An officer who was on the exercise yard at the time told the investigator that he arrived on J Wing 15 seconds after he heard Officer B's personal alarm, at the same time as another officer. He said the man was on the floor and Prisoner A was standing over him. They led him away. The prisoner told the officers that the man had attacked him in his cell and he retaliated by stabbing him in the neck. Prison staff took him to the segregation unit. He appeared to be in shock but complied with the officers.

54. The SO (who was first aid trained) applied pressure to the man's neck wound. At 3.38pm, an officer radioed for further medical help. A nurse replied by radio to say there was already a nurse on J Wing. The officer asked the control room to call an ambulance. The control room operator phoned for an emergency ambulance and recorded this in the control room log at 3.40pm.

55. The officer radioed at 3.41pm and again asked for a nurse to attend and said that this was a code red medical emergency, which indicates severe blood loss. At 3.42pm, he called a code red again. A nurse arrived with a medical emergency bag and, at 3.43pm, radioed for all nurses to come to J Wing.

56. The nurse examined the man. He was still breathing but had lost a lot of blood. The nurse and her colleague took over his care. Shortly afterwards, he stopped breathing. The nurses placed him on his back and started cardiopulmonary resuscitation (CPR). A nurse inserted an airway device into his mouth and used a suction machine to try and maintain his airway. They connected a defibrillator which did not advise a shock. The nurses were unable to find any signs of life. Other officers and nurses arrived and helped with the resuscitation attempt and locked the other prisoners in their cells.

57. At 3.45pm, an officer radioed the control room to say that the man had been stabbed in the neck. At 3.51pm, the control room phoned the police and asked them to come to the prison. Paramedics arrived at 3.52pm and took over emergency treatment. At 4.05pm, they confirmed that he had died.

**After the man's death**

58. The Head of Reducing Re-offending was the duty governor that day and managed the incident. In his police statement, he said that he arrived on J Wing five minutes after he became aware of the incident and officers locked prisoners in their cells quickly.

59. In his police statement, a unit manager said that when Prisoner A arrived at the segregation unit, he told him that, for a couple of days before the incident, prisoners had been coming up to him and mentioning his offence. The prisoner

said that he had previously got on well with the man and he had thought it strange that he had come into his cell and questioned him about his offence. He told the SO that the man then pulled out a shank from his pocket and attacked him by stabbing and punching him. He said they fought for approximately five minutes before he got the upper hand on him and used a shank to stab him.

60. The police arrived and confirmed that they would start a criminal investigation. A large section of the wing was sectioned off as a crime scene.

61. Around 5.45pm, prison staff responded to the cell bell for cell J-1-207. When they opened the door, Prisoner B said he wanted to go back to his own cell, where the incident had occurred. Staff noticed that, although there was a lot of blood at the scene, he looked clean, as if he had just had a shower. (It is not clear that he would have had time to do so.) They moved him to a cell on G Wing and informed a SO that they had found a prisoner who might have been involved in the incident.

62. At 9.00pm, the deputy governor set up a care team area and debrief suite for staff. He chaired a hot debrief meeting for all staff involved in the emergency and ensured that staff wrote statements. The care team and the members of the chaplaincy team attended the wing to offer support to staff and prisoners.

63. The prison issued notices informing prisoners of the man's death and outlining the support available to them. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by the death. On 7 January 2014, the Governor led a critical incident debrief.

## Family Liaison

64. Prison managers asked a SO and a chaplain to act as the prison family liaison officers. Initially they had difficulty finding the man's next of kin contact details and then had to wait until the police gave permission for them to go. (It appears that the contact details had not been appropriately entered on his NOMIS record. While this did not hold up notification of his family this should not have happened.) The SO and chaplain left the prison at around 7.00pm, to inform the man's father of his death.

65. At 8.28pm, the man's sister phoned the prison and said that she heard that her brother had been stabbed. Prison staff told her that the family liaison officers were on their way to see her father and she should contact him for information.

66. At 8.40pm, the family liaison officers arrived at the man's father's house, accompanied by the police. Several of his siblings were also there. The family liaison officers explained the circumstances of his death. The police told the family that a homicide investigation was underway and that they would lead the family liaison. The police liaison officer remained in daily contact with the family and gave them information about the investigation and the post-mortem.

67. On 5 January 2014, with the agreement of the police, a SO telephoned the man's family to offer them the opportunity to visit the prison. On 22 January, the police and the SO visited them. The police updated them on their investigation and told them that as the post-mortem had now been completed, the prison would help with further arrangements. The SO answered a number of questions from the family about his death. The prison offered to contribute to funeral costs in line with Prison Service guidance. The funeral was held on 6 February 2014.

## Information received after the man's death

68. On Sunday 22 December, a prisoner told an officer that he wanted to speak to the Samaritans as he was distressed by what he had seen the day before. He said that three other prisoners on the wing, including Prisoner C, had bullied the man into attacking Prisoner A and two of them had also attacked Prisoner A the week before. He said that Prisoner A had been too scared to tell officers. Intelligence was also received that a prison officer had been telling prisoners about other prisoners' offences. The prison passed this information to the police.

69. On Wednesday 25 December, Christmas Day, a manager spoke to Prisoner C in the segregation unit. Prisoner C told him that he had been in Prisoner A's cell when the man had goaded Prisoner A about his offence and then attacked him with a shank. He said he had been unable to stop them fighting and Prisoner A stabbed the man in the neck. He said he then ran out of the cell. This information was passed onto the police. He was later arrested and was charged with murder and common assault (against Prisoner A), and three counts of passing a weapon to a prisoner. The police investigation established that he had supplied the weapons used by both the men during their fight.

## Post-mortem

70. The post-mortem examination found that the man died following a penetrating injury to the neck, which resulted in a complete division of both the left jugular vein and carotid artery, causing severe blood loss. Toxicology investigations showed no evidence of common drugs or alcohol in the blood or urine.

## The criminal investigation

71. Prisoners A and C were arrested after the man's death. Prisoner A was charged with murder, and Prisoner C was charged with murder, common assault and three counts of passing a weapon to a prisoner. Both were acquitted by a jury at Crown Court on 10 August 2014.

## ISSUES

### Clinical care

72. In his clinical review the clinical reviewer noted that the man had no significant medical or psychiatric issues while he was in prison. He concluded that the care the man received while he was in prison and during the fatal incident was equivalent to that he could have expected in the community. He noted that the man received a catastrophic injury resulting in severe blood loss. He concluded that resuscitation attempts were unlikely to have been successful due to the nature of the injury.

### The man's risk of violence to others

73. The man had a history of violence towards prison staff and other prisoners, yet there were no alerts about this on his NOMIS record. We accept that this omission did not affect the outcome in this case, but it is important that procedures designed to identify and manage the risk of violence are followed. Prison Service Instruction (PSI) 73/2011, about the management of NOMIS, the electronic prison record, states that the "Alerts" system must be kept up to date to ensure staff safety, the protection of vulnerable offenders and public protection. PSI 74/2011 (which covers procedures for early days in custody) requires Alerts on NOMIS to be created and updated.

74. The PER form that accompanied the man from Nottingham to Lindholme noted that he had a history of violence and assaults on staff, but Lindholme reception staff told us that they were not informed of his recent poor conduct at Nottingham. Even when they became aware of his conduct, they did not update the Alert screen until 18 December.

75. While this failure to record risk information on NOMIS did not have a direct impact on the man's death, who was no longer sharing a cell at the time, we are concerned that this information was not flagged up as it should have been and not taken into account until some weeks after he arrived at Lindholme. In that time, he had shared a cell with Prisoner A, who he later attacked on 21 December 2013, although he was seemingly unaware of the prisoner's offence at the time. We make the following recommendation:

    **The Governor of Lindholme and the Governor of Nottingham should ensure that all important and relevant information about a prisoner's risk and violent behaviour is recorded as an alert on their NOMIS record.**

### Emergency response

76. PSI 03/2013 *Medical Emergency Response Codes,* issued in February 2013, contains a mandatory instruction that prisons should have a local protocol, which gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. Lindholme has a local procedure, (126/2013), which is in accordance with the protocol.

77. When the man was fatally injured, there were approximately 50 prisoners on the ground floor landing, and eight prison staff on J Wing who were either in the office or carrying out duties in other parts of the wing and exercise yard. Two officers, who appear to have been the first officers to have noticed the commotion on the ground floor, immediately radioed the control room for all staff to attend J Wing. They did not know what the incident was. The control room operator asked all staff to attend J Wing at 3.37pm.

78. A SO arrived at the incident very quickly and shouted for officers to get a nurse and call an ambulance. An officer radioed a nurse and then the control room to ask for an ambulance to be called. While this caused only a slight delay, it was evident by then that the man was hurt and covered in blood and someone should have called an emergency medical response code red. This would have alerted the control room to call an ambulance immediately and informed healthcare staff and officers responding of the nature of the emergency. The officer radioed an emergency code red at 3.41pm, after he had made the other radio calls.

79. It is clear that there was a lot of confusion when the man was stabbed, and the clinical reviewer has said that the nature of the injury was such that he was unlikely to have survived no matter what attention he received. However, officers should have called a code red as soon as they found him. In other circumstances, even a small delay might have a significant impact on a person's chance of survival. We make the following recommendation:

    **The Governor should ensure that all relevant staff are aware of their responsibilities during medical emergencies and use the appropriate medical emergency code to communicate the nature of the emergency and direct the control room to call an ambulance immediately.**

**Preservation of evidence**

80. In the aftermath of the emergency, officers locked prisoners in their cells. Prisoner B, who shared a cell with Prisoner A and who had witnessed the incident in the cell, was locked into a cell with two other prisoners. This only came to light some hours later.

81. The police told the investigator that they were shocked that it took prison staff so long to establish where Prisoner B was, and that this could have compromised both prison security and the police investigation. The Prison Service Order in force at the time of the incident (PSO1400) stated that when staff attend a serious incident, any other prisoner who might have been involved in the incident should be safely secured. This did not happen in this case.

82. PSO 1400 has been replaced by PSI 09/2014 (Incident Management) which continues to make it clear that staff should preserve evidence when there is a serious incident. There were a lot of prisoners on the wing at the time and we understand there was a need to secure the area as quickly as possible and lock prisoners away. However, prison staff should be aware when there is such a serious incident that there is a need to identify quickly which prisoners should be held separately as suspects or witnesses. As Prisoner B shared a cell with Prisoner A, the importance of this should have recognised. It also appears that

a prisoner was able to leave the cell with the weapon used on the man and dispose of it through a window, without staff being aware. We make the following recommendation:

**The Governor should ensure that staff responding to serious violent incidents preserve all relevant evidence and that prisoners who could be suspects or direct witnesses are quickly identified and held separately until the police arrive.**

## RECOMMENDATIONS

1. The Governor of Lindholme and the Governor of Nottingham should ensure that all important and relevant information about a prisoner's risk and violent behaviour is recorded as an alert on their NOMIS record.

2. The Governor should ensure that all relevant staff are aware of their responsibilities during medical emergencies and use the appropriate medical emergency code to communicate the nature of the emergency and direct the control room to call an ambulance immediately.

3. The Governor should ensure that staff responding to serious violent incidents preserve all relevant evidence and that prisoners who could be under suspects or direct witnesses are quickly identified and held separately until the police arrive.

| Action Plan | | | | | |
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| **No** | **Recommendation** | **Accepted/Not Accepted** | **Response** | **Target date for completion and function responsible** | **Progress (to be updated after 6 months)** |
| 1 | The Governor of Lindholme and the Governor of Nottingham should ensure that all important and relevant information about a prisoner's risk and violent behaviour is recorded as an alert on their NOMIS record. | Accepted | **Lindholme**<br>Reception staff have received guidance to ensure the PER is correctly monitored and appropriate information is recorded on NOMIS. An ongoing assessment of risk is now in place to ensure that where risk changes are identified, alerts are recorded as required by the safer custody department and the offender manager. In addition, a Staff information Notice has been issued reminding staff of their obligation in updating PNomis records.<br><br>**Nottingham**<br>Any information affecting risk is identified as part of the reception/ induction process and recorded on the PNomis case notes. A follow up process of reviewing any risk and behavioural information will also take place in the Offender Management Unit and PNomis will be updated accordingly. A Staff information Notices has been issued reminding staff of their obligation in updating P-Nomis records | 30/04/2015<br><br>Head of safer Operations,<br>Head of Safer custody,<br>Head of OMU<br><br>30/04/2015<br><br>Head of safer Operation,<br>Head of Safer custody,<br>Head of OMU. | |

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| 2 | The Governor should ensure that all relevant staff are aware of their responsibilities during medical emergencies and use the appropriate medical emergency code to communicate the nature of the emergency and direct the control room to call an ambulance immediately. | Accepted | Operational orders and notices to staff have previously been issued detailing the emergency code procedure that is to be used for all ambulance calls. This operational order will be re-issued along with an update clarifying that any member of staff can request a call for an ambulance. The Head of Operations will ensure all ambulance calls have used the correct codes. | 01/04/2015<br><br>Head of Operations. | |
| 3 | The Governor should ensure that staff responding to serious violent incidents preserve all relevant evidence and that prisoners who could be under suspects or direct witnesses are quickly identified and held separately until the police arrive. | Accepted | A notice to staff outlining their responsibilities in ensuring that evidence is preserved where at all possible and suspects are quickly identified and held separately until the police arrive will be issued. Training in evidence perseveration will be provided by the security departments and the police and will be targeted at Custodial Managers and residential Supervising Officers. | 30/05/2015<br><br>Head of Security | |