Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Greenall a prisoner at HMP Lowdham Grange on 20 November 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Lee Greenall was found unresponsive in his cell at HMP Lowdham Grange on 20 November 2016. He was 40 years old. I offer my condolences to Mr Greenall's family and friends.

Soon after Mr Greenall arrived at Lowdham Grange, there was intelligence that he might have been the subject of intimidation by other prisoners. I am concerned that this was not investigated. After this, Mr Greenall was allowed to self-isolate. He chose not to attend work, education or exercise, and stayed in his cell for most of the day, leaving only to collect meals. Despite Lowdham Grange having, in theory at least, a comprehensive personal officer scheme and a zero tolerance approach to violence and bullying, there is little evidence that staff interacted with Mr Greenall, encouraged him to take a part in the prison's regime or properly assessed whether he was being intimidated or bullied. While Mr Greenall's death appears to have been unexpected to staff, it is entirely conceivable that a better level of engagement might have identified that he was at risk of suicide or self-harm.

I am also concerned that there were deficiencies in the prison's mental health referral processes and in the emergency response.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2017**

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Summary

Events

1. On 11 February 2016, Mr Greenall was remanded to HMP Nottingham. It was not his first time in prison. Mr Greenall was very briefly monitored under suicide and self-harm procedures.

2. On 13 May, Mr Greenall was transferred to HMP Lowdham Grange. Intelligence reports submitted a week later indicated that other prisoners might have been threatening him. On 24 May, an officer noted red bruising on his face. Mr Greenall told the officer it was a result of slipping in his cell and no further action was taken.

3. Mr Greenall chose not to work or take part in education. He spent all of his time in his cell, did not take exercise outside and only left his cell to collect his meals. Officers had little meaningful contact with him and very little information is recorded about his time at the prison.

4. On the night of 15 September, an officer tried to refer Mr Greenall to the prison's mental health team for assessment because he was behaving strangely. Due to an administrative failure, the referral was never made.

5. At around 9.40pm on 20 November, an officer found Mr Greenall lying face down in his cell, bleeding from his head, with a telephone cord tied around his neck. Staff checked for signs of life, but found none. They tried to resuscitate Mr Greenall but when the paramedics arrived, he was pronounced dead.

Findings

6. Mr Greenall isolated himself at Lowdham Grange, and we are concerned that no one actively engaged with him or encouraged him to participate fully in the prison's regime.

7. Despite several intelligence reports and instances of Mr Greenall having unexplained injuries, staff did not investigate why Mr Greenall chose to remain in his cell for much of the day or whether he felt intimidated or threatened by other prisoners.

8. Mr Greenall had no contact with mental health services. The failed referral to the mental health team was a missed opportunity for professional clinicians to review his mental state and to support him appropriately.

9. During the emergency response there was a slight delay in calling the ambulance.

10. When staff found Mr Greenall, he had no signs of life and staff believed that he had been dead for some time. Despite this, they continued resuscitation efforts contrary to national guidelines.

Recommendations

- **The Director should ensure, in line with the personal officer scheme, that:**
  - **Personal officers understand their responsibilities in communicating with and encouraging prisoners;**
  - **Have the time to get to know prisoners;**
  - **Identify their needs;**
  - **Encourage them to participate in prison regimes; and**
  - **Make regular case history notes.**

- **The Director should ensure that all information about bullying is fully co-ordinated and investigated, that staff consider whether victims are at increased risk of suicide or self-harm, and that apparent victims are effectively supported and protected with meaningful, long term solutions which address their individual situations.**

- **The Director should ensure that staff know how to refer prisoners to the prison's mental health team and that electronic referral systems work as they should.**

- **The Director should ensure that control room staff call an ambulance immediately a medical emergency code is received, without waiting for further confirmation.**

- **The Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.**

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator visited Lowdham Grange on 30 November 2016. He obtained copies of relevant extracts from Mr Greenall's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Greenall's clinical care at the prison.

14. The investigator interviewed twelve members of staff and two prisoners at Lowdham Grange in January and February 2017.

15. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. We have given the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Greenall's mother to explain the investigation. Mr Greenall's mother was concerned that her son's substance misuse and mental health needs were not managed appropriately. She was concerned that staff had not adequately interacted with Mr Greenall, especially as he had spent a lot of time in his cell.

17. Mr Greenall's family received a copy of the initial report. They did not make any comments which led to any factual changes within the report.

Background Information

HMP Lowdham Grange

18. HMP Lowdham Grange is a medium secure prison, managed by Serco, which holds around 900 men. There are five houseblocks, typically holding 120-130 men. It holds long-term prisoners, many of whom are serving life sentences or indeterminate sentences. Nottinghamshire Healthcare NHS Foundation Trust provides general healthcare, which includes 24-hour nursing cover.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Lowdham Grange was in June 2015. Inspectors reported that, despite a settled population, the quality of personal officer work was limited and disappointing, with some officers not demonstrating good knowledge of the prisoners in their care. Inspectors reported that nearly half of prisoners said they had felt unsafe at some time, that there were high levels of violence against staff and prisoners and formal support for victims was underdeveloped. Inspectors recommended that the prison implement plans to increase staff supervision during high risk periods and introduce formal support for victims of bullying and violence.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2016, the IMB reported their concerns about low staffing levels at Lowdham Grange and how there were not enough on duty at weekends to maintain control of a difficult prison population. The IMB reported that the safer custody team continued to work hard safeguarding the welfare of prisoners, despite increasing levels of anti-social, and at times, violent behaviour between prisoners.

Previous deaths at HMP Lowdham Grange

21. Mr Greenall was the second prisoner to take his life at Lowdham Grange since March 2013. The deaths of another two prisoners were linked to drug misuse. The other prisoner who took his life was found hanged in his cell in March 2016. In our investigation of that death, we identified the need for improvements to the personal officer scheme and in training staff to know when resuscitation is appropriate.

Assessment, Care in Custody and Teamwork (ACCT)

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

Background

23. Mr Lee Greenall had previously served time in prison for minor offences. On 11 February 2016, he was charged with attempted murder and was remanded to HMP Nottingham. Court staff completed a suicide and self-harm warning form because Mr Greenall had asked his solicitor about the death penalty. Staff at Nottingham started ACCT suicide and self-harm prevention procedures, and referred him to the prison's mental health team. Staff stopped monitoring him the next day as they decided that Mr Greenall was not at risk of suicide or self-harm.

24. On 19 February, the mental health team assessed Mr Greenall but discharged him from their care. Mr Greenall had further contact with the mental health team in March and April because he felt anxious and nervous. The assessing nurse noted that he was not depressed and had no thoughts of suicide or self-harm.

25. On 10 March, Mr Greenall was convicted for grievous bodily harm and robbery and on 22 April, was sentenced to 14 years in prison.

HMP Lowdham Grange

26. On 13 May, Mr Greenall was transferred to HMP Lowdham Grange and was given a cell in the induction unit. He told a nurse that he had no thoughts of suicide or self-harm and she noted that Mr Greenall was not taking any medication for mental health issues.

27. The next day, an officer interviewed Mr Greenall as part of his induction. The prison chaplain also spoke to him. Mr Greenall raised no concerns.

28. On 19 May, an officer completed an intelligence report which said that a number of prisoners had gathered around Mr Greenall's cell door to say that he was a "wrong un" for attacking a woman. The intelligence was forwarded to unit managers.

29. On 20 May, an officer completed another intelligence report which said that prisoners had identified Mr Greenall from a television programme and that his victim had been an elderly woman. He noted that he did not think anything would happen to Mr Greenall and he would be moved to another wing the next week. The intelligence report was shared with Mr Greenall's offender supervisor and again with unit managers. (There was no evidence that staff investigated the issue or supported Mr Greenall.)

30. On 24 May, an officer noticed that Mr Greenall appeared to have bruising and reddening to his face. Mr Greenall said he had slipped in his cell. Officers asked a nurse to see Mr Greenall, as they believed he might have been assaulted. Mr Greenall did not allow the nurse to examine him, and, in any case, the nurse could not see any obvious marks on Mr Greenall's face.

31. On 27 May, Mr Greenall told staff to leave him locked in his cell. Mr Greenall told an officer "Just leave me, I'm fucking fine". The officer noted that unit managers needed to be told that Mr Greenall might have been threatened. (The investigator found no evidence that managers took any action in light of this

information.) He said Mr Greenall came out of his cell to collect his food but did not mix with other prisoners. He said that this was not unusual as a lot of prisoners stayed in their cells.

32. On 7 June, Mr Greenall was moved to a single cell on L Wing, a standard wing. All cells on L Wing have a telephone, toilet and shower, and prisoners can lock their cells without asking an officer. An officer showed Mr Greenall his cell and told him to ask staff if he needed anything. Mr Greenall told her he had everything he needed. She said Mr Greenall preferred to stay in his cell, watching television.

33. On the night of 15 September, an officer noted that Mr Greenall had behaved strangely, shouting and banging his window and cell walls. He said Mr Greenall was usually quiet, spent a lot of his time in his cell and did not mix with other prisoners. Mr Greenall told him that he had heard a woman calling him in his cell. The officer asked him to be quiet. He concluded that Mr Greenall might have heard voices and noted that he would refer him to the mental health team. He followed guidance on the wing's computer terminal and tried to refer him electronically. Despite this, the process did not work and no referral was made. (The officer did not check whether the referral had been made, contact the mental health team by email or telephone and did not tell anyone else about the referral.)

34. During his time at Lowdham Grange, Mr Greenall chose not to work or take part in education and therefore received a small unemployment payment. Mr Greenall regularly purchased items of food from the shop with this money. (There is no evidence to suggest that any of his purchases were given to other prisoners.)

35. An officer said that although she had never had an in-depth conversation with Mr Greenall, he never talked of self-harm or discussed anything with staff. She said Mr Greenall was not interested in education or applying for work, did not go outside for exercise and was happy to stay in his cell, leaving only to collect his meals. She said that this behaviour was not unusual. (The investigator viewed CCTV footage of the day that Mr Greenall died which indicated that Mr Greenall remained in his cell and had no significant interaction with staff during the day.) The officer said that there were issues with bullying on the wing, but saw no incidents to suggest that Mr Greenall was being bullied and she did not believe that he was.

36. An officer said that Mr Greenall never came to the wing office to ask for anything and described him as polite and quiet. He said he did not get to know Mr Greenall as he preferred to stay in his cell. He said he did not witness any incidents of bullying against Mr Greenall.

37. Several officers told the investigator that prisoners chose to remain in their cells on the wing. An officer believed that some prisoners might have feared other prisoners. Other officers suggested that L Wing was one of the worst wings in the prison for bullying. However, the unit manager said that no significant bullying issues had been brought to his attention while he had managed L Wing.

Emergency response

38. At around 5.45pm on 20 November, an officer locked Mr Greenall in his cell. He said he recalled that Mr Greenall was lying on his bed, watching television. He said Mr Greenall smiled and stuck his thumb up to indicate that he was okay.

39. At 9.40pm, during a roll check, an officer looked through the observation panel on Mr Greenall's cell door and saw him lying face down on the floor of the cell. He said that he saw blood on the floor. He radioed medical emergency codes blue and red at 9.41pm, and said that Mr Greenall was on the floor, bleeding from his head. (A code blue and code red indicate a life threatening situation. A code blue indicates that a prisoner is unconscious or not breathing, and a code red indicates that there is a significant loss of blood.)

40. The officer asked the night manager if he could go into the cell. The night manager told him not to go in as he did not know the prisoner and it might have been a ploy. He told him to wait for him to arrive as he would be there within a minute.

41. An officer, who worked in the communications room, said he asked for further details about the incident before calling an ambulance about a minute later. The ambulance emergency operator was put through to the wing and an officer gave them additional information about the incident.

42. The night manager arrived around a minute and a half after the emergency codes were called, and unlocked the cell door. An officer arrived soon afterwards and went into the cell. The officer checked for signs of life, but found none. He noticed a telephone cord tied tightly around Mr Greenall's neck. Another officer and he removed the cord. An officer told the investigator that he believed Mr Greenall had been dead for some time as he was cold and showed signs of rigor mortis. (He speculated that Mr Greenall might have used the cord to strangle himself for sexual gratification. We have seen no evidence that this was the case.)

43. Mr Greenall was moved from his cell to the landing, where there was more room. An officer started cardiopulmonary resuscitation and continued with the emergency response nurse, who arrived at 9.44pm. The nurse attached the defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) but it found no shockable heart rhythm. They continued resuscitation efforts.

44. At 10.10pm, paramedics arrived but pronounced at 10.14pm that Mr Greenall had died.

Events after Mr Greenall's death

45. On 21 November, a prisoner who lived on L Wing complained to managers that Mr Greenall was being bullied by some prisoners for his shop purchases and had meals taken from him. He said he had spoken to staff about the bullying before Mr Greenall's death, but managers had done nothing and had ignored the concerns of both prisoners and staff.

46. After Mr Greenall's death, three intelligence reports were submitted about prisoners reporting that Mr Greenall had been bullied. An officer had also submitted a report on 26 November about her conversation with two prisoners, who had said that a day or so before Mr Greenall's death, prisoners had seen Mr Greenall with a bump on his head. The officer reported that Mr Greenall had told a prisoner that he had fallen over in the shower.

Contact with Mr Greenall's family

47. Mr Greenall had named his mother as his next of kin. The Director of Lowdham Grange broke the news of Mr Greenall's death to his mother in person that evening. The prison's family liaison officer contacted Mr Greenall's mother the next day to offer support and she visited the family on 23 November. The prison offered to contribute to Mr Greenall's funeral in line with national instructions.

Support for prisoners and staff

48. An Assistant Director debriefed the staff involved in the emergency response and offered support. Lowdham Grange notified other prisoners of Mr Greenall's death and offered them support. Officers checked on prisoners assessed as at risk of suicide and self-harm, in case that had been affected by the news of Mr Greenall's death.

Post-mortem report

49. The post-mortem examination established that Mr Greenall had died from hanging. Toxicology tests found, apart from caffeine, no drugs in his body.

Findings

Personal Officer Scheme

50. Lowdham Grange's personal officer scheme requires staff to engage positively with prisoners at all times and record their interactions and case notes on at least a weekly basis. The scheme encourages prisoners to make positive use of their time and participate in the prison's activities and routines.

51. Mr Greenall arrived at Lowdham Grange on 13 May, six months before he died. Throughout his time at the prison, officers made just two entries about Mr Greenall's welfare in his case notes. Neither his personal officer nor his offender supervisor made any entries. This echoes the concern of HM Inspectorate of Prisons that, despite a settled population, the quality of personal officer work was limited and disappointing and some officers failed to demonstrate good knowledge of the prisoners in their care.

52. There is no evidence to suggest that officers on L Wing ever tried to have a meaningful conversation with Mr Greenall or encouraged him to work, complete a course or go outside. No one tried to get to know Mr Greenall and we are concerned that staff considered it normal for him to remain in his cell. One officer said that officers were often cross-deployed to other wings in the prison which meant that staff did not often know the prisoners on their wing. We are very concerned about the lack of interaction and make the following recommendation:

The Director should ensure, in line with the personal officer scheme, that:

- **Personal officers understand their responsibilities in communicating with and encouraging prisoners;**
- **Have the time to get to know prisoners;**
- **Identify their needs;**
- **Encourage them to participate in prison regimes; and**
- **Make regular case history notes.**

Tackling bullying and violence reduction

53. PSI 64/2011 sets out how violent prisoners should be managed effectively. It says that all verbal and physical acts of violence must be challenged, appropriate sanctions for perpetrators must be applied robustly, fairly and consistently, and victims must be supported and protected.

54. Lowdham Grange's local violence reduction strategy requires a zero tolerance approach to violence and places the responsibility for tackling issues of violence with staff and prisoners. It requires all incidents of violence or threats to be recorded, challenged and addressed proactively and says that:

- Staff should record incidents in intelligence reports and case history notes.
- Incidents should be reported to wing managers, who should take appropriate action to investigate and record the rationale behind their decisions in a number of formal documents

- Victims should be offered appropriate support, including speaking with the prisoner and if necessary onward referral to other supportive services in the prison including psychology, mental health, offender supervisors and others.

55. Mr Greenall had little meaningful interaction with staff at Lowdham Grange. While he never told staff that he was being bullied or intimidated and denied it when challenged, intelligence reports indicated that he might have been bullied and staff were concerned about the levels of bullying on L Wing. We are concerned that in the circumstances, no one - neither managers nor officers - investigated the issue of potential intimidation and violence, despite Mr Greenall's self-isolation and unexplained injuries. We were also concerned that some of the officers interviewed said they were not aware of the violence reduction strategy.

56. Although we cannot know why Mr Greenall took his life, there are recognised risk factors that increase the risk of suicide and self-harm, including being a victim of violence or intimidation. None of the staff we spoke to considered that Mr Greenall was at risk of suicide or self-harm. This comes as no surprise because staff had no meaningful interaction with Mr Greenall and he had denied thoughts of suicide and self-harm when asked.

57. The PPO has published a range of publications, identifying the links between bullying and suicide. In a review of self-inflicted deaths, published in June 2011, we found evidence of bullying and intimidation in 20 per cent of the cases we reviewed. In a follow-up report of October 2011, 'Violence reduction, bullying and safety', we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying and recognising that individuals who have been the victim of bullying are potentially at greater risk of suicide and self-harm. We repeated similar messages in our review of all self-inflicted deaths in prisons in 2013/14 and pointed to the need for all reports or suspicions that a prisoner is being threatened or bullied to be recorded and thoroughly investigated and for the potential impact on the victim's risk of suicide to be considered. Inspectors also reported that prisoners felt unsafe at times and that there were high levels of violence against staff and prisoners.

58. Staff at Lowdham Grange should have been more alert to the possibility that Mr Greenall was being bullied and responded more proactively, particularly as he was isolating himself, was not taking part in prison life and there was intelligence and some evidence (albeit some months before his death) that he might be the victim of violence or intimidation.

59. While we understand that Lowdham Grange are reviewing their violence reduction strategy, including providing support to victims, we make the following recommendation:

The Director should ensure that all information about bullying is fully co-ordinated and investigated, that staff consider whether victims are at increased risk of suicide or self-harm, and that apparent victims are effectively supported and protected with meaningful, long term solutions which address their individual situations.

Identifying risk of suicide and self-harm

60. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.

61. Mr Greenall had no known history of attempted suicide or self-harm and he isolated himself throughout his time at Lowdham Grange. As we identified earlier in this report, staff should have interacted with Mr Greenall in a more meaningful manner and investigated the allegations of intimidation. If staff had done so, they might have identified that he was at risk of suicide or self-harm.

Mental health referral

62. Mr Greenall denied any mental health concerns, self-harm or suicidal ideation during a mental health review soon after he arrived at Lowdham Grange. As a result, it was reasonable that Mr Greenall was not added to the mental health team's caseload and they took no further action.

63. Despite this, after an incident on 15 September, an officer tried to refer him to the mental health team but was unsuccessful because of a failure in the electronic referral system. Neither he nor anyone else tried to refer Mr Greenall subsequently. This was a missed opportunity for Mr Greenall's mental health needs to be identified and addressed, and for Mr Greenall to be appropriately supported. We make the following recommendation:

    The Director should ensure that staff know how to refer prisoners to the prison's mental health team and that electronic referral systems work as they should.

Emergency response

64. PSI 03/2013 says that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly says that control room staff should automatically call an ambulance whenever there is an emergency code and a member of the prison healthcare team or a duty manager need not attend the scene before emergency services are called. The PSI notes that it is better to act with caution and call an ambulance as it can be cancelled later, if not needed. The PSI is clear that control room staff should not check with managers, healthcare staff or others at the scene before calling an ambulance but should be alert to updates and keep the ambulance service informed.

65. An officer appropriately radioed medical emergency codes blue and red when he found Mr Greenall. However, there was a delay of around a minute before the officer in the control room called an ambulance. The officer said that this was because the ambulance operators always required additional information and he used this time to find out more about the incident before he called an ambulance. This is contrary to Lowdham Grange's policy which requires an ambulance to be called when an emergency code is used. As we have said in a previous

investigation report about a death at Lowdham Grange, delays can have a significant impact on a person's chance of survival during an emergency. While in this case, the delay would not have affected the outcome for Mr Greenall as he had been dead for some time, in another emergency any delay could be critical. We make the following recommendation:

The Director should ensure that control room staff call an ambulance immediately a medical emergency code is received, without waiting for further confirmation.

Resuscitation

66. European Resuscitation Council Guidelines for Resuscitation 2015 which were shared with prison managers in September 2016 say that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 on making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

67. An officer said that when he examined Mr Greenall he could not find a pulse, Mr Greenall felt cold and he believed that he had been dead for some time. The clinical reviewer concluded that the decision to start cardiopulmonary resuscitation was not in line with guidelines and that a non-clinician could make a "diagnosis of death", when there were no signs of life and rigor mortis was present. We agree and recommend that:

The Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

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