

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Samuel Harrison a prisoner at HMP Lincoln on 25 September 2017

A report by the Prisons and Probation Ombudsman

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*



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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.

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

Mr Samuel Harrison died in hospital from head injuries on 25 September 2017, after being punched by another prisoner at HMP Lincoln two weeks before. He was 29 years old. I offer my condolences to Mr Harrison's family and friends.

The prisoner who punched Mr Harrison was charged with manslaughter, but was found not guilty in December 2018. He admitted to punching Mr Harrison but said it was in self-defence, which was accepted by the jury at his trial.

It is unclear what led to the other prisoner punching Mr Harrison in self-defence. Mr Harrison used psychoactive substances (PS) in prison but it is unknown whether he had taken them on the day of the incident. There was no intelligence to link the two men and I am satisfied that staff could not have foreseen or prevented Mr Harrison's death.

A month before the incident, Mr Harrison had complained of being bullied. Staff should have supported him using the prison's violence reduction measures but failed to do so. The investigation also found that the prison did not respond to Mr Harrison's drug use in line with the prison's substance misuse strategy. I cannot say, however, whether either of these issues played any part in his death.

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

Sue McAllister CB
Prisons and Probation Ombudsman

June 2019

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Summary

Events

1. On 22 February 2017, Mr Samuel Harrison was sentenced to two years in prison for burglary and sent to HMP Lincoln. He was moved to HMP North Sea Camp on 8 June, before returning to Lincoln on 20 July.
2. On 12 August, Mr Harrison told an officer that he was being bullied for his canteen (his order from the prison shop). The officer recorded that she had reported this to a supervising officer, but no further action was taken.
3. On three occasions in August, Mr Harrison was suspected of being under the influence of psychoactive substances (PS). On 25 August, he was moved to HMP Humber to give him a fresh start, away from the drug culture at Lincoln. However, he was returned to Lincoln on 1 September after a court appearance.
4. On 11 September, prisoners alerted staff that Mr Harrison had collapsed in the shower. Initially, both prisoners and officers thought Mr Harrison was under the influence of PS, but when nurses attended they realised Mr Harrison had sustained a significant head injury and some prisoners told staff he had been assaulted. Mr Harrison was taken to hospital where he had brain surgery and was placed in an induced coma. He never regained consciousness and died on 25 September.
5. Another prisoner was charged with Mr Harrison's manslaughter. He admitted to punching Mr Harrison but said this was in self-defence. This was accepted by the jury in his criminal trial and he was found not guilty.

Findings

6. There was no intelligence to indicate that the prisoner who punched Mr Harrison posed a risk to other prisoners. There was also no intelligence linking him and Mr Harrison. We are satisfied that staff could not have foreseen or prevented the incident on 11 September.
7. Mr Harrison was restrained when he was taken to hospital. A nurse completed the medical section of the escort risk assessment saying that Mr Harrison's risk of escape was severely compromised by his state of health but there is no evidence the manager who authorised restraints took account of this.
8. The shower area was not treated as a crime scene initially and was cleaned, which meant that important evidence was not preserved. The prisoner who punched Mr Harrison was also allowed free movement around the wing for eight hours before he was moved to the segregation unit.
9. When Mr Harrison told staff he was being bullied, they did not support him under the prison's violence reduction measures as they should have done.
10. Staff failed to follow the prison's substance misuse strategy when they suspected Mr Harrison was under the influence of drugs. Staff should have referred him for a suspicion drugs test but failed to do so.

11. It is unclear, however, whether the alleged bullying or Mr Harrison's drug use played any part in his death. We do not know whether Mr Harrison had taken any drugs on 11 September as his blood was not tested. While prisoners speculated that the assault was linked to Mr Harrison's drug debts, the investigation has not established a link between these and the prisoner who punched him.

Recommendations

- The Governor should revise the prison's escort risk assessment form so that it requires staff to show that they have taken a prisoner's current state of health, and its impact on their mobility, into account when assessing the prisoner's level of risk.
- The Governor should ensure that after a serious incident, all evidence is preserved, witnesses and suspects identified and separated, and all information requested by the police disclosed as a matter of urgency.
- The Governor should ensure that any reported incidents of bullying or violence are recorded and investigated in line with Lincoln's policy and, if appropriate, violence reduction measures are started.
- The Governor should ensure that all prisoners suspected of taking drugs are tested within required timescales.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator visited Lincoln on 4 October 2017, and obtained copies of relevant extracts from Mr Harrison's prison and medical records.
14. We suspended our investigation in November 2017, pending the outcome of criminal proceedings against the prisoner charged with Mr Harrison's manslaughter. Lincolnshire Police agreed that the investigator could continue with parts of her investigation and gave permission for her to interview prison staff but not prisoners.
15. The investigator and an Assistant Ombudsman interviewed eight members of staff in March 2018. We resumed our investigation in December 2018, after Lincolnshire Police told us that the prisoner charged with Mr Harrison's manslaughter had been found not guilty.
16. Another investigator completed the investigation. Lincolnshire Police provided her with all witness statements obtained from staff and prisoners. She spoke with Lincolnshire Police and Lincoln Crown Court to understand more about the circumstances of the prisoner's acquittal. She interviewed the Governor of Lincoln and a prison manager in April 2019.
17. We informed HM Coroner for Lincolnshire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Harrison's mother to explain the investigation and to ask if she had any issues she wanted the investigation to consider. Mr Harrison's mother wanted to know how her son was discovered and if there had been any delay in him receiving medical treatment.
19. We shared a copy of our initial report with Mr Harrison's mother. She raised several issues that did not impact on the factual accuracy of the report, which we have responded to separately.
20. The prison also received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

Background Information

HMP Lincoln

21. HMP Lincoln holds up to 729 remanded and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, which include a vulnerable prisoners' unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover. There is no inpatient unit at Lincoln.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Lincoln was in January and February 2017. Inspectors reported that the prison remained overcrowded, which, along with the age of the prison, meant there were significant challenges in keeping conditions decent for those held. Inspectors reported that the prison had an excellent relationship with local police and that there had been some impressive work to manage the challenges around PS.
23. Inspectors found intelligence gathering was comprehensive and security information analysed well. However, although the prison took steps to tackle them, target-searching and suspicion drug testing were behind schedule. Inspectors noted that the drug strategy committee meeting was poorly attended and did not effectively steer the prison's strategic approach to drug treatment. Psychosocial support for prisoners with substance misuse problems was found to be better than at the last inspection, however, prisoners' access to services was regularly interrupted by regime curtailments.
24. Inspectors found levels of violence had increased since their last inspection and were high overall. Over a quarter of prisoners said they felt unsafe at the time of the inspection. The strategic management of violence reduction was improving but some processes for dealing with poor behaviour had not yet been fully embedded. There continued to be a heavy reliance on the use of the basic level of the IEP scheme

Independent Monitoring Board

25. 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 31 January 2018, the IMB reported that the prison had implemented a robust drug strategy, but the availability and use of PS continued to cause additional pressure on prison and healthcare staff.

Previous deaths at HMP Lincoln

26. Mr Harrison was the eighth prisoner to die at Lincoln since September 2015. Of the previous deaths, five were from natural causes and two were self-inflicted. There have been four deaths since, two self-inflicted, one drug related and one from natural causes.

27. We have previously made recommendations to Lincoln about ensuring a prisoners' medical condition is fully considered when authorising the use of restraints.

Incentives and Earned Privileges (IEP) Scheme

28. Each prison has an Incentives and Earned Privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Mercury Intelligence System

29. The Mercury Intelligence System is a national IT system for managing and analysing intelligence in HMPPS. Mercury enables the transfer and sharing of intelligence within and between establishments, both in custody and in the community. The aim of Mercury is to maintain control and order within prisons, prevent escapes and reduce the supply of drugs and mobile phones in prisons.
30. Staff submit Intelligence Reports (IRs) which must be graded. If the member of staff assesses that the intelligence identifies that there is a clear, implied or potential threat to the security objectives of the establishment, the intelligence must be processed immediately and graded "high". Security Management must then be informed immediately, so that an appropriate response is taken to counteract any threat. Intelligence graded "medium" must be analysed by management within 24 hours and "low" within 72 hours.

Psychoactive Substances (PS)

31. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
32. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
33. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

Mr Samuel Harrison

34. On 22 February 2017, Mr Samuel Harrison was convicted of burglary, sentenced to two years in prison and taken to HMP Lincoln. This was his first time in prison.
35. A nurse completed an initial health screen and noted that Mr Harrison had historically experienced drug-induced psychosis, anxiety and depression because of using drugs. Mr Harrison had received treatment as an outpatient at a psychiatric hospital some years earlier. Mr Harrison agreed to be referred to the mental health team for counselling, linked to a bereavement.
36. During the next few months, Mr Harrison complied well with the regime at Lincoln and staff described him as polite and respectful. On 8 June, Mr Harrison was moved to HMP North Sea Camp, a category D (open) prison (for prisoners who pose a low risk in relation to security and protection of the public, and can be trusted in open prison conditions).
37. On 19 June, a mental health nurse recorded that Mr Harrison said that he was settling in well at North Sea Camp and did not feel the need for support at that time. Mr Harrison said that drugs had previously fuelled his anxieties and now that he was no longer using them, he felt less in need of support. He was discharged from the mental health team. Mr Harrison was reviewed by the substance misuse team on 30 June and reported no issues.
38. On 20 July, Mr Harrison was moved back to Lincoln as he was being investigated for a serious offence, allegedly committed before he entered prison. He was recategorised to C (prisoners 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). A nurse completed the initial healthscreen and recorded Mr Harrison had no issues. He declined to be referred to the mental health or substance misuse teams.
39. On 12 August, an officer recorded in Mr Harrison's prison record that Mr Harrison 'had a bit of a bad week last week saying he was being bullied for his canteen. SO was aware of this and dealing with it. He [Mr Harrison] seemed a lot happier this week but have not had a chance to talk to him about it yet. He is no problem on the wing and is polite to staff and conforms to the regime.' The officer told the investigator she had no recollection of the details of this entry. There is no evidence Mr Harrison was supported as part of Lincoln's violence reduction measures.
40. On 15 and 16 August, Mr Harrison was suspected of being under the influence of illicit substances during his education classes. The tutor said Mr Harrison had gone to the toilet several times during her class and when he returned was quiet, disengaged and had red eyes. When challenged Mr Harrison said he was just sleepy. Mr Harrison was given an IEP warning about his behaviour.
41. On 17 August at 8.22pm, an officer found Mr Harrison fighting with his cellmate. The officer asked for staff assistance and then he and another officer unlocked the cell. One of the officers said it appeared that Mr Harrison and his cellmate

were under the influence of drugs, probably psychoactive substances (PS). Mr Harrison had started to assault his cellmate and a fight broke out in the cell. Although officers suspected both prisoners of being under the influence of PS, the nurse who had attended to examine them said that he thought only Mr Harrison appeared to be. The nurse asked for Mr Harrison's name to be entered on the list of prisoners known to use PS, but no one referred him to the substance misuse team.

42. Staff moved Mr Harrison and his cellmate to A Wing as their cell was not habitable. The next day a bladed weapon was found in the cell, along with cocaine and paper soaked in PS. Mr Harrison and his cellmate were charged under prison rules, but the adjudication was not proceeded with as the charges were not laid within 48 hours.
43. On 25 August, Mr Harrison was moved to HMP Humber. He was a category C prisoner and the move was organised to give him a 'fresh start' away from the drug culture at Lincoln. On 1 September, Mr Harrison appeared at Lincoln Crown Court for an offence of burglary and returned to Lincoln as it was the local prison. On 6 September, after he had completed his induction, Mr Harrison was moved to B Wing.

Prisoner A

44. On 16 April 2010, Prisoner A was sentenced to six years imprisonment, with a five-year extended licence period, for wounding with intent and possession of an offensive weapon. He was released from prison on 25 April 2016. He had his licence revoked when he was arrested for being drunk and disorderly, and he was taken to Lincoln on 25 July 2017. There is nothing in Prisoner A's prison record to suggest he posed a direct risk to other prisoners.
45. On 29 August, Prisoner A, an enhanced prisoner, started work as a gym orderly, a trusted position. A Physical Education Instructor (PEI) noted in Prisoner A's prison record that he 'had not started well and he had been told twice what was expected of him [he was not working hard enough]. Noted that he worked well when instructed but any further issues and he may have to be removed'.
46. Prisoner A was never identified as posing a risk of harm to Mr Harrison or any other prisoner. The PEI said he had known Prisoner A for several months and never saw him either threaten or be violent towards another prisoner. The PEI described Prisoner A as powerfully built and said that his physical presence would be sufficient to intimidate. Although there was no security intelligence, other prisoners said anecdotally that Prisoner A was controlling on the wing and bullied other prisoners. Historical information entered on the Mercury intelligence system contained information which suggested Prisoner A had been involved in the drug culture at other prisons.

Events leading to the death of Mr Harrison

47. Prisoners on Mr Harrison's wing said he was known to regularly take illicit drugs. A friend of Mr Harrison's said that Mr Harrison had used illicit substances when he first arrived at Lincoln and had told him the move from Lincoln to North Sea Camp was well timed as he had accrued debts of around £400, which he could

not pay. Mr Harrison's friend said that when he realised Mr Harrison had returned to Lincoln, he thought his old debts would cause him problems. He said Mr Harrison continued to use drugs at Lincoln and said he did not seem himself in the weeks before he was punched by Prisoner A and had become more withdrawn. He said Mr Harrison had by this time accrued a debt of nearly £1,000.

Events of 10 and 11 September 2017

48. During the night of 10/11 September, Mr Harrison's cellmate was allegedly banging and making a noise because he was due to get released (some prisoners make a noise on their last night as a way of celebrating). He declined to be interviewed.
49. An officer started his night shift around 7.45pm. He said he was on B Wing for around one to one and a half hours, then the night patrol took over. An operational support grade (OSG) was the night patrol officer, but did not recall any noise or banging coming from Mr Harrison's cell or any other disturbances during the night. The officer said that he had no recollection of any disturbance on the wing or noise coming from Mr Harrison's cell, although he said that prisons are often noisy during the night.
50. An officer said she completed the early morning roll check on B Wing, starting around 5.00am, and that it took approximately 20 minutes to complete. She heard no noise. Cell bell records show that at 5.09am (reset at 5.10am) and 5.43am (reset within a minute) the cell bell for Mr Harrison's cell had been pressed. The officer said she did not recall the cell bell being pressed, although she said prisoners often got disturbed when the roll check was completed and it was not unusual for them to press their cell bells asking what time it was or make other requests. Nobody had any recollection of why the cell bell had been pressed and recalled nothing of any concern.
51. On the morning of 11 September, at around 8.00am, all prisoners were unlocked to use the wing facilities, have breakfast and access the showers. Officer A had opened the cells of prisoners on the third landing, including Mr Harrison's cell, B3-11. Several prisoners said that they saw a verbal altercation between Mr Harrison and Prisoner A. One prisoner said he heard Prisoner A shout at Mr Harrison, asking him why he was banging last night and Mr Harrison replied that he had not been banging.
52. Two prisoners spoke to Mr Harrison for several minutes on the third landing. One of them said it was around 8.15am, and Mr Harrison asked him if he knew where he could get some 'mamba', a slang term for PS. This prisoner said Mr Harrison seemed in good spirits, but that he had often seen him 'spaced out' and that Mr Harrison frequently used PS. He told Mr Harrison he did not know where he could get PS and Mr Harrison walked off.
53. Prisoner A used the wing telephone at 8.16am, and spoke to his partner. During the conversation he said, 'I feel like doing someone in jail.' Prisoner A did not make any specific threat or mention any individual.
54. Closed Circuit Television (CCTV) shows at 8.33.12am, Prisoner A and Mr Harrison walked along the third landing on B Wing towards the shower recess.

Prisoner A entered the recess at 8.33.24am, followed by Mr Harrison a second later. At 8.33.54am, Prisoner A left the recess. There is no CCTV coverage of the actual shower recess for dignity purposes.

55. Another prisoner was in the shower recess during the time Mr Harrison was injured. He told police that he heard someone ask Mr Harrison why he was banging the night before and saw a black male, whose name he did not know, had hold of Mr Harrison's clothing. He then heard a noise which sounded like a punch or fall. This prisoner said he did not leave the shower cubicle or intervene as he was fearful of getting involved in prison disputes. When he left the shower, he saw a white male prisoner, whose name he did not know, trying to assist Mr Harrison. The prisoner who was in the shower said he left it a few minutes before informing staff Mr Harrison had been punched, so as not to raise attention that he had informed on another prisoner. An officer, who was on the landing below, said in her police statement that this prisoner told her someone had been punched in the shower, but did not name him.
56. The two prisoners who Mr Harrison had asked about obtaining PS walked past the showers and saw Mr Harrison on the floor. One prisoner refused to give any information and declined to make a statement for the police. The other prisoner said he initially thought Mr Harrison had fallen and banged his head, which was next to a small step near the shower. He said that Mr Harrison looked in a bad way, that he had blood in his nose and mouth and appeared to be having a seizure. He thought Mr Harrison may have been under the influence of PS. He said he tried to put Mr Harrison into the recovery position and hoped that Mr Harrison would regain consciousness (as he did not want him to get into trouble with prison staff), but after a few minutes became worried that he was not improving so went and informed prison staff.
57. At 8.41am, Officer A and Officer B were on the third landing supervising prisoners. They were approached by two prisoners, who told them there was someone in the showers who needed assistance and was bleeding. Both officers said the prisoners who spoke to them did not do so with a sense of urgency and were quite calm. They followed them into the shower recess and saw Mr Harrison lying on his back on the floor, conscious and breathing, but groaning and not making any sense. Both prisoners were trying to reassure Mr Harrison and put him in the recovery position.
58. Officer B said this is often how prisoners present when under the influence of PS, and he thought that Mr Harrison was under the influence and used his radio to request healthcare assistance from the response nurse (radio call sign Hotel 1) for a PS incident. Officer B said he commented to the prisoners gathered outside the recess about the effects of PS, when one prisoner (unknown) said Mr Harrison had been 'given a good hiding'. Officer B said prior to this he had assumed that Mr Harrison had fallen and hit his head due to the effects of PS.
59. Officer C saw Officer B at the recess area, and that prisoners had started to gather outside, so went to investigate. He told the prisoners to move away and saw Mr Harrison lying on the floor. Officer C was joined by a senior officer (SO) and they tried to keep Mr Harrison calm and placed him in the recovery position. Officer C described Mr Harrison as 'murmuring' and said when he was placed in

the recovery position Mr Harrison vomited dark coloured blood several times. Officer C said in his police statement that he noticed a large bump on the back of Mr Harrison's head, that his pupils were dilated, that he was sweating and that there was a clear fluid 'with a hint of red leaking out of Sam's ear'. They removed Mr Harrison's jacket and placed it under his head. Officer B instructed other prisoners to move away from the recess.

60. A healthcare support worker (radio call sign Hotel 5) acknowledged the request for healthcare assistance as she was close to B Wing. She found Mr Harrison breathing but unable to respond coherently. She noticed there were blood splatters on both walls about a metre high, and that Mr Harrison had blood coming from his left ear and nose, and realised it was a serious head injury and not necessarily just as a result of using PS. She asked for an emergency ambulance to be called and for the assistance of the response nurse.
61. The response nurse (Hotel 1) said that the healthcare support worker responding to the initial request allowed him to secure the medications he was in the middle of dispensing. He said that when he arrived at the shower recess, although the signs were similar to a PS incident, he also noticed fluid coming from Mr Harrison's nose and ear and that there were blood splatters on the wall and blood on Mr Harrison's clothing. Mr Harrison had a bump to the back of his head about 7cm long. The nurse said that it was difficult to take Mr Harrison's observations, as he was agitated, but his oxygen saturation level and breathing were normal, but his heart rate was on the low side (48bpm). The symptoms were not typical of a PS incident which usually resulted in a rapid pulse. The healthcare support worker removed Mr Harrison's T-shirt to check for any other injuries, but saw none.
62. Lincolnshire Ambulance Service records show an ambulance was requested at 8.44am. Paramedics arrived at the prison gate at 8.48am and were with Mr Harrison at 8.50am. Paramedics said Mr Harrison had dilated pupils (which can be a sign of illicit drug use) a slightly increased respiratory rate, had blood in his ear and nose and a swelling to the back of his head. He had a slow pulse. Although he was semi-conscious, Mr Harrison was not responding and was very agitated. At 9.14am, paramedics administered naloxone (used to reverse the effects of opioid drugs) but it had no effect. Mr Harrison left Lincoln at 9.36am and he was taken to Lincoln County Hospital. Restraints were applied, but removed in the hospital at 10.10am and were never reapplied.
63. A custodial manager (CM), the operational manager, asked Officer C to place the clothes removed from Mr Harrison into evidence bags, which he did.
64. Prisoners who were employed on the wing as cleaners, were asked by wing staff to clean the shower area. One of the prisoners who mopped the shower said there was blood on the wall and floor. The CM told police that he was only in charge of the incident for around an hour and as he believed that Mr Harrison's injury was sustained as a result of a PS attack, he did not treat the shower recess as a crime scene. The duty governor said that information about a possible assault only started to become apparent as the morning progressed, but after the scene had already been cleaned.

65. CCTV shows that there were no prisoners on the third landing of B Wing between 9.00am and 9.32am, as staff had cleared it. At 10.05am, Prisoner A and several other prisoners were associating on the ground floor of B Wing. At 10.08am, Prisoner A left his cell on the ground floor landing with a bag, thought to be his gym kit, and he spent several minutes talking to a prisoner who was cleaning before walking away at 10.10am, still carrying the bag. At 10.12am, Prisoner A went up the stairs to the third landing, walked past the shower recess before arriving at the gates at the far end of the landing, where there were two other prisoners. An officer (unknown) unlocked the gate and allowed all three prisoners to leave the wing at 10.13am. At 10.30am, Prisoner A walked back through the gate at the far end of the wing, past the shower recess and walked down the stairs to the ground floor, but out of view of the camera.
66. CCTV shows at 11.13am, Prisoner A spent a few minutes talking to several prisoners on the ground floor, before he went to two different cells near the stairwell at 11.22am. At 11.41am, several dozen prisoners moved through the area, having returned from work or education. Prisoner A went back up to the third landing at 11.46am. He used the telephone at the end of the landing between 11.48 and 11.53am. There was nothing in this telephone call about the incident with Mr Harrison. Prisoners were locked up between 12.30 and 2.00pm.
67. At around 12.45pm, Mr Harrison was transferred to Queens Medical Centre. He was not restrained and two officers followed behind the ambulance in a taxi. Mr Harrison underwent surgery to reduce the pressure in his brain, caused by a blood clot, and was placed in an induced coma.
68. Lincoln identified that Prisoner A had been in the recess with Mr Harrison just before he was discovered, and that prisoners had also given Prisoner A's name to staff as being involved in the incident. The PEI was asked to take Prisoner A to the segregation unit as they had a good rapport. CCTV shows that the PEI and other officers arrived at Prisoner A's cell at 4.57pm. The PEI said Prisoner A did not question the decision to move, packed his belongings and calmly walked to the segregation unit with him, unrestrained, escorted by a CM at 5.11pm. Prisoner A's clothes were taken and bagged for the police.

Events after 11 September

69. On 12 September, police attended Lincoln and arrested Prisoner A at 12.05pm, for grievous bodily harm with intent. Staff passed Mr Harrison's and Prisoner A's clothes to Lincoln Police. Prisoner A was moved to HMP Nottingham on 20 September.
70. Mr Harrison had a further operation on 24 September. He never regained consciousness and on 25 September at 5.00pm, a hospital doctor pronounced his death.
71. At 6.30pm, Lincoln contacted the duty governor at HMP Nottingham and informed him that Mr Harrison had died. The duty governor made the decision to inform Prisoner A about ten minutes later. He described Prisoner A as shocked when he was first informed, but then he was described as calm. He said Prisoner A commented 'that's what happens when you get involved in drugs'.

Information obtained after Mr Harrison was injured

72. The telephone calls made by Mr Harrison in the weeks before he was injured show that he was either in debt or laundering money and he had paid sums of money to various people. The police were unable to link any debts between Mr Harrison and Prisoner A.
73. Prisoners on B Wing said they had heard differing accounts of what had happened. Some thought Mr Harrison had been assaulted because he was wrongly believed to have been the prisoner banging and keeping prisoners awake during the night before. Others thought that Prisoner A had assaulted Mr Harrison because of his drug debts, or been paid to assault him because of these debts.

Acquittal of Prisoner A

74. During his police interview on 12 September, Prisoner A said he had spoken to Mr Harrison about his drug use, in an effort to help, and spoke to him in the shower recess out of the way of other prisoners. Prisoner A said he was going to retrieve a gym slip from Mr Harrison, as the gym session was no longer available. Prisoner A said he did not ask Mr Harrison about banging (the noise the previous night), but told him he was 'bang out of order' for putting his name down for the gym then using drugs. Prisoner A said Mr Harrison was wobbling, then fell to the floor. Prisoner A said there were other prisoners around who went to assist Mr Harrison and he left the recess.
75. On 24 May 2018, Prisoner A was charged with Mr Harrison's manslaughter. During the trial Prisoner A admitted for the first time that he had punched Mr Harrison, once, in self-defence. The jury accepted his account and on 14 December 2018, he was found not guilty.

Post-mortem report

76. The post-mortem report concluded that Mr Harrison died following complications of a traumatic head injury. The injury was consistent with his head striking a hard floor surface. The pathologist noted bruising around Mr Harrison's eye socket, but was unable to determine if this was caused as the result of a punch, or as a result of the injury caused to the back of his head. It is unknown whether Mr Harrison had taken any illicit substances before sustaining his injuries because he had been treated in hospital for 14 days before he died, so blood samples were not available for analysis.

Contact with Mr Harrison's family

77. The prison appointed an officer as the family liaison officer (FLO) and a CM as his deputy as soon as the hospital confirmed that Mr Harrison had sustained a serious head injury. The FLO met Mr Harrison's family at the hospital and explained what had happened. He and his deputy provided Mr Harrison's family with ongoing support. The Governor and the prison chaplain also visited the family. Lincoln provided financial assistance to Mr Harrison's mother for her travel, accommodation and expenses during the time Mr Harrison was in hospital. Mr Harrison's funeral was held on 4 December 2017, and the prison contributed towards the cost in line with national policy.

Support for prisoners and staff

78. The prison posted notices informing other prisoners of Mr Harrison's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Harrison's death.
79. Although we were told that staff involved in the incident on 11 September and the bed watch staff present when Mr Harrison died on 25 September, attended a debrief and were offered support, we were not provided with any evidence.

Findings

Mr Harrison's safety

80. We do not know for certain what happened on the morning of 11 September 2017. Prisoner A said during his trial that he punched Mr Harrison, once, in self-defence, and this was accepted by the jury. We do not know what prompted Prisoner A to act in self-defence and we do not know if Mr Harrison had used illicit substances that morning as it was not possible to test his blood.
81. There was no security intelligence to link Mr Harrison and Prisoner A. We consider that the prison had no reason to have predicted this incident, or to have kept them apart.

Emergency Response

82. The prisoners who discovered Mr Harrison believed that he was under the influence of an illicit substance. They attempted to keep him safe, while the effects of the drugs wore off, so that that he did not get into trouble. However, when they realised his condition was not improving, they informed staff around seven minutes later.
83. Prison Service Instruction (PSI) 3/2013, *Medical Emergency Response*, requires prisons to have a medical emergency response code protocol, which contains mandatory instructions for governors and directors to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance.
84. Officer B did not radio a medical emergency as he believed Mr Harrison showed typical symptoms of being under the influence of PS. He did ask for immediate healthcare assistance, which arrived promptly. When healthcare staff assessed Mr Harrison they quickly recognised that he potentially had a serious head injury and an ambulance was requested. Paramedics were with Mr Harrison within six minutes. We are satisfied that, once prison staff had been alerted that Mr Harrison needed assistance, he received quick and appropriate medical attention.

Restraints, security and escorts

85. A nurse completed the medical section of Mr Harrison's escort risk assessment for his hospital transfer on 11 September. He recorded that Mr Harrison's physical capacity was severely compromised by his injury.
86. An OSG in security completed the escort risk assessment and noted that restraints should be used (a single cuff), but removed for an emergency with the authority of the duty governor, and that two officers were required to escort Mr Harrison. A CM endorsed this risk assessment and the deputy governor authorised that restraints should be applied.
87. The person escort record (PER), a document that accompanies all prisoners when they move between police stations, courts, hospitals and prisons, has been endorsed that hand cuffs were applied to Mr Harrison at 9.20am. At 10.05am,

after Mr Harrison had arrived at hospital, an escort contacted the duty governor to request permission to remove restraints as Mr Harrison was going to receive medical treatment. Permission was granted and restraints were removed at 10.10am. They were never reapplied.

88. Although there was medical input to the escort risk assessment, we saw little evidence that the authorising manager took this into account when making the decision to apply restraints to Mr Harrison. The Governor said that while it was evident Mr Harrison had a head injury, the significance and seriousness of the injury was not known until he had been assessed in hospital, and that there was still a suspicion that he may have been using PS. The Governor said that prisoners who take PS can often become violent or aggressive when the effects wear off, which can sometimes be very quickly, and there was a duty by the prison to protect staff and the general public. The Governor said he was satisfied that the decision to remove restraints was made at the earliest opportunity.
89. We accept that there is a need to balance decency against security issues. We consider that it was reasonable to apply restraints until Mr Harrison's medical condition had been fully assessed, given there were valid reasons to suspect he may also have been under the influence of PS. However, there is also a requirement to demonstrate that medical information has been fully considered alongside security information and that decisions regarding the application of restraints are fully justified and documented. We make the following recommendation:

The Governor should revise the prison's escort risk assessment form so that it requires prison staff to show that they have taken a prisoner's current state of health, and its impact on their mobility, into account when assessing the prisoner's level of risk.

Management of the incident and preserving evidence

90. PSI 09/2014, *Incident Management* [applicable at the time], says that prisons should have contingency plans in place to ensure serious incidents are resolved with the minimum of harm to staff, prisoners and the public, and that evidence is preserved.
91. In our Learning Lessons Bulletin on homicides published in September 2016, we said that prison staff should also ensure that they safely secure all other prisoners who they believe might have been involved in the incident. Such prisoners may be suspects or witnesses, and it may be detrimental to the police investigation if they can discuss their version of events with others. As well as securing any prisoners potentially involved with the incident, it is important that staff also ensure that any physical evidence is not tampered with. Appropriate and prudent action by prison staff in the aftermath of a serious incident can contribute towards the delivery of justice when a criminal offence has occurred. However, when errors are made immediately after a serious incident, it is possible that the police investigation and any prosecution can be compromised.
92. Officer B completed an incident report at 10.07am, which recorded Mr Harrison had allegedly been assaulted. Although prison staff were told by prisoners soon after Mr Harrison had been discovered that he may have been assaulted, they do

not appear to have passed this information to the CM at the scene or the CM in the security department. The CM at the scene did not treat the shower recess as a possible crime scene, and the area was cleaned by prisoners. Important evidence could therefore have been lost. The Governor said that although several prisoners had suggested that Mr Harrison had been assaulted, information was vague and their focus was on ensuring Mr Harrison got to hospital.

93. The prison notified Lincolnshire Police of a possible assault at around 11.20am. Prisoner A remained on B Wing, freely moving around when prisoners were unlocked, for over eight hours after the incident, until he was moved to the segregation unit at 5.11pm.
94. We accept that Lincoln prioritised ensuring Mr Harrison went to hospital as soon as possible. However, as soon as staff identified that an assault may have taken place, and until they could learn more about the incident and inform the police, we consider that the scene should have been preserved immediately as a potential crime scene. We therefore make the following recommendation:

The Governor should ensure that after a serious incident, all evidence is preserved, witnesses and suspects identified and separated and all information requested by the police disclosed as a matter of urgency.

Violence reduction measures

95. All prisons should have a coordinated approach to identifying indicators and risks of bullying and violent behaviour, including the impact of PS and associated debt. All allegations of violence, bullying, or intimidation should be taken seriously and investigated appropriately. Suspected perpetrators should be monitored and challenged through effective interventions and potential victims supported as part of a robust violence reduction strategy.
96. Mr Harrison was apparently in debt to other prisoners, due to his use of PS. Drug-related debts can make prisoners vulnerable to bullying, intimidation and violence. Mr Harrison told an officer on 12 August that he was being bullied for his canteen (his order from the prison shop). The officer recorded that she had informed the wing SO, but could not remember who. None of the SOs on B Wing recalled being given this information and we found no evidence that these allegations were ever investigated.
97. We cannot say that Mr Harrison's involvement with drugs or any associated debts were linked to him sustaining his injury. However, he did tell an officer that he was being bullied and in these circumstances, Mr Harrison's vulnerability should have been recognised and managed in line with Lincoln's Violence Reduction measures. We accept that if there is no actual evidence of bullying and prisoners were unwilling to discuss or give specific details, it is very difficult to have an effective support plan to manage either the alleged victim or perpetrator. However, despite Mr Harrison telling staff he was being bullied in August for his canteen, there is no evidence anything was done to investigate the circumstances and staff at Lincoln did not follow their own violence reduction policy. We therefore make the following recommendation:

The Governor should ensure that any reported incidents of bullying or violence are recorded and investigated in line with Lincoln's policy and, if appropriate, violence reduction measures are started.

Drug strategy

98. Lincoln has a drug strategy which sets out their commitment to reducing and eradicating the supply of illegal substances and how they will support prisoners to address their substance misuse issues.
99. Prisoners can be drug tested if there is a suspicion that they may have used drugs and staff have three days to complete the test following the submission of an intelligence report. Mr Harrison was reportedly under the influence of drugs on several occasions during education classes in August 2017, and on another occasion fighting with his cellmate when under the influence. However, despite this information being submitted in intelligence reports and Mr Harrison being placed on report, suspicion drug tests were not completed. It was evident from interviews that staff, at the time, did not routinely ask for a suspicion drug test when someone was suspected of being under the influence.
100. The Governor said that at the time, Lincoln had poorer staffing levels and fewer staff trained to carry out drug tests. He said there is now a new Drug Strategy that is less risk based and more suspicion tests are completed. He said Lincoln had been introducing a supportive process via the IEP scheme, based on principles of rehabilitation, rather than punishment and staff had undertaken training and were encouraged to refer prisoners to Addaction (substance misuse services). All managers had undertaken the Rehabilitative Adjudication training and were applying this to prisoners placed on report.
101. The Governor said Lincoln has also purchased a refurbished rapid scanner (to detect drugs) which had reduced the amount of PS entering the prison 'massively' and transformed the prison. He said there were now significantly fewer incidents of PS use.
102. While we accept that since Mr Harrison's death there have been some significant changes at Lincoln, we found that many staff did not routinely refer for a suspicion drug test. We therefore make the following recommendation:

The Governor should ensure that all prisoners suspected of taking drugs are tested within required timescales.

**Prisons &
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