

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ean Smith a prisoner at HMP Lincoln on 10 November 2018

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 Ean Smith was found hanged in the showers at HMP Lincoln on 10 November 2018. He was 61 years old. I offer my condolences to Mr Smith's family and friends.

Throughout his time at Lincoln, Mr Smith was anxious about his relationship with his wife and told staff that he would end his life if she left him. On 10 November 2018, he realised that his relationship with his wife was over and made two telephone calls to her saying he could not go on without her. Mr Smith's wife telephoned the prison to say she was concerned about her husband, but by the time prison staff found him, he was dead.

The investigation found that up until the time of the telephone call from his wife, prison staff would not have known that Mr Smith was at imminent risk of suicide. However, their response to his wife's telephone call was inadequate and they should have found him much more quickly than they did. I am unable to say whether the delay affected the outcome.

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

July 2019

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Summary

Events

1. On 6 December 2016, Mr Ean Smith was remanded in custody, charged with sexual offences, and sent to HMP Lincoln. He was later sentenced to four years and three months in prison and was due to be released in January 2019.
2. Throughout his time at Lincoln, Mr Smith told staff that he worried about whether his relationship with his wife would survive and that if she ever left him, he would end his life. On three occasions, staff monitored Mr Smith under suicide and self-harm prevention procedures (known as ACCT). The last period of ACCT monitoring ended on 31 August 2017.
3. Mr Smith had depression and met with a prison therapist frequently. She noted that his mood was very closely linked to the amount of contact he had received from his wife and how anxious he was about the state of their relationship. Mr Smith met his therapist on 7 November, and then she saw him again on the wing on 9 November. Both times, she assessed that he was not at risk of harming himself.
4. On the morning of 10 November, Mr Smith received an email from his wife saying she was no longer in love with him. He made two telephone calls to her that afternoon saying he was sorry for everything and that he would be dead soon.
5. At around 3.00pm, Mr Smith's wife telephoned the prison and said she felt that her husband had just made a 'goodbye' call. A supervising officer (SO) on Mr Smith's wing went to Mr Smith's cell to try to find him but it was empty. When he shouted Mr Smith's name, someone said he had gone to the gym.
6. At around 4.00pm, an officer went to find Mr Smith as he was due to start his job as a healthcare orderly. Mr Smith's cellmate told him he had last seen Mr Smith around 2.45pm, walking towards the showers. When the officer and Mr Smith's cellmate got there, they found Mr Smith hanging. Healthcare staff attended and carried out cardiopulmonary resuscitation (CPR) until ambulance paramedics arrived. They pronounced Mr Smith's death at 4.46pm.

Findings

7. Before Mr Smith's wife telephoned the prison, staff would not have been aware that Mr Smith was at imminent risk of suicide. However, we consider that the response to the telephone call was inadequate. The SO should have made greater efforts to locate Mr Smith after he found his cell empty and should not have accepted that Mr Smith was at the gym without checking.
8. It is likely that Mr Smith took his life shortly after his cellmate saw him heading to the showers at 2.45pm and that the delay in finding him made no difference, but we cannot say for sure.
9. The officer who found Mr Smith hanging did not call a medical emergency code, which resulted in a short delay in the emergency response. The delay did not

affect the outcome as it appears Mr Smith was dead when found, but it is important that staff follow the agreed medical emergency procedures.

Recommendations

- The Governor should ensure that when staff are alerted to serious concerns about a prisoner's welfare, they ensure the prisoner is located and spoken to as soon as possible.
- The Governor should ensure that all prison staff are made aware of and understand the need to use appropriate codes to communicate a medical emergency, in line with national and local instructions, and that control room staff call an ambulance immediately when a medical emergency code is called.

The Investigation Process

10. 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.
11. The investigator visited Lincoln on 15 November 2018. She obtained copies of relevant extracts from Mr Smith's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison. The clinical reviewer attended joint interviews with the investigator at Lincoln on 11 December. The investigator also interviewed four members of staff by telephone on 15 January 2019.
13. We informed HM Coroner for Central Lincolnshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Smith's wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised no issues.
15. We shared our initial report with the Prison Service. They found no factual inaccuracies, and their action plan is annexed to this report.
16. We provided a copy of our initial report to Mr Smith's wife. She did not point out any specific factual inaccuracies in the report but told us that she had been undecided about whether to leave her husband.

Background Information

HMP Lincoln

17. HMP Lincoln houses up to 729 remanded and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, including a Vulnerable Prisoners Unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Lincoln was in January and February 2017. Inspectors reported that vulnerable prisoners received good care, although the prison's application of ACCT procedures was disappointing. Inspectors said that there had been four self-inflicted deaths since their last inspection but no plan to monitor the implementation of key PPO recommendations. They said that ACCT paperwork was reasonably good, but too many were inadequate. Prisoners at risk of suicide and self-harm said they received very good support from staff. The inspectors found that prisoners and staff had a good relationship, which was a real strength.

Independent Monitoring Board

19. 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 said that efforts continued to be made to improve the ACCT process and the time prisoners spent out of their cells had improved considerably. The Board noted there were a high number of prisoners with mental health problems who appeared to be well managed by the mental health team, but there was no one available from the mental health team at night or weekends. It also noted that despite a business case having been made, there was still no CCTV on E Wing.

Previous deaths at HMP Lincoln

20. Mr Smith was the eighth prisoner to die at Lincoln since November 2016. Of the previous deaths, one was self-inflicted, one was drug-related, four were from natural causes and one was a homicide. There have been no deaths since. There are no similarities between Mr Smith's death and the previous deaths at Lincoln.

Assessment, Care in Custody and Teamwork

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of an ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held. As part of the process a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be

closed until all the actions of the caremap have been completed. 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

22. On 6 December 2016, Mr Ean Smith was remanded in custody, charged with sexual offences against family members, and sent to HMP Lincoln.
23. A nurse conducted his reception health screen. He told her he had fractured his shoulder two days earlier, when he fell from a tree trying to hang himself. He said he had a history of depression and had been a heavy drinker. The nurse started suicide and self-harm prevention procedures (known as ACCT) and referred Mr Smith to the mental health team and to the fracture clinic. Mr Smith declined a referral to the prison's substance misuse service.
24. Mr Smith attended court on 3 January 2017, and pleaded guilty to all the charges against him. On 1 February, he was sentenced to four years and three months in prison. He told staff he had expected a longer sentence. (He was due for release in January 2019.)
25. Staff managed Mr Smith under ACCT procedures until 10 February. He said he had support from his wife and daughter and they gave him a reason to live. Staff decided that his risk had reduced and stopped ACCT monitoring.
26. A mental health nurse, assessed Mr Smith on 15 February. Mr Smith said his suicidal thoughts had lessened and he had no current plans, but was not sure he would ever stop thinking about suicide completely. She met Mr Smith on 9 March, in the first of 14 sessions of Inter-personal Therapy (IPT, which focuses on the way relationships affect people and can be used to help anxiety and depression). Mr Smith said he did not think there would ever be a time when he did not think about ending his life and said if his wife decided to leave him it would increase his risk. She continued to see Mr Smith until 24 July 2017, when she left the prison. During the IPT sessions they discussed how Mr Smith continued to think about suicide and self-harm but had no current plans, and that he was fearful his wife would leave him and that she was the reason he was alive.
27. On 20 June, staff started ACCT procedures after Mr Smith lost his temper, banged his head against a metal post and said he felt like killing himself.
28. On 22 June, Mr Smith's wife telephoned the prison because Mr Smith had told her he felt like killing himself. Staff held an ACCT review. Mr Smith told staff his medication was not working effectively. He saw a prison GP that afternoon, who increased his antidepressant medication. Staff stopped ACCT monitoring on 26 June as Mr Smith said he was now on the correct medication.
29. On 22 August, staff started ACCT procedures after Mr Smith's wife telephoned the prison, concerned that Mr Smith had been saying "goodbye" to her in a telephone call earlier that day. Mr Smith told staff he was frustrated that his complaints were not being answered and staff were not listening to him. Staff stopped ACCT monitoring on 31 August, as Mr Smith said he was less frustrated as things had moved forward.
30. On 29 November, Mr Smith began Cognitive Behavioural Therapy (CBT - recommended for anxiety and depression) with a therapist and member of the mental health team. They met a further three times up to 20 March 2018.

31. On 10 May, Mr Smith met with a nurse as part of the Veteran Care Through Custody (VCTC) scheme (Mr Smith was ex-RAF). Mr Smith told her he had been feeling low, but felt he did not need to be referred to the mental health team at that time and he was aware of the support the VCTC could offer him.
32. The therapist met with Mr Smith on 30 May. He told her that his mood was low because of the 'prison routine'. He said his wife was visiting him and that she continued to support him.
33. An officer met with Mr Smith on 1 June, and explained he was his key worker. They discussed Mr Smith's housing and employment situation on release. Mr Smith said he might have accommodation issues as he was selling his house, and was waiting for probation to let him know which areas he could live in. Mr Smith said he had a good relationship with his family and no financial problems as he received an RAF pension.
34. The therapist met with Mr Smith on 21 June. She noted that he presented well and that he now had a job as a healthcare orderly which had helped him maintain a more positive outlook.
35. The therapist met with Mr Smith on 9 August. She noted that he presented well but was worried about his relationship with his wife and that when they discussed this, he was scratching his scalp in the same place, suggesting some emotional discomfort. When they met again on 31 August, she noted that he was slightly unkempt and he reported ongoing difficulties with his relationship, which was affecting his day to day activities and self-care. She noted that Mr Smith posed no risk to himself or others.
36. The therapist met with Mr Smith on 19 September, for a mental health assessment. She noted that Mr Smith, who was normally clean shaven, presented with a full beard and he said it was due to a reduction in visits from his wife. He said he felt like ending his life on release if there was no chance of re-establishing his relationship with his wife. He said he remained hopeful that the relationship would continue and put his wife's reduced contact down to being busy with her children during the school holidays. He said he did not want to be monitored under ACCT. She noted that Mr Smith had 17 weeks left of his sentence and that his anxiety was centred around his release and his relationship with his wife. They agreed to meet weekly.
37. On 24 September, the therapist discussed Mr Smith in a team meeting as she was concerned that his risk of suicide and self-harm might have increased due to the reduced contact from his wife. It was agreed that she would liaise with the Offender Management Unit (OMU) about preparing Mr Smith for his release.
38. The therapist met with Mr Smith on 3 October, and noted that his mood was still very much influenced by his wife's lack of contact. Mr Smith said he had spoken to somebody from probation about his release and that his daughter had visited the day before. He told her that he had no plans or intent to harm himself. She told Mr Smith she would tell his offender manager about his contact with the mental health team, to which Mr Smith agreed.

39. During their meeting on 17 October, the therapist assessed Mr Smith's level of depression as high and his anxiety level as high. However, he said he had no thoughts of suicide or self-harm at that time. Mr Smith shared emails from his wife, and they discussed how she might be feeling and how his current emotional outlook might be influencing how he was interpreting the emails. She encouraged Mr Smith to source estate agents so he could look for somewhere to live on release.
40. During a meeting on 24 October, Mr Smith told the therapist that his medication had been adjusted and he felt "a bit funny but not suicidal". Mr Smith said he had been in touch with estate agents and was waiting to hear back from them. She noted that Mr Smith still had thoughts of suicide but no current plans.
41. The therapist met with Mr Smith again on 31 October. She noted that his mood had deteriorated and he had become unkempt due to the reduced contact from his wife. Mr Smith told her his sleep was poor due to worries about his future and he was uncertain about his relationship with his wife. She asked him if he was about to kill himself and he said, "not at the moment". He said he was having a telephone call with his wife that evening. He also said he had put his name down for a prison workshop about work and housing on release.
42. In an email to Mr Smith dated 5 November, his wife said she loved him and always would but could not see a way forward for them and suggested that on his release, he could perhaps move away and start afresh. Mr Smith replied the next day and said he did not want to start afresh without her and asked if she was still 'in love' with him.
43. On 7 November, the therapist met with Mr Smith. He showed her an email from his wife. (The therapist did not record the date of the email, but it appears to have been the one dated 5 November.) She noted that they discussed how relationships evolve and that Mr Smith's wife had said she still loved him. She recorded, '[Mr Smith] is continuing to focus on the possible negative outcome of their relationship upon his relief [sic]', and 'has little hope regarding his future without his wife should that be the case'. She noted that he did not have any current plans or intent to harm or kill himself. She told Mr Smith that she would be on leave the following week but would see him on her return and that he should contact the mental health team in her absence should the need arise.
44. Mr Smith rang his wife at 5.56pm on 8 November. He told her that he was refusing to eat because of a bad smell from the cell next door, that he had not received any mail and was waiting for a visit from her.
45. The therapist saw Mr Smith on the wing on 9 November. She noticed a strong smell of faeces from a nearby cell. Mr Smith said he had told officers that he would go on hunger strike if they did not move the prisoner next door who was causing the smell. She noted subsequently that the situation had been resolved, as the other prisoner had been moved. She also noted that Mr Smith posed no risk to himself or others at that time. Mr Smith later spoke to his wife on the telephone and said that he was eating again.
46. Mr Smith called his wife at 5.02pm, the next day, 9 November. Mr Smith was frustrated at the lack of association on the wing that day. Mr Smith asked if she

had received any emails. His wife said she had and would respond later. An email from Mr Smith's wife sent at 10.07pm that evening, said that she was no longer 'in love' with him but would always love him, yet could not understand how he could have committed his offences. (Emails are printed off by prison staff and then placed in the internal mail so it is likely Mr Smith received this email on the morning of 10 November.)

Events of 10 November 2018

47. On 10 November, Mr Smith arrived at the healthcare hatch at 8.00am, to carry out his duties as the healthcare orderly. This involved calling up prisoners to collect their medication. A senior paramedic employed by the prison, and healthcare assistant told the investigator that Mr Smith had seemed in a good mood that morning and they had chatted normally.
48. Mr Smith telephoned his wife at 2.05pm on 10 November. He told her he had received her email and was "sorry for everything". Mr Smith said he could not handle not being close to his wife and wanted a relationship, and told her to "go ahead disseminating the money". His wife said "no, because you're not going to do anything" and Mr Smith replied that he would not need the money and that there was no future for them, and that he could not carry on.
49. Mr Smith telephoned his wife again at 2.23pm. He said that everything had been his fault, that it had taken him longer to realise (about their relationship) and that he could not go on without her. Mr Smith said that she did not want his shadow hanging over her and that he had messed things up. He asked that she apologised to everyone for him and that he would be dead soon. His wife said he should not think that way and Mr Smith said, "yes, I will be, this is what this is all about, in case you hadn't noticed. As much as I don't want to, I have to for your sake. You need to move on." Mr Smith finished the call by saying he loved her. Mr Smith's cellmate saw him at approximately 2.45pm, heading towards the showers with a rolled-up towel.
50. Mr Smith's wife telephoned the prison at 3.00pm, and told the switchboard operator about her concerns for her husband after their telephone call. The switchboard operator spoke to, an operational support grade (OSG) in the control room, and said that Mr Smith's wife was concerned as she felt that Mr Smith had just made a 'goodbye' telephone call. The OSG told the switchboard operator she would speak to somebody on E Wing and that Mr Smith's wife should call back in half an hour. The OSG then spoke to a Supervising Officer (SO) who was in the E Wing office.
51. The SO told the investigator that the OSG had telephoned him at around 3.10pm to say that Mr Smith's wife was concerned about her husband. The SO said that the OSG only mentioned concerns and did not mention that Mr Smith's wife thought her husband might take his life. He went to Mr Smith's cell, but it was empty so he walked around the wing shouting out Mr Smith's name. A prisoner shouted back that he had gone to the gym. The SO did not know whether Mr Smith was a gym member or not, so returned to his office and rang the gym to check he was there, but the line was engaged. The SO became distracted as there were several prisoners waiting to speak to him and issues to deal with, so he did not call the gym again.

52. The SO telephoned the OSG to say that he had been unable to speak to Mr Smith, as he thought he was at the gym. At approximately 3.40pm, the switchboard operator called E Wing for an update and another OSG said Mr Smith was in the gym.
53. An officer went to Mr Smith's cell on E Wing at around 4.00pm, to ask him to start work at the medication hatch. Mr Smith was not there, so the officer assumed he was already at work.
54. At around 4.10pm, the officer asked Mr Smith's cellmate, if he knew where Mr Smith was. He said that he had last seen him walking towards the shower area at around 2.45pm. They walked to the showers, where the officer saw Mr Smith's arm and the back of his head. The officer said, "hurry up Smithy, you've got a job to do", but received no response. The officer walked further into the shower and saw Mr Smith hanging by a ligature made from a green bedsheet. Mr Smith was fully clothed, his eyes appeared sunken, his tongue and lips looked blue and he felt cold. The officer shouted out for staff assistance and used his anti-ligature knife to cut Mr Smith down. He felt for a pulse but could not find one.
55. A custodial manager (CM) heard the officer's shout for help, and went to the shower area where he helped him lower Mr Smith to the floor. He said Mr Smith felt cold, was not breathing and his eyes were open.
56. A senior paramedic was on the floor above giving out medications with a healthcare assistant (HCA). They had started at 4.00pm and had noticed that Mr Smith was not there, which was unusual. The senior paramedic said he heard shouting at around 4.15pm and the HCA said he heard a call for staff assistance so he pressed the general alarm bell. They immediately ran down to where they had heard the shouting. Neither knew what they were responding to, so had not picked up their emergency equipment. The CM had tried to radio a code blue emergency call, but had been unable to because of the general alarm. As the senior paramedic and HCA approached the shower area, they heard somebody say it was a code blue, so the senior paramedic ran into the shower area while the HCA went to get the medical emergency equipment. The CM made the emergency call at 4.18pm, and an ambulance was called at 4.21pm.
57. The senior paramedic saw Mr Smith lying on the floor of the shower area with a ligature, made from a green bedsheet, around his neck. He removed the ligature from Mr Smith's neck and started cardiopulmonary resuscitation (CPR). The HCA returned with an emergency bag, containing oxygen and a defibrillator. They continued CPR and attached the defibrillator. The defibrillator advised there was no shockable rhythm and to continue CPR. The paramedics arrived at 4.24pm, and pronounced Mr Smith's death at 4.46pm.

Contact with Mr Smith's family

58. The prison's family liaison officer (FLO) and a chaplain visited Mr Smith's wife at 6.00pm on 11 November, to break the news of his death. The prison contributed to Mr Smith's funeral in line with national guidance.

Support for prisoners and staff

59. After Mr Smith's death, a CM debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
60. The prison posted notices informing other prisoners of Mr Smith's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Smith's death.

Post-mortem report

61. Mr Smith's post-mortem report concluded his cause of death was hanging. The toxicology examination found no evidence of illicit drug use.

Findings

Managing Mr Smith's risk of suicide and self-harm

62. Mr Smith was managed under ACCT procedures on three occasions at Lincoln: from when he first arrived on 6 December 2016 until 10 February 2017; from 20 to 26 June 2017; and from 22 to 31 August 2017. We consider that on each occasion, staff correctly identified that Mr Smith was at risk of suicide and self-harm and managed him appropriately under ACCT.
63. Throughout his time in prison, Mr Smith said that he thought about suicide. He also said repeatedly that he would end his life if his wife left him. He met frequently with a therapist and would often discuss his worries about his relationship with his wife. She noted that Mr Smith's anxiety centred around his relationship with his wife, as well as his release.
64. On 7 November 2018, three days before he died, Mr Smith met with the therapist and showed her an email from his wife. This appears to have been the email in which Mr Smith's wife said she could not see a way forward for them and that he should perhaps start afresh when he was released. On 10 November, Mr Smith received an email from his wife saying that she would always love him but was no longer 'in love' with him and could not understand how he could have committed his offences. Mr Smith made two telephone calls to his wife later that day saying he could not go on without her, that he was sorry and that he would be dead soon. Mr Smith's realisation that his wife no longer wanted to be in a relationship with him seems to have been the trigger for him to take his own life.
65. We have considered whether the therapist should have started ACCT procedures on 7 November. It is clear from her notes of her meetings with Mr Smith that his concerns about his relationship with his wife was an ongoing issue that they discussed frequently. When interviewed, the therapist accepted that Mr Smith's wife leaving him would have been a trigger for suicide but she did not consider that the emails she saw from Mr Smith's wife indicated that she was about to leave him. She assessed his risk of suicide and self-harm and was satisfied that he did not have any plans to harm himself at that time. The therapist saw Mr Smith again on 9 November, the day before he died, and assessed that he did not pose a risk to himself or others at that time. We consider it was not unreasonable for her to assess that Mr Smith was not at imminent risk of suicide when she saw him on 7 and 9 November.
66. Prison staff would have been unaware of the contents of the email that Mr Smith received from his wife on the morning of 10 November. They would also have been unaware of the contents of the telephone calls he made to his wife until his wife called the prison at around 3.00pm. We consider that prior to 3.00pm, prison staff would not have known that Mr Smith was at imminent risk of suicide.

Response to wife's telephone call on 10 November

67. In her telephone call to Lincoln at around 3.00pm on 10 November, Mr Smith's wife said she was concerned about her husband as she felt he had just given her a "goodbye call". The OSG in the control room passed this message to a SO on E Wing, who went to Mr Smith's cell but found it empty. When the SO shouted

out for Mr Smith, a prisoner said he had gone to the gym. The SO said he rang the gym but the line was engaged so he did not speak to anyone at the gym to establish whether Mr Smith was there.

68. Mr Smith's cellmate told the investigator that Mr Smith never went to the gym. He said that he saw Mr Smith heading to the showers with a rolled-up towel at about 2.45pm. He was discovered hanging there at around 4.15pm, after staff had gone to find him so he could start work at the medication hatch.
69. We are concerned that staff did not make more effort to find Mr Smith after the telephone call from his wife. It is unclear exactly what the OSG said to the SO when she called E Wing and whether she specifically said that Mr Smith's wife was concerned he would kill himself, but it is clear that the SO was told that Mr Smith's wife had concerns about his welfare. When the SO found Mr Smith's cell empty, he should have found out where he was, and not just assumed he was at the gym. This resulted in Mr Smith not being found until an hour later. Mr Smith was last seen alive, walking to the showers, at around 2.45pm.
70. It is possible that he was already dead by the time the OSG telephoned E Wing. However, we cannot say for sure and therefore cannot say whether the delay in finding Mr Smith affected the outcome.
71. We make the following recommendation:

The Governor should ensure that when staff are alerted to serious concerns about a prisoner's welfare, they ensure the prisoner is located and spoken to as soon as possible.

Mental health

72. The clinical reviewer noted that Mr Smith had regular support from the prison's mental health team and was prescribed appropriate medication for his depression. Mr Smith engaged in fortnightly IPT meetings with a mental health nurse and then monthly CBT with the therapist.
73. The clinical reviewer concluded that the support given to Mr Smith was in accordance with NICE guidance on treating depression and that, overall, his clinical care was equivalent to the care he could have expected to receive in the community.

Emergency response

74. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system. Lincoln's local policy instructs staff to call a medical emergency code blue when a prisoner is unconscious. The calling of a medical emergency code instructs the control room to call an ambulance immediately.
75. An officer told the investigator he knew he should have radioed a medical emergency code blue but 'froze' when he found Mr Smith. A CM called a code blue a few minutes later at 4.18pm, and control room staff called an ambulance at 4.21pm.

76. Control room staff said this delay was because they were obtaining more information about Mr Smith before calling the ambulance, but this is not in line with policy, which says an ambulance should be called immediately in response to a medical emergency code. It made no difference in this case because it appears Mr Smith was dead when found, but it is important that the correct medical emergency procedures are followed so that prisoners can receive life-saving treatment as quickly as possible. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand the need to use appropriate codes to communicate a medical emergency, in line with national and local instructions, and that control room staff call an ambulance immediately when a medical emergency code is called.

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