

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Craig Redman a prisoner at HMP Lincoln on 27 April 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.

The Ombudsman's 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 Craig Redman died in hospital on 27 April 2018 after being found hanging in his cell at HMP Lincoln. He was 31 years old. We offer our condolences to Mr Redman's family and friends.

Mr Redman had a significant history of illicit drug use and a history of anxiety and depression. He had been monitored under Prison Service suicide and self-harm monitoring procedures (known as ACCT) until a week before his death. Although the investigation found some deficiencies in the way the ACCT procedures were carried out, we are satisfied that it was appropriate for them to have ended when Mr Redman's mood improved. The post-mortem found that Mr Redman had used psychoactive substances immediately before his death and it is possible that this affected his mood and his behaviour before he hanged himself.

We are concerned at the apparently ready availability of illicit drugs at Lincoln and share the concerns of HM Inspectorate of Prisons and the Independent Monitoring Board about this issue.

There were also some deficiencies in the emergency response, although we do not consider that this affected the outcome for Mr Redman.

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

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**December 2018**

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# Summary

## Events

1. Mr Craig Redman had a significant history of illicit drug use. He also had a history of anxiety and depression but had not been prescribed any medication.
2. Mr Redman had been serving an indeterminate sentence for public protection since 11 November 2007. On 4 July 2016, he was convicted of escaping from lawful custody (absconding from HMP Prescoed, an open prison) and sentenced to six months, to be served concurrently with his indeterminate sentence.
3. On 9 October 2017, Mr Redman was released on licence from HMP Warren Hill. On 24 October, he was recalled into custody at HMP Lincoln for breaches of his licence conditions.
4. On 28 March 2018, Mr Redman self-harmed and staff immediately began monitoring him under Prison Service suicide and self-harm prevention procedures (known as ACCT). The ACCT was closed on 19 April when staff assessed that Mr Redman's mood had improved and that he was looking forward to what he expected would be a favourable parole hearing on 2 May.
5. On 27 April, at 5.13am, a member of staff found Mr Redman hanging in his cell. An ambulance was requested, staff began cardiopulmonary resuscitation and continued until paramedics arrived. Paramedics took over emergency treatment, but at 5.37am, pronounced Mr Redman dead.
6. The post-mortem toxicology tests found that Mr Redman had used psychoactive substances immediately before his death and the pathologist concluded that this may have affected Mr Redman's behaviour.

## Findings

### Management of risk of suicide and self-harm

7. We found that ACCT procedures at Lincoln were not conducted in line with mandatory national instructions as not all case reviews were multidisciplinary, and there were some inappropriate assessments of Mr Redman's risk of self-harm. However, we are satisfied that it was appropriate to close the ACCT on 19 April, and that Mr Redman gave staff no indication that he had further thoughts of suicide after that.

### Psychoactive Substances

8. Mr Redman abused illicit drugs, including psychoactive substances (PS) commonly known as "spice". There is no evidence to support Mr Redman's statement that he was bullied for drug debts. Toxicology results show that Mr Redman used PS immediately before his death, and it is possible that this have affected his mood and behaviour. We are concerned at the ready availability of illicit drugs at Lincoln and that Mr Redman was able to access illicit drugs while in prison.

## Clinical care

9. The clinical review concluded that overall the care provided to Mr Redman was equivalent to that which he could have expected to receive in the community.
10. However, the clinical review found there were issues with the recording of the input of the mental health services in medical records. The mental health crisis plan for Mr Redman was not recorded in the notes, nor was the handover between the outgoing therapist, with whom Mr Redman appeared to have developed a therapeutic relationship, and the senior mental health nurse. Despite the recorded agreement to provide ongoing support to Mr Redman, he was discharged from the mental health services within a month of that agreement without any follow up.
11. We are concerned that when, as in this case, substance misuse practitioners record a prisoner's medical notes on different case management systems, this means there is no single, comprehensive record of a prisoner's clinical history. As a result, there was no co-ordinated approach to Mr Redman's care at Lincoln.

## Emergency response

12. We found that not all staff on duty at night had a radio and when staff discovered Mr Redman hanging in his cell they did not immediately go into the cell. While this did not affect the outcome for Mr Redman it certainly could in other emergencies.

## Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including conducting ACCT reviews as specified in the national instructions.
- The Head of Healthcare should ensure all healthcare providers, including substance misuse workers, record all interventions in a prisoner's primary medical records so all information is documented, enabling appropriate continuity of care for each prisoner.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
  - all night staff have radios and radio an appropriate emergency code; and
  - night staff enter cells as quickly as possible in a life-threatening situation.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact him. No prisoners responded.
14. The investigator visited Lincoln on 4 May. He obtained copies of relevant extracts from Mr Redman's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Redman's clinical care at the prison.
16. The investigator interviewed ten members of staff and three prisoners at Lincoln in May. All the interviews were conducted jointly with the clinical reviewer.
17. We informed HM Coroner for Central and West Lincolnshire of the investigation. He gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Redman's mother, to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Redman's mother did not raise any concerns.

# Background Information

## HMP Lincoln

19. HMP Lincoln houses 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. Drug agency Addaction provides psychosocial and integrated clinical services.

## HM Inspectorate of Prisons

20. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Lincoln in February 2017. Inspectors found the prison overcrowded, and due to its age as a Victorian prison, there were significant challenges in keeping conditions decent for prisoners. There were increased levels of violence, often linked to the prevalence of drugs. However, inspectors found the way Lincoln tackled the use of psychoactive substances to be effective and there was a good working partnership with the police. Inspectors found the management of prisoners at risk of suicide and self-harm was not robust enough.

## Independent Monitoring Board

21. 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 annual report, published in July 2018, the IMB was very concerned about the very high levels of self-harm. The IMB noted that there were no mental health staff available at night or at weekends to support officers dealing with prisoners with mental health problems. The IMB was also concerned about the availability and use of psychoactive substances which caused additional pressures for both nursing staff and officers.

## Previous deaths at HMP Lincoln

22. Mr Redman's was the fifth self-inflicted death to occur at Lincoln since January 2015. In two of the previous self-inflicted deaths we made recommendations about the management of suicide and self-harm procedures.

## Assessment, Care in Custody and Teamwork (ACCT)

23. 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. 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 prisons at risk of harm to self, to others and from others (Safer Custody)*.

### **Psychoactive Substances (PS)**

24. 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.
25. 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.
26. HM Prison and Probation Service (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

27. Mr Craig Redman had a custodial history dating back to 2005. In November 2007, he was convicted of robbery and false imprisonment and received an indeterminate sentence for public protection (IPP). On 4 July 2016, Mr Redman was convicted of escaping from lawful custody from HMP Prescoed and given a further six-month sentence to be served concurrent with his IPP sentence. Mr Redman had a significant history of PS use and a history of anxiety and depression.
28. On 9 October 2017, Mr Redman was released on license from HMP Warren Hill. On 24 October 2017, he was recalled into custody at HMP Lincoln after breaching his night time curfew licence condition.
29. A nurse saw Mr Redman in reception. The nurse recorded that Mr Redman was not on any prescribed medication but he had a history of illicit drug use. Mr Redman said he had no thoughts of self-harm or suicide. He recorded that Mr Redman appeared calm and relaxed and that his blood pressure and pulse were normal.
30. On 30 October, Mr Redman self-referred to be seen by the mental health team. On his referral form Mr Redman wrote: "Could I have an appointment with mental health". He gave no other detail or information about why he wished to see the mental health team.
31. On 2 November, a senior mental health nurse saw Mr Redman as result of his self-referral. Mr Redman denied he had any thoughts of self-harm or suicide but said he had taken an overdose some three years earlier. Mr Redman said he was an IPP prisoner, had been in prison for ten years, had been recalled for poor behaviour at the Approved Premises in Leicestershire and that he was low in mood. Mr Redman said he had used illicit drugs in the past but denied using drugs since he arrived at Lincoln. She recorded that Mr Redman was calm and polite, there was no evidence of any psychotic symptoms and she would see him again for a full mental health assessment.
32. On 24 November, the senior mental health nurse saw Mr Redman to conduct a mental health assessment. Mr Redman said that he was from South Wales and at the age of 13 had been placed in care because he was disruptive. He described himself as "an angry kid". He said he was bullied at school and while in care because he was "ginger and had freckles". Mr Redman said that throughout his time in prison he had had support from his mother and sister. Mr Redman said he hoped to return to live with his mother in South Wales.
33. The senior mental health nurse completed two health screening tools: patient health questionnaire – 9 (PHQ-9) (a tool to determine depression); and general anxiety disorder - 7 (GAD-7) (a tool to determine anxiety). The PHQ-9 indicated that Mr Redman had mild depression; and the GAD-7 indicated Mr Redman had mild anxiety. She recorded Mr Redman had a history of using illicit drugs, including PS. She referred Mr Redman for ongoing support from the mental health team for low mood and anxiety.

34. Between 6 December and 22 February 2018, Mr Redman had 13 one-to-one interventions with a psychosocial wellbeing practitioner and member of the mental health team. She recorded that as well as her interventions with Mr Redman, she also liaised with Mr Redman's probation officer based in South Wales.
35. On 6 February, the psychosocial wellbeing practitioner recorded that Mr Redman admitted he used "spice". Mr Redman said that he wanted a move to another prison, preferably HMP Warren Hill, as he found it difficult to cope with the high turnover of prisoners. He said he was in £50 debt for spice but he did not want to move wings or be treated as a vulnerable prisoner. Mr Redman did not name the prisoner(s) he was in debt to. She completed a security report that included the fact that Mr Redman was in £50 debt for spice but had not said who he was in debt to.
36. On 16 February, the psychosocial wellbeing practitioner recorded that she had spoken to Mr Redman's probation officer. Mr Redman's probation officer had said the probation service's recommendation at Mr Redman's next parole hearing would be that Mr Redman should be released on licence to an Approved Premises in Cardiff prior to his return to the community. She recorded that she saw Mr Redman on the wing and told him what his probation officer had said to her.
37. On 27 February, a nurse recorded in Mr Redman's medical record that she had had a discussion with the psychosocial wellbeing practitioner and received a handover about Mr Redman because she was due to leave her post. It was agreed that the nurse would continue to provide support to Mr Redman.
38. On 21 March, Mr Redman had an appointment with the nurse but he did not attend. She went to see Mr Redman in his cell. Mr Redman said he did not want to engage with the mental health team anymore as said he felt "ok". He denied having any thoughts of self-harm or suicide and said he was aware of how to self-refer to the mental health team if he wished to engage in the future. She recorded that she discharged Mr Redman from mental health services. There was no further follow up by the mental health team.
39. On 28 March, at 11.15pm, Mr Redman pressed his cell bell and an operational support grade responded. He found that Mr Redman had self-harmed by making a superficial cut to this left wrist. Mr Redman said he wanted to move wings and refused to see anyone from healthcare. He called for assistance and opened an ACCT document, completing the concern and keep safe form.
40. A custodial manager responded and saw Mr Redman in his cell. He completed the immediate action plan and assessed Mr Redman as being at high risk. His level of observations was set at hourly throughout the day and night until the first case review.
41. A nurse also responded to the call for assistance. She recorded that Mr Redman had made a superficial cut to his left wrist but he refused any assessment or treatment.

42. On 29 March, at 11.45am, an officer assessed Mr Redman as part of ACCT procedures. Mr Redman said he was “losing his head” and he owed a large debt for spice. He said he had made a cut to his wrist with a razor blade and that it had been a suicide attempt. Mr Redman said he intended to kill himself and had planned to do so. Mr Redman said that he wanted to move wings because of a large spice debt.
43. At 11.20, a supervising officer (SO), chaired the first ACCT case review with an officer, a nurse, a member of the mental health team, and Mr Redman present. Mr Redman said that he had current thoughts of self-harm, he was in debt for spice and that he wanted a move from C wing to A wing. The SO and a nurse assessed Mr Redman as being at raised risk of suicide and self-harm, and increased the level of observations to every 30 minutes, along with conversations during the morning, afternoon and evening. The SO completed the ACCT caremap which contained two actions: for Mr Redman to move to A wing as he requested because of his debts, and for Mr Redman to receive information about his parole. The next case review was set for 5 April.
44. On 31 March, a supervising officer held an ACCT case review with Mr Redman. No-one else was present and no one from healthcare had any input into the review. The SO held the review with Mr Redman as he had moved to A wing on 30 March. Mr Redman said he felt much better and had no thoughts of self-harm. She recorded that she had discussed at length the parole process with Mr Redman. She assessed Mr Redman as being at a low risk of suicide and self-harm, and reduced the level of observations to every two hours, with a conversation in the morning, afternoon and evening. She updated the caremap and closed both actions as Mr Redman had moved to A wing and had a parole hearing scheduled for 2 May. The next review was set for 5 April.
45. On 5 April, another supervising officer held an ACCT case review with Mr Redman. No-one else was present and no one from healthcare had any input into the review. Mr Redman said he had no plans of self-harm or suicide but he did think about it. He said he used the thought of his mother as a coping mechanism. Mr Redman said he no longer engaged with the mental health team as his key worker had left and he did not want to get to know another person. Mr Redman said he socialised a little on the wing but did not want to share a cell or move cells. He assessed Mr Redman as being at a low risk of suicide and self-harm, and the level of observations remained unchanged. The next review was scheduled for 9 April.
46. On 9 April, the SO held an ACCT case review with Mr Redman. Again, no-one else was present and no one from healthcare had any input into the review. Mr Redman said he was relaxed and settled, with the occasional passing thought of harming himself but no intention of doing so. Mr Redman said he was focused on looking forward to his parole hearing. He said he had a small group of friends he socialised with. He assessed that Mr Redman’s risk of suicide and self-harm was low and reduced the level of observations to one observation and one conversation in the morning, afternoon and evening, with three observations during at night. The next review was set for 19 April.

47. Mr Redman's prison phone records show that he spoke to his mother on 13 and 14 April. The investigator has listened to these calls. Mr Redman sounded upbeat, looked forward to his parole hearing on 2 May, and hoped to be released to South Wales. He gave no indication he had thoughts of self-harm or suicide. These were the last calls Mr Redman made to his mother.
48. On 19 April, a SO chaired an ACCT case review with a member of the mental health team and Mr Redman present. Mr Redman said his head "was in a better place", he had good contact with his family and he looked forward to his parole hearing on 2 May. He recorded that both the caremap actions were closed. He and the member of the mental health team agreed that Mr Redman's risk of suicide and self-harm was low and agreed to close the ACCT. It was noted that the ACCT may need to be re-opened if Mr Redman was not granted parole at the hearing on 2 May. A post-closure review was scheduled for 26 April.
49. On 26 April, at 2.30pm, an Addaction substance misuse recovery worker saw Mr Redman in his cell. Mr Redman said that he did not want to engage with Addaction substance misuse services. He said he wanted to be back in Wales with his family and would be prepared to engage with the substance misuse team in the community.
50. At 2.55pm, a supervising officer held the ACCT post closure interview with Mr Redman. Mr Redman said that he had support from his family and the staff and he had no thoughts of self-harm or suicide. He recorded there were no issues or concerns and there was no need to re-open the ACCT.
51. Mr Redman's security records show that he had a history of illicit drug use since 2014. The investigator found that, apart from Mr Redman's disclosure that he was in debt for spice in February 2018, there was no other evidence or intelligence that Mr Redman had used illicit drugs, was in debt or was bullied after his arrival at Lincoln on 24 October 2017.
52. Two fellow prisoners each told the investigator that Mr Redman was a regular user of PS. Another prisoner said his cell was next door to Mr Redman's. He said he had spoken to Mr Redman on the evening of 26 April. Mr Redman appeared fine and he was playing music in his cell.

### Events of 27 April

53. CCTV footage of the wing shows that at 3.05am Mr Redman's cell bell light came on. (Prisoners have a button in their cell which they can press to summon urgent assistance from staff. When the cell bell is activated this illuminates a light outside the cell which remains on until a member of staff comes to the cell and deactivates it.) an operational support grade was the night duty member of staff on A wing and he answered Mr Redman's cell bell at 3.07am. He remained at Mr Redman's cell door for 30 seconds before moving away.
54. The operational support grade told the investigator that he had no recollection of answering the cell bell, why Mr Redman had pressed his cell bell, or that he spoke to Mr Redman.
55. At 5.13am, CCTV footage shows the operational support grade arrived at Mr Redman's cell to do the early morning roll check. (This is a physical check of all

prisoners.) He told the investigator that when he got to Mr Redman's cell he noticed that the light in the cell was on. He opened the observation panel and saw Mr Redman hanging from the window bars in his cell by a ligature made from bedding.

56. The operational support grade did not have a radio, so he went to another operational support grade who was on the wing, to use his radio to call an emergency. The other operational support grade immediately radioed a code blue emergency, which indicates a prisoner is unable to breathe or having difficulty breathing. He also used the wing office phone to contact a custodial manager (CM) who was in charge of the prison.
57. The control room log shows the operational support grade called the code blue over the radio at 5.13am and an ambulance was called immediately.
58. The custodial manager and two officers immediately responded to the code blue. They entered the cell, cut Mr Redman down and began cardiopulmonary resuscitation (CPR).
59. The CM told the investigator that all operational support grade staff that work nights carry a cell key in a sealed pouch for use in emergencies to enter a cell where there is a danger to life. Additionally, each member of staff working on nights should have a radio. He said that staff faced with a life-threatening situation should enter a cell to protect life, subject to a dynamic risk assessment. He said it took less than 60 seconds from the time the operational support grade spoke to him for him to reach Mr Redman's cell.
60. CCTV footage shows that a nurse and a healthcare support worker, arrived at Mr Redman's cell at 5.14am. They both continued with the resuscitation and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, so they continued with CPR.
61. Paramedics arrived at 5.22am and took over Mr Redman's care. They continued with CPR and, after a period of treatment, paramedics pronounced Mr Redman dead at 5.37am.

### **Contact with Mr Redman's family**

62. As Mr Redman's mother lived in South Wales, Lincoln asked HMP Cardiff for assistance in breaking the news of Mr Redman's death to his mother. Family liaison officers from HMP Cardiff visited Mr Redman's mother at her home address at 10.35am, to break the news of her son's death and offer condolences. In the days that followed, another family liaison officer from Lincoln maintained contact with Mr Redman's mother and, in line with Prison Service instructions, the prison contributed to the costs of the funeral.

### **Support for prisoners and staff**

63. The Head of residence and services held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
64. The prison posted notices informing staff and prisoners of Mr Redman'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 Redman's death.

### **Post-mortem report**

65. A post-mortem examination found that the cause of Mr Redman's death was hanging. The pathologist noted that the toxicology results showed that Mr Redman was under the influence of PS at the time of his death and that it was possible that this had affected Mr Redman's behaviour in the period leading up to his death.

# Findings

## Management of risk of suicide and self-harm

66. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.
67. Staff correctly opened an ACCT on 28 March, immediately after Mr Redman had self-harmed. A SO chaired the first case review with input from an officer and healthcare staff and assessed that Mr Redman was at a raised risk of self-harm and increased the level of observations to half-hourly. We consider that Lincoln correctly assessed Mr Redman's level of risk and that the level of observations was appropriate.
68. The next three case reviews were held on 31 March, conducted by a SO and on 5 and 9 April by another SO. These reviews were conducted by a single member of staff, without any input from healthcare staff. Both supervising officers assessed that Mr Redman was at low risk of self-harm and reduced the level of observations to three observations during the day and night. ACCT reviews should, where possible, be multidisciplinary and not conducted by a single member of staff. We make the following recommendation:
- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including conducting ACCT reviews as specified in the national instructions.**
69. Despite these shortcomings, we consider that the decision to close the ACCT on 19 April was appropriate and consider that Mr Redman had received appropriate support from staff, and that the actions on the caremap had been completed. Mr Redman gave no further indication that he had thoughts of self-harm or suicide.
70. Toxicology results show that Mr Redman was under the influence of PS at the time of his death and it is possible that this affected his behaviour.

## Psychoactive Substances

71. Mr Redman was a regular user of PS. Mr Redman's security records show that he had had a history of PS use and associated debt since 2014. After his arrival at Lincoln in October 2017, Mr Redman's security records show that he said he was in debt for drugs in February and March 2018, but he would not give any names of those he was in debt to. The investigator has found no other intelligence or evidence to indicate that Mr Redman was being bullied. Mr Redman declined to engage with substance misuse recovery groups at Lincoln.

72. Toxicology results show that Mr Redman used PS immediately before his death. Reported side-effects of PS include mood swings, anxiety, paranoia and suicidal thoughts. It is therefore possible that Mr Redman's actions were influenced directly by PS use.
73. We are concerned that Mr Redman was able to obtain PS while in Lincoln. Although staff seem not to have been aware that Mr Redman was in debt for PS until he told them, they accepted that this was plausible, although there was no evidence or intelligence to corroborate that admission. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern about the ready availability of drugs at Lincoln and it is obviously a cause for concern that Mr Redman could obtain and use them without staff being aware.
74. Lincoln is not alone in facing this problem –the availability of drugs, including PS, is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in our view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.
75. In a recent investigation, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of drug-related deaths being investigated. The Chief Executive has told us that HMPPS plans to issue a national drug strategy by the end of 2018. We therefore make no further recommendation at present.
76. Nevertheless, the scale of the challenge facing prisons in addressing the risks of PS needs to be properly acknowledged. It is simply not acceptable that prisons are expected, at worst, tacitly to accept the kinds of behaviours which may have led to Mr Redman's death, and, at best, deploy interventions which will only ever achieve limited success. This is a national problem which needs national solutions and an open acknowledgement of the resources required to address it effectively.

### **Clinical care**

77. The clinical reviewer judged that overall the care that Mr Redman received from healthcare staff at HMP Lincoln was equivalent to the care he would have received in the community. She comments that Mr Redman had a long history of illicit drug use.
78. However, the clinical reviewer had concerns about the way the input of the mental health services was recorded in medical records. Mr Redman's mental health crisis plan was not recorded in his notes, nor was the handover between the outgoing therapist, with whom Mr Redman appeared to have developed a therapeutic relationship, and the senior mental health nurse. Despite the recorded agreement to provide ongoing support to Mr Redman, he was discharged from the Mental Health services within a month of that agreement without any follow up.

79. The clinical reviewer also commented that the drug rehabilitation service recovery workers did not record entries on a prisoner's medical records in SystemOne. This meant that Mr Redman's records were not, in effect, correctly maintained as there was little opportunity for comprehensive oversight of his clinical history and so no coordinated approach to his care by all health providers at Lincoln.
80. Although no actual failing arose in respect of Mr Redman, the clinical reviewer found that Lincoln's healthcare record-keeping does not comply with the General Medical Council and Nursing and Midwifery Council standards. We agree with her comments and make the following recommendation:

**The Head of Healthcare should ensure all healthcare providers, including substance misuse workers, record all interventions in a prisoner's primary medical records so all information is documented enabling appropriate continuity of care for each prisoner.**

### Emergency response

81. We are concerned about the emergency response on 14 July. Officers have a key in a sealed pouch for use in an emergency at night. Prison Service Instruction 24/2011, which covers management and security at nights, states that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.
82. When an operational support grade found Mr Redman hanging, he did not open the cell and told us that he did not consider doing this. We appreciate that it can be difficult for staff in such situations to make instant decisions but when there is a potentially life-threatening situation, it is essential to act quickly. We would normally expect prison staff to go into a cell as soon as possible in case there is a chance of saving someone's life.
83. Additionally, the operational support grade had to go to another operational support grade to raise the alarm as he did not have a radio. A custodial manager told us that all night staff on duty should have been issued with a radio.
84. While these issues did not affect the outcome for Mr Redman, it is important that prison staff understand their roles in a medical emergency, as early intervention when someone is found hanging can save their life. We make the following recommendation:

**The Governor should ensure all prison staff are made aware of and understand their responsibilities during medical emergencies, including:**

- **that all night staff have radios and radio an appropriate emergency code; and**

- **that night staff enter cells as quickly as possible in a life-threatening situation.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations