Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Adams a prisoner at HMP Lindholme on 13 November 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

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

Our Values

We are:

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

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

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 Darren Adams was found hanging in his cell at HMP Lindholme on 12 November 2017 and died in hospital the following day. He was 55 years old. I offer my condolences to Mr Adams' family and friends.

Mr Adams had only been at Lindholme for six days before he hanged himself. Although staff at Lindholme were monitoring him under Prison Service suicide and self-harm prevention procedures when he died, they underestimated his risk of suicide and failed to put adequate measures in place to reduce his risk.

I am also concerned that healthcare staff did not try to resuscitate Mr Adams after he had been found hanging because they incorrectly believed he was already dead. The investigation identified a number of other deficiencies with the emergency response, which Lindholme needs to address.

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
Acting Prisons and Probation Ombudsman **May 2019**

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Summary

Events

1. In March 2000, Mr Darren Adams was convicted of murder and sentenced to life imprisonment, with a minimum term of 18 years. He spent time at several prisons before being transferred to HMP Garth on 19 December 2012.

2. In August 2017, Mr Adams' security category was reduced and he asked to be transferred to HMP Lindholme. In October, he was assaulted by another prisoner. He asked a member of staff to check whether Lindholme had a vulnerable prisoner (VP) unit, but was not told it did not.

3. On 7 November, Mr Adams was transferred to Lindholme. He immediately told officers that he was at risk because he had committed his offence in Hull and that he was shocked that Lindholme did not have a VP unit.

4. On the afternoon of 8 November, an officer started Prison Service suicide and self-harm monitoring (known as ACCT) after Mr Adams told another officer that he had a noose and would jump off the toilet. A prison manager made an urgent referral to the mental health team. The following day, a mental health nurse saw Mr Adams, though he denied any thoughts of suicide. The nurse planned for a psychiatrist to assess Mr Adams but this did not happen before his death.

5. At approximately 6.40am on 12 November, an operational support grade spoke to Mr Adams about him covering his observation panel. An hour later, an officer checked on Mr Adams and found him suspended by a ligature in the toilet area. The officer called for urgent assistance and entered Mr Adams' cell when other officers arrived. When nurses arrived, they checked Mr Adams but did not start cardiopulmonary resuscitation (CPR) because they believed there were clear signs of death, including rigor mortis.

6. The control room called for an ambulance at 7.50am and paramedics reached Mr Adams just after 8.05am. Paramedics started CPR, gave Mr Adams oxygen and adrenaline, and attached a defibrillator, which shocked him four times. At 9.25am, after Mr Adams' circulation had returned, the paramedics took him to hospital. However, Mr Adams' condition deteriorated and at 3.13pm on 13 November, hospital doctors declared that he had died.

Findings

Assessment of Mr Adams' risk of suicide and self-harm

7. Staff underestimated Mr Adams' risk of suicide and self-harm by not placing sufficient weight on his possible access to lethal methods to hurt himself and his apparent mental health issues. We found no evidence that staff looked for a noose after Mr Adams told staff on 8 November that he had one in his cell.

8. We found a number of deficiencies with the ACCT process. Healthcare staff did not attend Mr Adams' first ACCT case review, a caremap action was inappropriately recorded as complete and staff did not observe him on the

specified hourly basis - on one occasion he was not checked for an hour and 45 minutes.

Emergency response

9. The officer who found Mr Adams called an urgent radio message rather than the correct emergency code and he did not immediately enter the cell. Control room staff failed to call for an ambulance promptly, despite being told that Mr Adams had been found hanging.

10. There was a delay in the resuscitation attempt as the nurses who arrived at Mr Adams' cell failed to start CPR because they believed there were clear signs of death, including the presence of rigor mortis. We note that paramedics managed to restart circulation and agree with the clinical reviewer that it was unlikely that rigor mortis had set in. We consider that the nurses should have attempted resuscitation.

Mental health

11. Although a mental health nurse saw Mr Adams promptly following the opening of the ACCT, we agree with the clinical reviewer that she did not record a clear plan of care in Mr Adams' medical record and there was no record that she had made an appointment with the psychiatrist.

Staff support

12. We are concerned that a member of staff heavily involved in Mr Adams' ACCT management was asked to support those staff who had been involved in the emergency response. We are also concerned that healthcare staff were not invited to a hot debrief after Mr Adams' death.

Data loss

13. We found that staff at Garth did not tell Mr Adams that an intelligence report that referred to "Darren" had been taken by a prisoner, and after he was assaulted, possibly in connection with the information in the intelligence report, staff did not check on him.

Transfer from Garth to Lindholme

14. Before his transfer to Lindholme, Mr Adams said he wanted to be moved to a prison with a VP unit. Despite staff at Garth finding out that Lindholme did not have a VP unit, they did not tell Mr Adams.

Recommendations

- The Governor and the Head of Healthcare at HMP Lindholme should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:
    - staff consider all risk factors, including suicidal statements and access to lethal methods, when assessing a prisoner's risk;
    - healthcare staff attend all first ACCT case reviews;

- staff do not record ACCT caremap actions as complete until a prisoner's risk has been reduced; and
- staff adhere to the frequency of observations set out in the ACCT document and that observations take place at unpredictable times.

- The Governor at HMP Lindholme should ensure that when prisoners say they have ligatures, staff search them and their cells as soon as possible and remove any ligature. Until this is done, staff should constantly observe them and be ready to intervene immediately if necessary.

- The Governor at HMP Lindholme should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
  - staff enter cells as quickly as possible in a life-threatening situation;
  - staff radio an appropriate emergency code; and
  - control room staff call an ambulance as soon as an emergency code is called.

- The Head of Healthcare at HMP Lindholme should ensure that staff are competent in assessing rigor mortis and conditions unequivocally associated with death.

- The Head of Healthcare at HMP Lindholme should ensure that healthcare staff complete medical records in line with the General Medical Council and Nursing and Midwifery Council's guidance, recording full details of care plans and referrals.

- The Governor at HMP Lindholme should ensure that all managers follow the national guidelines for dealing with a death in custody or serious incident, including that:
  - all staff, including staff who are members of the care team, are offered appropriate and timely support from someone unconnected to the incident; and
  - a debrief is held promptly after the death of a prisoner and that all staff, including healthcare staff, are invited.

- HMPPS should ensure that when lost data contains information about a prisoner whom it may be possible to identify, and which may pose a risk to the prisoner's safety, the prison is advised to consider notifying the prisoner of the loss.

- The Governor at HMP Garth should ensure that all prison staff are made aware of and understand the local violence reduction policy and their responsibilities, including that:
  - staff support and protect victims; and
  - staff take appropriate measures against perpetrators to address violent or antisocial behaviour.

- The Governor at HMP Garth should ensure that when a prisoner expresses concerns about moving prisons, those concerns are identified and addressed before the transfer is completed.

The Investigation Process

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

16. The investigator visited Lindholme on 23 November 2017. He obtained copies of relevant extracts from Mr Adams' prison and medical records.

17. NHS England commissioned a clinical reviewer to review Mr Adams' clinical care at the prison.

18. They interviewed ten members of staff at Lindholme on 14 and 15 December 2017. The investigator also interviewed one member of staff at Lindholme on 14 December and three members of staff at HMP Garth on 8 January 2018.

19. We informed HM Coroner for South Yorkshire (East District) of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. One of the Ombudsman's family liaison officers (FLO) contacted Mr Adams' partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked why Mr Adams had been transferred from Garth to Lindholme as he had been at Garth for nearly ten years.

21. Solicitors representing Mr Adams' family contacted the FLO and asked the investigation to review CCTV on the day leading up to his death. The investigator was unable to review CCTV footage for this period because the prison said that the hard drive had been corrupted and the footage could not be retrieved. Details of the CCTV footage viewed has been provided in separate correspondence to the family's solicitors.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

23. Mr Adams' partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Lindholme

24. HMP Lindholme is a medium security prison near Doncaster, which holds 1,015 men. Care UK provides healthcare services and healthcare staff are on duty between 7.30am and 7.30pm every day.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Lindholme was in October 2017. Inspectors reported that levels of self-harm were higher at Lindholme than at other prisons and that the quality of care for prisoners at risk was mixed. This was reflected in the variable quality of assessment, care in custody and teamwork (ACCT) case management documents, with caremaps not robust enough and some reviews not sufficiently multidisciplinary.

26. Inspectors found that only 14% of prisoners rated the overall quality of health services as good. They found that chronic staffing shortages, a lack of consistent clinical leadership and the considerable number of medical emergencies related to drug intoxication had had an impact on health service delivery. The integrated mental health team offered a wide range of one-to-one support but prisoners experienced excessive delays in accessing interventions, and overall provision was not meeting the high level of need.

Independent Monitoring Board

27. 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 at Lindholme, for the year to 31 January 2017, the IMB reported that they continued to see issues with the staff completing ACCT documents incorrectly. They said that some issues were the result of poor clerical work, some arose from documents which lacked completion of observations and others from a lack the quality of “conversation” entries.

28. The IMB also had major concerns with staffing levels in the healthcare department and that the mental health team been under strength for much of the year, which meant that some prisoners with mental health issues were not always identified. However, they did not find any evidence that those who may have suffered from mental health were poorly treated.

Previous deaths at HMP Lindholme

29. Mr Adams was the fourth person to take his own life at Lindholme since January 2016 and the sixth overall. We have previously made recommendations about staff responsibilities during medical emergencies, when to enter a cell when a prisoner is at risk and when it is inappropriate to attempt resuscitation.

HMP Garth

30. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Greater

Manchester Mental Health NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust provide health services.

HM Inspectorate of Prisons

31. The most recent inspection of HMP Garth was in January 2017. Inspectors reported that about 85 prisoners were held separately because of fears for their safety and that the prison's current approach to violence reduction was limited, one dimensional and not working. They found that prisoners at risk of self-harm were well cared for and that the quality of ACCT case management had improved.

32. Inspectors also found most prisoners were negative about the access to and quality of health services. Despite chronic staff shortages, they found that the quality of care was mostly good and that mental health support had improved.

Independent Monitoring Board

33. In its latest annual report at Garth, for the year to 30 November 2016, the IMB reported that the prison had a complex and challenging population who presented significant risks across many areas, including risk of harm to themselves and others. They found that 85 prisoners were under threat on the Residential Support Unit. The IMB also reported that, following a tender exercise, the healthcare supplier was due to change.

Assessment, Care in Custody and Teamwork

34. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and 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.

35. 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (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.

36. 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

37. On 18 August 1999, Mr Darren Adams was remanded to prison on suspicion of committing a murder in Hull. On 17 March 2000, he was convicted and sentenced to life imprisonment, with a minimum term of 18 years. Mr Adams spent time at several prisons before being transferred to HMP Garth on 19 December 2012.

38. In May and August 2014, Mr Adams believed that he was at risk from other prisoners and that one had taken his cell key. Staff supported Mr Adams by placing him on a Challenging Antisocial Behaviour (CAB) document and replacing the lock on his cell door. From August 2014, there was no record that Mr Adams felt unsafe. He was regularly found in possession of "hooch" (illegally brewed alcohol) throughout his time at Garth.

39. On 2 November 2016, the Parole Board considered whether to release Mr Adams, as his minimum term was due to end on 1 April 2017, but decided not to release him. Mr Adams applied for an oral hearing to consider a transfer to an open prison and a hearing was planned for April 2017.

40. On 14 March 2017, Mr Adams told his offender manager that he was concerned about moving to a prison closer to Hull as he felt he was at risk of retribution due to his offence. He did, though, want to return to Hull to live with his partner when he was released.

41. On 13 April, the Parole Board met for the oral hearing but Mr Adams' offender manager and his offender supervisor were not present so the Parole Board could not make a decision. They deferred the hearing until 2 November.

42. On 18 May, the offender supervisor recommended Mr Adams be reduced from category B (prisoners who do not require maximum security but for whom escape still needs to be made very difficult) to category C status (prisoners who cannot be trusted in open conditions but who are unlikely to try to escape) as his behaviour had improved immensely. On 1 June, a prison manager rejected the recommendation.

43. On 21 June, Mr Adams told a nurse that an unknown prisoner had a "hit out on him" but he did not know why. Mr Adams said that the situation made him mentally ill so a nurse referred him to the mental health team. On 24 June, a mental health nurse, reviewed Mr Adams, though he said he did not need any mental health support. She noted that Mr Adams talked appropriately and there was no obvious sign of any psychotic symptoms, low mood or perceptual abnormalities. She told Mr Adams how to access mental health services in the future but took no other actions.

44. On 27 June, Mr Adams told a senior officer that he was under threat from other prisoners, though he would not identify them. The senior officer opened a CAB document and told Mr Adams that he should self-isolate or move to another wing. Officers watched Mr Adams every day but did not see him have any problems with other prisoners. On 5 July, a prison manager closed the CAB as Mr Adams said the risks had reduced. On the same day, Mr Adams appealed the decision not to reduce his security category.

45. On 13 July, one of the Ombudsman's investigators visited Garth to investigate a self-inflicted death in the prison. While the investigator was interviewing at the prison, some documents were taken by a prisoner and subsequently passed among other prisoners. The PPO investigator did not realise at the time that the documents had been taken. Prison staff subsequently found these documents and contacted the PPO investigator who confirmed that they were missing from his file. One of the documents was the deceased's suicide note which mentioned "Daz Adams" and said, "All the best mi old mate we had some me and you. Keep ya chinn up you silly fucker ha! ha! Love you mate… [sic]." Another document, an intelligence report, said a prisoner named "XXXX" had provided information about the deceased being in debt and a previous suicide attempt.

46. On 7 August, a senior prison manager reviewed Mr Adams' recategorisation appeal and overturned the decision not to reduce his security category. The offender supervisor told the investigator that Mr Adams asked to move to HMP Lindholme or HMP Wealstun, both category C prisons.

47. On 17 August, a prison manager and a senior prison manager spoke to Mr Adams about the loss of the suicide note but did not mention the intelligence report. The prison manager recorded that Mr Adams was not concerned about the loss. The prison manager told the investigator that the Safer Custody department subsequently checked regularly whether Mr Adams was placed on Prison Service suicide and self-harm monitoring (known as ACCT) or on a CAB in order to monitor whether there had been any negative impact. (He was placed on neither while he remained at Garth.) She also said that she received advice from the National Incident Reporting team that a person's personal information is only compromised when they can be absolutely identified so she did not need to discuss the intelligence report.

48. On 2 October, an integrated drug treatment system healthcare assistant, reviewed Mr Adams, who said that he had been on a CAB as he had refused to brew "hooch". Mr Adams said that he felt "down" and wanted to be prescribed sertraline (an antidepressant). She referred Mr Adams for a medication review.

49. A week later, the Parole Board deferred the oral hearing, scheduled for 2 November, as his offender manager was not available. It did not take place before Mr Adams died.

50. On 16 October, a member of staff completed an intelligence report, which said that Mr Adams was seen with a black eye, which could have been due to his security file being attached to a deceased prisoner's suicide note. The intelligence report also suggested that Mr Adams could have been hurt due to disposing of another prisoner's "hooch" and said that he wanted to be moved to a prison with a vulnerable prisoner (VP) unit.

51. On 16 and 30 October, a locum prison GP saw Mr Adams, who said that his mood had been poor for two months, caused by being in prison for 20 years without a release date. On both occasions, Mr Adams said that he had no thoughts of taking his own life. He prescribed Mr Adams sertraline.

52. On 24 October, a transfer clerk sent an email to Lindholme's Observation, Classification and Allocation (OCA – responsible for arranging prison transfers)

department and said that three prisoners, including Mr Adams, wanted to transfer there. The transfer clerk also asked whether Lindholme had a VP unit and an OCA administrator said that it did not. The transfer clerk told the investigator that either the offender supervisor or Mr Adams' drug key worker had asked her to ask about the VP unit as a general question rather than because Mr Adams needed to be moved into one. The offender supervisor told the investigator that Mr Adams had asked whether Lindholme had a VP unit as he was concerned about his offence.

53. On 7 November, Mr Adams was transferred to Lindholme, following an overnight stay at HMP Leeds. During initial health screens at Leeds and Lindholme, Mr Adams told two nurses that he did not have any thoughts of taking his own life. At Lindholme, Mr Adams declined a mental health referral.

54. During the induction process at Lindholme, Mr Adams told an officer that he was at risk because he had committed his offence in Hull. The officer said that he would discuss Mr Adams at a Safety Intervention Meeting (SIM) and that he should tell staff immediately if he felt under threat. The officer told the investigator that Mr Adams was shocked that Lindholme did not have a VP unit.

55. Later that day, an officer noted that Mr Adams displayed paranoid behaviour and that he refused to leave his cell for association. The officer called the mental health team the following morning and asked them to review Mr Adams as soon as possible. Another officer also noted that Mr Adams had erected a barricade in his cell to stop other prisoners "getting him". He asked Mr Adams to remove the barricade but he rebuilt it.

56. On the morning of 8 November, a SIM, involving numerous staff from the Safer Custody department, discussed Mr Adams. An officer said that he had searched the internet and found information about Mr Adams' offence but no photographs. The SIM decided that Mr Adams was not complying with the regime so he needed to be moved from the induction unit, where he was currently held, to a normal location, though this did not happen before Mr Adams' death.

57. At 1.30pm, an officer opened an ACCT after Mr Adams told an officer that he had a noose and would jump off the toilet. Mr Adams also said that he had cut himself and that he wanted to see healthcare and mental health as he was under threat. The officer told the investigator that Mr Adams had threatened to kill himself though he did not recall seeing the presence of a noose or any evidence that he had cut himself.

58. Fifteen minutes later, an officer recorded in Mr Adams' observation record that he had made superficial cuts to his left arm and that healthcare staff could not gain access to his cell as he had erected a barricade. He noted that Mr Adams was beginning to engage with staff.

59. At 2.30pm, a prison manager completed an immediate action plan. He decided that staff should observe Mr Adams four times an hour and that he needed to be seen by the mental health and substance misuse teams.

60. Later that afternoon, a nurse and an officer examined Mr Adams after he cut himself. They noted that Mr Adams had barricaded his cell, was threatening to

hang himself and had refused to collect his methadone (he received a daily 6ml dose) due to the risk from other prisoners. Mr Adams said that he felt under threat in the prison and that he had only agreed to move to Lindholme because Garth had told him that he would move to a VP unit. He said that he heard people outside his cell saying that they were going to stab him and that staff would allow this to happen.

61. After further discussions, Mr Adams removed the barricade and the nurse cleaned his wounds, which she described as superficial. The nurse and officer then spoke with a substance misuse matron about Mr Adams' methadone but were told that it could not be delivered to him. They arranged for him to collect it in the morning before other prisoners were unlocked. After being told this by the officer, Mr Adams said that he would not leave his cell as he believed officers would unlock other prisoners so they could assault him.

62. At 4.00pm, an officer assessed Mr Adams as part of the ACCT process. Mr Adams said that he was terrified that prisoners would find out about his offence and kill him, and that staff would open his door to allow this. Mr Adams said that he had ligatured and cut his wrist but that he did not want to die. Mr Adams said that he wanted to move to a prison with a VP unit but the officer said that this may not resolve his issues. The officer decided that Mr Adams needed to be seen by the mental health and substance misuse teams.

63. At 6.00pm, a senior officer held the first ACCT case review with Mr Adams. No one else attended. Mr Adams said he was a target for other prisoners and that staff were "in" on this. The senior officer told the investigator he tried to reassure him. The senior officer decided that Mr Adams presented a low risk of suicide and self-harm (on a scale of low, raised and high) and that staff should observe him on an hourly basis. He scheduled the next ACCT case review for 9 November.

64. The senior officer also completed Mr Adams' caremap (designed to identify the main areas of concern and the actions required to reduce risk), adding an action that Mr Adams should see the mental health team.

65. At 12.07pm on 9 November, an officer escorted Mr Adams to the methadone clinic to collect his methadone. While at the clinic, a nurse assessed Mr Adams' substance misuse needs though he said he would not collect his methadone the following day. Mr Adams refused his methadone on 10 November but collected it on 11 November. The nurse planned to discuss him at a healthcare meeting but this did not happen before his death.

66. At 2.00pm, a mental health nurse saw Mr Adams for a mental health review as part of the ACCT process. She recorded that Mr Adams said that he had not slept for weeks and that he was refusing food because prisoners were "messing" with it. He said that prisoners knew about his crime, had called him a "nonce" and that prisoners and staff planned to "get him". He denied any thoughts of suicide but said that he had hurt himself because he was scared. Following the review, the nurse recorded that she planned for a psychiatrist to assess Mr Adams. This did not happen before his death and there is no record that she made an appointment.

67. At 3.00pm, a senior officer held a second ACCT case review with Mr Adams. A nurse, an officer and another senior officer also attended. The senior officer recorded that Mr Adams needed a medication review because his transfer had affected his methadone prescription. Mr Adams said he still did not want to leave his cell. The attendees kept his observations at one per hour. The senior officer scheduled the next ACCT case review for 13 November.

68. The senior officer recorded on Mr Adams' caremap that the mental health review action had been completed. He also added actions to the caremap that Mr Adams needed reviews of his medication, substance misuse and location. There is no record that these reviews took place before Mr Adams' death.

69. On 10 November, an officer recorded in Mr Adams' observation record that he had erected a barricade and covered his observation panel due to his paranoia about other prisoners. The officer informed the wing manager about the barricade, which Mr Adams removed at approximately 8.00pm.

70. The following day, an officer recorded in Mr Adams' observation record that he declined his lunch, though he accepted two brew packs (which contain tea, coffee and breakfast cereals).

Events on 12 November 2017

71. Between 12.01am and 5.49am on 12 November, an operational support grade (OSG) officer, checked on Mr Adams on eight occasions at irregular times. She recorded in Mr Adams' observation record that he was awake for much of the night but he said he was okay when she spoke to him.

72. At 6.41am, the OSG recorded in Mr Adams' observation record that he had covered his observation panel. She asked him to remove the obstruction and he briefly removed it so that she could see him but then put it back.

73. At approximately 7.40am, an officer went to Mr Adams' cell to do an ACCT check and found that the observation panel was covered with paper. He knocked on the door and shouted for Mr Adams to respond but he did not answer. The officer then looked through a small gap in the paper and saw Mr Adams suspended by a ligature in the toilet area. He used his radio to call an urgent message and said that a prisoner on an ACCT was suspended by a ligature. The control room log noted that the officer called the urgent message at 7.45am. Despite seeing the ligature, the officer did not enter Mr Adams' cell. He told the investigator that he did not enter Mr Adams' cell as he was afraid of being assaulted or taken hostage.

74. Two officers responded to the urgent message and the three officers attempted to open Mr Adams' cell door, though he had barricaded the door. An officer forced his arm into Mr Adams' cell and cut the ligature, made from bedding, that had been attached to the bathroom light fitting. The officers then forced their way into Mr Adams' cell and removed the barricade. Three nurses then arrived at Mr Adams' cell. A nurse described Mr Adams as being blue with mottled skin. Another nurse described him as having no vital signs and the start of rigor mortis in his hands. The nurses decided not to start cardiopulmonary resuscitation

(CPR), though they did attach a defibrillator which did not detect a shockable heart rhythm and advised to continue CPR.

75. The control room log noted that information for the ambulance was requested at 7.48am and an ambulance was called at 7.50am. The Yorkshire Ambulance Service noted that an ambulance was requested at 7.51am.

76. At 8.05am, an ambulance arrived at the prison, shortly followed by a rapid response vehicle. Paramedics found that Mr Adams did not have a pulse but they started CPR. They also attached a defibrillator, which shocked Mr Adams on four occasions, and gave him oxygen and adrenaline. At 9.25am, Mr Adams' circulation had returned so the paramedics took him to the hospital. Officers did not restrain Mr Adams.

77. The ambulance arrived at hospital at 9.40am and hospital doctors admitted Mr Adams to the critical care unit. Mr Adams' condition deteriorated and at 3.13pm on 13 November, hospital doctors declared that he had died.

Contact with Mr Adams' friends and family

78. On 12 November, the Governor contacted Mr Adams' partner to tell her that he had been taken to hospital. The following day, the prison appointed a prison manager as the FLO. Prior to Mr Adams' death, the FLO visited his partner in hospital to offer her support.

79. On 14 November, the FLO contacted Mr Adams' partner by telephone to offer her condolences, support and further information. She followed this up with a visit to the home address of Mr Adams' partner on 16 November. She continued to support Mr Adams' partner until his funeral, which was held on 29 November. The prison paid for the costs of the funeral in line with national instructions.

Support for prisoners and staff

80. After Mr Adams' death, the Head of Residence and Safety debriefed the prison 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.

81. The prison posted notices informing other prisoners of Mr Adams' 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 Adams' death.

Post-mortem report

82. The post-mortem examination found that Mr Adams' death was caused by a hypoxic brain injury (when the brain does not receive enough oxygen to function correctly) caused by hanging. The toxicology examination revealed medication within therapeutic ranges, which had no impact on Mr Adams' death.

Findings

Assessment of Mr Adams' risk of suicide and self-harm

83. Prison Service Instruction (PSI) 64/2011 'Safer Custody' sets out the processes that should be followed when an ACCT has been opened. This includes that the case review team must review the level of risk that a prisoner presents taking into account all available information, that healthcare staff must attend the first ACCT case review and that the caremap must aim to address the prisoner's issues identified during the ACCT assessment. It also includes that staff must follow the planned frequency of observations and that observations must be at unpredictable times. Guidance on these processes is also contained in the ACCT documentation and it states that a prisoner should be regarded as a raised risk of suicide and self-harm when they present frequent suicidal ideas, there is evidence of mental illness and there is current self-harming behaviour.

84. When an officer opened the ACCT document on 8 November, she recorded that Mr Adams was in possession of a noose and had cut himself. An officer recorded the same during the ACCT assessment and considered that he needed to be seen by the mental health team. Another officer told the investigator that he could not recall the presence of a noose, but as it was mentioned in two ACCT documents, we consider that Mr Adams may well have been in possession of a noose. These documents recorded Mr Adams' frequent suicidal ideas, evidence of mental health issues and current self-harming behaviour yet a senior officer decided, during the first ACCT case review, that Mr Adams only presented a low risk of suicide and self-harm. There was no record that his risk was considered during the second case review. We are concerned that by underestimating Mr Adams' level of risk, particularly in light of his asserted willingness to create and use a noose, this resulted in fewer ACCT case reviews and less frequent observations. We are also concerned that there is no record that officers searched for the ligature.

85. Healthcare staff did not attend Mr Adams' first ACCT case reviews, despite Mr Adams having said that he wanted to see healthcare and mental health when threatening to harm himself. We are concerned that during interviews with a senior officer and an officer, they said that healthcare staff did not often attend ACCT reviews.

86. Following the first ACCT case review, a senior officer added a caremap action for the mental health team to see Mr Adams. This action was marked as having been completed on 8 November, despite Mr Adams not being seen by a nurse until 9 November. Although the nurse saw Mr Adams on 9 November and was involved in his second ACCT case review, she was unable to resolve his mental health issues and wanted him to be seen by a psychiatrist. This did not happen before his death. We are concerned that not only was the action to see the mental health team marked as having been completed before it actually was, but also a new action was not added despite Mr Adams' ongoing mental health issues.

87. A senior officer set the level of observations at once an hour but we are concerned there were six instances when staff did not review him within an hour,

with the longest gap being an hour and 45 minutes. We are also concerned that many observations took place exactly an hour after the last observation and not at unpredictable times. We make the following recommendations:

The Governor and the Head of Healthcare at HMP Lindholme should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:

- **staff consider all risk factors, including suicidal statements and access to lethal methods, when assessing a prisoner's risk;**
- **healthcare staff attend all first ACCT case reviews;**
- **staff do not record ACCT caremap actions as complete until a prisoner's risk has been reduced; and**
- **staff adhere to the frequency of observations set out in the ACCT document and that observations take place at unpredictable times.**

The Governor at HMP Lindholme should ensure that when prisoners say they have ligatures, staff search them and their cells as soon as possible and remove any ligature. Until this is done, staff should constantly observe them and be ready to intervene immediately if necessary.

Emergency response

88. PSI 03/2013, 'Medical Emergency Response Codes', contains a mandatory instruction that staff must call a code blue if a prisoner is not breathing or is unconscious and that on hearing the code blue, control room staff must call an ambulance immediately.

89. PSI 24/2011, 'Management and Security of Nights', states that staff have a duty of care to prisoners, to themselves, and to other staff, and that preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be immediate danger to life then a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.

90. When an officer found Mr Adams, he called an urgent message, rather than a code blue, and said that Mr Adams was hanging by a ligature. Although a nurse told the investigator that she responded to the urgent message as quickly as if a code blue had been called, we are concerned that failing to use the correct emergency code may result in unnecessary delays in the future. We are also concerned that despite being told that a prisoner had been found hanging, the control room did not call an ambulance until five minutes after the urgent message.

91. After calling the urgent message, the officer did not enter Mr Adams' cell by himself. He told the investigator he was afraid of being assaulted or taken hostage, despite describing Mr Adams as being suspended with a ligature and his face being blue. While we appreciate the distress of seeing a prisoner in such circumstances and that an officer must have regard for their own safety when considering whether or not to enter a cell alone, we do not understand why the officer concluded that it was not safe to enter Mr Adams' cell given what he had seen. By failing to follow PSI 24/2011 and immediately enter Mr Adams' cell,

there was an unnecessary delay in treating Mr Adams. We make the following recommendation:

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

- **staff enter cells as quickly as possible in a life-threatening situation.**
- **staff radio an appropriate emergency code.**
- **control room staff call an ambulance as soon as an emergency code is called.**

92. In March 2016, the National Offender Management Service (now HM Prison and Probation Service), the Royal College of Nursing and the Royal College of General Practitioners introduced 'Guidance to support the decision-making process of when not to perform Cardiopulmonary Resuscitation in prisons and immigration removal centre (IRC)'. The guidance says, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines say that resuscitation should not be attempted where rigor mortis (stiffening of the body after death that normally appears around two hours after the deceased has died) or hypostasis (pooling of blood) is present.

93. When the nurses reached Mr Adams, it had been approximately an hour since the OSG had seen him alive. During interviews with two nurses, they said that they did not try to resuscitate Mr Adams because he displayed signs of rigor mortis, stiffness and mottled skin, and that they followed the guidance that CPR should not be attempted. However, when paramedics arrived at 8.05am, nearly an hour and a half after Mr Adams had been seen alive, they immediately started CPR. We note that the Yorkshire Ambulance Service Patient Care Record did not make any reference to Mr Adams showing any signs of rigor mortis or mottled skin and that there did not appear to be any discussion about not starting CPR. We also note that at 9.25am, Mr Adams' circulation returned.

94. We understand the difficulty of making decisions such as these in challenging and distressing circumstances. We note, though, the view of the clinical reviewer that, as rigor mortis does not usually appear until two hours after a person has died and as Mr Adams had been seen alive an hour earlier, it was unlikely that rigor mortis had set in. Therefore, we agree with the clinical reviewer that considering the resuscitation guidance, the nurses should have attempted resuscitation. We make the following recommendation:

The Head of Healthcare at HMP Lindholme should ensure that staff are competent in assessing rigor mortis and conditions unequivocally associated with death.

Mental health

95. When Mr Adams arrived at Lindholme, he refused a referral to the mental health team. However, after Mr Adams was placed on an ACCT, a nurse quickly saw him. While the nurse recorded that she wanted Mr Adams to be seen by a psychiatrist, we agree with the clinical reviewer that she did not record a clear plan of care in Mr Adams' medical record and there is no record that she made

an appointment with the psychiatrist. We appreciate that Mr Adams hanged himself three days after a nurse reviewed him so there was limited time for further treatment or for the psychiatrist to see him. However, we consider that there should have been a clear treatment plan. We make the following recommendation:

The Head of Healthcare at HMP Lindholme should ensure that healthcare staff complete medical records in line with the General Medical Council and Nursing and Midwifery Council's guidance, recording full details of care plans and referrals.

Staff support

96. PSI 64/2011 sets out the actions that should be taken when a prisoner is seriously ill and following a death in custody. This includes that prisons must ensure that staff working with seriously ill prisoners are supported and that all staff involved in a death, including healthcare staff, should be invited to a debrief.

97. After Mr Adams had been found, a senior officer attended the emergency response. However, he was later asked to support the staff involved as a member of the prison's care team. As the senior officer had significant dealings with Mr Adams, we consider that he also needed to be offered support and that a care team member who was not directly involved with Mr Adams should have provided support.

98. Following Mr Adams' death, the Head of Residence and Safety debriefed the prison staff involved in the emergency response on 14 November. However, the nurses were not present and a nurse told the investigator that she had not attended any other debrief sessions. We are concerned that the healthcare staff were not appropriately supported. We make the following recommendations:

The Governor at HMP Lindholme should ensure that all managers follow the national guidelines for dealing with a death in custody or serious incident, including that:

- **All staff, including staff who are members of the care team, are offered appropriate and timely support from someone unconnected to the incident.**
- **A debrief is held promptly after the death of a prisoner and that all staff, including healthcare staff, are invited.**

Data loss

99. PSI 16/2016 'Information Sharing Policy' defines personal data as "data which relate to a living individual who can be identified… from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller".

100. In July, a prisoner took paperwork from a PPO investigator, who was investigating another death in the prison, that made both an explicit and an implied reference to Mr Adams. While neither document referred to Mr Adams' offence, one of the stolen documents was an intelligence report that noted that

"Darren" had passed information to staff and it is possible that other prisoners may have seen this and drawn a negative conclusion about Mr Adams.

101. We acknowledge that prison staff were not responsible for the data loss and that they notified the PPO investigator of the missing documents when they became aware. A prison manager and a senior prison manager spoke with Mr Adams about the loss of the suicide note but not the intelligence report. While we appreciate that the prison manager received advice that personal information is only lost when a particular individual can be absolutely identified, we consider that this conflicts with PSI 16/2016. We consider it likely that the prisoner who took the paperwork would have been able to identify Mr Adams from the personal data contained in both documents and that the information in the intelligence report could only have come from someone close to the deceased prisoner. On that basis, we consider that staff at Garth should have told Mr Adams about the loss of the intelligence report and allowed him the opportunity to consider the implications.

102. We are also concerned that staff did not check on Mr Adams after a member of staff created an intelligence report that said he had been injured due to the loss of his security file. While we appreciate that the intelligence report also said that he had disposed of "hooch", and that this could have been the reason that he was injured, staff should have taken steps, such as placing him on another CAB document or moving him to a VP unit, to support him. We make the following recommendations:

HMPPS should ensure that when lost data contains information about a prisoner whom it may be possible to identify, and which may pose a risk to the prisoner's safety, the prison is advised to consider notifying the prisoner of the loss.

The Governor at HMP Garth should ensure that all prison staff are made aware of and understand the local violence reduction policy and their responsibilities, including that:

- **staff support and protect victims; and**
- **staff take appropriate measures against perpetrators to address violent or antisocial behaviour.**

103. Given the Ombudsman's involvement in the loss of sensitive data, on 2 August, an Assistant Ombudsman, wrote to all the Ombudsman's investigators informing them about the loss of this paperwork and highlighting the need to protect documents carefully when visiting prisons.

Transfer from Garth to Lindholme

104. In August 2017, Mr Adams had been recategorised as a category C prisoner and asked to be transferred to Lindholme or Wealstun. However, in October, an intelligence report noted that Mr Adams had been injured and he wanted to be moved to a prison with a VP unit. He said the same to his offender supervisor and raised the same concerns after he had moved to Lindholme. At a similar time to these events, a transfer clerk asked Lindholme whether it had a VP unit.

105. While the transfer clerk thought that she had been asked to make a general request to Lindholme, we believe that the question was asked to determine whether that establishment was suitable for Mr Adams. When she found that Lindholme did not have a VP unit, we consider that this information should have been passed to Mr Adams, giving him the opportunity to make representations against the move. We make the following recommendation:

The Governor at HMP Garth should ensure that when a prisoner expresses concerns about moving prisons, those concerns are identified and addressed before the transfer is completed.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141