Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stacey Lockwood, a prisoner at HMP Humber, on 2 August 2019

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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 Stacey Lockwood was found hanged in his cell at HMP Humber on 2 August 2019. Mr Lockwood was 41 years old. I offer my condolences to Mr Lockwood's family and friends.

Mr Lockwood had a number of risk factors for suicide and self-harm, including a history of mental health issues and substance misuse. He had already tried to hang himself in March 2018, while in custody, and had thoughts of suicide at Humber which he shared with other prisoners.

I am concerned that Mr Lockwood told healthcare staff that he believed he was going to die when he turned 41, but they did not share this information with officers. Mr Lockwood turned 41 the day before he killed himself. I share the clinical reviewer's concerns that Mr Lockwood was prematurely discharged from the care of the mental health team.

I am also concerned that prisoners told us that Mr Lockwood was taking psychoactive substances (PS) regularly on the drug recovery wing, that intelligence suggested that Mr Lockwood was heavily engaged in the supply of drugs in the prison, and that the toxicology report confirmed that Mr Lockwood took PS before he killed himself. I am not satisfied that Mr Lockwood's drug use and involvement in the drug culture was sufficiently challenged or investigated.

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 **October 2020**

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Summary

Events

1. On 23 March 2018, Mr Stacey Lockwood was sentenced to six years in prison for burglary and taken to HMP Hull. He had a significant history of mental health issues and substance misuse.

2. A few days after arriving at Hull, Mr Lockwood tried to hang himself. He was taken to hospital and put into an induced coma but recovered.

3. On 28 March 2019, Mr Lockwood moved to HMP Humber.

4. At Humber, Mr Lockwood was prescribed a methadone maintenance programme and the substance misuse team reviewed him regularly. He lived on the drug recovery wing, but prisoners told the investigator that Mr Lockwood often took psychoactive substances (PS).

5. After he referred himself to the mental health team on 3 April, Mr Lockwood was reviewed by a mental health caseworker, a nurse and eventually a psychiatrist. Mr Lockwood said that he thought he would die when he turned 41.

6. On 4 July, the psychiatrist assessed that Mr Lockwood had no symptoms of severe mental illness, but set out a care plan to support him around his 41st birthday on 1 August 2019. He specified that officers should be made aware of Mr Lockwood's heightened level of risk at that time.

7. On 8 July, a mental health nurse discharged Mr Lockwood from the mental health team, but did not alert officers to the risk around his birthday or put any other aspects of the care plan in place.

8. During a routine check at 8.05pm on 2 August, an operational support grade (OSG) found Mr Lockwood hanging from a ligature made of bedsheets attached to the cell window. The OSG radioed a medical emergency. Officers and healthcare staff attempted to resuscitate Mr Lockwood until paramedics arrived at 8.23pm. The paramedics continued resuscitation efforts but pronounced Mr Lockwood dead at 8.42pm.

Findings

Assessment of risk

9. Mr Lockwood's risk factors for suicide and self-harm included his mental health issues, a history of substance misuse and a previous serious suicide attempt.

10. Mr Lockwood told staff that he would die when he turned 41, so his birthday was a possible trigger for an increased risk of suicide or self-harm. On 4 July, a psychiatrist recognised this trigger and asked the mental health team to liaise with officers on the wing to increase support around Mr Lockwood's birthday. We are concerned that the mental health team did not brief officers or provide any additional support to Mr Lockwood and that officers did not know that Mr Lockwood

might be at increased risk. This was a missed opportunity to prevent Mr Lockwood's death.

Clinical care and mental healthcare

11. The clinical reviewer found that the care provided to Mr Lockwood was of a mixed standard and overall not equivalent to that he would have received in the community.

12. We share the clinical reviewer's concern that the mental health team did not carry out the plan outlined by a psychiatrist on 4 July to support Mr Lockwood around the time of his 41st birthday. We also share his concern that the nurse who discharged Mr Lockwood from mental health services on 8 July did so prematurely and unilaterally.

Drug strategy and substance misuse services

13. The toxicology report found that Mr Lockwood had taken PS before he died and prisoners told us that Mr Lockwood often took PS. This is particularly concerning as he was on the drug recovery wing, designed to help prisoners with substance misuse issues.

14. Officers told our investigator that they did not know that Mr Lockwood was taking PS, but in June 2019, an intelligence security assessment suggested that Mr Lockwood was heavily involved in the drug culture. However, Mr Lockwood was never tested for drugs at Humber and his cell was only searched once. We are not satisfied that Mr Lockwood's involvement in the drug culture was sufficiently challenged or investigated.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff, in particular, healthcare staff follow national and local guidance for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, that they:
  - identify and recognise triggers for suicide and self-harm, remain alert to the changes in a prisoner's risk caused by these triggers and act when appropriate offering support; and
  - share information about a prisoner's mental health or risk factors for suicide and self-harm to provide collaborative care and treatment.
- The Head of Healthcare should ensure that prisoners are only discharged from secondary mental health services following multidisciplinary discussion.
- The Head of Healthcare should ensure that there is an effective system in place to monitor compliance with care plans.
- The Head of Healthcare should:
  - share this report with Nurse A and discuss the Ombudsman's findings with him;

- consider whether any further action is required; and
- report back to the Ombudsman.

- The Governor should ensure that:
  - effective supply and demand reduction strategies are properly implemented to help reduce the availability and abuse of drugs, including PS;
  - staff are vigilant to signs of drug use and take appropriate action; and
  - there is a robust use of intelligence and drug testing to reduce the supply of and demand for drugs, including PS.

The Investigation Process

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

16. The investigator visited Humber on 15 August 2019. He obtained copies of relevant extracts from Mr Lockwood's prison and medical records and interviewed two prisoners and one member of staff.

17. The investigator interviewed seven members of staff and a prisoner at Humber on 26 and 27 September, and a psychiatrist by telephone on 31 October.

18. NHS England commissioned an independent clinical reviewer to review Mr Lockwood's clinical care at the prison. He conducted nine interviews jointly with the investigator.

19. We informed HM Senior Coroner for Kingston-upon-Hull and the East Riding of Yorkshire of the investigation. The Coroner gave us the results of the toxicology report. We have not received the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. Mr Lockwood's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

21. 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. The action plan has been annexed to this report.

Background Information

HMP Humber

22. HMP Humber is a medium security prison in Yorkshire that holds approximately 1,000 men. It was created in 2014 by the merger of two previously separate prisons, HMP Wolds and HMP Everthorpe. City Health Care Partnership provides healthcare services. There are always healthcare staff on duty.

23. In August 2018, Humber was selected to be part of the '10 Prisons Project', which seeks to improve safety, security and decency in the prisons involved. The project is focused on reducing violence, improving living conditions, preventing drugs from entering the prison and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

24. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Humber in December 2017. Inspectors reported that two-thirds of prisoners said that it was easy to get drugs in Humber and a third of prisoners said that they had developed a drug problem while there. Inspectors reported that the use of psychoactive substances (PS) was particularly bad, although levels of supply had reduced after additional security measures were introduced, including the photocopying of mail to prevent paper soaked in PS from entering the prison. Inspectors reported intelligence did not always result in timely suspicion drug testing and searching taking place, with prisoners suspected of using drugs often not being tested.

25. Inspectors also reported a very high level of mental health need at Humber. They found that prisoners with mental health problems received prompt assessments and reasonable individual support. However, the small integrated mental health nursing team had high caseloads, and there were insufficient interventions to meet longer-term needs.

26. Inspectors reported that the strategic approach to suicide and self-harm was good, the mental health team worked effectively with the prison, and the quality of ACCT monitoring was also good. Mental health in-reach staff attended many ACCT reviews, as did members of the drug and alcohol recovery team (DART). Inspectors reported that most officers had completed recent mental health training, either through the safer custody training or their prison officer training.

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 their latest annual report, for the year to December 2018, the IMB reported that PS was still a major concern but a proactive approach by prison management had reduced the supply of drugs into the prison.

Previous deaths at HMP Humber

28. Mr Lockwood's was the second self-inflicted death at Humber since August 2017. We raised concerns about the availability of PS and prison drug strategy in the previous investigation.

Psychoactive Substances (PS)

29. 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.

30. 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.

31. 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.

Incentives and Earned Privileges (IEP) Scheme

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

Key Events

Background

33. On 23 March 2018, Mr Stacey Lockwood was sentenced to six years in prison for burglary and taken to HMP Hull.

34. On 28 March, Mr Lockwood tried to hang himself. He was taken to hospital and put into an induced coma but recovered. Mr Lockwood remained on ACCT monitoring until 20 April.

35. He moved to HMP Leeds in May 2018 and HMP Wealstun in November 2018. On 20 February 2019, Mr Lockwood returned to Hull. There were no further suicide attempts or incidents of self-harm recorded.

36. Mr Lockwood had an extensive history of substance misuse from a young age. He had received treatment from mental health services in the community, although he had no clear diagnosis.

HMP Humber

37. On 28 March 2019, Mr Lockwood moved to HMP Humber. At his reception health screen, he told a nurse that he had a history of substance misuse. Mr Lockwood was on a methadone maintenance programme taking 20ml of methadone daily. The nurse recorded that Mr Lockwood appeared mentally stable and did not have any thoughts of suicide or self-harm. The nurse referred Mr Lockwood to the drug and alcohol recovery team (DART). He told the investigator that he did not refer Mr Lockwood to the mental health team because he was unaware of his history of mental health issues and attempted suicide.

38. On 29 March, a DART recovery worker reviewed Mr Lockwood. Mr Lockwood told him that he wanted to maintain his current dose of methadone. He explained the risks of taking illicit drugs as well as methadone and informed Mr Lockwood about DART services. The DART team regularly reviewed Mr Lockwood and offered him one to one support while he was at Humber.

39. On 3 April, Mr Lockwood self-referred to the mental health team. Five days later staff allocated Mr Lockwood a single cell on the drug recovery wing, where he remained until he died.

40. On 12 April, a mental health caseworker reviewed Mr Lockwood. Mr Lockwood told him about his mental health history and said that he had tried to kill himself a year earlier. He said however that he did not have any current thoughts of suicide or self-harm. The mental health caseworker recorded that Mr Lockwood believed that life was not real and that he would not die if he hanged himself. Mr Lockwood said that he believed that life repeated itself and stated that his life was going to end when he turned 41 (on 1 August 2019). He said however that “he will not die, as he never does”. He assessed that Mr Lockwood was not an immediate risk to himself but referred him for a full mental health assessment.

41. During a mental health assessment on 26 April, Mr Lockwood repeated to Nurse A, a mental health nurse, that his life would end at 41 and said that he was hearing

voices. Nurse A told the investigator that Mr Lockwood reassured him that he did not have any plans to kill himself, and that he assessed that Mr Lockwood had delusional ideas, but was not at imminent risk of suicide or self-harm. Nurse A referred Mr Lockwood for a psychiatric assessment.

42. On 22 May, Mr Lockwood's cell was searched during a routine wing search. (This was not an intelligence-led search.) Staff found no drugs or unauthorised items. They did not search Mr Lockwood's cell again before his death.

43. On 24 May, Nurse A reviewed Mr Lockwood. Mr Lockwood continued to say that he was hearing voices, but these voices were "happy voices". Mr Lockwood said that he wanted to take mirtazapine (an antidepressant) and not antipsychotics. Nurse A assessed again that Mr Lockwood was at no risk of suicide or self-harm.

44. On 28 May, Nurse A recorded that Mr Lockwood's case was discussed at a multi-disciplinary team meeting. Nurse A said that he believed that Mr Lockwood was delusional and a consultant psychiatrist agreed to assess Mr Lockwood.

45. On 4 June, staff placed Mr Lockwood on the enhanced regime under the IEP scheme. Mr Lockwood had a job serving food - a job for the most trusted prisoners. He remained an enhanced-level prisoner until he died.

46. On the same day, Mr Lockwood told an officer, his keyworker, that he wanted to achieve category D status now that he had been granted enhanced status. Over the next few weeks, he asked an officer what he needed to do to be granted category D status at his next review in September.

47. On 17 June, Mr Lockwood told an officer that other prisoners were saying things about him which were not true. The officer and a prisoner told the investigator that prisoners were talking about issues related to Mr Lockwood's job as a lead server, such as complaining about the quality of the food. Mr Lockwood repeated these concerns to the officer two weeks later. The officer encouraged him to resolve the issues himself. Prisoners told the investigator that Mr Lockwood was respected and liked and that it was unlikely that he had been particularly affected by this issue.

48. On 24 June, Nurse A reviewed Mr Lockwood. He recorded that Mr Lockwood had no psychotic symptoms on this occasion. Mr Lockwood said he was having problems with his memory and that he was not taking any illicit drugs. Nurse A recorded that Mr Lockwood did not have any suicidal ideas.

49. On 25 June, Mr Lockwood told a DART recovery worker, that he was "drug free" and that he had agreed to reduce his methadone by 1ml every two weeks with the aim of being detoxed by the time he was released. A month later Mr Lockwood requested his methadone dose be reduced to 15 ml daily. It remained unchanged until he died.

50. On 29 June, an officer submitted a security intelligence report as Mr Lockwood and three other prisoners appeared to be passing pieces of paper between them, which might have contained drugs. The officer also recorded this in the wing's observation book and informed the wing's custodial manager. In their intelligence assessment, the security department noted that Mr Lockwood was possibly one of the biggest drug dealers on the wing. Officers submitted no further relevant intelligence reports about Mr Lockwood at Humber.

51. On 4 July, a psychiatrist carried out a full mental health assessment of Mr Lockwood. The mental health case worker was also present during the assessment. Mr Lockwood repeated that he was going to die when he was 41. He said that his death would happen "naturally" so he "would go into the next stage of his life which was going to be a better life without pain". He said that he had no plans to kill himself.

52. The psychiatrist assessed that Mr Lockwood had no symptoms of severe mental illness and that his ideas were not delusional, but a fantasy. He assessed that Mr Lockwood's risk of suicide and self-harm was low because he presented well. The psychiatrist told the investigator that he did not think it was necessary to start ACCT monitoring. He identified that Mr Lockwood would be at heightened risk around his 41st birthday and requested additional support around that time. He recorded the following care plan for Mr Lockwood:

- no change to medication;
- as a precaution, increased support from the mental health team when Mr Lockwood turns 41;
- wing officers to be made aware of potential risks when Mr Lockwood turns 41;
- follow up by mental health team; and
- further medical review as per need.

53. The psychiatrist did not speak to Nurse A about his plan, but clearly recorded it in the medical records and expected him to action it. On 8 July, Nurse A discharged Mr Lockwood from the care of the mental health team. He told the investigator that he did so because after reading the psychiatrist's assessment he understood that he had not identified any mental health issues at that time. Nurse A said that he made this decision on his own.

54. Neither Nurse A nor the mental health caseworker put the psychatrist's care plan into action. Mr Lockwood had no further contact with mental health services and officers did not know that he was to be considered at heightened risk around his birthday.

55. On 31 July 2019, Mr Lockwood told a prisoner that he was going to hang himself "one day". The prisoner told the investigator that Mr Lockwood did not say when he was going to do so and he did not believe him. Another prisoner told the investigator that, two weeks before Mr Lockwood died, he told him that he had a dream that he was going to die "now". Another prisoner told the investigator that Mr Lockwood talked about how he dreamt that his death was going to involve his neck. The prisoners told the investigator that they did not speak to officers about these conversations.

56. Both prisoners also told the investigator that they noticed that Mr Lockwood had blisters on his neck. A prisoner said that Mr Lockwood explained that he had made the marks accidentally with a key. Both prisoners said that they did not tell anybody about these marks. The officers we spoke to, including an officer, did not notice any marks on Mr Lockwood's neck.

57. On 1 August (Mr Lockwood's 41st birthday), a prisoner said that at around 2.00pm, Mr Lockwood gave him psychoactive substances (PS) in the exercise yard. He told the investigator that Mr Lockwood did not take PS in the yard, but said he was

going to use it in his cell. A prisoner said that for his birthday, Mr Lockwood said he only wanted to take PS and "get high".

58. A prisoner told the investigator that Mr Lockwood was taking PS twice a week. Two prisoners also told the investigator that Mr Lockwood was taking PS a lot at Humber. Both prisoners said that Mr Lockwood did not take PS in front of them, but in his cell on his own.

59. At around 2.50pm, Mr Lockwood called his next of kin who wished him a happy birthday. Mr Lockwood complained that he had been locked up all day as there was no electricity on the unit. He made plans to call her again that weekend.

60. At around 3.00pm, Mr Lockwood spoke to an officer and told her that his offender supervisor had told him that he was going to recommend him for category D at the review in September. The officer said that Mr Lockwood was very happy about it. She also said that she was aware that it was Mr Lockwood's birthday, but he had never said that he thought he was going to die on this day. She also said that nobody from the mental health team had informed her that Mr Lockwood could have been at higher risk of suicide or self-harm during this time. The officer said that she did not notice anything concerning about Mr Lockwood during their conversation.

Events on 2 August 2019

61. The next day, 2 August, a prisoner spoke to Mr Lockwood at around 1.30pm and told the investigator that he seemed happy. That afternoon, an officer helped Mr Lockwood sort out an issue with something he had ordered from the prison shop. She said that Mr Lockwood was in "good spirits". She said that she and other members of staff on the wing, had no concerns about Mr Lockwood and remembered that he was laughing and joking.

62. That afternoon, a prisoner had coffee with Mr Lockwood in the prisoner's cell. He said that Mr Lockwood left his cup behind and shouted that he was going to pick it up the next day. He told the investigator that Mr Lockwood did not appear to be under the influence of any drugs and that he seemed fine.

63. At 4.48pm, an officer locked Mr Lockwood in his cell and asked him if he was alright. Mr Lockwood replied yes and did not raise any concerns. Around four minutes later, the officer returned to check on him. She told the investigator that Mr Lockwood was turning on his television. She did not have any concerns about Mr Lockwood and said that he did not appear to be under the influence of drugs.

64. During a routine check at 8.05pm, an operational support grade (OSG) found Mr Lockwood hanging from a ligature made of bedsheets attached to the window. The OSG radioed a code blue emergency (indicating that a prisoner is unconscious or having difficulty breathing).

65. At 8.06pm, an officer arrived at the cell and cut the ligature. The officer said that Mr Lockwood's eyes were open, his pupils dilated, and his face was a greyish colour. The officer and the OSG placed Mr Lockwood on the floor. The officer tried to find a pulse, but found none, and thought that Mr Lockwood was not breathing. The officer started to attempt resuscitation.

66. At 8.07pm, a supervising officer (SO) and an officer arrived and helped with resuscitation. Less than a minute later, an officer brought the emergency medical bag and defibrillator to Mr Lockwood's cell.

67. At 8.09pm, two nurses arrived and continued resuscitation efforts. At 8.23pm, paramedics arrived at the cell and delivered advanced life support, before they pronounced Mr Lockwood dead at 8.42pm.

68. Mr Lockwood left a suicide note in his cell which he did not address to anybody. Mr Lockwood wrote that "it was his time" and that he was "now happy".

Post-mortem report

69. The post-mortem report had not been provided to the investigator at the time of issuing our initial report. The toxicology report found PS in Mr Lockwood's body. The toxicologist noted that PS could lead to suicidal ideation and self-harm, among many other psychiatric symptoms. Methadone was also detected in Mr Lockwood's body at levels consistent with therapeutic use.

Contact with Mr Lockwood's family

70. At 10.22pm, the Governor and an OSG went to visit Mr Lockwood's mother, as he had nominated her as his next of kin. As they could not speak to her, they went to Mr Lockwood's sister's house instead and broke the news of Mr Lockwood's death to her. Mr Lockwood's sister later broke the news to his mother.

71. On 3 August, at 9.45am, the OSG called Mr Lockwood's mother and offered support. The next day, the OSG went to Mr Lockwood's mother's home and offered support in person. His mother's partner, Mr Lockwood's two sisters and his brother were also present.

72. On 28 August, Mr Lockwood's funeral took place. The prison contributed to the costs of the funeral, in line with national policy.

Support for prisoners and staff

73. After Mr Lockwood's death, a prison manager 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.

74. The prison posted notices informing other prisoners of Mr Lockwood'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 Lockwood's death.

Findings

Assessment of risk

75. Prison Service Instruction (PSI) 64/2011, which covers safer custody, provides a non-exhaustive list of a number of risk factors and potential triggers that might increase the risk of suicide and self-harm, and requires staff to take appropriate action, including starting ACCT procedures or referring a prisoner to the mental health team, if necessary.

76. The PSI says that triggers could increase the risk of suicide and self-harm in prisoners, and that is important that staff need to be alert to the hidden triggers, such as anniversaries. It stresses that it is vital that staff remain alert to the changes in a prisoner's risk caused by the triggers and act when appropriate, offering support.

77. Mr Lockwood had a history of mental health issues and substance misuse and had a significant recent suicide attempt. He had thoughts of suicide which he shared with other prisoners. Mr Lockwood was also apparently taking drugs (PS) frequently, which is a well-known risk factor for suicide and self-harm and can affect the prisoner's mental health.

78. Mr Lockwood 41st birthday on 1 August 2019 was a clear trigger for his suicide. Mr Lockwood had unusual thoughts about dying when he turned 41 years of age which he shared with healthcare staff. This was recognised as a trigger for suicide or self-harm by the psychiatrist on 4 July during a mental health assessment. The psychiatrist considered that Mr Lockwood's risk was higher around his birthday and created a care plan for Mr Lockwood to have extra support from the mental health team and officers during this period. Nurse A and the mental health caseworker however failed to carry out the psychiatrist's care plan, and did not offer extra support or tell officers about Mr Lockwood's heightened risk around his birthday. We consider that this lack of communication between the mental health team and officers contributed to Mr Lockwood's death.

79. In our thematic review of mental health issues, published in January 2016, we said that it is vital that relevant information is communicated to prison staff, when that information might affect the prisoner's safety or welfare. When prison staff are well informed about a prisoner's safety or welfare issues, this can help them to relate to that prisoner's behaviour, to recognise distress and to respond in the most appropriate manner to support that prisoner. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that all staff, in particular, healthcare staff follow national and local guidance for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, that they:

    - **identify and recognise triggers for suicide and self-harm, remain alert to the changes in a prisoner's risk caused by these triggers and act when appropriate offering support; and**
    - **share information about a prisoner's mental health or risk factors for suicide and self-harm to provide collaborative care and treatment.**

Clinical care and mental healthcare

80. Mr Lockwood had a history of mental health issues and involvement with mental health services, but did not have any physical health issues.

81. The clinical reviewer found that the care provided to Mr Lockwood was of a mixed standard and overall not equivalent to what he would have received in the community.

Discharge from mental health services

82. On 8 July 2019, Nurse A discharged Mr Lockwood from mental health services without consulting anyone else. Nurse A's rationale for his decision was not clear from his interview with our investigator. The clinical reviewer was concerned that Nurse A made the decision unilaterally outside of a multidisciplinary team meeting. We share this concern. We also consider that Nurse A showed poor judgement.

83. The Healthcare Manager told the clinical reviewer that there was no protocol for the discharge of patients from mental health services at the time of Mr Lockwood's death. However, following Mr Lockwood's death, he has put in place a protocol which provides that patients can only be discharged from the mental health service after agreement at a multi-disciplinary team meeting.

84. We make the following recommendation:

The Head of Healthcare should ensure that prisoners are only discharged from secondary mental health services following multidisciplinary discussion.

Mental health care plans

85. On 4 July 2019, a psychiatrist identified that Mr Lockwood was at an increased risk around his 41st birthday. The psychiatrist created a plan for the mental health team to put in place, including increased support from the mental health team and officers to be told that Mr Lockwood was at heightened risk when he turned 41. Neither Nurse A nor the mental health caseworker put these measures in place. In part, this was because Nurse A discharged Mr Lockwood four days later from the mental health services and overlooked following up the plan.

86. The clinical reviewer was very concerned that Nurse A did not act on the psychiatrist's recommendations. We consider that this was a significant oversight. If the care plan had been implemented, it may have prevented Mr Lockwood's death. We make the following recommendations:

The Head of Healthcare should ensure that there is an effective system in place to monitor compliance with care plans.

The Head of Healthcare should:

- **share this report with Nurse A and discuss the Ombudsman's findings with him;**
- **consider whether any further action is required; and**

- **report back to the Ombudsman.**

Drug strategy and substance misuse services

87. At the time of Mr Lockwood's death, Humber had a comprehensive substance misuse and supply reduction strategy, which had been issued in January 2019. The strategy aimed to tackle the problem of substance misuse by reducing demand, supply and promoting recovery through the DART.

88. The strategy included having a substance misuse service team that worked closely with prisoners, the use of a dedicated recovery wing to provide a supportive environment, and the use of intelligence to tackle demand and supply of illicit drugs.

89. Mr Lockwood was on a methadone maintenance programme and lived on the recovery wing. The substance misuse team worked closely with Mr Lockwood and he had no compliance issues with regards to his methadone. A DART recovery worker said that Mr Lockwood engaged very well during their sessions and his presentation was always positive. The clinical reviewer considered that Mr Lockwood's substance misuse care was well delivered at Humber.

90. We are concerned, however, that the toxicology report found PS in Mr Lockwood's blood at the time he hanged himself, and that prisoners told us that Mr Lockwood was taking PS regularly in his cell. We are particularly concerned that Mr Lockwood was taking drugs on the recovery wing, which is designed to help prisoners with substance misuse.

91. On 29 June, an officer noted that Mr Lockwood and three other prisoners appeared to be passing pieces of paper between them, which might have contained drugs and correctly submitted an intelligence report. We are concerned that, although the security intelligence assessment of this event suggested that Mr Lockwood was one of the main suppliers of drugs on the wing, Mr Lockwood was never tested for drugs at Humber, his cell was only searched on one occasion and he was never charged with offences related to substance misuse.

92. A custodial manager (CM) from the security department told the investigator that Mr Lockwood had links with other known dealers and users in the prison at the time. He said that the security department closed this intelligence report and took no further action because they regarded "informing the wing manager" as an appropriate and sufficient action. We do not agree and consider that more should have been done to investigate and challenge Mr Lockwood's drug use and involvement in the drug culture, for example by means of drug testing and intelligence-led searches.

93. The drug strategy lead told the investigator that the prison had been very successful in reducing drug supply chains. Positive drug tests had reduced by 59%. Prisoners also told the investigator that it is now more difficult to find PS and that fewer prisoners are using drugs. This is very encouraging, but we remain concerned that Mr Lockwood was apparently using and supplying drugs on the drug recovery wing without being challenged.

94. We make the following recommendation:

The Governor should ensure that:

- **effective supply and demand reduction strategies are properly implemented to help reduce the availability and abuse of drugs, including PS;**
- **staff are vigilant to signs of drug use and take appropriate action; and**
- **there is a robust use of intelligence and drug testing to reduce the supply of and demand for drugs, including PS.**

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