



**Investigation into the circumstances surrounding the
death of a man
at HMP Lincoln on 13 June 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2011

This is a report into the death of a man at HMP Lincoln on 13 June 2008. He was found by staff, hanging in his cell in E wing, the vulnerable persons unit. He was 39 years old.

This is the second time that my office has investigated a death in this family which must be very difficult for them to bear. I extend my sincere condolences to the man's family as well as others who have been affected by his death. I also apologise for the length of time it has taken for this report to have been completed and the added distress this may have caused.

This investigation was originally opened by one of my colleagues; who visited the prison and completed a number of interviews. However, he retired before finishing the investigation and it was reallocated to another investigator, in February 2010.

A review of the clinical care and treatment the man received was commissioned and carried out by Dr A of Lincolnshire Primary Care Trust. I am grateful to him for completing this review.

I would also like to thank the Governor and staff at Lincoln, as well as Detective Inspector G and Detective Sergeant K of Lincolnshire Police, for their assistance during the course of this investigation.

The man was accustomed to prison life and was recalled to Lincoln on 1 August 2007, after failing to keep in touch with his probation officer. He was moved to the vulnerable prisoners unit after getting into debt on his residential wing. He got into debts and felt pressured by other prisoners. These events may have been impacted on the man's thoughts when he took his own life. He was being monitored by the prisons suicide support measures and should have been moved to a safer cell.

My investigation was delayed whilst allegations about the conduct of a prison officer were considered. Neither I nor the prison, nor the police have found any substantive evidence that the officer's conduct was the cause of the man's death. However, there is circumstantial evidence that indicates the officer's actions might have led to the man being bullied by other prisoners.

I make ten recommendations. Several concern the management of prisoners subject to self-harm and suicide prevention procedures. The investigation has revealed failings in the completion of the documents relating to such procedures as well as shortcomings in the staffing and training of staff. I also recommend that staff seek medical assessments if a prisoner's physical or mental condition gives cause for concern over a period of time and that staff consider nicotine replacement if a prisoner at risk is on a basic regime, with limited access to tobacco. Staff expressed confusion about the protocol for calling an ambulance in an emergency and some were dissatisfied with the debrief meetings held. Accordingly, I make recommendations on these matters as well as the need for prompt resolution of complaints by prisoners.

At the draft report stage, the man's family provided detailed feedback. We are very grateful for their contribution to the investigation. Some changes in the report have been made to reflect their comments. The man's family continue to have

considerable concerns about the level of care he received while in prison and think that his death could have been prevented.

Jane Webb
Acting Prisons and Probation Ombudsman

September 2010

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SUMMARY

The man was recalled to prison on 1 August 2007, following a breach of his licence. On reception at prison, he had a health screen in which he told staff that he had no previous mental health treatment but that he had a history of drug and alcohol misuse. He was prescribed mirtazapine, an antidepressant and put on a detoxifying, reducing dosage of Subutex to prevent withdrawal symptoms.

The man was used to prison life and quickly settled into the regime. However, he started to deal in drugs and tobacco which resulted in debt, which he could not pay. After he was refused a move to another wing, the man harmed himself by cutting his wrists. He was subsequently moved to the vulnerable prisoners' unit.

Again, the man settled in at first and was promoted to enhanced level on the Incentives and Earned Privileges scheme (IEP). However, he again became involved in dealing Subutex and tobacco, which resulted in further debt. He then started bullying other prisoners and was made subject to the anti-bullying procedures as well as being placed on the basic IEP level. The man clearly found this difficult and appealed against it. At the time, he felt threatened by those to whom he owed money and from 9 June 2008, until his death he stayed in his cell and did not take part in association.

On 12 June 2008, the man asked to move to the segregation unit because of his fear of the prisoners who were threatening him. This was not approved. He subsequently harmed himself by cutting his arms and was made subject to the suicide and self-harm prevention procedures. Throughout 12 June 2008, the man was described as acting in a "paranoid" way and barricading himself into his cell. He continued to make allegations of bullying against prisoners but he refused to sign the statement to this effect unless he was allowed to move to the segregation unit. Governors then said he could not go to the segregation unit given that he was being monitored for his own safety and said that he would be more isolated in the unit.

On the morning of 13 June 2008, an officer was checking prisoners subject to suicide monitoring procedures when she found the man in his cell, hanging from the window bars by a ligature. A code 1 emergency call was made and an ambulance called. The man had barricaded his cell door, so staff had to collect a special key to unlock the doors outwards before they could assist him. As the cell was on the ground floor a senior officer went outside and cut the ligature. Eventually, staff gained access and pulled the man's body out of the cell. Resuscitation attempts were made by healthcare staff and paramedics but he was pronounced dead at 8.41am. Debriefs were held for staff and prisoners subject to suicide prevention monitoring were reviewed. Prison staff contacted the man's designated next of kin.

I make ten recommendations. Several relate to the completion of suicide and self harm monitoring documents as well as the provision and training of staff to undertake the procedures. Additional recommendations cover dealing promptly with complaints, obtaining medical assessments if a prisoner's physical or mental health appears to deteriorate, considering nicotine replacement if a prisoner at risk is on basic regime and procedures to be followed in the event of serious incidents of self-harm or suicide.

THE INVESTIGATION PROCESS

1. The investigation was opened on 18 June 2008, when the investigator Mr A, issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information related to the man's death to make themselves known to the investigator. A number of prisoners came forward and were subsequently interviewed. Mr A met the Governor, deputy governor and the chairs of the Independent Monitoring Board (IMB) and Prison Officers' Association.
2. Mr A was given access to the man's prison files, including the medical records. He later returned to Lincoln on 7 and 8 and 14 August 2008 and 2 September 2008 to interview staff and prisoners.
3. A clinical review of the man's healthcare whilst he was in custody was carried out by Dr A on behalf of Lincolnshire Primary Care Trust.
4. One of my Family Liaison Officers, (FLO's) Ms B, contacted the man's ex wife, his father and his sister to advise them of the investigation and invite them to raise any matters they would like to be addressed. Mr A and Ms B subsequently visited the man's sister and his ex wife. They raised a number of concerns for my investigation to consider. I hope that my report addresses their concerns.
5. Mr A was unable to complete the investigation as he retired from the office. It was re-allocated to another investigator, Ms C, on 1 February 2010. Ms C reviewed the documents. She also visited Lincoln prison and obtained further information, including Assessment, Care in Custody and Throughcare (ACCT) documents and other records relating to the man's time in custody. Ms C also met with Detective Sergeant G and Detective Inspector K.
6. Ms C re-interviewed an officer previously interviewed by Mr A. Throughout the investigation, she liaised with and met with Lincolnshire Police about their investigation into alleged offences by a prison officer who worked on the wing where the man died. Detective Sergeant K and Detective Inspector G shared police statements and a letter that the man wrote shortly before his death. The investigation into the behaviour of the officer and subsequent police enquiries resulted in a delay to the completion of this report.
7. On 11 March 2010, two of my family liaison officers, Ms D and Ms C visited the man's sister at her home, in response to her request. They discussed her original concerns and noted further issues. His sister had heard that a prison officer who had worked on the man's wing at Lincoln had been dismissed from the Prison Service for supplying drugs and mobile telephones and bullying prisoners. She believed that this officer had impacted on the man's state of mind when he took his life and wanted the investigation to clarify any involvement and what the prison did about this. The man's sister was aware that a colleague had reported the officer to the prison security department.

8. The man's sister also wanted to know why her brother had been prescribed mirtazapine. She understood that in the first few weeks of taking it there was a higher risk of suicide.

Post mortem and toxicology reports

9. A post mortem was carried out by Professor G, a forensic pathologist. A full copy of the report is attached as an annex to this report. The summary of his findings were that there was no evidence of natural disease that had contributed to the man's death and no marks that would raise suspicion about the man having been a victim to violent assault, or having been restrained against his will.
10. The toxicology report informed that there was nothing suspicious in the man's blood or urine.

HMP LINCOLN

11. HMP Lincoln was built in 1872 and is a category B prison holding male prisoners. New prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A prisoners being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult. The prison's design is typical of the times, with galleried wings spreading out from a central core. All cells have integral sanitation. It serves the nearby courts of Lincolnshire, Nottinghamshire and Humberside. The prison holds remand prisoners and those serving short sentences or waiting to be moved to another prison. It holds a maximum of 738 men, which includes a small number of remanded young offenders.
12. There are four main residential units. A wing consists of the first night centre and holds prisoners on induction. B wing holds sentenced prisoners and C wing holds remand and convicted prisoners. D wing is the segregation unit and E wing is the vulnerable persons unit. J wing holds prisoners on short duration drug treatment programmes.
13. Healthcare at Lincoln is commissioned by NHS Lincolnshire and is provided by Lincolnshire Community Health Services. There is inpatient accommodation.
14. The former Chief Inspector of Prisons completed an inspection of Lincoln in December 2007. She said of the prison, in general terms:

“Lincoln prison has gone through a difficult period, but this inspection found that normality had returned, with both accommodation and staff morale repaired following the disturbances. In effect, the prison had successfully turned a particularly unfortunate page in its history. The new governor still has plenty of work ahead to develop a fully effective local prison, particularly given the poverty of purposeful activity, but there are some solid foundations now in place.”

In respect of E wing, the former Chief Inspector of Prisons commented as follows:

“During the previous 10 months, 128 bullying information reports had been received. ... The most significant issue to have emerged was the disproportionate number of bullying incidents (56) alleged to have occurred on E wing.

The strategy to address bullying, and its consequences for both victims and perpetrators, was acknowledged to be inadequate, and a revised strategy was due to be launched shortly after the inspection. ... Allegations of bullying were followed up with some form of investigation, although this was frequently frustrated by prisoner's unwillingness to

appear as witnesses. ... There had been no formal training of staff in bullying matters.”

The former Chief Inspector of Prisons said of the vulnerable prisoners’ unit:

“The sex offenders alleged that others on the wing operated in a bullying fashion towards them. There was no compact to regulate expected behaviour, and the consistent involvement of staff in prisoners’ lives was ineffective.

“There was no clear protocol on how to decide whether a prisoner could be accepted onto the wing.” ... Between 40% and 50% of the bullying incidents reported each month emanated from E wing, and this had been the case for several months before the inspection. However, at the time of the inspection there were no prisoners on E wing on the basic level of the incentives and earned privileges (IEP) scheme, and none were being monitored under the anti bullying strategy.

“In group discussions, the vulnerable prisoners were the most negative group in regard to feeling that they were ignored by the establishment. They were the most critical of the personal officer scheme, and wing files examined on this wing showed the least evidence of entries made by staff about prisoners. On some days during the inspection, none of the staff on duty on E wing were regulars.”

15. The former Chief Inspector of Prisons made three recommendations:
- Clear protocols should be drawn up to establish which prisoners should be admitted onto E wing.
 - There should be regular staff on E wing.
 - The personal officer scheme on E wing should be re-launched.

Independent Monitoring Board (IMB)

16. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the Prison Service and the prison’s management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and any areas of concern.
17. Lincoln’s latest IMB report covers the period 1 February 2008 to 31 January 2009. The Board noted that “drugs and mobile phones continue to enter the prison but the proactive regime has resulted in a significant number of finds”. When referring to safer custody, the Board noted that there had been two deaths during the reporting year and 195 reported incidents of self-harm. They said that the Listener’s scheme was well used and there was a well regulated violence reduction policy.
18. Since this office assumed responsibility for investigating all deaths in prisons in 2004, 14 deaths at Lincoln have been investigated. Ten of these were

apparently self inflicted. The report of one of these has yet to be published. In respect of the other nine, none of the recommendations made are relevant here.

Assessment, Care in Custody and Teamwork (ACCT)

19. ACCT is the process used to monitor and support prisoners assessed as at risk of committing suicide or self-harm. Once placed on an ACCT plan, the prisoner is observed during the day and night at intervals determined by their perceived level of risk. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner within a prison.
20. Prison Service policy is that whenever, a prisoner harms himself, an ACCT plan must be initiated and the following procedures carried out:
 - A Concern and Keep Safe form must be completed as soon as possible after the initial risk has been identified.
 - An Immediate Action Plan must be compiled within 24 hours of the risk being identified.
 - An assessment interview must also be completed within the same time scale.
 - A first case review must also be held within 24 hours. At this review a Care and Management Plan (or Care Map) must be agreed with the at-risk prisoner. Subsequent reviews must also be planned if it is decided that the ACCT plan must remain open. When it is considered appropriate to close the ACCT plan, a post closure review must be held within seven days of closure. Case review panels must comprise a multi-disciplinary panel and must make judgements as to the level of risk the prisoner presents and how often he/she needs to be observed and engaged in conversation.

Association

21. Association is the period of time when prisoners are unlocked from their cells and are able to associate with each other.

Canteen

22. Prisoners can buy goods such as tobacco, sweets, soap, toothpaste etc via a process known as 'canteen'. However, canteen is also the term used for those goods once they have been purchased and are in a prisoner's possession.

Counselling, Assessment Referral Advice and Throughcare service (CARATs)

23. The CARATs team provides assistance to offenders with a range of drug or alcohol related problems. They assess prisoners and provide counselling and support, as well as referrals on release, and implement care plans.

Cell sharing risk assessment (CSRA)

24. The CSRA is used to assess the risk a prisoner poses to a cellmate if they are required to share a cell. All prisoners are subject to this assessment on reception and includes taking into account the situational context of any previous violence or mental health issues. It is a live document, which is reviewed at any point and follows the prisoner on transfers to another establishment.

Cut down tools

25. Cut down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with prisoners are issued with and must carry their own tool.

Emergency codes

26. Lincoln operates a code system to help staff alert their colleagues to an emergency through the radio network. Code 1 indicates a life-threatening emergency (for example, a heart attack or hanging). Code 2 indicates a non life-threatening act of self-harm.
27. When a code 1 is used, it is broadcast to healthcare as “hotel 1” and healthcare staff must attend with their orange emergency bag. Amongst other equipment, it contains observation equipment, a blood pressure machine, pulse meter, minor dressings, oxygen masks, ambu-bag (to assist with breathing) and some emergency medication such as adrenaline. Other equipment that should be carried to a code one includes an oxygen cylinder and a defibrillator (this monitors the heart’s activity).

Incentives and Earned Privileges scheme (IEP)

28. The IEP scheme was introduced to encourage and reward good behaviour in prisons. There are three levels: basic, standard and enhanced. Incentives include access to in-cell television, more private cash to spend, being able to wear their own clothes, more time out of cell and access to extra and enhanced visits. Each prison sets its own criteria to obtain each level.

Personal officer scheme

29. The personal officer Scheme was introduced to give prisoners a more consistent approach in a prison. The scheme is nationally operated but each prison has its own way of delivering it. Prisoners are given a named officer that they can approach for general advice or to resolve complaints. The officer also completes reports on prisoners for which they are responsible and ensures entries are made in their wing history files.

Police investigations into deaths in custody

30. The police are notified by the prison as soon as any death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that the Ombudsman's investigators are allowed to begin their own investigations.

Licence and recall

31. Prisoners are generally released into the community on licence partway through their sentence. They are given licence conditions which generally state that the released prisoner should attend at the probation office to see their probation officer on a pre-arranged basis. Conditions also relate to the prisoner living at a particular address and being of good behaviour. Licence conditions are linked to the risks that the prisoner poses and are specific to that particular individual and their offence. If a prisoner on licence fails to meet the conditions they will be recalled to prison to serve the remaining part of their sentence.

Listeners

32. Listeners support vulnerable prisoners, particularly those at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.

Rule 45/vulnerable prisoners' unit (VPU)

33. Prison Rule 45 relates to the segregation of prisoners for the good order of the prison or for their own protection. They can be moved to the vulnerable prisoners' unit or the segregation block.

Security Information Reports (SIRs)

34. A security information report may be submitted by any person who believes there to be a threat to national security or the security of a prison establishment. It can also contain information needed to keep good order and control within a prison and to prevent and detect crime.

KEY FINDINGS

35. The man was familiar with prison life, having served a number of short terms in custody. He was sentenced to three years and six months imprisonment on 16 January 2006 and released on licence on 29 June 2007. The man was recalled to Lincoln prison a few weeks later on 1 August 2007, for failing to attend a Probation appointment on 24 July 2007 and for not residing at his approved address for three weeks, having been evicted a few days after his release from prison.
36. On reception at Lincoln, the man said he was detoxifying from heroin with support from his community doctor. He also said that he had problems with his use of alcohol. He was therefore referred to the CARATs team.
37. In his first healthscreen assessment, the man said he had no concerns about harming himself and no mental health problems. However, the medical record states that he presented “in low mood” and that he discussed and agreed to resume taking mirtazapine, an anti depressant. He was also put on a managed withdrawal programme dosage of diazepam (to treat anxiety) and Subutex (to prevent withdrawal symptoms). This was given in a reducing dose over a two week period ending on 15 August 2007. The man was also prescribed ibuprofen and paracetamol (painkillers), zopiclone, (a short term sleeping tablet) and chloridiazepoxide, (an anxiety relieving drug, used when someone is withdrawing from drugs or alcohol). It is important to note that wing staff do not have access to clinical notes because these are confidential to healthcare and PCT.
38. The man was put on C wing at the prison and a note was made that he should not come into contact with another prisoner, Mr B, who was on B wing. His induction records inform that Mr B was then in a relationship with the man’s wife.
39. On 7 October 2007, the man approached staff with serious concerns for his safety because of the debts he had incurred on C wing. He said that he “owed 10 packs of tobacco to various people”. He therefore felt under threat and pressure to pay this back but could not do so at the time. He felt the debt would follow him to another prison or any other wing other than the Vulnerable Prisoners’ (VP) wing. The man was asked to make a statement naming who was putting pressure on him, but he refused to do this, so he was advised that he could not go to the VP wing. In response the man used a razor to make superficial cuts to his wrists. Staff therefore placed him on the ACCT suicide and self-harm prevention procedures.
40. As part of the ACCT assessment, the man reiterated his concern for his safety and said that he was not attempting to kill himself but to show staff how desperate he was to move to another wing. No triggers for the self-harm were recorded on the appropriate page of the ACCT documentation, but the concern and keep safe form said that the man had harmed himself because he was heavily in debt and unable to repay what he owed. He felt very threatened and vulnerable and asked to be made subject to rule 45 and go to

the VPU or the segregation block for his own protection. Officer A completed the assessment interview and noted that, as The man had now been granted VP status, he no longer had any further problems. He had cut his wrists as a cry for help rather than as an attempt to kill himself.

41. The man then moved to the VPU (E wing). Senior Officer A and Officer B carried out a review of the ACCT on 11 October 2007. The man said that most of his problems had disappeared now that he had moved wings. He believed there was no reason for staff to continue monitoring him under the suicide and self-harm procedures, so the ACCT plan was closed. A post-closure review date was set for 18 October 2007, but there is no evidence that it took place. The people present at the review stages of the ACCT were wing staff. There was no health or mental health input into the assessments or plans.

Allegations of bullying

42. On 14 January 2008, a prisoner made an allegation that the man had bullied him. As this could not be substantiated, no further action was taken. The man subsequently settled into E wing and records in the wing history book are positive, showing that he was eventually raised to enhanced IEP status on 14 February 2008.
43. A Security Information Report (SIR) completed on 13 March 2008 gave corroborated information that the man had verbally abused another prisoner in the workshop. The man was put on stage 1 of the violence and anti-social behaviour procedure (VAAB). The procedure requires wing staff to observe the prisoner on the VAAB and make notes about his behaviour.
44. The next day, wing staff saw the man with a large bag of canteen that they did not believe was his. A further SIR was completed reporting that The man tried to persuade the cleaners to obtain drugs from the main wings and he paid another weaker prisoner to act in a bizarre way. Staff put him on stage 2 of the VAAB and his status was reduced to the basic regime. Observations of the man's behaviour were continued.
45. A number of further SIRs stated that the man was dealing Subutex on the wing. This information came from other prisoners. Staff responded with a range of actions, from observation of the man and mandatory drug tests, to thorough cell searches. He was also referred to Ms E, a psychologist. In her report dated 27 March 2008, she recommends that his drug misuse should be addressed. She noted that he had applied to attend a drug programme but at that time it had been deferred because of the man's lack of motivation to engage.
46. Ms E also recommended that the man should "address his cognitive deficits" by attending the Enhanced Thinking Skills Programme (ETS). (The ETS programme teaches offenders to become aware of their thought processes and learn to change them so that their actions and behaviour changes, with a view to reducing their offending and lowering their risk.) Ms E said that the

man had been considered for a place on ETS at HMP Stocken in 2006, but was not offered a place because “he did not meet the intellectual functioning criteria”. Attendance on ETS programme has a particular criterion, which requires the attendee to have a certain level of thinking skills. This is assessed by psychometric tests. However, the man said he would discuss working on his thinking skills on a one to one basis but would not comply with targets if he had to do the whole of the remainder of his sentence. There is no evidence of the man taking part in either of the above programmes prior to his death.

47. On 28 April 2008, a prisoner reported that the man was receiving Subutex at visits and bullying prisoners in the medication/treatment queue. A further report alleged that the man had a mobile telephone.
48. Staff conducted a search on 13 May 2008 and found a number of items in the man’s cell. These were:
 - Excess tobacco
 - 14 batteries
 - Two pieces of foil
 - Half a Subutex tablet wrapped in a plastic bag (found in the man’s track suit bottoms)
 - Hand drawn map of the laundry area.
49. In line with prison policy, staff confiscated the property and reported the man for a disciplinary offence. A prisoner made a further allegation that the man paid a prisoner an amount of tobacco to assault another prisoner. Staff subsequently dismissed the man from his job in the laundry. Wing history records show that he was disinterested in this.
50. On 16 May 2008, a number of prisoners completed statements saying that the man was still “bullying and lending out”. (Lending out is a term used when prisoners lend out property or money for repayment or profit.) SIRs on 17 May alleged that he threatened another prisoner saying he would not be able to “ ... eat his tea tonight. Even if he was banged up, it would be taken care of”. (The term banged up means when a prisoner is behind his locked cell door.) This prisoner was recorded as being “frightened to come out of his cell”. Another prisoner said that the man had sold Subutex for £25 and was now pressurising the prisoner for the money, to the extent of threatening him by putting an unknown price on his head.
51. It is not clear from the records when the man came off stage 2 of the VAAB procedure but he submitted an appeal to Governor A on 22 May 2008, saying that he had been put back on stage 2 after “just being taken off basic on 21 April 2008”. The man’s comments were:

“ ... because I have been on stage 1 and 2 up until the 21 April, I was placed back on stage 1 on 24 April, for apparently bullying at laundry. I was 2 days from being back to usual, then on Saturday I was placed on stage 2.”

52. The man then complained about a number of officers and asked for evidence for why he had been put back on stage 2. He said in the appeal form that he had stopped bullying after his last incident. Governor A replied that he would investigate the matter further and write to the man again. The investigator asked for the subsequent response to this matter and was told that at the time of the man's death the complaint was still in the administrative processes.

Assessment, Care in Custody and Teamwork 28 May

53. An ACCT plan was opened on 28 May 2008 at 8.30am by Senior Officer B, when staff advised the man that he would be transferred to HMP Nottingham that day. The man was expecting a visit from his sons the following day and was very angry and upset that he would miss seeing them. He told the officer that if he was moved before his visit he would "cut up". According to Senior Officer B, the man then made superficial cuts to his wrists with a razor blade. He refused to be assessed or treated by healthcare staff. In view of his actions, he was placed on the ACCT monitoring procedures with hourly observations and conversations. At 4.05pm, Senior Officer C and Officer C reviewed the ACCT. The man said he had been waiting for ten months for a visit from his ex-wife and sons. He was also upset that he was on the VAAB stage 2 and felt he had been "set up". He said that he only cut himself so that he would be heard and did not tell staff who he thought had implicated him.
54. Senior Officer C wrote in the review that this was an isolated incident because the man wanted to make sure he would have his visit the day afterwards. She then closed the ACCT procedures at 4.20pm. The man did not transfer. On 4 June, Senior Officer B completed the ACCT post-closure review. The man said he had no problems, after having his visit.
55. Staff recorded in the wing history sheets that, from 9 June 2008, until the man's death, he refused to come out of his cell and declined exercise. On 11 June 2008, Officer D told Governor B that the man wanted to see her about his request to go to the segregation unit. Governor B made a number of enquiries with other managers about his request. Governor C told her that his allegations of bullying were being investigated and they did not think that the man's move to the segregation unit was justified at this stage. She asked Officer D to tell him that she would speak to the other governors the following day and a decision would be made about his location. She then emailed Governor D and Officer D, asking them to confirm whether they were dealing with the bullying investigation and the progress on it. She copied it to Officer E as the violence reduction manager. The investigator has not had sight of this email because it has been deleted from the system. Governor B then discussed the issue at the staff briefing on 12 June 2008 and asked Governor D to speak to the man about his request.

Evening and early morning of 12/13 June

56. Senior Officer B said that throughout 12 June 2008, the man's behaviour was "becoming increasingly bizarre". He put furniture behind his cell door and

barricaded himself in. He was screaming and shouting, pleading for Officer E not to hit him. Officers were initially concerned about his mental health, but said he became lucid a few minutes after each episode. This went on until lunchtime, when Officer F opened the ACCT monitoring procedure.

57. Officer F made the first note on the ongoing record in the ACCT document at 1.15pm. He said that he was concerned because the man told him that officers are talking about him all the time and that he has had enough and will “cut up if he hears anything else”. Officer F also mentioned that the man had shown him a blade that he was going to use.
58. The next page of the ACCT document is the immediate action plan, completed by Senior Officer B and Officer G at 2.30pm. It does not say if they removed the blade and it is not clear from any statements made subsequently. However, there is no further mention of the blade being in the man’s possession. The actions mentioned in the plan were as follows:
 - “Re his location – The man is happy to be alone at present. He is high cell share risk assessment (CSRA)
 - Re frequency of support – Hourly observations and conversations when awake.
 - Re phone access – As and when required
 - Re Listener access – High risk – unsuitable for Listeners – access to Samaritans phone.
 - Re other immediate interventions – the man states he was purely trying to instigate a move to D wing by threatening self-harm – states he has no intentions.”
59. At some time in the afternoon before 4.00pm, Officer E and Senior Officer B talked to the man in his cell. Officer E said that the man was acting “very paranoid, saying he had heard staff radios saying things like, he’s grassing you all up, it’s the man, he’s grassing you all up”. When the man calmed down he explained that he had taken £100 from a prisoner, Mr C, to buy drugs for him. He also said he owed prisoner Mr D £80 for Subutex and another prisoner £60 for tobacco. He said that he had planned to get these drugs through visits from his ex- wife but she did not bring them, leaving the man in debt to the two prisoners. He said that they had threatened to “slash” him a week ago and they were making threats through his cell door. He also said that prisoners from other wings were making threats to him for “grassing up his missus”. The officers checked cash disbursements and found that on 7 May 2008, Mr C had sent out £160 to the man’s ex-wife.
60. Officer E wrote what the man had told him in annex B of the VAAB records, so that anti-bullying proceedings could be started against the two prisoners. The man said that he felt under threat on E wing and the other wings and wanted to go to the segregation unit on D wing. Officer E told the man that he was unlikely to be moved because he was subject to ACCT procedures. The man then repeatedly said “well I’m not suicidal, I’m not going to hurt myself, it’s just a ploy to try and get off the wing”. He refused to sign his statement about the two prisoners because he would not be moved off the wing.

61. Officer E then made enquiries about the man's request to be moved, with Governor E, who said "well that's ok, move him". However, when he was told that the man was subject to ACCT monitoring he said that the man could not be moved because "that was different". The investigator asked why the man could not go to the segregation block if he was subject to ACCT procedures and was told that there was not enough support there and the risks to the man's health were potentially higher in that environment because of the isolation.
62. Later that afternoon, Officer E saw Governor D (Head of Residence) and told him about the man. Governor D said "well this can't go on like this because the poor lad is not going on exercise, he's not coming out of his cell; he's not getting anything at all". He said that he would speak with Governor E.
63. At 4.00pm, Officer C completed the man's ACCT assessment interview. This should be completed within 24 hours of the concern being raised. The man said he had debt problems on the wing and reiterated that he took money from other prisoners with the intention of supplying them with drugs, which he had arranged to be brought in via visits. The person with whom he made these arrangements had now spent the money and the debt now lay with him (the man). He wanted to go to D wing and at dinner time, said he would harm himself to get off the wing. He explained that he only said it to get moved and he "didn't mean it".
64. The man told the officer that prisoners were calling him names and said that he felt "hounded by the other prisoners and felt stressed out". The officer noted that the man was using the ACCT to manipulate the system and that he had no real thoughts of self-harm or suicide. The officer then commented on the section covering previous self-harm and suicide attempts that the man "has a history of self-harm, cut wrist this was to get off C wing last year, cut wrist again to get out of going on tx (transfer) to Nottingham last month". Of his current mental state, he said "feel ok, just want off E wing" and he had no current suicidal thoughts or intentions. In the section titled "Any other areas of discussion", it is recorded that the man "feels he has done the right thing and what has been asked of him by making statements and naming names. Feels stressed he is still here on the wing."
65. The action following the above assessment was completed by Senior Officer B, Officer C and the man. The man was advised that he would not be moving to D wing and due to his IEP basic status, he was unable to have tobacco. Staff agreed to keep the ACCT plan open but to reduce to minimum observations of three per day, to support the man. At this time, they assessed him as low risk of further risk of self harm. Staff then completed a care map with four objectives. For the man to:
 - Be in and out of his cell to use his time constructively.
 - To share a cell.
 - To be located in a safer cell.
 - To have family contact.

66. However, it was noted in the care map that “the man is refusing to engage in out of cell activities at present” and “the man is currently a high risk cell sharing assessment and is refusing to share”. Approval for him to be located in a safer cell was noted. (A safer cell is defined as one in which the opportunity for a prisoner to hang himself is minimised. The man was not in a safer cell, when he died.) He was said to be in regular contact with his children (although he had previously said he had waited ten months for a visit from them). The next review was scheduled to take place on 16 June 2008.
67. In the ongoing record, Officer G noted at 1.50pm that the man is “losing it – becoming paranoid”. After the assessment at 4.00pm, there are three entries at 6.30pm, 7.55pm, 11pm on 12 June 2008 and then at 8.05am on 13 June 2008, which is when the man was found hanging.
68. On the front sheet of the ACCT document neither the man's date of birth, nor the date that the ACCT was opened were recorded. The next page of the document did not include triggers or warning signs and was not signed by the man. The record of handover and briefing of ACCT documents page started at 1.30pm and the name of the officer is illegible but Officer H (the man's personal officer) also put his name on it.
69. At interview, Senior Officer B said that he believed the man when he said that he had only cut himself in order move cells and that he would not harm himself which is why he changed the observations to the minimum. He also said that if he had the power to move the man he would have done so because he knew him and saw his “bizarre behaviour” as a plea for help. He believed the man's situation was “dire”. Senior Officer B added that he saw him in the evening when another member of staff reported to him that he had barricaded everything up behind his cell door. The SO advised that staff take no action but should keep an eye on the man. After ten or 15 minutes the man had taken down the barricade. Senior Officer B said he spoke to the man but could not recall what they talked about.
70. At 8.30pm, the night Officer Support Grade (OSG) T went to the wing for a handover about prisoners on ACCT plans. He said there were 13 prisoners subject to ACCT monitoring on the wing. The OSG told the investigator that he was not ACCT trained at this time. He said he was told how to do ACCT monitoring by another OSG but he did not know if the other OSG had been trained. The man was on minimum observations, one in the morning, another in the afternoon and the evening but no night checks were required.
71. OSG T checked the man at 11.00pm and wrote in the ongoing record, “The man on his back, appears asleep”. He said he answered the man's cell bell later that night but he was not sure what time. (Each cell has a bell which prisoners can press if they need urgent help.) The man asked for a cigarette but OSG T said he did not smoke and could not give him a cigarette.
72. OSG T said that he carried out the morning roll check (count of prisoners) at approximately 5.40am. He saw the man sitting on his bed. He asked him if

he was okay but he did not answer. OSG T said that was not unusual and he had no concerns. The man's cell furniture was in the normal position at this time. OSG T said he did not hear any unusual shouting over the night, nor did he hear any furniture being moved. He left the wing at about 7.30am.

73. Mr E, a prisoner, told my investigator that he was in the cell next door to the man on the night of 12/13 June. About 8.00pm on 12 June 2008, he heard the man shouting out of his window, to another prisoner, Mr D. He heard the man shout, "I'll show you bastards tomorrow". He thought that the man meant he was going to hit Mr D or someone else who he was shouting to. Mr E heard OSG T at the man's cell door around 6.00am and he heard the man asking him for a light. The OSG refused and the man shouted, "I will punch your lights out". He heard the man's cell chair bang between about 6.00am to 6.30am and thought that the man, might have kicked it in temper. He also told the investigator that no morning roll checks were done, until the man was found at about 8.00am. However, a copy of the morning roll check was given to my investigator.
74. Mr F, a prisoner, told the investigator that in the evening of 12 June 2008, the man told him that a fellow prisoner, Mr C, had "grassed him up for dealing" so the man had "grassed up "Mr C" ". (The term grassed up is when one person informs on another.) Mr F said he had seen Mr C at the man's cell door on the night of 12 June 2008 and he heard Mr C say "If you grass me and I get put on bullying I'll show you what bullying is". An officer then moved Mr C away from the man's cell. Mr F said that the man had stayed in his cell for three or four days because he was being bullied by Mr C. He also said that he thought the man had mental health problems as he was erratic but did not have any concern that he would have harmed himself. He said the man would buy and sell anything and always had, "sweets, biscuits, tobacco etc but recently he had none".

13 June

75. Officer J came on duty at 7.45am on 13 June 2008 and was given a briefing. She told the investigator that she was the ACCT worker for the wing. (The ACCT worker is the person who checks all prisoners subject to ACCT monitoring, as per the instructions on the front of the ACCT document.)
76. Officer J explained that the man was having morning, afternoon and evening observations which meant the ACCT worker should have a meaningful conversation with him during these times and then complete the ongoing record. The officer said that she felt under pressure because there were so many prisoners subject to ACCT procedures. She had previously brought this to the attention of governors previously and had written it in the observations book. She said "there is no way I can keep prisoners safe, as is my job as keyworker, when there are 13 of them". She said there were 14 prisoners on open ACCTs on 13 June 2008, with one prisoner having constant supervision. Most of them were to be checked every half hour or hour.

77. Approximately 8.04am, Officer J went to the man's cell, E13 and looked inside through the door flap. She saw what she thought was the man standing, looking at the picture board on the wall. As she went to walk away, she felt that something was not quite right and so she checked again. She tried to open the door and Officer K, who had seen the distress in her face, went to help her. They were unable to open the door and Officer L also went to help.
78. Officer J called a code 1 emergency over the radio but the controller didn't hear clearly at first so she immediately put the call out again. Senior Officer B and Principal Officer A went to the man's cell door. The door had been barricaded by cell furniture and the man was hanging from a ligature, which was tied to the cell window bars. For a few moments the staff tried to open the door but realised that they could not open it. An officer went to get a special Allen Key that enabled them to open the door outwards. This key was kept in a locked cabinet in the office on the threes landing. Other officers and healthcare staff responded to the call and saw officers trying to kick the door inwards. As the cell was on the ground floor, Senior Officer B then ran outside the wing and used his cut down tool to cut the man down from the window bars.
79. Whilst Senior Officer B did that, the cell door was opened with the Allen Key. Officer L and Senior Officer D went in, climbed over the man's chair and bunk bed, onto the sink. They jumped over to where the man was lying, the ligature having been cut by Senior Officer B. Senior Officer D told the investigator that the barricade had been made by the man moving his cell chair against the door, then pushing the bunk bed and finally moved his cabinet against them.
80. There was not enough room in the cell for the healthcare staff to treat the man. Therefore, while they were waiting to get into the cell, they decided that it would be best to move him out of the cell, onto the landing to treat him. Senior Officer D and Officer L lifted the man onto the top bunk, whilst Officer M moved the other furniture out of the way. They then lifted him out of the cell and laid him on the landing and the nurses took over. My investigator asked Senior Officer D when an ambulance was called. He said that he was not sure whether if a code 1 was called; the controller would call an ambulance to put it on standby. Officer M said he asked control to call for an ambulance.
81. Nurse A responded to the code 1 call. She told the investigator that, whilst officers were trying to get the man out of the cell, she and the other healthcare staff discussed how they would manage the situation. They agreed that to treat the man in the best way it would be better to move him out, because there was very limited room in the cell. They was decided that Nurse B would take the man's airway, Officer E would carry out chest compressions and she and another nurse would get the equipment ready. All four had been fully trained to deliver cardio pulmonary resuscitation (CPR). In the meantime, Nurse A managed to get into the cell and make some observations of the man. She described him as "floppy and not moving. His pupils were fixed and dilated, there were no breaths". She checked for a pulse in his thigh and there was none.

82. As soon as the man was brought onto the landing, Nurse C started chest compressions at a ratio of 30 compressions to two breaths, as per clinical guidelines. Nurse A connected the defibrillator and Nurse B put in an airway and attached oxygen and an ambu bag. (A defibrillator measures electrical activity in the body and advises on the action to be taken. An ambu bag provides ventilation to a person who is not breathing.) Nurse B told the investigator that there were no signs of life at this time. The defibrillator advised not to shock. They carried on with compressions and oxygen until 8.20am, when the ambulance and paramedics arrived. The ambulance staff took over CPR and gave the man atropine, (Atropine is a drug used to increase the heart rate and reduce secretions.) to which there was no response. The man was pronounced dead at 8.41am.
83. Whilst this was happening, prisoners were taken back into their cells and a screen was put around the man. Staff also conducted a review of prisoners on the wing at risk of harming themselves.
84. Lincolnshire Police went to the prison and started an investigation. They took possession of the ligature and a letter that the man had written, dated 11 June 2008. My investigator received a copy of the letter from the police in May 2010. It was addressed to xxxx/to whom it may concern. In the letter, the man said that he had got into trouble on the wing and that he had given the names of the people to whom he owed money to staff. He also wrote that he had complained about staff and he believed they were going to let those to whom he owed money into his cell in the morning, "to drag me out to the shower rooms and ... I'm going home in a body bag". He went on to say that suicide would be less painful than what some prisoners had in mind for him.
85. The duty care team attended and spoke to some of the staff who were involved with the man. Governor F then had some meetings with the staff who had attended to the man. It is not clear from the interviews how many meetings took place but it seems that there was one called a hot debrief. (A hot debrief is a meeting for staff to discuss emotive issues and any lessons learned following serious events such as deaths in custody, hostage situations or escape attempts.) Staff did not seem to be clear as to the purpose of the meetings. Several of them said during interview that they did not feel that the hot debrief was useful. They said it seemed to be an attack on them rather than a supportive environment. My investigator was also told that in one of the meetings, Governor F had spoken about the man's brother having committed suicide previously and said that the man's girlfriend was meant to bring drugs into the prison for him. Staff did not feel that this was appropriate.
86. At the time of his death, the man had nominated a friend as his next of kin. After making extensive enquiries within the prison and Probation Service, the prison family liaison officer telephoned the man's ex wife and arranged for her to go to the prison. She then made arrangements for the man's funeral and agreed that the prison would pay the costs. When a death occurs in a prison

staff are required to contact the prisoner's listed next of kin, which is not always necessarily the legal next of kin.

87. When she went to the prison, the man's ex wife explained that the man had a sister and asked the prison liaison officer to inform her of his death. I understand the man's sister was not told of his death until later in the day and that this was by telephone. My investigator asked the Governor about this and was told that the prison did not have details or the address of his sister and relied on information obtained from the man's ex-wife.

Additional information given by prisoners and staff after the man's death

88. Over a few days after the man's death, a number of prisoners came forward to give information. One prisoner told my investigator that the man was dealing in Subutex and mobile telephones on the wing. He initially said that this was with the help of a prison officer, who was giving the man "a hard time" on the wing. However, when he was sent the interview notes for his signature, he denied that he had ever said that the officer was involved in the bullying. He made allegations about other officers on the wing and said that he had put in a complaint about one of them. However, when my investigator asked the prison for any information about this, she was told that there was no record of any complaints being made about that officer.
89. Mr G, another prisoner, wrote to Her Majesty's Inspectorate of Prisons (HMIP). In his opinion, the man's death was due to the negligence of prison officers. My investigator made enquiries and was told that HMIP had replied to Mr G telling him that the Ombudsman's office would deal with the issues when they investigated the man's death. He did not come forward to be interviewed at the time and, when my investigator made enquiries in 2010, he had been released.
90. My investigator made further enquiries about the allegations of a prison officer being involved in the man's death. She was told that about two weeks before the man's death, Senior Officer B had given information to the prison security department about the possibility that an officer was taking drugs and mobile phones into the prison. An investigation was started and in mid July 2008, an officer was suspended pending a disciplinary investigation. Lincolnshire Police were notified and a criminal investigation began. This was later considered when the police investigated the man's death and is discussed later in this report.
91. My investigator conducted a further interview with Senior Officer B on 11 March 2010, when he gave an account of what he thought might have happened between the man and the officer who was subject to disciplinary and criminal investigations. As a result of the information given in the interview, Lincolnshire Police made further enquiries with Lincoln prison staff and they re-interviewed Senior Officer B and two other staff members to clarify the issues raised, particularly with regard to the allegations that a prison officer had been involved.

Police statements and potential involvement of corrupt prison officer

92. Senior Officer B made a further statement to police on 21 May 2010. He told them that at no point had the man told him that he was being put under pressure by the officer but had said that he was being bullied by a prisoner. Senior Officer B said that he formed the impression that the man wanted to tell him more but “could not do so”. He said it was his personal opinion that the officer may have been behind the prisoners’ bullying of the man. Senior Officer B reported his concern on SIRs which were passed to the security governor. The allegations made against the officer were investigated by a Governor from another prison between February and May 2009. A number of disciplinary charges were laid relating to trafficking of contraband, entering into an inappropriate relationship with a prisoner and assisting prisoners to damage prison property.
93. The charges were heard at a Prison Service disciplinary hearing on 16 November 2009. All the charges were proved and the officer was subsequently dismissed. The matter was referred to the Lincolnshire Police for them to consider criminal charges. On 10 May 2010, the Crown Prosecution Service decided that there was not enough evidence to progress with any criminal charges.
94. No evidence arose from either the internal Prison Service investigation or from the police investigation to show that there was a connection between the prison officer and the man’s death.

ISSUES

Clinical care

95. Dr A, a consultant in public health medicine at Lincolnshire Primary Care Trust, conducted a review of the man's clinical care and treatment at Lincoln. Reception assessments revealed that the man admitted to daily use of drugs and alcohol. He had also harmed himself in the past, but at that time had no thoughts of self-harm or suicide. He had no mental health support in the community, but was referred for a mental health assessment at the prison. Subsequent appointments at the mental health clinic were either cancelled due to staffing levels or the man failed to attend. In respect of the management of the man's episodes of self-harm, Dr A considered that it "would seem unlikely therefore that prison staff could have foreseen that the man would hang himself."
96. Dr A concluded that it was unlikely that resuscitation could have been successful in this case. He said prolonged efforts were made to revive the man. All the equipment was in working order and the nurses' description of their attempt to resuscitate the man was in line with guidance from the UK Resuscitation Council.
97. The man had a repeated prescription of mirtazapine. However, this was not noted in his continuous clinical record. Dr A would have expected to see an indication of why this drug was started and a regular assessment of his progress whilst taking the drug. Dr A makes a recommendation concerning this, which I endorse.

The Governor and Primary Care Trust should advise healthcare staff that an entry should always be made in the continuous clinical record when a patient is prescribed an antidepressant drug. Patients on antidepressant drugs should be assessed at regular intervals, not less than monthly and entries should be made in their clinical record following each assessment.

Assessment, Care in Custody and Teamwork monitoring

98. The man was made subject to ACCT procedures on 7 October 2007, after cutting his wrist. He said he felt threatened by other prisoners on the wing because of debts he had created. The ACCT documentation was not complete. No triggers were recorded and there is no evidence of a post-closure review taking place on 18 October 2007. Also, there was no mental health input into the assessment. The man was briefly placed on ACCT monitoring on 28 May 2008.
99. On 12 June 2008, the man was again placed on an ACCT plan. Again, many key areas of the document were incomplete and it had not been signed by the man. The CAREMAP contained four objectives. I do not believe that the first two were achievable and although the third (for the man to be located in a safer cell) was approved and accepted, it regrettably did not take place.

There are no safer cells in the vulnerable prisoner unit where the man died and it is therefore unclear where he would have been placed.

The Governor should reinforce to staff that all ACCT documentation should be fully completed and that objectives set in the CAREMAP should be achievable and realistic.

100. The man was subject to being supported by the ACCT procedures when he died. He had not been moved to a safer cell and he was on minimum observations. Despite the fact that the man had moved his furniture and barricaded himself into his cell during the day of 12 June 2008, he was left in that cell overnight with no additional overnight monitoring put in place, allowing him to further barricade himself in when he took his life.
101. Staff said the man was “becoming increasingly bizarre”, during the day. He had barricaded himself into his cell and was acting “very paranoid”. He was also screaming and shouting allegations against staff. The man then harmed himself. Although a number of staff said that the man was acting in a clearly distressed way, no mental health assistance was requested and there was no mental health input into the ACCT.

The Governor should ensure that additional ACCT reviews are carried out following significant events, such as a prisoner’s behaviour deteriorating and that those reviews should be conducted as a multi disciplinary function, embracing the expertise of specialist staff such as the healthcare team, chaplaincy and others.

102. When the night OSG had contact with the man on the night of 12/13 June 2008, he did not record this on the ongoing record on the ACCT document. However, he said that he had never had ACCT training and had been told how to carry out ACCT procedures by another OSG.

The Governor should ensure that all staff who have contact with prisoners are given an appropriate level of ACCT training.

103. My investigator was told that there were 13 prisoners subject to ACCT monitoring during the night of 12 June 2008 and 13 the next day, including a prisoner on constant observation. Staff said that it was impossible to keep prisoners safe when there were so many to monitor. Despite bringing this to the attention of governors previously, nothing had changed.

The Governor should ensure that sufficient staff are provided to monitor prisoners subject to suicide and self-harm procedures and adjust the staffing levels to take account of the number of active ACCT plans.

104. Officers told my investigators that there was a marked difference and deterioration in the man’s behaviour, approximately two weeks before he died. Wing history sheets said that the man did not come out of his cell for some days. There is no evidence of any intervention to find out why the man was

behaving differently until 12 June 2008 when the ACCT was opened after he had harmed himself.

The Governor should ensure that staff seek appropriate medical assessments if a prisoner displays signs of a marked deterioration in their physical or mental condition.

Emergency calls

105. Some staff were unsure as to when to call an ambulance when a code 1 had been called. Although a code 1 indicates a life threatening emergency, it is unclear who is responsible for calling an ambulance.

The Governor should remind all staff of the procedures when serious self-harm or suicide occurs and an ambulance is needed.

Basic regime under the IEP scheme

106. The man had been on the basic regime for two periods, from 14 March 2008 to 21 April 2008 and then again from 26 April 2008 to the time of his death. Lincoln's Suicide and Self-harm policy paragraph 9.22, says that:

“staff should be aware that placing an at risk prisoner on basic regime (especially if it is for a prolonged time) will heighten risk because of the reduced access to support from family and friends involved in the loss of telephone calls and letters”.

On each occasion that the man was demoted to the basic regime, he was not subject to ACCT monitoring and, in any case, it was indicated that he had regular contact with family members. I therefore make no formal recommendation on this matter, but the Governor might wish to remind staff of the conflicts between the rigours of the basic regime and the increased risk to prisoners at risk of self-harm. In particular I suggest that the ACCT reviews should consider the impact of being on the basic regime and whether that might impact on the prisoners well being.

107. During the early hours of 13 June 2008, the man asked the OSG on duty for a cigarette or a light for a cigarette and was refused. Senior Officer B explained that as the man was on basic regime he was not provided with tobacco and could be seen going round the wing picking up “dog ends”. According to the Integrated Drug Treatment Service (IDTS), there is evidence that nicotine withdrawal can lead to prisoners taking their lives because of increased levels of anxiety and agitation.

The Governor should ensure that prisoners at risk of suicide or self-harm who require but do not have access to tobacco because they are on the basic regime are assessed by appropriate staff and consideration is given to providing nicotine replacement.

Violence and anti-social behaviour (VAAB) procedures

108. There is evidence that the man was bullying other prisoners to claim money for goods he had provided. He admitted this and appropriately made subject to anti-bullying procedures. The man denied a further instance of bullying and appealed to Governor A. At the same time, he also complained about a number of officers on the wing, saying that they were bullying him. Governor A replied to the man's complaint, saying he would investigate it further after the result of his appeal. My investigator was told that, at the time of the man's death, he was still waiting for a response to his appeal and complaint.
109. In a statement to police on 21 May 2010, Governor F explained that the man was using two different systems to appeal against the allegations of bullying against him and make a complaint about the officers. She said that she did not know if there had been a response before the man's death or what this response might have been. She was clear that the correct procedure had been followed by Senior Officer B and this was also checked by Governor A, who confirmed that Senior Officer B had carried out the correct action.

The Governor should ensure that prisoner complaints are investigated at the earliest opportunity as per Lincoln's Request and Complaints procedure and within the timescales set out in the policy. Prisoners who make a complaint should be kept informed of its progress.

Moving the man to the segregation unit

110. Staff decided that the man should not be moved to the segregation unit because he was subject to ACCT procedures. Governor F explained that a prisoner subject to ACCT would only be moved to the segregation unit in exceptional circumstances because it is not perceived to be a safe place for people threatening self-harm because of the isolation within the unit. She also said that statistics and policy indicates that there is a higher risk of death in segregation units than any other area. There is only one safer cell in the segregation unit, which has CCTV and special facilities. She said prisoners would only go there as a last resort once all other avenues had been explored. This would include prisoners being placed on confinement to their own cells, which is what the man was offered instead of a move.
111. Three governors were involved in the decision not to move the man to the segregation unit and from their comments, it would seem that they were not wholly agreed upon that action. Officer E and Senior Officer B also felt that the man should have been moved, based on their interaction with the man and with Senior Officer B's suggestion that an E wing officer was potentially involved in the circumstances.
112. The man was offered cell confinement, which it seems he had taken upon himself some days earlier, as a way to protect himself. This is at odds with the first two objectives set in his CAREMAP in the ACCT plan. However, had he moved to the segregation unit, he would have undergone a mental health

assessment, which may have enlightened staff about his unusual behaviour and possibly reduced the risk of him taking his own life.

113. The matter of whether the man should move to the segregation unit was considered by several managers, as well as discipline staff and the rationale for not doing so has been explained. There were conflicting views and I have found insufficient evidence to second guess their judgment and decisions.

Debrief

114. According to staff, two meetings were held after the man died: one, which was referred to as a hot debrief and another where Governor F called the staff to her office. Staff said the governor told them that the man's brother had taken his life previously and that he had arranged for his ex-partner to bring in drugs. Staff said they were extremely distressed and were pressed as to whether they were at fault. They considered that some matters discussed were inappropriate.
115. Some staff also considered that the hot debrief was not helpful. They said that they were questioned about what had happened and did not feel supported. Senior Officer E identified the man's body to the Coroner's officer but was not invited to the hot debrief. OSG T was not invited to the hot debrief and Senior Officer B was unable to attend because he was still completing police statements.
116. Prison Service Order (PSO) 2700 paragraph 5.3 states that after a death in custody or any incident of serious self-harm:

"Many staff experience "normal" short-term stress reactions (distress and tearfulness, shock, feelings of guilt) and need to be reassured that these reactions are normal. Debriefings are generally found useful after a death in custody if they provide an opportunity to share experiences, dispel inappropriate feelings of guilt and self-blame and provide reassurance that stress is normal in these circumstances. *There must always be a hot debrief immediately after the incident and provision for this should be made in local contingency plans. A senior member of staff must act as debriefer and a duty care team member must also attend.* The purpose is not to analyse or re-live the incident. Nor is it an opportunity to apportion blame or pre-judge investigation findings. The hot debrief should focus on reassurance, information sharing, normalisation and how staff can support each other. Particular reassurance is needed when the prisoner died after unsuccessful resuscitation attempts, when staff involved are more likely to feel a sense of failure. Staff wanting but unable to attend the debriefing should be followed up, as a group or individually."

From the information given by staff members, the debrief did not fulfil the above purpose. Staff were clearly left feeling uncomfortable and potentially at fault. The Governor will wish to consider these views carefully.

The Governor should ensure that after any incident of serious self-harm, staff are invited to attend a hot debrief, carried out under the guidelines of PSO 4710 and that relevant staff are able to attend. All staff involved in an incident of serious self-harm should be offered the services of the staff care team.

Supply of unprescribed drugs

117. I have come across the supply of unprescribed drugs in many investigations I have conducted following the death of a prisoner. I am aware the Prison Service works hard to combat this illegal trade within their establishments and Lincoln is no different. I am pleased therefore that Lincoln staff and security department and the police shared intelligence, which resulted in finding a source of illegal drugs and mobile telephones and taking the necessary actions.

Prison and Police investigation into the behaviour of a prison officer

118. The behaviour of the prison officer who was dismissed has been considered closely in this case. Whilst Senior Officer B gave a statement saying it was his opinion that the officer had been involved in bullying the man and that the atmosphere on the wing changed dramatically after the officer left, I can only find circumstantial evidence and opinion that this was the case. The disciplinary and criminal aspects are outside the remit of this office.

Family concerns

119. The family raised a number of additional concerns which have not been yet been addressed in my report.

- The prison chaplain attended the funeral although she had not been invited by the family.
- The man was refused access to a Listener.
- The man's sister was offered a visit to the cell where her brother took his life but it was after the cell had been cleared. She felt that the prison staff did not want to accommodate this.
- The prison family liaison officer was rude to the man's sister.

121. The chaplain explained that she attended the funeral in a personal capacity because she knew the man and had contact with him in the prison. She was known to the minister who was conducting the service as she lives locally and he introduced her to the congregation. He also asked her to read a passage during the service. She said she was very sad that the family were not satisfied with this. She did not wish to be disrespectful and was attending as someone who knew the man, not as a representative of the prison. She told my investigator that staff had a long discussion on how to avoid such issues in the future. Whilst I recognise that the chaplain's intentions were good, the wishes of the bereaved family are paramount. I trust that the Governor and chaplain will take steps to consult a family before attending or participating in

a funeral service.

122. The ACCT plan opened on 12 June 2008 indicates that the man could not see a Listener as he was too high risk. However, in place of this he was allowed use of the Samaritans phone. The prison told the investigator that the man's cell sharing risk assessment had placed him at too high a risk to have a Listener in his cell. It is important that the Listeners' safety is protected and I am satisfied that the decision about the man's access to a Listener was appropriate.
123. Regarding clearing the man's cell, I regret that, given the lapse of time, it was not possible to explore the circumstances, but I am satisfied that the prison acted reasonably in offering the man's sister the opportunity to visit.
124. Finally, the man's sister considers that the prison's family liaison officer was rude to her. I understand that the family liaison officer explained to the man's sister that, as she was not his nominated next of kin, she did not have the authority to change the funeral director after arrangements had been made by his named next of kin. I consider this to be reasonable in the circumstances. I regret that the man's sister felt that she was treated rudely and suggest that the Governor or family liaison officer considers whether an apology would be appropriate.

CONCLUSION

120. The man had been recalled to prison after breaching the terms of his licence. In spite of being familiar with the prison environment, he clearly had a difficult time. This stemmed mainly from his own actions in dealing in contraband. He became fearful of other prisoners to whom he owed money and made allegations of bullying. He was also accused of bullying others.
121. On more than one occasion, the man harmed himself and admitted he had done so to get his own way. Nevertheless, staff put in place monitoring procedures. However, they did not consider it appropriate to accede to his request to be segregated partly because of the increased isolation that this would entail.
122. I concur with the clinical reviewer's conclusion that staff could not have foreseen that the man would make a serious attempt to take his life. They initiated relevant action to monitor him when he harmed himself or threatened to do so, but there were some shortcomings in the way that procedures were taken forward. In particular they did not assess the deterioration in the man's state of mind and behaviour the day before he took his life.
123. The misconduct of the officer has been carefully investigated by the prison Service and the Lincolnshire Police and there is no substantive evidence to prove that it led to the man's decision to take his life.
124. I do not consider that these failings necessarily led to the man's death but they should be addressed to improve safety for other prisoners. It is clear from the letter left by the man that his fear of reprisals from other prisoners weighed heavily on his mind and it is possible that these worries affected him so greatly that he took the decision to end his life.
125. Finally, I regret that the man's family were not entirely satisfied with the conduct of all the prison staff. I hope that they are reassured that their views have been taken seriously and steps will be taken to avoid any repetition. My investigator gave her initial feedback to the Governor of Lincoln, when she attended to obtain documentation and the further statement from Senior Officer B.

RECOMMENDATIONS

To the Primary Care Trust and Head of Healthcare:

1. The Governor and Primary Care Trust should advise healthcare staff that an entry should always be made in the continuous clinical record when a patient is prescribed an antidepressant drug. Patients on antidepressant drugs should be assessed at regular intervals, not less than monthly and entries should be made in their clinical record following each assessment.

Accepted. The prison service say that a record is kept of all prescribed medication and that information is input onto the electronic patient record system. They say that all patients on anti-depressants are regularly reviewed by a healthcare professional and information is input into the patient electronic medical record.

To the Governor:

2. The Governor should reinforce to staff that all ACCT documentation should be fully completed and that objectives set in the CAREMAP should be achievable and realistic.

Accepted. The prison service say that robust daily and weekly management checks are completed by residential managers to fully comply with ACCT documentation. Orderly officers complete a daily check of ACCT documentation and have to sign and stamp each document once they have verified and agreed that the document is to the required standard.

3. The Governor should ensure that additional ACCT reviews are carried out following significant events, such as a prisoner's behaviour deteriorating and that those reviews should be conducted as a multi disciplinary function, embracing the expertise of specialist staff such as the healthcare team, chaplaincy and others.

Accepted. The prison service say that all managers are fully aware of the need to instigate additional reviews when required and appropriate including a significant event or change in behaviour. There may be a requirement during the night state that the multi-disciplinary review be conducted in the morning depending on the circumstances but this is evaluated on a case by case scenario. If this is deemed appropriate, observations are increased and recorded.

4. The Governor should ensure that all staff who have contact with prisoners are given an appropriate level of ACCT training.

Accepted. The prison service say that ACCT awareness training is scheduled through the monthly training days and staff are identified to attend.

5. The Governor should ensure that sufficient staff are provided to monitor prisoners subject to suicide and self-harm procedures and adjust the staffing levels to take account of the number of active ACCT plans.

Accepted. The prison service say that Wing Managers ensure that the appropriate level of staffing and support is available and that extra staff are deployed to a wing if there are a high number of ACCTs open.

6. The Governor should remind staff to seek appropriate medical assessments if a prisoner displays signs of a marked deterioration in their physical or mental condition.

Accepted. The prison service say that this is discussed as part of the ACCT training and induction. There are already embedded procedures for alerting the PCT and/or Mental Health staff should there be deterioration in the prisoners' mental or physical condition. Mental Health training is also offered to staff. Clinical leads are now allocated to each wing; nurses are office based in E wing as this is the nearest central location.

7. The Governor should remind all staff of the procedures when serious self-harm or suicide occurs and an ambulance is needed.

Accepted. The prison service say that a Governor's order will be issued on an annual basis reminding staff of the reporting codes for a medical emergency and the details that are required in order for the control room to provide information to the ambulance service.

8. The Governor should ensure that prisoners at risk of suicide or self-harm who require but do not have access to tobacco because they are on the basic regime are assessed by appropriate staff and consideration is given to providing nicotine replacement.

Accepted. The prison service say that this does take place. A referral for assessment by a nurse or GP could be made at any time.

9. The Governor should ensure that prisoner complaints are investigated at the earliest opportunity as per Lincoln's Request and Complaints procedure and within the timescales set out in the policy. Prisoners who make a complaint should be kept informed of its progress.

Accepted. The prison service say that the Request and Complaints procedure has been reviewed and operates to both the PSO and local policy. All complaints are logged and monitored for response dates and copies are delivered back for each prisoners. Prisoners can request further copies if necessary and progress is tracked and reported should an interim response be given in the first instance pending further investigation.

10. The Governor should ensure that after any incident of serious self-harm, staff are invited to attend a hot debrief, carried out under the guidelines of PSO 4710 and that relevant staff are able to attend. All staff involved in an incident of serious self-harm should be offered the services of the staff care team.

Accepted. The prison service say that the death in custody contingency plan was reviewed in September 2010 and highlights the requirement of the Duty

Governor to arrange for a hot debrief to be held and that staff care team services are offered.

Family response to draft report

The man's family raised a number of issues in response to the draft report. They remain very concerned about the level of care afforded to the man and believe that staff actions played a part in his death. In particular, they raised concerns about:

- The length of time it has taken to complete the report.
- The lack of a substantive link between a prison officer's conduct and the man's death.
- The lack of a full mental health assessment the day before the man died.
- How the ACCT process was managed and risk assessments made.
- How interviews with prisoners were carried out at the beginning of the process.
- The man's medication, in particular mirtazepine.
- That there was no mention of a postal order that was sent by the man's father.
- There were some factual inaccuracies, which have been amended.

The family urge the Governor to ensure that existing policies are followed carefully and recommendations made are acted upon to prevent further deaths in the prison. They believe that had the proper procedures been followed, the man's death might have been prevented.

The family sent a further letter in response to the report, which relates to clinical matters. I decided that there were no grounds to extend the investigation further as it would not add to the current conclusions. However, I have attached the letter as an annex to this report, with a view to the issues contained in the letter being addressed at the inquest.