



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Lincoln on in April 2012**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanging in his cell at HMP Lincoln on 2 April 2012. He was 42 years old. I offer my condolences to the man's family and friends. I apologise for the delay in completing this report.

The investigation was started by an investigator and completed by an assistant ombudsman. A review of the clinical care which the man received in prison was undertaken by a clinical reviewer. The prison cooperated fully with the investigation.

The man had been in prison since 1995 and had tried to kill himself several times. He had been in many different prisons during his sentence. The man arrived at HMP Lincoln on 22 June 2011 and originally lived in the vulnerable prisoners' unit but was moved to the segregation unit for his own protection in September, after he told staff that he was being bullied for his medication. A transfer was arranged to HMP Gartree, but the man refused to leave the segregation unit when he got there and was sent back to Lincoln a few days later. He then moved from the segregation unit to a wing where he shared a cell with another prisoner, but was kept separate from other prisoners.

The man was monitored as at risk of suicide and self-harm on three separate occasions at Lincoln between November 2011 and February 2012 and on each occasion monitoring ended before the actions on his caremap had been completed, contrary to Prison Service guidance. Although the man wanted to transfer to another prison he often refused to engage in offender behaviour courses, which he was told would prevent other prisons accepting him. On 3 April, an officer found the man hanging from pipes in his cell when he went to unlock his cell. Attempts to resuscitate him were unsuccessful.

I agree with the clinical reviewer that, overall, there does not seem to have been a sufficiently proactive approach to managing the man's mental health issues, and there are also concerns over medicines management. It is of particular concern that suicide and self-harm monitoring arrangements at Lincoln did not operate as effectively as they should have done. As well as the failure to ensure that caremap actions were completed before monitoring was ended, there was little consistency in case managers and key issues which would have affected risk, such as threats to self-harm or bullying, were often not discussed at case reviews.

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Prisons and Probation Ombudsman

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SUMMARY

1. The man received a mandatory life sentence for murder in 1995. He transferred to Lincoln in June 2011. He had made several attempts to kill himself in prison, and had a history of drug misuse and getting into debt.
2. The man was under the care of the mental health team at Lincoln. In September 2011, he moved from the vulnerable prisoners unit to the segregation unit for his own protection, after he told staff that some medication had been stolen from him. He transferred to HMP Gartree on 5 October but returned to Lincoln two days later as he refused to go to a residential wing because of problems he had encountered there previously.
3. Initially, the man continued to live in the segregation unit at Lincoln. He and another prisoner were then moved to B wing on 28 October, but kept separately from other prisoners. The man then moved to A wing. On 3 November, an ACCT (Assessment, Care in Custody and Teamwork, the Prison Service's suicide and self-harm prevention procedure) was opened after he harmed himself. Further ACCTs were opened in December and January. All three were closed before caremap actions to reduce risk had been completed.
4. The man moved to a cell nearer the wing office so that staff could monitor him. No progress had been made in arranging another transfer. The mental health team continued to see the man and, on 28 March, he told a mental health nurse that he had not eaten for six days as officers were not bringing him food. He said that officers had told other prisoners that he was a sex offender. The nurse said he had not heard anything about this issue before.
5. On the morning 3 April at 7.55am, an officer was unlocking cells on A wing when he found the man had strangled himself by a bed sheet attached to a pipe in his cell. Officers went into the cell quickly and cut the sheet from around the man's neck, but there were initial problems alerting other staff to the emergency. The first officer on the scene did not have a radio and the next officer had difficulty getting through to the control room. A general emergency alarm was pressed, which meant that staff attending were not aware of the nature of the emergency. Shortly afterwards, a Senior Officer radioed an emergency code which meant that an ambulance was then called automatically. The man was given cardiopulmonary resuscitation and paramedics arrived quickly and took over. Despite their efforts, prison staff and paramedics were unable to revive the man and he was pronounced dead at 8.24am.
6. The investigation identified concerns about the management of the ACCT process at Lincoln. In particular, caremap actions were not completed before ACCTs were closed and significant events such as self-harm and alleged bullying do not seem to have been discussed at

ACCT reviews. Despite being regarded as at risk of suicide and self-harm, we are also concerned that the man was allowed to keep his medication in possession when he was clearly vulnerable. Although he was prescribed antipsychotic medication, this was not regularly reviewed by a psychiatrist.

THE INVESTIGATION PROCESS

7. After the man's death notices were issued to staff and prisoners at HMP Lincoln inviting anyone with information to contact the investigator. No one came forward. The investigator visited the prison on 25 April 2012. He obtained various relevant records and documents about the man, spoke to the Governor and other members of staff and saw the cell where the man had died.
8. An Assistant Ombudsman interviewed six members of staff at Lincoln on 9 and 10 July 2012. The investigator interviewed another four members of staff, the man's former cellmate at Lincoln and another prisoner on 2 August 2012.
9. NHS Lincolnshire appointed a clinical reviewer to review the standard of the man's clinical care at Lincoln. His review is attached to this report.
10. The investigation report has been sent to the local Coroner.
11. We apologise for the delay in the production of this report. This was due to staffing issues during the course of the investigation resulting in a backlog of cases to be completed. The investigation and report was completed by the Assistant Ombudsman.
12. One of our family liaison officers contacted the man's partner and brother to inform them of the investigation to allow them to raise any issues they wished the investigation to consider. We did not receive a reply.

HMP LINCOLN

13. HMP Lincoln is a local prison serving the courts of Lincolnshire, Nottinghamshire and Humberside. It holds over 700 remand and sentenced prisoners in four main residential wings, one of which (E wing) holds vulnerable prisoners (kept apart from other prisoners usually due to the nature of their offences). D wing contains the segregation unit. Healthcare is commissioned by NHS Lincolnshire and provided by Lincolnshire Partnership Foundation Trust.

HM Inspectorate of Prisons

14. HM Inspectorate of Prisons last inspected Lincoln in August 2012. In their report, inspectors noted that they had serious concerns, and that the prison was not safe. While praising the Violence Reduction Co-ordinator, they said that she did not have enough time to carry out her role effectively. There was little attempt to investigate either individual incidents or patterns of violence, and the quality of investigations into bullying was poor.
15. A third of prisoners on the vulnerable prisoner wing (E wing) said that they had been victimised by other prisoners. Prisoners who were too frightened to leave their wings to go to work but who refused to name the perpetrator were punished by being sent to the segregation unit. The vulnerable prisoner wing was mainly for sex offenders but others who were frightened on the main wings also sought refuge there. There was no clear process for deciding who should be admitted to the vulnerable prisoner wing and some prisoners told inspectors that they had been denied admission without explanation.
16. Inspectors found that the standard of ACCT case management was generally inconsistent and the quality of entries in monitoring documents was mixed. While some care planning for prisoners in crisis was reasonable, they found others which were poor and too many prisoners on open ACCTs were held in the segregation unit without justification.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In the latest IMB annual report for the period to January 2013 the IMB noted that a survey had found that prisoners did not think that bullying was an issue so long as staff followed the anti-bullying policy. The IMB described the segregation unit as not fit for purpose, and they were concerned that some prisoners at risk of suicide and self-harm were held there.

Previous deaths in custody

18. The man's death was the first at Lincoln for almost three years. There have been three subsequent deaths. During one of these investigations, we raised the use of emergency radio with the Governor, who introduced a new system as a result. This was also an issue in this case. We have also made recommendations as a result of another investigation about the ACCT process at Lincoln in the case of a death after the man's. We recommended that information recorded on security information reports about a prisoner's risk should be conveyed to wing staff. We have similar concerns in this case.

ACCT - Assessment, Care in Custody and Teamwork

19. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

KEY EVENTS

20. In May 1995, the man was convicted of murder at Preston Crown Court and received a mandatory life sentence with a minimum period to serve of 12 years before he could be considered for release. He was held at a number of different prisons, including HMP Long Lartin, HMP Whitemoor, HMP Albany, HMP Parkhurst, HMP Bullingdon, HMP Gartree, HMP Garth, HMP Leicester and HMP Frankland, before his move to HMP Lincoln in June 2011. He had a long history of drug misuse and self-harm, and had made several attempts to take his own life in prison. At Garth in 2009, the man sometimes refused to live on a standard residential unit as he feared for his own safety. The man transferred from Garth to Frankland in an attempt to make a fresh start, but the move did not work out and he returned to Garth. He had regular input from the mental health team.
21. In January 2011, an offender supervisor at Garth wrote to the man's solicitors to advise them that his application to be recategorised to Category C (a lower security category than his current status) had been refused as he had done little work to reduce his level of risk. (The man had previously said that if he did not obtain category C status he was not sure he would finish his sentence.) The next month, the offender supervisor wrote to the solicitors acknowledging that the man had requested a move out of the North West area. However, the offender supervisor also wrote that a move to Gartree to complete an offending behaviour programme was unlikely as the man wanted to withdraw from sentence planning.
22. At this time, the man was located in the segregation unit at Garth for his own protection under Prison Rule 45 because he felt he was at risk from other prisoners. Garth sought a suitable category B prison with a vulnerable prisoner unit. Eventually a move to Lincoln was agreed.
23. A nurse assessed the man when he arrived at Lincoln. He told the nurse that he had been under the care of the mental health team at Garth, did not have any thoughts of self-harm, but had previously been sectioned under the Mental Health Act. The nurse noticed that he had previously failed a medication spot check (when he did not have the correct amount of medication in his possession) and noted that he should not be allowed to keep his medication in possession at Lincoln. He was prescribed amitriptyline (an antidepressant), quetiapine (an antipsychotic) an, paracetamol and dihydrocodeine (both pain killers) and trihexyphenidyl (to relieve tremors caused by other medication).
24. On 5 July, a mental health nurse assessed the man who said that officers had suggested he should ask about a single cell. When the nurse said that the mental health team could give an opinion, but this was a matter for the prison to decide, the man became defensive and refused to complete the assessment. A week later, he again declined to complete the assessment. The nurse told him to let them know if he

wanted the mental health team's input. When he returned to the wing, the man told officers that the mental health team had said that he should be in a single cell. An officer spoke to the nurse who said that, as his level of risk was unknown, it might be advisable to keep him in a single cell.

25. On 29 August, the man was told that his father had died. He saw a doctor the next day and said he was having difficulty coping. The doctor prescribed zopiclone to help him sleep. She also referred him to an ear, nose and throat specialist because he had lost hearing in his left ear.
26. On 4 September, a nurse noted that he had been found to be compliant with his medication when a spot check was made on the medication in his possession. (It is not clear when it was agreed that he should be allowed to keep his medication in his possession and there is no evidence of a risk assessment.) On 9 September, he was moved to the segregation unit on D wing for his own protection after he told staff that his medication had been stolen. A mental health nurse told him that he should have reported the theft earlier. (It is not clear from the records when the theft had occurred). The man reacted negatively and asked the mental health nurse to leave. The mental health nurse noted that he still had not had a proper mental health assessment and recommended that he be referred to a doctor's psychiatry clinic. The next day, it was decided that the man's medication should be administered under supervision and he would not be allowed to have it in possession.
27. The man remained in the segregation unit and attended his father's funeral on 16 September. Another mental health nurse, saw him later that day and the man said that he did not want any mental health involvement or support. He said he wanted to move to another prison as he felt he was wasting time at Lincoln as he could not complete many of the courses he needed to reduce his risk to the public.
28. On 23 September, the mental health nurse saw the man again when he said that he was frustrated that he had not got an immediate move. The mental health nurse noted in his medical record that the man needed to be relocated and assimilated back into the prison regime. She advised one of the managers that this should be a priority.
29. The man remained living in the segregation unit until 5 October when he moved to Gartree. However, he refused to go to a standard residential wing and was held in the segregation unit. He told the clinical team manager who assessed his health that he had problems with back pain and sleeping.
30. The next day, at a mental health review, the man told a nurse that he did not want to be at Gartree as he was scared for his life because he had refused to hold illicit goods and contraband for other prisoners

when he had previously been there. He said that he had not engaged well with the mental health team at Lincoln and had clashed with a particular member of the team. He said that he had a long-term diagnosis of severe personality disorder, had behavioural problems and that he relied on medication to control his symptoms. A doctor saw the man and told him that he could not prescribe amitriptyline which he had been taking, as they did not stock it at Gartree because of the risk of overdose. The man said that he had stopped taking it abruptly in the past with no ill effects. The doctor prescribed zopiclone to help him sleep.

31. On 7 October, the man returned to Lincoln as he had refused to leave the segregation unit at Gartree. When he returned, he refused to return to a standard wing because he said he feared for his safety. He was therefore placed in the segregation unit, for reasons of good order and discipline. He saw a duty governor, chaplain and member of the healthcare team each day. He asked several times for a transfer to HMP Preston to be with a brother who had just been sentenced to prison for the first time.
32. A doctor saw the man on 10 October and prescribed amitriptyline to help his mood. Later that day, he had a review of his segregation arrangements. He was told that the mental health team would assess him and a review was arranged for two weeks later. The man complained that the doctor had not prescribed zopiclone, but said that he felt safe in the segregation unit and was happy to wait a few weeks for a transfer to another prison.
33. The doctor saw the man on 17 October and prescribed zopiclone as he said that he was having trouble sleeping. The next day, he complained to a nurse that he was not allowed to keep his medication in his possession.
34. On 20 October, a nurse was asked to see the man urgently because staff were concerned about him. He said that he was coping with the death of his father, but the nurse thought that he was low in mood. He was reluctant to be assessed, but said that he had auditory hallucinations which were getting worse. The nurse recorded that she did not see any evidence of this during the meeting. Officers told her that the man was not coping on the segregation unit. The nurse planned a further assessment later that afternoon and also made an appointment for him to see a doctor on 26 October.
35. The nurse conducted the assessment at 1.30pm. She found that the man was fit to remain in the segregation unit, although she noted that his mental health might have got worse since he moved there. The man was not happy about being passed fit to remain in the segregation unit. A nurse said that this would be looked at again at the next segregation review on 24 October. The man asked if he could speak

to a mental health team member after that meeting, as he was uncomfortable talking about personal issues in a group environment.

36. On 24 October, a doctor saw the man and noted that he looked exhausted. He said that he was anxious about the possibility of being discharged from prison after 17 years. The doctor thought that this was not a good time to stop medication and prescribed a further course of zopiclone to help him sleep.
37. Later that day, the man refused to attend the segregation review. A nurse went to see him on the exercise yard. The man said that he was okay and might as well be in the segregation unit as anywhere else. The doctor visited the man on 26 October and maintained the same medication regime.
38. On 28 October, the man and another prisoner were moved from the segregation unit to B wing. They shared a cell on B wing but were kept apart from other prisoners, taking exercise and receiving medication when other prisoners were locked away and eating meals in their cell. They were observed hourly by staff until 30 October and then less frequently.
39. The prisoner was interviewed as part of this investigation. He said that, while they were in the segregation unit, both he and the man were asked to choose which prisons they wanted to be transferred to. However, shortly afterwards, staff told them that the prisons would not accept them. They were offered a move to B wing, but segregated from other prisoners on the wing for their own safety. The prisoner said that he was effectively given no choice about the move and felt pressured into it. He said that other prisoners on the wing knew that they had previously been on E wing and abused them through the door. He said that he felt let down by staff and the man threatened to cut himself. The prisoner said that staff moved the man to A wing shortly afterwards, even though they had wanted to remain in a cell together.
40. The move to A wing was an apparent attempt to integrate the man to a standard prison wing. On 3 November at 9.00am, an Assessment, Care in Custody and Teamwork (ACCT) was opened for the man. (The ACCT process is intended to provide additional support and monitoring for prisoners considered at risk of self-harm or suicide.) The first stage in the process is the completion of a Concern and Keep Safe form to identify the nature of the risk and the reason for opening the ACCT. This form was completed by an officer who wrote that the man had told staff he had deliberately hit his face on the cell wall after being moved to A wing. The officer noted that the man had swelling to his face and cheekbone. He wrote that he had spoken to the man who was "very agitated" and said he would continue to self-harm. The officer also noted that the man previously had vulnerable prisoner status. The man refused treatment from healthcare staff.

41. An Immediate Action Plan was completed on the same day. This is intended to identify steps that can be taken to keep a prisoner safe during the initial 24 hours of the ACCT, before a more detailed assessment interview takes place. It was completed by two of the unit managers, who recorded that the man would remain on a normal residential location, be observed every 15 minutes until the first review of his ACCT, and have access to a telephone as required. He was also aware of support that could be offered by Listeners (prisoners trained by the Samaritans to offer confidential peer support) but did not want to take up such support at that time.
42. The officer assessed the man at 9.50am that day. He made notes about the interview on the standardised ACCT assessment interview form. He wrote that the man feared for his safety in prison, after being moved from E wing to the prison's segregation unit, then briefly to Gartree before returning to Lincoln's segregation unit. Although the man had then agreed to move to B wing pending a transfer, this had not materialised and he felt "duped". The officer noted that the man had harmed himself by hitting his head against the wall of his cell, felt very scared, was low in mood and receiving medication for mental health issues. Regarding thoughts of self-harm, the man told the officer that he would "do the worst he could possibly do" if his situation remained the same, and said he would definitely attempt to kill himself. He also said he had no reason for living, that his father had recently passed away, and that he had other family members but did not want to bother them with his troubles. The officer wrote that the man was fully aware of the avenues of support that Lincoln had to offer.
43. On the afternoon of 3 November, a Senior Officer (SO) chaired the first ACCT case review held in the man's cell as he refused to leave it. An operational manager and an officer attended. There was no healthcare representative or staff from any other discipline present. The officer was not on duty but had been consulted about his assessment before the review. The SO noted that the man was talkative about his situation but very negative. He said he was not coping and was very scared for his safety. He said he had nothing to live for since the death of his father and would not last the weekend. The manager said he would liaise with the prison's lifer officer about a possible transfer to another prison. The man was assessed as a high risk of suicide or self-harm and a further ACCT review was arranged for the next day. Staff were required to observe the man every 15 minutes.
44. The next review was chaired by the SO at 2.25pm on 4 November, again in the man's cell. The only other member of staff present was the manager. The SO wrote on the review form that the man continued to feel down and "all over the place", but his level of risk was now indicated as low. On 7 November, the SO chaired the next review which was attended by a nurse in the man's cell. The man said he was not suicidal and did not intend to harm himself. His observations were

changed to once every hour, and his risk was identified as low. A further review was arranged for 10 November.

45. A caremap, which should give detailed and time-bound actions aimed at reducing the prisoner's risk, was started on 4 November. (This should have been completed following the review the previous day.) Only one issue was identified: the man's location at Lincoln. The goal was transfer out of the prison and the action required was liaison with Lincoln's categorisation and allocation unit.
46. On 10 November, an SO chaired a review attended by an officer and a nurse, again in the man's cell. The SO noted that the man feared for his safety, although he said he had no thoughts of suicide or self-harm. The SO wrote that the manager was continuing to try and arrange a transfer for the man. His level of risk was identified as low. A review was arranged for 17 November. The nurse noted in the medical record that the man had again refused input from the mental health team and had asked to speak to his brother in HMP Preston. This was not mentioned in the notes of the ACCT review.
47. The review on 17 November was again conducted in the man's cell. The SO, who chaired the review with the nurse and officer present, noted that the man was still not interacting with other prisoners. He again said he wanted to be transferred to another prison. He said he did not have any thoughts of harming himself, but thought nothing was being done to help him. The nurse recorded in the medical record that the man had kept his cell clean and tidy. The review panel agreed that the ACCT would be closed and that the man would no longer be monitored as being at risk of suicide and self-harm. A post-closure review (a meeting to check on the prisoner and see if any support procedures need to be reintroduced and to review the caremap) was scheduled for 24 November.
48. The post-closure review was completed as scheduled by an SO, who noted that the man remained frustrated and felt that he was not being kept informed about the progress of his transfer. Although he engaged with healthcare and unit staff, he was "being kept behind his [cell] door most of the time". The ACCT was not reopened as a result of the post-closure review, although there was still no progress with his caremap goal.
49. The man saw a doctor on 25 November and asked to be taken off amitriptyline, which he had been on for a long time. The doctor noted that he would soon be reviewed again by the mental health team and wrote that the man could have medication in possession if he passed the risk assessment. There is no record that this assessment was ever done.
50. On 6 December, another ACCT was opened after the man told an SO that he had swallowed razor blades and would harm himself again. He

said he wanted to speak to the manager about the progress of his transfer. The Immediate Action Plan included the man remaining in a single cell, half hourly observations, and telephone access when required. It was again noted that the man was aware of Listener support.

51. No assessment interview was completed. A note was made that the man refused to leave his cell for the interview. The SO noted that the man refused to participate in anything on the wing. The SO held a review at 5.20pm the same day, which the man also refused to attend. The only other person present was the assessor, an officer. The SO wrote on the review form that the man might self-harm if he was not transferred. The SO listed "Location at Lincoln" as the only issue on the caremap. The man's risk level was recorded as low and a further review was arranged for 8 December.
52. Another SO chaired the review on 8 December with the officer. There was no member of healthcare staff present. This time the man attended. The SO wrote that the man had accepted that he was going to be in prison for some time and was feeling more settled. He said he had no intention of self-harming. His risk level was recorded as low and the ACCT was closed. A post-closure review was scheduled for 15 December. There is no reference to this ACCT in his medical record.
53. The SO held the post-closure review and noted that the reason leading to the ACCT being opened – the man's transfer – had not been resolved and that he continued to spend most of his time in his cell, refusing to integrate. The SO wrote that the man did not engage with unit staff and had been given the opportunity to work as a wing painter but declined. He had refused to leave his cell to participate in the post-closure review. The ACCT remained closed.
54. The man refused to attend Lincoln County Hospital on 21 December for an outpatient appointment, but it is not clear from his medical record what the appointment was for. He signed a disclaimer stating that he did not want to attend.
55. An in-possession medication spot check was conducted on 15 January. The man did not have any of his medication left, when he should have had five days of dihydrocodeine, amitriptyline and quetiapine. His medication was stopped, although the doctor began issuing quetiapine the next day to be administered under supervision.
56. A further ACCT was opened on 17 January 2012. The Concern and Keep Safe Form and Immediate Action Plan forms were not in the documents the prison supplied to the investigator, but his medical record indicates that the man had cut himself with a blade above his right eye. The level of observations was set as hourly, but infrequently, night and day. The officer interviewed the man for an ACCT

assessment on 18 January, and recorded that the man's issues were about medication, which had been stopped after the spot check. He said his medication had been taken off him by another prisoner. The man said he should have vulnerable prisoner status, and had been assured that he could remain in his cell on A wing. He had made a cut above his eye and said he was going to cut off his ear. He told the officer that he would continue to cut himself unless his whole situation – medication, regime, location and transfer – was resolved. He also said he had eaten nothing for three days and said he would rather be dead if his situation did not change. The officer noted that the man had a long history of serious self-harm, and that he feared for his safety on the unit. He again said he did not want to burden his family members with his issues, but understood the avenues of support available to him.

57. The SO chaired an ACCT review that day which the man, an officer Slattery and nurse attended. The SO wrote on the review form that the man had harmed himself to get the attention of staff and remind them of his ongoing issues. The issues listed on the caremap were consistent with those identified during the assessment interview. Actions included moving the man to a single cell on A2 landing, bringing food to his cell and re-instating his medication. The man's level of risk was identified as low. A further review was arranged for 20 January.
58. An SO chaired the next review on 19 January with an officer and a nurse. The man refused to leave his cell as he said he was scared for his safety, so the review took place there. He told the SO that he thought about self-harm and dying all the time, and that he no longer wanted to engage with mental health services, although he later changed his mind. An action for him to engage with mental health staff was added to the caremap. The SO reduced the level of observations to hourly, with three conversations during the day, and three at night if the man was awake.
59. The nurse noted in the medical record that the man was receiving supervised medication. He had said that he was being bullied and these allegations were being investigated by wing staff. She described him as being argumentative for much of the meeting, and noted that his cell was dirty and untidy. She also noted that the man was to be moved to a cell nearer the wing office, with food and medication being brought to him.
60. On 20 January, an officer submitted two security information reports (SIR). The man had told him that another prisoner had gone into his cell and taken his medication. (It is not clear when this relates to.) The officer later spoke to the other prisoner under Lincoln's anti-bullying procedures. The prisoner told him that the man was selling his medication for tobacco, but after receiving the tobacco he refused to hand over the medication. The prisoner alleged that the man owed

over £100 and that other prisoners were “after him”. The SIR was reviewed by an operational manager who asked that the residential manager on A wing be informed so that they could support and challenge the man. This issue was not raised at subsequent ACCT reviews despite medication being one of the initial reasons for the man’s self-harm.

61. The SO conducted the next ACCT review on 24 January. An officer and nurse were present. The man refused to attend a review in the office. He said he wanted to know what was happening with his transfer. The level of observations was reduced to every two hours, with the level of conversations remaining the same. The nurse noted that his cell was tidy, and that he was keeping occupied with artwork in his cell.
62. On 26 January, an OSG completed an SIR after speaking to the man at 12.50am for an ACCT check. The man told him that he had razor blades hidden in his cell and then showed him an improvised weapon which he said he would hide if his cell was searched. The OSG also recorded this information in the on-going ACCT record. Earlier that evening, the OSG saw the man packing his belongings in his cell. The OSG asked him if he was moving on, and the man told him that “I’m going to be carried out”. He would not discuss the matter further. The OSG described the man as being in a very low mood. He later checked the man four further times. On one occasions, the man told him that he had headbutted the wall because of the pain in his back.
63. When the OSG was relieved by day staff, he told them of these events. The officer (whose signature on the ACCT record is unclear) asked the man about the blades. The man said that all prisoners had blades in their cell. He also said that there was no need for the OSG to be concerned about him.
64. An SO chaired the next ACCT review on 27 January with officer and a nurse, but made no reference to the events of the previous day. The man was not asked about what he had said to the OSG. The man said he was under threat from everyone because other prisoners knew that he had previously been on the vulnerable prisoner unit. The SO wrote that the man seemed to think everyone was against him. He again spoke about wanting to be transferred out of the prison and said he did not care if he lived or died. The nurse noted that the man was hostile throughout and said that he did not want any intervention from the mental health team.
65. A Rabbi attached to the chaplaincy at Lincoln, told the investigator that the man had moved to A wing in January, as officers hoped that he would leave his cell more. The Rabbi said that the man had previously asked him for some Jewish religious items such as a prayer book, skull cap and payer shawl. The Rabbi said that the man was heavily in debt because of tobacco. The Rabbi said he had asked officers if he could

arrange for the debt to be paid, but was told that this was not the best course of action as he might owe more than he admitted to. The Rabbi said that he saw the man on 19 January on A wing, when he admitted to owing £120 to other prisoners.

66. On 30 January, a SO chaired an ACCT review attended by an officer, nurse, a Principal Officer (PO) (the safer custody manager) and the man. The SO wrote that the man was becoming increasingly frustrated about his situation and felt vulnerable and at risk on A wing. The man acknowledged that he needed to take more control of his situation, and was advised to contact his solicitor. This was added as an action to the caremap. He was given some art work to help keep him occupied in his cell.
67. The nurse noted in the medical record that this was a difficult meeting, and that it initially focussed on negative patterns. She recorded that the SO abandoned the meeting and spoke to the PO. The meeting was then reconvened. The PO told the man that, if he was aggrieved by the way mental health team had dealt with him, he should address this through the correct processes. The nurse noted that the man had said that he would not access any prison courses and that it was clear that he was vulnerable.
68. A SO chaired the next review on 1 February, attended by an officer and nurse from the mental health team. The SO noted that the man came and appeared “chirpy and engaging”. He had been out of his cell that morning and said that he had found it daunting, but understood that it was part of his support plan for reintegration. His level of risk was recorded as low.
69. The SO chaired the next ACCT review on 3 February with an officer and nurse. The SO wrote that the man attended the review and was in good spirits. He had been out of his cell and associating with other prisoners. The man’s level of risk was recorded as low, and everyone involved agreed that the ACCT could be closed. There was no reference to the caremap goals, and of seven caremap actions, four were listed as ongoing (to provide the man with a safe environment, for staff to bring food to his cell, to arrange a transfer and for him to engage with the mental health team). A post-closure review was scheduled for 10 February.
70. The nurse noted in the man’s medical notes that he had asked for an increase in his medication at the ACCT review. She had told him that he would need to see a doctor, at which point he said that he would remain on the dose he was prescribed.
71. On 5 February, an officer noted in the man’s PNOMIS record that he was manipulating staff into fetching meals for him, even though his ACCT had been closed. The manager confirmed that staff were no longer required to fetch his meals.

72. On 6 February, the nurse assessed the man for two hours in the healthcare unit. The man told him that he felt under threat, that he should be being treated as a vulnerable prisoner but was on A wing instead. He was worried that people were out to get him because he was in debt and he was frustrated that he was still at Lincoln. He said that he heard voices more when he was frustrated and this sometimes led him to harm himself. The nurse said that the mental health team could help with antipsychotic medication and thinking skills courses. The man said that they could not help him and walked out of the assessment.
73. An officer submitted an SIR the same day after the man had told him that he would claim to be refusing food unless staff began bringing his meals to him, as they should as part of the his ACCT caremap. The officer noted that the ACCT had been closed as the man was no longer under threat. The manager advised the officer not to take food to the man and to follow the agreed procedures if he claimed to be refusing food.
74. The SO carried out a post-closure review on 10 February and noted that the reasons for the ACCT being opened had not been resolved, and were in fact increasing due to medical issues. He went on to say that the man's feelings about his situation had not changed and that he found it difficult to fend off thoughts of self-harm. The ACCT was not re-opened as a result.
75. On 14 February, the man did not turn up for a mental health assessment. The nurse went to see him, and the man said that he could not wait in the assessment room as he was under threat from other prisoners. The nurse agreed to see if in future he could be taken directly to the treatment room. The man said that he had written to the Governor to ask why he had been refused vulnerable prisoner status and was still waiting for an update about another prison transfer. Later that day, a healthcare support worker telephoned Guild Lodge, a medium secure psychiatric hospital where the man had been in 2005, to ask for further information about his time there.
76. At the next mental health review, on 24 February, the man engaged more with a nurse, who agreed to find out what was happening about his prison transfer from the lifer manager. The nurse told the man that they were chasing information from The Spinney, a psychiatric clinic where the man had previously been treated. He asked the man if he had considered going to a hospital dealing with personality disorders. The man said that he would let him know about this at their next meeting.
77. On 17 February and 6 March, an officer noted in the man's prison record that he was now employed as a wing painter and was expected

to help out with wing cleaning. However, he did not attend for work. On 8 March, the SO removed him from his job.

78. On 23 February, the PO, the safer custody manager, wrote to the man's solicitors, who had written to the prison on 9 February about his safety and wellbeing at Lincoln. They asked that his vulnerable prisoner status be reinstated. The PO explained that the man had declined an offer to move to the vulnerable prisoner unit when he had returned to Lincoln from Gartree in October 2011. He had subsequently moved to B and A wings as a vulnerable prisoner, which the PO conceded was difficult for the man as he was then isolated in his cell. She said that staff had tried to encourage the man to participate in wing activities, which had been partially successful. She finished by saying that they would continue to work with the man in every way possible.
79. The man's solicitors wrote again the same day (it is not clear if this was in response to the PO's letter). They asked what progress had been made to secure a transfer to a prison where the man could do the courses he required for sentence progression, but where he could also remain on a vulnerable prisoner unit. The lifer liaison officer replied on 12 March. He said that he was trying to arrange a move, but that the man had to show that he would engage with offending behaviour courses before another prison would accept him. He said that he did not know how long it would be before a transfer happened.
80. When interviewed, the PO told the investigator that the man was adamant that he wanted to keep his vulnerable prisoner status if he moved prison. She said that this made the chance of a successful transfer much more remote, as most prisons who accepted vulnerable prisoners took them on the basis of their offence (usually a sexual offence). The prisoner would need to be willing to participate in offender management courses. As the man was not a vulnerable prisoner because of his offence, he was unlikely to fit this criterion. The PO said that a move would have been "extremely difficult" unless the man gave up his vulnerable prisoner status.
81. The nurse saw the man again on 15 March. (He made the entry in the medical record retrospectively, some time later on 4 April, the day after the man's death. The nurse had asked the lifer liaison officer to attend, but he recorded that the man was rude and derogatory to the lifer liaison officer, claiming he was useless and had done nothing to get him moved. The lifer liaison officer had brought more forms to the meeting for the man to request a transfer, but the man ripped them up and said that the application had been made through his solicitor. After the lifer liaison officer left, the nurse noted that the man's attitude improved. The nurse said that he was now waiting for some information from the Priory Hospital (where the man had previously been treated) and once this was received they could discuss whether he should be referred to a personality disorder unit.

82. An officer submitted an SIR on 21 March when the man had told him that he had told an SO that he was going to slash another prisoner, but he would not say who. According to the SIR, the SO placed him on a disciplinary charge. The investigators have not seen any other evidence about this incident and there is no record of a disciplinary charge or hearing.
83. The man saw a doctor again on 22 March as he was still having difficulty hearing. She gave him some olive oil to try and soften the wax in his ear. He said that he was getting on well with his pain relief, but would like to be tested for possible food intolerance as he had intermittent problems with nausea and abdominal bloating.
84. The nurse saw the man on 28 March. He said that he had not eaten for six days as staff refused to take meals to him and he was being threatened by other prisoners as officers had told them that he was a "nonce". The nurse said that he would try and see the man on the wing the next day, or make another appointment. The nurse said that the man became quite abrupt, and said that he was already aware of all this information. The nurse told him that this was the first time that he had heard of this.
85. Another prisoner was in the cell next to the man on A wing. He told the investigator that he often used to give the man tobacco and, at approximately 11.00pm on 28 March, the night officer asked him if he would give the man a cigarette. Later that night, at 2.00am, the prisoner said he heard some banging from the man's cell, which he said was not unusual with the man. They then spoke through the window and through the pipes about some family difficulties that the man was having. The prisoner said that the man had often hinted to staff and prisoners that he would kill himself, but that he used to take this with a pinch of salt. He said that the man's biggest concern was getting out of prison. Several times during their conversation, the prisoner said that the man made comments such as he would leave Lincoln in a box, or that he had nothing. The prisoner was not unduly concerned and told the man that he would help him. He did not alert staff to this conversation.
86. At 7.55am on 3 April, an officer was unlocking cells on A wing. The man's was the first cell he came to. He opened the observation panel to look inside the cell, but found it blocked with paper. He asked the man to take the paper down and when he did not receive a reply he unlocked the cell. He then saw the man hanging from a water pipe by the sink, lying sideways but with his head and shoulders off the ground. The officer told the investigator that the man had used a bed sheet to hang himself. He said that he thought he was dead.
87. The officer did not have a radio. He told the investigator that there were not enough radios in the prison for each officer to carry one. He

shouted for help and his colleague, an officer, who was unlocking cells on the landing above, immediately started to head for the man's cell, which she could see from where she was. She tried to alert the control room by radio that there was an emergency, but was unable to get through as there were a lot of other messages being passed. As she reached the cell, she saw other staff arriving. As she was still unable to get through to the control room she pressed the personal alarm button on her radio. Shortly afterwards, the manager, who was on the wing, pressed the general alarm bell.

88. An officer was the first officer to arrive at the cell. He helped the officer cut the ligature. An SO heard the alarm bell and went to A wing. The orderly officer, in charge of the prison at the time, also responded. He told the investigator two nurses arrived very quickly, but when he realised the nature of the emergency he issued a Code 1 emergency call on the radio (which denotes a life-threatening emergency, and also means that an ambulance should be called automatically). The SO sent the nurse to get oxygen and began cardiopulmonary resuscitation (CPR) with the other nurse.
89. A nurse was working on B wing. She told the investigators that she did not hear a code 1 call, but heard a message asking all healthcare staff to go to A wing. When she got to the cell, she saw the nurses and SO giving CPR. She went to get further oxygen, and made sure that the man's medical notes were available for the ambulance crew when they arrived.
90. Paramedics arrived in the prison at 8.02am and at the cell at approximately 8.10am. In his statement, the SO noted that the first paramedic gave the man drugs while he continued CPR. Another paramedic arrived five minutes later. However, they were unable to resuscitate the man. A paramedic declared him dead at 8.24am.
91. The orderly officer told the investigator that one of the operational managers told him to return to running the prison regime and supervise the movement of prisoners to workshops shortly after the paramedics arrived. The orderly officer did not pass information to any other member of staff and, when asked, was not sure who had taken responsibility for managing the incident.
92. After the man's death, the Governor held a hot debrief, which provides an opportunity to discuss what has happened, deal with any immediate issues and ensure that staff involved receive appropriate support if necessary. The officer said that he found the debrief useful but the orderly officer said that he was not told about it so was not present.
93. The family liaison officer arranged to visit the man's next of kin, his ex-wife, with the Governor and arranged a car to take them to Blackpool. However, he noticed that the telephone number on the next of kin record was wrong (the investigator confirmed that there was a number

missing). The Governor was concerned that the address might also be incorrect and, mindful that another prisoner might inform the family of the man's death before they arrived, he decided to ask the police to inform the man's ex-wife.

94. The family liaison officer told the investigator that the prison contributed to the costs of the funeral. At the request of the man's family, no one from the prison attended the funeral. The family liaison officer said that they had returned the man's property to his family but they said that some letters and photographs were missing. The family liaison officer checked with the police, who initially checked his cell and they confirmed that they did not have any property.
95. The care team and chaplain were asked to attend A wing to give support to staff and prisoners.

ISSUES

Clinical care

96. A clinical reviewer reviewed the standard of healthcare the man received at Lincoln. He described the man as a clearly vulnerable person who suffered from mental instability. The clinical reviewer believed that the man displayed significant psychological symptoms in the three or four months before his death, which indicated a worsening of his mental health. The clinical reviewer commented that the man's lack of cooperation with mental health staff might have alerted them that he was becoming more at risk and that a fuller psychiatric assessment would have been appropriate, especially as he was taking antipsychotic medication.
97. It is clear that the man did not always engage with the mental health team and the last time a psychiatrist saw him was on 26 October. In February and March 2012, the nurse attempted to get further information from units who had treated the man in the past, which indicates that there were concerns about his mental health and previous treatment at the time. This information did not arrive before the man died. It is not clear why this information had not been requested earlier. Overall, there does not seem to have been a sufficiently proactive approach to managing the man's mental health issues. We make the following recommendation:

The Head of Healthcare should ensure that a full psychiatric assessment is completed when there are signs that a prisoner's mental health is deteriorating, particularly if they are on antipsychotic medication.

98. When the man arrived at Lincoln on 22 June 2011, the nurse noted that the man had failed an in-possession medication spot check when he was at Garth and indicated he should not be allowed to keep his medication in his possession at Lincoln. However, on 4 September, the nurse noted that he had passed a medication spot check. There is no record of when he was given permission to keep his medication in-possession and whether any risk assessment had been completed before that. The doctor saw the man on 25 November and noted that there was no reason why he could not keep his medication in possession if he passed a risk assessment. There is no record of such an assessment, but at a spot check on 15 January, the man did not have the amount of medication that he should have had. On 19 January, the nurse noted that the man was being supervised when taking his medication.
99. The man was known to harm himself, to have a pattern of getting into debt with other prisoners and had failed previous medication spot checks. We believe that he should have been seen as a high risk if he was allowed to keep his medication in possession. However, it is

unclear from the medical record how he came to have medication in his possession again. We are concerned that the risk assessment process was not clearly recorded in the medical record, especially for someone at risk for several reasons. Although he did not appear to harm himself by overdosing there is no evidence that the suitability of him having his medication in possession was considered at ACCT reviews when he regarded as at risk of suicide and self-harm. We make the following recommendation:

The Governor and Head of Healthcare should ensure that risk assessments to allow prisoners to keep medication in their possession are completed and recorded on the medical record.

Managing the risk of self-harm

100. Prison Service guidance is that ACCT case reviews should be multidisciplinary where possible and that the ACCT process will operate more effectively where there is continuity in attendance of staff from relevant departments and services. A member of the mental health team attended the majority of case reviews and there was usually a member of staff from the wing in addition to the senior officer who was chairing the review. However, for the ACCT that was open in January and February 2012, there were three different case managers for six reviews and the same manager did not chair consecutive reviews. It appears that reviews were chaired by whichever manager was on duty rather than being planned to allow continuity of case management. We make the following recommendation:

The Governor should ensure that there is continuity of case management in ACCT case reviews.

101. We have considered whether the man was being bullied. Staff submitted several security information reports about the man. One of these, completed by the officer on 20 January, concerned the theft of medication from the man's cell. The officer began anti-bullying measures and spoke to the other prisoner involved, which we believe to have been an appropriate response.
102. It is clear that the man often came into conflict with other prisoners, usually because he had got into debt with them. The Rabbi told the investigator about the scale of debt that the man had amassed in prison. The prisoner, who lived in the cell next door to the man on A wing, said that he thought the man was paranoid and said that people were out to get him. The prisoner often used to collect meals for the man so that he did not need to leave his cell. However, he said that he never saw the man being threatened and that people generally left the man alone.
103. Although the evidence might suggest that the man was not being bullied, we are concerned that information submitted in SIRs, and

elsewhere in the ACCT ongoing record, does not seem to have been properly considered and discussed at ACCT reviews.

104. There were several occasions when key information about the man does not seem to have been discussed. Examples of this include the events of 20 January, when the man alleged that medication had been stolen by another prisoner (who in turn alleged that the man was in debt on the wing), and the events of 26 January, when the man told the OSG that he had razors hidden in his cell. It is a concern that that there is no evidence that information so clearly related to the safety of a prisoner regarded as at risk of suicide and self-harm was not discussed at ACCT case reviews. We do not know if this was poor recording or that the matters were not discussed at all. In many cases, the medical record provided a fuller record of ACCT reviews than the ACCT document itself. We note that inspectors also found that entries in ACCT documents were often poor. We believe that it is vital that all important events and information related to the safety of a prisoner and how he is feeling should be discussed at ACCT reviews in order to review the level of risk accurately, to ensure there is appropriate support and update the caremap as necessary. We make the following recommendation:

The Governor should ensure that ACCT reviews consider and record all information about events affecting safety such as self-harm and potential allegations of bullying and that they are discussed with the prisoner in order to put in place appropriate support.

105. Prison Service Instruction (PSI) 64/2011, gives guidance to prison staff about managing the ACCT process and includes a mandatory instruction that ACCTs should not be closed until all the caremap actions have been addressed. When an ACCT was closed on 8 December 2012, the one caremap action - for the man to transfer to another prison – was still outstanding. When the last ACCT was closed on 3 February, there were five outstanding caremap actions. At the post-closure review, the SO noted that all of the caremap actions were ongoing, and that there were other problems “due to medical issues”. It is clear to us that the ACCT should not have been closed when it was and that issues were identified at the post-closure review which should have led to the ACCT being opened. The staff did not follow the instructions designed to ensure that appropriate steps are taken to reduce the risk of suicide and self-harm before an ACCT is closed. We make the following recommendation:

The Governor should ensure that ACCTs are not closed until all identified actions in caremaps have been completed.

Prison transfer

106. The man had been in a number of prisons before he arrived at Lincoln in June 2011. Soon afterwards, he requested a transfer, as he did not think that he would be able to complete the courses that he required at Lincoln. He was moved to Gartree the next month where he would have been able to participate in offender behaviour courses, but once there, he refused to leave the segregation unit because he said he felt threatened. After two days in the segregation unit at Gartree, he returned to Lincoln.
107. The issue of transfer was a caremap action on each of the ACCT documents. The lifer liaison officer had responsibility for arranging a move. It is clear that the man was frustrated by the lack of progress in obtaining another transfer and that he had lost faith in the lifer liaison officer arranging a transfer. In his reply to the man's solicitors on 12 March, the lifer liaison officer said that he was trying to arrange a transfer but this would be difficult until the man showed that he would engage in offender behaviour courses.
108. We accept that it must have been difficult for prison staff at Lincoln, who had arranged a transfer to Gartree, when the man returned shortly afterwards. However, there is little evidence to suggest that staff at Lincoln fully engaged with him to try to ensure an appropriate allocation to allow him to progress in his life sentence. We recognise that on at least one occasion the man refused to discuss this with the lifer liaison officer and tore up application forms for transfers on 15 March. However, it is also possible to understand the man's frustration at the lack of progress and the fact that the lifer liaison officer presented the man with application forms for a move suggests that nothing further had been done about a transfer. There is no evidence that staff actively engaged with the man about his move and we have found no evidence of a life sentence plan at Lincoln to make it clear what his objectives were at that time. Indeed, it is not clear what the purpose of the move to Lincoln was expected to achieve. As a transfer was a key concern and was identified as a caremap action in each of his ACCTs, we believe that more active efforts should have been made to engage the man and help arrange a transfer. We make the following recommendation:

The Governor should ensure that there is active engagement with life sentence prisoners about their sentence plan goals and how and where they will be met.

Emergency response

109. The officer did not have a radio when he found the man on the morning of 3 April and the officer said that she had difficulty alerting the control room because of other traffic on the radio network. As a result, she pressed her personal alarm. The manager then pressed the general

alarm. While this meant that a number of prison and healthcare staff came quickly, it also meant that staff did not know the nature of the emergency to allow them to bring appropriate emergency equipment.

110. Following a subsequent death at Lincoln, the investigator gave feedback to the Governor about the use of emergency codes and the Governor introduced a new system. Two emergency codes (red and blue) were introduced and a Notice to Staff was also issued on 22 February to clarify emergency procedures in the prison. The new instruction requires an emergency ambulance to be called immediately a code red or blue is called in line with national guidance in PSI 03/2013 which was issued in February 2013.
111. However, on this occasion, the officer was unable to make her message understood because normal radio traffic continued. It is important that emergency messages receive appropriate priority, especially at busy times such as morning unlock. We make the following recommendation:

The Governor should ensure that emergency code radio messages are given priority on the radio network.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that a full psychiatric assessment is completed when there are signs that a prisoner's mental health is deteriorating, particularly if they are on antipsychotic medication.
2. The Governor and Head of Healthcare should ensure that risk assessments to allow prisoners to keep medication in their possession are completed and recorded on the medical record.
3. The Governor should ensure that there is continuity of case management in ACCT case reviews.
4. The Governor should ensure that ACCT reviews consider and record all information about events affecting safety such as self-harm and potential allegations of bullying and that they are discussed with the prisoner in order to put in place appropriate support.
5. The Governor should ensure that ACCTs are not closed until all identified actions in caremaps have been completed.
6. The Governor should ensure that there is active engagement with life sentence prisoners about their sentence plan goals and how and where they will be met.
7. The Governor should ensure that emergency code radio messages are given priority on the radio network.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that a full psychiatric assessment is completed when there are signs that a prisoner's mental health is deteriorating, particularly if they are on antipsychotic medication.	Accepted	<p>Any person who has concerns about a prisoner's mental well being can contact the mental health team to make an urgent or routine referral. Urgent referrals are responded to by a clinician holding radio Hotel 6 within 4 hours. The clinician will decide if an urgent psychiatrist review is required and in any case will discuss any concerns raised with the team to ensure the appropriate level of support is provided</p> <p>The mental health team liaise with wing staff to discuss any concerns they may have and are easily accessible on the wings or by telephone if required.</p> <p>Anyone with concerns that a prisoner mental health is deteriorating can open an ACCT to ensure support is provided whilst further assessments are carried out.</p>	Completed	
2	The Governor and Head of Healthcare	Accepted	All prisoners who are prescribed medication have an in possession	Completed	

	<p>should ensure that risk assessments to allow prisoners to keep medication in their possession are completed and recorded on the medical record.</p>		<p>(IP) assessment carried out prior to being allowed IP medication. The assessment is carried out by a qualified nurse or the General Practitioner. The assessment will be carried out at the point of prescription need however prisoners are routinely placed on supervised medication for the first 7 days and then the risk assessment is completed.</p> <p>Assessments are carried out face to face with the prisoner. It asks if they are on an ACCT, if previously been on an ACCT and if so when, are they having any thoughts of deliberate self harm or suicidal ideation, can they read the instructions; do they know what the medication is for and do they understand the possible side effects and have they had IP medication before. When completed the assessment is kept with the prescription card and scanned onto systemOne.</p>		
3	<p>The Governor should ensure that there is continuity of case management in ACCT</p>	<p>Accepted</p>	<p>A notice to staff was issued on 30 April requiring case managers to ensure continuity of case management in ACCT case reviews. The safer custody team will be monitoring the consistency via regular audit checks and</p>	<p>30 April 2014</p>	

	case reviews.		discuss any issues in the safer custody meetings.		
4	The Governor should ensure that ACCT reviews consider and record all information about events affecting safety such as self-harm and potential allegations of bullying and that they are discussed with the prisoner in order to put in place appropriate support.	Accepted	<p>The quality of case reviews is monitored by the Head of Residence and Safety and reviewed by the Safer Custody Meeting. The Safer Custody Department, also responsible for violence reduction, ensures that case reviews reflect the reality of any bullying.</p> <p>The prison's internal audit assurance processes have focussed on safer custody and this has included "Safer Custody Teams should learn from incidents by analysing local safer custody data and the Violence Management Report on the Hub."</p>	Completed	
5	The Governor should ensure that ACCTs are not closed until all identified actions in caremaps have been completed.	Accepted	Decisions made to close ACCTs is monitored by the Head of Residence and Safety and reviewed by the Safer Custody Meeting. A new staff information notice will be issued to remind case managers to check the completion of Caremap before closing the document.	Completed	

6	The Governor should ensure that there is active engagement with life sentence prisoners about their sentence plan goals and how and where they will be met.	Accepted	Offender Supervisors work directly with offenders, including those servicing indeterminate sentences, on their sentence planning goals. This aspect of offender management is likely to be commented on positively in the forthcoming inspection report on HMP Lincoln.	Completed	
7	The Governor should ensure that emergency code radio messages are given priority on the radio network.	Accepted	An operational instruction will be produced giving clear guidance of staffs responsibilities in line with PSI 03/2013.	30 April 2014	