

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of a prisoner at HMP Lincoln on 22 February 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man was found hanged in his cell at HMP Lincoln on 22 February 2015, his 28th birthday. I offer my condolences to the man's family and friends.

The man transferred to Lincoln in January 2015 because of lack space at HMP Nottingham. He was upset at the move, as the distance from his home in Nottingham meant that his parents, who had health problems, were unable to visit. On 12 February, he cut his arm, and staff began to manage him under Prison Service procedures for those at risk of self-harm (known as ACCT). He harmed himself again on 16 February and, during the early hours of 22 February, night staff found him hanging in his cell. They were unable to resuscitate him.

The man had been identified as at risk of suicide and self-harm and was principally upset that his location at Lincoln prevented visits from his parents. While the investigation found that some staff at Lincoln made good efforts to support him, I am concerned that too little was done to progress his request for a transfer, apparently because of staffing pressures. Similarly, I am concerned that other steps were not taken to mitigate his anxiety, such as allowing him exceptional telephone calls to his parents.

The man killed himself in the early hours of his birthday, the day after the birthday of his brother who had also killed himself, but staff had not identified these as a trigger points. Ideally, he should not have been transferred from Nottingham in the first place, but, sadly, this case illustrates how easy it is for the needs of one particularly vulnerable person to be overtaken by the pressures on a crowded and overworked prison system.

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

**Nigel Newcomen CBE
Prisons and Probation Ombudsman**

April 2016

Contents

Summary

The Investigation Process

Background information

Key events

Findings

Summary

Events

1. The man had been released from a prison sentence in July 2014 but was recalled to HMP Nottingham in October 2014. He had an extensive history of mental health problems and self-harm, mainly by cutting, but had also taken overdoses. The suicide of his brother some years earlier had caused him ongoing distress.
2. In January 2015, the man was moved to HMP Lincoln. He was upset about this as it meant that his parents, who had health problems, could not visit him. At first, he lived on the vulnerable prisoner wing, as he had at Nottingham, but was moved to another wing after he and his cellmate barricaded their cell and demanded a move back to Nottingham. On 25 January, it was agreed he would live as a standard prisoner on the new wing.
3. On 12 February, the man self-harmed by cutting his arm and staff began Prison Service suicide and self-harm prevention procedures (known as ACCT). The man was still anxious about being away from his parents and staff emailed an internal request for a transfer back to Nottingham. This was not dealt with, apparently because the member of staff responsible had been given other duties. During the night of 16 February, the man cut himself again. The night manager emailed the officer responsible for transfers about a move to Nottingham. No action was taken.
4. The man's former cellmate moved back to the vulnerable prisoner wing on Friday 20 February. That evening, he also asked to go back and said that he was being pressurised to pay debts his former cellmate had left behind. The next day, Saturday 21 February, an officer agreed to help him with his application and said that the man was content. The man mixed with other prisoners that afternoon. No one was concerned about him, but one prisoner said he had seemed quiet and depressed. A prisoner told the investigator that he, the man, and some other prisoners had smoked 'mamba', a new psychoactive substance, that evening.
5. The night officer checked the man periodically during the night as part of ACCT procedures. Just before 2.00am on 22 February, he recorded that the man was writing a letter and had nodded when the officer asked if he was all right. When the officer checked again at 3.43am, he found the man had hanged himself with some bedding tied to the window bars. The officer radioed for emergency help. Other staff arrived quickly. They found no signs of life and began cardiopulmonary resuscitation. Paramedics arrived and took over emergency treatment. At 4.48am, they pronounced that the man had died.

Findings

6. The man had been identified as at risk of self-harm, which he said he used as a coping mechanism. He gave no indication that he was contemplating suicide. He told staff at Lincoln that he self-harmed because of the anxiety caused by not seeing his parents. Although he was always at some risk of suicide, his actions were unexpected and we consider it would have been difficult for staff to have

foreseen or prevented his actions. However, we are concerned that the man killed himself on the cusp of the birthday of his late brother and his own birthday and no one had identified these as potential trigger points for suicide or self-harm.

7. ACCT procedures were mostly appropriate and staff checked the man as required. However, we are very concerned that no action was taken on the principal caremap action to reduce his stress, by arranging a transfer to Nottingham. No one considered involving the man's family in the ACCT process, or allowing him to phone them.
8. The man suffered from back pain and there was some initial delay and difficulty managing the pain appropriately. However, the clinical reviewer was satisfied that his care was at least equivalent to that he could have expected to receive in the community. He considered a doctor should have reviewed him after he changed his medication, as increased risk of suicidal thoughts was a possible side effect, but noted this was checked at ACCT reviews. When he man was found hanging, there was a slight delay in summoning an ambulance. It is unlikely that this made a difference in this instance, but could do so in future.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Noting all relevant triggers in the ACCT document; Considering all known risk factors when determining the level of risk of self-harm;
 - Involving the prisoner's family in the ACCT process when appropriate and recording this in the ACCT plan.
- The Governor should ensure that all staff in the prison understand the importance of delivering ACCT caremap actions to help reduce a prisoner's risk of suicide and self-harm and that relevant departments prioritise and expedite any required actions.
- The Head of Healthcare should ensure that prisoners who identify medical problems on reception are referred to a GP or nurse practitioner for prompt medical assessment.
- The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.
- The Governor should ensure that that all prison staff understand the need to use emergency medical codes in line with the national instruction and the local protocol and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further confirmation.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Lincoln on 27 February 2015. He obtained copies of relevant extracts from the man's prison and medical records.
11. The investigator interviewed 11 members of staff and five prisoners at Lincoln in February and April 2015.
12. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
13. We informed HM Coroner for Central Lincolnshire of the investigation, who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted the man's parents to explain the investigation. The man's parents had the following questions for the investigation to consider:
 - Did the man have any trouble seeing a doctor about back pain?
 - Why did staff check the man only every two hours?
 - Why was the man moved from the wing for vulnerable prisoners?
 - Why was the man in a cell by himself?
15. On 8 July, the man's family's solicitors wrote to us. They asked whether he had been bullied at the prison and said that his family had been unhappy about how prison staff had informed them of his death and about the support they had received from the prison.
16. The man's family received a copy of the initial report. Their solicitor confirmed that they did not wish to make any comments on the report. NOMS received a copy of the initial report, and their action plan is annexed to this final report.

Background Information

HMP Lincoln

17. HMP Lincoln holds up to 729 remand and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, which include a vulnerable prisoners unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Lincoln was in November 2013. Inspectors noted that the prison was safer than it had been at the previous inspection 15 months earlier, and that levels of self-harm were lower. Some ACCT case management procedures were weak and not all agreed actions were followed up. However, staff were caring and helped prisoners deal with their issues. The number of drug tests had decreased and there was evidence of the increasing availability of new, less detectable drugs such as 'Black Mamba' (known generically as new psychoactive substances). Health services were much improved, and attendance rates at clinics were better.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 January 2015, the IMB reported that it had been a difficult and challenging year because of the number of prison officer vacancies. The IMB noted that there had been successful efforts to reduce non-attendance at health appointments and healthcare staff followed up missed appointments. The IMB was concerned about the increased use by prisoners of new psychoactive substances.

Previous deaths at HMP Lincoln

20. The man's was the fourth self-inflicted death at Lincoln since 2012 and there had been another since his death. There were no significant similarities with the circumstances of the other deaths.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22. The man had been in prison since May 2013 and was released on licence in July 2014. On 2 October, he was recalled to prison and returned to HMP Nottingham for breaching his licence conditions. He had an extensive history of mental health problems and self-harm, mainly by cutting, but had also taken overdoses. His prison record indicated some difficult behaviour in prison, including reports of being involved in debt, bullying, barricading, damaging his cell, fighting, and trading medication. He had been managed under ACCT procedures several times. A note in his record indicated that his brother had taken his own life on New Year's Day some years earlier. The man had found it difficult to come to terms with his brother's death. His record noted that the man was subject to the Sex Offenders' Register for life and had an indefinite Restraining Order prohibiting him from contacting his ex-partner.
23. On 13 January 2015, the man was one of several prisoners who was moved to HMP Lincoln because of a shortage of places at Nottingham. We have not seen any reasons why he was selected for transfer. His escort record did not contain warnings that he was at risk of suicide or self-harm, but noted that he had previously been managed under ACCT procedures. It recorded issues such as violence, drug use, and damage to prison property.
24. When he arrived at Lincoln, he told Nurse A that he did not misuse drugs or drink alcohol. He said that he had no thoughts of suicide and self-harm, but wanted to see the mental health team as he had suffered from depression in the past. He said that he was due to have a review with a doctor about a trapped nerve in his back.
25. At a first night interview, the man told an officer that he had previously been in Lincoln in 2012. He said he had no mental health issues, had never seen any mental health professionals, and had never attempted suicide or harmed himself. He said that he suffered from sciatica. He also said that he was in touch with his family and was expecting them to visit. The officer recorded there were no immediate concerns. The man asked to be allocated to the vulnerable prisoner unit, as he had been at Nottingham. He said that he was in debt to some well-known criminals, had previously been convicted of a sexual offence and other prisoners knew that he had previously been classified as a vulnerable prisoner. He was allocated a cell on E Wing, the vulnerable prisoner unit at Lincoln.
26. The man had an appointment to see the mental health team on 20 January, but did not attend. He also missed a rebooked appointment on 22 January. A mental health nurse went to see him to find out the reason. He said that no one had collected him to take him to the appointments and would like another one. He said that he had post-traumatic stress disorder, but had no thoughts of harming himself. The man complained of some dental pain, and the nurse gave him paracetamol. He received another mental health appointment for 27 January.
27. On the afternoon of 22 January, staff in the prison's textiles workshop spoke to the man about his poor attitude to work and reminded him of this again the next day. That evening, the man and his cellmate, prisoner A, barricaded themselves

in their cell and demanded a transfer back to Nottingham. Officers tried to reason with them but eventually cleared the barricades. Neither the man nor his cellmate offered any resistance. The man and his cellmate were moved to A Wing, where the man was given a single cell.

28. On 24 January, the man was found in possession of fermenting liquid. On 25 January, he asked to come off vulnerable prisoner status, as he wanted a fresh start. Supervising Officer (SO) A explained the risks to the man, including that other prisoners might make assumptions because he had been on E Wing. The man said he understood and signed a disclaimer.
29. On 27 January, Dr A reviewed the man's back pain. The man said that he had sciatica and suffered lower back pain after he was involved in a road traffic accident over a year previously. He had been taking co-codamol but had stopped because he did not want to take any opiates. The man said that he had stopped taking amitriptyline in October, as it had not helped. The doctor noted that the man had no loss of sensation in his legs, and referred him for an MRI scan and for physiotherapy. He prescribed duloxetine (which is usually used as an antidepressant but can be used for pain relief) and said he would reassess him in a month, after the scan.
30. That day, an occupational therapist, carried out a mental health triage assessment. The man told her that, when he was young, a psychiatrist had thought he might have traits of attention-deficit hyperactivity disorder. He said that he had used cannabis between the ages of 13 and 19. He had suffered from anxiety and depression since he was 16, when he had begun to self-harm by taking overdoses of tablets and cutting himself. He said that he had harmed himself most recently in October 2014, but had no current thoughts of self-harm. He said that he had seen a bereavement counsellor and a psychiatrist after his brother's death. He had not wanted to take medication but now thought that it might help. He said that he had been anxious and hyper-vigilant since coming off E Wing and his mood was low. She referred him for a fuller assessment and follow-up support.
31. The man's next mental health appointment was on 3 February, but he did not attend.
32. On 7 February, at a disciplinary hearing the man was awarded his punishment for the charges of making a barricade and for fermenting liquid. On the barricade charge he was awarded 21 days stoppage of 20% of his earnings, 14 days loss of association, and 21 days loss of canteen (where prisoners can order items from the prison shop), access to his private cash, and television. For fermenting liquid he was awarded 28 days stoppage of 20% of his earnings, 42 days loss of use of the gym, 14 days loss of association, and 21 days loss of canteen, private cash and television.
33. On 10 February, the man did not attend a physiotherapy appointment. The reasons were not recorded.
34. At 9.00pm on 12 February, the man showed a night patrol officer on A Wing, two cuts he had made to his arm. Nurse B treated the cuts. The man told the nurse that he had not seen anyone from the mental health team at Lincoln. The nurse

said he would contact them on his behalf and sent a notification on SystmOne, the electronic medical record.

35. The night patrol officer began ACCT procedures and noted in the 'concern and keep safe' form that the man was anxious about being away from his parents. The prison manager completed an immediate action plan and agreed with the man that she would contact the OCA (observation, classification and allocation office, which deals with prison transfers) and ask them to consider a transfer back to Nottingham. The man said he would not harm himself again. She told the investigator that she thought that his self-harm was an attempt to get someone to recognise his problem, which she had done. She did not consider that the man needed the additional support of a cellmate so noted he should remain in a cell on his own, and staff should check him at least once an hour. He was aware of Listeners (prisoners trained by the Samaritans to offer other prisoners confidential support) and the availability of a phone to contact the Samaritans.
36. The prison manager asked Officer A to contact the OCA about a transfer for the man. At 2.45am on 13 February, The officer emailed the OCA officer. The OCA officer told the investigator that, when he received a transfer request, he would usually write a transfer report and send a request to the other prison. However, at the time, there were staffing shortages at the prison and he was deployed elsewhere and unable to fulfil his OCA duties. No one else was covering them. He therefore did not take any action after he received Officer A's email.
37. At 2.30pm, Officer B assessed the man as part of the ACCT procedures. The man explained that he had cut himself because of the stress of not being able to see his parents. He said that he had no job, no money, did not feel safe on the wing, and did not want to have to borrow tobacco. He said that he cut himself to relieve stress, not to die, and had no wish to do so. He said that in the past he had harmed himself several times both in and out of prison, but had only made two previous suicide attempts;, both in the community and more than 10 years previously. He had no current thoughts of self-harm but said he could not rule it out. He still felt "pissed off", and did not like having to remain locked in his cell most of the time. He was on medication for pain relief and had poor sleep patterns, though he said he did not suffer nightmares or have a poor appetite. His parents were supportive but were unable to visit and, as he had no money for the telephone, they could only write to each other. He agreed that he would benefit from being on the same landing as his friend, prisoner A, as they gave each other moral support.
38. After the assessment interview, SO A held an ACCT case review with Officer B and Nurse C from the mental health team attended. The man said he was frustrated about the lack of contact with his family and said that he was waiting for a move to Nottingham. He said that he had not had any direct threats on the wing but he did not feel settled. He had limited funds but did not feel safe working in the workshops, and would like to work on the wing or have education in his cell. He said he was familiar with the support available and did not intend to harm himself. The SO told the investigator that he had no concerns that the man would take his own life, but thought he had self-harmed to draw attention to his problems. He noted on the ACCT form that the man's risk of self-harm was

- low. The review agreed to reduce the level of required observations from once an hour to once every two hours, and that staff should record a meaningful conversation with him each morning, afternoon and evening.
39. The SO noted two actions on the ACCT caremap (designed to reduce the assessed risks). Wing staff were to contact OCA about the transfer to Nottingham, the man had an appointment with the mental health team on 19 February and the activities team would take forward the man's concerns about work.
 40. A note on the ACCT record shows that the man spoke to other prisoners on the landing that afternoon, and went to see prisoner A. Staff monitored him in line with the required observations and no one noted any problems. The man saw a Listener in his cell in the evening of 15 February.
 41. At 9.25pm on 16 February, night patrol officer, B, responded to the man's cell bell and the man showed him that he had cut his right arm with a razor blade. Nurse D treated the cut. The night manager immediately convened an ACCT review, which Nurse D, Officer C, Officer D, and a healthcare support worker attended.
 42. At the case review, the man said that he had cut himself because he was still frustrated and angry about being in Lincoln, away from his parents. He said that duloxetine made him feel like he was on amphetamines and was stopping him from sleeping. He said that he did not know why the doctor had changed his medication. Nurse D referred him to a doctor for a review. He said he was bored as he did not have a job and had restricted access to the gym. He said that his self-harm was not intended as a suicide attempt and that he felt calmer after talking about things. The night manager said that she would follow up his issues, and the man said that if he felt stressed again he would press his cell bell. His level of risk was still assessed as low, and checks stayed at every two hours. The night manager scheduled an ACCT review for the next day so the issues could be followed up as necessary.
 43. The night manager reviewed the caremap. She added actions for a medication review, that he needed a job and that he should keep busy as he was anxious and restless. As it was night time, she could not address the issues immediately so she sent emails to several members of staff asking them to take the relevant issues forward. She made it clear that the man had harmed himself again. She said that the activities department replied to say that the man was on the list to start work in the textiles workshop in the next few days. Nurse E replied that she had made an appointment for him to see the doctor (although a GP had already discussed his medication on 17 February). The Head of Residence said that he did not think the punishment of loss of gym time should be rescinded as the man did not understand the seriousness of being found with fermenting liquid.
 44. The night manager asked, the manager responsible for the OCA, for an update on the man's transfer request. The manager responsible for OCA told the investigator that, when he saw the email, he asked the OCA officer if he had dealt with the transfer issue, but the officer said that he had been taken away from his post so had been unable to deal with it. The manager responsible for OCA did not reply to the night manager's email or take any further action himself, so nothing further was done to progress the transfer request.

45. At 10.15am on 17 February, SO B chaired an ACCT review, which Nurse F from the mental health team and a representative from the chaplaincy attended. The man said that he was not suicidal, and had self-harmed to relieve stress. He was aware of the Listener scheme and that he could phone the Samaritans if he needed further support. He said he was worried about his father's health, but his father could not visit, and he had no money to telephone him. The nurse said she would speak to the doctor about the man's medication. The man was worried about working in the workshops, as prisoners knew that he had previously been on E Wing and would identify him as a sex offender. The SO said he would ask the activities team about finding occupation for him, possibly in-cell education. His level of risk was still regarded as low and his level of observations remained unchanged, with one check every two hours. The SO did not make any changes to the caremap and update it with the actions they had discussed at the review. He scheduled the next review for 24 February.
46. Immediately after the review, Nurse F spoke to Dr B about the man's medication. The man said he wanted to stop taking duloxetine, and the nurse wanted to make sure that there would be no adverse effects if he did. The doctor noted that the man had previously been caught selling medication in 2010 and wanted to make sure that he was not manipulating staff into prescribing him drugs with a high trade value for other prisoners. The doctor told the nurse that there would be no adverse effects if he stopped taking the duloxetine, but she would not prescribe anything else without a consultation and until she had the results of his MRI scan. The nurse said that the man walked normally and did not appear to be in any visible pain.
47. During the afternoon and evening association period that day, officers noted that the man socialised with other prisoners. He told Officer E that he had asked the wing manager if he could help the cleaners until he got a job of his own, but there is no further record that anyone took this request forward.
48. Although the man had said he was anxious about reprisals from other prisoners, he was allocated a job in the textiles workshop and was due to start on 18 February. On the morning of 18 February, he told wing staff that he was not going to work as his medication was not right. Officer F offered to get a nurse to see him, but he refused so she gave him a behaviour warning under the Incentives and Earned Privileges (IEP) scheme. That day, the man spent some time with prisoner A and other prisoners during association periods. He collected his medication, but in the afternoon again refused to go to work. An officer gave him another IEP warning.
49. The man had a mental health appointment on the morning of 19 February, but did not attend. Nurse G, from the mental health team, went to see him in his cell and he said that he had been too anxious to attend, as he was worried about sitting in the waiting area with other prisoners. The nurse said that she would make him a 9.00am appointment, the first appointment of the day early the following week, so he would not have to spend time in the waiting area. She warned him that if he did not attend he would be taken off the list to see mental health staff. She told him that it was safe for him not to take duloxetine, but he would not get an alternative until after his MRI scan. She said that the man seemed content with this. He said he had no thoughts of self-harm. When she

returned to the healthcare centre, she made an appointment for the man for the following week.

50. Wing staff noted that the man talked with prisoner A during the afternoon and evening association on 19 February. An entry in his ACCT ongoing record on the afternoon of 20 February said that he was annoyed that prisoner A had moved back to E Wing but said that he would cope. Staff noted that he spoke with other prisoners during evening association.
51. At 8.45pm on Friday 20 February, the man handed a note to night patrol officer, B. In the note, he said that since prison, A, had moved back to E Wing, other prisoners had been pressurising him to pay debts for him since he had left. The man said that he had suffered increased anxiety since he had moved to his current cell, and asked to move back to E Wing. The night patrol officer passed the note to the night manager.
52. At the handover the next morning, the night manager briefed the custodial manager responsible for the daily operation of the prison and gave him the man's note. The custodial manager asked SO A to deal with it. The SO told the man that a move back to E Wing might not be possible, but asked if he wanted to move from A Wing to another wing. The man said he did, and the SO said he would try to arrange a move to B Wing. The SO said that the man seemed pleased with this.
53. SO A spoke to the supervising officer on B Wing, who agreed to accept the man after lunch. The SO told the man, but he later said that he had changed his mind and preferred to stay on A Wing and wait for a move to E Wing to be with prisoner A. They agreed that at some point over the weekend they would work on an application for vulnerable prisoner status. The SO told the investigator that the man was content with that approach. He did not appear distressed, and that he had no concerns that he might harm himself.
54. Another prisoner told the investigator that, during the evening of Saturday 21 February, he, the man and other prisoners smoked mamba, a new psychoactive substance. He said that the man did not seem upset, and he was not aware that he had problems on the wing.
55. A prisoner on A Wing said the man had spoken to him during evening association on 21 February. He said that he thought that the man had some debts on the wing, but he did not feel that the man was frightened or under particular pressure. He said that the man had been quiet and seemed depressed, but did not appear to be upset. He said he was not worried about his safety.
56. The prisoner who was in the next cell to the man and saw him during evening association. The man had told him that the next day was his birthday, and he had said that as he was unable to buy him a drink, he would make him a coffee instead, if he came to his cell in the morning. The man laughed, and the prisoner did not notice that he was upset in any way. The prisoner who was the man's neighbour on the other side, said he also spoke to him during the association period and wished him a happy birthday for the following day. A prisoner who shared the cell with the prisoner on the other side of the man, said to the man

that he would see him in the morning as they went into their cells, and the man had responded with a thumbs-up gesture.

57. Officers locked prisoners into their cells for the night at approximately 5.30pm. The man's ACCT record shows that when an officer checked him at 6.00pm he was writing a letter. At 8.00pm, he said hello. The night patrol officer and checked the man at 10.00pm, when he was sitting on his bed watching television. The prisoner next to the man said he did not hear anything from the man's cell after approximately 11.30pm, and neither did the prisoner on the other side or his padmate. They all said that they could hear if a prisoner in a neighbouring cell pressed his cell bell. Records show that the man did not press his cell bell that night. The night patrol officer checked the man again shortly before midnight, and he was still watching television. He checked the man again at 1.48am on 22 February. He was sitting on the floor writing a letter, and nodded when he asked if he was all right.
58. At 3.43am, the night patrol officer went to check the man again. He opened the cell observation panel, and saw the man hanging by bedding which he had tied to the bars in the windows. He radioed an emergency code blue (used in circumstances such as when a prisoner is unconscious or not breathing.)
59. For security reasons, at night staff, do not carry standard prison keys, but have a cell key in a sealed pouch for use in an emergency. The night patrol officer broke the seal and used the emergency key to open the cell door, as other staff arrived to help. Officer D went into the cell and cut the man down. Officer G helped lower his body to the floor and Officer D started cardiopulmonary resuscitation. Officer G checked the man but could not find any signs of life.
60. The officer on duty in the control room said when she heard the code blue call, clarified the location with the night patrol officer and asked if an ambulance was required. The night manager had arrived on A Wing as the night patrol officer opened the cell door, and confirmed that an ambulance was needed. The officer in the control room requested an ambulance at 3.45am. The ambulance service logs show that the ambulance was despatched at 3.48am.
61. Nurse H and a healthcare support worker, responded to the emergency call and arrived while Officer D was performing cardiopulmonary resuscitation. The nurse assessed the man, but could not find any signs of life. He told the investigator that he thought that the man was already dead. He attached a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) but it did not detect a shockable heart rhythm and they continued the resuscitation attempt.
62. The night manager went to the gate to allow paramedics into the prison. The ambulance log shows that the first response unit arrived at the prison at 3.53am, and an ambulance shortly afterwards. They took over emergency treatment but were unable to revive the man. At 4.48am, they pronounced the man dead.
63. The man left a note in his cell. He made it clear that he had taken his own life because the difficulties he had contacting his family, although he also mentioned that he had inherited prisoner, A's debt. He told his family that he loved them.

Contact with the man's family

64. At 9.30am, the prison's family liaison officer, left the prison with the Reverend, a prison chaplain, and a senior prison manager, to visit the man's parents and inform them of his death. However, they went to the wrong street in the same town, with the same name as that on which the man's parents lived. The family liaison officer then telephoned the man's parents to confirm their address. The man's father asked the reason, but the family liaison officer said he wanted to tell him in person. Ten minutes later, at 11.25am, after confirming the address, they went to the man's parents' home and informed them of the man's death. The man's parents were very upset, and the meeting was short. After this, a second officer took over as the family liaison officer. In line with national Prison Service policy, the prison contributed to the costs of the funeral.

Support for prisoners and staff

65. After the man's death, the senior prison manager debriefed the staff involved in the emergency response to allow them the opportunity to discuss any issues arising and to offer support. The staff care team also offered support. The night manager said that the contingency plans were not very clear.
66. The prison posted notices informing other prisoners of the man's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by the man's death.

Post-mortem report

67. The post-mortem report gave the cause of death as hanging. Test results showed no evidence that the man was under the influence of drink or drugs, including new psychoactive substances, at the time of his death.
68. An anonymous note left on A Wing two weeks after the man died suggested that another prisoner had bullied others, including the man, for money. There is no further information or intelligence to support this.

Findings

Management of risk of suicide and self-harm

69. The man had a history of self-harm, and his escort record noted that he had previously been managed under ACCT procedures. However, there were no current risk warnings. Nottingham had not identified any issues with the transfer and neither did the man when he first arrived at Lincoln. During the reception and induction process, he said he had no thoughts of suicide and self-harm. He had been back in prison for three months since his recall without any concerns. We are satisfied that there was no reason for staff at Lincoln to be concerned that the man was at risk of suicide and self-harm when he first arrived at the prison.
70. When the man harmed himself on 12 February, staff correctly began ACCT procedures. Reviews were multi-disciplinary and appropriately considered the issues raised in the caremap. Each of the three reviews was chaired by a different case manager, although we recognise that the first two were in response to the man's self-harm, one of which was convened quickly at night. Officers checked the man as directed, and the level of checks reflected his assessed level of risk.
71. When the man harmed himself again on 16 February, the night manager commendably convened a multidisciplinary ACCT case review even though it was late at night. After an act of self-harm, we would usually expect to see an increase in the assessed level of risk and an increase in observations. However, those at the review accepted the man's explanation and were satisfied that he had harmed himself out of frustration, not as an attempt on his life. She said she would follow up the issues raised, and all those present agreed to leave the level of observation and risk unchanged. She immediately followed up the issues raised with emails to the relevant people and arranged a review for the next morning to check progress. We are satisfied that this was a reasonable decision in the circumstances.
72. Guidance on the ACCT process is contained in Prison Service Instruction (PSI) 64/2011. The PSI says that potential triggers include anniversaries. The man's brother had died by suicide some years previously, and it would have been his birthday on 21 February. It was the man's own birthday on 22 February. Staff did not identify either of these dates as potential triggers.
73. PSI 64/2011 also states that prisons should consider involving families in the ACCT process when it might be beneficial. In April 2014, we published a thematic report on suicides by prisoners who were on ACCT. We noted that in a sample of 60 caremaps, prisoners' families had been involved in only ten. The man's major issue was the lack of contact with his family, as he did not have enough money to call them and they could not travel to Lincoln. Although staff tried to arrange a transfer to Nottingham, there is no evidence that they considered other options to help the man maintain contact with his family. NOMS has an assisted-visits scheme to help relatives visit prisoners, but staff did not discuss this with the man. Staff did not appear to consider whether they could authorise an exceptional telephone call.

74. While much of the ACCT process was well managed, we are concerned that The man's family were not offered the chance to be involved when contact with them was his major issue, and that trigger points were not identified. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Noting all relevant triggers in the ACCT document; Considering all known risk factors when determining the level of risk of self-harm;**
- **Involving the prisoner's family in the ACCT process when appropriate and recording this in the ACCT plan.**

The man's transfer

75. When the man harmed himself, he gave the main reason for having done so as the lack of contact with his parents whose health precluded them from visiting him in Lincoln. This was clearly identified in the ACCT assessment, a transfer back to Nottingham was noted on the caremap and it was discussed at the case reviews. After the first case review, Officer A, emailed the OCA officer in the OCA and asked him to consider a transfer. The night manager later asked the manager responsible for OCA, the OCA officer's manager for an update.
76. The manager responsible for OCA told the investigator that the OCA post was a single post, but because of staffing shortages in the prison, he often had to cover other duties and could not always complete his OCA work. He said he had not been able to deal with Officer A's email on 12 February. The OCA's manager confirmed that the OCA post was not always filled. However, when the OCA officer told him that he had not been able to do anything about progressing a transfer for the man, the manager responsible for OCA did not take any further action. He did not let those responsible for managing the man's ACCT know that nothing had been done and they were entitled to assume that the action was progressing. The officer responsible for OCA and the OCA officer did not discuss how they would resolve this difficulty.
77. When the investigator interviewed the OCA officer on 20 April, he said that the day of the interview was the first day in three weeks he had been able to work in the OCA role, as he had been required to cover other duties, and that this often happened.
78. Ultimately, it is for the Governor to decide how to use his staff each day. However, if a key function is not covered, this should be clear to all staff so that if necessary, they can make other arrangements to resolve issues. The night manager raised the matter directly with the officer responsible for OCA, but never received a reply. The transfer was the major concern for the man and we consider that this important issue was not given the priority it should have had been, either when first raised with the OCA, or when the night manager chased a response.
79. We do not know whether it would have been possible to transfer the man back to Nottingham but it is unacceptable that no one took effective action to help resolve the principal action identified to reduce a vulnerable prisoner's risk of suicide and

self-harm. While the lack of progress on the transfer was unacceptable, we also note that other areas of the prison were slow to deliver on other caremap actions. The man complained of being in his cell most of the day, and had his access to the gym restricted because of a disciplinary punishment. However, when the night manager suggested that he would benefit from releasing his stress by using the gym more, the head of residence refused to consider altering his punishment. The ACCT process cannot operate in a vacuum and, as its name suggests, relies on teamwork and the cooperation of all members of staff to help deliver safer prisons and a reduction in the number of suicides. We make the following recommendation:

The Governor should ensure that all staff in the prison understand the importance of delivering ACCT caremap actions to help reduce a prisoner's risk of suicide and self-harm and that relevant departments prioritise and expedite any required actions.

Clinical care

80. The man had an appropriate health screen when he arrived at Lincoln, gave his medical history, and asked to see someone from the mental health team. When he missed appointments, mental health staff went to see him. When he said he was anxious about the timing of the appointment, they rearranged his appointment so that it suited him better.
81. The man's parents said that he had had difficulty in arranging an appointment with the doctor, which was only overcome when they telephoned the prison. Records show that the man told the reception nurse about his back pain when he arrived at Lincoln on 21 January. He said that he was due to have a GP review but the nurse did not refer him to the doctor. He did not see Dr A until 27 January, two weeks later. The clinical reviewer considered that a prompt medical assessment should take place when a medical problem is declared at the reception health screen. This might have helped resolve the man's problems with managing pain. We make the following recommendation:

The Head of Healthcare should ensure that prisoners who identify medical problems on reception are referred to a GP or nurse practitioner for prompt medical assessment.

82. When the man saw Dr A on 27 January, he said that he wanted to avoid opiate-based medication. He said that he had been prescribed amitriptyline and it had not worked for him. The doctor referred the man for physiotherapy and for an MRI scan. He prescribed a course of duloxetine. Duloxetine has a dual effect and is sometimes prescribed as an antidepressant, but the doctor prescribed it simply for pain relief.
83. The clinical reviewer noted that a potential side effect of duloxetine is the possibility of increased thoughts of suicide after two to three weeks of beginning to take it. The manufacturer of duloxetine warns in the prescribing information that all patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behaviour, especially during the initial few months of a

course of drug therapy. Guidance from the National Institute for Health and Care Excellence (NICE) on prescribing antidepressants says that although the absolute risk of suicide or suicidal thoughts is thought to be small, people who have higher risk should be monitored for suicidal behaviour, self-harm, or hostility, particularly at the beginning of treatment or if the dose is changed.

84. To some extent the man was monitored through the ACCT process and he did not report any suicidal thoughts. However, there is no record that the man was specifically observed in accordance with this warning. This is especially important in prisons, where there is already an increased risk of suicide and vulnerability compared to the general population. We make the following recommendation:

The Head of Healthcare should ensure that doctors review and monitor prisoners prescribed medication that might increase suicidal ideation, in line with NICE guidelines.

85. When Nurse F spoke to Dr B after the ACCT review on 17 February, the doctor checked the man's medical history, notes from Dr A's consultation, and outstanding appointments. She was concerned that the man might be trying to obtain medication with a tradeable value in prisons. The man had previously got into trouble for selling medication in prison some years previously. Dr B noted that he was due for an MRI scan and had a doctor's appointment pending. The clinical reviewer said that Dr B had given a comprehensive account the use of non-pain killing drugs in the management of chronic pain, and of her concerns about the man's request to change his medication.
86. Overall, the clinical reviewer concluded that the level of care the man received at Lincoln was at least of the level he could have expected in the community.

Bullying, debt and drug use

87. A prisoner at Lincoln told the investigator that the man was in debt on the wing, and his debtors had been pressing him. He said that, after the man's death, he was told that the man had been in debt for new psychoactive substances and subutex. He thought he could detect that the man was sometimes under the influence of drugs.
88. One of the man's neighbours on the wing said that new psychoactive substances (NPS) were available on the wing but he had never seen any sign that the man was using them. He had not noticed him being bullied or intimidated in any way. He said thought that he recalled the man once saying that he had some NPS. He knew that the man had borrowed tobacco from at least two other prisoners, but did not consider he was under any immediate pressure to repay the debt. He saw no evidence that the man was being bullied or threatened. Another prisoner who knew that the man had asked other prisoners for cigarettes, but had not seen any sign of him being bullied or threatened over any debt. He had not seen the man being involved with drugs. Prisoner B said that he had seen the man smoking NPS on the evening of 21 February at about 6.30pm. However, prisoners were locked in their cells at 5.30pm that evening. In the note the man left in his cell, he said that did not take NPS.

89. The man's parents' solicitor told our family liaison officer that the man had been bullied since he had left E Wing. The prison had no intelligence while he was alive that the man was being bullied, was under threat in any way or was taking drugs. The post-mortem report did not indicate the presence of any drugs in the man's system, including synthetic cannabinoids. Although there have been suggestions since the man's death that he was being bullied and took drugs, we have not found any firm evidence that this should have been apparent to staff.
90. However, the man gave a note to night patrol officer, B on 20 February in which he said that he was being pressured to repay prisoner, A's debt and wanted to move. Although he recorded that he had been given the note in the ACCT document, he did not record what the note said. There is no other mention of the note in the ACCT document. SO A, who spoke to the man about a move, did not mention potential bullying or debt when we spoke to him about the man's reasons for wanting a move. He had also seemed scared about going to the workshops and the healthcare waiting room. We consider that staff should have taken much more note of the issues and actively supported the man in line with their anti-social behaviour policy. We make the following recommendation:

The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.

Emergency response

91. PSI 03/2013, Medical Response Codes, requires governors to have a medical emergency response code protocol and states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The instruction states that, when a medical emergency is called, the control room should call an ambulance immediately and there should be no requirement to wait for a member of healthcare staff or a manager at the scene to confirm that an ambulance is needed.
92. When night patrol officer, B, found the man hanging, he used the recognised code to alert other staff that it was an emergency. He broke the sealed pouch carrying emergency cell keys to access the man's cell. Other staff responded to the emergency call and went to the cell, cut the man down, and tried to revive him. Medical staff were quickly there and even though there were no signs of life and the nurse formed the impression that the man was dead, they continued with first aid until paramedics arrived. The clinical reviewer said that correct procedures were carried out and that staff attempted resuscitation according to protocol.
93. In line with PSI 03/2013, Lincoln has a two-code medical emergency response system, and using an emergency code should trigger the control room to call an ambulance immediately. The officer in the control room said that in practice it was common for control room staff to ask for confirmation that an ambulance was required only to be told that it was not. When the night manager called the code blue emergency, the officer in the control room did not call an ambulance until Ms Henson confirmed that one was required.

94. The delay was minimal, only a minute or so, and is unlikely to have affected the outcome for the man. Nonetheless, in an emergency, small amounts of time can make a difference. Lincoln's guidance to staff says that the emergency codes should be used only when the situation is life-threatening and immediate paramedic assistance is required, and makes it clear that the emergency codes will result in the control room calling an ambulance. The Governor issued a staff information notice in February 2015, only days before the man died, reminding staff of emergency code procedures. Despite this, it appears that staff use emergency codes for urgent healthcare attendance in situations when an ambulance is not required and that control room staff do not immediately call ambulances when an emergency call is used. We make the following recommendation:

The Governor should ensure that that all prison staff understand the need to use emergency medical codes in line with the national instruction and the local protocol and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further confirmation.

Contact with the man's family

95. The man's parents were not happy with how prison staff told them of the man's death. It is unfortunate that the family liaison officer had to telephone them to ask directions. He considered he was acting for the best in not telling them over the phone the reason why they were coming and national instructions state that prison staff should inform families of a prisoner's death in person whenever possible. We are satisfied that staff from Lincoln acted appropriately. The man's family said that the prison staff were only at their home for a few more minutes before leaving and they had little support from the prison.
96. The prison's family liaison log shows that the meeting with the man's family was difficult and acrimonious partly because of the telephone call, and that understandably his family were very upset. We recognise that it must have been extremely shocking and distressing for the man's parents, especially after the death of their other son. The prison staff said they left quickly because the situation had become difficult. Officer B left an information leaflet and contact details. After the initial visit, the second officer who took over as family liaison officer and said he responded to queries from the man's family.
97. Sadly, once a bereaved family loses trust in prison staff it is very difficult to repair that relationship. There is nothing that can be done now to put this right. We understand why the initial contact was difficult for both parties, and it is unfortunate that the prison staff went to the wrong address and had to phone the man's parents. However, we have found that after what was a very volatile and short meeting, there was no follow up contact from Lincoln and, according to the prison FLO log, all subsequent contact was prompted by the man's family. We do not make a recommendation, but the Governor might want to speak to the man's family to discuss the contact they had with his staff.

**Prisons &
Probation**

Ombudsman
Independent Investigations