

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Luke McDonnell a prisoner at HMP Lincoln on 19 June 2015

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

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mr McDonnell died in hospital on 19 June 2015, after he had hanged himself in his cell at HMP Lincoln on 14 June. He was 29 years old. I offer my condolences to Mr McDonnell's family and friends.

Mr McDonnell had been released from HMP Leicester on 2 June. At the time, he had been assessed as at risk of suicide and self-harm and was being monitored under procedures designed to protect prisoners at risk. The next day, he was remanded to HMP Lincoln, after being charged with further offences. When he arrived at the prison, staff did not identify him as at risk, although he had been regarded as at risk the day before, had recently self-harmed and had other risk factors.

Prison staff did begin suicide and self-harm prevention procedures two days later, after Mr McDonnell threatened to harm himself, but I do not consider the procedures were used well to support him. I am also concerned that staff did not properly investigate Mr McDonnell's claims that he had been assaulted and threatened, apparently because of his involvement in bringing new psychoactive substances into the prison, or took effective action to warn him of the dangers of using such substances.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2016

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Summary

Events

1. On 22 April 2015, Mr Luke McDonnell was sentenced to 12 weeks in prison, which he served at HMP Leicester. He had a history of depression, self-harm, and drug and alcohol problems. Staff began suicide and self-harm prevention procedures, known as ACCT, the day after he arrived, when he said that he would use a razor blade to kill himself. He frequently self-harmed and said he was upset at the recent death of his daughter. (It is not clear whether he had a daughter and his mother told us he did not.) He was stressed about being in prison, had no tobacco and wanted more medication. He was also worried about where he would live when he was released.
2. On 2 June, Mr McDonnell was released, but said he might commit another offence to get back to prison, as he had no accommodation. Later that day, he was arrested for threatening to cause criminal damage at a police station. On 3 June, he appeared in court and was remanded to HMP Lincoln, apparently because HMP Leicester was full. His escort record noted he had a history of self-harm, drug and alcohol use, concealing drugs in his body, a personality disorder and depression. Mr McDonnell appeared to be withdrawing from drugs but told a nurse he was not dependent on any drugs. Reception staff did not assess Mr McDonnell as at risk of suicide or self-harm. He began a methadone maintenance programme.
3. On 4 June, Mr McDonnell had a bad physical reaction after apparently taking 'Mamba', a new psychoactive substance (NPS). He later had a fit and was taken to hospital. The next morning, 5 June, he discharged himself from hospital, against medical advice. A nurse considered it was not safe to give him methadone that day, as he appeared drowsy and could have been under the influence of other drugs. He threatened to self-harm if he did not get methadone and the nurse began ACCT procedures. He received methadone again from the next day.
4. In the next few days, Mr McDonnell cut his wrist, threatened further self-harm, and opened a wound. He said that he was withdrawing from drugs, had no tobacco, was stressed and anxious and missed his daughter. Staff gave him some tobacco on 6 and 7 June. On 9 June, his left eye was cut and bruised and he said that prisoners had assaulted him to get Mamba he had brought into the prison. He would not name his attackers and a manager turned down his request to move to the vulnerable prisoners unit.
5. On 10 June, Mr McDonnell asked for a number (which he said was his partner's) to be added to his prison phone account. After his death, officers found that another prisoner had used the account. On 11 June, he threatened to cut his wrists unless he got tobacco. Staff did not give him any more and he had no money to buy some. On 13 June, he was moved to a cell on his own.
6. Fourteenth of June was Mr McDonnell's birthday. At lunchtime, an officer found him crying in his cell but he said he did not want to talk. He seemed more positive later, but said that he was stressed because he had no tobacco. Later

that evening, an officer found Mr McDonnell hanged in his cell. Prison staff tried to resuscitate Mr McDonnell. Paramedics gave emergency treatment and established a pulse. Mr McDonnell was taken to hospital but did not recover. He died on 19 June.

Findings

7. We consider that reception staff should have identified Mr McDonnell as at risk of suicide and self-harm when he first arrived at Lincoln. He had recently self-harmed, had substance misuse and mental health problems and had been regarded as at risk of suicide and self-harm, when he had been released from Leicester, just the day before. It appears the staff relied too much on his assurances that he would not harm himself.
8. A nurse began ACCT procedures two days later, when Mr McDonnell threatened to harm himself. Staff did not manage the procedures to support Mr McDonnell well. Some caremap issues identified to reduce his risk were marked as completed when no effective action had been taken; not all relevant staff attended ACCT case reviews; there was a lack of continuity of case managers; and Mr McDonnell's level of risk was not always reviewed after acts of self-harm.
9. Mr McDonnell told staff that he had been assaulted after bringing new psychoactive substances (NPS) into the prison. At first, this was not investigated and his request to move to the vulnerable prisoners unit was rejected, although Mr McDonnell had a cut to his eye and had a record of bringing drugs into prison by concealing them internally. Mr McDonnell would not name his alleged assailants, but we understand that this might have put him at greater risk, and we do not consider that the prison appropriately supported Mr McDonnell, after he made this allegation. We are also concerned that there is little evidence that Mr McDonnell was warned of the dangers of using NPS.
10. Mr McDonnell's mother was upset that an escorting officer at the hospital did not allow her appropriate private time with her son and we do not consider the officer acted with appropriate sensitivity.

Recommendations

- The Governor should produce clear local guidance about procedures for identifying newly arrived prisoners at risk of suicide and self-harm. In particular, this should ensure that reception and first night staff:
 - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
 - Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm, including information from NOMIS, suicide and self-harm warning forms and PERs.
 - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular:

- A multidisciplinary approach for all case reviews with attendance of relevant people involved in the prisoner's care and with continuity of case management where possible.
 - Setting caremap actions, which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.
 - Reviewing risk whenever an event occurs which indicates an increase in risk and holding a case review if required.
- The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.
 - The Governor should ensure that prisoners who use new psychoactive substances are referred to drug treatment services and warned about the dangers and risks to health.
 - The Governor should ensure that all staff involved in escorting seriously ill prisoners in hospital are aware of the standards of behaviour expected of them, are sensitive to the needs of families, and allow them appropriate privacy with their dying relatives at the end of their lives.

The Investigation Process

11. 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.
12. NHS England commissioned a clinical reviewer to review Mr McDonnell's clinical care at the prison.
13. The investigator visited Lincoln on 24 June 2015 and obtained copies of relevant extracts from Mr McDonnell's prison and medical records. He interviewed 26 members of staff at Lincoln in August and September, some jointly with the clinical reviewer. He interviewed one prisoner, who Mr McDonnell's family had identified. Several prisoners he wanted to speak to did not want to be involved in the investigation.
14. We informed HM Coroner for Lincolnshire of the investigation who gave us the preliminary cause of death and a post-mortem toxicology analysis. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers informed Mr McDonnell's mother about the investigation. The family liaison officer and the investigator met Mr McDonnell's mother. She said that an escorting prison officer had not allowed her appropriate privacy with her son at the hospital when he was in a coma. She asked about the procedure for updates between prison healthcare and hospital staff. She also had the following concerns, which we have covered in our report.
 - How did the prison manage Mr McDonnell's risk of self-harm?
 - What did the prison do when it was suspected that Mr McDonnell might have taken an illicit substance?
 - Was Mr McDonnell attacked by other prisoners for drugs? Was he being bullied and what action did the prison take?
 - Did Mr McDonnell apply to move to the vulnerable prisoners unit?
 - Did anyone assess Mr McDonnell's mental health?
 - Was Mr McDonnell's cell sealed after he was found hanged and taken to hospital?
16. Mr McDonnell's mother received a copy of the initial report. The solicitor representing her wrote to us pointing out some omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Lincoln

17. HMP Lincoln holds up to 739 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 was concerned about the increased use by prisoners of new psychoactive substances.

Previous deaths at HMP Lincoln

20. Mr McDonnell's death was the fifth apparent suicide at Lincoln since 2012. There has since been another self-inflicted death. In our investigation into the death of a prisoner at Lincoln in February 2015, we were concerned about the effectiveness of the ACCT caremap process. That prisoner also killed himself on his birthday.

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.

New Psychoactive Substances

22. New Psychoactive Substances (NPS) are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.
23. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence, and intimidation.
24. In July 2015, we published a Learning Lessons Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

25. On 25 July 2014, Mr Luke McDonnell was released from prison on licence. On 21 April 2015, he was arrested for theft and assault. A police officer noted in Mr McDonnell's Person Escort Record (PER – a document which accompanies all prisoners when they move between police stations, courts and prisons) that he was an alcoholic and suffered from depression. The police officer recorded that Mr McDonnell used drugs (heroin and methadone) and had a history of self-harm (he had cuts his wrists in 2012).
26. The next day, 22 April, Mr McDonnell appeared at Magistrates' Court. He was sentenced to 12 weeks imprisonment for the new offences and recalled to prison to serve the rest of his previous sentence. He was sent to HMP Leicester. On 23 April, officers began ACCT suicide and self-harm prevention procedures, when Mr McDonnell said that he had nothing to live for and intended to use a razor blade to kill himself. He said he was distressed because his daughter had died two months earlier; he had no family support and was homeless. (Mr McDonnell's mother told us that her son did not have a daughter, but Mr McDonnell apparently told staff that he had a daughter who had died of cerebral palsy.) He said he had taken a drug overdose two months earlier. Mr McDonnell began a methadone maintenance programme at Leicester. On 8 May, he was prescribed antidepressant medication because he said he felt depressed after his daughter's death.
27. Mr McDonnell was managed under ACCT procedures throughout his time at Leicester. He harmed himself ten times by making cuts to his arm or wrist; he variously explained that he was low in mood, missed his daughter, had problems with his medication, was worried about having nowhere to live when he was released, and wanted tobacco.
28. A prisoner at Leicester told us that Mr McDonnell was anxious that he would have no money and nowhere to live after he was released and said he would probably end up back in prison soon afterwards. Mr McDonnell told him that other prisoners had asked him to bring drugs back into prison when he came back, which would help his money situation.
29. On 28 May, an officer from the prison's accommodation services saw Mr McDonnell to discuss his housing when he was released. The officer told him that the council and other agencies did not have any accommodation for him, so he would need to register as a homeless person when he was released. The council would then try and find emergency accommodation.
30. Mr McDonnell was released on licence on the morning of 2 June and was subject to probation supervision until 14 July 2015. At the time of his release, he was still being managed under ACCT procedures and staff had assessed him as at raised risk of suicide or self-harm. Mr McDonnell told an officer, who spoke to him in the prison's reception before he was released, that he had housing problems and would prefer to sleep rough or commit another offence so that he would be recalled back to prison, rather than go to emergency accommodation. The officer said he tried to encourage Mr McDonnell to be positive and seek support.

He noted this in the ACCT document, which he then closed. Mr McDonnell left Leicester with £48 cash.

31. Later on 2 June, at 9.00pm, Mr McDonnell was arrested for threatening to cause criminal damage to a police station. He appeared at Magistrates' Court on 3 June and was sentenced to six weeks in prison. His escort record noted that he had a history of illicit drug and alcohol use, of concealing drugs on his body, of self-harm (including cutting while in prison), and that he suffered from a personality disorder and depression. Court custody staff did not complete a suicide and self-harm warning form.
32. At 6.55pm, Mr McDonnell arrived at HMP Lincoln, where an officer booked him in. (It appears that he had been taken to Lincoln, as Leicester was full.) The officer read Mr McDonnell's court warrant and escort record and interviewed him as part of first night procedures. He noted that Mr McDonnell had been released from Leicester the previous day, had no money, no fixed address and said he had no next of kin. Mr McDonnell told him that he was not in contact with his family, was not expecting any visits and did not want to telephone anyone. He said he had taken methadone the previous day and was prescribed medication for a personality disorder. He said he had a history of self-harm but did not have any current thoughts of suicide or self-harm.
33. The officer told us that it was busy in reception that evening, as eight prisoners had arrived at the same time as Mr McDonnell. He said he did not have the time to check Mr McDonnell's prison record or whether there were any alerts on NOMIS. (NOMIS is the prison records system, which has a section with a summary of serious incidents to help staff quickly identify potential risks.) He said he assessed Mr McDonnell's risk of suicide and self-harm based on the information he had received in the escort record and his body language. Despite the information in the escort record, he did not have any immediate concerns about his risk. Mr McDonnell signed standard prison documents to say that he was aware of the prison's rules and procedures and the officer explained how he could get support in the prison.
34. At an initial health screen, Mr McDonnell told a nurse that he was well and not dependent on drugs or alcohol. She noted his history of drug misuse in his SystemOne medical record and that he seemed to be withdrawing from drugs. Mr McDonnell did not want to be referred to the substance misuse team. He said he had a personality disorder, had been prescribed olanzapine (an antipsychotic sometimes used to treat bipolar depression), and wanted to be referred to the mental health team. She noted that she had asked the pharmacy team to confirm his medication with his community GP and she referred him to the mental health team. Mr McDonnell said that he had harmed himself by cutting his arms a week earlier, but had no current thoughts of suicide or self-harm.
35. The nurse told the investigator that she did not see the escort record and would have looked only briefly at Mr McDonnell's SystemOne medical record. She was not aware that he had been assessed as at risk of suicide and self-harm at Leicester and managed under ACCT procedures until he was released. She said that she had told reception staff that Mr McDonnell had recently self-harmed, but she did not think that he was at risk of suicide or self-harm.

36. Mr McDonnell went to A Wing, the prison's first night centre. He agreed to be assessed by the substance misuse team. A prison doctor prescribed 15ml of methadone (an opiate substitute used in drug treatment) until the prison received confirmation of his current medication.
37. The night manager in charge of prison that night printed from the NOMIS system, a list of new prisoners who were subject to ACCT procedures but could not find Mr McDonnell's ACCT document. He then realised that Mr McDonnell had been released from Leicester the previous day and that the ACCT alert on his NOMIS record had not been closed. He emailed the safer custody team to ask someone to check Mr McDonnell. As Mr McDonnell had been seen during the reception process, he did not think he needed to review him that night.

Thursday 4 June

38. On 4 June, a GP reviewed Mr McDonnell's community GP notes and prescribed olanzapine 5mg and sertraline 50mg (for anxiety and depression). Mr McDonnell had his methadone dose increased to 30ml a day and a member of the substance misuse team reviewed him each day until 7 June. He received 30ml of methadone each day for the rest of his time at Lincoln.
39. Mr McDonnell continued his induction that morning and saw a number of support agencies, including the chaplaincy team. Shortly before midday a mental health nurse assessed him in response to the nurse's referral. Mr McDonnell's mood was low. He said that he had last harmed himself a week previously, but had no current thoughts of harming himself. She noted that Mr McDonnell had been assessed as at risk of suicide and self-harm and managed under ACCT procedures several times between 2013 and 2015. He told her that his daughter had died three months earlier. She noted his main issues as depression, anxiety, a history of self-harm and bereavement. She booked another mental health appointment for 17 June 2015.
40. After seeing night manager's email to the safer custody team, the team's administrative officer checked Mr McDonnell's NOMIS record. She contacted Leicester and obtained a faxed copy of Mr McDonnell's ACCT document. She passed this to A Wing and asked someone to speak to Mr McDonnell and check if he still needed ACCT support. At 3.06pm, an officer noted in Mr McDonnell's prison record, that he had spoken to Mr McDonnell, who said that he was okay and did not need support. The officer told the investigator that he did not remember speaking to Mr McDonnell, so was unable to give any more information about how he appeared at the time.
41. At around 3.30pm, a nurse received a call asking for a nurse to see Mr McDonnell urgently. She went to his cell and found his breathing was laboured and his respiratory rate high. He looked grey and was unresponsive. His pupils were equal and reacting to light, his heart rate was high, his temperature was slightly low and his oxygen saturation levels were lowered. She gave him oxygen. Mr McDonnell's cellmate said that he had taken Mamba, a new psychoactive substance (NPS).
42. A GP also examined Mr McDonnell and his clinical observations quickly returned to within the normal range. Mr McDonnell said he felt tired. He agreed that Mr

McDonnell could stay in his cell and ask for help if he felt any worse. His cellmate agreed to keep an eye on him.

43. At 5.25pm, a nurse was asked to review Mr McDonnell. When she arrived at his cell, he was sitting on a chair talking to a manager at the prison. The manager said that Mr McDonnell had been walking along the landing to collect his dinner when he appeared to have had a fit. He had fallen on the floor and hit his head, which had left a red mark and bump above his left eye and a bruise underneath it.
44. Mr McDonnell told the nurse that he was okay but was hungry. He then had another fit for approximately three seconds. She placed him on the floor and asked for an ambulance. His respiratory rate had increased and his oxygen saturation had reduced to 89%. She gave him oxygen again. His heart rate was sometimes a little higher than normal, but he had a regular rhythm. Mr McDonnell's cellmate said that he had not smoked any more Mamba. Paramedics arrived, assessed Mr McDonnell and, at 6.06pm, took him to hospital, where he was admitted for observation.

Friday 5 June

45. At 5.30am the next morning, Mr McDonnell discharged himself from hospital against medical advice. He said he was feeling okay.
46. Just after 9.00am, when he was back at the prison, staff asked a nurse to check Mr McDonnell. He was sitting upright in a chair in his cell, but said he felt weak and dizzy but was alert and able to explain the previous day's events. He admitted taking an illicit substance the day before, but said he had not taken anything else. He said that he had lost a packet of pregabalin (used for neuropathic pain, anxiety disorder and epilepsy), but there is no record that he was ever prescribed pregabalin. His clinical observations were normal but his pupils were dilated and sluggish. She told him that he would be assessed later to see if it was safe for him to receive methadone, which he would not get if he was drowsy or appeared to be under the influence of an illicit substance. She advised him to eat, drink and rest.
47. At 1.32pm, an officer from the resettlement team went to see Mr McDonnell, to discuss his housing options when he was released from prison. Mr McDonnell appeared quite sleepy and did not engage fully with her. She arranged to see him again a week later.
48. At about 8.00pm that evening, a nurse from the substance misuse team reviewed Mr McDonnell. She did not give him methadone as he still appeared drowsy and she did not consider it was safe. Mr McDonnell said he would harm himself if he did not get methadone, and she began ACCT procedures. A manager decided that staff should check him once an hour until he could be assessed.

Saturday 6 June

49. At 9.10am on 6 June, an officer assessed Mr McDonnell as part of the ACCT process. Mr McDonnell said he was withdrawing from drugs and wanted his methadone. He understood why he had not received it the day before, but he said he was okay now and knew that he would receive it later. He said he had no tobacco as his cellmate had smoked his when he was at hospital. He said he

had depression, but this was not currently an issue for him. He told the officer that he had self-harmed just over a week before, but had done this for years as it helped him cope and relieved his stress. He said that he had no current thoughts of suicide or self-harm, and had no concerns about being released from prison.

50. After the assessment, a Supervising Officer (SO) held an ACCT case review, which a nurse from the mental health team attended. Mr McDonnell said he would be homeless when he was released from prison on 14 July and was not in touch with any of his family. He was looking forward to moving to C Wing. He said he had a history of self-harm but had not self-harmed at Lincoln. The review assessed Mr McDonnell as at low risk of suicide or self-harm, noted he was taking medication (methadone and olanzapine) and had been referred to the secondary mental health team. The SO scheduled the next ACCT case review for 12 June, and kept the level of observations at hourly.
51. The SO completed Mr McDonnell's ACCT caremap, which should identify a prisoner's main issues and concerns, with actions to reduce the risk of suicide and self-harm. The SO noted that he would contact the resettlement team to discuss Mr McDonnell's accommodation problems and the nurse would write to his community GP about referring him to a community mental health team. Mr McDonnell had said he wanted a prison job and the SO emailed the activities department to add his name to the waiting list.
52. Staff gave Mr McDonnell an emergency smoker's pack (an advance supply of tobacco) that morning, after he said that his daughter had recently died and he was struggling to cope. At around 3.00pm, he moved to a cell on his own on C Wing.

Sunday 7 June

53. At 10.00am, an officer noted in Mr McDonnell's ACCT record that Mr McDonnell told him that he had no tobacco. He said an incident had occurred on the wing the previous day that was his fault. Another prisoner was bullying him and his friends had tried to help him. At 3.20pm, Mr McDonnell told the officer that he wanted to apply for a move to E Wing (the prison's vulnerable prisoner's unit). He was given an application form to complete.
54. At 6.24pm, an officer found Mr McDonnell in his cell with cuts to his forearm. The orderly officer (in charge of the routine operation of the prison) went to his cell with a nurse. The orderly officer told the investigator that Mr McDonnell was sitting on a chair with his arm over a waste paper bin that was filling up with blood. He initially refused any treatment and said that he had harmed himself because he had no tobacco. After some persuasion, he handed over the razor blade he had used to cut himself. The nurse found that he had made a large, deep cut to his left forearm and needed hospital treatment. The duty governor agreed he could have a smoker's pack when he got back from hospital. While being treated at the hospital, Mr McDonnell told the doctor he had intended to kill himself.
55. Mr McDonnell returned to Lincoln at 9.30pm. A manager held an ACCT case review with no other staff present and wrote in the ACCT record that Mr McDonnell told him that he had harmed himself because of stress and anxiety

and had needed 13 stitches in his arm. His main concern appeared to be that he had had no tobacco. Mr McDonnell told the manager that he had wanted to end his life, but was okay now. The manager noted that he appeared settled and had no problems being alone in the cell. He arranged for Mr McDonnell to be given some tobacco and reminded him he could get support from Listeners and Samaritans. The manager assessed his risk of suicide and self-harm as high, and increased the level of checks to four an hour. He brought forward the next ACCT review to the next morning, when more staff would be available.

56. A nurse spoke to Mr McDonnell when he returned from hospital. He noted that the stitches would need to be removed in ten days, and he sent a task on SystemOne to ask the mental health team to review Mr McDonnell.

Monday 8 June

57. Due to an incident, C Wing was in a state of lockdown for searching for over half the day, which meant routine healthcare appointments did not take place. Mr McDonnell's ACCT case review did not happen. No reason was recorded in the ACCT document but we presume this was because of the security incident.

Tuesday 9 June

58. Around 8.00am on the morning of 9 June, Mr McDonnell was unlocked for a period of association (when prisoners can mix with each other on the wing) and to collect his medication. An officer told the investigator that, shortly after he was unlocked, Mr McDonnell told him that another prisoner had assaulted him in his cell and he was under threat. He said Mr McDonnell had a cut to his left eye.
59. A healthcare assistant examined Mr McDonnell and noted he had a small cut and swelling under his left eye. Mr McDonnell said that he did not have blurred vision, headache, nausea, vomiting, or dizziness, which might indicate a head injury, and refused any treatment. Mr McDonnell refused to name the person who had assaulted him. An officer reported this to a custodial manager, completed an incident report and noted the incident in Mr McDonnell's prison record. The information was sent to the safer custody team as part of the prison's violence reduction procedures. That day, Mr McDonnell applied to move to E Wing (the prison's vulnerable prisoners unit) because he said he had been assaulted on A Wing (not C Wing) and was receiving threats. The custodial manager countersigned the application, noted that he had allegedly been assaulted and sent it a prison manager.
60. At 1.10pm, an officer from the resettlement team recorded in the ACCT record that she spoke to Mr McDonnell about claiming benefits after his release from prison. Mr McDonnell said he would not claim any benefits but intended to "top himself".
61. At 2.15pm, an officer noted in Mr McDonnell's ACCT record that he had refused to go to work. He said he was being threatened but gave no further details.
62. At 4.30pm, a custodial manager and a nurse from the mental health team held an ACCT review. Mr McDonnell said his main issues were the death of his daughter and having nowhere to live. He said a prisoner had assaulted him to get some mamba he had brought into the prison, and he had also had trouble on A Wing,

because of this. (There were no reports of Mr McDonnell being assaulted or threatened on A Wing.) The manager noted that Mr McDonnell appeared well and he said that he had no intention of harming himself. The review assessed that his risk of suicide and self-harm was still high but that the frequency of observations could be reduced to two an hour and that staff should record three conversations a day with him. The next ACCT review was scheduled for 12 June. The manager noted on the caremap that he had asked representatives from the resettlement and chaplaincy teams to attend the next review. He marked the action as complete.

63. A manager refused Mr McDonnell's application to move to the vulnerable prisoner unit. He said he could not approve it unless Mr McDonnell was willing to identify the perpetrator of the alleged assault.
64. At 7.00pm, Mr McDonnell rang his cell bell and told an officer that he wanted to share a cell. The officer said this would not be possible at that time, but at 7.42pm, he told Mr McDonnell that he had spoken to the wing manager who would consider his request. Mr McDonnell appeared agitated and said that if he did not get a cellmate he would cut himself. When the officer next checked him at 7.55pm, Mr McDonnell said he was okay.
65. The night patrol officer, an operational support grade (OSG), noted that Mr McDonnell was watching television or sleeping until 10.00pm. When he checked him at 10.07pm, Mr McDonnell had harmed himself and his arm was bleeding. The OSG radioed a code red medical emergency (indicating loss of blood) and the control room called an ambulance immediately. A nurse attended and found that Mr McDonnell had removed the stitches from his previous wound, which was too deep to glue. He was taken to hospital for sutures. At the hospital, Mr McDonnell told the escort officers that he had harmed himself because of the death of his daughter and because he had no tobacco.

Wednesday 10 June

66. Mr McDonnell got back to the prison at 2.55am. Around 9.00am, a SO decided to move him to another cell to share with a prisoner. There was no ACCT case review after his self-harm the night before. Mr McDonnell said he felt happier with a cellmate, but still felt safer in his cell. During the afternoon association period, he told staff that he was okay. That day, he submitted an application to add a telephone number, for a woman he said was his partner, to his prison phone account.

Thursday 11 June

67. Around 8.10am, Mr McDonnell tried to use the phone and told an officer that the number he had added had not been activated. She spoke to the telephone clerk, who said that it would be available that evening. (At 5.27pm, a phone call lasting around 10 minutes was made from Mr McDonnell's phone account to the number he had given for the woman he said was his partner.) At some point on this day, a SO spoke to Mr McDonnell and gave him a copy of his recall information pack. The pack contained details about his breach of licence conditions following his release from prison on 2 June and the offence he committed on that day.

68. At 2.30pm, Mr McDonnell rang his cell bell and told an officer that he had not been coping well since his daughter's death. He asked for a smoker's pack, as he had no tobacco. She noted in the ACCT record that a SO had said that Mr McDonnell was not allowed a smoker's pack because he did not have enough money in his prison account to pay for one.
69. At 2.55pm, Mr McDonnell told an officer that he would cut himself if he did not get a smoker's pack. The officer said that he had taken a razor blade from Mr McDonnell so he could not harm himself, and had thrown it out of the window. His cellmate told the investigator that whenever Mr McDonnell was out of his cell he always appeared to be trying to get tobacco.

Friday 12 June

70. At 9.40am on 12 June, a SO, a mental health nurse and an officer held an ACCT case review. No one from the chaplaincy or resettlement teams attended – a caremap action from the last case review - and there is no record that they were invited. The SO noted that Mr McDonnell was low and looked subdued. Mr McDonnell said that he still feared for his safety on C Wing. He gave the names of two prisoners, who he said had attacked him. He said that the reason he had no tobacco was that it had been stolen. The SO said he would ask the duty governor about a move, and investigate the alleged assault. The nurse gave him Fortisip drinks, which he had previously had in prison, as his appetite was poor and he had not eaten much. The review now assessed Mr McDonnell's level of risk as raised, rather than high, but kept the level of observations at twice an hour. There were no outstanding caremap actions.
71. After the ACCT review, the SO tried to identify the prisoners Mr McDonnell said had assaulted him. As there was no one with those names on C Wing, the SO concluded that Mr McDonnell would be safe on C Wing. He told him that if he saw the perpetrators on the wing, he should discreetly tell staff.
72. At 10.50am, an officer from the resettlement team discussed Mr McDonnell's housing and employment plans after his release, with him. She said that she would apply for accommodation for him in the community. Later, nurses redressed Mr McDonnell's wound. He collected his dinner and joined other prisoners for an association period.

Saturday 13 June

73. On Saturday 13 June, Mr McDonnell collected his medication in the morning as normal. At 3.10pm, his cellmate started smashing the door observation hatch. Officers moved Mr McDonnell to another cell on his own. At 4.40pm, he said that he would be okay throughout the night without a cellmate. An officer spoke to him at 5.30pm. He was sitting in his cell smoking and said he was okay. (It appears that Mr McDonnell sometimes drew pictures in exchange for tobacco.) No one recorded any concerns about Mr McDonnell during the night.

Sunday 14 June

74. 14 June was Mr McDonnell's 29th birthday. None of the staff we interviewed were aware of this. In the morning, Mr McDonnell collected his medication, left his cell for an association period, watched television and drew pictures in his cell. He collected his lunch at 12.00pm.
75. At 12.30pm, an officer checked Mr McDonnell, who was crying. He said he was finding it difficult to cope after the loss of his daughter but when the officer asked if he wanted to talk about it, he said he was okay. At 1.00pm, when the officer next checked him, he was no longer crying. At 1.30pm, Mr McDonnell told the officer to leave him alone. Before going off duty at 1.45pm, the officer told Officer A that Mr McDonnell had suffered a recent bereavement and had been upset that morning.
76. At 2.25pm, when Officer A checked Mr McDonnell, he was sitting on the bed watching television. She noted in the ACCT record that he appeared calm and raised no issues when she spoke to him. He left his cell for an association period between 3.00pm and 4.00pm. She thought he was interacting positively with other prisoners. After Mr McDonnell was locked back in his cell, he watched television. He asked for a smoker's pack but she refused.
77. Around 5.00pm, Mr McDonnell collected his evening meal. Officer B took over from Officer A at around 5.20pm. He checked Mr McDonnell at 5.35pm, who was rolling a cigarette. At 6.37pm, Mr McDonnell said he was stressed because he had no tobacco. The officer said that he could not give him any tobacco. When he checked at 7.00pm, Mr McDonnell was adjusting the curtains at the window. At 7.25pm, he noted that Mr McDonnell was sitting on his bed rubbing his hands together. He did not respond when the officer spoke to him.
78. Around 7.40pm, Officer B heard a noise from near Mr McDonnell's cell, which he said sounded like a chair slipping and banging at the same time. He went to Mr McDonnell's cell, looked through the door observation panel and saw him hanging by a sheet attached to the window. He immediately opened the cell door and radioed the control room for assistance at 7.41pm, stating that he had found a prisoner hanging. At 7.42pm, a communications room operator called an ambulance. (It was not clear that he used the expected emergency code but there was no delay in the emergency response.)
79. Officer B cut the sheet from around Mr McDonnell's neck and laid him on the floor. He was warm and limp, but the officer could not find any signs of life. He started chest compressions. Two custodial managers arrived at the cell in approximately 90 seconds. A nurse and a healthcare assistant arrived.
80. A manager checked Mr McDonnell but could not find any signs of life; he was pale and his lips were blue. Officer B continued chest compressions. The nurse set up the emergency equipment, and the manager attached a defibrillator to Mr McDonnell. The defibrillator found no shockable heart rhythm and they continued with chest compressions.

81. Paramedics arrived at 7.50pm, and took over emergency treatment. They gave Mr McDonnell adrenalin and, at 7.53pm, detected a pulse. At 8.20pm, they took Mr McDonnell to hospital, where he was placed in an induced coma and admitted to the intensive treatment unit. A manager sealed Mr McDonnell's cell.

Events after Mr McDonnell's admission to hospital

82. Mr McDonnell had not given any next of kin contact details when he arrived at Lincoln, and staff were not able to identify a family member to contact that night. A SO was appointed as the prison family liaison officer.
83. On the morning of 15 June, the security department noticed that Mr McDonnell had made a phone call to his partner. The family liaison officer phoned the number, but the person who answered said she did not know Mr McDonnell and had never spoken to him. She said that her partner was a prisoner at Lincoln, and had phoned her using what she believed to be another prisoner's phone account. (The prisoner was released on 18 June. Prison staff did not interview him at the time and he did not respond when the investigator wrote to him.)
84. Probation staff at Leicester later found an address for Mr McDonnell's mother. The police visited and, although she no longer lived there, obtained her telephone number. The family liaison officer left a message at 4.18pm, and Mr McDonnell's mother called back within ten minutes. She had been unaware that her son was in prison. He explained what had happened and arranged to meet her at hospital at 6.30pm. Mr McDonnell had a scan that confirmed that he had brain damage. The next day, 16 June, the escort was reduced from two officers to one, because of Mr McDonnell's poor prognosis.
85. On 17 June, Mr McDonnell's mother phoned the family liaison officer. She was upset that the custodial manager, who was the escort officer, had refused to move away from the side of the bed, to give her privacy. Mr McDonnell's mother said that she had taken a photo of him with her phone, sleeping on duty and formally complained about the officer's conduct to the Governor. The escort officer was replaced with another officer, who moved away from Mr McDonnell's bed whenever visitors came.
86. On 18 June, doctors advised Mr McDonnell's family that it was unlikely that he would recover. Around 10.30pm, a nurse phoned the hospital for an update, as healthcare staff had done each day. A member of hospital staff said that they would ring back. She phoned again at around 11.00pm and spoke to a male healthcare assistant, who gave her another number for the ward. No one answered, so she rang the first number again. A female nurse said she would not give information about Mr McDonnell over the phone and that she should contact his family. She asked the nurse to call the prison to verify her identity and was placed on hold. Another person then came on the line and she again asked for an update about Mr McDonnell's condition. The hospital had passed the phone to Mr McDonnell's mother but she was unaware of this. His mother was understandably upset and ended the call.
87. On the morning of 19 June, the senior healthcare manager at the prison phoned the matron at the hospital, who apologised and said that hospital staff should

have given an update as agreed. She said that it was inappropriate that hospital staff had given the phone to Mr McDonnell's mother to update the nurse.

88. Mr McDonnell died at 10.40pm on 19 June, without regaining consciousness. The escort officer phoned the prison to inform them. The family liaison officer met Mr McDonnell's mother at the hospital at 11.00pm and offered condolences and support. In line with national Prison Service policy, the prison contributed to the costs of Mr McDonnell's funeral, which was held on 7 July.
89. When he visited Lincoln, the investigator found a note in Mr McDonnell's cell. Mr McDonnell had addressed this to someone he called "bro". In the note, he said that he had gone to Lincoln, as Leicester was full and had been "jacked", a prison term for drugs or possessions being forcibly taken. Mr McDonnell said that his friend should not worry as he would be released in a week and would "reload" and try again.

Support for prisoners and staff

90. A manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team offered support then, and after Mr McDonnell's death.
91. The prison posted notices informing other prisoners of Mr McDonnell's death, and offering support. Staff reviewed all prisoners identified as at risk of suicide and self-harm in case they had been adversely affected by Mr McDonnell's death.

Post-mortem examination

92. The post-mortem report recorded that Mr McDonnell had died from bronchopneumonia as a consequence of hypoxic brain injury resulting from hanging. The report identified that Mr McDonnell had damage to his rectum that was not the result of a natural disease. Tests showed no evidence that Mr McDonnell was under the influence of alcohol or illicit drugs, including NPS, when he died.

Findings

Assessing the risk of suicide and self-harm

93. Prison Service Instruction (PSI) 64/2011 (Safer Custody) and PSI 7/2015 (Early Days In Custody) list a number of risk factors and potential triggers for suicide and self-harm. Mr McDonnell had a number of risks outlined in the PSIs, but staff did not identify him as at risk when he arrived at Lincoln. He had a history of substance misuse and mental health problems. He had also reported the death of his daughter - a “significant recent life event” in the terms of the PSI.
94. Mr McDonnell had a history of self-harm. He had been on an ACCT at Leicester for two months before his release the day before, on 2 June. He had recently self-harmed in prison on 27 May. At the time of his release the previous day, he had been assessed as at raised risk of suicide and self-harm and staff had been required to check him at least every 30 minutes. The records of his ACCT history were visible as alerts on his NOMIS record and when he arrived at Lincoln on 3 June, his escort record noted that he had a recent history of self-harm. The reception officer did not check Mr McDonnell’s NOMIS record and said he did not know when Mr McDonnell had last self-harmed (which was only a week earlier). We are not satisfied that this was a sufficiently thorough reception screen.
95. PSI 7/2015 notes that all newly-arrived prisoners must be assessed as part of the reception health screen process to determine whether they are at risk of suicide or self-harm, and an ACCT Plan opened, or an existing ACCT continued, as appropriate. A nurse did not see the escort record and did not check Mr McDonnell’s SystemOne record, which would have identified his history of suicide and self-harm and that he had been managed under ACCT procedures at Leicester until the day before. Mr McDonnell told her he had cut his arms the week before, but she did not assess him as at risk. She said that she had told reception officers about the recent self-harm, but this is not recorded anywhere. As with the reception officer’s screen, we do not consider that the nurse’s assessment sufficiently took into account all the available information about Mr McDonnell.
96. PSI 7/2015 also states that prisoners returning to custody are at increased risk of suicide and self-harm. As Mr McDonnell was still being monitored under ACCT procedures when he was released on 2 June, this should have alerted staff, had they checked the records, that he was likely to be a continuing risk when he arrived at Lincoln a day later. We consider that staff at Lincoln should have begun ACCT procedures again when Mr McDonnell arrived at Lincoln, until it was clear that his risk of suicide and self-harm had reduced.
97. Staff judgement is fundamental to the ACCT system. It relies on staff to use their experience and skills, as well as local and national assessment tools, to determine risk. This must include the prisoner’s known risk factors as well as their presentation. While this did not affect the outcome for Mr McDonnell, as his risk was identified later, we are concerned that reception staff at Lincoln missed obvious risk factors and relied almost entirely on Mr McDonnell’s presentation and his assertion that he did not intend to harm himself. There is no evidence

that they balanced this against the information that arrived with him at the prison, or his other known risk factors. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying newly arrived prisoners at risk of suicide and self-harm. In particular, this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm, including information from NOMIS, suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

Management of ACCT procedures

98. We have some concerns about the management of ACCT procedures, after Mr McDonnell was identified as at risk of suicide and self-harm on 5 June. For example, there was no continuity in case management and four different managers chaired the four reviews, although we accept that one of these reviews was held at short notice after Mr McDonnell had self-harmed. National policy also requires that ACCT case reviews should be multidisciplinary where possible and include relevant people involved in the prisoner's care. We are pleased to note that nurses from the mental health team attended three of four reviews (the fourth was held at short notice). However, at the review on 9 June, a SO recorded that he had invited members of the resettlement and chaplaincy teams to the next review, but they did not attend.
99. On 7 June, Mr McDonnell harmed himself. The orderly officer, who was by himself at night, reviewed him when he got back from hospital but noted that another review should be held the next morning, when more staff would be able to attend. This did not take place the next day, apparently because of a general security issue. The case review was not held until 4.30pm on 9 June. This meant there was a significant delay in properly reviewing Mr McDonnell's risk, after a serious act of self-harm.
100. PSI 64/2011 contains a mandatory instruction that the case manager should not close the ACCT until all the goals and actions on the caremap have been achieved. At the third case review, a SO marked the goals on the caremap as complete, as soon as he added them to the caremap, without waiting to see if the actions had a positive effect on reducing Mr McDonnell's risk of suicide and self-harm. Some other issues raised by Mr McDonnell, such as the allegations of bullying and his constant demands for tobacco, were not addressed in the caremap. There was little evidence that staff discussed his safety at ACCT case reviews and how or whether this affected his risk. Although Mr McDonnell consistently said he was grieving for his daughter, there is little indication that staff discussed this with him or tried to support him at ACCT reviews, other than

noting a member of the chaplaincy team should attend an ACCT review, which did not happen.

101. We are not satisfied that the prison managed ACCT procedures fully effectively to support Mr McDonnell. We make the following recommendation

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

- **A multidisciplinary approach for all case reviews, with attendance of relevant people involved in the prisoner's care and continuity of case management where possible.**
- **Setting caremap actions, which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.**
- **Reviewing risk whenever an event occurs which indicates an increase in risk and holding a case review if required.**

Mr McDonnell's safety at Lincoln

102. When Mr McDonnell told an officer that he had been assaulted in his cell on C Wing on 9 June, he had a cut to his eye, said that he had also had trouble on A Wing, but refused to name the prisoners involved. He said that this was because he had brought Mamba into the prison and other prisoners had assaulted him to get it. A report was sent to the safer custody team, but they took no action. A manager rejected Mr McDonnell's request to move to the vulnerable prisoners unit because he refused to name the prisoners. Although he gave the names three days later, a SO could not identify the alleged attackers from these names. We do not know whether Mr McDonnell made them up in an effort to appear as if he was cooperating or whether he got them wrong.
103. The use of new psychoactive substances (NPS) in prisons is an increasing concern. In July 2015, we issued a Learning Lessons Bulletin about the use of NPS, including the dangers to both physical and mental health and the possible links to suicide and self-harm. We noted that trading in these substances in prison can lead to debt, violence and intimidation. It does not appear that staff at Lincoln had identified that Mr McDonnell might be at risk because of his involvement in this trade – particularly as it is likely that the NPS was intended for prisoners at Leicester.
104. It is evident that Mr McDonnell had access to NPS when he arrived at the prison. He was taken to hospital on 4 June, after having an adverse reaction to its use. There is no record that anyone followed this up with him or warned him of the dangers. Mr McDonnell's escort form had noted he had a history of concealing items in his rectum and, in the note found in his cell after his death, he indicated that he had brought drugs into prison (and planned to do so again). The post-mortem examination found evidence of damage to Mr McDonnell's rectum, which could be consistent with the forcible removal of drugs. After his death, it emerged that another prisoner had used Mr McDonnell's prison phone account, although we do not know whether he had been bullied for access to his phone account or whether he traded it for other goods.

105. Although Mr McDonnell was not initially prepared to name his attackers, and later gave names that a SO could not find, there was evidence suggesting that he had been attacked. He had a physical injury, and a record of concealing drugs to bring into prison. We consider that Mr McDonnell was not supported appropriately when he first alleged that he had been assaulted. Although we understand the caution about admitting people to the vulnerable prisoners' unit, we are concerned that this request was rejected solely because he would not name his alleged attackers. We are also concerned that there was no evidence of an appropriate response to his use of NPS. We make the following recommendations:

The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.

The Governor should ensure that prisoners who use new psychoactive substances are referred to drug treatment services and warned about the dangers and risks to health.

Clinical care

106. The clinical reviewer noted that the standard of physical and mental healthcare that Mr McDonnell received at Lincoln was equivalent to the care he would have received in the community. He did not identify any shortfalls in the care or service delivery provided, including mental health services.

Family liaison

107. Mr McDonnell was taken to hospital in a critical condition at 8.20pm on 14 June. Although his family were not informed until the next day, we are satisfied that this was because Mr McDonnell had not named any next of kin and that the prison appropriately tried to obtain details for them.
108. Mr McDonnell's mother told us that she was upset because an escort officer had acted insensitively and inappropriately when her son was in a coma in the intensive care unit. He had refused to move away from her son's bedside and allow her private time with him. We understand that the prison changed the escort personnel as soon as the problem was identified and we are satisfied that they took appropriate action. However, it is important that officers escorting seriously ill prisoners at hospital are clear about their responsibilities and what standards are expected of them. We make the following recommendation:

The Governor should ensure that all staff involved in escorting seriously ill prisoners in hospital are aware of the standards of behaviour expected of them, are sensitive to the needs of families, and allow them appropriate privacy with their dying relatives at the end of their lives.

**Prisons &
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