

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Craig Baldock a prisoner at HMP Lindholme on 25 February 2017

**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.

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

Mr Craig Baldock was found hanged in his cell at HMP Lindholme on 25 February 2017. Mr Baldock was 50 years old. I offer my condolences to Mr Baldock's family and friends.

Mr Baldock was serving an indeterminate sentence for public protection. He was over six years past his minimum term, and was frustrated about his lack of progress towards release. His death is a sad reminder of the stress and uncertainty that prisoners serving indeterminate sentences can face.

Mr Baldock admitted taking new psychoactive substances (NPS) at Lindholme and I am concerned that, even when he told staff this, little action was taken. I share the concern of the Inspectorate and the Independent Monitoring Board that NPS use among prisoners at Lindholme is rife. There were also occasions when Mr Baldock reported he was being bullied because he was in debt and, although he subsequently told staff the situation had been resolved, there was no investigation into the cause of his debt.

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

October 2017

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Summary

Events

1. On 6 October 2008, Mr Craig Baldock was convicted of wounding with intent and given an indeterminate sentence for public protection, with a minimum period to serve of two years and 20 days. He was transferred to Lindholme on 4 March 2016, in order to complete the Building Skills for Recovery (BSR) course, a programme designed to address offending behaviour and substance misuse.
2. Mr Baldock spoke freely about using new psychoactive substances (NPS) at Lindholme, but on 11 August 2016, told staff he had stopped using them. In September 2016 and February 2017, he told staff he was being bullied, although he said this was due to a tobacco debt.
3. A forensic psychologist met with Mr Baldock in January and February 2017, to complete a sentence planning and review report that would be submitted to the Parole Board. Mr Baldock was going to be recommended for transfer to an open prison but, on 8 February 2017, Mr Baldock admitted he was still using NPS. As a result, the report was amended to say that he would need further support with his rehabilitation.
4. On 25 February 2017, during the morning roll check at approximately 5.53am, an operational support grade (OSG) discovered Mr Baldock hanging in his cell. She radioed a medical emergency code but did not enter his cell until officers arrived. Staff carried out cardio-pulmonary resuscitation (CPR) but Mr Baldock was pronounced dead at 6.32am.

Findings

5. Mr Baldock was more than six years over his minimum tariff when he died. He was due to be recommended for transfer to an open prison, but following his admission that he was still using NPS, this recommendation was not made. He was informed of this on 22 February, and took his life three days later. While it appears that Mr Baldock's decision to take his own life was triggered by this news and his frustration at his lack of progression towards release, he had never self-harmed while in prison, or expressed any intention of self-harm. We consider that staff could not have foreseen his death.
6. However, we found that staff took little action to address Mr Baldock's frequent NPS use. Mr Baldock also reported incidents of bullying, which staff did not fully investigate. The widespread use of NPS by prisoners at Lindholme, and the detrimental impact this has on prisoner safety, was highlighted in a March 2016 report by HM Inspectorate of Prisons. A recent report by Lindholme's Independent Monitoring Board (IMB), published in January, found that NPS use among prisoners, although reduced, remained an ongoing issue. Lindholme needs to take action to address the availability of NPS.
7. Mr Baldock had a history of depression. We found that mental health reviews were not well managed at Lindholme. There was no clear referral system or waiting list. The prison's approach was haphazard and uncoordinated. The

clinical reviewer concluded that Mr Baldock's mental health care was not of the same standard he would have received in the community.

8. We are concerned there was a delay in entering Mr Baldock's cell when he was discovered. While the delay did not alter the outcome in Mr Baldock's case, any delay could be critical in future cases. Prison instructions are clear that staff should enter a cell immediately when a prisoner's life is at risk, where it is safe to do so. We also found that the use of CPR on Mr Baldock was inappropriate, given it was apparent he was dead when discovered.

Recommendations

- The Governor should ensure there are effective supply and demand reduction strategies to help eradicate the availability of new psychoactive substances, and that staff are vigilant to signs of its use and take appropriate action.
- The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated and the impact on the risk of suicide and self-harm is taken into account for apparent victims.
- The Head of Healthcare should ensure there is an effective mental health referral system in place, that all referrals are assessed for urgency, and prisoners are seen within prescribed timescale.
- The Governor should ensure that all staff understand the importance of entering a cell without delay when a prisoner's life is at risk, when it is safe to do so.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Lindholme on 1 March 2017. He obtained copies of relevant extracts from Mr Baldock's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Baldock's clinical care at the prison.
12. The investigator interviewed nine members of staff at Lindholme. Two prisoners declined to be interviewed. The clinical reviewer joined the investigator for some of the interviews with staff.
13. We informed HM Coroner for South Yorkshire (East District) of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Baldock's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Baldock's family wanted more information about the support he had received in respect of the parole process. They were given a copy of the initial report, but made no further comment.

Background Information

HMP Lindholme

15. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1000 men. Nottinghamshire Healthcare Foundation NHS Trust provides healthcare services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Lindholme was in March 2016. Inspectors found that drugs, especially new psychoactive substances (NPS) were easily available and had a significant and detrimental effect on the security and safety of the prison and, in particular, an impact on the safety of prisoners who were incurring debt. Too many prisoners felt unsafe and violence levels had increased. Inspectors found there was too little being done to understand the links between drugs and violence and too little action taken to reduce drug related violence.
17. Inspectors found that substance misuse support services did not meet current need. Too many prisoners were waiting to be assessed and there were insufficient interventions.

Independent Monitoring Board

18. 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 January 2017, the IMB reported that the amounts of New Psychoactive Substances (NPS) found in the prison had declined, but remained an ongoing issue at Lindholme, despite a rigorous searching programme.

Previous deaths at Lindholme

19. Mr Baldock's was the third self-inflicted death at Lindholme since January 2016. We repeat a recommendation in this report, previously made in 2016 about NPS.

Assessment, Care in Custody and Teamwork

20. 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.

New Psychoactive Substances (NPS)

21. New psychoactive substances are an increasing problem across the prison and immigration detention estates. 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. Psychological effects

can include psychosis and hallucinations, depression and suicidal thoughts, antisocial or paranoid behaviour and emotional and erratic behaviour.

22. As well as emerging evidence of dangers to both physical and mental health, there are other links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.
23. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff 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.

Indeterminate Sentence for Public Protection

24. The indeterminate sentence for public protection was created by the Criminal Justice Act 2003, but abolished in 2012. It was intended for prisoners whose offending was considered dangerous, but not so dangerous that they qualified for a life sentence. Prisoners serve a minimum term of imprisonment, after which the offender can be considered for release if they can satisfy the Parole Board that their risk of reoffending has sufficiently reduced.

Key Events

25. On 6 October 2008, Mr Craig Baldock was convicted of wounding with intent and received an indeterminate prison sentence for public protection with a minimum period to serve of two years and 20 days. This meant he was eligible to be considered for release in November 2010, subject to the Parole Board being satisfied that he was no longer a risk to the public.
26. Mr Baldock was transferred to HMP Lindholme on 4 March 2016, as part of his sentence progression. He was required to complete the Building Skills for Recovery (BSR) programme (a psychosocial programme to reduce offending behaviour and dependent substance misuse with an eventual goal of recovery), to address his dependency on crack cocaine, alcohol and new psychoactive substances (NPS).
27. On 4 March, a nurse completed Mr Baldock's health screen. She recorded that Mr Baldock had a history of substance misuse, but he did not want support from the substance misuse team. She recorded that Mr Baldock had a history of depression and made a referral for a mental health assessment. Mr Baldock told her that he had no thoughts of suicide or self-harm. Before his transfer, Mr Baldock had been prescribed citalopram, an antidepressant.
28. On 11 March, a nurse from the mental health team saw Mr Baldock for his mental health assessment. She recorded that Mr Baldock said he last self-harmed around ten years ago when he cut his arms. He said he had no thoughts of suicide or self-harm. She recorded that the primary care team would support Mr Baldock and there was no further action at that time.
29. On 4 April, Mr Baldock was deselected from the BSR programme as he had missed three sessions (6, 7 and 8) and when he arrived at session 9, he told the facilitator he felt unable to concentrate on the programme. Mr Baldock understood that by not attending the session he would have to complete the programme at a later date. He told the facilitator he would prefer to wait and restart the programme. Mr Baldock started work in the bike workshop on the same day.
30. On 5 April, the facilitator contacted Mr Baldock's offender supervisor at his previous prison, HMP Stoke Heath. She asked whether Mr Baldock would need to return to Stoke Heath, as he was no longer on the BSR programme. The offender supervisor asked if Mr Baldock could remain at Lindholme to complete the BSR course and then return to Stoke Heath.
31. On 16 May, the BSR programme manager saw Mr Baldock. She recorded that he wanted to return to the BSR programme at the next available opportunity. Mr Baldock told her that he was still using NPS. She advised him to contact the substance misuse service, but he said he did not need their support. No further action was taken.
32. On 1 June, a nurse saw Mr Baldock. He told the nurse he used NPS on a daily basis depending on availability. Mr Baldock told the nurse that all of the wings at Lindholme were "full of Spice" and prisoners were getting into debt because of it. Mr Baldock said he suffered from depression but was not taking his prescribed

medication as he felt it was not helping. It was agreed that Mr Baldock would join a substance misuse programme, but he did not attend an appointment on 24 June. The appointment was rearranged and he was seen on 11 August.

33. On 16 June, Mr Baldock saw his offender supervisor. She recorded that Mr Baldock intended to complete the BSR programme later. They discussed his offence and she recorded that he showed little victim empathy and tended to minimise his actions. Mr Baldock admitted that he had used NPS within the past three days. He said he was clinically depressed but was not taking prescribed medication and was using NPS instead. She advised him to approach both the mental health team and substance misuse team for support. Mr Baldock restarted the BSR programme on 25 July.
34. On 11 August, Mr Baldock saw a nurse as part of a substance misuse assessment. He told her he had stopped taking NPS, and was currently on the BSR programme. Mr Baldock said he felt good at present and had no intention of using illicit drugs again. A further appointment was scheduled for six weeks later.
35. On 16 August, a BSR facilitator wrote to the offender supervisor and Mr Baldock's offender manager. She said that Mr Baldock had been participating positively during the BSR programme and had passed a drug test which tested negative for all substances.
36. During the morning of 3 September, Mr Baldock passed a note to an officer asking if he could stay inside his cell as he was in debt. The officer began to support Mr Baldock under the prison's violence reduction plan and submitted an intelligence report. Later the same day, Mr Baldock told the officer that he did not want to be supported by the violence reduction plan as his problem was now "all sorted". Mr Baldock signed a violence reduction disclaimer.
37. On 8 September, a nurse saw Mr Baldock again as part of the substance misuse assessment. She recorded that Mr Baldock was pleasant and gave positive feedback about the BSR programme. Mr Baldock told the nurse he had not used NPS since June and had no plans to use it again. On 14 September, a BSR facilitator recorded that Mr Baldock engaged well on the programme.
38. On 22 September, Mr Baldock saw a nurse. He told the nurse that the BSR programme was the best course he had done in prison. Mr Baldock told the nurse he did not know whether he would be transferring back to Stoke Heath but he did not want to return there, as it might adversely affect his parole application. On 25 November, it was decided that Mr Baldock would not be returning to Stoke Heath, and all preparatory work for his next Parole Board hearing would be carried out at Lindholme.
39. During the morning of 20 December, an officer from the violence reduction team recorded that she had spoken to Mr Baldock about a problem with another worker in the bike workshop. He told her the prisoner had been bullying him for his tobacco. She told Mr Baldock that the other prisoner no longer worked in the bike workshop and asked whether this would make it possible for him to return there. Mr Baldock said he was happy to return to work that afternoon.

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40. On 13 January, Mr Baldock told a nurse he was waiting for a psychology report as part of his parole review. Mr Baldock said he did not intend to use illicit drugs again, despite all the temptation in the prison. The nurse recorded that Mr Baldock denied any suicidal thoughts or self-harm ideation.
41. On 8 February, the offender supervisor referred Mr Baldock to the mental health team. She recorded that she wanted someone to see Mr Baldock as he told her he was depressed, but was not taking antidepressants. He told her he had taken antidepressants in the past but had not given the medication an opportunity to take effect while at Lindholme. She recorded that Mr Baldock said he used 'Spice', an NPS, and other illicit medication to give him confidence to interact with others. She recorded this in Mr Baldock's case notes and emailed a mental health nurse.
42. During the morning of 18 February, Mr Baldock pressed his cell bell. An officer responded and Mr Baldock gave him a note. Mr Baldock wrote: "I'm staying behind my door because I owe some people if I don't pay there will be trouble today and I can't afford it with parole coming up I can't go anywhere else because they are well known all over the prison". The officer recorded that Mr Baldock said he had no thoughts of suicide or self-harm. The officer made an entry in the wing observation book and completed a security information report. Another officer saw Mr Baldock on 20 February, when he told her that he did not owe money anymore and the situation had been resolved. Mr Baldock seemed in a positive mood and signed a disclaimer that he did not want to be monitored by violence reduction procedures.
43. During January and February, a forensic psychologist saw Mr Baldock to complete a sentence planning and review report. (She saw him on six occasions: 12, 17 and 19 January and 2, 16 and 22 February.) She told the investigator she was going to recommend in her sentence planning and review report to transfer Mr Baldock to an open prison as he had appeared to be participating in programmes and activities to address his substance misuse. She had not shared these views with Mr Baldock. She said that she revised the recommendations after Mr Baldock disclosed to the offender supervisor on 8 February that he had continued to use illicit substances. She said she could no longer support the option of open conditions as he had not told the truth during his meetings (in January and early February) and he would need further support with his rehabilitation.
44. On 22 February, the forensic psychologist saw Mr Baldock to disclose and discuss her sentence planning and review report, and recommendations. She wrote that Mr Baldock was likely to use physical violence if under the influence of alcohol or if he was emotionally aroused. She noted that if he did reoffend it would likely be at a time when he was using substances, feeling stressed or depressed. Mr Baldock was likely to behave in a violent and aggressive manner as a way of expressing his emotions, gaining what he wanted, solving problems or protecting himself or others.
45. The forensic psychologist recommended that Mr Baldock should consolidate his learning from offending behaviour programmes, have further support for his

substance misuse and have a mental health assessment. She recommended that Mr Baldock should complete the Rehabilitation for Addicted Prisoners trust (RAPt) substance misuse course. She also recommended that he apply for a move to a therapeutic community where he could work on his emotion management and coping skills to develop alternative coping methods for avoiding substance misuse in the future.

46. Mr Baldock began to read the report but then told the forensic psychologist he did not want to read it anymore as the content was “negative”. Mr Baldock told her he did not want to discuss any aspect of the report and he decided to leave the disclosure session. He told her he had an appointment to see a nurse. She told the investigator she tried to convince Mr Baldock to read the report in detail but he declined and did not sign to show he had seen the report. She told Mr Baldock that if he wanted to discuss the report or ask any questions at a later date she would make an appointment to see him. Mr Baldock left the disclosure session and went to his appointment with the nurse.
47. On the same day, 22 February, Mr Baldock told the nurse that he had continued to use NPS since arriving at Lindholme and had not been honest previously. Mr Baldock said he had not wanted to disclose his use of NPS in case it affected his parole review. He said he did not think he would ever be drug free and the only way to manage it would be a methadone prescription. The nurse agreed to make an appointment with the substance misuse doctor to discuss treatment options. He had not had the opportunity to do so before Mr Baldock died. There was no indication that Mr Baldock had expressed suicidal thoughts to the nurse.
48. Around 8.35pm on 24 February, an operational support grade (OSG) started her night shift on J wing. Shortly after she arrived on the wing, she delivered post to Mr Baldock’s cell. (The police said that none of the letters collected from Mr Baldock’s cell after he died contained bad news or could be considered distressing.) Initially Mr Baldock did not acknowledge her when she arrived at his cell, but he then came to the cell door. She had a brief conversation with Mr Baldock and then continued to check other prisoners on the wing. Mr Baldock did not use his cell bell during the night.

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49. During a roll check at around 5.53am on 25 February, the OSG looked into Mr Baldock’s cell and saw him hanging from the top bunk in a seated position. She radioed a medical emergency code blue (indicating a prisoner is unconscious, not breathing or having difficulty breathing). Two officers and the night manager joined her. They went into Mr Baldock’s cell. An officer cut the ligature and staff lowered Mr Baldock to the floor. Staff noted that Mr Baldock felt rigid, but the night manager started cardiopulmonary resuscitation (CPR).
50. The prison control room received the emergency code blue radio message at 5.53am and telephoned for an ambulance immediately. (The ambulance service received the call at 5.54am.) When paramedics arrived, at 6.11am, they took over Mr Baldock’s care. At 6.32am, they pronounced that Mr Baldock had died.

Contact with Mr Baldock's family.

51. After Mr Baldock's death, a custodial manager was appointed as the prison's family liaison officer and he continued to support the next of kin and family. Mr Baldock's funeral took place on 29 March. The prison contributed to the costs, in line with national guidance.

Support for prisoners and staff

52. After Mr Baldock's death, the deputy governor debriefed the staff involved in the emergency response and the prison's care team offered support.
53. On the morning of 25 February, the Governor issued notices to staff and prisoners informing them of Mr Baldock's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed all prisoners who had been assessed as at risk of suicide and self-harm, in case they were adversely affected by Mr Baldock's death

Post-mortem report

54. The post-mortem examination found the cause of death to be hanging. A toxicology report found evidence of NPS and low levels of mirtazapine, an unprescribed antidepressant medication.

Findings

Assessment of Mr Baldock's risk of suicide or self-harm

55. Prison Service Instruction (PSI) 64/2011 on safer custody lists a number of risk factors and potential triggers for suicide and self-harm. Mr Baldock had a number of risk factors for suicide and self-harm, including substance misuse, a parole refusal or similar 'knock back', and a history of anxiety and depression.
56. In April 2014, the PPO issued a publication, Learning from PPO investigations; risk factors in self-inflicted deaths in prison. It highlights that an indeterminate sentence is an uncertain situation and for some could lead to hopelessness, which is associated with an increased risk of suicide. Prisoners generally affected were slightly older and had a history of self-harm. It says that an individual's level of risk is not fixed and that distressing and stressful events can have a sudden and critical impact. Where such information is known, staff working closely with the prisoner should be made aware.
57. Mr Baldock, who had been given an indeterminate sentence, was more than six years over his minimum tariff when he died. He was keen to progress to an open prison and was clearly upset when he realised that as a result of his admission that he continued to use NPS, the forensic psychologist would no longer be making a recommendation to transfer him to open conditions.
58. Mr Baldock's actions appear to have been sudden and unexpected. Mr Baldock had never self-harmed in prison or expressed any intention to self-harm. When he saw a nurse after being told about his parole review report, he gave no indication that he was particularly distressed or that he was contemplating suicide or self-harm. Therefore, we consider that prison staff could not reasonably have been expected to foresee that Mr Baldock was about to attempt to take his own life.

New Psychoactive Substances (NPS)

59. Mr Baldock had a long history of substance misuse before he arrived in custody. When he moved to Lindholme he was referred to the substance misuse team for ongoing support, along with the BSR course to address his dependence on NPS, crack cocaine and alcohol. It was not until 8 February 2017, that Mr Baldock admitted he had continued to use NPS daily and had no intention of stopping.
60. The PPO's Learning Lessons bulletin on NPS, issued in July 2015, says that NPS is a source of increasing concern in prisons and there was emerging evidence that there are links to a prisoner's physical and mental health, which in some cases can be linked to suicide or self-harm. Also, trading these substances in prison can lead to debt, violence and intimidation which, once again, can increase the potential for suicide or self-harm among vulnerable prisoners.
61. Lindholme issued its policy, Approach and Strategy for Tackling NPS, in January 2016. It sets out actions if a prisoner is suspected of using NPS. These include submitting an intelligence report, noting it in a prisoner's record, informing the healthcare department so they can hold a medication review, a referral to the

substance misuse awareness team, who will enrol the prisoner on an NPS awareness course, and to carry out an incentive and earned privileges (IEP) review. Very few of these actions were taken forward, despite Mr Baldock's admissions about using NPS.

62. It is clear that Mr Baldock's use of NPS and his admission on 8 February, negatively affected his parole application, which in turn appears to have affected his state of mind. This is yet another example of the damage caused to prisoner safety by NPS and illustrates why prisons must do all they can to eradicate its use. We repeat the following recommendation, previously made in an investigation into a death at Lindholme in 2016:

The Governor should ensure there are effective supply and demand reduction strategies to help eradicate the availability of new psychoactive substances, and that staff are vigilant to signs of its use and take appropriate action.

63. Furthermore, there were occasions when Mr Baldock felt unsafe and under threat at Lindholme. Given the association of NPS use with debt and bullying, and in turn the links to the risk of suicide and self-harm, we make the following recommendation:

The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated and the impact on the risk of suicide and self-harm is taken into account for apparent victims.

Mental Health

64. Following her meeting with Mr Baldock on 8 February, the offender supervisor sent an email to the mental health team requesting that Mr Baldock receive a mental health review. A senior mental health nurse responded a week later, on 15 February, when he said he spoke to her about the email. The nurse said that the offender supervisor did not believe the appointment to be urgent, and he advised her to re-refer Mr Baldock to the duty mental health nurse. There is no evidence to suggest this happened. The nurse told the investigators that he had not seen the need to put Mr Baldock on the waiting list himself, as he had had a conversation with the offender supervisor.
65. At interview, the senior mental health nurse said that there was no central mental health referral system at the prison, and that referrals could come from a number of sources and that routine referrals could wait a number of weeks before being seen. It remains unclear whether Mr Baldock was ever added to the mental health waiting list. The nurse told investigators that given Mr Baldock regularly saw a substance misuse nurse and a mental health nurse it was unlikely another member of the mental health team would have seen him. The nurse saw Mr Baldock in his role as a substance misuse nurse, so it is unlikely that he would have carried out a full mental health assessment, unless specifically asked to do so. Mr Baldock did not have a mental health assessment before he died.
66. The clinical reviewer concludes that Mr Baldock's mental health care was not equivalent to the standard he would have received in the community. The clinical reviewer was concerned that there was no clear referral pathway and that

referrals could be emailed to a member of healthcare staff for action, and not added to a waiting list or actioned in any way. We make the following recommendation:

The Head of Healthcare should ensure there is an effective mental health referral system in place, that all referrals are assessed for urgency, and prisoners are seen within prescribed timescale.

Emergency response

67. Lindholme's Night Staff Instructions about opening cells, published in 2013, say that under normal circumstances, no single cell will be opened at night unless at least three staff are present. However, where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night manager, and an individual may enter the cell. Staff should use their keys in the sealed pouch for immediate access. Staff have a duty of care to prisoners and themselves and to other staff. The preservation of life must take precedence over security concerns, but night staff should not take action that they feel would put themselves or others in unnecessary danger. The instruction then details what action should be taken when going into the cell.
68. When the OSG found Mr Baldock hanging in his cell, she immediately radioed a code blue (an emergency call to say a prisoner is unconscious or not breathing) but did not open the cell door because she said she was not permitted to open a cell alone. This is not in accordance with the Night Staff Instructions, which state that staff should enter, if it is safe to do so. Although we accept that the short delay in entering the cell made no difference to the outcome on this occasion, any delay could be critical in future cases and we make the following recommendation:

The Governor should ensure that all staff understand the importance of entering a cell without delay when a prisoner's life is at risk, when it is safe to do so.

69. In September 2016, the National Medical Director at NHS England wrote to Heads of Healthcare for prisons and Immigration Removal Centres alerting them to new guidance issued to support staff in making decisions on when not to perform cardiopulmonary resuscitation. The guidance was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines advise that resuscitation will be futile, and should not be attempted, where rigor mortis is present (rigor mortis is the stiffening of the body after death that normally appears around two hours after the deceased has died).
70. An officer who responded to the code blue described Mr Baldock as "rigid". We accept that staff acted in what they considered to be Mr Baldock's best interests. However, attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We consider it was inappropriate to try to resuscitate Mr Baldock and make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

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