

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Smith a prisoner at HMP Lindholme on 23 May 2016

**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 Smith died in his cell at HMP Lindholme on 23 May 2016. He was 32 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith had been in Lindholme since December 2014. His records show a well-behaved man who caused no problems for staff or other prisoners. When prisoners were unlocked on the morning of 23 May, a friend of Mr Smith's went to his cell and found him to be unresponsive, with a length of plastic tied around his neck. He alerted staff, but Mr Smith had clearly been dead for some time so no resuscitation was attempted.

On the night of 22 May, a roll check was not completed as it should have been, and a member of staff has since been subject to disciplinary procedures. There was a subsequent roll check, so the omission was not as serious as it might have been. However, I am concerned that when he was unlocked the next morning, the officer did not assure himself that Mr Smith's was alive and well. The Governor has since issued a notice to staff instructing them to ensure prisoners' wellbeing when unlocking cells.

I am satisfied that there were no reasons for staff to anticipate that Mr Smith would take his own life. Indeed it is not clear whether this was actually his intention and that his death may have been a tragic accident.

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 2017

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Summary

Events

1. Mr James Smith was serving a custodial sentence for burglary. He had experienced mental health problems in the past following the death of his partner, had made attempts on his own life, and been treated for depression. He had a history of alcohol misuse.
2. He arrived at HMP Lindholme in December 2014. He told a nurse in reception that he felt suicidal, and she opened Prison Service procedures to monitor prisoners at risk of self harm. The following day Mr Smith said that he had made the remarks when feeling under stress, and they were not true. He was taken off special monitoring procedures.
3. The mental health team worked with Mr Smith, and found he had no mental illness. He was discharged from their care in December 2015.
4. Apart from a suggestion that Mr Smith had some involvement in tobacco trading, he appears to have been a positive, well-behaved prisoner during his time at Lindholme.
5. When prisoners were unlocked on the morning of 23 May, a friend of Mr Smith's went to his cell and found him dead, with a ligature tied around his neck. Staff were called, but it appeared that Mr Smith had been dead for some time.

Findings

6. Mr Smith had been in Lindholme for some time and had no apparent problems. There was no intelligence to suggest that had problems with any prisoners and no evidence to suggest that he was being bullied or had any debts.
7. There was no indication that Mr Smith was inclined to cause himself any harm. He had made a comment on arrival in the prison in 2014 but retracted it the following day and had given no sign of being a risk to himself subsequently.
8. The prison officer responsible for conducting the roll check on the night of 22 May did not do so, and has been subject to disciplinary action. There was, however, a further roll check the following morning. This was carried out correctly, so there is no reason to believe that had the earlier check been made, that it would have made any difference to the outcome for Mr Smith. We do not make a recommendation.
9. Mr Smith was found in circumstances that, in the view of police investigators and in light of previous sexual behaviours disclosed to the police, raise the possibility that he inadvertently asphyxiated himself. This is, of course, only speculative and it is not possible to know whether Mr Smith intended to take his own life.
10. When a prison officer unlocked Mr Smith's cell on the morning of 23 May, he did not confirm Mr Smith's wellbeing. When a prisoner subsequently noticed something was wrong and the alarm was raised, it became apparent that Mr Smith had been dead for some time. Again, this short delay did not affect the outcome. The Governor has since issued a notice to staff, instructing them to

carry out a wellbeing check when unlocking prisoners. Accordingly, we do not make a further recommendation.

The Investigation Process

11. 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. One prisoner responded, and the investigator interviewed him.
12. The investigator visited Lindholme on 9 June. He obtained copies of relevant extracts from Mr Smith's prison and medical records. He had access to police statements and to the conclusions of the prison's internal investigation into Mr Smith's death. He interviewed four prisoners at Lindholme.
13. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison.
14. We informed HM Coroner for South Yorkshire (East district) of the investigation and he sent us the results of the post-mortem examination. We have given the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Smith's sister to explain the investigation and to ask whether Mr Smith's family had any matters it wanted the investigation to consider. Mr Smith's sister asked whether there were any indications that Mr Smith was being bullied. Mr Smith's family received a copy of the initial report. They did not raise any further issues.

Background Information

HMP Lindholme

16. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Nottinghamshire Healthcare Foundation NHS Trust provides healthcare services. These include a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Lindholme was conducted in March 2016. Inspectors found that there were issues with drugs and levels of violence, but that overall the prison was a respectful establishment. The report noted that the prison had improved since its previous inspection.

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 31 January 2016, the IMB reported that a greater presence of staff on the wings at Lindholme could have a positive effect.

Previous deaths at HMP Lindholme

19. Mr Smith's death was the sixth at Lindholme since the beginning of 2015. One of these deaths was from natural causes, two from drugs, and one was self-inflicted. There has since been a further death due to natural causes. There were no significant similarities between any of these deaths and that of Mr Smith.

Key Events

Reception

20. On 21 November 2014, Mr James Smith was sentenced to six years and six months imprisonment for aggravated burglary. He was sent to HMP Doncaster. Mr Smith had a history of mental health problems dating back to the death of his partner, and had made attempts on his own life. He was using prescribed antidepressants at the time of his offence. He also had a history of misusing alcohol, and in HMP Doncaster underwent a programme of alcohol detoxification.
21. On 1 December 2014, he was transferred to HMP Lindholme. The transfer papers that accompanied him noted that he had taken an overdose some three and a half years earlier. The papers also noted that he suffered from psychosis and anxiety. During his initial health screening, Mr Smith told the nurse that he had suicidal thoughts and the nurse started Prison Service procedures to protect prisoners thought to be at risk of harming themselves. These are known as Assessment, Care in Custody and Teamwork (ACCT). At a review the following day, Mr Smith said that he had been feeling under stress when he made the comment, and, in fact, he had no such feelings. ACCT procedures were closed.

Healthcare

22. In view of his previous mental health issues, the mental health team worked with Mr Smith. He engaged with the IAPT team (Improved Access to Psychological Therapies) on two occasions in 2015, for support when he suffered from anxiety. A psychiatrist reviewed him on 23 September 2015, and found that there were no signs of a severe or enduring mental illness. He was discharged from the IAPT service on 12 November 2015 and from the care of the mental health team on 14 December 2015.
23. While in prison, Mr Smith had ongoing difficulties with migraines and dizziness, and was in frequent contact with the healthcare services. Besides medication, he obtained new spectacles and painkillers to help him address these problems. The last time Mr Smith had complained of a migraine was 4 May 2016. On 9 May, a prison doctor prescribed him sumatriptan (to treat migraines), and Mr Smith did not complain of migraines thereafter.

Behaviour

24. Mr Smith's record shows that he was a positive prisoner who worked well, had a mature attitude, and did not cause staff any problems. There was no intelligence to suggest that he had any issues with other prisoners or engaged in any illicit activity.
25. After his death, however, some prisoners told the investigator that Mr Smith had been loaning tobacco to other prisoners on K wing, where he lived. There is no intelligence to support this information, but when he died there was a substantial amount of tobacco in his cell.

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26. A prisoner told the investigator that he and Mr Smith had sought compensation for a debt owed by a former prisoner at Lindholme who had left behind a jacket to sell for that purpose. Mr Smith had been unable to sell the jacket, and he had reclaimed it from him. There was, however, no animosity between them over the matter.
27. A fellow prisoner, who was a friend of Mr Smith, said that on 22 May, while talking, Mr Smith did not seem his usual self. He was quiet, and told him that he had been accused of insulting someone, although he would not identify this individual. He said that he saw Mr Smith that evening, by which time he seemed fine. Prison officers locked prisoners into their cells for the night at approximately 4.30pm.
28. On 22 May, an operational support grade (OSG) was the night officer on K wing. He told the police that he checked the doors to all cells at 8.30pm. An officer was due to undertake a roll check between 7.30pm and 9.00pm, but investigations show that he did not check on each individual prisoner as he should have done.
29. As Mr Smith was not on any special observations, the night officer, Officer A, did not make any further checks on him through the night. He said that Mr Smith did not come to his attention for any reason. The prisoner in the cell next door to Mr Smith said he did not hear anything untoward from Mr Smith's cell over the course of the night. The officer told the police that he conducted a roll check at 5.50am and all prisoners were present in their cells. He said that he did not specifically remember the check on Mr Smith, but did not notice anything out of the ordinary in any cell. CCTV footage confirmed him looking into Mr Smith's cell.
30. Officer B came on duty on K wing on the morning of 23 May. Shortly before 8.00am, he began unlocking the prisoners due to attend work and, according to CCTV footage, he reached Mr Smith's cell at 8.08am. He unlocked the door, pushed it open and shouted to Mr Smith, but did not look in before moving on to the next cell.
31. At unlock, another prisoner would usually go to Mr Smith's cell for a cup of coffee together before they went to work. He went to do so, and CCTV footage shows that he arrived at Mr Smith's cell twenty seconds after Officer B had unlocked it. He went into the cell and saw Mr Smith lying partly across his bed, with his feet tied to the bedstead. He told the police that Mr Smith was clearly dead. He stepped out of the cell and called to Officer B. The officer noted the urgency in his voice and went to Mr Smith's cell.
32. Officer B saw that Mr Smith had tied a ligature made from a thin piece of plastic cord. He had tied this between his ankles and his neck with the section around his neck cushioned from his skin by a piece of material. He had tied his ankles to his bed, and was lying naked with a stained towel beside him. The officer said that he could see that Mr Smith was clearly dead, but he nevertheless used his radio to call a code blue emergency, meaning a prisoner is not breathing or is

having difficulty breathing. This automatically triggered the control room to call for an ambulance.

33. Other prison staff responded to the emergency call. The prison officers had not yet cut the ligatures from Mr Smith, as they felt that he had been dead for some time. However, when a nurse arrived she told the officers to remove them. They did so and laid Mr Smith on the bed. The prison's clinical matron arrived at the cell. He applied a defibrillator (a life-saving device that can deliver electric shocks to the heart) but it did not detect any heart rhythm. Both nurses noted extensive rigor mortis in Mr Smith, who had evidently been dead for some time. Paramedics arrived at 8.21am and at 8.28am pronounced Mr Smith dead.

Contact with Mr Smith's family

34. Having identified Mr Smith's next of kin, the prison Governor and the appointed family liaison officer went to inform Mr Smith's family of his death. In line with prison service guidance, Lindholme offered to contribute to the costs of Mr Smith's funeral.

Support for prisoners and staff

35. After Mr Smith's death, the Duty Governor 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 also offered support.
36. The prison posted notices informing other prisoners of Mr Smith's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Smith's death.

Post-mortem report

37. The post-mortem report concluded that Mr Smith died from compression of the airway caused by a ligature. There were no other injuries to his body nor were there any signs that he had any illicit substances in his system.

Findings

Assessment of risk

38. Prior to arriving in Lindholme, Mr Smith had made attempts on his own life. On arrival, in 2014, he told a nurse that he felt suicidal, and spent a day under ACCT management. The following day he said that he had felt under stress, moving to a new prison, but he did not feel suicidal and ACCT procedures were ended. There were no further intimations during his time in Lindholme that Mr Smith was at any risk of harming himself. Although he told an IAPT worker in May 2015 that the coming weeks contained the anniversary of a significant death, and this was always a difficult time for him, there was nothing that could have caused prison staff to anticipate that he might attempt to harm himself.
39. Mr Smith was found in circumstances that reflected previous sexual behaviour that was uncovered during the police investigation. Taking into account the conditions in which he was found, police investigators considered it a possibility that he inadvertently asphyxiated himself. This is, though, impossible to know and we cannot comment on whether Mr Smith intended to take his own life.

Bullying

40. Mr Smith's family raised concerns about possible bullying. Throughout his time in Lindholme, there were no indications that Mr Smith had been involved in any bullying, either as a perpetrator or as a victim. There are no intelligence reports that indicate this, and staff were not aware of any other information to suggest so. Although he may have been involved in loaning tobacco, there is no suggestion that he was in dispute with anyone over this. Similarly, although he had a disagreement with another prisoner about the jacket, we have not found any evidence that this led to any further conflict between them.
41. After Mr Smith's death, rumours that Mr Smith's stereo had been stolen were raised by prisoners with prison staff. Mr Smith's property record does not show that he owned a stereo. Extensive analysis of the wing CCTV footage found nothing to support the rumours. There is no other evidence to support the claim.

Mr Smith's healthcare

42. The clinical reviewer noted that Mr Smith had a comprehensive medical screening at reception, with appropriate referral to the mental health team. Any physical health problems were promptly and appropriately addressed, and he was discharged from the mental health team in December 2015, content with the care he had received. The reviewer notes that after Mr Smith said he felt suicidal on arrival at Lindholme in 2014, there are no further references to him feeling at risk of harming himself in his medical records.
43. Mr Smith had problems with migraines throughout his time in Lindholme, and the healthcare team worked to try various remedies. Mr Smith reported migraines in late April and early May 2016. The prison doctor prescribed him some medication on 9 May, and Mr Smith did not complain of migraines thereafter.

44. The clinical reviewer concluded that the healthcare provided to Mr Smith in Lindholme was at least equivalent to that which he could have expected to receive in the community. Staff were not aware of any anxiety prior to his death, and could not have been expected to anticipate what happened.

Emergency response

45. An internal prison investigation found that an officer did not conduct the roll check on the evening of 22 May, although he had signed documentation to confirm that he had done so. The prison has taken disciplinary action against the officer.
46. When Officer B unlocked Mr Smith's door, he pushed it open and shouted to Mr Smith but did not look in before moving onto the next cell. Since Mr Smith's death, the Governor has published a notice to staff instructing them to conduct a wellbeing check as part of the unlock process. Officers unlocking prisoners must now ensure that they are responsive and not in need of any assistance. We therefore do not make a recommendation.
47. When the emergency call was made an ambulance was called. A nurse was in the cell without delay, quickly joined by more medical staff. Emergency equipment was available.

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