

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING  
THE DEATH OF A MAN AT HMP LINCOLN  
ON 17 NOVEMBER 2004**

**Report by the Prisons and Probation Ombudsman for England  
and Wales**

**May 2006**

This is the report of an investigation into the death of a man who died on 17 November 2004 after being found hanging in his cell in Lincoln prison the day before. He was 22 years of age.

I offer my sincere condolences to his family and friends on their loss.

My office was passed responsibility for investigating deaths in custody in April 2004. I would like to thank the three appointed officers from HMP Ranby who conducted the investigation on my behalf under transitional arrangements in operation at that time. Thanks also go to staff at Lincoln for cooperating fully with the investigation. I am particularly grateful to the officer who acted as the liaison officer.

I appointed one of my colleagues as my representative to oversee the investigation. The family liaison officer from my office visited the man's parents with the investigator to discuss the investigation and any questions they would like answered. The family liaison officer kept in touch with the man's parents to update them on the progress of the investigation and report.

I must also thank the Director of Health Improvement at West Lincolnshire Primary Care Trust, who conducted a clinical review of the man's healthcare needs whilst in prison.

The man was a troubled young man with many problems. He was a prolific self-harmer, and frequently suffered from suicidal ideation. His parents fought long and hard to find him the help that he needed but said they found the care available in the community severely lacking. In April 2004, the man was remanded into custody. He self harmed on many occasions and attempted to take his own life at least twice. For most of his time in Lincoln he was treated as an individual with very specific needs.

On 14 November, the man allegedly assaulted a member of staff (he pleaded guilty to this charge), after which he was taken to the segregation unit. On 16 November, he was found with a ligature around his neck. He died the next day in hospital.

This report makes both sad and grim reading. I am critical of some failures to adhere to elements of Prison Service policies concerning the care of prisoners who are at risk of suicide or self harm and in the segregation unit.

Following correspondence and further meetings with East Midlands Area Office and some staff at Lincoln, the report has been amended significantly in both its format and contents from the first draft. A number of the judgements in the earlier draft have needed to be revisited in light of additional information received. One of my Assistant Ombudsmen became involved with the investigation during this stage.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**May 2006**

## **Contents**

Summary

Investigation process

Background details of HMP Lincoln

Events prior to 14 November

Events from 14 November

The prison response after finding the man

Issues considered during the investigation

- The man's time in Lincoln prior to 14 November
- The man's general management on the F2052SH system
- The decision to segregate the man on 14 November
- The man's adjudication on 15 November
- The decision to segregate the man on 15 November
- The failure to carry out a self harm case review in the segregation unit
- The failure to carry out other assessments in segregation – mental health, safer cell, type of furniture
- The segregation regime
- Day to day management of the segregation unit
- The man's missed medication whilst in segregation
- The last entries in his F2052SH record
- The actions of the chaplain
- The man's injuries at his post mortem

List of recommendations

## Summary

This is the report of an investigation into the death of a man who died on 17 November 2004 at the United Lincolnshire Hospital after being found hanging in his cell in Lincoln prison the day before.

He was remanded into custody at Lincoln prison in April 2004.

During the reception process, he was seen by a doctor and referred to a psychiatrist. He was also identified as having serious self-harm tendencies and a F2052SH (a form that is opened when a prisoner presents a danger of self-harm or suicide) was opened. He remained on an open F2052SH, save for a period of a few hours on 17 June and 22 July, until his death.

The man spent the majority of his time in Lincoln in the health care centre. He frequently saw doctors, nurses and had five appointments with a psychiatrist during this time.

Between 18 June and the end of September, the man harmed himself on many occasions. Sometimes the man would suffer from hallucinations and would hear voices in his head. He used many forms of self-harm. Sometimes his actions could be extremely alarming, such as biting his arms causing significant damage to himself, attempting to cut part of his thumb off, and pushing a pen into his own neck. The man was found with a noose on five separate occasions including when he twice attempted hanging. The first of these attempts was on 7 July when he was found very quickly and did not require treatment from an outside hospital. The second attempt was on 15 August when he lost consciousness and did require outside hospital medical attention.

The man also used blades to cut himself on four occasions, and on 26 September drank cleaning fluid in an attempt to harm himself. He frequently expressed the desire to die. He was on anti-depressant and anti-psychotic medication. The man had last self harmed on 30 September. The medical team managed him extremely well. The clinical reviewer commented that his care was "more than satisfactory and could not have been more attentive".

On 28 October, the man was moved to B wing where he responded well. He was still extremely vulnerable but seemed to be mixing well with staff and prisoners. On 14 November, he went to collect his medication. He stopped to talk to another prisoner, and a member of staff asked him to move on. An argument ensued and it was alleged that the man hit the officer. He was taken to the segregation unit where the duty governor authorised his segregation until his adjudication the next morning. According to national policy, a prisoner on an active F2052SH must only be held in the segregation unit if there are exceptional reasons to do so. Although the exceptional reasons were not recorded on the Safety Algorithm as required, the duty governor had considered the reasons and justification for segregating him and his decision was reasonable in the circumstances. The staff nurse had already completed the relevant medical part of the Safety Algorithm and had

indicated to the duty governor that there were no healthcare reasons against him being in the segregation unit.

The following morning the man saw the doctor. She countersigned the previous evening's Safety Algorithm and determined him fit to see the adjudicator and fit for a further period in segregation if necessary. The adjudicating governor that day was also the governor in charge of running of the segregation unit. The man pleaded guilty to the charge of assault and the matter was referred to the independent adjudicator (district judge).

The adjudicating governor decided that the man should remain in the segregation unit for the Good Order or Discipline (GOOD) of the prison, with his first review of his segregation due within 72 hours.

According to the Prison Service Order on Segregation, there should have been a case review of the man's F2052SH by 5pm on 15 November (within 24 hours of him being put into segregation). No case review took place.

Other assessments should also have been carried out, but were not. There should have been a mental health assessment carried out by the medical team. This assessment is specifically referred to in the Safety Algorithm and in Prison Service Order 2700. A Care Plan should have been written and implemented as a result of this mental health assessment.

There was no recorded assessment made as to whether the man should have been put into the one safer cell in the segregation unit. That cell was already occupied by another prisoner, who was also on a self harm and suicide watch. He had a history of recent self harm attempts and a decision was made, but not recorded, by the adjudicating governor that this prisoner needed to remain in the safer cell. The local form about the type of furniture (wooden or cardboard) that the man should have in his cell was not completed. The man's cell had cardboard furniture in it because there was no wooden furniture available in the segregation unit at that time due to a number of incidents when prisoners had destroyed it.

The general regime to which the man had access in segregation was the same as for every other prisoner in the unit. He was able to use the showers, telephone, library books and take exercise outdoors. However, the other activities that he was permitted were extremely limited. Prison Service Order 1700 states that the person authorising segregation must consider measures to safeguard a prisoner's mental health whilst they are in segregation. It then goes on to list several such measures. Some of them are monitoring measures, such as increasing the level of staff observations, which Lincoln did put in place. But many other suggestions relate to filling the prisoner's time in a more constructive manner. Practical things such as access to a radio or television, newspapers, books and magazines to read. Hobbies or education to do in the cell. Encouraging prisoners to talk to their families, to the chaplain, medical staff and segregation staff. The man had no radio or television in his cell and nothing to read. In short, he had nothing to occupy his mind. The entries in his F2052SH book from his arrival in segregation at

5pm on 14 November were made five times an hour, and contribute nearly nine pages of entries. Out of all these entries, it seems that apart from a member of the Independent Monitoring Board who spoke to the man about his adjudication on 15 November, and being seen by the chaplain, there is no record of segregation staff engaging him in conversation. Every single entry is purely observational, mainly stating that the man is asleep or lying down. I am troubled that there is no record of any of the regular segregation staff trying to find out how he was feeling. It would have been a simple matter to ask how he was first thing in the morning, when collecting his lunch, when seeing if he wanted a shower or to go out on exercise. Lincoln told my investigator that consideration as to the items a prisoner should be allowed in his cell takes place at the first Good Order or Discipline review carried out within 72 hours of a person being put into the segregation unit. These items include a radio, television and hobby materials. However, the initial authorising operational manager also needs to consider what mental health safeguarding measures are appropriate for each individual prisoner prior to their first review. The man hung himself before his first GOOD review board became due.

On Tuesday 16 November, the man refused his anti-psychotic medication. Around 9am, the chaplain went to the segregation unit as part of her normal 'rounds'. A chaplain must speak to all prisoners in the segregation unit on a daily basis. She spoke with the man and he told her that he 'couldn't bear the thought of being down there for another 11 days'. The chaplain asked the man whether he had spoken to the staff about this or whether he wanted her to speak to the staff on his behalf. The man said he had not and declined her offer of a further visit later in the day. The chaplain went on to finish her segregation rounds. She made an entry in the Segregation Daily Log stating 'Revd chat 10 mins with the man' and then left the unit. She did not speak to staff about any concerns she had, nor did she make an entry in his F2052SH record. The chaplain completed an entry about him in the Chaplain's Journal on her return to the chaplaincy department.

At about 1.50pm, the man was observed by the prison officer and he made an entry in his F2052SH record stating that he was 'banging and shouting'. The officer made further observation entries in the man's F2052SH at 2pm and 2.05pm, saying 'quiet at present'. At some time between 1.50pm and 2.10pm, the officer left the unit in order to go to the stores. The duty senior officer looked into the man's cell at 2.15pm and could not see him clearly, although he thought the man was sitting with his back to the sink unit. The duty SO saw the prison officer at that moment and asked him to take a look. The prison officer thought he saw something around the man's neck and so the cell door was opened. They discovered a noose, made from his shoelaces, around the man's neck, attached to the sink taps. He was quickly cut down and CPR commenced. During this time, the chaplain made a retrospective additional entry in the Segregation Daily Log stating 'the man felt frustrated that he wasn't being listened too'. I have asked the governor to provide written advice and guidance to the chaplain on this issue, reminding her of her responsibility to raise any concerns she has about particular prisoners with staff at the time of her visit and to make appropriate

contemporaneous notes about her visits in documents such as the Segregation Daily Log, prisoner history files and F2052SH records.

The man was taken to Lincoln Hospital and placed on a ventilator. He died the following day with his parents at his side.

The deceased was an extremely vulnerable young man. During most of his time in custody he was treated with a high level of care. However, following his removal to the segregation unit, some national and local policies were not adhered to. Not enough was done to care for him or to safeguard his mental well being whilst in segregation.

The report makes 12 recommendations.

## **Investigation process**

In April 2004, I was passed the responsibility of investigating all deaths in custody. Under transitional arrangements the Head of Residence at HMP Ranby was appointed to conduct the investigation on my behalf. Two other officers also from HMP Ranby assisted the investigation. The Ombudsman's representative on the investigation was the lead investigator. Subsequently, one of my Assistant Ombudsmen, also became involved in the investigation and in writing this report.

The investigation team visited HMP Lincoln, where they met the in charge Governor. They visited the cell where the man was found. They also met with members of the Prison Officers' Association (POA) local branch committee and the Independent Monitoring Board (IMB).

Notices were issued to both prisoners and staff, inviting anyone who might have information relating to the man's death to make themselves known to the inquiry.

Along with the investigator, one of the Ombudsman's family liaison officers visited the man's parents to ascertain whether they had particular concerns or questions about the investigation. They were concerned that their son had been located in the segregation unit. They wanted to know about the decision to hold him there, and if he had received his medication. The man's parents were also concerned by a "black eye" that he had when they visited him in hospital. The family liaison officer remained in touch with them.

The investigation team interviewed prison staff who were involved in attempts to save the man's life, and staff and prisoners who knew him. Two members of the Independent Monitoring Board were also interviewed.

The team examined the man's prison record, medical records and a series of prison documents. They also assessed the care that he received against Prison Service orders and policies.

A clinical review of the man's healthcare whilst in prison custody was undertaken by the Director of Health Improvement at West Lincolnshire Primary Care Trust.

A first draft of this report was circulated in the early Summer of 2005. I received correspondence from East Midlands Area Office, the Governor of Lincoln, and from the adjudicating governor and the duty governor at Lincoln. This led to some further interviews being conducted and more information coming to light. As a result, the report has undergone further draft stages before reaching this final report. The report has been substantially revised to take account of comments received, additional evidence and interviews carried out.

## **Background details of HMP Lincoln**

Lincoln is a category B local prison of Victorian design, which opened in 1872. Parts of the prison are grade two listed buildings.

Lincoln receives adult male prisoners on remand/trial, convicted, sentenced and life sentences from magistrates courts in the Lincolnshire and Nottinghamshire areas, and from Lincoln and Nottingham Crown Court.

Lincoln has an operational capacity of 490 located on three wings, a segregation unit and a Healthcare Centre (HCC) with inpatient facilities. A wing is currently out of use due to refurbishment which will not be completed until Spring 2007.

### **Accommodation**

B wing has an operational capacity of 154 and holds mainly convicted prisoners, most of whom are employed.

D wing is the segregation unit, which has twelve cells including one special cell and one safer cell with C.C.T.V.

The Healthcare Centre is partially closed and can hold 11 prisoners. It also has one safer cell and one cell designed for prisoners who are subject to a constant watch. This has a floor-to-ceiling Perspex door offering full observation for those in crisis.

### **Reports**

The establishment had a full audit by the Standards Audits Unit (SAU) in August 2004 and the results linked to suicide and self-harm awareness resulted in an overall score of 89%. All the baselines for suicide and self-harm awareness were being fully met. It was noted by the audit team that there was a strong performance in regard to self-harm management.

The most recent inspection by Her Majesty's Chief Inspector of Prisons was in October 2003. The only recommendation in regard to self-harm issues was the recruitment of more Listeners. It was reported that there were good systems in place in regard to suicide and self-harm awareness. An HMCIP unannounced re-inspection report is due shortly after the completion of this investigation report.

The man was one of twelve prisoners on an open F2052SH at the time of his death.

## Events prior to 14 November

The man was remanded into custody in April 2004.

During the reception process, he was seen by a psychiatrist and referred to a psychologist. The man was also identified as having serious self-harm tendencies. An F2052SH (a form that is opened when a prisoner presents a danger of self-harm or suicide) was opened. Aside from two brief spells of several hours, he remained on an open F2052SH throughout his time in custody.

The man was located in the first night centre overnight on 19 April then spent some weeks on C wing before being located in the Healthcare Centre on 5 June. He remained on the HCC until 22 July. On 5 June, the 2052A - record of events states that he was "*admitted to HCC for mental observations*". His medical record contains many entries during this period of time. He was seen by various doctors and his mood was up and down. Sometimes he would join other prisoners for association and sometimes he would not. Meal times were the same: sometimes he ate his meals and sometimes he did not.

He then spent time on C and B wings, overnight on D wing (segregation wing) on 8 August 2004 and then back to the HCC until 28 October save for one short spell on E wing. The man was moved to B wing from 28 October where he remained until an alleged assault on an officer on Sunday 14 November.

The man had been cared for in the HCC for a considerable period of time. During this time, staff were concerned for his welfare. This is demonstrated in the medical notes. He was assessed by the prison's medical officer on 48 separate days (sometimes more than once) between 19 April 2004 and 16 November 2004. The longest period between these assessments was from 28 October until his death. He was also assessed by a consultant psychiatrist on five occasions between 4 May 2004 and 29 September 2004.

Between 18 June and the end of September, the man harmed himself on many occasions. Sometimes he would suffer from hallucinations and would hear voices in his head. He used many forms of self harm. At times this could be extremely alarming, such as biting his arms causing significant damage to himself, attempting to cut part of his thumb off, and pushing a pen into his own neck. The man was found with a noose on five separate occasions including when he twice attempted hanging. The first of these attempts was on 7 July, when he was found very quickly and did not require treatment from outside hospital. The second attempt was on 15 August when he lost consciousness and did require medical attention from outside hospital.

He also used blades to cut himself on four occasions during this time. On 26 September, he drank cleaning fluid in an attempt to harm himself. The man frequently expressed the desire to die.

Psychologists concluded that the man was not suffering from a mental illness but did have serious psychological problems. It was felt that he would benefit from one-to-one sessions with a psychologist on a regular basis. Lincoln does not routinely offer this service but did arrange for him to see a psychologist on five occasions.

The man appeared to be making good progress and on 28 October was moved to B wing where he shared a cell. He was subject to level two observations (five times per hour). A review of his F2052SH took place on the morning of 28 October in the HCC but it does not mention or suggest a change of location. It does mention that the man was bored and tired of living in a dirty cell. At 3.06pm it was recorded in the F2052SH that he is moved to B wing: *"says he is fine at present"*.

For the first two days on B wing it appears he did not mix much. There are many entries in the 2052SH that record him watching television, sitting on table during association, looking at the door etc. On the weekend of 30 and 31 October, it is recorded that he spent some time assisting the wing cleaners. He also had his hair cut and was interacting with other prisoners on association. Very little is recorded in the F2052A (a prisoner's history sheet) in regard to his behaviour from 28 October to 14 November, but the F2052SH does record him being out on association, exercise and assisting with wing cleaners on a regular basis.

A F2052SH case review held on 8 November recorded that he was making progress; he appeared to be at ease and was happy with his cellmate. A nurse was identified as his allocated nurse and available for him to speak to at any time. The level of observations was dropped to level one. The man commented on the review that he did not trust the Listeners and felt that they were not suitable for him. There is nothing recorded which indicates that the man presented any problems to staff whilst on B wing.

## Events from 14 November

On Sunday 14 November, the man went to collect his medication from C wing treatment room. He was on his way back to B wing when he stopped to talk to another prisoner. A wing officer, from a distance, shouted to him telling him to move on. The officer said that the man became abusive and did not in fact move on.

The wing officer approached the man and an argument ensued which was heard by a second wing officer. She approached the scene and observed the man attempt to assault the first wing officer. The alarm was raised, staff responded and restrained him using Control and Restraint techniques (C&R). He was then moved to D wing, the segregation unit. The staff nurse observed the C&R removal process, including the man's relocation into the Segregation Unit. Staff described him as being calm when located in D wing. He was taken to cell D1-003. The incident happened shortly before 4.45pm.

The staff nurse spoke to him in the segregation unit to see if he was okay. The man said he was fine and so she completed form F213 'report of injury to a prisoner' stating that the man had grazes to his right elbow and slight reddening to both wrists from the use of handcuffs. She then went on to complete the Segregation Safety Algorithm, a form that must be completed by both a medically qualified person and the duty governor in order to authorise segregation. The front page of the form is a series of tick boxes asking questions that may indicate someone is not able to undergo a period in segregation. The questions are aimed at identifying someone who is psychotic, awaiting transfer to a mental health setting, someone with a history of self harm or on an open F2052SH. This latter box was ticked 'yes', but the next question about whether the writer thinks the prisoner's mental health will deteriorate significantly if segregated, is ticked 'no'. The Algorithm therefore comes out that there were no healthcare reasons not to segregate him at that time. There is no space on the form for healthcare staff to make any comments; just tick boxes and one statement "It is my opinion that there are/are not any healthcare reasons to advise against segregation at this time". During interview, the staff nurse said she did not review the man's medical records before completing the Algorithm. She did say, however, that she knew about his history and previous self harm attempts and that he was on an open F2052SH. The staff nurse knew his level of observations would increase to five times an hour whilst in the segregation unit and also knew that, in the past the man had been in segregation and coped okay. She therefore felt that he would be able to cope with segregation this time.

The duty governor authorises segregation and is asked to complete sections C, D and E of the form. Section C asks for the duty governor's assessment, taking into account medical opinion and discussion with staff, healthcare and the prisoner. It then clearly states, "Important: A prisoner on an open F2052SH must only be located in the segregation unit in exceptional circumstances (which should be described below)..." There is a space on the form for comments. The duty governor did not record any exceptional reasons as he was required to. He did, however, explain to the investigation

team his reasons for deciding to keep the man in segregation until his adjudication the next morning. These were that he had allegedly assaulted a member of staff and had been restrained using C&R. The duty governor felt that the man was a potential risk to others. The duty governor saw that the staff nurse had completed the Safety Algorithm and had indicated there were no healthcare reasons against him remaining in segregation. He then went to talk to the man. His F2052SH record times this visit at 5.23pm. The duty governor asked the man if he was okay and said his reply was "yes" or "yeah". He then explained to the man that he would be kept in segregation overnight and that he would see the governor the following morning on adjudication. He said the man was perfectly calm and not aggressive or abusive. He said he left the cell door not having any concerns about his demeanour or behaviour.

The Safety Algorithm should be used to trigger the mental health assessment that is required by PSO 2700 (Para 4.2.1). No mental health assessment was carried out on the man by the staff nurse, nor anyone else within the medical team at Lincoln. Therefore, no resultant care plan was implemented.

It is policy at Lincoln to raise the level of observations to level two (five times per hour) for those prisoners located in the segregation unit who are on an open F2052SH. Most of the entries in the man's record are of poor quality, such as "in bed". This is repeated eight times at one point. "As above" and "no change" are also used on numerous occasions over the period when he was in segregation. The only entry in the F2052SH which indicates any real staff interaction with him is dated 16 November at 1.30pm. This states that he was banging his cell door, throwing things and was unhappy about being in the segregation unit. The prison officer recalled having a conversation with the man at this time and trying to calm him down. All other entries were pure observations and did not paint any sort of picture as to how the man was coping with segregation.

The man went before the adjudicating governor at 10.10am on Monday 15 November, charged with attempting to assault the first wing officer. Two members of the Independent Monitoring Board sat in on the adjudication as observers. The man pleaded guilty and stated that he did try to punch the officer in the chest. The man said the officer had poked him in the chest first and that this was why he had tried to punch the officer. The adjudicating governor referred the case to the independent adjudicator. He also sent a memo to the Governor informing her of the allegation the man had made and requested an investigation into the allegation. Neither member of the Independent Monitoring Board (IMB) had any problems with the way in which the man's adjudication was conducted and both felt that the man had been 'very fairly dealt with' by the adjudicating governor.

One of the IBM representatives spent some time talking to the man in his cell after the adjudication. A second prison officer was also present and agreed to collect the man's belongings for him from B wing. The IBM representative explained to the man the decision of the adjudicating governor to refer the charge to the independent adjudicator on 26 November. The man told him

that the officer he admitted hitting had provoked him by poking him in the chest with his finger. The IBM member explained to the man that he could not return to normal location and said that he seemed to settle down and was fine when he left him around 11.30am. He said the man was pleased to be getting his property from the wing. It is unclear from the interviews, F2052SH, segregation log book or police photographs whether he ever in fact received his property from B wing.

At 12pm, the adjudicating governor authorised the man to continue to be located in the segregation unit for the Good Order or Discipline of the prison. The governor said he was concerned about the allegations the man had made about being poked in the chest. He knew that the man was on an open F2052SH. No concerns had been raised by anyone with the governor and so no formal case review or further discussion with healthcare staff, the Independent Monitoring Board or segregation staff about the man remaining in segregation was deemed necessary. A doctor had seen him that morning and countersigned the Safety Algorithm conducted by the staff nurse the night before and 'fitted' him for adjudication and cellular confinement. The adjudicating governor said that the man had been very calm during the adjudication, 'He was very cool, calm and collected and I had concerns he would possibly assault another member of staff'. He said that the man was fully aware of what he had done to the first wing officer and showed no remorse for his actions during the adjudication. He told the man at the end of the adjudication that he was going to keep him in segregation on GOOD for a period of 72 hours to assess him about returning to normal location. The adjudicating governor said that no consideration was given to putting him into the Healthcare Centre at the point of him authorising GOOD. He said that neither the nurse the evening before, nor the doctor that morning, had expressed any concerns about him being in the segregation unit. Therefore, there was no justification or reasons to consider admitting him into healthcare. Admission to the Healthcare Centre is a decision that can only be made by the medical team, not the duty governor.

All of the cells in segregation are single cells. The one safer cell was already occupied by another prisoner who was also on an open F2052SH form and was a prolific self harmer. The adjudicating governor said normally in that situation an assessment would be done by the segregation senior officer as to which prisoner was thought most appropriate to go into the safer cell. The governor did not see any written assessment about this. He said he had considered the situation though and felt that because of the other prisoner's more recent and frequent self harming behaviour, that it was preferable for him to stay in the safer cell.

The regime the man was subject to was limited to the very basic entitlements all prisoners have in segregation. The man did not have a television or radio in his cell and there was little evidence of staff making many attempts to engage him in conversation. The entries in his F2052SH suggest that he did nothing but lie or sit on his bed, all day and all night. There are no entries in his F2052SH nor the Segregation Unit Log book to indicate he took a shower, exercise or made any phone calls either on the 15 or 16 November. The Log

book indicates that other prisoners did have showers, exercise and phone calls on those days. Lincoln told my investigator that consideration as to the items a prisoner should be allowed to have in his cell takes place at the first Good Order or Discipline review (due within 72 hours of segregation). These items include a radio, television and hobby materials. However, the initial authorising operational manager is required, under PSO 1700, to consider what mental health safeguarding measures are appropriate for each individual prisoner prior to their first review.

No F2052SH case review took place on 15 November as is required by Prison Service policy. Such a review would have enabled a multi-disciplinary team to look at all the issues leading up to the man's segregation, to assess him in person and to give him the opportunity to say how he felt and to decide what support he would need during his time in the unit. This review should have been carried out within 24 hours of his segregation.

There is no record of him receiving his medication for depression on 15 November, the day of the adjudication. The procedure for prisoners receiving medication when located in the segregation unit is for healthcare staff to deliver it to them in their cell. The investigation team were unable to ascertain the specific reasons why the man did not appear to have received his medication on this day. The nurse and out patient manager at Lincoln, was asked about the procedure for issuing medication to prisoners held in the segregation unit and the policy for dealing with those prisoners who refused to take prescribed medication. She stated, "the nurse in E wing pulls up the medications, puts them in a little bag and then takes them to the segregation unit and personally issues them." The policy for identifying prisoners who refuse to take essential medication is to put one of three stickers on the front of the prescription chart; this is then brought to the attention of the doctor. She stated on interview that this should have happened in the man's case and she was not sure why it did not. Segregation staff would not have been aware that the man had not received his medication.

The man had recently written to his parents and enclosed a visiting order. Visiting facilities are available every day in Lincoln. His parents had been on holiday and returned on 11 November. The content of the letter gave them cause for concern as he said he had been moved from healthcare because there was nothing else they could do for him. His mother booked a visit for Thursday 18 November. It is unlikely that he was aware of this fact as he did not telephone his parents on 15 or 16 November and the prison would not normally inform a prisoner about a forthcoming visit until the day before the visit took place.

One of the chaplains visited him in the segregation unit as part of her daily rounds during the morning of 16 November. She spoke with him at around 9am, for about ten minutes. She said that he eventually sat up in his bed and talked to her briefly. He told her he could not bear the thought of being in segregation for another 11 days. She asked him why he thought he would be in segregation for 11 days and had he asked the officers about that. The man replied that he had not and that they 'weren't bothered'. The chaplain

offered to speak to the staff about it but the man said he did not want her to. During the interview with the representative from the Independent Monitoring Board, he said that the adjudicating governor had told the man at the end of his adjudication that he would be kept in the segregation unit until the independent adjudicator came on 26 November, ie. 11 days from the date of the adjudication. The adjudicating governor said that he told the man he would be kept in the segregation unit for a period of 72 hours to assess him about returning to normal location. The man was clearly under the impression that he was to remain in segregation for 11 days. The chaplain asked whether he would like her to visit him again later in the day, but he declined. She then left his cell and continued on her segregation rounds with the other prisoners. She made an entry in the Segregation Daily Log stating ' chat 10 mins with the man ' and then left the unit. She did not speak to staff about any concerns she had, nor did she make an entry in his F2052SH record. The chaplain completed an entry about the man in the Chaplain's Journal on her return to the chaplaincy department. During interview, she was asked 'Would you make an entry (in the F2052SH) as a matter of course or only if you were concerned or something like that?'. She replied 'I think mainly only if I was concerned'.

There are no entries in his F2052SH record or Segregation Log book about him taking any exercise or a shower, or making any telephone calls that morning. The Log book indicates that other prisoners did have showers and exercise that day. Apart from an entry by medical staff about him refusing his medication at 11am, every entry states that he is sitting on or lying on his bed.

Several staff began assembling in the segregation unit on Tuesday 16 November as a meeting was scheduled to take place at 2pm. At 1.30pm, the first prison officer recorded in the F2052SH that the man was banging his cell door and throwing things around because he was unhappy about being in the unit. The officer then made the following entries in the F2052SH:

- 1.40pm "still banging and shouting"
- 1.50pm "as above".

At approximately 1.50pm, The officer went outside to have a cigarette. He then collected the cleaner and together they went to the stores to collect some items before returning to the segregation unit. He said that the visit to the stores did not take long as the items were already there waiting for him and all he had to do was sign for them. An investigation carried out by the Prison Service estimated that the walk to and from the stores would have taken no longer than three to five minutes at that time of the day. This would have put the officer back on the unit at 1.55pm or thereabouts. Although my initial information was that this walk to stores would take longer, my investigators have confirmed the Prison Service estimate. I discuss this further below.

The first prison officer then made the following two entries in the man's F2052SH record:

- 2.00pm "Quiet at present"
- 2.05pm "as above".

During the duty senior officer's interview, he stated: 'The first prison officer last saw him (the man) at 1.50pm, signed his book to that effect, then the officer took the orderly down to the stores because he had to get a kit change or we had no kit so that left me as the only actual officer on duty in there ... we got seven residents in there of which two were on level two observations so the next time I then looked at him was at quarter past. He sat on the floor with his back to the sink unit. I wasn't sure he was right, whether he was okay or whether he wasn't, I couldn't see clearly. At that moment in time the prison officer came back through the door with the orderly from the stores and I said 'Will you have a look here?'

The SO did not see the prison officer on the segregation unit between 1.50pm and 2.15pm. During this time, the officer had made two further entries in the man's F2052SH record. During a Prison Service investigation into this apparent anomaly, the prison officer said that the times of his entries would not necessarily be 'spot on' but that he would not have made an entry in the book if he had not done a check.

The adjudicating governor said during his interview that he arrived at the segregation unit around 1.50pm, saw the SO at the table at the far end, noticed that some representatives from the wings were missing and so left the unit to go up to the wings. The governor said he returned later to the segregation unit and thought he remembered seeing the first prison officer return. At that time he observed the SO walking back down from a cell, say something to the officer and the officer then looking through the man's cell.

During my initial investigation interview, the first prison officer said '... I did have to take our cleaner down to the clothing store and on my return from there the duty SO down there had asked me would I check on the man. He said he didn't look right. I didn't know what he meant by that at all.' When asked if he could recall where they were when they had this conversation he replied, 'I think I had just walked back into the office in the seg so upon that I walked down, looked through the spy hole and I could see what I thought was a shoelace around his neck and tied to the sink. With that I went to the office to get the fish knife and we went in the cell...'

The first prison officer got the fish knife (a knife used to cut through a ligature) and he and the SO opened the man's cell.

## **The prison response after finding the man**

The staff discovered a ligature made from the man's shoelaces attached to the taps on his sink. The first prison officer cut the ligature using a fish knife. A second SO then turned the man onto his back and checked for a pulse. There was none. The second SO and the first prison officer commenced Cardio Pulmonary Resuscitation (CPR), the latter giving chest compressions.

A code "one" was put out over the radio net by the adjudicating and three staff from healthcare (designated as hotel one) attended quickly and took over CPR. The prison doctor arrived shortly after with two more healthcare staff. He listened for heart sounds but there were none. He said that the man's pupils were not fixed or dilated at that point but there were no signs of life. The doctor stated on interview that, in his opinion, the man was clinically dead when he arrived, but CPR was continued with oxygen by mask. He confirmed that air was getting into both of the man's lungs. They then attached an automatic defibrillator which indicated that he was in asystole and not to shock.

Around this time, the chaplain made a retrospective additional entry in the Segregation Daily Log stating 'The man felt frustrated that he wasn't being listened too'. A representative from the Independent Monitoring Board and the first prison officer are clear that they saw the chaplain make this later additional entry. When asked during interview if this was the case, the chaplain replied, 'I can't recall. I would have thought I had written that all at the same time, I can't recall going back and making that entry but I can't be positive about that.'

The paramedics arrived at about 2.30pm and gate staff were prepared to let the ambulance in without any delay. The paramedics inserted an endotracheal tube and gave him adrenaline. The doctor gave more adrenaline intravenously and atropine. The man was then given three shocks by the automatic defibrillator which resulted in pulseless electrical activity (where the heart has electrical activity but no blood is being pumped around the body). Haemaccel was then given over the next 15 minutes and a palpable cardiac output was achieved. CPR was then stopped but oxygen was continued. The paramedics said the man's pupils were fixed and dilated.

The man was taken to Lincoln County Hospital, which is just across the road from Lincoln Prison. He was placed on a ventilator in the intensive care unit but died the following day at approximately 9.10pm.

The cell was sealed. The police had been automatically alerted when the ambulance was summoned. A hot debrief was held later that day, led by the adjudicating officer. One of the healthcare nurses said that the batteries in her radio failed but it was not felt that this had led to a delay in responding to the emergency. The medical team made considerable and sustained efforts to resuscitate the man and their efforts should be acknowledged.

The man's parents were told of what had happened by the Governor of Lincoln. She met the man's parents at the hospital. His parents were by his side in hospital when he died. One of their concerns was that he had a black eye and bruising to the hands. They understood he had been banging on his cell door, which could explain the bruised hands, but sought further information as to the cause of the black eye. The post mortem reported it as a "fresh injury".

The second SO ensured that case reviews of other prisoners on an open F2052SH were held to identify if they needed extra support. The watch on all these prisoners was increased.

The post incident care for staff was good. The first prison officer, the duty SO and the second SO Officer said that the staff care team at Lincoln had spoken to them and that a few other people had seen them to ask how they were and whether they needed to speak to anyone. The Independent Monitoring Board were also present. Some staff mentioned receiving a letter from the Staff Care and Welfare Service.

## **Issues considered during the investigation**

- The man's time in Lincoln prior to 14 November

A great deal of support was provided by the healthcare staff and the man was treated as an individual. Healthcare staff responded well, appropriately and respectfully to his needs. Wing staff were aware of his problems and encouraged him to participate in activities. It appeared that he was responding well.

On 7 June, a mental health in-reach nurse recorded that the man did not have a severe or enduring mental illness, and therefore would not be taken onto the mental health in-reach caseload. It was noted though that he would benefit from one-to-one psychological intervention. This service is not usually available at Lincoln. However, staff especially arranged for a psychologist to come into the prison and see him. The mental health nurse said that consideration should be given as to whether he could be transferred to a prison with a psychology service. There is no record of any consideration being given to a potential move except perhaps a note in his medical record on 6 August that he was not fit for transfer.

In his clinical review, the doctor said that in retrospect it seemed inevitable that the man's repeated self harming behaviour would at some point result in his death. He felt that the medical care was more than satisfactory and "could not have been more attentive".

The man progressed to normal location at the end of October. A lot of care and effort had gone into progressing him to the stage where he could cope with living on a normal wing. B wing staff spent considerable time with him. From interviews and entries in the F2052SH, it is clear that efforts were made to encourage him out of his cell to assist wing cleaners, use the gym, go out on exercise and interact with other prisoners and staff. One member of staff said, "On B wing he did approach me if he wanted something, he would always be very polite, very pleasant he would speak because he was allowed out to do extra cleaning duties." Another officer commented, "His general behaviour was fine, once or twice I got him out to help the cleaners, one day he was okay the next day he wouldn't want to do it but there was no problem with that."

It is clear from interviews that staff in healthcare and B wing were acutely aware that he was a man with specific and pressing needs and problems, and needed to be treated as such.

- The man's general management on the F2052SH system

The Safer Prisoners Committee did not discuss individual cases of prisoners on open F2052SHs at the time of the man's death. Discussing individual cases is useful: it draws attention both to the quality of entries made in the

daily observation section and to especially difficult cases and ensures they are managed appropriately. The Committee does not discuss particular individuals.

Between 18 June and 26 September, the man was found with a noose on five separate occasions, including twice where he attempted hanging. He also cut himself with blades on four occasions, as well as committing numerous other acts of self-harm. There is no evidence that any risk assessments were undertaken as to what items it was appropriate for him to have in his cell (blades, shoe laces, belts, matches, etc). Prison Service Order 2700 states that such items can be removed and returned to prisoners as long as the reasons for each decision are recorded on the F2052SH.

The man had three F2052SH case reviews on 9, 16 and 23 September. None of the reviews mentions the nooses, or discusses shoelaces, or mentions the self-harm attempts that he had made during this time period. All three support plans state 'continue ongoing support'. The level of attention and care by staff in healthcare may have been high, but this does not detract from the necessity for reviews of prisoners at risk of suicide or self harm to be more detailed, thorough and proactive.

Furthermore, no case review took place before the man was moved from healthcare to B wing on 28 October as is required by national and local policies.

**Recommendation 1 - The governor should remind all managers of their roles and responsibilities in relation to reviews of prisoners at risk of suicide and self-harm. Case reviews for prisoners must be carried out in accordance with national policy.**

It is clear from my investigation that the man was a very troubled young man. He had made many attempts at self-harm, including attempts to take his own life during his time at Lincoln. I am in agreement with the clinical review that healthcare staff managed the man well and compassionately. It was clear from interviews that many staff invested a lot of time and care in him to help him to cope with his situation and attempts at self-harm. This is shown by the fact that the prison medical officer had assessed him on 48 separate days between April and November 2004. (A man of his age in the general population would, on average, be expected to see his general practitioner on no more than one or two occasions in this time period.) The man was seen by a consultant psychiatrist on five occasions, and had also been assessed by the mental health in-reach team. However, I share the clinical reviewer's concerns at the lack of psychology input at Lincoln.

The National Institute for Clinical Excellence clinical guideline on the management of self-harm was published in July 2004 and the clinical reviewer concluded that it should be implemented at Lincoln. I endorse the recommendation made by him:

**Recommendation 2 - I recommend that West Lincolnshire Primary Care Trust and HMP Lincoln review the clinical guideline on the management of self-harm published by the National Institute for Clinical Excellence, and produce an action plan to implement this guideline within HMP Lincoln, as far as is possible within the prison setting, and as quickly as practicable.**

- The decision to segregate the man on 14 November

The duty governor authorised his initial segregation shortly after 5pm on Sunday 14 November. He authorised segregation overnight until adjudication the next morning. Several forms must be completed in order to authorise segregation, the most important of which is the Segregation Safety Algorithm. Part A of the form is completed by a qualified member of the healthcare team and indicates if there are healthcare reasons against segregation. The rest of the form is completed by the operational manager authorising segregation.

The Algorithm was developed in order that medical staff and prison managers would give very careful consideration to placing certain vulnerable prisoners into segregation. The man was exactly the sort of prisoner to whom PSO 1700 seeks to alert healthcare and prison governors when making decisions about segregation.

The staff nurse spoke to the man in the segregation unit to see if he was okay after being removed under C&R. She then went on to complete the medical section of the Segregation Safety Algorithm. She correctly ticked 'yes' to the question about whether he had a history of self harm, was on an open F2052SH or taking anti-psychotic medication. The follow up question about whether she thought the man's mental health would deteriorate significantly if segregated, was ticked 'no'. The Algorithm therefore indicated there were no healthcare reasons against segregation at that time. The staff nurse said she did not review his medical records before completing the Algorithm but that she knew about his history and previous self harm attempts and the fact he was on an open F2052SH. The nurse knew his level of observations would increase to five times an hour and also knew that, in the past, the man had been in segregation and coped okay. She therefore felt that he would be able to cope with segregation this time.

The duty governor authorising segregation is then asked to complete sections C, D and E of the form. Section C asks for the duty governor's assessment, taking into account medical opinion and discussion with staff, healthcare and the prisoner. It then clearly states, "Important: A prisoner on an open F2052SH must only be located in the segregation unit in exceptional circumstances (which should be described below)..." The duty governor did not record these exceptional reasons as he was required to. He was, however, able to explain his reasons for deciding to keep him in segregation until his adjudication the next morning. These were that the man had allegedly assaulted a member of staff and had been restrained using C&R. The duty governor felt that the man was a potential risk to others.

The duty governor took into account the nurse's view as to the man's suitability to remain in segregation and then went to talk to him himself. He said the man told him he was okay and that he explained to him he would be kept in segregation overnight. The governor said he left the cell door not having any concerns about the man's demeanour or behaviour.

I think the decision of the duty governor to keep the man in segregation overnight on Sunday 14 November was reasonable. However, the governor did not complete part C of the Safety Algorithm where he was required to describe the exceptional circumstances justifying why a person on an open F2052SH was being held in segregation.

Given my concern that the Safety Algorithm had not been properly completed, the investigation team examined others to ascertain whether this was a problem in the man's case alone or more widespread. We found other instances where the prisoner was subject to an open F2052SH and part C of the Algorithm had not been completed. Of 13 forms that were examined, nine were completed to an acceptable standard. This issue was examined further by the Prison Service. They concluded that the instructions relating to the completion of safety algorithms were ambiguous, and guidance for their completion should be issued.

**Recommendation 3 – The governor should ensure all operational managers who perform the task of duty governor are reminded about completing segregation safety algorithms in a full and comprehensive manner, giving reasons for their decisions and listing support measures put in place.**

- The man's adjudication on 15 November

At the man's adjudication on the morning of 15 November, the main person involved in the alleged assault, the first wing officer, was not present due to being on sick leave as a result of the incident with the man. Nor had the wing officer completed an incident report from the day before. The adjudicating governor asked the man what had happened. The man replied, 'I was talking to someone on C wing, the wing officer told me to go back to my cell. I was not ready. So I told him to fuck off. He then obstructed my conversation. I knew I was going to get a kicking so I don't know why he got in my way. He was also poking me in the chest. That was why I swung a punch at him. I think I hit him in the chest.'

The Prison Discipline Manual states in relation to allegations against staff made before or at an adjudication that, where the allegation appears too weighty or complicated to be investigated adequately during the hearing, the adjudicator should open but adjourn the proceedings to allow for a full investigation to take place separately.

The adjudicating governor wrote to the in charge governor later that day and asked for the allegation of assault by the officer on the man to be investigated.

In strict accordance with the Discipline Manual, the adjudication should have been adjourned pending these further enquiries and not remanded for the Independent Adjudicator. The adjudicating officer said that the Independent Adjudicator requested that any investigations necessary are carried out prior to him hearing the case. The adjudicating governor said he was confident that the investigation into the man's allegation against the officer would have been completed by 26 November, the date that the Independent Adjudicator was next due in the prison.

- The decision to segregate the man on 15 November

Prison Service Order 2700 paragraph 4.1.2.1 states, 'Prisoners who are at risk of suicide or self-harm must not be routinely held in the segregation unit under Rule 45 GOOD (YOI Rule 49) unless, exceptionally, *they are such a risk to themselves or others that no other suitable location is appropriate. Such prisoners must only be placed in a segregation unit in exceptional circumstances, or where all other options have been tried, but considered inappropriate* and only where it is possible to provide the degree of continual care identified as necessary in the prisoner's care plan. A case review must be held as soon as possible to take account of events leading up to the decision to segregate. If the decision is taken to locate prisoners at risk of self-harm within the segregation unit this must be for as short a period of time as possible, and the temporary nature of this must be reflected in the care plan.'

In justifying his decision to put the man in the segregation unit for reasons of Good Order or Discipline, the adjudicating governor described the man as 'cool, calm and collected' during his adjudication. He said that the man showed no remorse for his actions and gave him 'the impression he would do it again, given the opportunity'. He went on to explain that no segregation staff, members of the Independent Monitoring Board or medical staff (including the doctor), had indicated any concerns with the man remaining in segregation.

The man had not been on adjudication before for assaulting a member of staff or another prisoner. However, he had been violent with his possessions and damaged items in his cell. The Independent Monitoring Board members who observed his adjudication said that the man was calm and not threatening during the adjudication, but felt that they could not say whether the incident with the officer was 'out of character' for him.

The wing report prepared for the adjudication described the man as a 'quiet and inward person' who 'spends most of his time in his cell, keeps himself to himself'. However, this wing report was not seen by the adjudicating governor as it is only read out at the end of an adjudication, once a decision as to guilt or innocence has been made. Nor did the governor know about the man's previous adjudication history, and therefore whether he had been found guilty before of assaulting a member of staff.

The first wing officer had gone off sick and so would not be on B wing, were the man to have been returned there. However, it was not known how long the officer would be off work and the adjudicating officer said he could have returned to work the following day. He expressed concern about the man being put back on B wing in case the first wing officer came back to work.

The adjudicating governor desire to ensure order and control in the prison and to keep troublesome prisoners away from the main residential units is not to be criticised. I accept that no members of medical, segregation or other staff expressed any concerns to him about the man remaining in segregation and I understand his decision to keep the man there. However, PSO 2700 lays out specifically that prisoners on an open F2052SH should only be held in segregation under exceptional circumstances and where no other accommodation is deemed suitable or where other options have been tried and failed. The man was a very vulnerable man with a history of self harm and suicide attempts and was on an open F2052SH.

My own view is that, in this difficult situation, the adjudicating governor should have made a formal approach to both medical and relevant discipline staff and explored more rigorously the options of placing the man into healthcare or back on a normal residential wing. He could then have been in a position to document the reasons why neither of those options were suitable at that time and therefore why the decision to keep the man in segregation was the only remaining and appropriate one. Such an approach would have followed more closely, the guidance in PSO 2700.

- The failure to carry out a self harm case review in the segregation unit

The Segregation Safety Algorithm indicates in Part D that a full case review must be carried out for prisoners on an open F2052SH who are put into the segregation unit. PSO 2700 states that 'a case review must be held as soon as possible to take account of events leading up to the decision to segregate'. PSO 1700 further defines that this F2052SH case review must take place within 24 hours of the segregation decision.

Lincoln's local policy states that case reviews of a prisoner subject to a F2052SH must be conducted if a prisoner is located in the segregation unit on GOOD and that they must be chaired by a manager of the unit. Normally this is the senior officer in charge on that day. The policy does not specify a timescale.

No F2052SH review took place on him throughout his period in segregation. The 24 hour time limit imposed by PSO 1700 expired at 5pm on 15 November. I am extremely concerned that a case review did not take place, as it would have provided an opportunity to consider the man's needs carefully and thoughtfully. A multi-disciplinary team of staff would have sat down with him and considered the reasons leading up to him being in segregation, and what measures they could put in place to support him whilst he was in the unit.

The duty governor authorised the man's segregation at 5pm on 14 November. That day was a Sunday and at that time the main shift was ending and most staff would be going off duty. A full review should have involved himself as chair, medical staff, probation staff, the chaplain, a wing manager and the man. I do not think that it would have been reasonable for the duty governor to convene a full case review at that time on a Sunday. He should, however, have made it clear to segregation staff that a case review would need to be carried out the next day if the man remained in segregation. This could have been done verbally or by an entry in the segregation handover book.

The man's adjudication took place at 10.10am on 15 November. At the end of this adjudication, the adjudication governor told the man that he was keeping him in segregation under Prison Rule 45 – Good Order or Discipline. The form informing the man of this decision was signed by the adjudicating governor at 12pm. There were still five hours in which an F2052SH case review could have been held.

The adjudicating governor said that normal practice is for the senior officer in the segregation unit to co-ordinate and manage the F2052SH reviews. He said that, although staff told him the man was on an open F2052SH, he had not been told about the lack of a case review. He did not check the man's F2052SH booklet personally. He went on to say that his 'expectancy and assumption' was that it would and should have been completed when the man was put into segregation on 14 November. The adjudicating officer said that two more junior managers, the second SO and a principal officer (PO), also visited the segregation unit and that part of their role was to check entries and reviews in the F2052SH forms. Neither of these managers brought to his attention the lack of an F2052SH case review for the man. It is not clear from the interview with the second SO that he knew the Prison Service policy relating to holding a case review within 24 hours of segregation. He did not make specific reference to it when asked 'Are there any other sort of specifics that relate to prisoners on a F2052SH in terms of reviews or risk assessments?' nor when asked 'Would you do a review for somebody being located in there (segregation) as a matter of procedure or not?' There is only one entry in the man's F2052SH record that the second SO made (at 8.40am on 15 November). It is unclear whether he actually spoke to the man. The PO signed as having completed a manager's check on the man's F2052SH daily entries at 9.45am on 15 November and 8.20am the next morning, but she did not speak with the man. She did not raise the issue about the lack of a case review with anyone.

It would appear that several staff may have failed in both their awareness of the requirement for a case review and in bringing it about. The ultimate responsibility for having systems and procedures in place that ensure segregation rules, including F2052SH case reviews, are carried out appropriately, rests with the manager in overall charge of the segregation unit, the adjudicating governor. During a follow up discussion with him, he said he was confident at that time that the staff in the segregation unit had been appropriately trained and were aware of the various procedures that applied to

prisoners held in segregation units. He said the officers in the unit between 14 and 16 November were regular segregation staff. When asked what sort of training new staff to the unit received, he said that an informal induction was in place during that time. This included sessions on segregation regimes, reading the Prison Discipline Manual (about adjudications), reading PSO 1700 (on segregation) and PSO 1600 (on use of force). He said there was a printed copy of PSO 1700 in the segregation unit that staff could refer to at any time. The adjudicating governor went on to say he was confident that his senior officers in the unit knew the '24 hour rule' in regard to holding F2052SH case reviews and that the 'back up' would have been the second SO, the suicide and self harm co-ordinator.

The fact remains, that no F2052SH case review was carried out to assess the man and his situation within 24 hours of him being placed in the segregation unit, nor at any other time prior to his death. The adjudicating governor's confidence in his staff and more junior managers seems to have been misplaced.

**Recommendation 4 – The governor should remind all staff and managers who work in the segregation unit of the requirement to carry out an F2052SH case review within 24 hours of the decision to segregate. Lincoln's local policy should be amended to reflect this national requirement and procedures and management checks put in place to ensure that reviews are carried out when they become due.**

- The failure to carry out other assessments in segregation – mental health, safer cell, furniture assessment.

#### ***Mental health assessment***

The Segregation Safety Algorithm states clearly in Part C that a mental health assessment must be carried out when a person on an open F2052SH is put into segregation. Prison Service Order 2700 states at paragraph 4.1.2.2:

“A mental health assessment must be undertaken by health care staff of all prisoners at risk of suicide or self harm who are placed in the segregation unit, and the reviewed care plan implemented. The European Court has ruled that failure to follow such procedures for prisoners suffering from a mental disorder can constitute a breach of Article 3 (cruel and inhumane treatment). The decision to segregate must also be reviewed by healthcare staff.”

No mental health assessment was carried out. Consequently, no care plan was written detailing how the man would be supported during his time in segregation. This was a serious failing by the healthcare team.

The failure to carry out either an F2052SH case review or a mental health assessment (with the resultant care plan) is very significant. It meant that the two fundamental measures adopted by the Prison Service in its national policy for the care of those at risk of suicide or self harm in the segregation unit were

not followed through for the man and that therefore his needs were not properly considered.

**Recommendation 5 – The governor and PCT should issue joint guidance to the head of healthcare and medical staff at Lincoln reminding them of the requirement to conduct a mental health assessment and care plan for all prisoners subject to an F2052SH who are located in the segregation unit.**

### ***Safer Cell Assessment***

The segregation unit was dated and cramped. The cell doors in D wing offer poor observation for staff.

The man was put into a single cell in the segregation unit, D1-003. This cell can only be described as depressing. It had a poor quality of fixtures and fittings. The small cell window was high up and allowed only limited natural light. It offered no opportunity for a person to see through it, potentially increasing the sense of isolation. The man's cell was dirty and untidy, although this could have been because he chose not to clean it.

**Recommendation 6 – The governor should give urgent consideration to the refurbishment of D wing, with particular attention to the cell doors, windows, fixtures and fittings and in-cell electricity.**

*The Governor responded to this recommendation on seeing my report in draft by stating that she had prepared a Business Case to upgrade the segregation unit in December 2004. The proposal included plans to improve the drainage, cell doors and windows.*

The segregation unit at Lincoln does have one safer cell. This was already occupied at the time of the man's death by another prisoner on an open F2052SH. The adjudicating officer said in that situation an assessment would normally be done by the segregation senior officer as to which prisoner was thought most appropriate to go into the safer cell. The adjudicating governor said that he 'assumed' one had been done and that he did not do one on 15 November.

The adjudicating governor did not see any written assessment in regard to the man about this and none was given to my investigators. There were no entries in the man's F2052SH to indicate that any consideration had been given as to which cell he should have in the segregation unit. The adjudicating governor said he did consider the situation though and felt that, because of the other prisoner's more recent and frequent self harming behaviour, it was preferable for him to stay in the safer cell.

**Recommendation 7 – The governor should remind all staff who authorise segregation to assess which person in the unit would be most appropriately located in the safer cell. The factors considered and the decision made, should be recorded in writing.**

## ***Furniture assessment***

PSO 1700 states that, “A restriction of normal facilities (e.g. substituting cell furniture with cardboard furniture/ not allowing a prisoner a lighter or matches for cigarettes) must be supported by a risk assessment that clearly states why the restriction is being placed on that prisoner and how often the assessment will be reviewed.”

Police photographs show that the man had cardboard furniture in his cell. Lincoln has its own local policy regarding assessments as to whether prisoners should have ordinary wooden furniture in their cells or cardboard furniture. The adjudicating governor said that this assessment would normally be done when someone was put into segregation. No furniture risk assessment was completed when the man was put into the segregation unit. The in charge governor told my investigators that the man was given cardboard furniture simply because there was no wooden furniture available at the time of his segregation. This was due to a number of incidents in the unit in which prisoners had broken up their wooden cell furniture.

- **The segregation regime**

In the ‘initial segregation’ section of PSO 1700, there is a specific instruction that states “measures are put in place to safeguard the mental health of prisoners who are kept in segregation”. The section entitled ‘Promoting and Safeguarding the Mental Health of Prisoners Held in Segregation Units’ lists a number of measures that can be implemented in order to try to safeguard a person’s mental well being. It states that difficult cases should be managed by way of a case conference involving the governor, doctor, nurse and other relevant people. The practical measures listed include increased medical support, increased staff observations, providing Listeners, Samaritan phones, encouragement to keep in touch with their friends and family via visits, letters or phone calls, periods of exercise or fresh air, ways to relax such as listening to the radio, watching TV, reading newspapers or books, in-cell education or hobbies and talking to people (chaplain, segregation staff, mental health in-reach).

The second section of part C of the Segregation Safety Algorithm asks what specific measures are being put in place to safeguard the mental health of the prisoner prior their first review of segregation. This section of the form is blank. During the investigation, the duty governor said that he knew the level of observations on the man would be increased to five times an hour (level two obs) in accordance with Lincoln’s own policy about prisoners held in the segregation unit when they are on an open F2052SH. The duty governor also said that the man would have had access to a Listener or a Samaritans phone if he had asked, and that he would be seen by the doctor the following morning. The duty governor should have listed these measures on the Safety Algorithm so that staff were also aware that consideration had been given to supporting the man during his time in segregation.

I am concerned that the man was further segregated the next day by the adjudicating governor whilst on an open F2052SH and made subject to a very limited regime that involved long periods of being locked in his cell with nothing to occupy his mind. The man was not in the segregation unit as any form of punishment. It is clear from the entries in his F2052SH that he did nothing during his days or nights in segregation except sit or lie on his bed. He did not take a shower, exercise, make any telephone calls, read anything or write anything. Nor are there any entries indicating that segregation staff encouraged him to do so or even tried to engage in conversation with him. The man would have had access to a Listener or the Samaritans phone, but he did not ask for either.

Although the list of what the man could have in segregation included a "battery operated radio", he did not own such a radio. There were some in the segregation unit, but apparently these would only have been issued to him following his first GOOD review board (after three days in the unit) and would have been dependent on his behaviour. This is contrary to PSO 1700 which clearly asks operational managers to consider what things should be put in place to help someone cope with segregation at the Safety Algorithm stage, ie. at the time of initial sign up. The PSO does not say to limit the regime pending the outcome of the first review board. The man should have been given access to things that might have helped to occupy his mind such as newspapers, magazines, in-cell hobbies, a radio or television.

Careful thought should be given to the segregation regime to which prisoners on an open F2052SH are subject, particularly when they are also known to have mental health problems. I do not think that the letter or spirit of PSO 1700 on safeguarding a person's mental health was given due consideration by either authorising operational manager.

**Recommendation 8 – The governor should remind all operational managers of the section on safeguarding a prisoner's mental health in PSO 1700 and of the need to assess carefully what facilities and regime a prisoner in segregation should have access to. Their decisions should be recorded clearly and be accessible for segregation staff to see and implement.**

*Commenting on my draft report, the Governor responded to this recommendation by stating that changes were made to the segregation unit routines in January 2005.*

Whilst PSO 2700 does not advocate the automatic removal of items such as shoelaces, razors and belts from a prisoner thought to be at risk of self harm or suicide, it does state that items can be removed if there is justification for doing so and that these reasons are recorded. In the man's case, his previous known history of attempted hanging using shoelaces might have led to a decision to remove shoelaces from his possession for a short time prior to reviewing the situation.

**Recommendation 9 – The governor should remind all operational managers that PSO 2700 does permit the justified and explained removal of certain possessions that might be used by someone to commit an act of self harm or suicide for a limited time period. Operational managers authorising segregation of prisoners who are on open F2052SH / ACCT forms may wish to give consideration to the option of removing certain items.**

- Day to day management of the segregation unit

The segregation unit profile requires a senior officer and three officers to be on duty in the morning and afternoon and one officer during the evening. Officers are detailed from the B and D wing (segregation unit) pool of staff and the senior officer is detailed from the residential group of senior officers. PSO 1700 does not specify that staff working in segregation units must be part of a dedicated group. But the PSO does require certain criteria and training.

The situation in regard to the day to day running of the unit is of concern as there appeared to be little continuity or ownership amongst the officer or senior officer pool of staff. Any of the 11 residential senior officers could be detailed to work in the segregation unit on a daily basis. It is not surprising, therefore, that some segregation specific procedures such as F2052SH case reviews, furniture assessments and safer cell assessments had not been carried out.

**Recommendation 10 – The governor should consider establishing a dedicated group of senior officers to work on D wing who could be trained in the specific procedures that apply to the care of prisoners in segregation.**

*After seeing an earlier draft report, the Governor responded by stating that the segregation unit is now primarily managed by one of two senior officers. There is now far more consistent first line management of the unit.*

- The man's missed medication whilst in segregation

The man was on anti-psychotic medication but missed a number of doses, in particular in the days leading up to his death. There are no entries in his medical records or F2052SH to indicate whether he took any medication on 15 November. An entry on 16 November in his F2052SH records that he refused his medication at 11am.

Whilst I understand that he could not be forced to take medication, it is of concern that he missed doses and that I cannot ascertain what occurred with regard to his medication on 15 November. The clinical review indicates that missing anti-psychotic medication is significant for three reasons:

- 1) It is potentially harmful to stop some of these drugs suddenly. This includes venlafaxine, which the man was taking.
- 2) Refusal of medication may be an indicator of worsening mental state: lack of insight leads to patients feeling that they no longer need to take their medication.
- 3) If patients stop taking medication, their mental state can be expected to deteriorate.

I endorse the following recommendation from the clinical review:

**Recommendation 11 - Where a prisoner is on anti-psychotic medication and they refuse to take this medication, it should be reported to the medical officer, and recorded within both the nursing and medical case notes. The medical officer should state within the medical case notes what action they propose to take.**

- The last entries in the F2052SH record

The last five entries made in the man's F2052SH record by the first prison officer are as follows:

- 1.40pm 'still banging and shouting'
- 1.50pm 'as above'
- 2.00pm 'Quiet at present'
- 2.05pm 'as above'
- 2.15pm 'found with a ligature around his neck'.

From my initial investigation and interviews carried out during that time, both the duty SO and the adjudicating governor gave an account of events that seemed to suggest that the prison officer left the segregation unit with the cleaner to go to the stores around 1.50pm and returned very shortly before the SO asked him to check on the man because he was concerned about what he saw. The investigation identified this latter time to be around 2.15pm, the time at which the man was discovered hanging. My initial interview with the prison officer did not contradict this version of events. The officer said '... I did have to take our cleaner down to the clothing store and on my return from there the SO down there had asked me would I check on the man. He said he didn't look right. I didn't know what he meant by that at all.' When asked if he could recall where they were when they had this conversation he replied, 'I think I had just walked back into the office in the seg so upon that I walked down, looked through the spy hole and I could see what I thought was a shoelace around his neck and tied to the sink. With that I went to the office to get the fish knife and we went in the cell...'

As part of my original investigation, I asked a member of the Independent Monitoring Board at Lincoln to walk the route from the segregation unit to the stores and back again. They timed this walk to take between 15 and 20 minutes.

I asked the Prison Service Area Manager to investigate this issue under the Code of Conduct and Discipline as I was concerned that the first prison officer appeared to have made F2052SH entries about the man during times when he could not in fact have been in the segregation unit.

The Prison Service investigation estimated that the walk to and from the stores would have taken no longer than three to five minutes at that time of day. My investigators have since confirmed this. I accept that my original indication of the time it would take to make this journey was incorrect.

If the prison officer had left the unit at 1.50pm, this could have placed him back in the segregation unit at 1.55pm or thereabouts. When asked about the two entries between 1.50pm and 2.15pm, the prison officer said, 'I honestly can't specifically remember. I probably made an entry, then went out for a fag, then would have gone to the stores, making another check and entry on the way out. I would not have made an entry in the book if I hadn't done a check.' He also said that the times would not necessarily have been 'spot on' and that they were approximate. Thus, if the prison officer had left the unit for the stores at 1.50pm, he could have returned in time to make the entries at both 2pm and 2.05pm. However, this would not tie in with the original interviews with the second SO or the adjudicating governor, nor indeed the prison officer's own original investigation interview. These all indicate that the duty SO asked the prison officer to check on the man as he returned to the segregation unit from the stores. The time of this check was 2.15pm, when the man was discovered with a ligature.

There is no suggestion in any of the original three interviews that the prison officer had already returned to the segregation unit some 20 minutes earlier and had conducted two further checks on the man. When re-interviewed as part of the Prison Service investigation into these issues, the duty SO said that he had seen the prison officer walk from the office area of the segregation unit into the cells area at 2.15pm but was unsure whether prison officer had just returned to the segregation unit at this time. He said he 'assumed' the prison officer had just returned from the stores, but went on to say that the officer might have been back on the unit, but within the office area, for some time. The suggestion that the prison officer had been in the office area, unseen by the SO for 20 minutes and yet doing two checks of the man in the cells area of the unit seems unlikely to me. The segregation unit at Lincoln is small. The Prison officer does not put forward such a version of events during either of his two interviews, but states that he 'honestly can't remember' and that he can 'only go on the book as a reminder'.

One way in which the various accounts and timings can make sense is if the prison officer left the segregation unit to go to the stores much later than 1.50pm; in effect, after his check at 2.05pm. This would tie in with a return to the unit shortly before 2.15pm and with the fact that both the adjudicating governor and the duty SO recalled seeing the prison officer arriving on the unit and him being asked almost at once to check on the man. Only the duty SO's initial interview stated the time the prison officer left the unit to be 1.50pm.

The adjudicating governor was in the segregation unit at 1.50pm but did not say during his interview whether he saw the prison officer at this time or not – he only talked about the officer's return to the unit around 2.15pm. The adjudicating officer was not re-interviewed by the Prison Service investigation team to ask whether he remembered seeing the prison officer at his 1.50pm visit to the unit. The prison officer did not give a time for leaving the segregation unit during his initial interview nor during the Prison Service investigation interview. The duty SO said during his second interview (in connection with the Prison Service investigation) that he recalled the prison officer leaving the unit to go to the stores, that he could not be exact about the time, but accepted it was approximately 1.50pm, in line with his original statement.

I conclude that the most plausible explanation, given the differing accounts of all three staff, and given the prison officer's assertion that he would not have made an entry in the F2052SH record if he had not done a check, is that if he actually left the segregation unit to go to the stores shortly after 2.05pm, returning just before 2.15pm.

- The actions of the chaplain

Around 9am on 16 November, the chaplain went to the segregation unit as part of her normal 'rounds'. A chaplain must speak to all prisoners in the segregation unit on a daily basis. She said that the man eventually sat up in his bed and talked to her briefly. She spoke with him and he told her that he 'couldn't bear the thought of being down there for another 11 days'. She asked him why he thought he would be in segregation for 11 days and had he asked the officers about that. The man replied that he had not and that they 'weren't bothered'. She said she did not pay particular attention to that comment, as it could have been a throw away remark. The chaplain asked him whether he wanted her to speak to the staff on his behalf. The man said he did not want her to and declined her offer of a further visit later in the day. She told my investigators that she felt that was as far as she could go and that she could not force him 'to do or say anymore'. The chaplain went on to finish her segregation rounds with the other prisoners.

She made an entry in the Segregation Daily Log stating 'Revd chat 10 mins with the man ' and then left the unit. She did not speak to staff about any concerns she had, nor did she make an entry in the man's F2052SH record, although she was aware that he was classed as being at risk of suicide or self harm. During interview, she was asked 'Would you make an entry (in the F2052SH) as a matter of course or only if you were concerned or something like that?' She replied, 'I think mainly only if I was concerned'. This answer implies that the chaplain was not especially concerned about the man following her conversation with him.

The chaplain completed an entry about the man in the Chaplain's Journal on her return to the chaplaincy department.

The chaplain was in the segregation unit for the meeting that was due to start at 2pm. Whilst the man was being resuscitated by staff, she made a retrospective additional entry in the Segregation Daily Log stating 'the man felt frustrated that he wasn't being listened too'. Both the representative from the Independent Monitoring Board and the prison officer are clear that they saw the chaplain make this later additional entry. When asked during interview if this was the case, she replied, 'I can't recall. I would have thought I had written that all at the same time, I can't recall going back and making that entry but I can't be positive about that.'

I am unclear why the chaplain felt the need to write the additional comments about the man. If she was worried or concerned about him following her discussion with him that morning, she should have told staff of her concerns and made an entry in his F2052SH book and in the Segregation Daily Log. If she did not have concerns about him then I am uncertain why she felt the need to write retrospectively that the man felt frustrated at not being listened to by staff after he had been found and was being resuscitated. Either way, I find her actions inappropriate. If she was worried, she should have told staff and documented her concerns. If she was not worried, it is unclear why she made a later entry in the segregation paperwork.

**Recommendation 12: The governor should provide written advice and guidance to the chaplain, reminding her of her responsibility to raise any concerns she has about particular prisoners with staff at the time of her visit and to make appropriate contemporaneous notes about her visits in documents such as the Segregation Daily Log, prisoner history files and F2052SH records.**

- The man's injuries found at his post mortem

The man's parents were understandably concerned that, when they saw him in the hospital on 17 November, he had a black eye. The post mortem describes the bruising around his eye as a "fresh injury". My investigation team contacted the pathologist. He explained that a fresh injury meant that he believed it to have occurred up to 48 hours before the man's death. The injury could have been caused in a number of ways and, without more information, he could not conclude how the injury had occurred. However, he said it could have been caused by the man head butting a wall. We know that very shortly before he was found with the noose around his neck he had been shouting, banging his cell and throwing things, so it could have been caused at this time. The investigation team returned to Lincoln and asked staff from B and D wing if they remembered the man with a black eye. No-one recalled seeing him with a black eye. The staff nurse did not record that the man had a black eye when she assessed him after he had been taken to the segregation unit using C&R on 14 November, and the doctor did not make any note of such an injury when he saw him the next morning.

The pathologist recalled how he made handwritten notes from a discussion with the detective sergeant prior to conducting the post mortem. The DS had

reported that when the man was taken to the segregation unit he had said, “I want to die”. The pathologist was quite clear that this is what he had been told. However, it appears that this was an error. The senior investigating officer for the police reported they had not been told this by Prison Service staff and it was not in any of their statements.

## List of Recommendations

### Local

**Recommendation 1** - The governor should remind all managers of their roles and responsibilities in relation to reviews of prisoners at risk of suicide and self-harm. Case reviews for prisoners must be carried out in accordance with national policy.

**Recommendation 3** – The governor should ensure all operational managers who perform the task of duty governor are reminded about completing segregation safety algorithms in a full and comprehensive manner, giving reasons for their decisions and listing support measures put in place.

**Recommendation 4** – The governor should remind all staff and managers who work in the segregation unit of the requirement to carry out an F2052SH case review within 24 hours of the decision to segregate. Lincoln's local policy should be amended to reflect this national requirement and procedures and management checks put in place to ensure that reviews are carried out when they become due.

**Recommendation 6** – The governor should give urgent consideration to the refurbishment of D wing, with particular attention to the cell doors, windows, fixtures and fittings and in-cell electricity.

**Recommendation 7** – The governor should remind all staff who authorise segregation to assess which person in the unit would be most appropriately located in the safer cell. The factors considered and the decision made, should be recorded in writing.

**Recommendation 8** – The governor should remind all operational managers of the section on safeguarding a prisoner's mental health in PSO 1700 and of the need to assess carefully what facilities and regime a prisoner in segregation should have access to. Their decisions should be recorded clearly and be accessible for segregation staff to see and implement.

**Recommendation 9** – The governor should remind all operational managers that PSO 2700 does permit the justified and explained removal of certain possessions that might be used by someone to commit an act of self harm or suicide for a limited time period. Operational managers authorising segregation of prisoners who are on open F2052SH / ACCT forms may wish to give consideration to the option of removing certain items.

**Recommendation 10** – The governor should consider establishing a dedicated group of senior officers to work on D wing who could be trained in the specific procedures that apply to the care of prisoners in segregation.

**Recommendation 12:** The governor should provide written advice and guidance to the chaplain, reminding her of her responsibility to raise any

concerns she has about particular prisoners with staff at the time of her visit and to make appropriate contemporaneous notes about her visits in documents such as the Segregation Daily Log, prisoner history files and F2052SH records.

### Medical

**Recommendation 2** – I recommend that West Lincolnshire Primary Care Trust and HMP Lincoln review the clinical guideline on the management of self-harm published by the National Institute for Clinical Excellence, and produce an action plan to implement this guideline within HMP Lincoln, as far as is possible within the prison setting, and as quickly as practicable.

**Recommendation 5** – The governor and PCT should issue joint guidance to the head of healthcare and medical staff at Lincoln reminding them of the requirement to conduct a mental health assessment and care plan for all prisoners subject to an F2052SH who are located in the segregation unit.

**Recommendation 11** - Where a prisoner is on anti-psychotic medication and they refuse to take this medication, it should be reported to the medical officer, and recorded within both the nursing and medical case notes. The medical officer should state within the medical case notes what action they propose to take.

*West Lincolnshire Primary Care Trust had undertaken an internal review based upon these recommendations. Progress will be monitored through the West Lincolnshire Primary Care Trust clinical governance team.*