Investigation into the circumstances surrounding the death of a prisoner at HMP Lincoln on 12 May 2006

Report by the Prisons and Probation Ombudsman for England and Wales

September 2007

This is the report of an investigation into the death of a man who was found hanging in his cell at HMP Lincoln on 12 May 2006. Despite valiant efforts by prison staff to save his life, he was pronounced dead shortly after arrival at hospital. He was 30 years of age.

I would like to extend my own and my colleagues' sincere condolences to the man's family and to all those affected by his death.

The investigation was carried out on my behalf by two investigators from my office. A clinical review of the man's death was conducted by a doctor from the West Lincolnshire Primary Care Trust. I am most grateful to the Governor and staff at Lincoln for their co-operation and assistance during my investigation.

This report, as are so many from my office, is focused on the death of a young man with a history of mental ill health and substance misuse. During his time in prison, the man was moved from one establishment to another, often spending only days in one jail before being moved on to another. Consequently, no proper assessment of his needs could be made. Treatment such as this is often detrimental to those with mental health problems. I draw attention to my concern that some of the establishments where the man was located were either unaware of, or unable to help with, his problems.

As is the case in a significant proportion of the apparently self-inflicted deaths I investigate, the man who is the subject of this investigation had reported auditory hallucinations.

There was a failure to recognise the man's self-harm status when he was received at Lincoln, and I also criticise the apparent use of a Post-it note (now missing) to record important security information.

Nevertheless, my report concludes that the man was generally well treated during his time at Lincoln. The clinical reviewer reports that the man had been assessed thoroughly and frequently by appropriately qualified and competent staff at the prison. He concludes that the man's death could not have been foreseen or prevented.

My report includes a number of recommendations about processes that had no direct bearing upon the man's death but which could be improved.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2007**

CONTENTS

Summary	4
The Investigation Process	6
Background	7
HMP Lincoln	8
Key Findings	9
Issues	23
Recommendations	27

SUMMARY

On 8 September 2005, the man who is the subject of this investigation was sent to HMP Highdown on remand, having been arrested for assault. Staff at Highdown noted that the man had a history of psychiatric problems, and had previously attempted to take a drug overdose, but had no thoughts of self harm.

Several weeks later, on 21 October, the man was transferred to HMP Lewes, and then a week later he was moved to HMP Belmarsh where he remained until 7 December, when he was sent back to Lewes. At Lewes Crown Court on 7 December 2005, the man was sentenced to twelve months in prison with a two year extended licence.

On 19 December 2005, the man was moved to HMP Wandsworth. A risk assessment recorded no concerns with regard to his mental health. However, as a consequence of staff concerns, an Assessment, Care in Custody and Teamwork Care Plan (ACCT) was opened on 11 January 2006. It was closed the following day. (The ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give him support and help him through a period of crisis.)

On 16 January, the man was transferred to HMP Edmunds Hill. During the reception process it was recorded that he had mental health needs and heard voices in his head. However, it was noted that he had no thoughts of self harming.

On 13 February, the man attempted to hang himself with his stereo lead. As a consequence, an F2052SH was opened by staff at the prison. (An F2052SH was a document used to assess and observe prisoners at risk of self harm. It has since been replaced by the ACCT process but was in use at Edmunds Hill and many other prisons at the time.) He was placed on 24 hour supervision (constant watch).

On 16 February, the man was transferred to HMP Bedford for further assessment. Whilst at Bedford he was assessed by a community psychiatric nurse who diagnosed him with a personality disorder. He told nursing staff that he had attempted to hang himself because his parole had been refused, but denied any thoughts of self harm at that time.

The man was transferred to Lincoln, on an open ACCT document, on 2 March 2006. However, during the reception process, reception and healthcare staff failed to note that he was on an open ACCT and therefore at risk of self harm.

The man's records note that he immediately settled into the regime at Lincoln and commenced work in the tailors' workshop. However, on 8 March, he requested a repeat prescription for diazepam and was referred to the mental health team. Two days later, he told staff that he was unable to attend work that day because of his mental health problems.

On 14 March, the man was seen by a nurse who recorded that he heard voices in his head telling him to kill himself, and that he saw visions of cutting his wrists and hanging. The nurse immediately opened a F2052SH and the man was seen by the

prison doctor later that day. Over the following weeks, the man was in constant contact with healthcare staff, and received significant input from the mental health in reach team at the prison.

The man was taken off the F2052SH on 27 March. However, two days later he was found in his cell having made cuts to both his wrists. An F2052SH was immediately opened and the man was located in the healthcare centre, where he continued to have significant contact with primary healthcare and mental health professionals. On 27 April 2006, the F2052SH document was closed.

The man was moved from the healthcare centre to normal location on 29 April. Whilst on E wing, he continued to have contact with the mental health nurse and visiting general psychiatrist at Lincoln.

On the afternoon of 12 May 2006, the man was discovered by his cell mate hanging in his cell, and the alarm was raised. Staff attended to the man and efforts were made to resuscitate him. Sadly, he was pronounced dead shortly after arriving at Lincoln County Hospital, across the road from the prison.

THE INVESTIGATION PROCESS

1. Two investigators from my office, carried out the investigation into the man's death. Notices were issued to staff and prisoners informing them of the investigation and its terms of reference, and inviting them to contact the investigators should they wish to do so.

2. My colleagues visited Lincoln and were shown the healthcare unit where the man spent most of his time in the prison, as well as the cell on E wing in which he apparently took his own life. The investigating team met with the Governor of Lincoln and a representative of the Independent Monitoring Board. They also made themselves known to a representative of the local branch of the Prison Officers' Association. The investigators reviewed the man's prison record, health care records and other documentation. They interviewed a number of staff at the prison.

3. A clinical review was completed by a doctor from the West Lincolnshire Primary Care Trust. Interviews with medical staff were conducted jointly by my investigators and the clinical reviewer.

4. My investigator spoke with Lincolnshire police. The police confirmed that they had no concerns with regard to the circumstances of the man's death. My investigator also contacted the Coroner's office, and a copy of this report will be sent to the Coroner to assist him with his enquiries.

5. One of my family liaison officers contacted the man's family at the beginning of the investigation. The man's mother contacted another of my family liaison officers at the end of November 2006. The man's mother expressed her concern that her son had been taken off diazepam abruptly. She also questioned why he had not been on 'suicide watch' at the time of his death, having self harmed in previous weeks.

BACKGROUND

6. In 1998, the man sustained a serious head injury in an assault and spent time in hospital. He received help under Section 3 of the Mental Health Act for the ongoing mental health problems he suffered. He was prescribed anti-psychotic and anti-depressant medication whilst in the care of his local psychiatric hospital.

7. The man subsequently started to self harm. Occasionally, he would experience suicidal thoughts and he used illicit drugs, prescribed drugs and alcohol to deal with his feelings. By the time of his late twenties he was a poly drug user with ongoing psychological problems, and he experienced difficulties in controlling his emotions.

8. Between 3 and 7 September 2005, the man carried out three separate offences whilst under the influence of alcohol. He was arrested and remanded in custody until 27 October. This was his first time in prison. He was initially sent to HMP Highdown.

9. The man was moved around the prison estate frequently before finally being transferred to Lincoln on 2 March 2006.

10. At Lincoln, the man continued to experience difficulties handling his emotions which affected his ability to work and participate in prison life. He remained fairly reclusive and found it hard to socialise and interact with others.

11. The man became eligible for parole on 8 March 2006. However, the Parole Board felt that his mental health problems and tendency to self harm placed him in too vulnerable a position to be released early on licence. The Board said that this was compounded by the difficulty his probation area was having in finding suitable accommodation for him on release. The man was told that the Parole Board had rejected his application for release in April.

12. The man died on the afternoon of 12 May 2006, apparently at his own hand. He was aged 30.

HMP LINCOLN

13. HMP Lincoln is a category B, local adult male prison. Built in 1872, the prison receives prisoners direct from the courts across the East Midlands. It also receives serving prisoners transferred in from other establishments and has an operational capacity of 490.

14. The prison holds mainly remand and convicted prisoners serving short term sentences and a relatively small number of life sentence prisoners. The prison is divided into four residential units, a segregation unit, a first night in custody wing (FNC) and a healthcare unit for both inpatients and outpatients.

15. The most recent inspection report by Her Majesty's Chief Inspector of Prisons (HMCIP) was published in November 2005. It described Lincoln as a prison in recovery, working towards restoration of normal functioning and a good standard of regime. However, the report found that Lincoln was still underperforming in some crucial areas.

16. Lincoln's reception process was heavily criticised by HMCIP for the lack of privacy it gave to prisoners being interviewed for cell sharing risk assessments. The induction process was similarly criticised for assessing prisoners within hearing distance of others, and for rushing its delivery of information about the prison's facilities and regimes. The HMCIP report also commented that improvements needed to be made to the anti-bullying strategy, and to self harm and suicide procedures.

17. HMCIP found that healthcare provision had improved and that, despite being understaffed, the inpatient facility was a safe and therapeutic environment with a decent standard of care in evidence.

KEY FINDINGS

8 September 2005 to 2 March 2006

18. On 8 September 2005, the man was sent to HMP Highdown having been arrested and charged by police. A psychiatric report prepared by the Court Division Team said that the man was well known to psychiatric services. He had been admitted to a medium secure unit seven years previously for schizophrenia, and had a history of personality disorder. The assessor recorded that the man's current diagnosis was one of borderline personality disorder and alcohol abuse, that he was a risk to others when intoxicated, and that he complained of suicidal thoughts.

19. Upon reception, the man's personal details were entered in his prisoner record. However, no contact details were entered for next of kin, or someone to contact in case of emergency.

20. A first reception health screen (a process used to assess the physical and mental health of a prisoner on admission to prison) indicated that the man had psychiatric problems and a Suicide Self-Harm Warning Form (used to indicate a prisoner's likelihood of self harm) indicated that he had made previous attempts to overdose on medication. However, during his prison induction on 12 September, it was noted that the man had no thoughts of suicide or self harm but suffered from panic attacks. In his clinical review on behalf of Lincolnshire Primary Care Trust, the clinical reviewer notes that the man was seen by a psychiatrist on 23 September who diagnosed substance misuse, chronic low self esteem and features of borderline personality. As a consequence the man was given a reducing dose of diazepam as well as mirtazapine and olanzapine, with follow up from a psychiatric nurse and doctor. Two weeks later, the man was further prescribed zopiclone and it was noted on his medical records that he was "mentally stable, no evidence of psychosis or paranoia."

21. The man was moved to HMP Lewes on 21 October, and it was again noted on his prison records that he had a personality disorder. As a consequence, he was referred to the mental health in-reach team for an assessment. The assessment cited previous instances of drug and alcohol abuse, but concluded that he had no suicidal ideation present and seemed stable at that time.

22. Five days later, on 27 October, the man was transferred to HMP Belmarsh and was located in healthcare the following day. When assessed by staff during an exit plan, he was noted as having difficulties in asserting himself and as being bullied by other prisoners, but there were no self harm issues. In his review, the clinical reviewer notes that the man was seen by a psychiatrist on 1 November, and it was recorded that he was feeling agitated, uncomfortable and unhappy.

23. On 7 December, the man was moved back to Lewes. A cell sharing risk assessment (a document used to ascertain the level of risk that a prisoner is

to others and to himself) was completed by a member of reception staff. It was recorded that the man had mental health problems and that staff should monitor his behaviour. It was indicated that he was of medium risk to other prisoners. The same day he was sentenced at Lewes Crown Court to twelve months imprisonment with a two year extended licence.

24. Twelve days after being admitted to Lewes, the man was transferred to HMP Wandsworth. A risk assessment recorded no concerns with regard to his mental health, and nursing staff indicated that following the self harm assessment no concerns had been raised. However, on 11 January 2006, an ACCT document was opened. It was closed the following day. In his review, the clinical reviewer records that healthcare staff noted on 13 January that the man felt the medication he had been on had not been working or helping him. He complained of insomnia, panic attacks, and that he was hearing voices which were more like his own thoughts than anything else.

25. Several days later, on 16 January, the man was moved to HMP Edmunds Hill. During reception, it was noted that he had mental health needs and that he was full of "thoughts" and had voices inside his head. However, it was recorded that the man had no thoughts of self harming. In his review the clinical reviewer notes that the following day he was seen by a mental health nurse who, concerned that he was hearing voices, arranged single cell accommodation for him. On 27 January, it was noted that the man was still apprehensive and thought that something bad was going to happen to him.

26. On 13 February, the man tried to hang himself with his stereo lead. An F2052SH was opened, the man was placed on a constant watch, and he was seen by a doctor. The clinical reviewer notes in his report that it was decided to place the man on 24 hour supervision, that he should be seen by a psychiatrist for a complete review of his medication, that he should also see the mental health in-reach team, and that he would benefit from cognitive behavioural therapy. On 15 February, the man complained about being on olanzapine, wanting to be treated with quetiapine instead.

27. On 16 February, the man was transferred to HMP Bedford for further assessment. A letter from healthcare at Edmunds Hill confirmed that, once the man had been assessed, they would be happy to accept him back. The F2052SH opened at Edmunds Hill was closed and an ACCT opened in its place. The clinical reviewer notes that the man was assessed by a community psychiatric nurse (CPN) and diagnosed with personality disorder. The man told the CPN that he had attempted to hang himself because his parole had been refused, but reconsidered his actions as he did not want to die. He was reviewed further on 17 February and denied any thought disorder or self harm ideation at that time. (It is not apparent to what part of the parole process the man was referring.)

28. The man was informed by his probation officer on 21 February, that he would not be eligible for home detention curfew as originally advised

because he had been sentenced with an extended licence, making him ineligible. The clinical reviewer notes that, on the same day, during an assessment by a specialist registrar in psychiatry, the man said he had considered hanging himself because parole had been refused. However, an entry in his medical records, on 22 February, noted that he had tied a ligature around his neck because of bullying and because he owed money on the wings.

29. The clinical review says that the man was further seen by a CPN on 27 February. At that meeting it was recorded that there was no evidence of any thought disorder and, although the man had expressed some concerns with regard to his parole, no further acts of self harm had been attempted. There was no self harm ideation expressed.

30. Although the man had said he wanted to return to Edmunds Hill, he was transferred to HMP Lincoln.

The man's time at HMP Lincoln

31. The man arrived at Lincoln on 2 March. Part of the reception process included the completion of a cell sharing risk assessment (CSRA) which, as well as recording the risk that he could have been to others when sharing a cell, also said whether or not he was at risk to himself. The man arrived at Lincoln on an open ACCT document. The Prisoner Escort Record (PER) noted this and a previous PER form, kept in his record, also said that he suffered from "self induced psychosis". Nevertheless a senior officer (SO) in reception at Lincoln, completed the CSRA and recorded that the man had never shown any signs of anti-social behaviour or abused drugs or alcohol. He also recorded that the man was not currently dependent on drugs, was not on an open F2052SH/ACCT, and that there was no previous evidence that he had been.

32. During his interview with my investigators, the SO from reception was unable to recollect whether or not the open ACCT document had arrived with the man. The SO also said that, when filling out the CSRA, reference would not normally be made to the PER form. He said that, if four or five prisoners were being processed at one time, it would not be possible to have all the relevant documents on the desk together. At a prisoner induction board review later on 2 March, another officer endorsed the comments made by the SO in reception.

33. During their visit to Lincoln, my investigators visited the reception area of the prison and noted it was generally small and cramped. The desk used to interview prisoners upon first reception was small and located in the corridor only feet away from the main entrance to the unit. It was in a position where any interview completed would have been heard by other prisoners waiting to be processed. The investigators noted that the location of the reception centre, in the old administration block of the prison, placed considerable constraints on the level of facilities available to newly received prisoners.

34. After being interviewed by reception staff, the man saw a nurse from healthcare who completed the medical part of the CSRA form. During her interview with my investigators the nurse said she did not remember receiving an ACCT document from reception staff that day, and as a result noted on the CSRA form that there were "no concerns at present". However, the nurse wrote in the man's continuous clinical record, "mental health issues, no drug misuse and has previous self-harm/overdose. Asthmatic – referral completed." The prescription of mirtazapine and olanzapine, which had been previously prescribed to the man, continued at Lincoln. However, the planned reducing dose of diazepam, 5mg, was not continued beyond the seven day dose that had been prescribed by the medical officer at Bedford on 25 February.

35. Later on 2 March, the man was seen in the first night centre where Risk Assessment for Labour, Inmate Work Suitability Questionnaire and New Reception Security Assessment forms were completed. There are no further entries in the man's prison record until 6 March when he completed a wing application asking for a transfer back to Edmunds Hill, saying that he should have been transferred there from Bedford. The man was advised by staff that he had been sent to Lincoln due to population pressures, and when his paperwork arrived they would process his application details. The following day, 7 March, the man made an application to be transferred to Highdown in order that he could be closer to his family. There appears to have been no response from the prison to this request.

36. On 6 March, the man commenced work in the tailors' workshop. On 8 March, he was seen in the healthcare triage unit where he requested a repeat prescription of diazepam. He was referred to the mental health team. The man was also seen by a CARAT worker that day, and discussed with her his recent drug use, his expectation of release in the near future and that parole was an issue for him.

37. On 10 March, it was recorded in the man's wing history sheets that he had not caused any problems on the wing or in the tailors' workshop. However, on 12 March, he told staff that due to mental health problems he would be unable to attend work that day. The man's wing sheets note that staff contacted healthcare who advised that he should remain on the wing until seen by the mental health nurse on 14 March.

38. On 13 March, the man made an application for Change in Labour, saying that he would rather attend education than work in the tailors', because his medication made him unable to use the machinery there. The man appears to have received no response to his application.

39. On 14 March, the man was seen in healthcare by a nurse. She recorded that the man felt as if his head would explode, that he heard voices telling him to kill himself, and that he saw visions of cutting his wrists and hanging himself. She said that the man was still awaiting contact from the mental health in-reach team at the prison. The nurse opened an F2052SH citing suicidal thoughts and the visions that the man was having. The clinical

reviewer notes in his review that the healthcare doctor wrote in the man's medical notes later that day:

> "complains of paranoia, delusions, illusions (pictures on walls taking to him) and auditory hallucinations ordering him to hang himself. Descriptions of above just unconvincing. Accurately describes panic attack with tension in head and palpitations. I suspect this is his main problem currently."

40. The man was seen again by a nurse on 15 March. The nurse noted on his medical records:

> "there is no current clinical indication for a need to change from olanzapine or any clinical requirement for the reintroduction of a benzodiazepine which he is also requesting. Message left with in reach team as this man is on CPA."

Another nurse who attended a review of the man's F2052SH, also noted that he was hearing voices telling him to hang himself because he wanted different medication. At a further F2052SH review on 20 March, it was recorded that the man still had problems with his medication. Although he had become more settled, he occasionally still heard voices but these were not aggressive.

41. The man wrote a letter to the healthcare doctor on 16 March requesting a change in his medication. On 17 March, the man put in a wing application for a transfer further south, saying that he had been told that he could go to HMP Stocken as soon as spaces became available. Lincoln's response informed the man that the prison was given spaces at random and that he would be put on the list for transfer.

42. In an entry of 22 March, the healthcare doctor noted that the man was finding it difficult to leave his cell due to paranoid thoughts and that he wanted to go back onto quetiapine and diazepam. The man said that olanzapine made him feel drowsy.

43. Later that day, the man was seen by a mental health nurse from the mental health in-reach team. The nurse noted that the man had been attacked numerous times in the community and had been previously admitted to hospital where he was diagnosed with drug induced psychosis. The man told the nurse that he was currently feeling low in mood and motivation, was unable to concentrate and experienced disturbed sleep. He said that he had experienced visual and auditory hallucinations previously during drug induced psychosis. The nurse recorded that there should be a planned medication change to risperidone and trazadone, as the man was adamant that olanzapine and mirtazapine were ineffective. During her interview with my investigator, the nurse said that the man was, "generally, quite sort of, chatty and happy to engage in conversation."

44. The man's F2052SH was reviewed again on 27 March. It was decided to close the booklet. The review coordinator recorded that the man presented himself in a positive manner. He had some concerns about his medication but no thoughts of self harm. However, one of Lincoln's probation officers recorded on the man's probation notes that although he had reported no thoughts of self harm he was struggling to cope in custody.

45. On 29 March, the man was found in his cell on B wing having made cuts to both his wrists. He was transferred to the healthcare unit for treatment and an F2052SH was opened by a senior officer. The mental health nurse, who had previously seen the man on 22 March, recorded in his medical record that he had razor blade injuries to both wrists. He was anxious and coping poorly due to his personality disorder. She said the man was worried about his probation report and that he was repeatedly asking for his medication to be changed. He could not cope on the wings and was thinking about self harm. As during her first contact with the man, the nurse confirmed that he was "quite happy to speak to me about what had happened and how he was feeling at the time." The man remained in the healthcare unit for further assessment and observation and was given access to both Listeners and the Samaritans.

46. The mental health nurse saw the man again the following day. She wrote in his medical record that he had said he had planned to self harm, waiting for his cell mate to return to work in order to use his razors. The man told her he believed he should be prescribed diazepam. The nurse recorded that she told him repeatedly that this was not appropriate. She said that he continued to ask for a change to his medication, but was told he needed to continue taking it for it to be effective.

47. The probation officer at Lincoln completed the man's parole assessment report on 31 March. She wrote that she was unable to support his early release on licence.

48. On 1 April, the healthcare in-patient manager chaired the first review of the man's re-opened F2052SH. He recorded that the man was happy to chat, was more positive and felt safe in healthcare. The man was said to be unhappy with his medication and only wanted diazepam. It was said that he was near to his parole review and wanted a transfer to a category C establishment. During interview, the healthcare in-patient manager told my investigator that at the review the man appeared withdrawn, an observation that has been confirmed by a number of staff at Lincoln. Nevertheless, the in-patient manager found him willing to talk and sensed that the man was relieved to be in the healthcare centre.

49. In his clinical review, the clinical reviewer observes that the man:

> "was assessed by a specialist registrar in psychiatry on 5 April 2006. Her notes run to three sides. She noted that he had taken many overdoses in the past, had previously been detained under the Mental Health Act, and had been admitted to psychiatric hospitals as a

voluntary patient. His current presentation is that he was having panic attacks, occasional thoughts about harming self, especially at night, and that he was thinking about hanging himself. She decided to increase the dose of risperidone, and prescribed venlafaxine and zoplicone. He was to begin cognitive behavioural therapy and anxiety work with the in-reach staff."

50. Further reviews of the man's F2052SH took place on 6, 14 and 20 April 2006. On 6 April, it was noted that there had been no change since the last review and that he was eating and sleeping well. He was to remain in healthcare for further assessment. On 14 April, it was noted that the man said that he wanted diazepam for his panic attacks, and produced a diary that stated repeatedly he was having thoughts of self harm. On 20 April, it was recorded that the man should remain in healthcare for continued assessment, that he was still hearing voices telling him to self harm, and that it had been agreed to continue his level 1 observations.

51. The man had kept the diary referred to above as a consequence of a suggestion by the psychiatrist. It records the man's feelings from 6 April until the last entry on 18 April. He recorded anxiety, panic attacks, hearing voices and thoughts of suicide on a regular basis. His last entry said he was suffering from really bad panic attacks that morning and felt like cutting his wrists. The man mentioned wanting a change to his medication in his diary.

52. On 10 April, the man's outside probation officer submitted her parole assessment report. She too said she was unable to recommend parole for the man. On 11 April, he was again seen by the mental health nurse who recorded that he was a bit brighter and was hoping for a positive Parole Board outcome early the following week.

53. A number of entries in his medical record over the following days recorded that the man had become more settled on the unit. On 18 April, the mental health nurse noted that he was still awaiting his Parole Board decision. She wrote that the man, "States he wants to change his medication AGAIN. Advised him that this is not necessary or appropriate at this stage."

54. In his clinical review, the clinical reviewer notes that the man was:

> "reviewed by the specialist registrar in psychiatry on 19 April 2006. She says that he was claiming that voices all night were telling him to kill himself. He was constantly thinking about what has happened, and he feels guilt attacks. He was having panic attacks two to three times per day, and felt that everyone hated him. She decided to increase his venlafaxine, add diazepam, and reduce risperidone."

55. Entries on the man's medical records over the coming days record that there were no problems and that he remained settled on the healthcare centre. On 26 April, the man was seen again by the healthcare doctor. He noted that the man was settled but was still quite paranoid and was hearing

voices from the television. He also wrote that the man was considering a move to E wing and that he should remain on level 1 observations.

56. On 27 April, the man was seen again by the mental health in-reach nurse. She noted the man's intention to move forward with his life and that he wanted a move to E wing in order to attend education. She said that the man felt brighter from going out to the exercise yard in the sunshine.

57. That day also saw the man's final F2052SH review. The review coordinator, the in-patient manager, wrote that the man remained settled in healthcare and was hopeful of hearing something about his parole review. The in-patient manager noted that the man's reports had not been supportive of early release, in which case he would be in prison until September. He said that the man expressed no thoughts of self harm at this time and it was agreed with other reviewers that the F2052SH be closed. When interviewed, the in-patient manager confirmed that the man was fine on the day his F2052SH was finally closed. He recalled telling the man that staying in healthcare in isolation was not helpful, and that he really needed to move on and try to become more involved.

58. The man was transferred from the healthcare unit to E wing on 29 April. A Healthcare Centre Patient Discharge Summary (a form used to provide a brief history of a prisoner's care in healthcare to discipline staff on normal location) was completed by the in-patient manager. The form indicated that the man was no longer on an open F2052SH, and that he had been admitted to healthcare four weeks earlier as a consequence of self injury. It said that the man had not been a management problem and was keen to undertake education.

59. On 30 April, the man's wing sheets recorded that an application for vulnerable prisoner status was approved due to the nature of his offence and fears for his safety. On 3 May, the man submitted his appeal to the Parole Board. The man said that the reports were negative towards him. In addition to arguing for his release, he said that he was at risk of suicide as he could not deal with being in prison.

60. The mental health nurse saw the man on E wing on 5 May. She wrote that he was still awaiting the Parole Board's decision, but did not believe it would be positive as his probation officer wanted him to attend an alcohol treatment programme in prison. The mental health nurse also noted that the man had not been collected to attend the psychiatrists clinic on 3 May.

61. On 6 May, the control room received a telephone call from the man's grandmother. A note in his wing history sheets recorded that she had called over her concern that her grandson had not contacted her recently. A message was passed to the man for him to phone her. The man called his grandmother's number later that day and spoke with her for almost four minutes. The records also noted that he had last called his grandmother's number on 4 May.

62. The man was seen by his psychiatrist, on 10 May. In a letter the psychiatrist dictated to the healthcare doctor on 10 May (typed on 12 May), she reported that the man had rarely been going out to exercise due to feelings of anxiety. She said that he had had no recent panic attacks, but had no confidence and remained anxious that he would be assaulted if others found out about his offence. The psychiatrist wrote, in her letter to the healthcare doctor:

> "There was a note in his IMR saying that he had been trading Diazepam. I informed him of this and told him that we would be stopping his Diazepam. He denied that he had been trading Diazepam and said that his panic attacks had only ceased because of the Diazepam. He had little confidence in his other medication and was as usual adamant to change to his anti-psychotic drugs."

The psychiatrist recalled that there had been an entry in the man's inmate medical record which said "trading diazepam on the wings, please review". After seeing him on 10 May, the psychiatrist discontinued the man's prescription for diazepam, continued his prescription of risperidone and venlafaxine and asked the mental health nurse to contact local services in order to set up a psychiatric assessment in preparation for the man's release.

63. Although not mentioned in her letter to the healthcare doctor, the psychiatrist also recorded on the man's medical notes that he said he would kill himself if not given diazepam.

64. During interview, the psychiatrist confirmed that on 3 May the man should have attended a clinic with her but had not been brought to healthcare from the wings. The psychiatrist said she had been told that the man was trading diazepam. She said:

> "There was a Post-it note stuck on his IMR, on the outside of it, that was brought to my attention by the in-reach psychiatric nurse who had been seeing him and I think the wing officers had put it on his notes and passed it on to her, so it was shown to me and it was shown for a second time on the 10 May. After his death when I saw the copied notes, I saw no copy of the Post-it note."

65. When interviewed by my investigator, the mental health nurse confirmed that she brought to the attention of the psychiatrist the note indicating that the man was trading his diazepam. She said that the information "came in the form of a handwritten note on a piece of paper from the treatment room". The mental health nurse believed the note originated from the treatment room on E wing but could not remember if a particular nurse's name was written on it. The nurse said she recalled the man had been unhappy and adamantly denied he had been trading his diazepam.

66. The healthcare in-patient manager had had a lot of contact with the man whilst he was located in healthcare. During his interview, he said he

believed the man would not have been the type of prisoner to have dealt in drugs. He said that the man was too keen on making sure he got the drugs himself, as opposed to passing them on to others. My investigators found no evidence to suggest that the man was trading his Diazepam whilst he was at Lincoln.

67. During her last assessment of the man on 10 May, the psychiatrist noted on his records that he had said he would kill himself if he was not given diazepam, and that he was fixated on having his medication changed. When questioned about this, the psychiatrist said:

> "When he [the man] was told about the Post-it note he started to say immediately that, that's probably the only thing that had helped him here and again talking about how everybody else had let him down, nothing else had been done for him, and he was saying that if it was withdrawn he was going to kill himself despite the fact that we had agreed to it being for short term use only and his panic attacks had been much less prominent."

The psychiatrist said, "I hadn't seen it as a kind of serious intent to kill himself because we went on to talk about plans for the future." She went on to say she, "had been clear beforehand that I was going to stop [the man's diazepam]. The Post-it note just reinforced the idea that we needed to keep clear boundaries with him." The psychiatrist said that having been told of the man's threat to kill himself she examined his mental state, asking him questions about his mood, thoughts and plans for the future. She said that the man was optimistic about the future and that their discussion,

> "…led me to believe that he had appropriate future orientation and was not planning to kill himself at that time. I gained the impression that his comments were impulsive and made in order to try to elicit the response he wished i.e., to continue diazepam."

68. When asked if there was any witness to the man's threat of suicide the psychiatrist said that he had made his threat in front of the mental health nurse. She said that even though the man had recently been taken off an ACCT "There was no evidence to indicate that his risk was more elevated than usual at the time of threat…" The psychiatrist took the decision that an ACCT was not necessary. She said that she discussed the man's case with the mental health nurse after he had terminated the interview and they had agreed that his threats of suicide did not carry significant intent and as such no further action was taken.

69. During her interview with my investigators the mental health nurse said that she could not recall being in the room when the man made the threats to kill himself if he was taken off diazepam. However, in later correspondence she said:

> "I was present for some, but not all, of the time that the man was in

consultation with the Doctor, [the psychiatrist] on Wednesday 10th May 2006, as I was also assisting another Doctor who was carrying out a simultaneous clinic. I was not aware that the man had made any threat of suicide."

The mental health nurse added that it was only after the man had taken his life that she was made aware that he had made a verbal threat of suicide.

70. That evening, the man made a telephone call to his grandmother, speaking with her for approximately seven and a half minutes. Their conversation was predominantly of a domestic nature, talking about parcels being sent in to the prison and forthcoming visits. There was no indication that the man was either feeling low or considering suicide.

71. The man's cell mate told the police that the man appeared to be a loner and had few friends in the prison. He said he got to know the man a little better over a period of a week, during meal times and association. The other prisoner said that the man did not talk of self harming and, although he believed the man was not bullied on the wing, other prisoners would take the "mick" out of him. On the morning of 11 May, the other prisoner moved into the man's cell on E wing, having had problems with a previous cell mate. The man's new cell mate told police that the man talked about his "nana" and seemed to look forward to getting out of prison. That night, the man and his cell mate went to bed at about 9.30pm. The cell mate told police that the man awoke in the early hours before going back to sleep. They both awoke at around 7.45am on 12 May.

Events of 12 May 2006

72. The man's cell mate reported to police that he and the man cleaned their cell on the morning of Friday 12 May, before being locked up and watching the television together. He said the man appeared to be fairly calm, but at one point started fiddling with a disposable razor saying that he had had enough. The cell mate told police that he told the man not to be so stupid and threw the disposable razor out of the window. The cell mate did not tell officers about this incident at the time.

73. At about 10.30am, the man met with his CARAT worker. When interviewed by my investigators, the man's CARAT worker confirmed that they discussed a number of issues with regard to his parole and offending, and his problems with alcohol. She said that the man had given her no indication that morning as to what he was going to do. She said that, if he had, she would have opened an ACCT on him immediately.

74. A number of officers and staff at Lincoln described the man as being quiet. The CARAT worker described him as being like "a naïve little boy" who appeared lost. An officer on E wing recalled that the man "was a very quiet, withdrawn young man, [who] didn't mix well". Another officer said the man was, "Very quiet, keeping himself to himself, it was very difficult to engage in conversation with him, however as time went on, the longer period he was in

Lincoln the easier it was and the more he would talk to you and ask for things himself."

75. The man's cell mate told police that, when the man returned to his cell, he had asked the cell mate to write a letter for him. The cell mate said he had agreed to write the letter that afternoon. The cell mate also said that the man had just received a letter from his grandmother containing a £50.00 postal order and picture of his nephew. He said the man placed the picture in his drawer and screwed up the letter, unread.

76. The man had his dinner along with his cell mate at about 11.30am. Both of them then remained in their cell, the man smoking on the bottom bunk. At about 1.30pm, the cell mate was unlocked by an officer. The man's cell mate said that he left to attend the gym, telling the man that he would meet him straight afterwards in the exercise yard. The officer then asked the man if he wished to go on exercise, but the man declined. During interview, the officer said that "this was nothing out of the ordinary from what I can recollect he didn't normally go on exercise or anything like that".

77. The man's cell mate told police that on returning from the gym he went straight to the exercise yard. He remained there for about 20 minutes before returning to the wing at about 3.00pm, reaching his cell about 10 minutes later. On returning to the cell, the cell mate said that he looked through the spy hole and saw the man hanging by a ligature from the bunk bed inside. The cell mate raised the alarm immediately.

78. My investigators established that a senior officer was talking to another officer when they heard the man's cell mate shout "he's hanging, he's hanging". They immediately attended the cell and saw that the man was hanging by a ligature from the top bunk, facing the door. The senior officer called a code 1 on the radio and entered the cell. He then took the man's weight along with another officer. Another officer also entered the cell at about the same time and cut the ligature with an anti-ligature knife known as a 'Fish Knife'. (Fish knives are shaped like a fish, and contain a concealed blade in the mouth section which is designed to allow the user to get underneath the ligature. The action of pushing the knife forward cuts the ligature away from the body. At the time, only a small number of officers on the wing carried fish knives. I understand that all officers now carry them.)

79. The man was laid on the floor. Although he believed that the man had already died, the senior officer commenced mouth to mouth resuscitation and Cardio Pulmonary Resuscitation (CPR) without any protective equipment until nursing staff arrived. The two other officers withdrew from the cell upon the arrival of the first member of nursing staff to attend. Approximately two minutes later, other members of healthcare staff arrived with equipment including a defibrillator and oxygen. After applying a face mask, the nurses continued mouth to mouth resuscitation and chest compressions. The defibrillator was attached and shock administered. The incident log records that an ambulance was called at 3.21pm, and was

contacted again at 3.27pm with further information.

80. The paramedics arrived at Lincoln at 3.29pm, and were escorted to the man's cell arriving at 3.33pm. The paramedics continued CPR on the man with the assistance of nursing staff. Other nurses attended some minutes later with additional oxygen and at 3.45pm, on establishing that more oxygen was required, a nurse went to fetch it. The paramedics and nursing staff continued with CPR for about an hour. At 4.16pm, the ambulance left E wing and left the main gate of the prison at 4.20pm. Staff and paramedics continued to work on the man during the short journey across the road to Lincoln County Hospital. Shortly after arriving at the hospital, the man was pronounced dead at 4.30pm.

81. For the duration of the emergency, comprehensive logs and notes were kept by HMP Lincoln. A hot-debrief took place at 4.50pm, attended by a number of staff. (Medical staff who had responded did not attend as they had to continue treatments on the healthcare unit and wings.) Following the man's death, a review of all prisoners on open ACCTs was completed and staff were offered the facilities of the welfare team at the prison.

82. The family liaison officer at Lincoln became aware of what had happened at about 4.00pm. During interview, she told my investigator that because the man had not left any details of his next of kin it took some time to establish who should be contacted. The family liaison officer explained that the visits book revealed the man had been due to receive a visit on Sunday 14 May from two people. These people had differing names from the man but lived in his home area, although no relationship had been identified. It was later established that these people were in fact the man's mother and brother. The family liaison officer noted in the prison Family Liaison Log that, due to the difficulties in contacting a family liaison officer from a local establishment, the Coroner's Office asked the police to visit the home of the man's brother.

83. Police visited the home of the man's brother, but he was not in. They put a card through the letterbox asking him to contact them. The following day, the details of the man's grandfather were found by the prison and he was contacted at about 3.10pm on the Saturday afternoon. The man's mother contacted Lincoln prison at about 4.45pm. The man's family went ahead with their planned visit to Lincoln on Sunday and were met by the Governor. The family visited the man's cell and were given his property. After a discussion with the man's family, it was decided that the Prison Service would not attend his funeral although a floral tribute was sent and the prison paid the funeral expenses.

Clinical Review and Post Mortem Report

84. The clinical reviewer looked in detail at the level of healthcare the man received during his time in prison. In particular, the review considers the man's time at Lincoln.

85. In his review, the clinical reviewer says that staff should be commended for their efforts to resuscitate the man. The clinical reviewer was satisfied that all equipment was in working order and staff were appropriately trained. He also reports that immediate life support training was in the process of being undertaken by all relevant staff. He concludes that it was "…very unlikely that resuscitation could have been successful in this case."

86. The clinical reviewer confirms that the man was assessed for his mental health needs on numerous occasions, and was seen by a specialist registrar in psychiatry on three occasions, including an assessment two days before his death. The clinical reviewer concludes that the man had been "assessed very thoroughly and at frequent intervals. Staff communicated their findings with each other. It is hard to see how a more complete assessment could have been made." The clinical reviewer confirms that the man had been diagnosed some years previously as having a personality disorder, and that this was the diagnosis that the man had been given whilst at Lincoln. He says that, although treatment at Lincoln had been planned for the man, he had received little treatment for the condition by the time of his death. However, the clinical reviewer does "not feel that more intensive treatment of his condition would have altered the outcome of events."

87. With regard to the man's medication, the clinical reviewer notes that he had a history of wishing to change his medication and that he regularly requested diazepam. The clinical reviewer finds that on more than one occasion the man threatened to kill himself if it was not prescribed:

> "The specialist registrar in psychiatry explained to us that his behaviour is common in patients with personality disorder. There were good reasons for not changing his medication as he requested: she had negotiated a care plan with him at their previous meeting, and that it would be harmful to renege on this; his condition appeared to be improving, and thus his care could have been compromised if he had reverted to less effective treatments; she did not believe that this threat was a serious indication of intent to kill himself."

88. In his clinical review the clinical reviewer explained that the man had been "on and off" diazepam for some time prior to his death. He said that the drug was used for the short term relief, 2 to 4 weeks, of anxiety that is severe, disabling or subjecting an individual to unacceptable distress. The clinical reviewer added that: "Diazepam is indicated for short-term use only. Medical practitioners are discouraged from prescribing this drug." The clinical reviewer thought it unlikely that the refusal to prescribe diazepam on 10 May, contributed to the man's death.

89. The Post Mortem examination reported that the man's death was as a consequence of suspension by ligature around the neck.

ISSUES

Reception

90. The man arrived at Lincoln on an open ACCT document. The senior officer in reception, who carried out the man's initial interview, was unable to recall whether or not he had sight of the ACCT or PER (which also indicated that the man was on an open ACCT) when he completed the CSRA form. The fact that the man was on an open ACCT was also missed by all other members of staff working in reception and on the first night induction centre.

91. The reception senior officer pointed out that, when a number of prisoners were being processed at the same time, it would often not be possible to have all the relevant documents together on the desk due to the limited space available. During their visit to Lincoln, my investigators confirmed this, and discovered that the lack of space means that initial interviews are conducted within hearing of other prisoners, and in an open passageway.

92. After being processed by reception staff, the man was seen by a nurse from healthcare. The nurse could not remember having sight of the ACCT document or PER form during her health assessment of the man. Although she recorded that the man had some mental health problems, she concluded that there were no concerns at present. As a consequence of not having sight of the ACCT and PER forms, the nurse missed the fact that the man was considered to be at considerable risk of self harm.

93. What happened at his reception interview may have had little bearing on the man's death. Nevertheless, I believe that reception arrangements merit consideration, as did the Chief Inspector of Prisons in her most recent report on Lincoln in September 2005. The report mentioned the conditions in the reception area, in particular that Cell Sharing Risk Assessments (CSRAs) were completed at the desk in the main reception area. The Chief Inspector found this made it less likely that a prisoner would disclose anxieties or ask for help. The Chief Inspector recommended that CSRAs should be completed in private.

I recommend that the Area Manager in conjunction with the Governor reviews the facilities offered by the reception centre at Lincoln. Adequate accommodation should be provided so that all interviews with prisoners are carried out in private, with space to process documentation fully. All interviews should be completed out of the hearing of other prisoners.

I recommend that the Governor reminds all reception and healthcare staff of the importance of establishing whether or not a prisoner is on an open ACCT when entering the prison.

I recommend that nursing staff should have full access to all prison records held on a prisoner, including PER forms, during the initial health screen interview and assessment.

F2052SH and ACCT processes

94. I understand that Lincoln was one of the last prisons to transfer from monitoring prisoners at risk of self harm by use of the F2052SH to the new ACCT system. The man's F2052SH was closed days before the ACCT system came on line at Lincoln on 2 May 2006.

95. Two F2052SHs were opened by members of nursing and discipline staff at Lincoln. The first was as a consequence of one nurse's concerns about the man's thoughts of self harm. The second was opened by a senior officer in response to the man's self harm on 29 March 2006. Both were completed to a good standard. Nevertheless, a small number of improvements could have been made to the way that the man's F2052SHs were handled, including having a member of discipline staff present during his reviews, and greater consistency in the make up of review boards.

96. Whilst at Lincoln, my investigators took the opportunity of reviewing some current ACCTs opened on prisoners at risk. I am pleased to report that these were generally completed to a good standard. Although a number of minor issues were reported to the safer custody manager, my investigators considered these to be teething problems whilst staff became used to the requirements of the new processes.

97. However, it became apparent during the investigation that a number of staff, including nurses, had not been fully trained in the use of ACCT.

    I recommend that the Governor ensures that all staff are fully trained in the ACCT process.

Report that the man was dealing in diazepam

98. During interview, the mental health nurse said she brought the psychiatrist's attention to a note suggesting the man had been trading in diazepam. The psychiatrist described the note as a Post-it stuck on the outside of the man's IMR, and said that after his death it had disappeared from his records. Of all the staff interviewed, only the psychiatrist and the mental health nurse could recall the note. Both said they did not write it, although the mental health nurse believed it had originated from the treatment room on E wing. My investigators have been unable to establish who wrote this note, and what happened to it after the man's death. They have also found no evidence to suggest that the man was trading his prescription drugs at the prison.

99. It is clear in the psychiatrist's letter to the healthcare doctor on 10 May, that the Diazepam was withdrawn as a consequence of her belief that the man was trading his drugs. The psychiatrist confirmed this in her written statement.

100. The psychiatrist said that the prescription of Diazepam was only going to be as a short-term measure anyway and that the man had agreed to the arrangement. She told my investigators that the note reinforced the idea that clear boundaries needed to be kept with the man. However, the psychiatrist did not write in either the clinical record or in the letter to the healthcare doctor that her agreement with the man was that the prescription of Diazepam would be a short term measure only.

101. I am concerned that such important and sensitive information was simply recorded on a Post-it note, with no name or further explanation as to the source of the information. If the information was significant, it should have been recorded properly on the man's prison record, either by the submission of a Security Information Report (SIR) or by comprehensive notes being made in his prison record.

102. Although I make no formal recommendation, I would ask the Governor to remind staff of the need to record all sensitive and relevant information appropriately.

The Man's Threat of Suicide

103. During his consultation with the psychiatrist on 10 May, the man threatened to take his life if his prescription of diazepam was withdrawn. This was well documented by the psychiatrist on the man's medical notes. The psychiatrist says that she fully considered along with the mental health nurse the man's threat. She concluded that the risk "did not carry significant intent to warrant further action at that time." The psychiatrist believes that she discussed the man's threat of suicide with the mental health nurse, for her part the nurse does not recall having this conversation with the psychiatrist. However, despite this discrepancy I am satisfied that the psychiatrist gave full consideration to the man's threat of suicide.

Hot-Debrief

104. My investigation has established that not all staff were able to attend the hot-debrief. In particular, healthcare staff were unable to attend. Nor were some of the nurses asked to produce incident statements, even though they attended to the man in his cell.

I recommend that the Governor ensures that all those involved in responding to a self inflicted death are invited to attend the hot-debrief and any follow up de-briefs. All those involved in a response should be asked to provide written statements.

Notification of the man's death to his family

105. Although a prisoner record was completed for the man during the reception process at Lincoln, his next of kin details were not recorded. I appreciate that it is not always possible to obtain and record such details but, in the man's case, a number of problems occurred as a consequence of their

absence.

I recommend that the Governor reminds staff of the need to ensure that every effort is made in obtaining prisoners' next of kin details, either from prisoners or from their records.

106. Once next of kin details were established, a number of difficulties occurred when staff at Lincoln attempted to inform the man's family of his death. I am satisfied that these were beyond the staff's control and I believe that the prison could not have acted differently in the circumstances.

Clinical Review

107. In his clinical review, the clinical reviewer highlights the attempts that were made to revive the man and says that all staff should be commended for their efforts. I concur with this. I would also draw attention to the fact that the senior officer administered mouth to mouth resuscitation and CPR to the man without protection and with no concern for his own safety.

I recommend that the Governor commends all staff involved in the resuscitation attempt. In particular, the senior officer should be commended for his actions in attempting to save the man's life without consideration for his own safety.

I recommend that the Governor reminds staff of the benefits of carrying face protectors which provide adequate protection during CPR.

RECOMMENDATIONS

I recommend that the Area Manager in conjunction with the Governor reviews the facilities offered by the reception centre at Lincoln. Adequate accommodation should be provided so that all interviews with prisoners are carried out in private, with space to process documentation fully. All interviews should be completed out of the hearing of other prisoners.

I recommend that the Governor reminds all reception and healthcare staff of the importance of establishing whether or not a prisoner is on an open ACCT when entering the prison.

I recommend that nursing staff should have full access to all prison records held on a prisoner, including PER forms, during the initial health screen interview and assessment.

I recommend that the Governor ensures that all staff are fully trained in the ACCT process.

I recommend that the Governor ensures that all those involved in responding to a self inflicted death are invited to attend the hot-debrief and any follow up de-briefs. All those involved in a response should be asked to provide written statements.

I recommend that the Governor reminds staff of the need to ensure that every effort is made in obtaining prisoners' next of kin details, either from prisoners or from their records.

I recommend that the Governor commends all staff involved in the resuscitation attempt. In particular, the senior officer should be commended for his actions in attempting to save the man's life without consideration for his own safety.

I recommend that the Governor reminds staff of the benefits of carrying face protectors which provide adequate protection during CPR.