Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a prisoner at HMP Lincoln, on 31 October 2013

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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

The man was found dead in his cell at HMP Lincoln on 31 October 2013. He had been killed by his cellmate. The man was 73 years old. I offer my condolences to those who knew him. In May 2015, the man's cellmate was convicted of manslaughter on grounds of diminished responsibility.

Homicides in prison are rare and identifying those likely to carry out such killings can be difficult. Although psychiatric reports later concluded that the man's cellmate had been suffering from paranoid schizophrenia at the time of the attack, when he arrived at Lincoln he had no known mental health problems or history of violence. His initial health screen did not identify any concerns. I am satisfied that both the man's cellmate and the man had been appropriately screened to assess their risk for cell sharing. The cellmate's actions appear to have been sudden and unexpected and I consider that it would have been very difficult for prison staff to have predicted or prevented the man's death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2016**

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Summary

Events

1. The man was sentenced to nine months imprisonment for a sexual offence, in October 2013. He was initially held at HMP Leicester and arrived at Lincoln on 24 October. He had been in prison once before. Because the nature of his offence meant he might be at risk from other prisoners, the man lived in the vulnerable prisoner unit at Lincoln.

2. The man's cellmate was remanded to Lincoln on 29 October 2013 for sexual offences. He had not been in prison before. Because of the nature of his alleged offences, he also went to the vulnerable prisoner unit, where he shared a cell with the man.

3. An officer and a nurse assessed the man's and the man's cellmate's suitability to share a cell with another prisoner when they arrived at Lincoln and judged them both as a standard risk and suitable to share. Officers did not record any concerns about the man or the man's cellmate on 29 or 30 October.

4. When staff checked prisoners on the morning of 31 October, they found the man dead in the cell. The man's cellmate indicated that he had killed him. The police charged him with murder.

5. In May 2015, the man's cellmate was convicted of manslaughter on the grounds of diminished responsibility. At the trial, expert medical witnesses concluded that the man's cellmate had been suffering from paranoid schizophrenia and that he had had an abnormality in mental functioning at the time of the attack.

Findings

6. The reception process at Lincoln did not identify the man's cellmate as being a risk to other prisoners. The cellmate's offences were not violent. He had no previous convictions and no diagnosed mental health problems either in the United Kingdom or in his home country. His behaviour during the reception process and his brief time on the wing did not give prison staff any cause for concern. We do not consider that prison staff could have predicted the cellmate's actions or prevented the man's death. Control room staff did not call an ambulance immediately they received an emergency medical code, which caused a brief delay, which we bring to the Governor's attention. This did not alter the outcome for the man and we make no recommendations.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

8. NHS England commissioned a doctor to review the man's and his cellmate's clinical care at the prison.

9. On 6 November 2013, the investigator visited Lincoln and obtained copies of relevant extracts from the man's and his cellmate's prison and medical records. Our investigation was suspended at the request of the Crown Prosecution Service and resumed after the conclusion of the cellmate's trial in May 2015. In October 2015, the investigator interviewed four members of staff at Lincoln.

10. We informed HM Coroner for Lincoln of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted a friend of the man, who he had named as his next of kin. She explained the investigation and asked if she had any matters she wanted the investigation to consider. The man's friend was concerned that prison officers had considered that he was suitable to share a cell, as he had mental health problems. She wanted to know whether the man was sharing a cell with his cellmate because the prison was overcrowded. She thought that officers would have heard something that night, and could have discovered what had happened sooner. The man's friend received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence

12. The man's cellmate did not respond to a request to be interviewed for this investigation.

Background Information

HMP Lincoln

13. HMP Lincoln holds more than 700 remanded and convicted prisoners. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, which include a vulnerable prisoner unit. The prison has an inpatient unit and nurses are on duty 24-hours a day.

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of HMP Lincoln was in November 2013, shortly after the man's death. Inspectors reported that the prison was a safer place than at their previous inspection in 2012. All new prisoners were interviewed in private in reception and good attention was paid to risk and vulnerability issues. First night arrangements for vulnerable prisoners had improved and were good. Many prisoners shared cramped cells designed for one.

15. Inspectors reported that the prison had introduced a simpler system to tackle bullying and antisocial behaviour. Although they found that too many prisoners felt unsafe and victimised, far fewer prisoners in the vulnerable prisoner unit felt unsafe than at the time of the previous inspection.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report, for the year to December 2013, the IMB reported that although the prison was overcrowded, there were good relationships between staff and prisoners. A safer custody questionnaire had indicated that most prisoners said they had not experienced any antisocial behaviour in the prison.

Previous deaths at HMP Lincoln

17. The man's death was the first homicide we have investigated at Lincoln.

Key Events

The man

18. On 26 September 2013, the man was convicted of the sexual offence of voyeurism and bailed for sentencing. On 17 October, the man received a nine month sentence and was sent to HMP Leicester. When he arrived, an officer completed a cell sharing risk assessment, which is designed to identify prisoners at risk of seriously assaulting or killing a cellmate in a locked cell. The man had no convictions for violent offences or history of violent behaviour in prison. The officer assessed the man as a standard risk and suitable to share a cell.

19. At an initial health screen, the man said he had received treatment for depression and anxiety in the past, but he was not prescribed any medication for his mental health at that time. The nurse completed the healthcare section of the cell sharing risk assessment and agreed that the man was a standard risk.

20. The reception officer noted that the man had requested vulnerable prisoner status. Vulnerable prisoners are those who might be at risk among the general prison population because of the nature of their offences, usually sexual offences. They are kept in separate accommodation.

21. On 22 October, a prison GP reviewed the man's community medical records and noted that he had been prescribed a low dose antidepressant. The GP continued this prescription and suggested that the man should have a mental health review.

22. On 24 October, the man transferred to HMP Lincoln. At an initial health screen, Nurse A noted that he suffered from anxiety and depression and that he was taking an antidepressant, but was calm when she saw him. She referred him to the mental health team for an assessment. Nurse A recorded that he was suitable to share a cell but, because of his age, he would need a bottom bunk.

23. The man was again assessed as standard risk for cell sharing. He went to a double cell (E2-04) on E Wing, the vulnerable prisoner unit at Lincoln.

The man's cellmate

24. On 29 October, the man's cellmate was remanded to Lincoln charged with two sexual assaults. Among the documents that arrived with him were a Person Escort Record (PER – a document that goes with prisoners when they move between police stations, court and prisons), a court warrant and a police document with details of the two sexual assault charges. There was no record of previous offences from the police national computer, which sometimes arrives with prisoners.

25. Officer B assessed the man's cellmate in reception, and noted that this was his first time in prison. Officer B remembered that the man's cellmate talked about his fitness regime and had some expensive vitamins with him. He said that the man's cellmate was quite open, made good eye contact and his English was as good as his, although his PER had suggested that he needed a Polish interpreter. Officer B had no concerns about the man's cellmate's mental health when he spoke to him.

26. Officer B completed the man's cellmate's cell sharing risk assessment. He told the investigator that he takes into account how the prisoner behaves, the nature of

their offence and whether they have a history of violent offending. Officer B had no information about whether the man's cellmate had previous offences and there was nothing in the prison records as he had never been in prison before. He noted that the escort record had not identified any concerns about violent behaviour or his mental health. Because of the nature of the charges, The man's cellmate was assessed as a vulnerable prisoner.

27. At an initial health screen, Nurse C recorded that the man's cellmate had no mental or physical health concerns. He noted that he had seen no evidence of mental illness and described his behaviour and mental state as appropriate. The man's cellmate said he was not taking any medication. Nurse C recorded that he looked fit and well. In a statement for the police, after the man's death, Nurse C said he remembered the cellmate because he was the only vulnerable prisoner in reception that day. He said that the man's cellmate's English was good enough for him to complete the initial health screen without needing any interpretation. Nurse C said he had no doubts about his physical or mental state at the time and did not think he needed a mental health assessment.

28. Nurse C completed the healthcare section of the man's cellmate's cell sharing risk assessment. He indicated that there was no evidence of increased risk that the man's cellmate would harm another prisoner. Neither Nurse C nor Officer B considered that the man's cellmate was at risk of harming a cellmate. Until the police national computer record could be checked, The man's cellmate was provisionally assessed as suitable for cell sharing.

29. Officer B said that, as the man's cellmate did not smoke, there were few suitable options available for locating him on E Wing. He said that, ideally, he would have shared a cell with another foreign national prisoner or a younger person, because they would have had more in common. However, the wing was nearly full and, at the time, he could only locate him with the man, who was much older than him, but did not smoke. At around 5.00pm, the cellmate was taken to the cell on E Wing, which he shared cell with the man.

30 October 2013

30. On 30 October, the man's cellmate completed his prison induction, which included information about safer custody and violence reduction, the system for reporting bullying and the services of Samaritans and Listeners (Prisoners who are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.) That morning, information from the police national computer confirmed that the two sexual assault charges were the man's cellmate's first alleged offences. As there was nothing to show any increased risk, he remained a standard risk for cell sharing.

31. Officers did not record anything further about either the man or his cellmate in their prison records that day.

32. Around 6.30pm, Officer D locked E Wing prisoners in their cells. At 7.30pm, he checked all prisoners were present in their cell. He said he could not remember speaking to the man or his cellmate. At 8.40pm, Mr E, an operational support grade, who was the night patrol officer on E Wing that night, did another check by looking through the observation panels of cell doors. Mr E said that he had no

interaction with the man or his cellmate. At 9.00pm, Mr E recorded that he had counted all the prisoners on E Wing. He noted no concerns. The assistant night manager visited the wing at 10.00pm and 12.10am and he did not have any concerns.

31 October 2013

33. During the night, Mr E was required to patrol the landings every half an hour. Usually this is recorded on an electronic "pegging" system but this was not working properly that night. Mr E also needed to check eight prisoners on E Wing who were being monitored as at risk of suicide and self-harm. One of the prisoners had to be checked twice an hour and most of the others once an hour, so he was on the landings frequently. At other times he was in an office with an open door on the third landing. Mr E said he heard no noises that concerned him. Mr F, another operational support grade, was working on the adjacent next wing also said he heard no noises from E Wing during the night.

34. Around 5.35am, Mr E started counting the prisoners on E Wing. He said it took him five or six minutes to do the first landing. When he arrived at the man's cell on the second landing, he opened the observation panel and switched on the night light. Mr E saw the man's cellmate lying on the floor of the cell with a bucket (the cell waste bin) on his head. The man's cellmate jumped up, slid the bucket off his head and went to the door. Mr E then noticed the man on the bottom bunk completely wrapped in a blanket in a strange position. Mr E shouted to the man, but got no response. He asked him to wake the man but he refused. Mr E asked him to remove the blanket from the man's face and the cellmate said he was sleeping. Mr E asked him to lift up the man's arm which he did, but the man did not react. The man's cellmate was quite close to the door so Mr E could not see into the cell properly.

35. Mr E was concerned about the man. He shouted for Mr F and radioed the night manager to come immediately to the man's cell. When Mr E and Mr F looked through the observation panel, the man's cellmate had moved away from the door and they noticed a pool of blood at the back of the cell. At 5.45am, Mr E radioed a code red emergency (indicating a life-threatening incident involving blood).

36. At night, prison staff on wings do not carry standard keys but have a cell key in a sealed pouch for use in an emergency. Mr F used the emergency key and, as he unlocked the door, the night manager, the assistant night manager and Nurse G arrived. The night manager tried to get into the cell but a dustpan was wedged underneath the door. The staff forced the door open and the assistant night manager removed the man's cellmate from the cell. Nurse G said that she examined the man and found that there was a large open wound on his throat and there was blood on his face and the mattress. Nurse G could find no pulse. The man's skin was cold and his limbs were stiff. Nurse G did not attempt resuscitation, as it was evident from the presence of rigor mortis that the man was dead.

37. At 5.47am, the night manager radioed the control room to call an ambulance and the police. The control room called the emergency services at 5.48am. Paramedics arrived at the cell at 6.05am and at 6.08am, recorded that the man was dead.

38. Mr E said that the man's cellmate was calm and detached. The night manager said he asked him how he had injured the man. The man's cellmate made a stabbing gesture (although he had not actually stabbed him) and told the night manager he had used plastic cutlery. When the night manager asked whether he still had the weapon, he said it was still in the cell.

39. Two prisoners on the floors above and below the man's cell (in E3-04 and E1-6) told the police that they said they had heard noises coming from the cell between 8.30pm and 9.30pm. They did not hear anything more from the cell until the man was found dead the next morning. One of the prisoners said he was about to use his cell bell to call staff when the noises stopped.

Contact with the man's next of kin

40. The police broke the news of the man's death to a friend he had named as his next of kin. Prison staff visited her at her home later that morning. In line with Prison Service policy, the prison contributed to the costs of the funeral, which took place on 20 December 2013. The Governor attended. He also met the man's friend on 7 February 2014 to discuss the background to the man's death and to answer her questions.

Support for prisoners and staff

41. After the man's death, a prison manager debriefed the staff involved in the emergency response to give them the opportunity to discuss any issues arising, and to support them. The staff care team and chaplaincy also offered support.

42. The prison posted notices informing other prisoners of the man's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by the man's death.

Post-mortem report

43. A post-mortem examination recorded the man's cause of death as blunt force trauma to his head and strangulation.

The cellmate's trial

44. The man's cellmate was charged with murder but, during the course of his trial, jurors heard from medical expert witnesses that he had subsequently been diagnosed with paranoid schizophrenia. While the man's cellmate was responsible for the man's death, he had experienced an "abnormality in mental functioning" at the time of the attack. The jury found the man's cellmate guilty of manslaughter with diminished responsibility. The judge issued a mandatory hospital order, under section 37 of the Mental Health Act, for the man's cellmate to be detained at a secure mental health facility.

Findings

Assessment of risk

45. Prison Service Instruction (PSI) 9/2011 instructs that cell sharing risk assessments (CSRA) must be completed as part of the reception process when prisoners are first received into custody. They must be based on evidence of risk and completed before allocation to a shared cell. PSI 9/2011 says:

> "The CSRA process assesses the risk that a prisoner will murder or be severely violent towards a cell mate. Following extensive research, the indicators of heightened risk are now well known and most can be checked quickly from evidence sources."

46. The indicators of heightened risk listed in the PSI, include previous life threatening assault, murder or manslaughter of another prisoner; a serious sexual assault of an adult victim of the same sex; healthcare assessment of increased risk; racial or homophobic motivated offences; repeated violence in custody; arson; kidnap/false imprisonment; significant prisoner vulnerability and officers' observations.

47. The man's cellmate had none of the indicators of heightened risk when he arrived at Lincoln. Officer B said he reviewed the escort record and spoke at length to the man's cellmate as part of his risk assessment. He did not have the police national computer (PNC) records, but he could see from prison records that the man's cellmate had not been in prison before. Officer B assessed the man's cellmate as standard risk. The PNC records the next day, confirmed that the man's cellmate had no previous convictions. Nurse C, who completed the healthcare section of the risk assessment, identified no increased risk to others.

48. There is no record that the man was concerned about sharing a cell. Nurse A knew about the man's mental health problems when she updated his cell sharing risk assessment on 24 October, and she considered he was suitable to share a cell with another prisoner. The man did not have any of the risk factors listed in PSI 9/2011, which would have indicated that he was not suitable to share a cell or that he was significantly vulnerable to attack by other prisoners.

49. PSI 09/2011 requires that a cell sharing risk assessment is reviewed "where new or additional information becomes known which indicates increased risk". No such information was received about the man or his cellmate.

50. A Prisons and Probation Ombudsman (PPO) Learning Lessons publication in December 2013, 'Prison homicides' noted that half the prisoners died while locked in their cell with their cellmate. When prisoners have a history of violence they pose a risk to other prisoners. The man's cellmate had no known history of violence when he was remanded to Lincoln and there was nothing to suggest that he would act violently. There was no indication of any problems between the man and his cellmate. We consider that it would have been very difficult for prison staff to have predicted or prevented the man's death.

Mental health

51. The man's cellmate had no diagnosed mental health condition before the man's death. After the man's death, his cellmate was diagnosed with paranoid schizophrenia. At his trial, an expert witness testified that he was suffering from an "abnormality of mental functioning" at the time of the attack.

52. Nurse C found no evidence of mental illness at the time of the man's cellmate's initial health screen. Officer B said that the man's cellmate showed no signs of mental health problems during their conversation in reception. The man's cellmate's had the required health screens when he arrived at Lincoln and there was nothing to indicate any evidence of mental illness in the man's cellmate's records or in his presentation. No staff during his time at Lincoln reported any concerns about his behaviour or later presentation, which indicated a need for a full mental health assessment or any signs of a psychotic illness.

Emergency response

53. When Mr E discovered the extent of the man's injuries, he immediately radioed an emergency code red. The control room officer recorded the code red at 5.45am. When the night manager arrived at the cell he radioed the control room and requested that both the police and an ambulance be called. The control room recorded the night manager' request at 5.47am and called the ambulance at 5.48am. It was immediately evident from the presence of rigor mortis that the man had been dead for some time. However, control room staff should have called an ambulance as soon as they received the code red message. As there was only a slight delay, which would not have affected the outcome for the man, we draw this to the Governor's attention but, in the circumstances of this investigation, we make no formal recommendation.

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