Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Ministry of Justice** **2 Governor HMP Lincoln**
1	**CORONER** I am Paul D SMITH, HM Senior Coroner for the coroner area of Greater Lincolnshire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 06 July 2020 I commenced an investigation into the death of Luke Owen ASHCROFT aged 33. He died in Lincoln County Hospital on 1 July 2020. He had been admitted to hospital from his cell within the Care and Separation Unit at HMP Lincoln on 24 June 2020 [redacted]. At the time he was discovered he was unconscious. The investigation concluded at the end of the inquest on 16 March 2026. The findings of the inquest jury were that: [redacted] When: Between 06.36 and 06.54 on 24 June 2020. Where: In cell J 109 within the Care and Separation Unit at HMP Lincoln. We find that: An initial screen and subsequent triage by healthcare staff were missed opportunities to initiate an effective healthcare plan, including medication review and consideration of risk control measures such as an ACCT from an earlier date. Risk-pertinent information sharing between disciplines and systems was inadequate; procedures intended to prompt discussions, including an algorithm, were not followed correctly. This led to mitigations in place for Luke to be inadequate for his circumstances when in the CSU. When the ACCT procedure was implemented on 23 June 2020, the immediate actions and details of the plan were inadequate to effectively address the risks Luke's circumstances presented. Failures by a prison officer to carry out the basic requirements of the ACCT plan led to Luke being neglected at a time of crisis. The jury concluded that; On the balance of probability, considering all the evidence we have heard, we are satisfied that Luke Ashcroft did not intend to take his own life and therefore record a conclusion of death by misadventure
4	**CIRCUMSTANCES OF THE DEATH** 1. The death of Mr Ashcroft was confirmed at Lincoln County Hospital at 08.10 am on 1 July 2020. A later post mortem examination would find that the cause of death was 1a Hypoxic

	Brain injury 1b consistent with ligature application. A toxicology screen identified a number of substances not prescribed to Mr Ashcroft together with evidence of [redacted] a synthetic cannabinoid. 2. Mr Ashcroft had been admitted to Lincoln County Hospital on 24 June 2020 from HMP Lincoln where he was being detained. 3. Luke Ashcroft was 33 at the time of his death. As a child he had been diagnosed with ADHD and prescribed medication. His behaviour was on occasion challenging but was managed by his family. 4. As he grew older his mental health problems worsened. He became addicted to drugs and that addiction impacted upon his mental health. In 2017 he was formally diagnosed with schizophrenia and was prescribed medication for that condition. 5. On 21 May 2020 he was released from HMP Humber on licence. As a consequence of his failure to comply with the term of his release was recalled to prison on 23 May 2020 and sent to HMP Lincoln. On arrival he tested positive for opiates and cocaine. He was already on a methadone (heroin substitute) programme, which was continued at Lincoln. 6. Shortly after arriving at HMP Lincoln, on 27 May, he told healthcare staff that he had spiders living inside his body. He was prescribed antidepressant and antipsychotic medication but continued to report his belief that he was infested by spiders. As a consequence, on 14 June he was seen by Healthcare and referred for an urgent appointment with a psychiatrist. That was fixed for 23 June. 7. On 22 June, Mr Ashcroft became more distressed about the spiders and barricaded himself in his cell. He was subsequently moved to the segregation unit (known as the Care and Separation Unit (CSU)). A nurse assessed that he was medically fit to be segregated. 8. On 23 June, a psychiatrist assessed Mr Ashcroft and diagnosed him with a condition of delusional parasitosis (a fixed but false belief that the body is infested with insects). He found that Mr Ashcroft was having 'an acute psychotic episode'. He ordered tests to exclude any physical cause but considered it likely that Mr Ashcroft would require further assessment and treatment in a secure psychiatric hospital. He was then moved to another cell within CSU after causing some damage to his cell. 9. Later that day, a nurse started suicide and self-harm procedures (known as an ACCT) after Mr Ashcroft told her that he had spiders in his body and was ready to kill himself. He remained in the CSU after a further assessment. 10. Mr Ashcroft was subject to five observation checks an hour. The officer responsible for the checks during the night of 23 June into 24 June failed to carry out numerous checks but falsified the ACCT log to say he had in fact done so. His last entry in the ACCT log was at 6.50am which described that Mr Ashcroft was pacing in his cell. That entry was false. CCTV showed that his last check was made at 6.36am. 11. At 6.54am upon commencing his shift, the day shift officer checked Mr Ashcroft. He saw him lying on the cell floor [redacted]. The officer called for assistance. As soon as he heard colleagues arrive on the unit, he entered the cell and cut the ligature from Mr Ashcroft's neck. Another member of staff called a medical emergency code and healthcare staff arrived quickly. 12. The emergency services attended and Mr Ashcroft was taken to hospital, where his death was confirmed on 1 July.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) I received evidence in relation to the availability of telephone access for inmates at HMP Lincoln. I was told that, in the main, the prison had in-cell telephony, permitting prisoners access to telephones 24 hours a day, subject to them having sufficient phone credit and subject also to necessary security restrictions upon the numbers to be called. The position was said to be different in CSU. I was told that in-cell telephones were

	precluded by virtue of the construction of the unit, but that each cell was allocated a corded phone, which remained outside the cell until requested by the inmate. At that point it would be passed inside for use (as long as the unit was not then on "patrol state" during which time additional staff would be required to attend to permit the cell door to be opened). Once provided, the phone would remain in the cell for as long as the prisoner wished to retain it. Cell J 109 which housed Mr Ashcroft was said to be equipped with an anti-ligature door fitting. I was told that as a consequence, it was only possible for the phone to be passed over the top of the door, where it would dangle on its cord. That position, described from June 2020 was said to continue. I was told that cell J 109 was equipped with variable glass panels to the door, permitting improved observation of the inmate. It was selected for Luke Ashcroft in part as a consequence of him being subject to the ACCT procedures and subject to regular observations. It was recognised that he should be provided with telephone access. My concerns are twofold. Firstly, whilst not directly relevant to the death of Luke Ashcroft, I am concerned about the clear and obvious risks of self harm posed by the provision of a corded telephone, secured at one end, suspended at head height in a cell commonly occupied by prisoners, who may seek to self harm. I was told that the cell J109 had no ligature points and that the door was fitted with anti ligature fittings. As a consequence, that was the only method of securing telephone access. That same issue may extend to other cells in the CSU. Whether at head height or otherwise, the provision of a corded phone may well be an issue in potential cases of self harm and appears incongruous in comparison with other steps taken to ensure safety within that cell. The risks of an inmate utilising that cord in an act of self harm are self evident. Secondly, the mechanism of provision of telephone access on CSU appears to require a prisoner requesting such provision before the cells are locked down. Thereafter, whilst a request can be made by a prisoner, telephone provision may depend upon the availability of additional officers to attend whilst the cell is unlocked and the telephone provided. That is not certain to take place. Given the proper availability to prisoners in crisis of freephone access to Samaritans and similar services, the possible absence of a handset to access such services is a matter of concern.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by May 15, 2026. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons I have also sent it to Nottinghamshire Healthcare, Family of Mr Ashcroft and the Prison and Probation Ombudsman who may find it useful or of interest.

	I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 20/03/2026** [redacted] **Paul D SMITH** **HM Senior Coroner for** **Greater Lincolnshire**