Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Lomas, a prisoner at HMP Pentonville, on 22 May 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Edward Lomas was found dead in his cell on 22 May 2024 at HMP Pentonville. He was 62 years old. I offer my condolences to Mr Lomas' family and friends.

Although post-mortem and toxicology examinations were unable to establish the cause of his death, he left writing in his cell that indicated he had deliberately taken an overdose of prescribed and illicit medication the day before. He made clear that he had planned to end his life for reasons connected to the community. He was grateful to and complimentary of the staff who looked after him and apologised for the stress his death might cause them. We have investigated his death on the basis that it was self-inflicted. His was the third apparently self-inflicted death in three years at Pentonville.

Although Mr Lomas had some significant risk factors for suicide and self-harm and had expressed some thoughts of ending his life, he showed a level of determination and planning that meant it would have been extremely difficult for staff to recognise the severity of his risk and prevent his death.

Mr Lomas hoarded his prescription medication and obtained prescription medication illicitly elsewhere which allowed him to take an overdose. More needs to be done to ensure medication is robustly monitored. The clinical reviewer concluded that Mr Lomas' medication in possession assessment was not reviewed as it should have been, responses to Mr Lomas' healthcare applications were often delayed and there was not a clear pain management pathway for Mr Lomas' back pain.

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

Adrian Usher
Prisons and Probation Ombudsman **April 2025**

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Summary

Events

1. On 4 October 2023, Mr Edward Lomas was remanded to HMP Pentonville charged with a number of sexual offences. It was his first time in prison. Mr Lomas applied for and was granted vulnerable prisoner (VP) status due to the nature of his offences.

2. A GP continued his community prescriptions for a variety of conditions including a historic back injury and osteoporosis (a health condition that weakens bones). From 12 October, Mr Lomas was allowed to have his medication in possession.

3. During October and November, Mr Lomas applied several times for pain relief for chronic back pain without response. On 6 December, Mr Lomas described feeling helpless, low, depressed and irritable during a clinic appointment and the nurse referred him to the mental health team. He denied thoughts of suicide or self-harm.

4. On 5 January 2024, Mr Lomas was sentenced to 12 years six months in prison. On 15 January, he told the prison chaplain that he was sad he was not in touch with his family and sometimes wished he could go to sleep and not wake up. He denied active plans to harm himself or end his life and the chaplain concluded that Prison Service suicide and self-harm monitoring procedures (known as ACCT) were not necessary at that time.

5. On 7 February, Mr Lomas complained to the healthcare department that he was still in pain due to his back injury, his mental health was deteriorating, and he thought of ending his suffering himself. The Business Hub alerted wing staff and an officer completed a welfare check.

6. A GP completed a mood review on 21 February and referred Mr Lomas to a specialist clinic for pain management. On 16 April, a GP prescribed Mr Lomas amitriptyline for his back pain.

7. On 14 May, Mr Lomas told a member of the chaplaincy team that he had made a list of plusses and minuses about his life. The member of the chaplaincy team discussed whether to start ACCT procedures with the safer custody manager. They decided ACCT procedures were not required because Mr Lomas had a lot of protective factors and did not appear to be in crisis.

8. On 21 May, Mr Lomas' cellmate was released from prison. Wing staff agreed that his new cellmate would move in the following morning to allow Mr Lomas to pack his previous cellmate's belongings. Staff and prisoners who knew Mr Lomas well did not detect anything unusual in his behaviour.

9. At about 7.45am on 22 May, staff found Mr Lomas unresponsive in his cell. Nurses gave him cardio-pulmonary resuscitation and paramedics attended and confirmed life extinct at 8.00am.

10. Writing recovered from Mr Lomas' cell indicated that he had taken an overdose of amitriptyline and gabapentin (a painkiller) with the intention of killing himself for

reasons outside of prison. The post-mortem confirmed he had ingested both substances, but the pathologist was unable to say whether these caused his death.

Findings

11. Generally, we consider that Mr Lomas received good support from staff who took time to get to know him. Although they were sometimes concerned about his risk of suicide, we found that their decisions not to begin suicide and self-harm monitoring procedures were considered and reasonable.

12. Mr Lomas was not referred to the safer custody team after he received a long sentence, and an ACCT was not opened as it should have been according to local process. This was a missed opportunity to explore Mr Lomas' risk to himself.

13. Medication queues were not properly monitored, and spot checks of prisoners allowed their medication in possession were not sufficiently rigorous. As a result, Mr Lomas was able to hoard his prescribed medication, illicitly obtain medication not prescribed for him and take it with the intention of ending his life.

14. The clinical reviewer concluded that the healthcare received by Mr Lomas was not always equivalent to that he should have received in the community. In particular, Mr Lomas' risk assessment for being given his medication in possession was not reviewed after he was prescribed amitriptyline as it should have been. He did not receive appropriate care for his back pain and the prison did not have a clear pain management pathway.

15. Although Mr Lomas had some significant risk factors that indicated he was at risk of suicide and self-harm and had expressed some thoughts of ending his life, he showed a level of determination and planning that meant it would have been extremely difficult for staff to recognise the severity of his risk and prevent his death.

Recommendations

- The Head of Drug Strategy and the Lead Pharmacist should develop officer training on monitoring medication and the risks associated with prisoners using unprescribed medication and ensure it is delivered.

- The Head of Healthcare should ensure that when high or medium risk medications such as amitriptyline are prescribed, the prescriber ensures that a further in-possession risk assessment takes place in line with local and national policy.

- The Head of Healthcare should introduce a robust quality assurance process to ensure that prisoner applications are promptly responded to and healthcare staff record any action taken.

- The Head of Healthcare should set out a clear pain management pathway for prisoners and ensure staff follow it.

The Investigation Process

16. HMPPS notified us of Mr Lomas' death on 22 May 2024.

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

18. The investigator visited Pentonville on 30 May 2024. She obtained copies of relevant extracts from Mr Lomas' prison and medical records, and body worn video camera (BWVC) footage and staff radio communications from 22 May. The prison later provided CCTV footage. Further information was provided by the Metropolitan Police and London Ambulance Service.

19. The investigator interviewed 15 members of staff and two prisoners at Pentonville in May, August and October 2024.

20. NHS England commissioned a clinical reviewer to review Mr Lomas' clinical care at the prison. She and the clinical reviewer jointly interviewed seven staff, including the clinical staff.

21. We informed HM Coroner for Inner London North of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

22. The Ombudsman's office contacted Mr Lomas' ex-wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Lomas' ex-wife asked how he was allowed to have medication in possession when he was obviously at risk of suicide, why he was not on suicide watch and how another prisoner had managed to obtain her address and write to her. We have answered the first two questions in the body of the report. We asked the prison if they knew how the other prisoner had obtained her address, and they said they had investigated and concluded that Mr Lomas provided it to them. The prisoner had been released from Pentonville at the time of the investigation. We understand Mr Lomas' ex-wife reported the matter to the police.

23. Following consultation with the Head of Healthcare at Pentonville the third recommendation was amended to focus on applications and not complaints and applications.

Background Information

HMP Pentonville

24. HMP Pentonville is a local prison in London that primarily serves the courts of north and east London. Practice Plus Group, in partnership with Barnet, Enfield and Haringey Mental Health Trust, provides healthcare services.

HM Inspectorate of Prisons

25. The most recent full inspection of HMP Pentonville was in July 2022. Inspectors highlighted eight priority concerns, including that the prison was severely overcrowded and could not safely or decently care for the number of prisoners it was required to hold.

26. HMIP returned to Pentonville in April 2023 to conduct an independent review of progress. Inspectors identified reasonable progress on five of their key concerns but were extremely disappointed to find that the prison was even more overcrowded than in 2022. Improvements had been made to support prisoners in the early days of custody and most of the shortfalls in primary care services had been addressed. Although staffing levels had improved there was still pressure on the daily management of the regime and time out of cell was limited. The rate of self-harm at Pentonville had continued to reduce and was the lowest among all reception prisons.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 March 2023, the IMB reported concerns that due to high numbers, not all vulnerable prisoners were held on the Vulnerable Prisoners Unit (VPU) and were therefore not completely separated from the rest of the prison population. Opportunities for education and activities on the VPU were very limited. The key work scheme was barely operating due to staff shortages and the priority of security operations. Regular safety meetings were held which was a significant improvement and were attended by Listeners and prisoner representatives for the first time since Covid-19. Improved analysis of safety data was available to prison management and to the IMB. Another positive development was a fortnightly Safety Intervention Meeting.

Previous deaths at HMP Pentonville

28. There were five deaths at Pentonville in the three years before Mr Lomas' death. Two of these were self-inflicted and three were due to natural causes. There were no similar issues between one of the self-inflicted deaths and the deaths from natural causes and Mr Lomas' death. Our investigation into the second self-inflicted death is ongoing.

29. Since Mr Lomas' death, there have been two further deaths at Pentonville up to mid-January 2025. One of these was suspected to be due to drugs and the other was self-inflicted.

Assessment, Care in Custody and Teamwork

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

Key worker scheme

31. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*.

32. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Incentives Scheme

33. Each prison has an incentives scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Key Events

October – December 2023

34. On 4 October 2023, Mr Edward Lomas was remanded to HMP Pentonville charged with a number of sexual offences. It was his first time in prison.

35. Mr Lomas told a nurse at an initial health assessment that he had no significant history of mental illness, suicidal thoughts and self-harm or substance misuse. He denied any current suicidal thoughts. The nurse noted that Mr Lomas looked well. A GP continued his community prescriptions for a variety of conditions including asthma, a historic back injury and osteoporosis (a health condition that weakens bones). As is standard for new arrivals, Mr Lomas was not allowed his medication in possession meaning he had to collect it daily from the medication hatch on his wing.

36. The same day Mr Lomas applied for and was granted vulnerable prisoner (VP) status due to the nature of his offences. This meant that he would only mix with other vulnerable prisoners and would be kept separate from the rest of the prison population. He was allocated to the prison's vulnerable prisoner unit (VPU) on F4 and F5 landings. As these were full, staff moved him to a cell on A5 landing which is used for prisoners waiting for a space in the VPU.

37. On 5 October, a pharmacy technician reviewed Mr Lomas' GP summary care record and a GP prescribed two further medicines for him. These were also not given to him in possession. On 7 October, Mr Lomas applied to healthcare to request strong pain relief for back pain. There is no record of the response to this request and staff did not prescribe him any medication.

38. On 12 October, a pharmacy technician completed a risk assessment to decide whether Mr Lomas could have his medication in possession. Her assessment was based on discussion with him and a review of his clinical record. As part of the review the technician is required to search for relevant keywords such as suicide and self-harm. The technician answered "N/A" (not applicable) to questions about Mr Lomas' status including whether it was his first time in prison and whether he had experienced a recent life changing event. They concluded that Mr Lomas was low risk and suitable to have 28 days medication in possession at a time.

39. On 21 October, Mr Lomas again requested strong medication for back pain and asked for an additional mattress to help reduce the pain. Again, there is no record of any response or prescription as a result.

40. On 25 October, a trainee counselling psychologist completed a routine psychological therapies assessment with Mr Lomas (offered to every new prisoner at Pentonville). She reported that he became emotional when speaking about his family but had also told her he was settled in prison and liked the staff. Mr Lomas said he had been prescribed antidepressants 30 years previously when he became depressed after marital breakdown. He said he had no current thoughts of suicide or self-harm and would talk to staff if he felt low.

41. On 2 November, Mr Lomas again requested painkillers for back pain. He also asked to be referred for physiotherapy and for his back brace to be brought into the prison.

Once more there is no record of the response to this request and no prescription for painkillers.

42. On 14 November, Mr Lomas again requested a special mattress and said he was in agony and getting very little sleep. Staff did not respond to this request.

43. On 29 November, a GP prescribed Mr Lomas pain-relieving gel for his back pain. On 6 December, he described feeling helpless, low, depressed and irritable during a clinic appointment for a skin condition and the nurse referred him to the mental health team. He denied thoughts of suicide or self-harm.

44. On 12 and 19 December, Mr Lomas attended the Still Time quiet prayer group in the Chaplaincy. A prison chaplain said Mr Lomas was very quiet in the group but was happy to talk more privately at the beginning and end of the sessions. She said he was pleasant, calm and seemed happy to be in the background.

45. On 14 December, Mr Lomas moved to a cell on F4 landing in the VPU and on 20 December, the planned care meeting triaged his mental health referral and prioritised him for the prison Wellbeing Group (a group run by the healthcare department to provide emotional support to prisoners).

January – May 2024

46. In January, Mr Lomas began working as proofreader on the Voice of the Ville prisoner magazine. The creative writing tutor said she saw Mr Lomas every other day. She said he enjoyed his job on the magazine and also attended the creative writing workshops in the library.

47. On 4 January, a prison offender manager (POM) completed Mr Lomas' pre-sentence report. In the risk section, he noted that Mr Lomas had reported a number of health conditions and had questioned whether he would survive his sentence. He concluded that this did not indicate a risk of suicide as Mr Lomas had also said that he was enjoying prison because everyone was nice to him.

48. On 5 January, Mr Lomas attended court and was sentenced to a total of 12 years and six months in prison. When he returned to prison, there is no evidence that anyone in reception recognised his change in status or reassessed his risk as they should have done.

49. On 15 January, a prison chaplain visited Mr Lomas after he did not attend the Still Time prayer group. Mr Lomas told her that he had not gone to the group because he had not been unlocked. He said he had recently been sentenced and was remorseful for his crimes. He was very sad that his family had cut him off. Mr Lomas said he had made friends on his landing and staff were supportive. She asked him whether he felt like harming himself and Mr Lomas said that he sometimes wished he could go to sleep and not wake up. He said he was usually hospitalised once every year with chest problems and hoped that this year was his last.

50. The chaplain told the investigator she considered whether to start ACCT procedures but decided against it because Mr Lomas was clear he had no active plans to kill or harm himself and when directly challenged he denied having thoughts or plans to end his life. Mr Lomas said he would like to speak to the mental

health team, and she said the wing supervising officer promised to make a referral and to ensure Mr Lomas was unlocked for the Still Time prayer group the next day. There is no evidence staff made this referral. She said she is a trained ACCT assessor and usually erred on the side of caution and started ACCT procedures if she was in any doubt about a person's safety. She said she was confident that Mr Lomas was not at risk of suicide at this point, but she had been keen to make sure he was referred to the mental health team.

51. On 17 January, Mr Lomas saw a nurse about elbow pain and did not mention his mental health or ask about a referral. On 23 January, 30 January and 6 February he attended the Wellbeing Group and engaged well. He stopped attending the group after this as he preferred to attend the Still Time prayer group.

52. On 7 February, Mr Lomas completed a prisoner complaint form. On the form he indicated his complaint was about self-harm and did not concern discrimination due to a protected characteristic. He said, "My mental health is spiralling down into depression and every night all I can think about is ending my suffering myself. PLEASE HELP." He said he had asked for help from the GP, the mental health team and the chemist but had not received any. He asked for an antidepressant and talking therapy.

53. The same day Mr Lomas saw a prison GP because he had a lump on his elbow. The GP was on a sabbatical during the investigation and was not interviewed. According to the clinical record Mr Lomas did not mention mental distress or ask for an antidepressant.

54. The Business Hub triaged Mr Lomas' complaint form on 8 February and marked it for action by healthcare with a target response for 15 February. The same day, the Business Hub manager went to F Wing to alert staff to the content of the complaint form. She spoke to an officer and asked her to check on Mr Lomas.

55. The officer said she was not Mr Lomas' keyworker, but worked regularly on his landing and had been on duty when the manager came over. Mr Lomas told her that he was in constant pain from a bad back, and this was affecting his mental health. She said she contacted healthcare who told her that they would process the complaint and reply to Mr Lomas. She reassured Mr Lomas that his complaint would be acted on and said Mr Lomas was grateful for this. He reassured her that he would speak to staff if his mental health deteriorated. She said she intended to see Mr Lomas again to check the outcome of his complaint, but shortly afterwards she was moved off prisoner facing duties after a serious incident and did not see him again.

56. On 9 February, a GP answered Mr Lomas' complaint form and told him he had booked him a GP appointment for 21 February.

57. For unknown reasons, the Equality Manager also answered Mr Lomas' complaint on 14 February. He wrote that he was sorry that Mr Lomas was going through a difficult time and encouraged him to speak to a member of staff or a Listener (a prisoner trained by The Samaritans to provide confidential peer support). He added that the equalities team was unable to help further because they could find no evidence of discrimination due to a protected characteristic.

58. On 21 February, a prison GP saw Mr Lomas in response to his complaint form of 7 February. He completed a mood review with Mr Lomas which showed he had mild depression. He prescribed Mr Lomas citalopram (an antidepressant). Mr Lomas asked for gabapentin (a strong painkiller) for his chronic back pain, and he referred him to the psychiatrist to review his request. Mr Lomas told a pharmacy technician that he was going to stop taking his citalopram a week later after it made him feel unwell.

59. On 5 March, a Supervising Officer (SO), promoted Mr Lomas to enhanced level of the incentives scheme. The SO said he had worked on F Wing since November 2023 and interacted with Mr Lomas most days. He said Mr Lomas was always cheerful, helpful and polite and was a "model prisoner".

60. The same day, the psychiatrist attempted to see Mr Lomas, but he was attending activities off the wing.

61. On 20 March, a prison GP completed another mood review with Mr Lomas. Mr Lomas said his mood was stable but again made a request for gabapentin for chronic back pain. The GP noted that the psychiatrist was due to see him at his next clinic.

62. On 9 April, Mr Lomas attended the Still Time prayer group and a member of the Chaplaincy team recorded that he participated well.

63. In an article published in the April edition of the Voice of The Ville, Mr Lomas said that he had found prison a very positive experience. He said he had nowhere to go on release and so intended to stay in prison for as long as possible.

64. On 16 April, Mr Lomas attended the psychiatrist's clinic. The psychiatrist is a consultant psychiatrist and addiction medicine specialist. He said Mr Lomas was referred to him because he had reported a previous prescription for gabapentin in the community and he was asking for it to be prescribed for neck pain that stopped him sleeping. The psychiatrist said he prescribed a low dose of amitriptyline (an antidepressant also used to treat nerve pain) and instructed the prison GPs to review Mr Lomas to see if he responded well to it and to increase it if necessary.

65. On 24 April, a prison GP increased Mr Lomas' amitriptyline from 10mg to 20mg daily at his request. He said that in the past, amitriptyline was never given to prisoners in-possession because of its toxicity. However, changes had been made across prisons to give prisoners more responsibility for their medication. To mitigate risk from this, prisoners were only given a one-week supply at a time. Pharmacy staff did random spot checks in conjunction with wing staff to check prisoners were not hoarding medication. He said that once a prisoner has had a risk assessment and been deemed suitable for in-possession medication, the decision is not usually revisited if they are subsequently prescribed different medication, even if that medication might be known to be toxic in overdose.

66. Mr Lomas attended the Still Time prayer group on 7 May and a chaplain noted that he seemed very positive. On 14 May, she spoke to him in more detail after he asked about the Official Prison Visitor scheme (OPV – unpaid volunteers who visit prisoners who do not receive visits from friends or family). When she returned him to his cell, she said Mr Lomas gestured towards a piece of paper that was laying on

the table and said he had been writing about the plusses and minuses of his life. He said the minuses included having no family and no affection. She said she focused on some of the plusses he had listed which he told her included music and the friends he had made in prison. He agreed with her that there were a lot of plusses. She said she only saw the piece of paper from the cell doorway.

67. After their conversation, the chaplain said she spoke to a Custodial Manager (CM) from Safer Custody about Mr Lomas' list because she wanted a second opinion about whether to start ACCT procedures. She said they agreed that Mr Lomas had a realistic understanding of his situation. She said Mr Lomas engaged well with everyone. She said she decided that Mr Lomas simply had a realistic picture of his life. He did not appear different or sad. His main concern appeared to be what would happen when he was released, and she knew this was a long time away.

68. The CM said the chaplain told her she had spoken to Mr Lomas, and he had put a list together of pros and cons about being alive. She said the chaplain was concerned that this was not something that most people would do and wanted to talk through whether it was appropriate to open an ACCT document.

69. The CM said she asked the chaplain if Mr Lomas' pros list was bigger than his cons list, and she said that it was, and that Mr Lomas had acknowledged that in their conversation. She said the chaplain confirmed that Mr Logan had said that there were a lot of good things about his life in prison and that staff were supportive. They went through Mr Lomas' situation and noted that he was engaging in groups, had the support of the Chaplaincy and F Wing officers, he was eating and taking his medication and he got on with his cellmate. She said it was not unusual for prisoners to be reflective about their sentences. They concluded that there was no evidence that Mr Lomas was in crisis, and they decided ACCT monitoring was not necessary at that time.

70. Prisoner A lived in the cell next door to Mr Lomas. He said he first met Mr Lomas on A Wing when he was working as an Insider helping new prisoners. He said Mr Lomas was always smiling and well spoken. Mr Lomas liked playing pool and guitar and got on well with his cellmate. Mr Lomas asked him a lot of practical questions about prison life and how to get things done. Mr Lomas generally kept himself to himself but always seemed happy when they spoke. He did not talk deeply about how he was feeling and never really opened up about his emotions. He said he did not see anything in Mr Lomas' behaviour or demeanour to cause him concern. He spoke to him every day and did not see any outward sign that Mr Lomas was considering ending his life.

71. Prisoner B also lived in the cell next door to Mr Lomas. He said he had known Mr Lomas for about three and a half months. He said Mr Lomas was quiet, friendly, helpful and was always smiling. He also said that sometimes Mr Lomas seemed a bit lost and in his own world. In the week leading up to his death, Mr Lomas had seemed fine and had played pool with him as normal on the wing. He had not seen any sign that Mr Lomas was in distress or unhappy but acknowledged that he was a quiet man, so it was hard to tell.

72. During his time at Pentonville, Mr Lomas did not have any visitors, nor did he call anyone other than his solicitor. He had funds available to him should he have

wished to do so but said he had no one to contact as he was estranged from his family.

21 May 2024

73. On 21 May, Mr Lomas attended the Still Time prayer group. A chaplain said Mr Lomas was generally quite quiet at the meeting but, on 21 May, he joined in more with the conversation. She took him back to his cell afterwards and they walked through the gym. As they did so, Mr Lomas commented on the space and said he would really like to play his guitar in there. She said goodbye and told him she would see him at the group the following week. Mr Lomas said that he hoped he would see her, but he was not sure whether it would clash with his new job in the library. Mr Lomas also asked her if she could find him a large print Bible. She said she would find out for him and let him know.

74. The same day Mr Lomas' cellmate was released on bail from court. Mr Lomas agreed that another prisoner he knew on the landing above could move into the cell but asked that his new cellmate move in the next day to allow him to pack away his previous cellmate's property and tidy up. Prisoner A said he spoke to Mr Lomas that evening. They had a general conversation during which he had no concerns about Mr Lomas' state of mind.

75. That evening an officer completed a routine check of the prisoners on F4 known as the evening roll count. CCTV showed she checked Mr Lomas' cell at 9.32pm and spent several seconds talking to him through his door. She said she was a regular F Wing officer and remembered Mr Lomas as a cheerful man who played the guitar and helped other prisoners tune their guitars. She did not remember Mr Lomas having any concerns apart from asking about his medication for his back pain. She said she spent some time chatting to Mr Lomas that evening because she noticed that his cellmate had been released from court. She said Mr Lomas told her that he was going to pack his cellmate's belongings and give them to staff in the morning.

Events of 22 May

76. The investigator watched CCTV and body worn video camera (BWVC) footage, listened to radio traffic and obtained police statements and London Ambulance Service (LAS) records. The following account is taken from all those sources. The clocks on the different sources are not synchronised but are all within about one minute of each other. For simplicity, timings have been taken from the CCTV clock. Mr Lomas' cell was a double cell designed for a prisoner with mobility issues. It is twice as big as a standard cell and has two doors, each with their own observation panel. Only the door on the right-hand side was in use at the time. Mr Lomas' bed was in the left-hand section of the cell immediately in view of the observation panel in the left-hand door.

77. An Operational Support Grade (OSG) completed a routine check of all the prisoners on F Wing, known as the early morning roll count. At 5.25am, he checked Mr Lomas' cell. He spent almost a minute looking through first one and then the other observation panel in the two doors to Mr Lomas' cell. He was absent from work at Pentonville at the time of the investigation and was not interviewed.

78. Officer A started his shift at 7.30am and started a routine check of prisoners. He started on the third landing and then went up to the fourth landing. CCTV showed he looked through the observation panel in the left-hand door of Mr Lomas' cell at 7.41am. He said he could see Mr Lomas laying on his back on the bed. He could not see him moving or breathing and said something did not look right so he observed Mr Lomas for a couple of minutes. He said he saw what he thought was food mess on Mr Lomas' mouth and chest.

79. Officer A said he shouted to Mr Lomas but got no response. He said some prisoners can breathe very shallowly and appear to not be breathing so he radioed Officer B because he wanted a second opinion. He did not receive a response and was not sure if the transmission went through. (We have confirmed that it did not.) At 7.43am, he went down to the wing office on the second landing and told Officer B he could not get a response from Mr Lomas. She then accompanied him to Mr Lomas' cell.

80. Officer B looked through the observation panel at 7.45am. She said Mr Lomas was slumped across the bed with his arms hanging limply over the side and what looked like vomit on his chest. She immediately asked Officer A to radio a code blue emergency (to indicate a prisoner had stopped breathing or was having breathing difficulties) while she opened the right-hand cell door. The prison radio traffic and LAS call showed that the communications officer called an ambulance less than 90 seconds after the code blue was received and an ambulance was dispatched immediately.

81. Officer B said she tried to find a pulse but could not, and her first impression was that Mr Lomas had died. She and Officer A attempted to put Mr Lomas in the recovery position, but he was very stiff and heavy. Officer B asked the pharmacist working in the landing pharmacy to help. As they were trying to move Mr Lomas, two SOs arrived.

82. Both SOs arrived within a minute of Officer B. SO A said he was in the wing office when he heard the code blue on the radio. He and SO B also tried to move Mr Lomas because they saw he had vomited and were concerned he was choking however he was too stiff. He said he moved aside when healthcare staff arrived and, as he left the cell, he noticed some papers behind the cell door that had been pushed out of sight as staff entered the cell.

83. A healthcare assistant arrived at 7.47am, followed within seconds by a nurse with the emergency equipment. The nurse started cardio-pulmonary resuscitation (CPR).

84. Ambulance paramedics arrived at 7.57am. They performed some basic checks on Mr Lomas and, at 8.00am, confirmed life extinct.

Contact with Mr Lomas' family

85. The prison appointed a family liaison officer. He and a senior manager visited Mr Lomas' next of kin on the day he died and broke the news of his death in person. At the request of the family, the prison organised and paid for Mr Lomas' funeral in line with national guidance.

Support for prisoners and staff

86. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

87. After Mr Lomas' death, a senior prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

88. The prison posted notices informing other prisoners of Mr Lomas' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Lomas' death. Listeners attended the wing to speak to prisoners. The two prisoners spoken to for this investigation said they had been well supported.

Writing recovered from Mr Lomas' cell

89. On one piece of paper dated 4 May 2024, Mr Lomas wrote that he was feeling better every day because he knew that the "nightmare of his life was almost at an end". He said prison life was fine, but he was could not bear being ostracised from his family and the thought that he would not see them again. He said that there was only one way to show them how sorry he was for what he had done. He said he had 1000mg of amitriptyline and 3600mg of gabapentin and hoped that would "do the trick". Mr Lomas thanked staff for their kindness and apologised to them. He said he was not unhappy or depressed, but he did not want to live without his family.

90. On another piece of paper dated 9 May, Mr Lomas wrote that he was truly sorry to everyone at Pentonville as they had been very kind to him and had made him feel like part of a new family. He said he missed his real family too much and did not want to live without them.

91. On another piece of paper, he listed some bequests to his family. On a third piece, he wrote that he had taken 800mg of amitriptyline and 2400mg of gabapentin and put "DNR" (do not resuscitate) in big letters. In a diary he wrote across 21 and 22 May that he had taken all his pills while playing music

Post-mortem report

92. Toxicology showed that Mr Lomas had taken amitriptyline and gabapentin at some point before death. The level of amitriptyline was approaching the concentration associated with toxicity but was lower than a typical fatal concentration. The concentration of gabapentin was consistent with therapeutic use.

93. The pathologist gave the cause of death as unascertained. The pathologist concluded that it remained undetermined whether Mr Lomas died from natural or toxicological causes.

Inquest

94. The Coroner's inquest held in February 2025 gave the medical cause of death as:

    1a acute poly-drug toxicity

    2 systemic sarcoidosis, chronic bronchiectasis

95. The Coroner recorded a verdict of suicide following the consumption of medication and listed Mr Lomas's ability to stockpile prescription medication and illegally acquire illicit medication with HMP Pentonville as contributory factors.

Findings

Assessment of Mr Lomas' risk of suicide and self-harm

96. As noted, the cause of Mr Lomas' death could not be ascertained by post-mortem examinations. However, given the writing found in Mr Lomas' cell after his death, in which he described taking an overdose of amitriptyline and gabapentin, we have investigated his death on the basis that it was self-inflicted.

97. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, (in place at the time of Mr Lomas' death and since replaced by the Prison Safety Framework) lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making. In January 2025, this PSI was replaced with *The Safety Framework*.

98. Mr Lomas had a number of risk factors that indicated he was at risk of suicide and self-harm including sexual offences, family breakdown and his age and length of sentence. There were three occasions on which Mr Lomas indicated that he had thoughts of ending his life. On two of these, 15 January and 14 May, staff properly considered whether ACCT monitoring was appropriate and decided that it was not. Staff judgement is fundamental to the ACCT process. Both staff knew Mr Lomas well, considered his protective factors and concluded he was not in crisis. We are satisfied that their decisions were considered and reasonable in the circumstances.

99. On 7 February, Mr Lomas indicated that he had thought about suicide in a complaint to healthcare about pain relief. We consider that it was good practice for the Business Hub manager to personally alert wing staff to the content of this complaint and ensure Mr Lomas received a welfare check. Mr Lomas told the officer completing the check that his complaint related to his back pain and did not indicate he was in mental distress. We also note that he saw a GP about a separate matter the same day he submitted his complaint and did not refer either to chronic pain or to mental distress. Although, overall, we consider the immediate response to this complaint was satisfactory, we consider that for completeness the safer custody team should have also been informed.

100. Risk of suicide fluctuates according to context and can increase in response to significant events and changes in circumstance. In this respect there was one significant missed opportunity to assess Mr Lomas' risk of suicide and self-harm on 5 January when he received a long sentence. Prison Service Order (PSO) 3050, *Continuity of healthcare for prisoners*, says that events such as attending court or sentencing at court, are factors that might have a significant impact on the health of a prisoner. When prisoners pass through reception on their return from court, prisons are required to have protocols in place for risk assessing them to identify any potential suicide and self-harm issues. Prison Service Instruction (PSI) 07/2015, *Early days in custody*, states that there must be arrangements in place to

assess prisoners whose status or demeanour may have changed after a court appearance by video link.

101. The process at Pentonville is for ACCT procedures to be started on all prisoners that receive a long sentence. In addition, reception staff should send an email alert to the safer custody team. The safer custody administrator confirmed they had not received an email about Mr Lomas' sentence and no ACCT was opened. The reception CM said she was unable to find out why this had not happened, but it might have been that an unusually high number of prisoners passed through reception that day. In combination with severe delays in the prison's Offender Management Unit processing sentencing information, this meant that wing staff were unaware Mr Lomas had received a significant sentence until after he died. There is no evidence Mr Lomas was seen by a nurse in reception on his return from court as he should have been. This was a missed opportunity to reassess Mr Lomas' risk.

102. We have not seen any evidence to indicate that there is a systemic issue with changes in circumstance not being picked up in reception. A number of changes to sentencing policy to reduce the prison population have put Offender Management Units under severe strain. We understand from the Head of the Offender Management Unit at Pentonville that measures have since been put in place to ensure sentencing information is processed more quickly and that delays have reduced. The Governor will want to ensure that prisoners are assessed appropriately after appearing in court.

103. Mr Lomas showed a considerable degree of planning and intent to end his life. We consider that, even if ACCT procedures had been put in place on the four occasions above, it would have been extremely unlikely that the prison would have been able to prevent his death. Mr Lomas was an articulate man and was able to convince staff and prisoners that knew him that he was happy in prison and looking to the future. With hindsight, it is significant that Mr Lomas asked that his new cellmate move in the following morning. However, he gave a plausible reason for this because his previous cellmate's belongings were still in the cell, and he had offered to pack them up. We are satisfied that there was nothing to indicate to staff that Mr Lomas was at heightened or imminent risk of suicide in the period leading to his death.

Diversion of medication and spot-checks

104. We are concerned that Mr Lomas was apparently able to hoard his amitriptyline and obtain gabapentin illicitly. The clinical reviewer addresses his prescription for amitriptyline in detail in her clinical review and we repeat her main concern about this in the section below.

105. At interview, clinical staff told us that medication queues were not always adequately supervised by officers. Wing staff confirmed that staff shortages meant that it was not always possible for staff to supervise the medication hatch and run the daily activities on the wing. All prisoners who have their medication in possession are subject to spot checks from a pharmacy technician accompanied by an officer. The lead pharmacist told us that staff are not always available to accompany pharmacy staff which meant that spot checks often did not take place.

She had agreed with the Head of Security that security staff would oversee spot checks with wing staff to make them more efficient, but this had not occurred consistently.

106. The lead pharmacist confirmed that these areas of concern were discussed regularly at the monthly prison drug strategy meeting and that senior managers were supportive of improvements. However, this did not always filter down to wing staff and result in meaningful change. She said on one occasion she had accompanied wing staff on spot checks and encouraged them to be more rigorous and this had led to several issues with in-possession medication being uncovered. She thought increased staff awareness through training would help officers understand the importance of proper supervision of medication hatches and spot checks.

The Head of Drug Strategy and the Lead Pharmacist should develop officer training on monitoring medication and the risks associated with prisoners using unprescribed medication and ensure it is delivered.

Clinical care

107. Overall, the clinical reviewer concluded that the physical healthcare received by Mr Lomas was not always equivalent to that which he would have received in the community. She noted that it was not possible to form a view on equivalence on some issues which were unique to prison healthcare. She also identified a number of instances of good practice. We highlight her main concerns below and endorse some of her recommendations. However, the Head of Healthcare will wish to consider the clinical reviewer's other concerns and recommendations which are not repeated here.

Prescription of amitriptyline and risk assessment to keep it in possession

108. The clinical reviewer found that the prescribing of amitriptyline in possession for seven days was broadly in line with national and local prescribing policy. However, crucially, Mr Lomas did not have a review of his in-possession risk assessment when this new medication was prescribed. This was contrary to national and local prescribing guidelines and appears to have resulted in Mr Lomas being able to hoard enough to take his own life. We endorse the following recommendation:

The Head of Healthcare should ensure that when high or medium risk medications such as amitriptyline are prescribed, the prescriber ensures that a further in-possession risk assessment takes place in line with local and national policy.

Response to healthcare applications

109. The clinical reviewer found that it was not always clear what the outcome had been following healthcare applications made by Mr Lomas and some responses were significantly delayed. We make the following recommendation:

The Head of Healthcare should introduce a robust quality assurance process to ensure that prisoner applications are promptly responded to and healthcare staff record any action taken.

Back pain treatment

110. The clinical reviewer found that Pentonville did not have a clearly defined pathway for pain management, and this contributed to a delay of over six months for Mr Lomas to have his back pain adequately assessed and prescribed medication. His request for a special mattress was not addressed. We make the following recommendation:

The Head of Healthcare should set out a clear pain management pathway for prisoners and ensure staff follow it.

Governor to note

Early morning roll count

111. Given Mr Lomas' condition when he was discovered unresponsive at about 7.45am and the contents of his final letters, it is likely that he was already dead at early morning roll check some two hours earlier. The primary purpose of a roll check is for security, to check that all prisoners are present. Staff should also satisfy themselves of each prisoner's safety, but do not need to get a response from them. We note that the night patrol officer spent some time trying to see into Mr Lomas' cell before moving on. From Officer A's description at interview, although it was not obvious to see whether Mr Lomas was breathing, his presentation gave him some concern.

112. While it is unlikely that discovery at this time would have changed the outcome for Mr Lomas, we consider night staff should call for assistance if they are in any doubt about the health and safety of a prisoner, in the same way that Officer A did at the subsequent check. The Governor will want to ensure that this is routinely happening.

Keyworking

113. Many prisons, including Pentonville, struggle to provide regular keywork due to staff shortages and the current exceptional capacity pressures. Priority is often given to the most vulnerable prisoners. Mr Lomas had no recorded keywork sessions in over seven months at Pentonville (although the welfare check requested by the Business Hub manager on 8 February was recorded as keywork). Mr Lomas clearly felt supported by a number of different staff at Pentonville and lived on a small unit with more regular staff who it is evident spoke to him on a regular basis. We do not consider that he should have been identified as a priority for keywork.

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