

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Serban, a prisoner at HMP Lewes, on 10 April 2025

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



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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 Daniel Serban was found dead in his cell with a ligature tied around his neck at HMP Lewes on 10 April 2025. He was 52 years old. I offer my condolences to Mr Serban's family and friends.

There was no indication that Mr Serban was at risk of suicide or self-harm when he arrived at Lewes or during the three days he spent there. I am satisfied that staff could not have foreseen Mr Serban's actions.

I make no recommendations.

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

February 2026

Contents

Summary	1
The Investigation Process.....	2
Background Information.....	3
Key Events.....	4
Findings	7

Summary

Events

1. On 7 April 2025, Mr Daniel Serban, a Romanian national, was remanded in prison charged with stalking, sexual assault and burglary. He was sent to HMP Lewes. It was his first time in prison.
2. During his induction, Mr Serban told staff that he had no thoughts of suicide or self-harm. Staff recorded that Mr Serban engaged well and raised no concerns.
3. At around 8.28am on 10 April, another prisoner alerted staff after finding Mr Serban lying on his bed unresponsive. Staff found Mr Serban had a ligature tied around his neck. They cut the ligature, started CPR and radioed a medical emergency code. When paramedics arrived, they saw signs of rigor mortis (stiffening of the body after death) and pronounced life extinct at 8.46am.

Findings

4. We found that staff appropriately assessed Mr Serban for suicide and self-harm risk when he arrived at Lewes. We are satisfied that Mr Serban gave no indication that he was at risk, either when he arrived or over the next three days, and that staff could not have foreseen his actions.
5. The clinical reviewer concluded that the care Mr Serban received was equivalent to that which he could have expected to receive in the community.
6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Serban's death on 10 April 2025.
8. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact her.
9. The investigator visited Lewes on 17 April. She obtained copies of relevant extracts from Mr Serban's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Serban's clinical care at the prison. The investigator and the clinical reviewers interviewed eight members of staff.
11. We informed HM Coroner for East Sussex of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
12. The Ombudsman's office contacted Mr Serban's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Serban's mother raised no issues but said she would like a copy of the report.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS. They found no factual inaccuracies.
14. We sent a copy of our initial report to Mr Serban's next of kin. Mr Serban's next of kin raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence.

Background Information

HMP Lewes

15. HMP Lewes is a local prison serving the courts of East and West Sussex. Practice Plus Group provides healthcare services. Nurses are available 24 hours a day.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Lewes was in February 2024. Inspectors reported that leaders had overhauled early days processes to improve the experience of prisoners, although they recognised there was more to do. There was a good focus on settling prisoners in and all necessary assessments were completed. The early days timetable included an informative peer-led induction in a comfortable room as well as a visit from the chaplaincy, an introduction to the gym and an education screening.
17. Inspectors also reported that the rate of self-harm was rising and above the average of other reception and resettlement prisons. Formal structures to address self-harm were developing. The strategy and action plan to reduce suicide and self-harm were suitably comprehensive, and the safety meeting was well attended and reviewed a range of data.
18. At the time of the inspection, there were 11 trained Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners).

Independent Monitoring Board

19. 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 January 2025, the IMB reported that the prison revised its reception and induction processes for new prisoners during 2024, and the Board's view was that the new processes were much improved.
20. The IMB also reported that during the reporting period, 651 self-harm incidents were recorded, a 5% increase compared with 620 in 2023/24, and up by around one third since 2022/23. So, whilst incidents of self-harm were up, the rate of increase was slowing. The large majority (85%) were classed as low in severity, and the total also included ongoing self-harm behaviours by a small number of prisoners, some of whom had complex mental health problems.

Previous deaths at HMP Lewes

21. Mr Serban was the ninth prisoner at Lewes to die since April 2022. Of the previous deaths, four were from natural causes, one was self-inflicted and three were drug related. Up to the end of August 2025, there has been a further drug related death.

Key Events

22. On 7 April 2025, Mr Daniel Serban, a Romanian national, was remanded in prison charged with numerous offences including stalking, sexual assault and burglary. He was sent to HMP Lewes. It was his first time in custody.
23. The reception nurse completed Mr Serban's initial healthcare screen. Mr Serban's first language was Romanian but he spoke and understood English. Mr Serban told the nurse that he had previously suffered with depression and anxiety but had no current thoughts of suicide or self-harm. The nurse recorded that she had no immediate concerns but made a standard referral to the mental health team.
24. Officer A conducted Mr Serban's first night interview and completed an initial custody care record. The record was comprehensive and recorded that Mr Serban was asked a multitude of questions about his health and wellbeing and his current circumstances.
25. Officer A recorded that Mr Serban presented well and engaged clearly. Officer A highlighted Mr Serban's risk factors for suicide and self-harm (it was his first time in prison and his alleged offence was against a family member) and noted that Mr Serban said that he had no thoughts or history of self-harm. Mr Serban was located on the induction wing.
26. That night, staff recorded regular welfare checks. Staff noted that Mr Serban slept throughout the night.
27. On 8 April, Officer B completed a Basic Custody Screening Tool (BCST2). Mr Serban told Officer B that he had previously been diagnosed with depression but had no current thoughts of self-harm. Officer B recorded that it was Mr Serban's first time in prison and he engaged well and showed no signs of anxiety. He also noted that Mr Serban would be moved to the Vulnerable Prisoner (VP) wing, when there was a space. (VP wings are found in most prisons across the country and are designed to keep vulnerable prisoners and sex offenders away from the main population of the prison for their own safety.)
28. Later that morning, Mr Serban made a phone call to his son in Romania. (After Mr Serban's death, a Romanian speaker listened to the call and said that Mr Serban gave no indication that he was considering taking his life.)
29. On 9 April, Mr Serban was moved to the VP unit. He was placed in a double cell but he was the sole occupant.

Events of 10 April

30. There were no CCTV cameras on Mr Serban's wing so the following account is taken from prison records, staff statements/interviews, body worn video camera footage and South East Coast Ambulance Service records.
31. At around 7.15am, Officer C completed the morning roll check. Officer C said that he remembered seeing Mr Serban lying in the top bunk bed and he could see his

feet. He assumed that Mr Serban was asleep. (The morning roll check does not require officers to get a response from the prisoner.)

32. At around 7.45am, Officer D and Officer E unlocked the cells on Mr Serban's landing. Officer D was responsible for unlocking Mr Serban's cell. At the same time, Officer E was having trouble unlocking the shower door and Officer D stopped to help her. After unlocking the cells, they stood on the landing answering prisoner queries. At around 8.28am, a prisoner called to Officer E to come to Mr Serban's cell. When Officer E got to the cell, she saw that Mr Serban was lying on his bed with a ligature tied around his neck and there was blood coming from his nose. She radioed a code red (a medical emergency code used to indicate severe blood loss that alerts healthcare staff and tells the control room to call an ambulance immediately) but it was not transmitted over the radio network because the network was busy with other people transmitting.
33. A few seconds later Officer D and a supervising officer (SO) heard someone call for staff and could see a commotion on the landing. They quickly responded and cut the ligature from Mr Serban's neck. Just over a minute later, the SO radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). The operational support grade (OSG) in the control room immediately called for an ambulance.
34. Several officers responded to the code blue. After around three minutes, Officer F climbed onto the top bunk bed and started CPR. Healthcare staff arrived and told the officers to move Mr Serban to the floor. The officers lifted Mr Serban to the floor, and healthcare staff continued CPR.
35. At around 8.44am, paramedics arrived. Paramedics assessed Mr Serban and noted that he was stiff and had rigor mortis (stiffening of the body that occurs roughly two to six hours after death). At 8.46am, they declared life extinct.

Contact with Mr Serban's family

36. On 10 April, the prison appointed two family liaison officers (FLOs). There was no address or telephone number recorded for Mr Serban's next of kin so the prison contacted the police to see if they could help. Hampshire Police gave the prison the address of Mr Serban's wife.
37. At around 2.45pm, both FLOs arrived at Mr Serban's wife's address and informed her of his death.
38. Over the following weeks, the FLOs offered support to Mr Serban's family. In line with national policy, the prison contributed towards Mr Serban's funeral costs.

Support for prisoners and staff

39. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners 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.

40. After Mr Serban's death, a 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.
41. The prison posted notices informing other prisoners of Mr Serban's death and offering support. Listeners were deployed and staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Serban's death.

Post-mortem report

42. The post-mortem report concluded that Mr Serban died from ligature strangulation.

Findings

Assessing Mr Serban's risk of suicide and self-harm

43. The Prison Safety Policy Framework requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under a process known as ACCT.
44. Mr Serban had some risk factors for suicide and self-harm, including being in prison for the first time and having been remanded for an offence against a family member. The investigator interviewed Officer A who completed Mr Serban's first night interview. Officer A told the investigator that he remembered interviewing Mr Serban and that he engaged well during the process and did not express any thoughts of suicide or self-harm.
45. Officer A told the investigator that he was aware that it was Mr Serban's first time in prison and that he had been charged with a sexual offence, so he took Mr Serban to a private room to be interviewed and made sure that he spent extra time with Mr Serban. Officer A also said that he did not just rely on Mr Serban's presentation to decide whether he was at risk of suicide and self-harm, he looked at all the appropriate documentation as well.
46. Officer A told the investigator that he was an experienced first night officer, that he had previously started ACCT monitoring on prisoners that had told him they had no thoughts of suicide or self-harm, and that he would have initiated ACCT procedures immediately had he identified any concerns about Mr Serban's wellbeing. It was clear that Officer A was trained and competent in the ACCT process and completed a thorough first night interview with Mr Serban.
47. The following day, Officer B completed a Basic Custody Screening Tool (BCST) and told Mr Serban about how the Listeners, Samaritans and the chaplaincy could offer support while he was in prison should he need it. Officer B recorded that Mr Serban presented well and engaged clearly.
48. We are satisfied that staff appropriately assessed Mr Serban for suicide and self-harm risk when he arrived at Lewes, and that it was reasonable for them to conclude that he did not require the support of ACCT procedures at that time. Mr Serban subsequently gave no indication that he was struggling with his mental health or that he was in crisis. We are satisfied that staff could not have foreseen Mr Serban's actions.

Delay in identifying that Mr Serban was dead

49. Officer D unlocked Mr Serban's cell at around 7.45am. Around 45 minutes later, another prisoner alerted staff that something was wrong, and staff found Mr Serban unresponsive. When paramedics arrived at around 8.45am, around one hour after Mr Serban was unlocked, they assessed that Mr Serban was dead as he had rigor mortis. As rigor mortis occurs around two to six hours after death, Mr Serban was dead when he was unlocked.

50. Prison Service Instruction (PSI) 75/2011 Residential Services states that staff should assure themselves of the wellbeing of prisoners during or shortly after unlock. Clearly the officer who unlocked Mr Serban did not comply with this.
51. Officer D said that she and Officer E were both unlocking cells and she did not remember specifically unlocking Mr Serban's cell. In the statement she made after Mr Serban's death she wrote that, at the same time, Officer E asked her to help unlock the shower door as she was having trouble, and that prisoners had started to ask her questions. During the interviews, the investigator asked several other officers about the process that they follow when unlocking. All said that they always check a prisoner's welfare during unlock.
52. Given that we found no evidence of a systemic issue, we do not make a recommendation.

Clinical care

53. The clinical reviewer found that the clinical care Mr Serban received was of a good standard and equivalent to that which he could have expected to receive in the community.
54. The clinical reviewer found that the reception health screening was completed to a good standard and no concerns were noted regarding Mr Serban's presentation or risks. The reception nurse correctly made a standard referral to the mental health team but due to the short time Mr Serban was in prison, he was not seen before he died.

Inquest

55. At the inquest, held from 30 September to 6 October 2026, the jury concluded that Mr Serban died by suicide.



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