Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Damon Hardman, a prisoner at HMP Lewes, on 8 June 2023

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 focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Damon Hardman died on 7 June 2023, having been found hanging in his cell at HMP Lewes the day before. He was 49 years old. I offer my condolences to Mr Hardman's family and friends.

Mr Hardman had been at Lewes for three months and at various times was noted to be concerned about his safety and was possibly isolating himself in his cell. On the day before his death, he said that there was a bounty on his head. While various risks were considered at different times, it is unclear whether the true level of risk was established. There was no overall assessment of how the various possible risks might have impacted on Mr Hardman's mental health and risk of harm to himself.

The clinical reviewer concluded that Mr Hardman's clinical care was partially equivalent to that he could have expected in the community. This is because of the delay in access to mental health support which did not happen before his death.

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 **June 2024**

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Summary

Events

1. On 20 March 2023, Mr Damon Hardman was remanded to HMP Lewes charged with various offences including criminal damage, dangerous driving and attempted assault.

2. On 30 March, Mr Hardman requested help for his mental health, and he was added to a waiting list for discussion by the mental health team.

3. In April and May, Mr Hardman told staff that he was at risk of assault due to events surrounding his index offence and debts. He made a number of requests to move wings and at times it seems he was self-isolating and not coming out of his cell. At times, he also tried to order an excessive amount of vapes, which may have indicated he was in debt.

4. On 19 May, Mr Hardman saw a mental health nurse who added him to a waiting list for support with paranoia. She also intended to refer him to a GP for the possible prescription of antidepressants but failed to do so.

5. On the morning of 6 June, Mr Hardman's mother telephoned Lewes and said that he had just told her that he was in fear as a 'bounty' was being offered to harm him. An officer spoke to him, but at around 5.00pm he collected his evening meal and told a wing manager that he was no longer under threat.

6. At around 5.08am on 7 June, Mr Hardman was found hanging from a ligature tied to his cell window bars. The patrol officer did not have a cell key, but he radioed a medical emergency code and staff responded quickly. Officers went into the cell and began cardiopulmonary resuscitation (CPR). Nurses arrived two to three minutes later and took charge of Mr Hardman's care.

7. Although staff requested an ambulance immediately, they did not make it clear that an ambulance was needed urgently so it was classed as a non-immediate response. Staff made a follow-up call to the ambulance service almost 30 minutes later and the request was then prioritised. An ambulance arrived at the prison five minutes later and paramedics established a pulse. They took Mr Hardman to hospital, where he died the next day.

Findings

8. At the time Mr Hardman was in Lewes, the key-worker scheme remained suspended following the COVID-19 pandemic and he did not qualify for enhanced well-being checks. Staff did not speak to Mr Hardman to establish his true level of fear and concerns. However, we have concluded that it was reasonable that he was not considered a risk of suicide.

9. Mr Hardman requested help for his mental health in March and May, but he was not discussed by the mental health team before his death.

10. The officer who found Mr Hardman hanging in the early morning of 7 October did not have a cell key as his key-pouch was broken. The information about the nature of the medical emergency was insufficient which led to a delay in the ambulance arriving. This may have been critical for Mr Hardman.

The Investigation Process

11. HMPPS notified us of Mr Hardman's death on 8 June 2023. 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. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Hardman's prison and medical records.

13. The investigator interviewed eight members of staff and two prisoners at Lewes on 8 and 9 August. She subsequently interviewed two other members of staff by video-call.

14. NHS England commissioned a clinical reviewer to review Mr Hardman's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with healthcare staff. The investigation was subsequently reallocated to another investigator.

15. We informed HM Coroner for East Sussex of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

16. The Ombudsman's office contacted Mr Hardman's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She said that her son told her on 6 June that another prisoner had 'put a price' on his life and he asked her to tell the Governor. She telephoned the prison and spoke to the safety officer. The safety officer said that he would speak to her son and then call her back, but he did not return her call. This issue is covered in this report.

17. We shared the initial report with Mr Hardman's mother and with HM Prison and Probation Service (HMPPS). HMPPS provided clarification of the role of Officer A and about the operation of the keyworker scheme at Lewes. We have amended paragraphs 46 and 75 to take account of this information.

Background Information

HMP Lewes

18. 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

19. The most recent inspection of HMP Lewes was in May 2022. Inspectors reported that staff shortages were affecting outcomes in prisoner safety, respect and purposeful activity. Prisoners were spending 22 hours a day locked up while workshops and classrooms remained empty. Inspectors found that the level of violence was too high and the strategy and action plan for dealing with violence was not informed by thorough analysis of available data and intelligence. Prisoners at risk of suicide and self-harm were not appropriately cared for with inadequate care plans that did not reflect the prisoner's risks and triggers. Inspectors noted that the key-worker scheme, post COVID-19, remained largely suspended. Only those deemed high risk were identified for contact, but even that group received little more than basic welfare checks.

20. Inspectors found that 69% of prisoners at Lewes reported that they had mental health needs but only 11% said that it was easy to see a mental health worker.

21. In February 2023, HMIP reviewed the progress made by Lewes since the 2022 inspection. Inspectors found that retention of officers had become critical. Although the Governor had introduced a new regime that aimed to allow most prisoners to have five hours a day out of their cells, at least half of the population spent around 23 hours each day in their cells and time allocated to undertake daily tasks such as showering and collecting medication was inadequate. Levels of recorded violence remained similar to the previous inspection and not enough was being done to investigate incidents or manage perpetrators. Inspectors found that the rate of self-harm had increased since the previous inspection and efforts to improve the quality of ACCT documentation had not yet been effective. There were unacceptably long delays in response to cell bells.

22. Inspectors found that some improvements had been made in healthcare delivery since the earlier inspection, with improved staffing levels. They noted, however, that there was still a staffing shortfall of around 30% with a reliance on agency nurses. Partnership working between the prison, NHS commissioners and the healthcare provider had improved, and a new population health needs assessment had been produced by the NHS to guide commissioning and to improve services for patients.

Independent Monitoring Board

23. 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 January 2023, the IMB

reported that the prison had been severely impacted by shortages of prison staff, in particular because many of the staff were sick, on annual leave or on restricted duties. The IMB reported that there had been a near 40% increase in incidents of self-harm, but no increase in the number of ACCTs opened. Staffing issues had also impacted on healthcare provision, so mental health services had struggled to keep up with assessments and there were long waits for prisoners to see the psychiatrist.

Previous deaths at HMP Lewes

24. Mr Hardman was the 14th prisoner to die at Lewes since March 2020. Of the previous deaths, three were self-inflicted, eight were from natural causes and two were drug-related. As of March 2024, one further prisoner had died of natural causes.

25. In our investigation into a death in January 2021, we found that there was a lack of meaningful contact with the prisoner.

26. In an investigation into a death in May 2021, we found that various known risk factors were each considered in isolation, with little consideration of the prisoner's overall risk.

Key Events

27. On 20 March 2023, Mr Damon Hardman was remanded to HMP Lewes charged with various offences allegedly committed between June 2022 and March 2023. These included criminal damage, dangerous driving, threatening words or behaviour, attempted assault, attempted robbery and theft. Mr Hardman told reception officers that he had no thoughts of suicide or self-harm.

28. A nurse saw Mr Hardman for a reception health screen. Mr Hardman said that he had schizophrenia (where people interpret reality abnormally) and also had post-traumatic stress disorder (PTSD) from childhood trauma. (PTSD is a mental health condition that might occur when a person has experienced or witnessed a traumatic event.) However, he said that he was no longer taking medication for those conditions as he felt well. He said that he had a history of drug misuse, including heroin, but had not used heroin for three years. He repeated that he had no thoughts of suicide or self-harm.

29. Mr Hardman also saw a GP who noted that he was receiving methadone in the community for opioid substitution. The GP prescribed methadone for ongoing maintenance therapy.

30. On 21 March, Mr Hardman moved from the induction wing to K wing (which holds prisoners receiving support for substance misuse). He had his secondary health screen that day and again said he had no thoughts of suicide or self-harm. Staff from the substance misuse team also spoke to Mr Hardman. He said he felt a little low about being in prison and said that his partner, who was seven months pregnant, had also been arrested and taken to prison.

31. On 30 March, a nurse from the mental health team saw Mr Hardman for a standard wellbeing review. She told the investigator that wellbeing reviews are a low-level intervention to assess how a prisoner is coping. Mr Hardman said that from the age of nine, he had experienced auditory hallucinations which were consistently derogatory towards him. Mr Hardman said that he had attempted suicide in the community by taking an overdose in 2020, but he had no current thoughts of suicide or self-harm. He also said that he was looking forward to the birth of his child and wanted to be a good father. She noted that Mr Hardman would be listed for discussion at the mental health team allocation meeting to consider possible support for low mood. At the time there was large backlog of patients awaiting discussion at the allocation meeting.

32. On 17 April, Mr Hardman's court case was adjourned until 13 June.

33. On 20 April, Mr Hardman asked to see the mental health team as his PTSD was getting worse and he wanted medication. Staff booked a wellbeing review for 19 May.

34. On 24 April, an officer noted that Mr Hardman had a mature attitude and socialised well with other prisoners. The officer also noted that the substance misuse team had approved Mr Hardman's move from K wing to a standard prison wing. However, Mr Hardman said that he had 'issues' with other prisoners around the prison and had asked to move to F wing under Prison Rule 45

(separation of vulnerable prisoners from the rest of the prison population) for protection. He was waiting for a reply.

35. In his Rule 45 application, Mr Hardman wrote that he had been threatened by members of a local travelling community with whom he had been in dispute. He wrote that the people involved had run over his pregnant partner and he had responded by running into them with his car. He gave the surnames of people who had threatened him, and he wrote that he felt vulnerable and was scared for his life.

36. A Custodial Manager (CM) told the investigator that F wing held around 150 vulnerable prisoners, including older prisoners and prisoners moved there for protection. However, he said that a lot of prisoners who did not meet the criteria applied to move to F wing and would then destabilise the wing by bullying the more vulnerable prisoners. With Mr Hardman's Rule 45 application, it was noted that there was no information in his security record to suggest that he was under threat. He signed the document to say that he did not approve Mr Hardman's application, and this was approved by Lewes' Head of Residence. He said that Mr Hardman could have appealed the decision if he had wished to do so.

37. The CM also told the investigator that K wing was a small and quiet wing that only held around 14 or 15 prisoners and so prisoners could be reluctant to move on from it. He said that staff would speak to prisoners about moving either to A wing, which was the main wing for prisoners on methadone maintenance therapy, or to move to a general wing.

38. Mr Hardman had been due to move to A wing, but on 14 May, he told an officer that he was under threat from prisoners there due to an unpaid debt of around £150 for vape capsules and illicit medication. He named one of the prisoners involved. Staff submitted an intelligence report and after triage the action noted was for the wing to manage the issue.

39. On 19 May, a nurse saw Mr Hardman following his request the previous month for a review of his mental health. Mr Hardman said he felt paranoid due to possibly being under threat from others, and he wanted antidepressants. She noted that Mr Hardman denied thoughts of suicide or self-harm. She again noted that Mr Hardman was listed for discussion at the mental health allocation meeting. He had not yet been discussed since first being listed for discussion on 30 March, and nor was he discussed before his death.

40. The nurse did not note any plan to deal with Mr Hardman's request for medication. She said at interview that if she had serious concerns about a prisoner's mental health, she would send a task to the GP to ask for antidepressants to be prescribed as soon as possible. However, when she had no such concerns, she would advise the prisoner to request a GP appointment. She said that she would ordinarily have told Mr Hardman about requesting a GP appointment but acknowledged that she did not record that day whether she did in fact do so.

41. Mr Hardman moved to C wing, a standard wing, on 19 May. On 24 May, Mr Hardman moved to A wing. A CM said that he was not involved in the move and presumed that Mr Hardman moved because he was on methadone maintenance.

He said the move would have been directly arranged between an officer on C wing and an officer on A wing. He said that he would have hoped that the message about Mr Hardman's concerns about A wing would have been discussed between the officers, but he could not say if that was the case. Mr Hardman's electronic prison record (known as NOMIS) does not contain reference to any such discussion. The CM said that Mr Hardman kept to himself, and no concerns were raised about him during morning or afternoon briefings, nor was he discussed during any of the weekly safety intervention meetings when prisoners needing additional support were discussed. He confirmed that the key-worker scheme, where prisoners have periodic one-to-one meetings with a dedicated officer, was not operating at the time Mr Hardman was in Lewes. He said that it was only prisoners who were identified as being at risk who received additional support.

42. On 24 May, staff submitted a security report to say that Mr Hardman had exceeded the maximum number of seven vape capsules that he was allowed to buy through his canteen (prison shop) order. There is no record that staff asked Mr Hardman why he had tried to order so many.

43. The investigator asked the CM about the action taken when prisoners ordered too many vape capsules. He said that even when prisoners order more than the permitted number, they still receive the full amount ordered. He said that the only way an excess number is noticed is if staff check the canteen sheet before handing it on to the Business Hub. The member of staff might then submit a security report, as happened on this occasion with Mr Hardman. The onus is then on the security team to share that information with wing managers so they can speak to the prisoner to ask why he has ordered an excess number. He said that he received no emails about Mr Hardman's excess order. The other wing CM also said that he received no such emails.

44. On 31 May, an officer saw Mr Hardman and noted that he was compliant with the wing regime, was getting on with other prisoners and had raised no concerns.

45. On 5 June, Mr Hardman again tried to order too many vape capsules through his canteen order. There is again no record that staff asked Mr Hardman about this excess order.

46. At 10.13am on the 6 June, Mr Hardman rang his mother to say that a person in the community had "put a £3,000 bounty on him" and he asked her to tell the prison. Mr Hardman's mother telephoned Lewes and asked to speak to the safer custody team. The call was transferred to Officer A, a landing officer who also had duties as a safer custody officer. Officer A told the investigator that he spoke to Mr Hardman, who confirmed what his mother had said. Mr Hardman gave the names or nicknames of two prisoners whom he believed posed the threat. He told Mr Hardman that he would speak to the wing managers who would aim to keep him safe. He said that Mr Hardman did not seem nervous, and he thanked him for helping him. He said that he did not believe there were any indications that Mr Hardman was at risk of harming himself.

47. After speaking to Mr Hardman, Officer A spoke to a Supervising Officer (SO), he emailed the wing managers and made an entry in Mr Harding's NOMIS records. He also submitted an intelligence report and after triage the action noted was that

the correct action had been taken as Mr Hardman had been moved to A wing. (The location of the two prisoners Mr Hardman named is unclear. The prison said they could not identify one of them from the name Mr Hardman gave. They thought they could identify the other prisoner named but there is no evidence that any particular action was taken in response.). He said that he had intended to call Mr Hardman's mother to tell her what he had done, but he became involved in other duties and forgot to do so. He did not make an entry in the wing observation book.

48. The CM recalled being copied into the email from Officer A. He said he was working an early shift that day and believed that the email was discussed during the lunch-time handover meeting. He thought that the plan was for the SO to speak to Mr Hardman for a decision on what should happen. He said that options would have included moving Mr Hardman to a different wing and allowing him to self-isolate in his cell pending a wing move if necessary.

49. Mr Hardman rang his cell bell five times that day, the last time was at 3.40pm. Staff did not record why Mr Hardman rang his cell bell. The investigator noted long delays in some of the calls being answered but was told that officers used 'fobs' to confirm and cancel cell visits but some staff were still waiting to be issued a fob, which might account for the apparent delays.

50. The SO confirmed that Officer A spoke to him about Mr Hardman and had included him in an email. He told the investigator that he went to A wing where officers told him that Mr Hardman had been self-isolating but was no longer doing so. (CCTV shows that Mr Hardman had left his cell several times over the previous days, so it is not clear to what extent he was self-isolating.) The SO said that he spoke to Mr Hardman as he was collecting his evening meal. (CCTV shows that Mr Hardman was unlocked at 4.50pm to collect his meal and he was then locked back in his cell at 5.00pm.) Mr Hardman said that he was no longer under threat and was no longer self-isolating. The SO said that Mr Hardman seemed fine. He acknowledged that it would have been better to have spoken to Mr Hardman in private, but said he did ask one of the officers, whose name he could not recall, to check him again later on.

51. The investigator spoke to a prisoner and friend of Mr Hardman. He said that he had known Mr Hardman for close to 30 years. He said that Mr Hardman had always struggled with his mental health and had long-term problems with drug abuse. He said that when Mr Hardman was on K wing, he told him that he was under threat from prisoners on C wing. When Mr Hardman came to A wing, they were both then on the same landing. He said that Mr Hardman was paranoid and would hide in his cell toilet at times. He said that the last time he saw Mr Hardman was at around 4.30pm when he collected his methadone. He said that Mr Hardman should have come out of his cell in the morning for his methadone, but he had stayed in his cell.

52. Mr Hardman's final telephone calls were two calls to his partner (who had been released from prison) that afternoon: a 15-minute call at 5.06pm and a five-minute call at 5.42pm. In their conversations they spoke about the circumstances surrounding their court cases and about the potential of risk of reprisal from the other people involved. Mr Hardman said that every day was a mental and physical battle and that he might be a "done man" as the other people involved

did not play fair by fighting one-on-one. However, he also said that he had been able to come out of his cell a little bit that day, although prisoners were generally locked in their cells for the majority of each day. He also said that he had damaged his cell so he would not have a cell mate. The investigator's assessment was that Mr Hardman sounded concerned for his welfare.

53. An Operational Support Grade (OSG - OSG A) worked night shifts on A wing. He said that his shift started officially at 8.20pm, but his practice was to arrive for work at 7.30pm so he could properly interact with prisoners when making his first routine check. CCTV indicates that he reached Mr Hardman's cell at 8.15pm. He said that Mr Hardman joked with him about having recently "lost" his cellmate and being the sole occupant of his cell, he said being the sole occupant was how he liked it. He told Mr Hardman to ring his cell bell if he needed anything and he continued with his check.

54. OSG A would ordinarily have been provided with a cell key in a sealed key-pouch to allow him to unlock cells in an emergency, but his allocated key-pouch was broken and was in for repair. The investigator understood from him that there were a limited number of key-pouches that evening so there was no spare available for him.

55. Mr Hardman did not ring his cell bell during the night and OSG A had no reason to check him.

7 June

56. At 5.00am on 7 June, OSG A began his morning routine check. He reached Mr Hardman's cell at around 5.08am and saw him hanging from a ligature made from a bed-sheet which was tied to the window bars. He noted that while Mr Hardman's feet were on the floor, all his weight seemed to be taken by the ligature. He radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). He said that if he had had a key-pouch, he would have broken the seal and gone immediately into the cell. However, he did not believe that much, if any, time was lost as response staff arrived very quickly.

57. CCTV shows that two officers arrived within around 30 to 40 seconds of the code blue call. Officer B unlocked the cell and Officer C cut the ligature. Officer C also cut a length of bedsheet with which Mr Hardman had tied his hands. After checking Mr Hardman for a pulse, both officers began CPR. Two nurses arrived within around two to three minutes and took charge of Mr Hardman's care. The nurses checked Mr Hardman with a defibrillator, inserted an airway and gave oxygen.

58. When the code blue call was made a control room OSG (OSG B) followed prison protocol by immediately telephoning 999 to request an emergency ambulance. The ambulance service operator asked if Mr Hardman was breathing, and OSG B said that all she knew was that it was a code blue emergency, and that healthcare staff were with him in his cell. The operator asked if he could speak to someone dealing with the emergency, but OSG B told him that would not be possible. The operator told her that an emergency ambulance had been arranged as a category 2 response (a category 2 response is for an emergency

such as a stroke where the patient's condition is not immediately life-threatening).

59. At 5.35am, a CM radioed OSG B for an update on the estimated arrival time of the ambulance. OSG B telephoned 999 and spoke to the same ambulance service operator. When she told the operative that Mr Hardman had been found hanging and was not breathing, the operative told her that the response had been upgraded to a category 1 response, and an ambulance would arrive in around three minutes.

60. The ambulance arrived at the prison at 5.40am and paramedics reached Mr Hardman a few minutes later. The paramedics took charge of Mr Hardman's care and were able to establish a pulse. At 6.42am, the paramedics took Mr Hardman to hospital where he was placed in intensive care.

61. At 8.58am, Lewes' managing chaplain telephoned Mr Hardman's mother to tell her that her son had been taken to hospital and was in a serious condition. He went to the hospital, where he met Mr Hardman's mother and other family members.

62. Mr Hardman's condition deteriorated in the night and staff informed his family. Life support was withdrawn at 11.09am on 8 June, and Mr Hardman died at 11.53am.

Further contact with Mr Hardman's family

63. On 9 June, one of Lewes' trained family liaison officers went to Mr Hardman's mother's home with the managing chaplain. They spoke about the circumstances of Mr Hardman's death and offered the family support.

64. Lewes contributed to Mr Hardman's funeral expenses in line with national instructions.

Support for prisoners and staff

65. After Mr Hardman's death, a CM 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.

66. The prison posted notices informing other prisoners of Mr Hardman's death. Staff identified two of Mr Hardman's friends who were struggling with the incident. They were referred to Listeners (prisoners trained to offer support) and the mental health team for support.

67. The prison posted notices informing other prisoners of Mr Hardman's 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 Hardman's death.

Post-mortem report

68. The pathologist gave Mr Hardman's cause of death as hanging. A toxicology report noted methadone in Mr Hardman's system at a level consistent with a person prescribed daily methadone as part of a heroin support programme. Mr Hardman also had unprescribed mirtazapine (used to treat anxiety and depression) in his blood, but not at an excessive level.

Findings

Assessment of risk

Mr Hardman's location and possible risk from others

69. Mr Hardman reported several times that he was at risk at Lewes. He said that he had had problems in the community with members of a local travelling family and in April asked to move to F wing, the vulnerable prisoners' wing. He later reported that he was fearful of moving to A wing as he had a debt of £150 to prisoners there after buying vape capsules and illicit medication. He gave the names, or nicknames, of several prisoners who possibly posed a threat towards him. Despite this concern, he nevertheless moved to A wing on 24 May with no apparent resolution to his concerns about moving there and no evidence of any particular action to investigate the credibility of his fears. On 6 June he reported that he understood that a £3,000 bounty had been placed on him. Officer A thought that morning that Mr Hardman seemed genuinely concerned about the threat, but later that day he collected his evening meal and assured an SO that he was no longer under threat.

70. When the investigator listened to Mr Hardman's telephone conversations, she concluded that he did seem genuinely concerned. Also, one of his prisoner friends said that in addition to self-isolating, there were times that Mr Hardman hid in his cell toilet.

71. We also note that on at least two occasions, Mr Hardman bought an excess number of vape capsules through his canteen order. The investigator was told that someone should have spoken to him to find out why he had purchased so many, but no one did so. We do not know whether this was intended to pay off debts.

72. Lewes' Head of Security told the investigator that each day her team analysed all intelligence security reports received in the previous 24 hours. She said that consideration of each report included whether there was other supporting evidence and whether the prisoner might be trying to manipulate a wing move. She said that where appropriate her team would liaise with staff who knew the prisoner, such as their keyworker or offender manager. She said that wing staff would then be told what action was needed to keep the prisoner safe.

73. During Mr Hardman's time in Lewes, the keyworker scheme had been suspended and replaced by enhanced wellbeing checks for priority groups, including younger and older prisoners. As Mr Hardman did not fall within any of the priority groups, he did not receive enhanced wellbeing checks. While his records contain regular contact by officers, there was no consistent member of staff involved who might have established a closer relationship with him to explore the true reality of his fears.

74. HMIP found in 2023 that not enough was being done at Lewes to investigate incidents of violence or to manage perpetrators. In our investigations into two self-inflicted deaths at Lewes in 2021, we found a lack of meaningful contact with

the prisoner in one of the cases and in the other we found that his risk factors were considered in isolation with little consideration of his overall risk.

75. The Head of Safety, Diversity and Inclusion told the investigator that Lewes has still not been able to fully reinstate the keyworker scheme. However, since Mr Hardman's death the prison has focused on how best to identify prisoners that might need additional support. He said that any prisoner who had not had an entry in their NOMIS record will be scheduled for a keyworker session that week. In addition, Lewes operates a priority keyworker list populated through referral from the weekly safety intervention meeting (SIM) following discussion of the most complex, vulnerable, and violent prisoners in the prison. He said that prisoners who have committed violent acts or have been the victims of violence or are self-isolating were managed using a challenge, support and intervention plan (CSIP). He said that prisoners managed on CSIP were given individualised targets and were reviewed regularly to assess progress. He said that he was confident that if this process had been in place before Mr Hardman's death that he would have been referred to the SIM and his risk factors would have been formally assessed. In view of the action taken by Lewes to address this matter we make no recommendation.

Mr Hardman's risk to self

76. PSI Prison Service Instruction (PSI) 64/2011, Safer Custody, 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.

77. As already outlined, Mr Hardman had several risk factors including his possible risk of assault through debts or incidents in the community that might have followed him into the prison. There were also times when he may have been self-isolating. However, the mechanisms and processes at Lewes at the time were not sufficiently robust to allow staff to properly assess Mr Hardman's vulnerability or risk to self. As set out in the earlier section, the prison has made changes to some processes since Mr Hardman's death, which they consider will improve outcomes for prisoners like Mr Hardman. We make no recommendations in this report to allow time for the changes to embed.

Emergency response

78. When the OSG A saw Mr Hardman hanging, he radioed a code blue emergency but was unable to go into the cell as his key-pouch was broken. CCTV confirms that response staff arrived very quickly. The Head of Safety, Diversity and Inclusion said that the prison now had sufficient spare key-pouches to ensure that all night staff could carry a cell key. We make no recommendation.

79. OSG B in the control room telephoned the ambulance service without delay. However, when the operator asked her if Mr Hardman was breathing (one of two

standard questions emergency operators ask before an ambulance is dispatched), OSG B could not answer. As a result, the ambulance was not dispatched as a priority until she provided further information half an hour later.

80. Following Mr Hardman's death, a CM revised the notice to control room staff. The new notice includes advice not to use the terms "code blue" or "code red" (to indicate a prisoner is bleeding) when speaking to the ambulance operator as these terms may not be widely understood. The revised notice makes clear that control room staff must get as much information as possible to pass to the ambulance operator and, if required, the operator should be transferred to the nearest landline to speak to staff at the scene. The revised notice also instructs that the ambulance service operator should be asked for an estimated time of arrival and that information should be passed on to the officer in charge and to the prison gate. When paramedics reached Mr Hardman, they were able to regain a pulse. This may indicate that the delay in the ambulance arriving could have been critical to the outcome for him.

81. It has been acknowledged by HMPPS nationally that policy and practice with regard to calling ambulances in precisely circumstances such as these, is not optimal. At a conference hosted by the PPO in January 2024 and attended by HMPPS and representatives from the ambulance service, HMPPS made a commitment to tangible improvements in this policy area. In these circumstances, and with the additional changes introduced at Lewes, we make no recommendation.

Clinical care

82. The clinical reviewer concluded that Mr Hardman's care at Lewes was partially equivalent to that which he could have expected to receive in the community. She noted that the areas of non-equivalence related to mental health provision. This included the time taken for Mr Hardman to be discussed at the mental health team allocation meeting. He was initially referred on 30 March. He then applied to see a mental health nurse on 20 April but was not seen until 19 May. The clinical reviewer noted that since Mr Hardman's death the process had changed so that applications were checked and triaged daily, and a response sent to the prisoner on the same day.

83. On 19 May, the nurse again listed him for discussion at the allocation meeting, but he had still not been discussed or seen again by the time of his death. Staff did not tell Mr Hardman how long he might have to wait so this was a third time that he was left without much understanding of what mental healthcare was being offered to him.

84. The Head of Healthcare told us that, at the time, there were about 250 prisoners that needed to be discussed at the allocation meeting. This backlog was due to staff shortages. Since Mr Hardman's death, the healthcare provider PPG has employed a Quality Improvement Lead at the prison. Weekly meetings now take place during which prisoners are discussed. There is also now a Mental Health Service Manager in post after a ten-month vacancy. Given the changes already made, we make no recommendation regarding the delays to Mr Hardman's mental healthcare.

85. Following the nurse's assessment on 19 May, she concluded that Mr Hardman should be assessed by a GP to consider starting antidepressants, but she did not make this referral. This was another missed opportunity for Mr Hardman's mental health to be reviewed.

86. The clinical reviewer has made a number of recommendations to the Head of Healthcare which she will need to carefully consider.

Governor to note

Cell bells

87. The investigator noted long apparent delays in answering cell bells. HMPPS guidance notes that staff should aim to respond to cell bells within five minutes. Mr Hardman's record noted instances when it appeared to have taken in excess of an hour to answer some of his calls. Staff said that it was possible that bells were answered promptly but delays were recorded due to availability of the key fobs used to switch off bells. We note, however, that HMIP identified delays in answering bells following their visit in February 2023. The Governor will wish to assure himself that cell bells are being answered promptly.

Prisoner support

88. Both of Mr Hardman's friends spoke about receiving limited support following Mr Hardman's discovery on 7 June and his subsequent death. Lewes told us that notices were posted informing other prisoners, staff reviewed prisoners assessed as being at risk of suicide, and Mr Hardman's friends were referred to the mental health team and Listeners. The Governor will wish to assure himself that the processes in place are adequate to ensure prisoners are offered appropriate support following a death in custody, in particular in the case of close friends of the deceased prisoner.

Mr Hardman's toxicology report

89. Mr Hardman's toxicology report noted that there was mirtazapine in his system at a therapeutic level. He had not been prescribed this medication. Although we cannot say for sure, it is likely that Mr Hardman obtained this medication from other prisoners. Indeed, in mid-May he told an officer that he was under threat due to an unpaid debt for vapes and illicit medication. The Head of Security said that Mr Hardman should have been offered substance misuse support as a result. There is no evidence that this happened.

90. The Head of Security told us that illicit use of mirtazapine was not generally a problem at Lewes, and it was not a drug that prisoners generally tested positive for during mandatory drug tests. She said that medication queues were supervised by staff and intelligence did not indicate that diversion of medication in general was a significant issue at Lewes.

91. The Governor will wish to assure himself that robust actions are being taken to prevent medication being illicitly traded and that prisoners receive appropriate substance misuse support following intelligence that this is occurring.

Inquest

92. An inquest into Mr Hardman's death on 30 June 2025 concluded that his cause of death was suicide.

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