Investigation into the circumstances surrounding the death of a man at HMP Lewes in April 2007

Report by the Prisons and Probation Ombudsman for England and Wales

January 2009

This is the report of an investigation into the death of a man at HMP Lewes in April 2007. The man electrocuted himself in his cell. He had been in prison custody on remand for the murder of his young son for just three days. The man was 52 years of age.

My colleagues and I offer condolences to the man's family and friends for their loss.

This investigation has been undertaken by one of my colleagues. I would like to thank the Governor of HMP Lewes and his staff for their participation in the investigation. The deputy director of community service, Hastings & Rother Primary Care Trust (PCT) and East Sussex Downs and Weald PCT, undertook the review of the man's clinical care. I also greatly appreciate her assistance.

During his brief time in custody at HMP Lewes, there were no specific concerns in respect of suicide or self harm identified about the man. However, staff were aware that he had been charged with the murder of his own son, was in custody for the first time and was the subject of abuse from other prisoners. While the man was adamant that he did not have any suicidal or self-harm intentions, the decision not to open an ACCT form to initiate special support and monitoring must have been a borderline one. Indeed, given his vulnerable status, the man was in fact placed in a camera cell (albeit the monitor was not regularly observed and was turned off when staff needed to use the socket for a photocopier).

In addition, due to the seriousness of the charge he faced, the man had been referred to the Mental Health In reach Team as a routine part of the induction process. He was waiting for a mental health assessment when he died.

The circumstances of the man's death are very unusual. His was only the second death by electrocution in a prison in 20 years, and it is the first such death that I have investigated.

My report includes three recommendations.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2009**

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SUMMARY

The man handed himself into police custody at a police station in North Wales, on 4 April 2007. He told police he had murdered his son. The man was transferred to a police station in Surrey the next day. At the police station he did not express any thoughts of suicide or self harm and a mental health assessment by a doctor did not raise any concerns. However, due to the nature of the charge he faced, he was monitored in a camera cell and initially checked by police staff every 15 minutes (this was reduced to 30 minutes on 6 April).

The man was transferred to HMP Lewes on 7 April and was located in the first night centre (K Wing). A nurse completed the first reception health screen form for him. (The purpose of this form is to gather medical information from the prisoner about his physical and mental health.) The man was co-operative and told the nurse that it was his first time in prison. He did not declare any current physical problems or any medical history. He said he did not have any mental health problems, either past or present. There was nothing in the man's behaviour that led the nurse to fear that he might harm himself or take his own life. The nurse referred the man to the Mental Health In reach Team (MHIRT) for an assessment as it was a routine requirement for prisoners charged with murder or manslaughter.

The same day (7 April 2007), an officer completed a first night interview and cell sharing risk assessment. The man again denied that he had any suicidal or self harm intentions and was not placed on an Assessment, Care in Custody and Teamwork (ACCT) form. (ACCT is the system used by HM Prison Service to monitor and support a person at risk of suicide or self-harm.) The man was located in a cell with a camera but was not subject to formal observation. The camera was not routinely monitored and, in any event, is not set up to record events.

The next day, prisoners on the wing directly above K Wing started shouting abuse at the man. It appears they had read about his circumstances in the Sunday newspapers. The man agreed to speak to a Listener (a prisoner who is trained by the Samaritans to help other prisoners who are having difficulties). However, the two Listeners on the man's wing refused to assist because of concerns about their safety if other prisoners found out. One Listener also had personal feelings about the charge against the man. As a consequence, the man spoke to the Samaritans. He also agreed to be placed on a special regime for his own safety (this meant he was unlocked on his own, separately from other prisoners). There were no issues or concerns noted on 9 April and no further abuse was levelled at the man from other prisoners. The man was still located on K Wing, pending a decision on where to locate him long term.

On 10 April 2007, at approximately 6.05am, the man was found to have electrocuted himself in his cell. He had used a power cable from his electric kettle which he had attached to his chest and plugged in to the wall socket. Cardiopulmonary resuscitation was attempted by staff and paramedics but the man was pronounced dead at 6.41am.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical record and statements made by prison staff.

2. A clinician was asked to carry out a review of the man's clinical care. I am grateful for this review being undertaken in a timely manner.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation, and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

4. One of my family liaison officers contacted the man's step-brother and mother. They declined a meeting and did not ask for any concerns to be investigated. I hope this report helps the man's family better understand what happened in the time leading up to his death, and addresses any concerns and questions they may have.

5. My investigator discussed aspects of the man's treatment with both staff at Lewes and the clinical reviewer. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing. During the course of the investigation 11 members of staff were interviewed. My investigator spoke with the Coroner's Officer in relation to her investigation and all statements taken for the Coroner were also obtained.

HMP LEWES

6. HMP Lewes was built in 1853. It is a local prison and houses trial/remand and sentenced adult prisoners. In March 2002, Lewes lost the court commitment to receive and hold young offenders, although a small group of prisoners aged under 21 are held on remand as a facility to the local courts in the Sussex area. The prison has now opened a wing (F Wing) to accommodate vulnerable prisoners. Lewes holds approximately 558 prisoners at any one time.

7. The provision of healthcare within HMP Lewes is the responsibility of East Sussex Downs and Weald Primary Care Trust. Primary care is delivered by medical staff and registered nurses, and the healthcare centre has the opportunity to draw upon the range of healthcare services within the local NHS Trust. There is an inpatient ward with 18 beds and a constant watch cell. This is staffed by registered nurses and is intended to provide for both the physical and mental health needs of those patients requiring 24 hour primary nursing care.

8. In a full announced inspection in 2003, HM Chief Inspector of Prisons, Dame Anne Owers, described Lewes as a good local prison. However, Dame Anne expressed concern about the lack of services for vulnerable prisoners and suggested they should be moved to a more appropriate site and their places taken by short-term prisoners requiring resettlement in the locality. An unannounced follow-up inspection in August 2005 found that many of the recommendations from the 2003 inspection had been implemented and the prison had continued to improve in a number of areas. Managers and staff across the prison have put much effort into addressing the issue of suicide and self-harm and Lewes had been a pilot for the Prison Service's new suicide and self-harm prevention measures. However, provision for vulnerable prisoners remained extremely limited

9. Dame Annes's report concluded that other aspects of safety had also improved (concerns about the segregation unit and first night arrangements had been addressed, positive drug test levels were low and detoxification arrangements were excellent). The report noted, "Lewes had sustained the respectful staff–prisoner relationships which were identified in the 2003 inspection. This went some way to mitigating the limitations of the old and occasionally inadequate accommodation which was, nevertheless, well looked after and clean."

10. There have been seven other deaths at Lewes since April 2004, three from natural causes, three apparently self inflicted, and one suspected homicide (to date, five investigation reports have been completed by my office). There are no common issues between the death of the man and my other investigations in Lewes.

KEY EVENTS

11. On Wednesday 4 April 2007 at 12.25pm, the man arrived at a police station, in North Wales. He told police there that he had murdered his young son. They checked on the Police National Computer (PNC) which showed that he was sought by Surrey Police in connection with the murder of his son.

12. The next day, at 4.40am, the man arrived at a police station in Surrey. A Prisoner Escort Record (PER) form was completed for the man's transfer from Wales to Surrey. There were no ticks in the risk boxes on the PER form particularly relating to the risk of suicide or self harm. A risk assessment was undertaken by a custody officer in Surrey, and again no risk factors or concerns were identified. However, due to the nature of the charge that the man faced, he was placed in a camera cell and observed every 15 minutes. At 6.30am, another assessment of risk was undertaken by a custody officer and the man was assessed as a high risk of self harm.

13. At 11.20am on 5 April, the man was examined by a doctor regarding a hand injury. The doctor noted that the man had abrasions, bruising and minor swelling to his right hand. The doctor concluded that the man was not suffering from any hallucinatory or delusionary symptoms. At 2.28pm, another assessment of risk was undertaken by a custody officer and the man was still assessed as a high risk of suicide or self harm. At 8.50pm, the doctor saw the man again, this time to assess his mental health. The doctor noted that the man was "tearful at the insight into the gravity of his actions". He concluded that the man was "withdrawn but cognitive" and did not have any suicidal intent. The man rejected the offer of a sleeping tablet, but said he wanted to know that one was available if he needed it later. The doctor left the man a sleeping tablet. The doctor noted that the man was to be reviewed by a doctor the next day if required. At 9.52pm, custody staff reviewed the assessment of risk of suicide or self harm which was still considered to be high.

14. On 6 April (Good Friday), the man remained in the camera cell on 15 minute observations which continued until 11.56pm. Once the man had been in custody for almost 48 hours without incident, custody staff decided that he no longer needed 15 minute observations. The man remained in the camera cell but on less frequent observations (every 30 minutes). It was noted in the custody record that a review might be necessary in the morning.

15. On Saturday 7 April, the frequency of observation was reviewed but the man remained on 30 minute observations. The assessment of risk was reduced from high to medium. The man was taken to appear at a Magistrates' Court, where he was remanded in custody to appear at the Old Bailey at a later date.

16. During the afternoon, reception staff at HMP Lewes received a telephone call from the Magistrates' Court informing them that a high profile prisoner (the man) was being transferred from the court to the prison. An officer had already completed his shift and should have finished work at 4.30pm. However, since he was working over the Bank Holiday weekend and would be

the main person on K Wing (the Induction Unit), the officer decided he would stay on and interview the man when he arrived from court. Before the man's arrival, the officer considered where to locate him on K Wing. There were two cells available, K-12 and K-15. Both are shared cells and K-15 is a camera cell. The officer thought K-15 would be best for the man as he considered that the man might need special observation due to the nature of the charge he faced. (The camera does not record and is for observation purposes only.)

17. Another officer prepared the induction paperwork for the man before he arrived at Lewes. He completed basic personal details on the cell occupancy compact, regime compact and incentive and earned privileges scheme (IEPS) agreement form. The officer also prepared the initial housing needs assessment document.

18. The man arrived at Lewes late on 7 April and was located in K-15. The officer showed the man his cell and explained that there was a camera to observe him as it was his first night in custody. He told the man that the camera was not constantly observed by staff. The officer showed the man where the cell bell was and said he should only use it in emergencies.

19. The officer completed the cell sharing risk assessment. The man confirmed his name and asked to be called by a shortened version. The officer told my investigator that the man was coherent and fluent when he spoke to him. The man told the officer that he did not have any concerns about sharing a cell but would prefer to be on his own. He also said that he did not get angry or frustrated. The officer decided the man would not be a risk to anyone else, so assessed him as a low risk for sharing a cell. The cell sharing risk assessment was agreed by a nurse.

20. The officer also completed a first night interview with the man. He spent an hour with him completing the interview. The officer told my investigator that the man answered all the questions openly and was calm throughout the interview. He recalled that the man maintained good eye contact. The officer's opinion was that the man was a very intelligent man from a good family background. The officer asked the man whether he had ever committed an act of self harm or contemplated suicide to which he replied that he had not.

21. The officer also asked the man whether he felt like committing an act of self harm or suicide to which he again replied no.

22. In interview, the officer recalled that the man did not express any concerns apart from how he could get a radio and how he would be treated by other prisoners. The officer said he was honest with the man and explained that, if other prisoners became aware of his alleged crime, then his safety might be threatened. The officer told the man that he could apply for vulnerable prisoner status under Prison Rule 45 and be located in F Wing, the small Vulnerable Prisoner Unit (VPU). The man said he would consider it. He asked to make a telephone call to his mother but the officer told him he would not be allowed to have a PIN phone account due to the nature of the charges

against him. However, he told the man that he would arrange for him to speak to his mother. The officer told my investigator that, in his opinion, the man "was aware of the situation he was in and did not come across as a person in 'shock' so as not to understand the questions put to him".

23. The man also saw a nurse who completed the first reception health screen form. (The purpose of this form is to gather medical information from the prisoner about his physical and mental health.) The nurse told my investigator that the man did not give her any concerns regarding his mental health or any indication that he might take his own life. She said that the man was co-operative and told her it was his first time in prison. The completed form records that the man did not have any physical health problems or any medical history or mental health problems, either past or present. Page 7 of the form relates to a mental health assessment and says to record an impression of the prisoner's behaviour and mental state or tick 'nil of note'. Neither was done in this case.

24. The nurse referred the man to the Mental Health In reach team (MHIRT) due to the nature of his offence. However, the section on page eight of the form 'refer for mental health assessment' was not ticked. It was 'routine' rather than mandatory to refer prisoners charged with murder to the MHIRT. The nurse completed a standard 'in reach team referral' form. The reason for the referral was noted as 'charged with murder' and no other details were provided. The process at the time was that the referral would have been collected by a nurse the following morning with all the other medical records and dealt with accordingly. In this case, the referral was placed in the MHIRT in tray for them to deal with. In interview, the nurse said that the man did not want to be assessed further by a doctor. Page 15 of the health screen form, which records a prisoner's general medical history (physical and mental), was not completed.

25. On 8 April (Easter Sunday), the first night officer arrived at work at 7.15am. He checked all the cells and prisoners on K Wing and from the camera monitor he could see that the man was asleep. At 10.00am, the officer checked the Sunday newspapers to see if there were any reports about the man. There was an article in the News of the World that named the man but did not say which prison he was in. The officer said he was concerned for the man's safety should other prisoners read the article in the newspaper. The officer spoke to a Governor and expressed his concerns. The officer suggested the man should be unlocked separately from other prisoners for his own safety and the Governor agreed.

26. The officer spoke to the man and explained that he had concerns for his safety and recommended that he have a separate regime from other prisoners. The man agreed and signed a special contract, a 'protection package', which meant he had separate association and was not allowed to share a cell. The contract said:

    - To remain on my own and not to share a cell with anyone.
    - To remain locked up at times when other prisoners are out.

- To be opened up for a shower on my own when staffing levels allow once a day.
- To be opened up for meal times separately to the other prisoners.
- To be opened up for association of no more than half an hour a day when staffing levels and time periods allow.
- To use the phone in the times above.
- That I will have very limited exercise in the open air and only when times and staffing levels allow.

27. Following the man's agreement to the special contract, the officer completed a revised cell sharing risk assessment. The man was now assessed as a high risk of sharing a cell and this was agreed by the duty manager on Monday 9 April.

28. Shortly after lunch on Sunday 8 April, the officer heard a loud noise coming from A Wing which is directly above K Wing. Some prisoners on A Wing were shouting abuse at the man. They were shouting out the man's name and calling him a child killer, saying they were going to kill him. The officer saw rubbish being thrown down from A Wing. The officer went to check that the man was alright and spoke to him through the cell door. The man asked the officer to make the prisoners stop shouting. The officer told the man he could not stop the prisoners shouting. The abuse carried on and the officer went to the man's cell again. The man asked the officer if he could move to another prison. The officer explained that he could not be moved at that time. The officer asked the man if he wanted to speak to a Listener. (A Listener is a prisoner trained by the Samaritans to help other prisoners who are having difficulties.) He initially refused but eventually agreed (at first, the man was concerned about talking to other prisoners). The officer asked two Listeners who shared a cell on the First Night Centre to speak to the man. However, they declined to do so because of concerns about possible consequences and abuse from other prisoners. One of the Listeners also had personal objections connected to the man's charge.

29. Later that day, an officer conducted the PE induction for the man. (The officer sees all new prisoners as a matter of course to explain about the use of the gym.) In interview, he recalled that he spoke with the man for a few minutes and asked if he wanted to use the gym. The man explained that he could not use the gym as he had a separate regime to other prisoners. The officer said that the man appeared calm and seemed to have accepted being in prison. The officer gave the man information about the gym and told him if his circumstances changed to let him know.

30. By 2.00pm the abuse from A Wing had stopped, and the man asked an officer if he could speak to his mother. The officer phoned the man's mother and spoke to her for a while, explaining that her son was being looked after. The officer told her he would send an information book on Lewes prison. The man then spoke to his mother and daughter from a previous marriage. After the telephone call, an officer asked the man if he was alright. My investigator has listened to a taped record of the telephone conversation which the prison provided after the man's death (his telephone calls were not being monitored).

During the phone call, the man appeared upset but did not indicate that he had any suicidal or self harm intentions.

31. In the evening, the abuse from A Wing started again. On the advice of the Orderly Officer, an officer offered the man the use of a Samaritans' phone at 7.16pm. The man appeared very shaky but denied any thoughts of self harm. The man spoke to the Samaritans for approximately 11 minutes. The officer retrieved the Samaritans' phone from the man and asked him if he was alright. The man said he was fine and thanked the officer for the use of the phone. The officer said that the man did not appear distressed.

32. There are no entries in the man's wing history sheet for Monday 9 April (Easter Bank Holiday). The first night officer was on duty between 8.30am and 8.45pm. He told my investigator that he checked on the man throughout the day and that he was fine. There was no abuse from prisoners on A Wing during the day. A Senior Officer (SO) was in charge of A Wing and informed the officer that he was monitoring the prisoners on A Wing. The SO told them he did not want to hear them shouting any more abuse at the man.

33. A nurse (RMN) visited K Wing on an unrelated matter and noticed that the man had been charged with the murder of his son. She expressed concern to a colleague that a mental health referral should be made for him. (This is confirmed by another nurse (RMN), who was on duty that day.) The nurse was satisfied that the matter was in hand, although she was aware that the Mental Health In reach team (MHIRT) had not yet received the referral. In interview, she recalled that there was nothing of concern in the man's behaviour.

EVENTS ON 10 APRIL 2007

34. On Tuesday 10 April at 5.45am, an officer support grade (OSG) was completing the morning roll check. (The roll check is a visual check of prisoners and confirms that each prisoner is in their cell. The figures are then collated for the whole prison and recorded.) The OSG saw the man 'semi-recumbent' (half sitting/half lying) on the floor. He thought the man was watching television. The OSG described to my investigator that the television was switched on and was on the table in the cell. The table has a shiny surface and the OSG said that he could see the reflection of the television. The OSG did not think it was unusual to see the man sitting on the floor as he said some prisoners sleep on the floor, or even under their beds. The OSG recalled that when he saw the man he was facing the television, which was on his left, and he was looking towards it. The OSG continued the roll check and gave the figures to the communications room.

35. The OSG said he then felt a bit concerned about the position in which he had seen the man. He could not explain why he felt concerned (he told my investigator it was just a feeling he had). The OSG decided to check the man again at approximately 6.05am. He then saw that the man had his head on one side and was holding an electrical power cord.

36. It appears that the man had plugged in the power cord from an electric kettle and switched on the electricity, having exposed the conductors (live and neutral wires) and strapped them to his body. He had attached pieces of aluminium foil to his chest onto which he placed the conductors. The man had also bridged the fuse in the plug with a piece of aluminium foil.

37. The OSG immediately called on his radio for assistance. The radio call went to a SO. At 6.06am, two officers and a SO arrived. One of the officers had heard the radio call between the OSG and the SO to say there was an electrocution on K Wing. She met the SO on the way and ran to K Wing with him. The assistant night orderly officer then arrived, having been contacted by the SO to meet him on K Wing. The officer saw the SO and an officer at the door of K1-15. There was a definite smell of burning. The OSG cut the power to the cell and the officer opened the door on the SO's instruction. The table was behind the door and the man was lying behind it. The SO managed to push the table out of the way and entered the cell. The SO checked the man but could not feel any pulse. He pulled the power cord from the plug. At 6.08am, the SO called healthcare via his radio to tell them that there was a Level 1 medical emergency. He also contacted the communications room to ask for an ambulance. The ambulance was called at 6.10am.

38. An officer went to collect the nurses from the healthcare centre as healthcare staff do not carry keys to the rest of the prison at night. There was little room inside the cell for staff to carry out cardiopulmonary resuscitation (CPR). The SO, the OSG and an officer moved the man out of the cell by his feet, as his head was against the cell wall. They laid him on his back on the landing. The SO and the OSG commenced CPR. The SO maintained an airway through mouth to mouth resuscitation and the OSG administered chest compressions. When he arrived at the healthcare centre, the officer told the nurses to bring the emergency bag with the resuscitation equipment.

39. At 6.10am, the officer arrived back on K Wing with two nurses. They did not bring a defibrillator. One of the nurses took over chest compressions from the OSG and the other nurse applied oxygen via an ambu bag. The nurse noted that the man had fixed and dilated pupils and did not have a heart beat or pulse. Paramedics arrived at 6.20am and took over resuscitation. They asked the SO to obtain a defibrillator as they had not brought one with them. The SO collected the defibrillator from the orderly officer's office. The nurse phoned the duty doctor at 6.35am. Police arrived shortly after and took statements from staff. The man was pronounced dead at 6.41am.

40. A Governor broke the news of the man's death to prisoners in K Wing and answered any questions they had. The prisoners were immediately offered the support of Listeners and Samaritans. ACCT case reviews were undertaken for all prisoners in K Wing who were being monitored.

41. Staff involved were supported immediately by staff care and welfare and were also offered Samaritans' support

ISSUES

Mental health referral and ACCT

42. The Prison Service has various strategies to assist prisoners at risk of suicide or self harm. Prisoners can be monitored by an Assessment, Care in Custody and Teamwork (ACCT) form. (ACCT is the system used by HM Prison Service to monitor and support a person at risk of suicide or self-harm.) Prisoners can speak to a Listener. They also have access to Samaritan support over the telephone.

43. Prison Service Order (PSO) 2700, 'Prison suicide and self harm management,' recognises the following:

> "Prisoners charged with homicide are a particularly high-risk group, and within this prisoners charged with homicide against a partner or family member are at an exceptionally high risk of suicide. Reception/first night staff must be made aware of the suicide and self-harm risks associated with prisoners who are charged with offences related to violence against a family member and/or homicide. Care of such prisoners will require close monitoring of trigger points, for example during any trial or around key anniversaries … Establishments must make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and/or domestic murder/murder of a family member. Such provision must include ensuring a record is maintained to show what action has been undertaken."

44. It was routine at Lewes (but not mandatory) for staff completing the first reception health screen to refer prisoners charged with murder or manslaughter to the mental health in reach team (MHIRT). The nurse completed the first reception health screen and told my investigator that the man did not give her any concerns regarding mental health or self harm. She said that the man was co-operative and told her that it was his first time in prison. He had no current physical health problems nor any medical history or mental health problems, either past or present. The nurse routinely referred the man to the MHIRT due to the nature of his offence. However, the man had not been seen by 10 April (Tuesday) as the preceding days had been a Bank Holiday weekend.

45. There is the facility at Lewes to refer prisoners to an RMN for urgent mental health assessment if a weekend or Bank Holiday delays a referral to the MHIRT but it was not used. On balance, given the circumstances of the charge he faced, I believe that further consideration should have been given to referring the man for an urgent mental health assessment rather then relying on a routine referral. (In saying this, I appreciate that the decision was a marginal one, given that the man did not give any indication that he would take his own life).

46. I note that the record of the first reception health screen was poorly completed with some sections not filled in. The nurse included very little detail under the

'reason for referral'. The first reception health screen is a vital part of the reception process and the healthcare manager must be confident that healthcare staff use the form effectively.

The healthcare manager, in conjunction with the PCT, should conduct a training review to ensure that healthcare staff are competent to complete first reception health screens. Relevant training should be organised if required.

47. The nurse (RMN) visited K Wing on an unrelated matter on 9 April, and noticed that the man had been charged with the murder of his son. She expressed concern to a colleague that the man should be referred for a mental health assessment. The nurse said she was satisfied a referral was in hand and saw nothing of concern in the man's behaviour. The nurse completed an MHIRT referral form and placed it in the MHIRT in tray for them to pick up at the next shift. Members of the MHIRT are only available between Monday and Friday. The man arrived at Lewes on Saturday but, as it was a Bank Holiday weekend, the referral would not have been picked up by the MHIRT until Tuesday. I understand that the process for referral to the MHIRT has changed since the man's death. Once a referral has been completed the form is passed to an RMN and verbally communicated to them for a further assessment to take place immediately. The prisoner will then see a member of the MHIRT at a later date. I welcome the fact that it is now mandatory at Lewes to refer prisoners charged with serious crimes for a mental health assessment.

48. No ACCT was opened for the man during his short time at Lewes. The man was seen by various members of staff, and had the opportunity to voice concerns over his wellbeing but did not do so. Given the offence with which he had been charged, its circumstances, the abuse from other prisoners, and the fact that this was the man's first time in custody, a case for opening an ACCT could have been made notwithstanding how the man presented. Even without the benefit of hindsight, the decision not to have done so must have been marginal. However, I do not think the circumstances were such that staff could have predicted that the man would attempt to take his own life. Although the decision could clearly have gone the other way, I do not think staff should be criticised for not opening an ACCT. They had the benefit of seeing and assessing the man and making a professional judgement.

The man's location

49. The man was located in a camera cell on K Wing so that staff could observe him more easily. During his induction, staff explained to the man there was a camera in the cell to observe his movements. The camera does not record and it was not viewed on a regular basis. I understand that the monitor was also sometimes unplugged in the wing office to enable the photocopier to be plugged in. I accept that the man had not been assessed as at risk of suicide or self harm, but he was in the camera cell because he was judged vulnerable due to the nature of the offence with which he had been charged. I question

the benefit of using a camera cell in these circumstances if the camera is not routinely observed and not always plugged in.

As a matter of urgency, the Governor should review the camera arrangements on K Wing.

50. Following verbal abuse from other prisoners, the man agreed and signed a special contract (a 'protection package') which meant he had separate association and was not allowed to share a cell. This was for the man's own safety and careful consideration was given to the decision, albeit the effect may have been to have made the man feel isolated and 'singled out'. However, given the abuse the man was receiving from other prisoners, I believe the decision to implement a special contract was entirely reasonable in the circumstances.

Listeners

51. I am very disappointed that two Listeners refused to speak to the man. When this became known, the Prison Service's Safer Custody Group discussed this issue with the Samaritans' National Prison Support Facilitator, who raised it directly with Lewes's Supporting Samaritans branch (Brighton). My investigator also made enquiries with Lewes's Safer Custody staff. Two Listeners working on the First Night Centre declined to listen to the man.

52. Members from the local Samaritans' branch in Brighton visited Lewes after the man's death to discuss these issues in more detail with the two Listeners. I understand that one Listener has since resigned and the other Listener was 'stood down' from the scheme.

53. Listeners are expected to follow the same non-judgemental principles as Samaritans, and this is covered in the Listeners' training and selection process. I am pleased that following the man's death, all Listeners at Lewes were reminded in their weekly briefing with the Samaritans that they should be non-judgemental. The branch ran training sessions for new Listeners in September 2007 which focussed on the importance of being non-judgmental and impartial, using the lessons learnt in this case.

54. There are no formal recommendations that I need make in relation to this matter. However, in collaboration with the Samaritans, Safer Custody group may wish to consider if the circumstances described in this report should be shared more widely to ensure there can be no recurrence.

Healthcare response

55. When healthcare staff responded to the finding of the man they did not bring a defibrillator with them. The paramedics who attended did not have a defibrillator either. In the man's case it is unlikely this made a difference to the outcome, but it could have done so.

56. The two nurses say it was an oversight that they did not bring a defibrillator in responding to a Level 1 emergency. Local instructions explain that the member of healthcare staff holding Hotel 1 responsibility should "respond to the radio message by retrieving the emergency medical bag from the healthcare office and attending the location of the incident, giving first aid if necessary. If the message relates to a Level 1 medical emergency the CPR equipment must also be taken to the location." The healthcare manager told my investigator that she intends to ensure that there is a defibrillator and possibly emergency kits on each wing.

    The healthcare manager should ensure that healthcare staff responding to an emergency have ready access to a defibrillator and bring it to the emergency as required, according to local instructions.

Electrical issues

57. On 11 April, two independent electricians from a local electrical company tested the electrical wiring in the man's cell at the request of the prison. Their report shows that a visual inspection of the wiring and the socket within the cell was undertaken, and both were found to be satisfactory. Both the socket and the wiring connections were secure. A forensic scientist was asked by Sussex Police to examine the plug and wires of the power cable from the kettle. In his report, the scientist says:

    "I have been asked to determine if the modifications to this item prevented the safety device, located outside the cell, from working. Further, I have been asked to determine if the adaptation of the fuse within the plug prevented it from working."

    "The purpose of a fuse within a plug is to prevent damage to the power cord in the event of excessive current passing through the conductors. If excessive current flows then the fuse should 'blow' and stop the flow of electricity to the appliance. The normal fuses, dependent on the application, fitted within plugs are 3, 5 or 13 amp. However, they will not protect against current flowing through the human body."

    "A Residual Current Circuit Breaker (RCCB) is a form of protective device in a circuit. Both the neutral and live conductors are connected to this device. Under normal working conditions the live and neutral currents are equal. If an insulation fault occurs and the current flows to earth, the live and neutral components will no longer be equal and therefore, the device will 'trip'. This type of device will detect small currents and greatly reduce the risk of death due to electrocution by cutting the current flow almost instantaneously."

    "A miniature circuit breaker (MCB) is a form of protective device which overcomes the traditional problem associated with fuses. When a MCB 'blows' it needs to be reset and not replaced as a fuse does. An MCB operates when an over current is detected and will automatically switch off

or ‘trip’. They do not protect against current flowing through the human body.”

“I examined the length of plastic coated power cord attached to a plug (the power cord from the man’s electric kettle). The power cord had three wires, live, neutral and earth. All had been correctly connected to the appropriate terminal in the plug. A 5 amp fuse had been fitted which is a safety feature. If the fuse had been in the circuit when the current was flowing it may have blown, dependent on how much current was flowing through the body. It should be noted that even small currents can be fatal and another factor is the time that the current is passing. However, this fuse, which was intact, had been bridged using metal foil which effectively removed protection from the circuit.

“I noted that the outer white plastic sheathing had been stripped to expose the inner plastic coated conductor wires (Brown – live, Blue – neutral) and the earth wire (Yellow / green). There was a metal spade connector on the brown wire. The plastic coating of the blue wire had been cut to reveal the inner copper conductors. There was burning present on these wires. The plastic coating of the earth wire had been cut. However, only a small part of the inner copper wires had been exposed. The earth wire is effectively another safety feature within an electrical circuit. If current flows to earth, the fuse and/or circuit breakers should effectively work to cut off the electrical supply. Each of the three wires was tested and found to conduct electricity.”

58. From his examination the scientist is of the opinion:

“The fuse, which is effectively a safety device within the plug, was by-passed within the electric circuit and therefore, would not blow in the event of excessive current flowing. The earth wire, another safety feature, had been cut, although a small amount of copper wire could be seen at the end of the wire. If this wire had been connected to the body then the safety devices, outside the cell, in my opinion, would have operated. The modifications to this plug and the power cord (covering with aluminium foil) have effectively prevented the safety device from operating.”

Conclusions

63. It is very rare for a prisoner to kill himself by electrocution. In that respect, there are limited lessons from the death of the man for the Prison Service as a whole.

64. However, it is much less rare for a prisoner facing charges of murder involving a family member to take his own life. Although any over-use of ACCT procedures carries its own risks, the judgements made in respect of the man were marginal ones that could easily have gone the other way. It may have been that location in a camera cell was believed to offer a degree of additional protection. However, a monitor that is not routinely observed (and indeed, one that is turned off when the socket is required for the photocopier) offers

only partial protection. The Governor of Lewes will, therefore, wish to consider the implications of this report with great care.

RECOMMENDATIONS

The healthcare manager, in conjunction with the PCT, should conduct a training review to ensure that healthcare staff are competent to complete first reception health screens. Relevant training should be organised if required.

As a matter of urgency, the Governor should review the camera arrangements on K Wing.

The healthcare manager should ensure that healthcare staff responding to an emergency have ready access to a defibrillator and bring it to the emergency as required, according to local instructions.

GOOD PRACTICE

The officer's concern for the man and his professional approach throughout should be commended.

Comments following draft report:

The Prison Service has accepted the recommendations.

Having read the draft report the man's family further emphasised their concerns that he was not referred for a mental health assessment on arrival at Lewes. This issue has been addressed in my report. (paragraphs 47-50).

The man's family also asked why he was not under 24 hour observation considering the circumstances of his alleged crime. Again, this issue has been considered in my report. (paragraph 53).

Finally the man's family are concerned that there was no defibrillator on hand when CPR was carried out on the man. I agree this was a failing and the following recommendation was made in response:
'The healthcare manager should ensure that healthcare staff responding to an emergency have ready access to a defibrillator and bring it to the emergency as required, according to local instructions.'