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

Report by the Prisons and Probation Ombudsman for England and Wales

September 2008

This is a report into the circumstances of the death of a man who was a remand prisoner at HMP Lewes in July 2007. An officer who checked on the man discovered him hanging from the toilet door. She summoned immediate assistance and staff and paramedics attempted cardio pulmonary resuscitation. The man was taken to the local hospital where he was pronounced dead at 7.12am. He was 36 years old. I offer my sincere sympathy and condolences to his family and friends for their loss.

I apologise for the length of time it has taken to produce this report. The investigation was carried out on my behalf by one of my colleagues. A clinical review of the man's healthcare at HMP Lewes was undertaken by East Sussex Downs and Weald Primary Care Trust. I am grateful for the comprehensive review. I would also like to thank the Governor of Lewes and his staff for their co-operation and assistance with this investigation. Particular thanks go to M, the former Head of Security for his help throughout the investigation process as liaison officer.

The man who died was a French foreign national prisoner and it was his first time in prison. In addition to the difficulty of being in a foreign prison, he was also affected by Operation Safeguard, the use of police cells to hold prisoners when prisons have reached their operational capacity. During the five months he was in prison, he appeared in court three times and on each occasion was taken to a different prison. Following two of his court appearances, he spent the night in a police cell en route to an establishment many miles from the court and his home area. The overcrowding in prisons has an impact on all prisoners. The man, in prison for the first time, in a foreign country, in a justice system that he did not understand, must have been unsettled. Moving frequently in a short period of time and adjusting to new regimes and staff must have compounded the difficulty. Throughout his time in prison, the man had serious concerns about his health and the impact imprisonment was having on his heart. Doctors who examined him found no sign of heart problems but the man did not accept their reassurances. After his death, staff found letters in his cell addressed to his family. In them the man said that he felt unable to carry on living in prison.

I make three recommendations, primarily covering healthcare issues and suicide and self harm monitoring procedures.

Jane Webb
Deputy Prisons and Probation Ombudsman **September 2008**

CONTENTS

Summary 4

The investigation process 5

HMP Lewes 6

Key findings 8

Issues 16

Conclusion 19

Recommendations 20

SUMMARY

The man was born on in 1971. He died on the morning of 24 July 2007, at the age of 36 years, in HMP Lewes. He had been remanded into custody on 20 March 2007. He went to HMP Elmley in Kent, after an overnight stay at a police station en route. It was his first time in prison.

At Elmley, the man told staff he was concerned about his physical health but that he had no mental health problems. A prison doctor concluded that he was not depressed, nor did he need investigations into his physical health. Staff identified the man as a foreign national and he attended an additional module, specifically for such prisoners, during induction.

On 10 April, the man returned to court from where he was remanded into custody until 25 May. After another overnight stay in a police station, he went to HMP Belmarsh in London. Again, the man told staff about his heart problem and expressed dissatisfaction and puzzlement with the legal process. He was examined the following day by a doctor who noted that he could not hear any heart murmur. The doctor again recommended a single cell for medical reasons and prescribed medication for anxiety. Two weeks later, the man had an electrocardiogram test. The results showed no abnormalities with his heart. After being alerted by his family, mental health staff assessed the man. The nurse concluded that the man was very anxious but was not showing signs of mental illness.

The man returned to court on 25 May. Although he expected to be given bail, he was again remanded in custody and taken to HMP Lewes, near Brighton. The following day, during a consultation with a doctor and nurse, the man became very anxious and tearful. The nurse opened a suicide and self-harm support plan to give additional support and also referred him to the mental health inreach team. Unfortunately, the referral was misfiled and not actioned until 2 June. The ACCT plan was closed the day after it was opened as the man explained that his anxiety and upset was because he felt that the healthcare staff had not understood him during the consultation. The man then appeared to settle into life at Lewes and began work in one of the workshops.

The man’s personal officer noticed on 21 July that he again seemed anxious. He spent some time with the man, reassuring him that both wing and healthcare staff were there to help him, if he needed it.

Three days later, at 6.05am, an officer found the man hanging from the toilet door. She summoned help which arrived very promptly. Healthcare staff administered cardiopulmonary resuscitation (CPR) until paramedics arrived. The man was taken to the local hospital where he was certified as having died.

Prison staff contacted the French Consulate to arrange for the news to be broken to his family in France. Consulate staff also arranged for the family to

come to England. They visited the prison before returning to France with the man’s remains. I have made three recommendations.

THE INVESTIGATION PROCESS

1. The man died on Tuesday 24 July 2007. My investigator opened the investigation two days later when she visited the prison. She met the Governor, the head of healthcare as well as representatives of the Independent Monitoring Board and the Prison Officers' Association. She saw the man's cell on C wing and was given copies of his prison records.

2. The investigator returned twice more to Lewes to conduct interviews with wing staff. She and the clinical reviewer interviewed healthcare staff together. She did not visit HMPs Elmley and Belmarsh as the man spent only a short time in each prison. However, the prison records supplied by staff at Lewes comprised all the man's documents, including records from Elmley and Belmarsh.

3. Members of my staff offered to meet with the man's family during their visit to England in the days after his death but they declined. One of my family liaison officers wrote to the man's sister to ask if the family had any concerns that they wanted to be included in the investigation. His sister raised a number of issues on behalf of the family. The majority of them concern the Criminal Justice System and are, therefore not matters that I can investigate. However, the family wish to know how information about the man's health was communicated from one prison to the next. I hope that this report goes some way to answering their concerns.

HMP LEWES

4. Lewes prison was built in 1853. It is a local prison which houses trial/remand and sentenced adults. Lewes has now opened a large wing (F Wing) to accommodate vulnerable prisoners. The prison holds approximately 558 prisoners at any one time.

5. 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 provides for both the physical and mental health needs of those patients requiring 24 hour primary nursing care.

6. In a full announced inspection in 2003, HM Chief Inspector of Prisons (HMCIP), Ms Anne Owers, described HMP Lewes as a good local prison. Ms Owers did, however, express concern about the lack of services for vulnerable prisoners. She suggested that they 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. The prison had continued to improve in a number of areas - with the exception of vulnerable prisoners, for whom provision remained extremely limited. 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.

7. As a result, most of the recommendations in the earlier inspection report had been implemented and the rate of self-harm was much reduced. The 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.”

8. The most recent report of the Lewes Independent Monitoring Board is from 2006. It concluded that,

   > “Overall, HMP Lewes is a humanely managed prison which has some excellent features and provides a safe and largely decent environment protecting the vulnerable and respecting diversity.”

   The report also noted that the prison,

> “responded well to the increase in (foreign nationals) FNs in the prison by improving links with the Immigration and Nationality Directorate (IND), and increasing monitoring and the regular flow of information to FNs.”

9. There were two deaths of prisoners in Lewes in April 2007. My report on the first death included recommendations to improve ACCT procedures and use of the defibrillator. I am pleased to note that staff opened an ACCT plan for the man promptly and used a defibrillator during the resuscitation attempt. The second death was the subject of a police investigation and my investigation began only two months ago.

KEY FINDINGS

10. The man appeared at Brighton Magistrates' Court on in March 2007. He had been charged with assault by beating and making threats to kill against his partner of ten years. He was granted bail with the condition that he did not return to the flat he shared with his partner. The man later told a prison officer that he misunderstood this requirement and thought that it only prohibited him from staying at the flat. He therefore went to the door of the flat to ask for his possessions. As a result, the Crown Prosecution Service appealed against bail.

11. The man was then remanded in custody until a date to be fixed later. He spent the night at Dartford Police Station and arrived at HMP Elmley in north Kent the following day. The documents do not show why the man spent the night at the police station. It might well have been that it was too late to complete the journey to Elmley.

HMP Elmley

12. At Elmley, the man told staff that he was French and gave his parents' name and address in France when asked for his next of kin. He also told staff that although he could speak English, he could not read or write in it. A nurse interviewed the man and completed a First Reception Health Screen form. The man told the nurse that he had concerns about his physical health. The nurse wrote "occasional heart palpitations (anxiety). Would like to see doctor" and referred him to the doctor. The man said that he did not use drugs and only drank alcohol socially. He further said that he had never been treated for mental health problems and did not feel like harming himself.

13. From reception, the man was taken to the First Night Centre. A member of staff completed the Cell Sharing Risk Assessment to decide whether he could safely share a cell with another prisoner. After assessing the man as a low risk, the officer noted that it was his first time in prison.

14. A member of the healthcare staff also completed a form to say that the man was well enough to take part in the induction process. (Induction is the process during which prisoners learn about life in prison and receive information to help them settle into the regime.) The member of staff noted at the bottom of the form that the man was worried about his property, which was in a hotel in Brighton. He was told to discuss this with the legal aid staff and his solicitor.

15. The following morning, a prison doctor examined the man. He concluded that the man was not depressed, nor did he need any investigations into his health. The man completed induction over the following two days. He told staff that when he was released from prison he would return to his parents' home in France. He also said that he had spoken to his family and told them he was in prison. An induction officer highlighted that this was his first time in prison and that he was a foreign national prisoner.

The man therefore attended the foreign national module of induction. Elmley's induction form describes this session as

> "Information relating to immigration, repatriation, deportation. The opportunity to meet with the FN Legal Services Department, Prisoner Reps and read induction literature in their own language and afforded the time to discuss any outstanding issues they may have."

He also attended a Well Man Clinic, during which he said that he did not use drugs and did not have any problems with alcohol use.

16. On 29 March, the man was examined by a prison doctor, who then instructed staff to move him to a single cell for medical reasons. The man later told staff that he was getting up several times a night with palpitations and was concerned about disturbing his cellmate. This worry had added to his anxiety.

17. The man was taken from Elmley to Brighton Magistrates' Court on 10 April. Each time a prisoner is escorted out of prison, prison and escort service staff must complete a Prisoner Escort Record (PER) form. Serco escort staff who completed the PER form for the man used three separate dates on the form. As well as the correct date, it was also recorded as 5 April and 7 April. In Section B of the form, rather than give the time of each check on the man, the escort officer merely recorded, "08.20 Various cell checks en route". An hour later, he made a similar entry. I will arrange for these matters to be brought to the attention of Serco managers.

18. The magistrates sent the man to Lewes Crown Court to be tried on 25 May and remanded him in custody until then. The man again spent the night in a London police station, but the documents do not give the name of the station or the reason for the stay. However, the medical forms completed by a police doctor, indicate that he examined the man at 11.38pm. Again, it may well be that the man spent the night at a police station as it was too late to complete the journey. the man said that he suffered from a heart murmur and heart palpitations for which he took medication. He did not name the medication but described it as "heart tablets". He also said that he was taking sleeping tablets.

HMP Belmarsh

19. The man arrived at Belmarsh on 11 April. Again, he went through the induction process, including a Well Man clinic and was given information for foreign national prisoners. The officer noted that the man was quite tearful at the beginning of their interview. When he asked what was wrong, the man replied that it was because he was in prison and he felt that his solicitor had not done a good job. The officer also noted that the man had no thoughts of suicide or self-harm.

20. The man was examined for palpitations by a doctor the next day. The doctor could not detect any but noted that the man was very anxious. He also recorded that the man said that sharing a cell was increasing his anxiety. The doctor therefore asked wing staff to allocate the man a single cell. On 26 April, the man was given an electrocardiogram (ECG), a medical test that records any problems with the heart's rhythm. The test showed that his heart was normal.

21. On 23 April, the foreign national co-ordinator received a telephone call from a member of the French Consulate. The diplomat said that the man's family were concerned about his mental health as his telephone calls to them did not make sense. As a result, foreign national co-ordinator referred the man to the Mental Health Inreach Team (MHIT).

22. Two days later, a prison doctor examined the man. The doctor recorded that the ECG and blood test results were normal. He noted that the man looked extremely anxious and was tearful. The man told the doctor that he could not sleep. He kept waking up and regularly had palpitations that lasted for about ten minutes. As the doctor examined him, he said that he was having palpitations at the time. However, the doctor could not hear a murmur and the man's pulse was regular, although quite fast. The doctor prescribed propanolol hydrochloride, a medication used to treat a number of conditions including anxiety and heart rhythm disorders.

23. Later that day, a member of the MHIT assessed the man. The man said that he was not feeling low, neither did he intend to harm himself in any way. He was surprised to have been referred to the MHIT and denied ever having mental health problems. The nurse concluded that he was showing no signs of mental illness, although he was anxious about a number of issues. The man told the nurse that he had heart problems, which were not helped by being in prison. He found Belmarsh more restrictive than Elmley and would like more time out of his cell. Finally, he had not yet spoken to his solicitor in detail and did not have enough money to telephone him. The nurse agreed to contact his solicitor and ask him to visit the man. She did so and the solicitors, in turn, contacted the man.

24. On 25 May, the man went to Lewes Crown Court for a Plea and Case Management Hearing. (This is a preliminary hearing that deals with the administrative aspects of a trial.) The man expected to be given bail, but he was again remanded and this time was taken to Lewes prison.

HMP Lewes

25. At Lewes, the man went first to reception and then to the First Night Centre on K wing. The duty member of healthcare interviewed him and completed a Transfer Reception Screening form. The form is divided into sections dealing with physical health, mental health and drug and alcohol use. The man again asserted that he had a heart murmur and palpitations. He indicated that he was concerned about his heart and that he felt the medication he was taking was not working. The reception nurse

explained that he would see a doctor the next morning and the man was content to wait until then. The nurse put a sticker on the front cover of the man's medical records to highlight that he needed a doctor's appointment.

26. The nurse is an experienced Registered Mental Nurse (RMN) who has worked at Lewes for a number of years. He told my investigator that the man spoke English well enough for them to have no problems communicating together. Other than the man's wish to have his medication changed, he did not appear agitated or upset and the nurse had no concerns about his mental health.

27. The following morning, the prison doctor examined the man in the presence of a charge nurse. The man explained about his heart problems but the doctor could not find anything untoward. During the consultation, the man became very tearful. The doctor and charge nurse were concerned about his mental health, so they decided to refer him to the mental health in-reach team (MHIT) and also opened an Assessment, Care in Custody and Treatment (ACCT) plan. (The ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give him the support he needs to help him through a period of crisis.) The charge nurse completed a referral form for the in-reach team. Unfortunately, the form was apparently filed in the medical records rather than being placed in the MHIT's in-tray. The team received the referral ten days later, after a nurse discovered it in the man's records. The clinical reviewer discusses this oversight in her report at Annex 2.

28. The charge nurse completed the first part of the ACCT plan, listing the reasons she opened it. (The ACCT plan is at Annex 3.) She recorded that the man was, "Very tearful ++" to show how upset he was. She also noted that he had thoughts of harming himself and that it was his first time in prison. She then drew up the Immediate Action Plan which consisted of the support from staff and access to a Listener, if and when the man wished to speak to one. (Listeners are prisoners trained by the Samaritans to help other prisoners who are having difficulties.) The charge nurse then passed the ACCT plan to the man's wing manager, who was the ACCT case manager.

29. Once an ACCT plan is opened, an assessor must interview the prisoner within 24 hours and draw up a Care Map. The Care Map lists the problems facing the prisoner, sets out goals and how to achieve them. An officer who is an ACCT assessor spoke to the man at about 9.00am on 27 May and completed the Care Map. He told my investigator that the man was polite and appeared to be calm and reflective. He also said that, although the man spoke English with a fairly heavy French accent, he could understand him. The man explained that he was concerned that money he had in Belmarsh had not been sent with him to Lewes. Also, he did not understand why he was in prison. He denied any thought of harming himself. He explained to the assessor that he had heart murmurs and was concerned that the stress of being in prison would induce a heart attack.

30. The assessor explained how money is transferred between prisons and suggested the man check in a day or two that his money was at Lewes. He then referred the man to the bail information officer and advised him how best to contact his solicitor. The assessor told my investigator that, at the end of the interview, he was satisfied that the man was not going to harm himself. He said that the man's manner was calm, he made good eye contact and, although anxious about his health, his money and bail, he was not distressed.

31. Immediately after the interview, the assessor discussed the man with the senior officer (SO) who was the wing manager that day. The SO spoke to a member of the healthcare staff (he cannot remember who) and confirmed that they were aware of the man's health concerns. He then held the first ACCT case review, with both the assessor and the man in attendance.

32. The SO asked the man how he was feeling and what his concerns were. The man patted his chest and said that he had heart problems. He was concerned that the stress of being in prison and possibly having to share a cell would trigger a heart attack. Also, he was not sure that the healthcare staff had understood him the previous day. He explained that he felt that they thought he wanted to die, rather than he was worried that his heart problems would lead to his death. His tears had been as the result of frustration at feeling misunderstood rather than from being unable to cope with his problems.

33. During the case review, the man appeared calm and rational. The SO reassured him that the healthcare staff had understood him and he was being referred to an outside consultant. At this news, the man was visibly relieved and started to smile. The SO told my investigator that it was "almost as if a weight had been lifted" from the man. The SO told him that the doctor had said that he should have a single cell for medical reasons.

34. The man then explained that he did not understand why he was in prison or how his case was progressing. He was also unsure whether, as a foreign national prisoner, he would be deported. The SO referred him to the bail information officer and the foreign national officer as part of the care plan. He also supplied official paper so that the man could write to his solicitors. Having discussed the four problems the man had raised and taken steps to address them, the SO decided to close the ACCT plan, with the assessor's and the man's agreement. The man also said that he had no intention of harming himself.

35. The SO recorded that the post-closure review should be held on 3 June. After an ACCT plan is closed, there must be at least one review when staff check how the prisoner is feeling and how they are coping. Although the SO scheduled an interview, there is no record in the ACCT plan or any other document to indicate that it took place.

36. The assessor worked on K wing for the rest of the day and observed the man mixing with other prisoners on the wing. Later that day, the man was moved to a single cell and given foreign national prisoner information in French. He was referred to the bail information officer and then, sometime during the next day or two, he went to the office to check what had happened to his money from Belmarsh.

37. The man moved to a single cell on A wing on 30 May, where he remained for three weeks. The following day, one of the prison doctors examined him as he was complaining of anxiety and palpitations. The doctor suspected the palpitations were related to anxiety and prescribed Mirtazapine, an antidepressant. Five days later, the man returned to the healthcare centre and said that he was not feeling any better. The doctor changed his medication and prescribed promethazine, a sedative, for five days.

38. On 2 June, an officer noted in the man's wing history sheet that he was very polite and mixed well with staff and prisoners on the wing. (The history sheet is a booklet in which staff record important information about prisoners for other members of staff to read.) The record also said that the man was unemployed and that there were no further issues. The same day, the misplaced mental health referral reached the mental health in-reach team.

39. The following day, a Registered Mental Nurse (RMN), assessed the man. The RMN spent about an hour with the man and recorded that was "very, very anxious and tearful". She assessed his mental state and concluded that there was no evidence of depression. She noted that the man talked at length and somewhat repetitively about his problems. He told her about his heart murmur and the treatment he had received in prison. He said that he was not reassured by the ECG result being normal, as an ultrasound was a better test to detect his palpitations. He expressed his fear that because of his heart problems, he might go to sleep one night and not wake up. He then spoke about the reasons why he was on remand and his lack of understanding of the justice system. He told the RMN that he had applied for bail but had not heard whether this had been granted.

40. The RMN concluded that, as the man did not have a mental illness, he did not need further input from the MHIT. However, she addressed each of the problems he had described. She spoke to nursing colleagues and a doctor in the prison outpatients' department about the man's heart condition. They told her that he "had been seen about it and reassurances had been given to him".

41. The RMN also contacted the bail information officer to chase up the bail application. When contacted by the bail officer, the solicitors said that bail had been refused and they had written to the man with the news. The RMN also discussed the man with one of the landing officers. He agreed to encourage the man to spend more time out of his cell and take part in

association. Finally, she gave the man leaflets containing information about how he could manage his anxiety. However, there is no evidence to show whether she checked if the man could read English and it is doubtful whether he could understand them.

42. On 23 June, the man moved from A wing to C wing. Two days later, he went to the wing office and asked to return to A wing where he felt more comfortable. The man's personal officer spoke to him in his cell for approximately 15 minutes. The man said that the prisoners on C wing were "worse" than those on A wing. The personal officer reassured him that the wings, and the prisoners on them, were the same and the man grew calmer. He said that he had a heart murmur and suffered from anxiety, for which healthcare staff were treating him. He also mentioned that he would like to spend more time out of his cell. The officer explained to how to apply for a job and later the same day, the man started assembly work in one of the workshops. The personal officer told my investigator that, after the man started work, his anxiety appeared to decrease.

43. The personal officer spoke with the man on a number of occasions over the next month. The man spoke mainly about his dislike of being in prison and concern about his health. Generally, the personal officer felt that the man had settled into life on the wing and that his job had helped greatly.

44. However, on 21 July, the personal officer noted in the wing history sheet that the man was again looking anxious, although he continued to mix with other prisoners during association and exercise periods. The personal officer said that he reassured the man that he could always approach officers, particularly himself, if he needed help. He also encouraged him to make a doctor's appointment if he continued to be concerned about his health. The personal officer concluded by reiterating that he was there to help the man, should he need help. There are no further entries in his history sheet.

24 July

45. At 8.30pm, the officers on night shift came on duty and at 9.00pm the prison went into night patrol state. At night, all prisons operate with a reduced staff. The wings were patrolled by officers and Officer Support Grade (OSG) staff, as is usual. During night patrol state, only Oscar 1 carries a full set of keys to unlock all gates and cells. Oscar 2 has keys that allow movement through the prison. Wing staff and nurses do not have access to keys allowing them free access around the prison and have to be escorted. The officers and OSGs are each issued with a cell key in a sealed pouch for use in emergencies. The staff instructions are that during the night state, a cell may only be unlocked by a single member of staff where there is, or appears to be, immediate danger to life.

46. A senior officer was the night orderly officer (radio call sign Oscar1), the most senior officer on duty in the prison. He had an assistant night orderly officer (Oscar 2). On the night of 23 July, a female officer was on duty on

C wing. She told my investigator that, until the morning roll call, it had been a normal night shift. She started the roll check, counting the prisoners on the wing. She reached the man's cell at approximately 6.05am and looked through the observation glass into the cell. She saw the man hanging by a bed sheet from the toilet door. (Cells in Lewes have a toilet and basin in a separate room with an internal connecting door.) She immediately called for assistance over her radio, saying that it was a level one emergency as a prisoner was hanging. She then began to open her emergency key pouch.

47. The SO was in the Orderly Officer's office when he heard the female officer's call. He ran towards C wing, meeting another officer on the way. He estimated that it took seconds for them to reach the man's cell. He unlocked the door and went in, followed by the two officers. The female officer used her anti-ligature knife to try to cut through the sheet but as it had been folded over many times, it was too thick to cut through. (Anti-ligature knives are shaped like a fish, and contain a concealed blade in the mouth section which is designed to allow the user to get underneath the ligature. The action of pushing the knife forward cuts the ligature away from the body.) The two officers supported the man while the SO unhooked the sheet from the door. They then laid the man on his back on the floor. The SO went to the healthcare centre to collect the emergency response nurse. As he moved through the prison, he left the gates unlocked to enable the nurse to go directly to the man's cell.

48. A Registered General Nurse (RGN) was in the healthcare centre with two colleagues when she heard the female officer's call. She collected the bag containing the emergency equipment and went to wait at the door to the healthcare centre, along with a male colleague. The SO arrived and the nurses ran through the prison to the cell. The RGN asked the officers to call for an ambulance and a doctor. The man felt warm to her touch and she heard faint sounds coming from his chest. The nurses therefore started cardio pulmonary resuscitation (CPR) and set up the heart start machine. This machine, also called a defibrillator, treats victims of sudden cardiac arrest by delivering a shock to the heart.

49. The SO called for an ambulance at 6.08am. He also asked for the duty governor to be called and members of the care team to support the staff afterwards. The paramedics arrived at 6.20am and took over the man's treatment. At 6.45 am they moved the man to the ambulance. Ten minutes later, the ambulance left the prison and went to the Royal Sussex County Hospital. On arrival, the man was taken to the Resuscitation Department where hospital staff examined him. Sadly, they could do nothing more for him and the duty hospital doctor pronounced his death at 7.12am.

50. After the man's death, staff found two letters in his cell with a note on the envelope that they were for his family. The prison chaplain assumed his role as family liaison officer (FLO). The man had not given an address for his next of kin so the FLO contacted the French Consulate who arranged

for French police to break the news to the family. Consulate staff also arranged for the family to come to England to accompany the man's body home. During their stay, they visited Lewes where they saw the man's cell and met staff.

ISSUES

The legal process

51. Throughout his time in prison, the man raised the same two issues when staff asked him how he was. The first was that he was sometimes puzzled by, and often frustrated with, the justice system. While investigating this issue is outside my remit, I am pleased to note how speedily staff tried to help the man. Officers and nurses referred him to those who could answer his questions. Bail information officers and foreign national officers helped explain procedures to him. On one occasion, a nurse contacted the man's solicitor to ask him to contact the man, which the solicitor then did. In Lewes, as part of the ACCT care plan, the SO referred him to the bail and foreign national officers and gave him stationery for writing to his solicitor. The foreign national officer supplied my investigator with copies of the information he gives to prisoners. It is produced in a number of languages, including French.

Health

Physical health

52. The man's second and major concern during his time in prison was how imprisonment was affecting his heart problem. In each prison, he told staff that he had a heart murmur. He complained of palpitations, especially at night. I believe that medical staff treated his complaints seriously, sending him for tests and giving him medication. However, the test results did not reveal any heart disease and doctors concluded that the palpitations were caused by stress. The man did not fully accept this diagnosis and maintained that, as well as suffering from anxiety, he had a heart murmur.

Mental health

53. When staff asked the man about his mental health, he always replied that he had never had such problems. However, on two occasions during his time in prison, he was assessed by staff from mental health teams. The first time was at Belmarsh, after information from his family that his telephone calls to them were not making sense. The second occasion was at Lewes after he became very upset during his examination by the doctor. The mental health nurses who examined him both concluded that he was showing no signs of mental illness but that he was very anxious. Each nurse noted his concerns and referred him to the relevant people who could help him.

54. When the man arrived at Lewes, the reception nurse assessed his physical and mental health. He concluded that the man's main concern was to see a doctor about his heart murmur and medications. He referred the man to the doctor and explained that the appointment would take place the following day. The man appeared content with this. The reception nurse had no concerns about the man's state of mind.

55. However, the following morning, when the man spoke to the doctor, he became very upset. The doctor and the charge nurse were concerned enough to open an ACCT plan and to refer the man to the MHIT. It is very unfortunate that the referral form was misfiled and that the assessment was delayed as a result. The clinical reviewer addresses this issue in her review and makes a recommendation. She also notes that staff at Lewes have already improved procedures to ensure that such misfiling does not happen again.

The Head of Healthcare should establish an audit of referral processes as regards referring to other/in-reach services.

Attempted resuscitation of the man

56. When the female officer discovered the man, she immediately called for assistance over her radio. The SO and other officer arrived at the cell in a matter of seconds, loosened the sheet and laid the man on the floor. The SO then went to collect the nurses from the healthcare centre. He was mindful of the twin requirements of ensuring the security of the prison and enabling the nurses to move quickly to the man, once he had unlocked them from the healthcare centre. The clinical reviewer highlighted that in resuscitation every second counts and, the more quickly nursing staff can get to the scene, the better for the patient. She advised that officers should be made aware of this urgency, as indeed, the SO was. The Governor and Head of Healthcare may wish to examine the issues surrounding getting nursing staff to an incident as quickly as possible. Once the nurses reached the man, they began CPR and the attempted resuscitation was carried out appropriately.

57. The clinical reviewer concluded that:

> "all the healthcare staff involved in the care of the man acted with professionalism and with sound clinical judgment and to the best of their abilities had acted in good faith in all aspects of care from assessment to referral to administering emergency care."

She made a number of recommendations to improve policies and procedures, which I endorse. The recommendations that are directly relevant to the man's care are included in this report. I have written to the Head of Healthcare about the recommendations that are of a more general nature. A copy of the letter is at Annex 14.

The Head of Healthcare should ensure regular reviews of documentation occur, to ensure signatures and dates are correct and recorded on all documents.

ACCT

58. Prison Service policies and procedures are set out in Prison Service Orders (PSOs) and each one deals with a specific topic. PSO 2700 'Suicide Prevention and Self-Harm Management' gives instructions about the requirements for ACCT plans. The charge nurse opened the ACCT promptly and passed the plan to the case manager. The ACCT assessor completed the assessment well within the timescale. He then attended the first case review, as did the man and they and the SO all concluded that the ACCT should be closed.

59. However, PSO 2700 stipulates that after an ACCT plan is closed, a post closure interview must be held within seven days. During the review, staff should ask the prisoner how they are coping and what strategies they have for dealing with their problems. The SO who chaired the review that closed the man's ACCT plan scheduled a post-closure review for six days later on 3 June. However, there is no record of the review taking place. It would have been beneficial for staff to discuss the man's problems with him as, from the observations of the RMN, he quite clearly was still troubled.

    The Governor should remind all staff of the requirement in PSO 2700 to hold at least one post-closure interview and of the importance of making a written record of the meeting.

60. This gap was, to some extent, filled by the RMN who carried out the delayed mental health assessment on 2 June. She spent time listening to the man's concerns and then addressed each of them. She provided leaflets on dealing with anxiety but the other three worries could have been addressed by officers on A wing, had a review meeting been held.

61. During his interview with my investigator, The SO said that staff in the First Night Centre (FNC) open many ACCT plans. Managers identified a need to have more trained assessors to prevent a backlog of plans waiting for that highly important part of the process. Two members of the FNC are now trained assessors and the prison intends to train more FNC staff in this important role. The SO said that the intention is to have at least half the FNC officers trained in the future. I commend this initiative, showing as it does the commitment of staff at Lewes to helping vulnerable prisoners in their care.

CONCLUSION

62. Throughout his time in prison, the man worried constantly about his health. Staff tried to reassure him that he was suffering from anxiety attacks, rather than a heart condition but he was not convinced. In the days leading up to his death, staff noticed that the man was looking anxious. His personal officer spoke with him and encouraged him to ask staff for help. Sadly, the man kept his own counsel. In his final letter to his parents he said,

> "I have had enough of living in prison. I am someone who likes travelling and loves nature. I no longer have the strength to live in prison."

RECOMMENDATIONS

1. The Head of Healthcare should ensure regular reviews of documentation occur, to ensure signatures and dates are correct and recorded on all documents.

   The Prison Service accepted the recommendation.
   “Prisoner medical records will be all electronic at Lewes by December 2008, with password protected entries so there will be the ability to recognise the nurse/doctor/healthcare professional who has made entries.”

2. The Head of Healthcare should establish an audit of referral processes as regards referring to other / in-reach services.

   The Prison Service accepted the recommendation.
   “Audit of referral processes will commence September 2008.”

3. The Governor should remind all staff of the requirement in PSO 2700 to hold at least one post-closure interview and of the importance of making a written record of the meeting.

   The Prison Service accepted the recommendation.
   “This instruction is already included in HMP Lewes’ Safer Custody