

**Investigation into the circumstances surrounding
the death of a man
at HMP Lewes in December 2005**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2006

This is the report of an investigation into the death of a man in December 2005 at HMP Lewes. He died as the result of a cut to the left internal jugular vein apparently by his own hand. The man was 48 years old.

My colleagues and I would like to extend our condolences to his family and to those touched by his passing.

The investigation was undertaken by two of my colleagues. I would like to thank the Governor of HMP Lewes and his staff for their ready participation in the investigation. I am particularly grateful to the Security Governor who acted as the establishment's Liaison Officer with the investigation team.

The Head of Healthcare at HMP Lewes was identified Sussex Downs and Weald Primary Care Trust (PCT) to undertake a review of the man's clinical care, and I greatly appreciate her assistance. I judge her review as both comprehensive and a fair representation of the clinical services at HMP Lewes. However, as the clinical reviewer is the Head of Healthcare at Lewes prison, I wonder if it was appropriate for the PCT to ask her to undertake the review. Colleagues in Prison Health may consider this is a matter on which guidance should be offered to all PCTs with a prison in their area.

This report makes three recommendations, all based on the clinical review. It also refers to police information relating to the man's risk of suicide that the Coroner may wish to explore in more depth.

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Prisons and Probation Ombudsman

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SUMMARY

The man was born on 6 September 1957. He was 48 years old when he died at HMP Lewes, apparently by his own hand, in December 2005. Having been charged with committing a serious sexual offence, his trial was due to start the following day at the Crown Court.

The man had first been remanded into custody from the Magistrates' Court on 18 April 2005. At the court he had been seen by a Forensic Community Mental Health Nurse who concluded that the man was at risk of self-harm or suicide. A self-harm warning form was completed by a senior custody officer at the court identifying the risk.

The man was received at HMP Elmley where, during his First Reception Healthscreen, he denied any thoughts of suicide or self-harm.

The only notes in his medical record from Elmley are that he fell from his bed or a chair on 26 April and hit his right lower ribs which were sore. He was taken to the local hospital with a request from the prison's medical officer that the hospital assess him for possible complications of the rib injury and to check his cardiovascular system. He was discharged later the same day with ibuprofen tablets for the injury. The discharge letter also indicates that he underwent an ECG examination.

On 5 May, the man did not attend a doctor's appointment, but no reason was noted and it is unclear what the appointment was for. He remained at Elmley until he appeared at the Crown Court on 22 July 2005, following which he was remanded to HMP Lewes. On reception at Lewes, he again denied he had any thoughts of self-harm or suicide. He did not come to the attention of staff and the only notes in his medical record are that he missed sick parade on 30 August and again on 1 November. He complained of indigestion on 13 September, for which he was treated and he was signed off work that day.

While he was at Lewes, there is no evidence that he gave any indication to anyone else that that he had suicidal thoughts. Nevertheless, it would seem from comments made by his wife that he found it difficult to cope with prison life and his children expressed concern to her about his wellbeing following a visit. Judged overall, his time at Lewes was entirely unremarkable. However, the fact that police information that he had been downloading articles about suicide from the internet at the time of his arrest was not known by prison staff may have led them to underestimate the risk.

The clinical review concludes: "it is my opinion that healthcare staff, prison officers and paramedic staff acted appropriately when responding to the emergency and when they attempted to resuscitate the man." However, the clinical reviewer has identified a number of areas where improvements could be made to the systems of recording and to some procedures. She makes a number of recommendations, three of which I have endorsed.

THE INVESTIGATION PROCESS

1. My investigators studied all relevant prison records relating to the man. These included his main prison record, his medical records and statements from prison staff.
2. Sussex Downs and Weald Primary Care Trust identified a General Manager and Head of Healthcare at HMP Lewes, to carry out a review of the man's clinical care. I am grateful for this review being undertaken in a most 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. This recorded the cause of death as hypovolaemic shock leading from a haemorrhage caused by a cut to the left internal jugular vein. Ischaemic heart disease was found to be present but did not contribute to his death. 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 met with the man's wife (the couple had separated) in the company of one of my investigators. She told them of her concerns which are considered later in this report. The wife said that that when two of their four children visited their father in prison, they noticed deterioration in him. They reported that he had become withdrawn and depressed and had lost weight. The wife asked why this was not noticed and acted upon by prison staff and why he was not placed on suicide watch or given the opportunity to speak to someone. She was also concerned that, on the morning after his death (the day of the planned trial), news of the man's death was reported on the local radio station and teletext. She was not happy with the prison's explanation that they had to inform waiting press at court. In addition, a front page report in a local newspaper had made reference to her marriage and she wanted to know where the press had got the information from. She also asked where the man's mobile telephone and bank card were as they had not been returned. I hope this report and the clinical review provides her with answers to her questions.
5. My investigators discussed aspects of the man's treatment with staff at Lewes and the clinical reviewer.
6. Six members of staff were interviewed during the course of the investigation. They were offered the opportunity of being accompanied by a work colleague or Trade Union official.

HMP LEWES

7. Lewes prison was built in 1853. It is a local prison which houses trial/remand and sentenced adults. 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 large wing (F Wing) to accommodate vulnerable prisoners. The prison has an operational capacity of 558.
8. The provision of healthcare within HMP Lewes is the responsibility of 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. Medication is administered on a weekly and/or monthly basis to those prisoners who have been assessed as suitable to safely manage their own medication. It is administered on a daily basis to other prisoners, when either they are considered to be at risk or the medication is unsuitable to be held in their cell.
9. There is an in patient 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.
10. In a full announced inspection in 2003, Her Majesty's Chief Inspector of Prisons (HMCIP) described HMP Lewes as a good local prison, but expressed concern about the lack of services for vulnerable prisoners and suggested 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, and 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.
11. As a result, most of the recommendations in the earlier inspection report had been implemented and the rate of self-harm was much reduced. HMCIP also concluded that other aspects of safety had improved (concerns about the segregation unit and first night arrangements had been addressed, positive drug test levels were low and detoxification arrangements were excellent). HMCIP 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.'
12. There have been four other deaths at Lewes since April 2004, three from natural causes and one apparently self inflicted death. There are common issues between the death of the man who is the subject of this report and one of the natural cause deaths, to which I shall refer later in this report.

EVENTS PRIOR TO 11 DECEMBER 2005

13. My investigators were told by the Coroner's Officer that when the man was first arrested he had 43 pages printed from the internet on how to commit suicide. He appeared before the Magistrates' Court on 18 April 2005. The Prisoner Escort Record (PER) from the Police Station to the Magistrates' Court did not mention the internet pages. Part A of the PER, completed by the custody assistant had the 'other' box ticked for concerns, but there were no details recorded of what this might refer to. The man was not noted to be at risk of self-harm or suicide.
14. A psychiatric report was completed at the Magistrates' Court by the RMN, which noted the man was agitated and distressed and believed he would not survive prison due to the nature of the alleged offences and his previous employment as a police officer. The report also noted that, since his arrest, he had a poor appetite and problems sleeping. Night sleeping tablets had been prescribed for him. He had expressed a desire to kill himself. The RMN considered there was a high risk of him committing suicide. A self-harm warning form was completed by a senior custody officer at court. That day the man was remanded in custody to HMP Elmley. The PER for the man's transfer between the Magistrates' Court and HMP Elmley appears to have gone missing.
15. A full Induction was completed at HMP Elmley, which included a First Reception Healthscreen completed by the staff nurse. She saw the self-harm warning form forwarded by the Court and has noted it on the healthscreen. She recorded that the man had no thoughts of self-harm. When my investigators spoke to her, she could not recall completing the healthscreen or whether she had specifically asked the man about the psychiatric report. In fact she could not recall whether she saw the psychiatric report, although she agreed that she must have been aware of the concerns about him as she signed the self-harm warning form. She explained that she would normally see a psychiatric report if one had been completed.
16. The staff nurse said it would appear that she did not have any concerns about the man's wellbeing as she did not open a self-harm warning form (F2052SH). She said she had referred him to the safer custody officer, using a standard memo, due to the potential risk of self-harm because of the nature of his charges and the fact that he was an ex-police officer. This memo was not found in the man's paperwork. She reiterated that she was not sufficiently concerned to put him on a F2052SH, and the idea of the memo is to identify those prisoners who potentially could be at risk of self-harm or suicide but have not given any specific indication of that intention.
17. A Secondary Health and Well Person Assessment was carried out which was unremarkable. It is not clear who completed this form and there is no entry made in the man's medical record. A cell share risk assessment was completed by the wing. This noted that the man was a Rule 45 prisoner (vulnerable prisoner status) and stated that he had no thoughts of self-harm and had been misunderstood. There was no mention of the psychiatric report. The man was considered a low risk of sharing a cell with others (that is, he was considered suitable for multi-cell location).

18. The man was transferred to HMP Lewes on 22 July, following his appearance at the Crown Court. The PER completed for his transfer between Elmley and the Crown Court shows he was on constant watch at 7.35am, but there are no further details. No suicide or self-harm warning box was ticked. There is no PER now available for his transfer between the Crown Court and Lewes Prison. When he arrived at Lewes, he underwent a standard induction programme. The Induction Audit Checklist shows that he had a legal aid interview, chaplaincy interview, bail information interview and a PE induction.
19. The induction checklist also notes that a healthscreen interview was completed by a nurse, but there is no written record of what took place. In interview, a wing nurse said he vaguely recalled triaging the man when he arrived at Lewes but again there is no documentary evidence of this. The Head of Healthcare explained that the policy is that all prisoners, including transfer prisoners, should have a full reception healthscreen. There is no evidence that this happened in the man's case. The Head of Healthcare explained that, since she has been in post (January 2006), she has tried to make improvements to all healthcare services, including reception screening and follow-ups. She said that, prior to January 2006, it would appear that when healthcare staff were under pressure in reception, they briefly reviewed previous healthscreens from other establishments without undertaking a new one.
20. A cell share risk assessment was completed by the duty officer. The man answered 'no' when asked if he had previously been subject to a F2052SH. The officer considered he was a medium risk (that is, there was no immediate risk to others of him sharing a cell with somebody else, but the situation would need to be reviewed regularly). It was noted that the man said he would share a cell with a 'mature, sensible, clean person.'
21. The man requested Rule 45 status due to his previous employment as a police officer and the nature of his alleged offence. He was transferred to the Vulnerable Prisoners Unit under Rule 45 on 25 July.
22. On 5 August, a wing officer spoke to the man about the psychiatric report which had been forwarded to Lewes by Elmley. It is not clear when this was forwarded by Elmley, but a note records that it was received at Lewes on 5 August. The officer was asked to talk to the man about the report. In interview, the officer said he did not see the psychiatric report, but as far as he was aware it said that the man was vulnerable and could be at risk of self-harm. The entry in the man's core record by the officer notes: 'spoke to the man about psychiatric report and issues about self-harming, he has not got a clue why the report has come from the Magistrates' Court, does not feel suicidal or like self-harming. No issues.'
23. On 30 August, there is a note in the man's medical record that he did not attend sick parade. There is no record of what action, if any, was taken as a result. It is not clear either why the man was receiving medical attention.
24. On 13 September, it is noted in the man's medical record that he was suffering from indigestion and was vomiting, and he was signed off work.

25. On 1 November, there is another note in his medical record that he did not attend sick parade. Again, there is no record of any action taken as a result and no record of why the man was receiving medical attention.

EVENTS ON 11 DECEMBER 2005

26. On 11 December 2005, at approximately 4pm, the first landing officer went to lock the man's cellmate back into the cell. He said he looked through the observation hatch and, as he could not see anything, he unlocked the door and pushed it open. He looked down at the threshold of the door and noticed blood on the floor. He then saw the man sitting in a chair at the back of the cell, with his back to the sink, facing his bed. He could not see very clearly as it was dark in the cell, with the only light coming from the landing. He shouted for help, as he could not use his radio because the battery was dead. He saw the second landing officer running towards him he entered the cell. The second landing officer saw the prison officer making his way to the cell and told him to get medical help.
27. The second landing officer arrived at the cell door and immediately went and pressed the general alarm located approximately two cells away. He then re-entered the cell. The man had a cut to the left side of his neck. The first landing officer fetched some gloves from the second landing officer. The second landing officer had a sealed emergency medical pouch, which included one pair of gloves, which he had obtained from healthcare years previously. It is not clear what else was in the medical pouch.
28. The prison officer radioed for medical assistance and collected the First Aid Box and the Emergency Intervention Bag from the wing office. Both landing officers carefully laid the man flat on the floor. The second landing officer checked the man's airway, while the first landing officer performed chest compressions.
29. At around 4.05pm, the wing nurse responded to the emergency call and arrived with emergency equipment. The second prison officer arrived at the same time. The man was moved within the cell to ensure more space to continue resuscitation. Both landing officers then left the cell. The wing nurse continued with the resuscitation, along with the second prison officer. The wing nurse told my investigator that it proved difficult to obtain good chest compressions and airway breathing initially. He changed masks and airways until eventually he administered mouth-to-mouth resuscitation effectively. During this time he said that he noticed two lacerations, one on the left side of the man's neck and another on his larynx, and he placed some gauze swabs on the wounds to stop the bleeding. He found a toothbrush handle, which had a blade welded to it and he placed it on a plate by the sink.
30. The principal officer (PO) who was the orderly officer at the time of the man's death, called for an ambulance by radio at approximately 4.05pm. At approximately 4.11pm, the Sussex Ambulance Paramedics arrived and took over the management of the man's airway, while the wing nurse and the second prison officer took it in turns to perform heart massage. The paramedic crew then intubated and cannulated the man, while administering 1200mls of Hartman's solution and adrenaline. (Hartman's solution is used to replace essential fluids lost from the body.)

31. After approximately another 20 minutes, the paramedics decided to transfer the man to the Accident and Emergency (A&E) Department at the local hospital. He left the prison by ambulance at approximately 4.55pm. Resuscitation was continued by the paramedic crew, the second prison officer and a senior officer (SO), in the ambulance until approximately 5.11pm.
32. The man was pronounced dead on arrival at the A&E Department at approximately 5.17pm.

EVENTS AFTER 11 DECEMBER 2005

33. The duty governor contacted the man's daughter on her mobile telephone, and also spoke to his wife. Later that night, he visited the man's wife and children to offer condolences and support. He was also able to give some more detail about the circumstances and a contact number for the coroner's office.
34. A letter of condolence was sent to the man's wife by the Governing Governor on 19 December. Flowers were sent by the prison and they contributed towards the cost of the funeral. The chaplain and a governor acting as the prison family liaison officer attended the man's funeral on behalf of the prison.
35. The post mortem recorded the cause of death as hypovolaemic shock leading from a haemorrhage caused by a cut to the left internal jugular vein. Ischaemic heart disease was found to be present but did not contribute to his death.
36. Staff who were interviewed agreed that the support offered by the Post Incident Care Team after the man's death was very good. They found the hot debrief, on 15 December, very useful. The second prison officer told my investigators that the prison offered to pay for massage for his shoulder as he pulled some muscles whilst performing CPR.
37. Following the concern expressed by the man's wife, the governor who was at the time the family liaison officer for the prison made enquiries into the press release. The following is the direct wording that was passed to him as a result (I note it does not give any indication of the man's former occupation or of the location of his family and was issued after the man's family had been told of his death): 'We can confirm the death in custody of a man at HMP Lewes (DOB). The man was discovered in his cell by staff at 16:00hrs on Sunday 11 December, he appeared to have cut his own throat. Staff immediately attempted to resuscitate him and an ambulance was called. However he failed to recover and was pronounced dead at 17.17hrs. Every death in custody is a tragedy, and our sympathies are with the family and friends of the man at this time. The Police, Coroner and Next of Kin have been informed. As with all deaths in custody, the Prisons and Probation Ombudsman will conduct an investigation.'
38. The press notice also includes the following: 'If asked: "The man was on remand for rape, and had been in custody since 18.04.05. He was not on an open ACCT form. He was from East Sussex." If asked what the man used to cut his throat: 'We cannot comment further as this is now subject to an investigation by the Prisons and Probation Ombudsman.'"

ISSUES

Clinical Care

39. The clinical review was undertaken by the healthcare manager on behalf of Sussex Downs and Weald PCT. She concluded that the healthcare staff, prison officers and paramedic staff acted appropriately when responding to the emergency when they attempted to resuscitate the man. However, the clinical reviewer drew attention to a number of issues concerning standards of record keeping and assessing prisoners' mental and physical health needs. She has made a number of recommendations which I endorse.
40. It is not clear from the reception induction checklist completed at Lewes what form of reception healthscreen the man had when he was transferred from Elmley. This meant that staff did not have a clear picture of his current health status.

The Healthcare Manager must ensure that all prisoners new to the prison or transferred from another prison are given an appropriate healthscreen and followed up, and that a system of clinical audit is developed to ensure staff compliance.

41. The man refused to attend a medical appointment at Elmley and did not attend sick parade on two separate occasions at Lewes. There is no record of any follow-up or reasons for why he refused or failed to attend. There does not appear to be any routine process at Lewes for following up and establishing reasons for non-attendance. This was mentioned as an issue in a previous investigation of a death from natural causes at HMP Lewes.

Where a prisoner refuses to attend an appointment, a reason for refusal should be sought and documented in the medical records, signed by the patient and witnessed by staff. Refusals to attend should be brought to the attention of a Senior Nurse.

42. The clinical review also indicates that it is sometimes difficult to decipher who has made the entries in the medical records, as there are only signatures, names are not printed and there is no covering signature sheet available. This was also mentioned as an issue in a previous investigation of a natural cause death at Lewes.

The healthcare manager must remind staff to print their name next to their signature in medical records. A signature sheet must also be available for cross referencing official documents if required.

43. I agree with the clinical reviewer's conclusion that healthcare staff, prison officers and paramedic staff acted appropriately when they responded to the emergency and attempted to resuscitate the man. The prison's contingency plans for dealing with a death in custody were followed. However, the first landing officer could not call for assistance by radio because his radio batteries were not charged.

Sharing information

44. It is of concern that several Prisoner Escort Records have either gone missing or were not completed when the man was moving from prison to court and from court to prison. Furthermore, on the occasions that PERs could be evidenced they were often incomplete. Such records are a key tool for the sharing and transfer of information between departments and organisations.
45. Good record keeping helps inform the care process and ensure the continuity of care and management of an individual. It also enables early detection of changes in a prisoner's demeanour or mental health and therefore assessments and interventions to be put in place in a timely manner.
46. It has been identified by the Coroner's Officer that the man was received into police custody with information downloaded from the internet about suicide. It is of great concern that this information was not passed onto the escort staff and to the Prison Service. As this is a matter concerning the police, I have judged it to be outside my remit. However, the Coroner may wish to explore this matter in more detail as part of the inquest procedures.
47. I am concerned that the psychiatric report prepared by the RMN at court was not seen by one of the wing officers when he was asked to talk to the man about those issues on 5 August. It would certainly have been beneficial for him to have seen the report before he spoke to the man.

Risk of suicide and self-harm

48. The man denied that he had any thoughts of suicide or self-harm when he arrived at Elmley and later when he was transferred to Lewes. He did not give staff at either prison any cause for concern. However, he was a vulnerable prisoner, in view of his alleged offence and his previous occupation as a police officer and this had been identified by a RMN at court.

Contact with the man's family

49. The man's wife was concerned that news of her husband's death was reported on teletext and the radio shortly after she had been told. This followed the procedures set out for a death in custody, which include the routine publication of a press notice including details of offence. This is standard practice for the Prison Service's National Operations Unit, and is usually done when it is confirmed that the family have been informed of the death, as was the case here. I think these procedures are proper given the necessary public interest in any fatality occurring in a closed institution. However, it would clearly be helpful for next of kin to be advised at an early stage that a press notice will be issued, as details of the death may appear in the media which may be distressing for the family. It might also be useful to suggest that next of kin may want to contact other family members quickly. I understand that staff in Prison Service Headquarters are currently working to resolve this issue.

50. My investigators have tried to locate the man's mobile telephone and bank card. There is no trace of the items at Lewes and the police have no record of them either.

Conclusion

51. The man died from an apparently self-inflicted cut to the left internal jugular vein while in custody at Lewes. From comments made by his wife he was a well loved father but he was struggling to cope with prison life and two of his children expressed concern to her about his wellbeing following a visit. His time at Lewes was unremarkable; it appears he was very quiet and rarely associated with other prisoners.

52. During his time at Lewes, there is no evidence that the man gave any indication that he had suicidal thoughts. However, the fact that police information that he had been downloading articles about suicide from the internet at the time of his arrest was not known by prison staff may have led them to underestimate the risk.

RECOMMENDATIONS

HEALTHCARE

The Healthcare Manager must ensure that all prisoners new to the prison or transferred from another prison are given an appropriate healthscreen and followed up, and that a system of clinical audit is developed to ensure staff compliance.

Where a prisoner refuses to attend an appointment, a reason for refusal should be sought and documented in the medical records, signed by the patient and witnessed by staff. Refusals to attend should be brought to the attention of a Senior Nurse.

The healthcare manager must remind staff to print their name next to their signature in medical records. A signature sheet must also be available for cross referencing official documents if required.

The Prison service has accepted all the recommendations.