



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

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

Our Vision

*To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision.*

This is the report of an investigation into the death by murder of a man at HMP Lewes in April 2007. The man, a sentenced prisoner, was found lying on the floor of his cell in the Care and Support Unit with a ligature around his neck, just after midnight. His cellmate was subsequently charged and convicted of his murder. He was 25 years old.

The death of a loved one is always hard to bear. To lose someone in the circumstances outlined in this case must have caused the family considerable distress. I wish to offer my sincere condolences to the man's family and friends for their loss.

The investigation was led by my one of my investigators. I am grateful to the Governor and staff of HMP Lewes whose assistance was of great help to my investigators. I am also grateful to the DCI at Sussex Police whose liaison with my investigator was of great assistance.

The man's death was initially thought to have been self-inflicted. However, it was later established that he had been murdered. My investigation has found that prison procedures were appropriately carried out during his imprisonment. Although information came to light that, with hindsight, might have raised doubt about the relationship between the two prisoners, I am satisfied that staff could not reasonably have foreseen the likelihood of his cellmate taking such extreme action.

I apologise for the delay in the publication of this report, this was due, in part, to the police investigation and subsequent court case. I make one recommendation in this case relating to cell sharing risk assessments and I also invite the Governor to consider the handling and recording of critical incident debriefs.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

May 2010

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SUMMARY

At the time of his death, the man was 25 years old and serving a six year sentence at HMP Lewes. He was found on the floor of his cell, just after midnight in April 2007, by staff who had responded to a cell bell. He had a ligature around his neck. The prisoner, who shared his cell, was subsequently charged and found guilty of his murder.

The man had first arrived at Lewes on 22 September 2006, having been committed into custody for trial, together with co-defendants. He was initially charged with murder. He had been assessed at court by a mentally disordered offender assessment and diversion team due to the nature of the allegation against him. This team found no evidence of mental health problems or self-harm and suicidal intent.

Later that day, on reception at Lewes, further healthcare checks, including a subsequent assessment by a forensic psychiatrist, found neither any remarkable physical health issues nor any mental health concerns. Initial cell sharing risk assessments found the man to be low risk, and this assessment was maintained in later reviews. He was consistently described by staff as polite, compliant and generally mixed well with others.

As the man's co-defendants were also on remand at Lewes, the prison took care to ensure they were kept apart. There is no evidence they had any contact.

He fell down the wing stairs on 27 November, knocking himself unconscious. He was quickly transferred to hospital, received appropriate treatment and recovered satisfactorily. There is no evidence that anyone else was involved in this incident.

He was subjected to an apparently unprovoked assault by other prisoners on 21 December. He was again taken to hospital and found to have facial injuries, including a broken bone in his left cheek. He was treated appropriately and returned to prison the following day with a follow up appointment.

As the man's cellmate had warned staff that he would be attacked again, the Governor decided on 22 December, under Prison Rule 45, to locate him in the Care and Support Unit (CAS) for his own safety and protection. Regular reviews in the unit indicated that he was making good progress. No problems were identified regarding his location in CAS.

The man's cellmate arrived at Lewes on 19 January 2007. His Cell Sharing Risk Assessment (CSRA) identified him as a medium risk. Some days later he was located in the Care and Support Unit and shared a cell with the man. No concerns were raised about this cell sharing arrangement. There is evidence that the man thought his cellmate to be supportive and that they were friendly.

The man's trial began on 5 March and concluded on 18 April. He was found not guilty of murder, but guilty of manslaughter and was sentenced to six years imprisonment the following day. He was re-assessed by healthcare staff following his trial and found to be positive in attitude, with no self-harm or suicidal intent.

Healthcare staff continued to see him every day as required by the segregation regime, but no problems or concerns were recorded as being raised with them. He posted four letters to friends on 23 April, all of which were read by staff.

Just after midnight, a cell bell alarm was pushed from both prisoners' cell. The cellmate told the staff who responded that the man had hung himself. Other prison and healthcare staff responded within minutes to a radio alarm call, and swiftly began cardio pulmonary resuscitation. Paramedics arrived about 20 minutes later and, maintaining resuscitation efforts, transferred him to the County Hospital. A doctor pronounced his death at 1.05am.

The man's next of kin were told of his death later that day by the chaplain and Governor. The staff care team were informed and prisoners were notified as well. Owing to the lapse of time and the unavailability of key staff, it has been difficult to establish whether a critical incident debrief was held.

Police conducted an investigation into the man's murder and during this time the Ombudsman's investigation was halted. Statements provided to the police by other prisoners and visitors to the cellmate indicate that he had said that he intended to kill the man and make it look like suicide, that he had a fascination with killing someone and he had been playing games of pain with the man. Tragically, it seems that his threats to kill him were not taken seriously. If the prisoners or visitors had told prison staff they could have taken action and I believe the man's death might have been prevented.

I make one recommendation relating to the need to review a CSRA if security information suggests that a prisoner has an inappropriate interest in another prisoner's personal affairs.

THE INVESTIGATION PROCESS

1. One of my investigators visited Lewes on 26 April 2007 to open this investigation and liaised with senior prison staff and the police. All relevant prison records relating to the man were made available. These included his main prison record, medical records, and statements made by staff relating to his death.
2. Later that day, the Ombudsman's investigation was halted, as the police concluded his death was a possible homicide and they initiated a murder investigation. This took precedence over the Ombudsman's investigation which could not resume until after any subsequent trial.
3. My investigation was re-opened after the trial and conviction of the cellmate for murder in May 2008. Another one of my investigators led the investigation and visited Lewes to interview staff. Sussex Police gave him case summary documents, particularly those in relation to the cellmate, and an outline of the case. The cellmate's other prison records were not available due, firstly, to the suspension of the investigation and, secondly, as he had been transferred to another prison. My investigator later received copies of the cellmate's CSRA documents.
4. Unfortunately, by June 2008 virtually all the staff who had known the man and his cellmate had either retired or had transferred to other establishments. My investigator was therefore only able to interview one member of staff who had been working on the Care and Support Unit at the time of the man's death. This interview was recorded and the transcript is attached to this report.
5. The investigator has studied all the relevant prison records available relating to the man, as well as the documentation made available by the police. As the death was due to murder, a review of his clinical care was not commissioned.
6. HM Coroner for East Sussex was informed of the nature and scope of my investigation. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.
7. One of my Family Liaison Officers wrote to the man's parents to inform them of my investigation and that it had been suspended, shortly after his death. The Family Liaison Officer wrote to them again once my investigation had resumed and there has been continuing contact with their solicitors. I hope this report helps to address any questions the man's family might have regarding the care he received whilst in prison custody.

HMP LEWES

8. HMP Lewes is a category B male local prison holding adult remand and short term convicted prisoners as well as remand young adults. It serves the courts of East and West Sussex. At the time of the man's death, it had an operational capacity of 558, which has now increased to 723 prisoners.
9. The majority of the accommodation, at the time, was shared cells, although there were some single cells. The additional accommodation has been achieved through the opening of a new single cell block housing 174 prisoners.
10. Incoming and outgoing mail is monitored by staff. Ten percent of prisoners' mail is normally read. If an individual is subject to mail monitoring all of his incoming and outgoing mail may be read.

Care and Support Unit

11. The Care and Support Unit, which closed shortly after the man's death, was attached to the segregation unit, but in a separate annex. It accommodated up to nine prisoners in four double and one single cell. The CAS unit held prisoners who had been removed from general association under Prison Rule 45 for either the good order or discipline of the prison or in their own interests. The unit provided support and development to prisoners aimed at enabling them to acquire new skills and strategies that would aid reintegration to normal location or on transfer or release.

Night state

12. At night, all prisoners are locked in their cells and the number of staff in the establishment is much lower than during the day. The night orderly officer is in overall charge of the prison. The night orderly officer visits each wing or unit at intervals through the night. Wings and units are in the care of night patrol officers, responsible for monitoring security and safety. At Lewes, the patrol staff include both trained prison officers and operational support grades (OSGs). The night orderly officer carries a set of keys that allow him to access all areas of the prison. Wing or unit patrol officers carry cell keys in a sealed pouch for emergency use only. Written instructions prevent any officer from opening a shared cell alone.

Her Majesty's Chief Inspector of Prisons

13. The most recent inspection by Her Majesty's Chief Inspector of Prisons was unannounced and took place in August 2007. One of the recommendations in that report is pertinent to the issues raised in this report. She recommended that reintegration planning for prisoners on the Care and Support Unit should be further developed, with targets that aim to improve prisoners' behaviour and increase their coping skills.

Independent Monitoring Board (IMB)

14. The IMB report to the Secretary of State for 2007-08 described the Segregation and Care and Support Unit as well run. The report commended staff for the skill, sensitivity and flexibility with which they managed needy prisoners within the unit.

None of the issues raised within the IMB report are relevant to the circumstances of the man's death.

Previous deaths at HMP Lewes

15. The Ombudsman became responsible for investigating all deaths in custody in April 2004. There are no similar recommendations in this case to any self-inflicted or natural causes deaths investigated at Lewes.

KEY EVENTS

16. The man was charged initially, together with two others, with the murder of a homeless man in Brighton. He appeared at a Magistrates Court on 22 September 2006. A Prisoner Escort Record (PER) was prepared by Sussex Police for his journey from police custody to court. It identifies one security risk (that he may possess weapons, based on his previous offence of possessing a knife), drugs and alcohol issues, and one other. No self-harm or suicide risks were identified. (The PER is a record of all escorted journeys made by a prisoner, it includes a section highlighting any known risks involved in moving that prisoner.)
17. At court on 22 September, the man was assessed by the East Sussex mentally disordered offender assessment and diversion scheme, a service provided by the National Health Service (NHS). He was referred to the service due to the nature of the murder allegation and to check any mental health issues. Their assessment found no evidence of mental illness, or of any self-harm or suicidal ideas or intent. It summarised his history, noting that he had been homeless in the Brighton area for a year, and that the victim of the alleged offence had also been a homeless man. The assessment recorded that he was under high levels of stress, which he was managing, but was asking for night sedation to help him sleep.
18. The court committed the man into prison custody awaiting trial at Crown Court on 6 October. He was taken from court to HMP Lewes. On reception at Lewes, he was recorded as a homeless man, and gave the name of a girlfriend as his next of kin.
19. The Cell Sharing Risk Assessment (CSRA) completed on the man's first reception at Lewes identified no immediate risk. (A CSRA is undertaken, normally on reception and assesses any risks a prisoner may pose to sharing a cell with another prisoner.)
20. The first health screen was completed on reception as required, and the second health screen was completed later the same day. Neither revealed any remarkable health issues. The possibility of depression was noted, but he was assessed as generally well. He was reviewed by the doctor the following morning who recorded there were no mental health concerns or any markers of depression.
21. After completing the reception process, the man spent a short time in the First Night Centre. The record of his time on this unit indicated that he was polite, presented no concerns, but had to be kept apart from his co-defendants. His prisoner personal record clearly recorded a warning flag identifying that, in relation to his cell location, he must be separated from his co-defendants (who were also being held in the prison).
22. Records show that on 25 September the man's induction into the prison was complete. His CSRA was reviewed and indicated that he continued to be low risk and the need to refer him to the housing officer was noted. He was seen and assessed by a community psychiatric nurse from the mental health in-reach team, the same day. She found that he presented no evidence of severe or

enduring mental health problems. However, given that he had been remanded into custody on a charge of murder, she recorded a team decision to arrange for him to be assessed by a forensic psychiatrist.

23. A forensic psychiatrist assessed the man on 29 September. He found no evidence of existing mental illness, or enduring illness in the past. He diagnosed insomnia for which he prescribed medication to help establish his sleep pattern, and recorded that the man said he would never harm himself. The psychiatrist concluded there was no need for any psychiatric follow up.
24. There is a record of an Authorised Contact Restriction, dated 6 November, which was served on the man and which he signed to indicate he understood. At the request of Sussex Police, his contact with the woman he had described as his girlfriend and nominated next of kin was restricted, and he was not allowed to write, telephone or contact her through third parties. Although there is no record of his response to this restriction, there is nothing to suggest any continuing adverse reaction.
25. The man was taken to Sussex Police on 23 November, to be charged in respect of an assault occasioning actual bodily harm offence which had been committed before his main offence.
26. He reported that he fell down the wing stairs on 27 November and was knocked unconscious. He was treated in the healthcare unit and taken to hospital, returning later in the day. He had a severe gash which was sutured and he was appropriately monitored. He admitted having taken his cellmate's medication the previous evening, and was warned against repeating this behaviour. He was reviewed satisfactorily on the wing the following day.
27. On 21 December, the man was subjected to an assault by other prisoners. He reported that he had been assaulted whilst lying in his bed, named one of the assailants and requested police involvement. He was taken immediately to the hospital where it was confirmed he had facial injuries and a broken bone in his left cheek. He received treatment and a follow up outpatient appointment was arranged. The prison carried out an appropriate investigation into the alleged assault but no formal charges were made against any prisoner.
28. Following the assault, the man's former cellmate told staff that other prisoners suspected him of being a sex offender, and warned staff that he would be attacked again. The Governor authorised a decision, under the good order and discipline Prison Rule 45, to move him to the Care and Support Unit (CAS), attached to the segregation unit. The decision to authorise segregation was properly recorded as necessary to ensure his safety and protection. The Initial Segregation Safety Screen, with input from a medical officer, indicated there were no healthcare needs which would make segregation inappropriate. There is no record of any police involvement, which had initially been requested by him. He was moved to the unit during the afternoon of 22 December.
29. In line with the prison policy for the CAS Unit, regular reviews of the man's progress were undertaken throughout his time there. The reviews took place at least fortnightly and recorded his progress. Comments on him were complimentary. He was described as a "quiet, polite and compliant man", who

mixed well with others on the unit. A prison officer, a member of staff on the CAS unit, confirmed this written description of him when interviewed by my investigator. Seen as always willing to help, it is noted he was one of the only prisoners willing to clean up the unit, and that he was looking for a job when one became available. He started attending education and achieved a key skills certificate in problem solving in February 2007.

30. Each CAS review confirmed that the man should be kept on the unit for his own protection. The medical record shows that healthcare staff continued to see him every day. (These were primarily the routine healthcare checks required on a segregated prisoner.) No major concerns were flagged following the checks.
31. On 3 January 2007, the man was taken to the Magistrates Court regarding the assault offence. The court committed him for trial at the crown court, and he returned to Lewes prison on remand.
32. The man's cellmate arrived at Lewes prison on 19 January. He is recorded as having been recalled to prison from parole. The cellmate had previously been sentenced on 16 June 2005 to a four year six month custodial sentence for robbery. His recall to prison coincided with being arrested and charged with a further serious offence of robbery. The court remanded him into custody in respect of this further offence.
33. A CSRA carried out on the cellmate identified him, in a tick box section of the form, as a medium risk to himself or a cellmate. A hand written entry goes on to say that staff believed he was at risk of harming himself. There was no indication that he was likely to be a threat to a cellmate.
34. Although initially located in the healthcare centre, the cellmate moved to the CAS unit and soon began sharing a cell with the man. The prison officer described the cellmate as a 'poor coper'. She recalled him as a likeable person and believed that he was placed in the CAS unit as he could not manage in larger environments. She said that he was working with the mental health in-reach team and believed that he liked being in the prison environment. She was not able to recall precisely how they came to be sharing a cell. She thought it likely that either or both had asked to be allowed to share a cell. She described how on the unit the normal pattern is that when two prisoners found someone they liked and got on with, and if they then asked to share a cell, it would be approved as long as the CSRA did not identify any risk. She recalled that they both got on together, would laugh and joke, and that she did not see any problem with them sharing a cell.
35. A further CSRA review of the man was undertaken on 20 January. This review maintained that he continued to be low risk. The review did contain a note, as an aide memoire, questioning whether prison intelligence had any information regarding risk, but without changing the conclusion. Two CAS reviews at the end of January recorded him as making good progress, mixing well, and seemed to be fine on the unit. Subsequent reviews reiterated these assessments.
36. The man was taken to hospital on 9 February for an outpatient appointment to review progress on his injuries following the assault in December. The specialist registrar in oral and facial surgery recorded that his injury had healed

satisfactorily, though he still felt some jaw pain, for which he was prescribed ibuprofen. His drugs chart shows that, together with some paracetamol, these were the main medications prescribed to him.

37. An outgoing letter sent by the man, dated 12 February, was intercepted by prison staff. In the letter, he described his cellmate as "my mate". A report following a further intercept, dated 27 February, suggests that he was attempting to find out information on another inmate being held at Lewes who was alleged to have assaulted an ex-girlfriend of his cellmate.
38. The man appeared at the crown court regularly during his trial from 5 March until 18 April. On 19 April, the jury found him not guilty of murder, but guilty of manslaughter. He was sentenced to six years imprisonment. CAS reviews in March and April, including the last undertaken on 11 April, continued to report progress, and did not identify any problems or concerns.
39. Healthcare staff assessed the man in reception on his return from court on 18 April. The medical record notes that although shocked, following the manslaughter conviction, his attitude was positive and he spoke about education and family support. It was identified that he had no history of self-harm or any suicidal thoughts, and said he wanted to return to his cell in the CAS unit where he had a supportive cellmate. Healthcare staff continued to review him every day following his sentence up to 23 April. The records show that no problems were identified or disclosed. He was last seen by healthcare staff asleep on his bed on 23 April. The same day, he sent four letters to his friends, all of which were monitored, but none were withheld. None of the letters suggested any fears relating to his cellmate.

Events on the day of the man's death

40. At approximately 12.02am an Operational Support Grade (OSG), who was carrying out night patrol duties, answered a cell bell call from the cell occupied by the man and his cellmate. When she opened the observational panel in the cell door, the cellmate asked for help saying his cellmate had hanged himself. She saw the man lying on the floor with a ligature around his neck, and asked the cellmate to feel for a pulse, but he refused to touch him. The OSG immediately called for assistance using her prison radio. Local operational instructions prevented her from entering a cell alone holding more than one prisoner.
41. Within three minutes a Senior Officer (SO), the night orderly officer, arrived with the assistant night orderly officer and an officer. The officer unlocked the cell door and the night orderly officer saw the man on the floor with a torn bedsheet ligature around his neck. The cellmate was immediately taken out of the cell. The officer removed the ligature and the man was moved to the landing floor. Neither the assistant night orderly officer nor the officer could find a pulse, so the officer immediately started cardio pulmonary resuscitation (CPR) chest compressions while the assistant night orderly officer undertook mouth to mouth resuscitation. The night orderly officer checked for a carotid (neck) pulse but could find none. The man was blue in colour.
42. Two nurses arrived within minutes, accompanied by the OSG. One nurse set up the defibrillator (a machine that applies electrical impulses to the heart and

advises whether there is any rhythm which might be stimulated) and applied oxygen.

43. Staff continued CPR, taking turns, until the paramedics arrived at around 12.25am. The paramedics took over the life support management, maintaining CPR, and requested police attendance. The man was taken to hospital at 12.50am, arriving at 1.00am. At 1.05am a hospital doctor pronounced that the man had died.
44. The duty governor had been advised of events at 12.30am. The police were called to the prison at 12.30am, arriving after the man had been taken to hospital. The night orderly officer used the Lewes' orderly officer incident pack checklist to ensure a record was kept of the steps to be taken in the event of a death in custody. The area office and national operations unit were informed by 1.40am.
45. The police maintained a guard on the cell, which was later sealed. Police interviewed the cellmate in the early hours of the morning, and the prison co-operated fully with the police investigation.
46. The duty governor arrived at the prison at about 1.00am. He ensured that all the necessary documents were completed and carried out a "hot debrief" before staff went off duty. A member of the care team attended and offered support to staff. (Hot debriefs are primarily carried out to ensure staff have the opportunity to discuss emotive issues and any lessons learned following serious incidents. Minutes are not always taken at these meetings.) A critical incident debrief was arranged for the following month.
47. Notices both for staff and prisoners were prepared and displayed later that day. They advised of the man's death, and reported that the early indications were that he had taken his own life.
48. The Chaplain informed the man's parents that their son had died sometime between 11.00am and 12.30pm. The Chaplain was also the prison family liaison officer appointed to deal with any family issues. The Governor wrote a letter of condolence to the family the same day. The police subsequently appointed their own family liaison officer who maintained contact with the family.
49. A post mortem was carried out at the hospital. It found that the man had died as a result of asphyxia caused by constriction of the neck.

Murder investigation

50. During the last week in April, the police interviewed a number of prisoners at Lewes as well as the cellmate's ex-girlfriend and her friend. Statements provided to the police indicated that he had said that he intended to kill the man and make it look like suicide, that he had a fascination with killing someone, and he had been playing games of pain with him. One prisoner said that he thought he had heard the cellmate laugh between 11.40 and 11.50pm on 23 April. (There is no evidence that any of this information had been communicated to prison staff before the man's death.)
51. The cellmate was arrested by the police on 27 April. During questioning, he initially described how he had found the man hanging. He denied elements of the

statements other witnesses had made. During the night, however, when he was being monitored under suicide prevention procedures, he was heard saying that he may or may not have killed the man. He returned to Lewes on 28 April. That evening he told prison staff that the man had not committed suicide but that he had killed him. He admitted to having strangled him and then attempted to make it look like suicide. He signed a record of these admissions, written by a senior officer, which he later retracted. On 3 May, he was re-arrested on the basis of this further evidence. Following an interview in which he offered no comment, he was charged with the man's murder.

52. On 20 May 2008, at Crown Court, the cellmate was found guilty of the man's murder. He was sentenced to life imprisonment.

ISSUES

53. The man was murdered by his cellmate. Although it became evident during the murder investigation and subsequent trial that the cellmate had expressed to others ideas about killing the man, there is no evidence that prison staff were informed. The evidence suggests that the cellmate only expressed these ideas in the few days and the afternoon immediately before the murder, and they had not been considered a serious intent by the individuals he told.
54. Prior to the murder, prison staff thought that the man and his cellmate got on well together. The officer told the Ombudsman's investigator that the cellmate had not told her he had any problems with the man or was contemplating killing him. Neither had the man given any indication that he was worried about his cellmate. She could not recall anything unusual about either of them the day before the murder and said that she would never have thought the murder was going to happen. I am satisfied that there is evidence that the man had considered him to be a supportive cellmate.

Cell Sharing Risk Assessments

55. The officer said that approval for the man and his cellmate to share a cell would not have been given had anything in their cell sharing risk assessments given cause for concern. The man's CSRA continued to assess him as low risk whilst his cellmate's assessment was medium risk. However, CSRAs tend to be very individualised assessment documents. They primarily assess whether an individual prisoner poses a risk to a cellmate, based on their individual characteristics. They do not ordinarily consider the ongoing relationship between prisoners sharing a cell. In this case, the man's last CSRA review undertaken on 20 January, before he began sharing a cell with his cellmate, contained a note questioning whether prison intelligence had any information regarding risk. At that point there would have been nothing of any particular relevance. The cellmate's CSRA identified him as a medium risk and he was considered to be more of a risk to himself. However, by late February, prison intelligence was questioning the man's interest in his cellmate's ex-girlfriend.
56. There is no evidence recorded that these questions led to any review of either their cell sharing risk assessments. I consider that this kind of intelligence information should have led to a formal review of both their CSRAs, taking account of any potential relationship dynamics between the prisoners sharing the same cell. However, I accept it is doubtful, given the positive evidence presented to prison staff of their friendly relationship, that a review might have led to a change in assessment of cell sharing. Nevertheless, undertaking such a review might have led to staff being more alert and aware of any small indications of changes in the relationship between the two. I therefore make the following recommendation to the Governor of Lewes.

The Governor should ensure that any security and intelligence information relating to a prisoner's interests in the personal affairs of his cellmate should lead to a formal Cell Sharing Risk Assessment review.

Care and Support Unit reviews

57. I am satisfied that the procedures and processes for segregation in the Care and Support Unit at Lewes fulfil the requirements of PSO 1700. The CAS unit provides a different form of support for prisoners and is not a normal segregation. It has a much higher staff ratio than on normal location, allowing for work with prisoners toward normal integration on the wings. The reviews of the man's progress demonstrate precisely the positive achievements that he was making.
58. However, as with my comments above in respect of CSRAs, the reviews tend to be very individualised assessment documents which fulfil the function of continued authorisation for segregation. They tend not to contain much assessment about the relationships between either prisoners sharing a cell, or on the unit generally, other than generalised summaries such as "mixes well with others". I believe that a more staff intensive unit providing support should record more detailed assessment of prisoner relationships. This would form part of the planning system to allow prisoners on the CAS under good order or discipline to return to normal location. As I am aware that the CAS unit closed some time ago I do not make a formal recommendation on this matter.

Critical incident debrief and employee support

59. My investigator found that prison and healthcare staff responded quickly and professionally to the alarm raised for the man. It is clear that they did all they could to assist him until the paramedics took over. Processes to secure the area and inform all the relevant personnel were followed through, including effective liaison with the police.
60. A hot debrief took place following the incident and a member of the care attended to provide support to staff. It appears that all appropriate follow up actions were carried out after the man's death.

Family Liaison

61. Although I have been unable to establish the details, I am satisfied the man's family were informed of his death as soon as possible. The Governor referred to follow up support being available through the Chaplain, who was also the prison's FLO, in the letter of condolence sent to the man's parents on the day of his death. However, the murder investigation clearly took precedence and the police appointed their own family liaison officer.
62. I note that a new Prison Service and Police Service protocol "Prison, Probation and Immigration Related Deaths in Custody – A Protocol for Police Investigations" is due to be published which will set out how the respective services will work together when an investigation is being conducted into the possible murder of a prisoner. This should help to clarify all the appropriate responsibilities and roles for each service. In particular, it should ensure a clarification of the relative roles of police family liaison and the Prison Service's family liaison responsibilities.

CONCLUSION

63. It appears that both the man and his cellmate were content to share a cell together on the Care and Support Unit. I can find no evidence to suggest that he feared for his safety whilst sharing the cell with his cellmate. Staff on the unit did not identify any concerns relating to either man that may have led to them reconsidering their CSRA. Had the prisoners who were interviewed by the police or the cellmate's girlfriend believed that he actually intended to kill the man, it is likely that they would have informed staff. Tragically, it seems that the threats to kill him were not taken seriously. If they had taken action on this information I believe his death could have been prevented.

RECOMMENDATIONS

The Governor should ensure that any security and intelligence information relating to a prisoner's interests in the personal affairs of his cellmate should lead to a formal Cell Sharing Risk Assessment review.

In response to the recommendations, the National Offender Management Service (NOMS) drew attention to inaccuracies in paragraphs 22, 36 and 58, relating to the requirement to review CSRAs. These errors have been amended.

NOMS also asked if we would reconsider the recommendation in the light of the inaccuracies. Given that the recommendation calls for a review in the light of new information rather than a requirement for routine review, this recommendation will stand.

As requested, the protocol referred to in paragraph 65 has been clarified by insertion of the full title - Prison, Probation and Immigration Related Deaths in Custody – A Protocol for Police Investigations. The protocol has been drawn up between the National Offender Management Service (NOMS), UK Border Agency, Youth Justice Board and the Association of Chief Police Officers (ACPO).