

**Investigation into the death of a man
in July 2012 at HMP Lewes**

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

June 2013

This is the report of an investigation into the death of a man, a prisoner at HMP Lewes. He was found hanging in his cell in July 2012, less than two days after he arrived at the prison. He was 69 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. NHS East Sussex Downs and Weald commissioned a clinical reviewer to carry out a review of the man's medical care in custody. Lewes prison cooperated fully with the investigation.

It is clear that a number of staff made efforts to engage with the man, alleviate his fears and assess his needs during his short time at Lewes. However, it is of concern that his risk of suicide and self-harm was not identified when he arrived at the prison. Assessing the risk a prisoner poses to himself involves balancing the prisoner's demeanour and behaviour against known risk factors and staff appear to have relied too much on their assessment of the man's personal presentation, rather than on the known indicators of risk. Greater weight should have been given to his static risk factors including his previous suicide attempt, depression, recent bereavement, the circumstances of his offence and the fact that this was his first experience of prison. The investigation also identified some deficiencies in the emergency response.

We cannot know whether there would have been a different outcome if suicide and self-harm monitoring had been implemented, particularly as it is unlikely that the man would have been regarded as the highest level of risk, but it would have offered some opportunity for the prison to put further supportive measures in place.

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.

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Prisons and Probation Ombudsman

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SUMMARY

1. On 29 June 2012, the man was convicted of a number of historical sexual offences. He had previously been on bail and was remanded to HMP Lewes for sentencing. He was 69 and this was his first time in prison. Shortly after his arrival, a nurse assessed the man. He noted that the man was nervous but did not consider that he presented a risk of self-harm or suicide, although he scored highly on an anxiety and depression assessment. The nurse was also unaware of his previous attempt at suicide. The nurse passed the results to the doctor, who prescribed him painkillers and noted he should be reviewed by a doctor early the next week. The man did not receive this medication.
2. After the man's health screen with the nurse, he was interviewed by an officer with whom he discussed a previous suicide attempt and his shock at coming to prison. The officer also concluded that he was not a risk of self-harm or suicide. No one the investigator spoke to said they had any concerns about the man's risk. We are concerned that there was little consideration that he had a number of identified static risk factors which made him a high risk of suicide, which were not considered in the round. There was too much reliance on his personal presentation.
3. The man's cell sharing risk assessment was not adequately completed before he was allocated a cell. He was described as quiet and spent most of his time in his cell reading and watching television.
4. The man was discovered hanging with a plastic bag over his head during the morning roll check at 5.45am on a day in July, less than 48 hours after his arrival at Lewes. Although an emergency code system was not used to raise the alarm, officers responded quickly. After they had cut him down, the officers involved did not cut the shoelace from his neck or remove the plastic bag. They did not check for signs of life but believed he was dead and did not begin resuscitation. It took healthcare staff 13 minutes to reach the man's cell and begin resuscitation attempts. As rigor mortis appeared to have set in, this was unlikely to have affected the man's chances of survival, but this was an unacceptable delay, which could be crucial in other incidents.

THE INVESTIGATION PROCESS

5. This office was notified of the man's death on 1 July 2012. Notices were issued, inviting staff and prisoners to contact the investigator with any relevant information. No one came forward. The investigator visited Lewes on 11 July and met the Governor, a senior officer (SO) Safer Custody Manager, an officer, a senior officer and the Branch Secretary of the Prison Officer's Association (POA). She also collected relevant documents relating to the man.
6. During the visit, the investigator interviewed the family liaison officer (FLO) who had been in contact with the man's family and the Chair of the Independent Monitoring Board (IMB). The man had not made any applications to the IMB.
7. The investigator returned to the prison on 9 August, where she interviewed six members of staff and one prisoner.
8. NHS East Sussex Downs and Weald commissioned a doctor to carry out a clinical review of the healthcare the man received. She completed her review on 7 September.
9. Her Majesty's Coroner for East Sussex was notified of the investigation and will receive a copy of this report to assist with his enquiries. HM Coroner provided witness statements and the man's post-mortem report which recorded his cause of death as hanging.
10. The coroner's officer took statements from two of the man's sons on behalf of Sussex police. They asked why their father had been allowed to keep his shoelaces and was given a plastic bag in prison. They also questioned why their father had not been able to get numbers from his mobile telephone.
11. One of our family liaison officers (FLO) spoke to the man's wife to explain the investigation process. His wife identified no specific issues that she wished the investigation to cover. The man's family received a copy of the draft report and reiterated a number of the concerns identified. In particular, they were concerned that despite relatively high scores on his HADS assessment, prompt action was not taken. They therefore welcomed the recommendation relating to this issue.

HMP LEWES

12. HMP Lewes is a local prison in East Sussex which serves the courts of East and West Sussex, and holds up to 723 remand and sentenced adults and young offenders on remand. Healthcare at the prison is provided by NHS East Sussex Downs and Weald. There is an inpatient unit with space for 19 prisoners.

HM Inspectorate of Prisons

13. HM Inspectorate of Prisons' last published inspection report of Lewes is of an inspection in May 2010. The report of a more recent inspection in 2012 has yet to be published. In 2010, the Chief Inspector concluded:

“Early days in custody were generally well managed and the response to bullying and violence was robust ... Suicide prevention arrangements were under review and we saw examples of caring and thoughtful work with prisoners at risk ... Relationships between staff and prisoners remained very good, although the personal officer scheme required further development. Diversity was generally well managed, but work with foreign nationals and older prisoners was underdeveloped. Faith and health care services were both generally good.”

14. At the 2010 inspection the Inspectorate were concerned that vulnerable prisoners waited on the first night wing for allocation to M wing, sometimes as long as two weeks.

Independent Monitoring Board (IMB)

15. The IMB is made up of independent, unpaid members of the local community who help ensure standards of care and decency are maintained. In their last report for the period ending January 2012, the IMB noted:

“With the emphasis now that all staff have to be trained in the use of ACCTs [suicide and self-harm prevention measures] and in the operation of the review system concerning prisoners identified as being at risk of self-harm/suicide, a greater awareness of the importance of a ‘safer custody’ in the prison is being created.”

Previous deaths at Lewes

16. This man was the thirteenth prisoner to die at Lewes since the Ombudsman began investigating all deaths in prison in 2004. Of the previous deaths, six were due to natural causes, one was the result of a drug overdose, another was a murder and the remaining four were self-inflicted. None of these previous deaths raised issues similar to this investigation. The man's death was one of three apparently self-inflicted deaths at Lewes in July 2012. We do not yet know whether there is any link between this man's death and those which followed shortly afterwards.

KEY EVENTS

Friday, 29 June

17. On 29 June 2012, at a Crown court, the man was convicted of sexual offences against three children, one of whom was his daughter. The offences were committed between 1973 and 1993.
18. The man, who had previously been on bail, was remanded into custody for sentencing and went to HMP Lewes. A Person Escort Record (PER) accompanies each person when they move between a police station, court and prison with information about the individual's risks and needs. The man's PER did not indicate that he presented any risk of suicide or self-harm.
19. A senior officer (SO) told the investigator that, due to the nature of his offence, the man was held in a separate room from other prisoners for his own protection. He was then taken to the first night centre (K wing), for a reception health screen at about 5.30pm. A nurse completed the man's health screen and noted that he had been prescribed co-codamol and diclofenac (painkillers) along with medication for his "nerves" by his GP. He recorded that the man's general practitioner (GP) should be contacted for a summary of his medication. His blood pressure was 176/99, which the clinical reviewer indicates was high. He also had arthritis and the nurse recorded that he would refer him to the doctor about his physical health.
20. The man said he had no thoughts of self-harm or suicide and the nurse wrote that he "conversed well, good eye contact and posture. Does appear slightly nervous but understandable due to charge and situation he is now in." He told the nurse that a psychiatrist had treated him for depression over 30 years before. He had also suffered a bereavement the previous December.
21. The nurse told the investigator that he was unsure if he knew the offence for which the man had been convicted. If so, he would not have known the details and he did not consider it was his "position" to do so. He said he had no concerns that the man presented a risk of self-harm or suicide and that he would have begun suicide and self-harm monitoring procedures if he had.
22. The nurse completed the Hospital Anxiety and Depression Scale (HADS) with the man. He told the investigator that this was due to the man's previous history of depression and his presentation at that time. The HADS is composed of twelve questions (with scores from 0 - 3) which aim to gain a basic assessment of whether someone is anxious or depressed. The man scored 15 for anxiety and 16 for depression. The nurse said these scores were reasonably high and he referred the man to the doctor for further assessment. This was a routine referral rather than an urgent one, which meant it was the doctor's decision when he would assess him. The clinical reviewer further clarified that a score above 8 out of 21 on the HADS might indicate psychological distress, possibly leading to a diagnosis of depression and/or anxiety.

23. Around 6.30pm, an officer completed the man's first night interview. The Officer described this as a brief assessment to find out how a prisoner is feeling, whether they have any concerns and to assess if they present a risk to themselves or others. He said the man seemed very quiet and a bit nervous. He thought this was understandable as it was the man's first time in prison at the age of 69. The officer was aware of brief details of the man's offence but they did not discuss it in depth. He said he was shocked to come to prison, had not expected it and was nervous and scared.

24. The man told the officer he had tried to commit suicide in the 1990s by taking an overdose. They did not discuss this any further. He said he had no current thoughts of suicide or self-harm or issues with drugs or alcohol. The officer noted in the man's core record:

“[The man] was very quiet and nervous as it was his first time in prison as well as the nature of offence which he was anxious about ... No other immediate concerns at this time.”

25. The man did not wish to make a telephone call as he said he had made all the calls he needed to at court. He also declined the opportunity to speak to a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) He signed a communications compact to indicate he understood how the telephone and mail systems worked at Lewes.

26. The officer told the investigator that he feels confident in assessing the risks of suicide and self-harm. He said that although the man seemed nervous and scared, he did not assess him to be a risk of self-harm or suicide as he had answered all the questions immediately and seemed determined he was not going to harm himself. The officer said he had good eye contact and positive body language.

27. The officer completed the first page of the Cell Sharing Risk Assessment (CSRA – which assesses a prisoner's risk of violence to others in a locked cell.) He concluded that the man was a standard risk and therefore suitable to share a cell. He did not have confirmation of whether the man had any previous convictions and therefore he could not fully complete the CSRA until he received this the following Monday. The rest of the CSRA should have been completed by healthcare staff and authorised by an officer or manager, depending on the risk assessment but this was not done.

28. The man was given a single cell on K wing on a vulnerable prisoner (VP) landing. (VPs are those who may be at risk from other prisoners for reasons such as owing money to other prisoners, or the nature of their offence). The officer told the investigator that he would have put the man in a cell with another prisoner. However, due to the nature of his offence, he needed to be placed in a cell with a prisoner who had committed a similar offence for his own safety, and no suitable cells were available at the time.

29. A fellow prisoner on K wing, who was an orderly and Listener, saw the man arrive on the wing. As a Listener, he tries to speak to all the new arrivals to check how they are feeling. He asked the man if he had any problems and the man said he was fine. One of his jobs as an orderly is to serve dinner. He said that, when the man collected his meal that evening, he did not appear upset.
30. At around 7.00pm, a doctor began work at the prison. The nurse who had earlier completed the man's health screen gave the doctor his HADS score and the reception health screen. The doctor told the investigator that the HADS score is used to monitor prisoners who suffer anxiety and depression, particularly if a medical professional is considering prescribing medication. The score can be used to monitor the success of the medication over time. The doctor did not see the man but reviewed the documents. He was satisfied that there were no concerns about him other than his reasonably high HADS score, which indicated he was suffering from "significant depression". The doctor said this score provided a basis on which to assess the man further.
31. Around 7.30pm, the doctor prescribed paracetamol and naproxen (recommended as an alternative to diclofenac). He told the investigator that the man was to be reviewed on "sick parade" after they had got more information from his GP about the medication he had been prescribed in the community. The doctor explained that this meant the man would have been assessed by a doctor early the following week, hopefully once the information from the community GP had been received. He told the investigator that if he or the nurse had been sufficiently concerned about the man's mental health, they would have arranged for a mental health professional to assess him that evening.

The day preceding the man's death

32. Most prisoners only stay on K wing for their first night in prison. However, there was no suitable cell available for the man on M wing where vulnerable prisoners are allocated. An officer explained the man would have stayed on K wing for the weekend and moved once a cell became available. While he lived on K wing, he did not have any access to time in the open air.
33. On the day preceding the man's death, prisoners on K wing were unlocked around 9.15am for association (when prisoners can socialise with each other and make telephone calls.) An officer was working on the wing all day. She said that the man was very quiet and did not come out of his cell much during association periods. During the morning he went to the wing office to ask for his medication. He spoke to a nurse.
34. When the investigator spoke to the nurse in October 2012, the nurse could not recall the man or having any conversation with him. She explained that paracetamol are always available for nurses to give to prisoners and that if these had been given it would have been recorded on his medical record or prescription chart. There is no such record.

35. As there is no pharmacy open at the prison over the weekend, access to some medications, such as naproxen, is restricted and prisoners may not receive their medication until Monday. However, the nurse said that if the man had said he was in pain or the medication was urgently needed, arrangements would have been made to ensure he had received either naproxen or a substitute. As there is no record that he received any medication on his prescription chart, the nurse could only assume that he had not told her he was in pain.
36. At around 11.40am, when an officer was locking prisoners in their cells for lunch, the man asked if he could get some telephone numbers from the mobile telephone handed in with his property on reception. The officer assumed that he wished to have the numbers authorised on the prisoners' telephone system. She told the investigator that this can take anything up to two weeks although some numbers, such as that of the man's wife, would be much quicker to authorise.
37. The officer told the man that they could not access his mobile at that time as it was lunch time and reception staff would be preparing for the arrival of prisoners that afternoon. She said she would help him get the numbers on Monday. The officer said he seemed fine with this. She locked him in his cell until association time at around 2.00pm when prisoners were free to associate with others until 4.45pm.
38. Around 4.00pm, a fellow prisoner who was also a Listener on K wing was serving the meals and noticed that the man had not collected any food. He went to his cell and persuaded the man he should have something to eat as he would not get anything else till the next morning. The man collected some dinner and returned to his cell. Around 4.15pm-4.30pm, the fellow prisoner said the man was lying on his bed reading a book. He again asked the man if he was okay and he said he was. He did not see any signs that he was at risk of harming himself and said he would have spoken to another Listener colleague if he had been concerned. At no point did the fellow prisoner speak to the man in his capacity as a Listener.
39. An officer who works on K wing told the investigator that the man had seemed fine when he collected his dinner and that she had no concerns about him. She said that he had kept to himself during his time on the wing and mainly stayed in his cell reading.
40. Around 4.45pm, two officers locked all K wing prisoners into their cells. Neither could remember who had locked the man into his cell. One of the officers checked the man's cell at 7.00pm for the evening roll check (this is to ensure all prisoners are in their cells and the door is secured). He was watching his television.
41. An officer began work at 8.00pm that evening. His first job was to complete the final roll check of the day. When he did so, he too observed the man sitting on the edge of his bed, watching television.

Day of the man's death

42. On the day of the man's death, an officer was completing the morning roll check at 5.45am. When he looked through the observation panel of the man's cell, he saw that the man was in a kneeling position at the end of the bed. The officer then realised he had a plastic bag over his head and was hanging from the top bunk. The officer immediately radioed for assistance saying there had been a "hanging on K wing".
43. The officer did not hear a response to his first request for assistance so he put out another request shortly after the first. He then realised that he had one more cell to check next to the man's (a prisoner was subject to suicide and self-harm monitoring measures), so he did this. He estimated that within seconds of the original request for assistance, the senior officer and his deputy arrived on the wing. Another officer stood outside the cell and completed a log of events.
44. The senior officer who was responsible for responding to all incidents in the prison overnight and his deputy were in the central area of the prison when they heard the emergency call. They immediately went to the man's cell and, on the way, the senior officer sent a further officer to collect healthcare staff. The senior officer acknowledged that there had actually been two emergency calls over the radio in quick succession. As he had been so preoccupied with getting to the man's cell immediately, he had not responded to the first one. He was not far from K wing and estimated he arrived within minutes and just after his colleague's second request for assistance.
45. The senior officer unlocked the man's cell and went inside with the officer who originally discovered the man. The senior officer said his initial instinct was that the man had died. He had used a shoelace to hang himself and the plastic bag was one commonly available in the prison, used for goods bought by prisoners. Only those who were regarded as very high risk of self-harm or suicide would have such items removed. The senior officer said that the man was suspended only a little way from the floor and when he cut the shoelace with his cut-down tool, he remained in the same kneeling position. He told the investigator that the man was completely stiff and he believed rigor mortis had set in. He requested an ambulance. Control room staff logged that an ambulance was on its way to the prison at 5.47am.
46. The senior officer said that because he believed the man was dead he reacted differently to the situation. He said there was a "pause between events" after he had cut him down and before healthcare staff arrived. He estimated they arrived around a minute after him. The officer who originally discovered the man estimated five minutes elapsed from the time he raised the alarm to healthcare staff arriving.
47. Two nurses were both in the healthcare centre when they heard the emergency call over the radio. They had responsibility for responding to any emergencies during the night. As they were locked into the healthcare centre at night, they picked up the emergency bag and waited by the gate to be collected.

According to the nurses' statements, the original request for help by the officer who discovered the man occurred at 5.50am and at 5.54am they were collected by a further officer and taken to the man's cell.

48. According to the log of events and their own statements, the nurses got to the man's cell at 5.58am. They cut the shoelace from his neck and removed the plastic bag from his head. They lay him on his back and checked for vital signs. One of the nurses said the man was stiff and cold to the touch and he believed he was dead. The nurse told the investigator that he knew he and the other nurse could make the decision not to attempt to resuscitate him if they felt there was no chance of his survival. However, he did not feel confident in making this decision as he had not been in that position before.
49. One of the nurses began chest compressions while the other tried to start administering breaths. She was unable to open the man's mouth due to the stiffness in his jaw. The nurse also attempted to insert a catheter via his nostrils which was unsuccessful. They continued with cardiopulmonary resuscitation (CPR) at a rate of 30 compressions to 2 breaths using an Ambu bag (a mask used to assist resuscitation). The nurses then attached defibrillator pads to the man's chest but there was no shockable rhythm detected and they continued CPR until the paramedics arrived around 6.07am. The paramedics assessed the man and attached their own defibrillator. They pronounced him dead at 6.10am.
50. The post-mortem report recorded the cause of death as hanging.
51. A note was found in the man's cell after his death, on which he had written, "To [the man's wife], I love all of you. Be happy. Gone with [the man's son]. I did not do it." (The man's son had died the previous year).
52. A fellow prisoner and Listener had heard the emergency response. At around 8.30am, two officers went to his cell to explain what had happened and that as a result prisoners would be unlocked later than usual, at around 10.00am. He told the investigator that the officers checked on his welfare and he was also supported by the Samaritans and debrief for Listeners.
53. A senior officer was appointed as the family liaison officer (FLO) with an officer as a back-up. She was at home when she was informed of the man's death and went immediately to the prison, arriving at 9.00am. The man's family lived in Scotland, but she was aware that he had been on trial locally. She found an address nearby in his wallet and hoped that his wife might still be staying there. She informed the police that she was going to the address and waited for the staff member accompanying her to be relieved. They left the prison at 11.30am.
54. At 1.00pm, the family liaison officer arrived at the address which was the home of the man's mother-in-law, but his wife had already returned to Scotland. She told her that her son-in-law had died and she gave her his wife's and stepdaughter's contact details in Scotland. The family liaison officer arranged with Strathclyde Police for them to tell the man's wife and stepdaughter of his

death. At 1.30pm, the police confirmed they had told her and the family liaison officer said she would telephone her as soon as she was back at the prison.

55. The family liaison officer telephoned the man's wife at 3.10pm. Over the following days, the FLOs remained in contact with his wife and sons and returned his property to them.
56. On 6 July, the Governor wrote to the man's wife and family to express his condolences and offered her the opportunity to visit the prison to speak to staff and prisoners. He also offered assistance in paying her husband's funeral expenses and included information about bereavement support. The prison subsequently paid the full cost of the repatriation of the man's body to Scotland and the funeral, which was held on 19 July.
57. All staff interviewed said that they had felt adequately supported following the man's death, with the exception of one nurse, who said he had found out about the man's death from a friend who worked at the prison. He had not been offered any direct support but said he knew how to access it if he felt he needed to. A hot debrief (a meeting to check on staff welfare following serious events and emergencies, such as deaths in custody) was held for staff on the morning of the man's death. A critical incident debrief (for staff to reflect on the emergency, and check on the continuing welfare of the staff involved) was held two weeks later.

ISSUES

Assessing the man's risk of suicide

58. The man told the reception nurse and officer that he had no thoughts of suicide or self-harm and they both judged from his body language and interaction that he answered honestly. However, he also told staff he was nervous, shocked and scared about being in prison for the first time and he had not expected it. He scored highly on a screening tool to assess anxiety and depression.
59. PSI 64/2011, Management of prisoners at risk of harm to self, to others and from others, lists a number of factors which increase a prisoner's risk of suicide. Those relevant to the man include that he had only just been remanded into custody, had previously attempted suicide, had a previous mental illness diagnosis and suffered from physical pain. The offence type is also relevant, particularly for those convicted of violence against a family member. He had been convicted of sexual offences against his daughter. The PSI also identifies triggers which might increase a prisoner's risk of suicide or self-harm. Also of relevance was that he had just been convicted, he had suffered the bereavement of his son the previous December and this was his first time in prison.
60. The nurse who completed the man's health screen upon arrival at the prison, told the investigator he was unsure if he knew the offence of which the man had been convicted, and certainly knew no details as he considered it was not his "position" to do so. Given the potential relevance of a prisoner's offence on their risk of suicide and self-harm, nursing staff should ensure they are aware of this information. The clinical reviewer also comments:
- "With the benefit of hindsight it is possible to detect a number of static risk factors for suicide including male gender, over 60 years of age, a bereavement the previous Christmas, complaint of chronic pain, previous suicidal acts or gestures, albeit that they were many years before. There was also a history of treatment for a mental health disorder, depression in the past and a statement that [the man] made that he was currently in receipt of medication 'for his nerves' although it has not been clarified exactly what that was."
61. She concludes:
- "...this would appear to have been a relatively unpredictable event based on [the man's] presentation at reception and on healthcare screening. It may be helpful to ensure there is training in relation to static or stable risk factors of suicide as well as reliance placed on dynamic features of suicide risks. There is no ideal risk assessment tool and it does rely upon the clinician making the risk assessment to form a judgement about risk."
62. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national

assessment tools, to determine risk. It is not an exact science. However, we are concerned that staff relied so heavily on the man's personal presentation, when he had a number of known risk factors when he arrived at Lewes. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors in comparison to how he appeared to staff.

The Governor should ensure that all the known risk factors of a newly-arrived prisoners are fully considered and documented when determining their risk of self-harm or suicide.

Use of the Hospital Anxiety and Depression Scale

63. Due to the man's presentation and answers given during the reception healthscreen, the nurse completed the HADS with the man. This indicated that he was scoring high for anxiety and depression. The clinical reviewer concludes that the use of the HAD scale by the nurse was useful and appropriate.
64. The prison doctor considered the man's HADS score and decided that he did not need to see a mental health professional urgently but could be reviewed in a few days once his community GP records had been obtained. The clinical reviewer states that Lewes has no protocol indicating when the HADS should be completed or actions to be taken following a high score. We agree with the clinical reviewer's conclusion that in the absence of a protocol regarding how to process a high score on the HADS, the doctor and nurse cannot be criticised. She recommends the introduction of such a protocol.

"This is of course a screening tool ... rather than a risk assessment tool and its use needs to be supported by a protocol as to what the follow on actions should be when elevated scores emerge."

65. The clinical reviewer states that, ideally, the man might have seen a mental health professional who could have combined these static risk factors with an assessment for symptoms of mental disorder, along with a risk assessment in relation to suicide and self-harm.

The Head of Healthcare should introduce a protocol for the application of the Hospital Anxiety and Depression Scale and train staff in its use.

Medication

66. The prison doctor prescribed the man paracetamol and naproxen on the night of his arrival at Lewes. The next day, an officer said the man came to the wing office and asked a nurse for his medication. The nurse cannot recall this conversation but said that if he had been in any pain, she could have arranged

for dispensing of his medication immediately. Since this is not documented in the medical record or prescription chart, she could only assume that he had not told her he was in any pain.

67. The investigator also spoke to the head of nursing and quality. He said that unless the man had complained of pain, paracetamol and naproxen were medications which could reasonably have been delayed until after the weekend, once the pharmacy had opened. Although we do not believe it had any impact on the man's death, the medication should have been dispensed in line with the doctor's indication. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners are promptly given medication prescribed by the doctor.

Cell sharing risk assessment

68. An officer completed the first page of the CSRA at the reception interview. The second page is then supposed to be filled in by healthcare staff and the risk assessment authorised by an officer or manager. The nurse who carried out the man's health screen on arrival at the prison could not account for why he had not completed the second page of the CSRA. He told the investigator he would normally complete them all at the end of his shift. As a result the authorisation of the assessment had also not been filled in.

69. Prison Service Instruction (PSI) 09/2011, Cell sharing risk assessment, states:

“Risk assessments must be completed as part of the reception process when prisoners are first received into custody. They must be based on evidence of risk and completed before allocation to a shared cell. In prisons with a first night centre with single cells, the form may be completed there. If the PNC record is not available on the first day in custody this must be checked so that the risk assessment is finalised the next working day.”

70. Although the man was allocated a single cell, the officer said that he would have placed him in a shared cell if there had been an appropriate place available. The PSI clearly states that risk assessments must be completed when prisoners are first received into custody and before allocation to a shared cell. We therefore make the following recommendation:

The Governor should ensure that all sections of the cell sharing risk assessment are completed during the reception process when prisoners are first received into custody.

Emergency code system

71. When an officer discovered the man, he requested assistance by announcing over radio that there had been a “hanging”. Staff told the investigator that there was no emergency code system in place at Lewes. For example, a code blue would indicate that a prisoner had stopped breathing. It is good practice for a

prison to operate an emergency code system. This informs staff not only that there is an emergency but also of its nature and enables them to better prepare, including taking the correct emergency equipment.

The Governor should introduce an emergency code system.

Entering the man's cell

72. Both Lewes' safer community strategy and death in custody contingency plan instruct that, after someone is discovered hanging, staff should enter the cell as soon as possible and may do so alone. The officer did not enter the man's cell when he discovered him but checked the last prisoner left on his roll check and once the senior officer had arrived they entered the cell together.
73. The officer told the investigator that as soon as he had got over the initial shock of finding the man, the senior officer had arrived and immediately entered the cell. The officer said that if his colleague had not arrived so quickly, he would have gone into the cell and cut him down on his own. We note that the officer summoned assistance promptly and that in this case the delay in going into the cell would not have made a difference. However, in similar situations even a few seconds delay could alter the outcome if a person is unconscious.
74. The clinical reviewer highlights that those first discovering the man should have cut the shoelace from his neck and taken the plastic bag off his head. She concludes that it was unlikely to have improved his chances of survival since rigor mortis appeared to have set in, but is nevertheless best practice.
75. Lewes' death in custody contingency plan indicates that having cut a prisoner down, staff should immediately cut the ligature from their neck, place them on their back on the floor, check for signs of life and if the prisoner is not breathing, attempt resuscitation. We make no criticism of the senior officer's decision not to attempt resuscitation as it appears that rigor mortis had set in. It is notable that none of the officers seemed to check him for signs of life. Although it was unlikely to have improved the man's chances of survival, staff should have followed the instructions in the contingency plan and removed the plastic bag from his head. This is particularly pertinent in light of the apparent delay before healthcare staff arrived at the man's cell. We therefore recommend that:

The Governor should ensure that all staff are aware of and follow the safer custody strategy and death in custody contingency plan when dealing with an emergency situation.

Emergency response

76. The time of the initial call by the officer for assistance was recorded as 5.45am on the officer's log of events at the cell, officers' statements and the control room log. The nurses' statements indicate that this happened at 5.50am. The senior officer said he called an ambulance after he had got to the cell, which the control room recorded at 5.47am.

77. The nurses recall that they were collected from healthcare at 5.54am and arrived at the man's cell at 5.58am. The log of events, completed by an officer at the scene of an emergency, also shows that they got to the man's cell at this time. The log is intended to be an accurate description of events and the times that they occur. It indicates that it took 13 minutes from the discovery of the man for healthcare staff to arrive.
78. The investigator walked the route which the officer would have taken from the centre of the prison, to collect the nurses from healthcare and on to K wing. Even allowing for time for a number of doors to be unlocked and locked, it took under five minutes.
79. When the apparent delay was highlighted by the investigator, the senior officer was surprised and believed it must have been due to an error in the times people had recorded. He said the nurses arrived very soon after they had got to the man's cell and it would only have taken the officer around five minutes to get from the centre of the prison and bring the nurses to the man's cell.
80. One of the emergency response nurses said that he and his colleague collated their timings straight after the emergency response, that they were approximate and based on timings from the log of events. The nurse estimated it was around five or six minutes from the time he heard the emergency call to when they got to the man's cell. All staff interviews and statements describe a similar sequence of events in which medical staff were at his cell without delay. However, this is not in keeping with the timings recorded on the incident log, which indicate it took 13 minutes for nurses to get to the man's cell. One of the main purposes of the log of events is to provide an accurate account of timings and we have seen nothing to indicate that the timings in the logs were incorrect. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that healthcare staff respond to medical emergencies without delay.

First aid training

81. None of the discipline staff interviewed had received basic first aid training, including emergency life support. The clinical reviewer recommended that officers should be trained to undertake CPR. HMP Lewes safer community strategy 2011/2012 notes:

"HMP Lewes will ensure that discipline staff and others who have offender contact are trained in the use of the equipment held in the emergency response kits, and emergency first aid and resuscitation procedures."
82. The senior officer told the investigator that the prison had recently started a voluntary first aid training programme with a view to all staff eventually being trained. The SO estimated that by August 2013, 50 per cent of staff would be trained. We welcome this plan but it is important too that there are sufficient

first aid trained staff on duty at all times which a voluntary arrangement might not ensure and at least not for some time.

The Governor should ensure that there are sufficient first aid trained staff on duty in the prison at all times.

Informing the man's family

83. PSI 64/2011 states:

“Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source. Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison.”

84. Although the man's wife lived permanently in Scotland, the family liaison officer was initially hopeful that she would still be staying at an address which was relatively local to the prison. However, before she left the prison she tried to identify the prison nearest the man's wife's house so that their FLO could break the news if she had already returned to Scotland. The SO could not do this quickly, so she took the details of the local police station with her.

85. Since the man's wife had already gone back to Scotland, the police broke the news to her around 1.30pm. This was nearly eight hours after her husband had been discovered. However, we are satisfied that this delay could not have been avoided. It is also clear that, in this situation, it was not possible for the family liaison officer to quickly identify the nearest prison and it was appropriate that the local police broke the news to the man's wife.

CONCLUSION

86. The man was 69 years of age, imprisoned for the first time following his conviction for a number of sexual offences committed between 1973 and 1993. He was shocked and nervous at being in custody but said he had no thoughts of self-harm or suicide. Less than 48 hours later, he was discovered hanging in his cell.

87. Although we have made several recommendations for improvements at Lewes, it is clear that a number of staff and a prisoner made efforts to engage with the man, alleviate his fears and assess his needs. We conclude that his death could not have been predicated or prevented.

RECOMMENDATIONS

The Prison Service accepted all the recommendations and their comments are reflected under each one.

1. The Governor should ensure that all the known risk factors of newly-arrived prisoners are fully considered and documented when determining their risk of self-harm or suicide.

“A review of self harm and suicide information sharing pertaining to static and dynamic risk factors is to be commissioned.”

2. The Head of Healthcare should introduce a protocol for the application of the Hospital Anxiety and Depression Scale and train staff in its use.

“A protocol will be introduced.”

3. The Head of Healthcare should ensure that all prisoners are promptly given medication prescribed by the doctor.

“A review will be commissioned regarding the prescribing, issuing and stock control of medicines.”

4. The Governor should ensure that all sections of the cell sharing risk assessment are completed during the reception process when prisoners are first received into custody.

“Relevant departments been advised of the requirement to complete all sections of the CSRA. Managers responsible for this recommendation will carry out daily checks. This will be monitored as an agenda item at the Safer Custody meeting.”

5. The Governor should introduce an emergency code system.

“A review of current procedures will be commissioned and the codes will be published to all staff.”

6. The Governor should ensure that all staff are aware of and follow the safer custody strategy and death in custody contingency plan when dealing with an emergency situation.

“A Notice To Staff will be issued, signposting staff to the required information.”

7. The Governor and Head of Healthcare should ensure that healthcare staff respond to medical emergencies without delay.

“A review of current procedures will be commissioned.”

8. The Governor should ensure that there are sufficient first aid trained staff on duty in the prison at all times.

“ A training programme has been initiated to ensure that sufficient staff are trained in emergency first aid at work.”