
A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

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

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 of a man at HMP Lewes who was found hanging from his bed frame in July 2012. He was 34 years old. I offer my condolences to his family and friends.

A clinical reviewer carried out a review of the man's clinical care and treatment on behalf of the local Primary Care Trust. Lewes prison cooperated fully with the investigation.

The man spent nearly 12 months at Lewes during two separate periods in 2011 and 2012. The first period was as a remand prisoner after his arrest in connection with the death of his step-father. After being bailed for four months, he returned to Lewes in January 2012 when he was convicted of manslaughter. He was later sentenced to 11 years imprisonment.

In letters found in his cell after his death, the man said he had been subject to intolerable scrutiny from prisoners trying to find out information about him which he thought was being orchestrated by the prison or the local police. We found no evidence of this. While I do not believe this was directly connected with his death, I am concerned that he appears to have been threatened by another prisoner and this was never properly recorded and investigated.

This report makes a number of recommendations, including the need to respond appropriately to alleged threatening behaviour, better risk assessments for in-possession medication, the importance of first reception healthcare interviews, and improvements to emergency procedures. There is also a need to ensure that there is no unnecessary delay in informing families about a death in custody. While the man had a number of risk factors which would have suggested he was at risk of suicide or self-harm, he gave little indication to those who knew him that he intended to harm himself and I consider that it would have been difficult for the prison to have foreseen or prevented his death.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man first arrived at Lewes at the end of March 2011 charged with offences connected with the death of his step-father. This was his first time in prison custody. He was bailed in September 2011 and returned to Lewes in late January 2012 after he was convicted of manslaughter. In March, he was sentenced to 11 years imprisonment.
2. When he was first convicted, the man seemed to have settled into prison life. He was appointed as a wing equalities representative, he began training to become a Listener¹, started IT classes and attended weekly guitar lessons. He had received counselling in the prison when he was on remand. The counsellor maintained contact with him when he returned, but he had not needed much further support.
3. At the end of June 2012, the man asked to move to a different wing, because he said he had had an altercation with another prisoner. He did not wish to complain but there is some evidence that he was threatened by the other prisoner. From letters found in his cell, it appears that he was anxious that other prisoners were trying to collect information about his case and he thought that either the prison or the local police force was orchestrating this surveillance. He believed that the surveillance continued on his new wing.
4. As part of his sentence progression, the man would need to move to a new prison. He carried out some research and selected HMP Lowdham Grange as his preferred option. He spoke positively to his family, staff and other prisoners about this move.
5. On Tuesday 24 July, the counsellor saw the man at his request. The counsellor noted that wing staff were relieved when she arrived as they were anxious about him as he had not been out of his cell for several days, not even to collect food. The counsellor found that he was extremely agitated and they discussed coping strategies. After an hour, he calmed down and she told him that she would see him again on the following Monday, 30 July. The counsellor asked wing staff to make sure he started collecting food again, but she did not consider that formal suicide and self-harm monitoring procedures were needed to safeguard him.
6. A few days later the man was given written confirmation that he would be moving to Lowdham Grange the following Tuesday. He was found hanging in his cell just over two hours later. Prison staff cut the ligature and attempted to resuscitate him. Paramedics arrived but despite further efforts to resuscitate, him his death was pronounced at just after 9.00pm.
7. The investigation found that insufficient use was made of the P-NOMIS electronic recording system to note, in particular, a problem that the man reported about being threatened by another prisoner. There was also some

¹ Listeners are prisoners trained by the Samaritans to provide the same service as Samaritans offer in the community. Conversations between a Listener and a user of the Listener service are confidential, just as are conversations between the Samaritans and a member of the general public.

poor practice in the way his amitriptyline was dispensed. No evidence was found of any orchestrated surveillance of him (this was a matter that concerned him and his family).

THE INVESTIGATION PROCESS

8. The investigator visited HMP Lewes on 2 August 2012 and met the Governor, a representative from the Prison Officers' Association and a member of the Independent Monitoring Board. He visited the man's cell and was shown around the wing. He was given a copy of his prison and health records. Notices were issued to staff and prisoners informing them of the investigation and inviting them to contact the investigator if they had relevant information. No one came forward in response.
9. The investigator interviewed 22 members of staff and five prisoners and also spoke to the man's solicitor.
10. The investigator informed the local Coroner of the investigation and a copy of this report has been sent to the Coroner to assist his enquiries.
11. A clinical reviewer carried out a review of the man's clinical care and treatment on behalf of the local Primary Care Trust.
12. One of the Ombudsman's family liaison officers contacted the man's family to inform them of the investigation and to offer the opportunity to indicate areas they wished the investigation to cover. The family liaison officer and the investigator met the man's wife and her family and on another occasion, his mother and cousin. Issues raised by his family, are summarised below:
 - The family were concerned that the man had been on the vulnerable prisoners' wing (M wing) when he was in Lewes the first time, but had not gone back there when he returned after conviction. They asked whether a later wing transfer was due to him complaining about bullying.
 - They questioned why he had not been provided with specific support for prisoners at risk of self-harm or suicide, particularly as he suffered depression.
 - They asked whether he was subject to surveillance organised either by the prison or the police, including cell searches. His family said this caused him a great deal of distress and as a result he became anxious and isolated.
 - The family asked if he was bullied, and about the way the prison dealt with a problem that he had had with another prisoner on A wing.
 - His family asked how his amitriptyline medication was administered. They were very concerned tablets were found in his cell and that he had said other prisoners asked him about them.
 - His family asked why he had not received a reply to a letter he had written to the prison Governor. They were concerned about

confidential information in the letter and the potential repercussions. His family also questioned the whereabouts of other private papers.

- His family were aware of another death at Lewes in early July and asked if this could have been a trigger for his actions as he had discussed it with them.

HMP LEWES

13. HMP Lewes is a Victorian prison which holds up to 723 remand and convicted male prisoners. It consists of five main residential units. Healthcare was commissioned by the local Primary Care NHS Trust.

HM Inspectorate of Prisons

14. HM Chief Inspector of Prisons last inspection of Lewes before the man's death was in May 2010. The report of a more recent inspection in November 2012 has yet to be published. The Chief Inspector's 2010 report included:

"There was no longer a separate vulnerable prisoner wing. M wing was now integrated with approximately half of its 94 prison sex offenders, with no significant restrictions to regime ... and most prisoners said they felt safe ...

"The safer custody team maintained a comprehensive violence reduction database. In 2010 to date, over 200 ... report forms had been submitted and appropriately investigated as a result of violent or antisocial behaviour ... only 20 were for more serious events ... The safer custody team regularly checked observation books to ensure that all incidents were reported and recorded ...

"Safer custody was given a high priority throughout the establishment, and notice boards clearly identified inappropriate behaviour and a zero tolerance approach to bullying ..."

Independent Monitoring Board

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. There were three self-inflicted deaths at Lewes in the five years preceding the man's death, including one on 1 July, 2012. There was another self-inflicted death at Lewes three days after his death. The investigator reviewed the circumstances surrounding these other deaths. The only obvious significant similarity between the other deaths and that of his was that in the death on 1 July, the member of staff who discovered the death failed to use an emergency code when summoning assistance.

KEY EVENTS

29 March 2011 – September 2011

17. On 29 March 2011, the man was arrested in connection with the death of his step-father. He spent two days in police custody before appearing at Magistrates' Court. While there, a mental health nurse raised a suicide/self-harm warning form, noting he had a history of depression, that it was his first time in custody and he was charged with homicide². He was remanded into custody at HMP Lewes on 31 March. The staff at the prison were aware of the suicide and self-harm warning from the court but did not consider him to be at risk and so did not open an ACCT³ plan.
18. A nurse conducted a first reception healthcare assessment. The man denied having ever attempted to harm himself and said that he had no current thoughts of self-harm or suicide. He said he suffered from myalgic encephalomyelitis⁴ (ME). The nurse noted his impression that his mental health state was stable.
19. The man was moved to the inpatient unit in the healthcare centre to monitor his ME. He was seen that evening by a mental health nurse. He said he was prescribed amitriptyline (an anti-depressant commonly used in the treatment of ME). This was continued in Lewes. She noted that in addition to a diagnosed condition of ME, he suffered from irritable bowel syndrome (IBS).
20. On 8 April, the man moved from the healthcare centre to A wing, a standard wing which holds remand prisoners. He then moved to M wing on 12 April. M wing serves several functions including housing vulnerable prisoners (prisoners at risk from others, often because of the nature of their offence). An entry in his records referred to lack of sleep and rest having an adverse impact on his health. A transfer to M wing was seen as something that would help with this. The investigator was told that there were more single cells on M wing.
21. A counsellor attached to the chaplaincy department started seeing the man from the end of April, after he requested counselling. In a statement about their contact, she wrote that their first session, on 26 April, lasted almost two hours and the man presented as: "highly distressed and traumatised [and] could only tell me his story through sobs". She noted that although he said he found it difficult to relate the events leading to his arrest, it also seemed clear that he was relieved to have an outlet for his trauma. After this initial meeting, they met for one or two counselling sessions each month until he was released on bail in September. She told the investigator that at their meetings he spoke about his family, about his schooling and about how his life had been in general. She said that when she first met him he was not eating properly and was not looking after himself but as time went on he settled.

² People charged or convicted of murder or manslaughter are at a higher risk of suicide than the general prison population.

³ ACCT stands for Assessment, Care in Custody and Teamwork. It is the process through which support is given to prisoners deemed at risk of self-harm or suicide.

⁴ A condition of unknown cause and characterised by symptoms of chronic fatigue. Chronic Fatigue Syndrome (CFS) is often used to describe the same condition.

22. From May, the man was under the care of the mental health in-reach team. There was no evidence that he was suffering from any thought disorder or paranoia, but he had feelings of guilt and anxiety about his court case. He said he had no history of self-harm or suicide attempts. He said that he had had some thoughts of harming himself but had no intention of acting on those thoughts.
23. Throughout June, the man reported feeling low, anxious and having difficulty sleeping. He continued to receive support from nurses and the counsellor. At the end of June he was discussed at a multi-disciplinary team meeting when it was noted that it would be important to reassess his mental health state following his imminent attendance at court.
24. On 5 July, during a routine consultation, the man told a nurse that he was being bullied on the wing. She advised him to speak to a wing officer, but he appeared reluctant to do that so she spoke with an officer, who noted that he would observe his interaction with other prisoners. Neither the nurse nor the officer completed a Security Information Report (SIR) or made an entry in the P-NOMIS (electronic) record or in the wing observation book about this as the prison's violence reduction strategy requires.
25. By the end of July, the man was the M wing equalities representative and was interested in being trained as a Listener as he had been impressed by the Listeners who had helped him. He was also training as a mentor for prisoners with reading difficulties.
26. Throughout August, the man described feeling angry at his situation, including with himself. At a consultation on 30 August, with a consultant psychiatrist, he reported that his mood had been "consistently low" over the previous three weeks. She agreed to double the dose of amitriptyline to 100 mg per day which was the dose of amitriptyline that he had taken in the community. He soon began reporting an improvement in mood.
27. The man was released on bail on 20 September until his trial on 26 January 2012, when he pleaded guilty to manslaughter. He was convicted and remanded back to Lewes to await sentencing.

From 26 January 2012

28. Court staff noted in the man's person escort record (PER) that he had had thoughts of suicide or self-harm within the previous six months. The form also noted that he suffered from depression, anxiety and chronic fatigue.
29. When he arrived back at Lewes, a nurse saw him and decided that a first healthcare reception screen interview was unnecessary as it had not been that long since he was last in custody. (In fact it was four months, and 10 months since he was last in custody.)
30. The man spent his first day back at Lewes in the first night centre. During his induction interview he said he had expected custody that day and that he had

never harmed himself and had no thoughts of doing so. After spending the night on the first night induction centre, he moved to a shared cell on A wing the next day.

31. An entry in the man's records when he arrived on A wing said:

"He has the medical condition ME. This causes extreme exhaustion therefore needs to be located [on the ground floor] and lower bunk as repetitive movements wear him out. Was previously on [M wing] because [it has a] lift and [him needing] a single cell as does need more sleep than [others]."

32. A Church of England Chaplain at Lewes had known the man throughout his remand at Lewes and continued to see him after his conviction. He said he encouraged him to develop his interest in becoming a Listener, to attend the information technology (IT) workshop and to attend weekly guitar classes held in the chapel. To help him develop his guitar skills, the chaplaincy team loaned him a guitar. He took up these suggestions.
33. Entries in the man's clinical records on 14 and 15 February indicate that he had asked for a single cell. He reported that disturbed sleep caused him physical problems and that he had previously been in a single cell. Neither entry mentioned any plan to deal with his request.
34. On 1 March, one of the prison pharmacists noted in the man's clinical records that his prescription chart indicated that he was now holding amitriptyline in his own possession. She noted that this medication was high risk as it was very toxic in overdose. She recommended that the medication be issued under supervision for both his safety and the safety of other prisoners. Despite this recommendation, no alteration was made to the prescription. There is no evidence of a risk assessment regarding him having his medication in possession.
35. The man appeared at court on 22 March and was sentenced to 11 years imprisonment. When he returned to Lewes he told a nurse that he was relieved that everything to do with his trial was now concluded, although he said that he had expected a sentence of eight or nine years. He said that his relationship with his wife was still very strong and he had no thoughts of self-harm. He said that he was planning to speak with a Listener that evening.
36. On 23 March, another of the prison pharmacists noted that her colleague's advice of 1 March, that the man should not be allowed to retain amitriptyline in possession, had not been followed and she asked that the suggestion be considered.
37. An officer noted on 5 April that the man had asked to move to a single cell and he had advised him to speak to someone from healthcare to see if a doctor would authorise a single cell on medical grounds. (Evidence from several staff was that they tried to allow him sole occupancy of his cell but there were times when this was not possible and he had to share the cell.)

38. A note in the man's records on 13 April confirmed that he had become the A wing equalities representative and that he had held this position on M wing while on remand.
39. The counsellor had also resumed contact with the man when he returned to custody. She said that although he had "ups and downs" he was more comfortable than he had been when on remand. He sometimes complained about other prisoners "targeting" him and stealing items such as coffee and his biscuits and she reminded him to be more careful as others did not always have his standards. She said he was concerned about surveillance and asked her whether the cameras in the visits hall were fitted with microphones. She said she thought not and her understanding was that the cameras were just to check whether there was any passing of illegal drugs. She did not share this information with prison staff.
40. On 30 April, one of the prison doctors noted that the man needed a lot of sleep due to his ME and a cell-mate interfered with this. He noted: "... written for single cell ... genuine case". It is not clear when he was given a single cell.
41. The man's cell was subject to a random search on 16 May. (Lewes' cell-search protocol requires that every cell must be randomly searched within a 26 week cycle.)
42. An officer made an entry in the man's records on 17 May describing him as a "very popular figure on the wing" and who was always polite. An officer noted that his expectation would be that he would soon be moving to another prison and that he had confirmed that he was ready for this. He had previously discussed his preference to move to HMP Lowdham Grange in the Midlands and this was being arranged.
43. The doctor saw the man on 21 May and reported abdominal problems. As well as pain, his symptoms included diarrhoea and constipation and occasional blood in his faeces. He prescribed a laxative (movicol) and arranged to review him the following week. He reviewed him on 28 May, when the man was still suffering abdominal pain. He prescribed asacol (medication used to treat ulcerative colitis).
44. The man had a video conference with his legal team on 30 May to discuss a possible appeal against his length of sentence. (The process for such video conferences is that the prisoner is taken to the private video link room. The room is sound proof and the escorting officer waits outside the room.) The man was concerned that prison officers might be able to overhear the discussion but his legal team advised him that they would refer only to general legal principles and matters already in the public domain. His solicitor told the investigator that it was not unusual for prisoners to raise such concerns but she had no reason to suspect any improprieties in the way Lewes organises video conferences.
45. In mid June, the man completed Samaritan training to become a Listener. He said he had been motivated to become a Listener because of the benefit he had gained from speaking to Listeners.

46. SO 1, an A wing SO, told the investigator that the man was a quiet person who seemed to cope quite well, he followed a routine and associated with a select group of other prisoners. He said that he appeared to have come to terms with his sentence and was talking about his next prison move as well as his long term plans after release.
47. In a letter to the Governor, found in his cell after his death. The man said that he had spoken to SO 1 on 21 June after being threatened by a prisoner he had found in his cell. He wrote that he told the SO that he had been subject to intense scrutiny by other prisoners who were trying to find out information about his case by trying to steal and search his legal documents. He said he told the SO: "I can't live like this anymore, Gov".
48. The SO told the investigator that the man often came to his office for a general chat. He recalled an occasion when he told him about finding another prisoner in his cell going through his papers and also saying that he was no longer comfortable on the wing. He said he told him that he would speak with the other prisoner but he said he did not want any action taken. The SO told the investigator that without independent witnesses it was not possible to pursue the matter any further through the prison's bullying and violence reduction procedures. The SO added that he had not been aware of other prisoners showing any particular interest in his business. He did not make an entry on the P-NOMIS system about his discussion with him or submit a Security information report (SIR).
49. The investigator spoke to others about the incident the man had described. A Listener and A wing violence reduction representative told the investigator prisoners often want to find out information about other prisoners and he believed that this was why the other prisoner had gone into his cell. He said that he tried to mediate. The other prisoner agreed to meet to discuss the matter but the man would not, and he did not wish to complain formally about the other prisoner. He said that he informed SO 2 about the situation.
50. SO 2 told the investigator that the Listener had alerted her to a conflict between the man and another prisoner. He told her that the man and the other prisoner had agreed to "keep their distance". She told him that she would "keep an eye" on the other prisoner and she also said she told that prisoner that he "was on her radar". She did not make a P-NOMIS entry or submit a SIR about any of this.
51. She told the investigator that the man came to her office later that week to tell her that SO 1 had agreed to move him to L wing. She told him that he did not meet the criteria for L wing as that wing only holds category C⁵ prisoners, and he was category B. She asked him if his request to move was to do with the problem he had had with the other prisoner. He told her that he and the other prisoner had agreed to keep their distance, that he did not want to pursue a complaint about the other prisoner and just wanted to move to a new wing

⁵ All convicted prisoners are categorised at one of four levels: A, B, C or D. Categorisation is based on the prisoner's offence as well as their risk of escape and risk to the public if they were to escape. Category A is the highest category and D the lowest.

without any fuss. She told the investigator that she considered his safety to be paramount and so she arranged for him to be transferred to C wing.

Time on C wing

52. The man transferred to C wing on the morning of 23 June. An entry made in his records several days later stated that he had settled well on the wing and was very polite and co-operative. It mentioned that he was a Listener and had been attending the "Sycamore Tree" victim awareness project. The letter to the Governor found in his cell after his death was dated four days after his arrival on C wing. In it he said other prisoners started asking him about his conviction within two days of his move.
53. The guitar tutor told the investigator that he ran guitar classes for around ten pupils on Fridays in the chaplaincy, although sometimes classes would be cancelled if the chaplain was unavailable. He said that the man attended most of the classes. He did not think that he had a particularly close friend in the group, but he was likeable and he seemed to get on with most people. The last guitar class that he attended was on 29 June.
54. The man attended an IT workshop for four sessions each week of morning and afternoon sessions on Tuesdays and Thursdays. Two of the IT tutors explained that between 20 to 24 prisoners attended IT classes with a wide range of IT knowledge and experience. Most were in the main teaching room and about six, including the man, did more advanced work in a side room. The tutors described him as quiet and studious and only occasionally needed any help. Neither tutor noticed that he had any difficulties with any of the other prisoners.
55. The last IT session the man attended was on the morning and afternoon of 3 July. After that he missed 14 sessions. He reported being sick eight times, there were three occasions when the IT workshop was closed, twice when he went instead to chapel or faith services and one when he was moving cell.
56. Another prisoner who had completed the same advanced IT training as the man told the investigator he had asked him why he had stopped attending the course. He said that he was "pissed off" but he did not explain what he meant. The prisoner told the investigator that there were only about four prisoners in the IT room where he and the man worked and he had not seen him having problems with other prisoners. He added that his impression of him was that he was not a person equipped to cope with prison life.
57. On 7 and 9 July, the man was visited by his mother, sister and cousin. His cousin told the investigator that he spoke about having difficulties with other prisoners. However, he spoke in a guarded manner due to the lack of privacy in the visits hall. He also mentioned that he was still awaiting a response to a letter of complaint that he had sent to the Governor. His cousin said that he was in a low mood on 7 July, but was in a better frame of mind at the second meeting.

58. The man complained to a nurse on 12 July of feeling fatigued and generally unwell for the previous two days. An appointment was made for him to be seen by a doctor.
59. On the morning of 16 July, a nurse was called to the chapel to see the man, who was complaining of feeling dizzy and unwell. He said that he had had an upset stomach for the last few days and that he had not been eating or drinking very much. The nurse advised him to eat and drink more.
60. Later that day, the man had a legal visit from his barrister and his solicitor. She told the investigator that the visit lasted around an hour and was mainly about a potential appeal. He told her that other prisoners had been going into his cell and searching his legal documents. He said that he had written to the Governor, although he had not received a response. She told him that it was time that he moved to a prison for long-term prisoners and he agreed he would like her to help with this. She told the investigator that there was nothing in his demeanour to cause her concern that he was at risk of harming himself. She said that she later telephoned the member of staff at Lewes who dealt with prison transfers and she was told that his transfer was imminent.
61. The man telephoned his sister on 20 July. [Prison telephone calls are recorded, and can be subject to monitoring. After his death, the investigator listened to the recording.] A lot of their discussion was about one of her sons. After this call he telephoned his cousin. He told his cousin that he had completed a victim awareness course which he described as "pretty full on". He also made a comment that "it's a fucking burden". He added that he was looking forward to moving to a new prison. The cousin asked him if he was feeling better than he had been on 7 and 9 July. He said he was a little better.
62. The man telephoned his wife on the afternoon of 22 July. He told her that he was "tired of prison". She told him that he had "battled" through other obstacles in his life and that he would get through his present difficulties too. On 23 July, a note was made in his clinical records that he had not attended a doctor's appointment that day.
63. The counsellor told the investigator that she received a message on Tuesday 24 July that the man was anxious to see her. She went to the wing just before lunch time and said that he was shaking. Although he had smiled when he first saw her it was not his usual smile. They spoke in his cell and she said that he appeared anxious in a way she had not seen before. She noticed that his lips appeared very dry. He showed her a copy of a letter that he said he had sent to the Governor, but said that he had not received a response. He spoke about difficulties he had had with other prisoners on the wing trying to find out information about him and said that this was affecting his sleep. He spoke about prison and said that he would be in the prison system for ever. She told him that he needed to be sensible about his sentence which he should view as likely to be a case of serving half of the eleven years to which he had been sentenced. She noticed a packet of tablets which he said were asacol tablets for stomach and bowel problems. She told him not to do anything "silly" and he insisted he would not.

64. The counsellor told the investigator that she spoke to the man about coping strategies, such as developing his relationship with his young nephew and maintaining contact with his wife. She told him to write out his problems on separate pieces of paper and work out a plan for working through them. She also advised him to eat properly and told him that staff would bring food to him if he did not feel able to go to the servery. She said that she spent over an hour with him and she believed he was much better by the end. She agreed to see him again the next Monday. She said that when she left his cell she told one of the officers (later found to be Officer A) that she did not think he warranted being placed on ACCT, but she asked that staff keep an eye on him including ensuring he was collecting his meals. She did not make a P-NOMIS entry about her meeting with him.
65. Officer A told the investigator that he first met the man during his time on remand on M wing and then met him again after he arrived on C wing. The officer said that he was a quiet person who interacted with a small number of other prisoners. In the last week or so of his life, he spent most of his time in his cell but when he asked him about this he said he was dealing with paperwork about an appeal against his sentence. The officer said that he was still taking his breakfast pack and was collecting his evening meal, but for lunch he stayed in his cell and ate items he had bought from the prison canteen⁶. He had no concerns about his safety and did not make an entry in the wing observation book or P-NOMIS about what the counsellor had told him.
66. The man telephoned his mother at about 6.00pm on 24 July. He spoke about his imminent transfer to Lowdham Grange saying that he was tired of Lewes and was ready for a new start. He said that he had not been attending his IT course lately because of the approaching move. His mother asked if he had seen the counsellor lately and he told her that he had not seen her for a while.
67. Lewes' Safer Custody Manager manages the Listeners and as such had had regular contact with the man. He told the investigator that he had been working an evening shift on 25 July when the man spoke to him about his move to Lowdham Grange. He said that he did not want the manager to think he was letting him down by leaving Lewes just after he had completed his Listener training. He reassured him about this and that he would be able to apply to be a Listener in Lowdham Grange if he wanted. He said he was looking forward to moving as he needed to get on with his sentence. The manager told the investigator that the conversation lasted around ten minutes and that was the last time he saw him. He said he had never been concerned about him.
68. A prison chaplain visited the man in his cell on 26 July. He said he spoke very positively about the support he had received from his counsellor two days before and said he was looking forward to moving to Lowdham Grange, which he was expecting to happen the following week.

⁶ The word canteen refers to the prison shop. Prisoners are able to spend their own money on items such as tobacco, toiletries and sweets. They submit their orders by completing canteen sheets.

69. A Listener based on C wing told the investigator that he had been on the same Listeners course as the man. He said he did not witness him having a difficult time with other prisoners. He said that he noticed him begin to spend less and less time out of his cell. On 26 July, the man spoke to him in his role of Listener. He was not able to tell the investigator about their conversation due to Listeners' rules on confidentiality. However, he said that he appeared unusually cheerful, so much so that he asked him if he had "taken something".
70. Another C wing Listener, who had been on the same course, said that the man mentioned that he had had problems with other prisoners on A wing, but he was not aware of any such problems on C wing. He said that he would have intervened had he heard of any incidents. He said that he spoke to him on the evening before his death and he seemed happy.
71. The investigator spoke to a Listener on A wing. He said he and the man played chess together and there were several occasions when he spoke with him in his role as a Listener. He told him that he had had clothing and canteen items stolen from him (on A wing) but he would not say who had done it. The Listener said that he saw him on both 26 and 27 July, and he seemed his usual self.

Day of the Incident

72. At 9.00am the man was assessed by a nurse as being fit for transfer (this is a standard assessment when a prisoner is to be transferred to a new prison).
73. On Fridays at Lewes evening lock-up is at 5.15pm. At that time an officer gave the man a letter confirming that he would be transferring to HMP Lowdham Grange on 31 July. She told the investigator that she would not normally give such letters at night time as some prisoners might not consider a prison transfer to be good news. However, in his case she knew he was eager to move so she thought that he would be pleased to receive the official confirmation of this. His response indicated that he was pleased and he said he would see her in the morning.
74. At just before 7.00pm, an officer carried out the final roll check of the evening. (The purpose of the roll check is to ensure that all prisoners are present and in the correct cells). The man was sitting on his bed reading a book and she did not speak to him.
75. Just after 8.30pm, an Operational Support Grade⁷ (OSG) was delivering canteen sheets for shop orders and was making a cell check at the same time. When she looked through the observation panel of the man's cell she saw that he was hanging from a noose that he had tied to the upper part of the bunk bed. She radioed that a prisoner was hanging and asked for assistance. She then tried to open her sealed key pouch⁸ so she could unlock the door but was unable to break the seal.

⁷ Operational Support Grade staff do not receive the same level of training as prison officers staff and have limited direct contact with prisoners.

⁸ At night time, most staff carry keys in a sealed pouch that should only be opened in the case of an emergency.

76. Officer B told the investigator that he and Officer C were on K wing when they heard the emergency call. They ran to C wing, which he thought took no longer than 30 seconds. Officer D had also arrived on the wing and was just ahead of them. He unlocked the cell door and he and both officers went into the cell. They cut the noose which freed the man from the bed frame. Officer B said that the remnant of the noose was very tight around his neck but when Officer C began to prise it away from his neck, it snapped off. Officer C checked for a pulse but found none. He then started cardio-pulmonary resuscitation (CPR), giving a set of 30 chest compressions. He again checked for a pulse, but again without success. At that point, three nurses arrived from healthcare and took over efforts to resuscitate him. Officer D then requested an emergency ambulance. Nurses checked him with a defibrillator⁹ which instructed that no shock be given and that CPR should continue. The nurses continued giving sets of chest compressions and emergency breaths, stopping only to check the defibrillator.
77. Paramedics arrived at about 8.45pm. Resuscitation efforts continued until around 9.07pm when death was pronounced.

Events after the man's death

78. One of Lewes' family liaison officers (FLOs) was contacted at home and informed of the man's death. She arrived at the prison at around 10.30pm. She checked his records and she found that he had named his sister as his next-of-kin at an address in Sussex. His records also contained a postcard that indicated that his sister had moved, but gave only the name of a town in Cheshire and not the full address. The Coroner's officer was at the prison and obtained an address for the man's mother. The FLO and a colleague went to that address but discovered that she had moved. The staff returned to the prison but decided that as it was so late by then they would reconvene in the morning to try to establish contact with his family.
79. When staff checked the man's visitor records the next day they found his sister's full address. By then it was around 9.30am and to minimise further delay, Cheshire police were contacted and asked to break the news. At just around 11.20am, Cheshire police informed the prison that they had not been able to contact her, but they had discovered that his mother was at an address in North Wales. Cheshire police contacted the North Wales police and asked them to visit. She was informed of the news at just after midday. The FLO spoke to her that afternoon. He had listed his mother when he was first remanded and his sister after he was sentenced.
80. The man's mother-in-law telephoned the FLO the next day to say that she had heard the news from his uncle and she wanted to know why her daughter had not been contacted directly by the prison. The FLO explained that it was only his mother and sister that he had listed as people to be notified in the case of an emergency.

⁹ A defibrillator measures electrical activity in the heart and gives audible instructions on management of the patient such as whether or not an electrical shock should be given.

81. A hot debrief meeting had been held on the evening of the man's death to allow staff involved in the response to talk about what had happened. Staff were informed about the support available through the care team. Other prisoners at Lewes were informed of his death the following day and case reviews were carried out for prisoners on open ACCTs.
82. Several days after the man's death letters and other writings were found in his cell. These included goodbye letters and reminiscences. He wrote that he had been subject to intolerable scrutiny from prisoners trying to find out information about him, which he believed had been orchestrated by the prison or the police. He wrote that "the last month had been the worst" of his life. All the writings were undated and some were clearly written days before his death.

ISSUES

The man's letter to the Governor

83. After the man's death a letter addressed to the Governor was found in his cell. The letter dated 27 June 2012 was computer produced. When the counsellor visited him on 24 July, he showed her the letter and said that he not yet received a reply to the original. The prison said there was no record that it had ever been received. The investigator checked the prison database of complaint letters to the Governor and there was no record of the letter.
84. There is no obvious reason why the man should have taken the time to write a lengthy letter of complaint but then not send it. Nor is there an obvious reason why he would have discussed a lack of response with the counsellor if he had not sent the letter and was not genuinely expecting a reply.
85. However, neither is there any reason for Lewes not to have dealt with the letter in the way that they would deal with any letter of complaint. We are not therefore able to explain what happened to the original, assuming that there was indeed an original. It is possible that the man did not send it or that it went missing before being logged.

Surveillance

86. The theme that runs through the letter is what the man described as an intolerable level of scrutiny since his conviction on 26 January. He explained that there had been repeated incidents of prisoners asking for details of his conviction and his sentence. He said there had been incidents where prisoners had tried to snatch legal documents that were in his hand or his pocket, and that he had found prisoners searching his cell after he returned from using the showers. He said when he confronted one prisoner, that prisoner had threatened to scar his face. He wrote that prisoners were passing information to officers and he believed that the scrutiny was being sanctioned by the prison. He said that one prisoner had informed an officer that he had some information to pass on. He concluded by saying: "I understand that the prison is obliged to cooperate with the investigation of prisoners but surely there must reach a point at which this is outweighed by the emotional wellbeing and safety of the prisoners themselves".
87. The officer said that he was shocked by what the man had written. He denied any involvement in receiving or collecting information about him.
88. Prisons do monitor prisoners. At the most basic level, this will be simple observation of all prisoners as they move around the prison, as they interact with other prisoners and as they interact with visitors. Staff have to observe prisoners for indications of trading in illicit items such as drugs or mobile telephones, evidence of bullying or for any reason that a prisoner may be at risk of harm to himself. Information about security matters such as prisoners involved in drug dealing or having possession of a mobile telephone is sometimes passed to staff by other prisoners. When this happens, this is treated confidentially to protect the informant. No information of this nature

was collected about the man and there were no security or other reports submitted as a result of any staff observations.

89. Prisons also use covert surveillance as permitted by the Regulation of Investigative Powers Act 2000. Covert surveillance is conducted when: "... it is necessary and proportionate to do so for the purposes of preventing crime/serious crime, preventing disorder, or on the grounds of public safety". This includes surveillance granted on application by a police force. The Act contains authorisation procedures to ensure, among other things, that the surveillance justifies potential contravention of the right to respect for private and family life as established under the Human Rights Act 1998. The investigator spoke to Lewes' Head of Security Intelligence and examined the records of prisoners subjected to covert intelligence gathering. The man's name was not included.
90. It is possible, and even likely, that some prisoners sought information about the man to satisfy their own curiosity or to see if there was some weakness they could use to exploit him. We are satisfied that there was no official 'surveillance' of him sanctioned by the prison or the police as he and his family seemed to suspect.

Bullying

91. The man wrote in his letter to the Governor of the occasion when he found another prisoner in his cell. He said that when he confronted the prisoner, he was threatened with a weapon. He added in the letter that he did not want any action to be taken against the other prisoner as that might put him at greater risk. The letter is consistent with what he said to another prisoner and to SO 2 when she spoke with him after being alerted by the prisoner.
92. When SO 2 spoke with the man he told her that he did not want to pursue the matter. As there were no independent witnesses she said she was unable to take the matter further, although she said she spoke to the other prisoner to let him know she was watching him. SO 1 also recalled him reporting concerns to him. He said that there was nothing he could do without a formal complaint from him about the other prisoner.
93. Despite the man's insistence about not pursuing a complaint there were steps that staff could and should have taken. It would have been appropriate for staff to have submitted a security information report (SIR) to place on record that there was an allegation against the other prisoner of a threat of violence. This information would be of use in the case of any other allegations of inappropriate behaviour on the part of this prisoner. Staff should have made an entry in his electronic (P-NOMIS) record to indicate that he had reported a problem with another prisoner as required by the prison's local violence reduction policy. Without such a record, the evidence that he might be vulnerable or at risk of bullying was lost. For obvious reasons many prisoners are reluctant to divulge directly the names of prisoners who are threatening them or bullying them. This should not preclude prison staff investigating and monitoring where threatening behaviour has been alleged. In this case, staff

knew the name of the other prisoner involved and could have taken some action under the anti-bullying and violence reduction strategy.

The Governor should ensure that staff complete SIRs wherever suspicion that a prisoner has been involved in bullying or threatening behaviour is reported and wherever possible the prisoner is monitored and managed under the prison's violence reduction strategy.

Record Keeping

94. There were a number of occasions where we consider staff should have made entries in the P-NOMIS system, but failed to do so. For instance, during the man's first time at Lewes a nurse made separate entries in his clinical records about him reporting suicidal thoughts on one day and on another day recorded that he was being bullied by another prisoner. Wing officers do not have access to prisoners' clinical records so without a P-NOMIS entry this information would be lost. Later in this section we discuss the counsellor's consultation with him on 24 July when we again consider that a NOMIS entry should have been made.

The Governor should ensure that staff note important information in prisoners' P-NOMIS records and/or the wing observation book as appropriate.

Clinical issues

Amitriptyline prescription

95. The man was being prescribed the anti-depressant amitriptyline for symptoms associated with his condition of ME, which he had been receiving in the community. During his first time in Lewes while on remand, he appears to have been receiving his amitriptyline under supervision. That means he would take each dose in front of the nurse who dispensed it to him. When he returned to Lewes on 26 January 2012, he was again prescribed amitriptyline. The prescription chart was marked that the dispensing of the medication be supervised, but at some point the word supervised was crossed through. On 1 March, a pharmacist noted in his clinical records that, as amitriptyline is very toxic in overdose, the medication should be given under supervised conditions. On 23 March, another pharmacist made an entry in the records pointing out that her colleague's earlier instruction had been ignored and she asked that the decision to allow him to have amitriptyline in-possession should be reconsidered. It appears that at some point he again began to be issued amitriptyline under supervision, although the prescription charts are unclear.
96. Nor is it clear that staff ever formally assessed the man's suitability to hold medication in-possession for the period his amitriptyline was being dispensed this way.
97. While post mortem toxicological analysis indicated that amitriptyline levels in the man's blood samples was consistent with prescribed levels, a number of amitriptyline tablets were found in his cell after his death. To have permitted

him to hold this medication in-possession allowed the possibility of him taking a serious overdose. It also put him at risk of having the medication taken from him by other prisoners.

The Governor and Head of Healthcare should ensure that documented risk assessments are completed before prisoners are allowed medication in-possession.

First healthcare reception screen interviews

98. When prisoners arrive in custody a reception nurse should carry out a first healthcare reception screen interview to explore matters such as the person's physical and mental health history, any history of self-harming behaviour, any present thoughts of self-harm or suicide, their present treatment needs, any need for referral to healthcare practitioners. When the man returned to custody on 26 January 2012 the reception nurse decided that a first healthcare reception interview was unnecessary as had been out of custody for "only two months". In fact, four months had elapsed since he was last in custody. Moreover, there had been a significant change in his circumstances in that he had been convicted of manslaughter against a family member. He also had a history of depression and other factors which might have indicated he was at increased risk of suicide and self-harm. When the investigator spoke to the Head of Healthcare about this matter he was informed that procedures would be changed so that reception nurses would no longer have such discretion, but should always carry out a first healthcare reception screen interview when prisoners return to custody. It is a requirement of PSI 74/2011 that all incoming prisoners are medically examined. This is further supported by PSO 3050 – Continuity of Healthcare for prisoners which specifically requires prisoners returning to prison following sentencing to have a healthcare screen.

The Head of Healthcare should ensure that healthcare reception interviews are conducted as required by Prison Service instructions.

The man's location

99. The man had two clinical conditions, ME and IBS, that made it preferable for him to occupy a single cell. During his first time in Lewes he was allocated to M wing (part of which is used to hold vulnerable prisoners). Although nothing is recorded to explain why he went to that wing, the investigator was told that the most likely reason was not because he was deemed to be vulnerable, but to allow him a single cell. (There are a greater proportion of single cells on M wing compared to the other wings in Lewes.)
100. When the man returned to Lewes after his conviction on 26 January, he went first to A wing before later being transferred to C wing. An entry by one of Lewes' doctors on 30 April indicated that he should have a single cell and that his was a genuine case. The prison was unable to confirm the periods when he was the sole occupant of a cell and periods when he shared during this second period. We accept that prisons must manage constant pressure on demand for spaces but it seems inconsistent that it was some time into his

second period at Lewes before his medical need for a single cell was authorised by a doctor.

The Governor and Head of Healthcare should ensure there is a robust process to identify prisoners who have a medical need for a single cell.

The notice of the man's transfer to Lowdham Grange

101. Once the man had been convicted and sentenced he understood that he would move to an appropriate prison where he would serve a substantial part of the sentence. He carried out his own research and selected Lowdham Grange as his preferred prison. Lowdham Grange holds prisoners serving sentences of a minimum of four years with suitable programmes for such prisoners, while most prisoners at Lewes are on remand or serving short sentences. He indicated to staff and others that he was looking forward to the move. When confirmation was received that he would be moving on 31 July, the officer delivered the confirmation slip to him just before evening lock-up. She told the investigator that she would not normally deliver a confirmation slip at that time but believed that that he would be pleased to receive the news. His reaction appeared to confirm her belief.
102. We consider that this was an appropriate decision to deliver what was regarded as welcome news. There was no indication that news of the transfer would cause the man any adverse reaction, although it is possible it brought home to him the length of his sentence.

The man's presentation in his final weeks

103. The counsellor went to see the man on 24 July at his request. It is apparent from her description of him that he was extremely anxious. He told her that he had not been collecting food from the servery and she noticed that his lips were very dry. They talked for over an hour, by the end of which they had spoken about coping strategies and she considered he was in a much better frame of mind. She advised him to start eating properly and told him she would see him again on the following Monday. She then spoke with Officer A to tell him that she was not too concerned about him, but asked that staff pay attention to his food consumption. She told the investigator that she did not consider it appropriate to open an ACCT plan.
104. ACCT is the procedure used to monitor and support prisoners at risk of harming themselves. Once subject to ACCT procedures, the prisoner is supervised at regular intervals according to the perceived level of risk and is involved in regular case reviews. An ACCT plan should be opened in the case of a prisoner being identified at risk of suicide or self-harm. Guidance on ACCT also recognises groups of prisoners who are at higher risk of suicide and self-harm compared to the norm. Such groups include:
- Those in prison for the first time (the man was in prison for a second time by the time of his death although the two spells were linked to the same offence and only separated due to a period on bail)

- Those with a change of status or transfer (he had been convicted in January, sentenced in March and was awaiting imminent transfer to a new prison)
 - Those accused of violent offences, particularly against a family member
 - Those sentenced to life imprisonment or equivalent
 - Those with a mental health disorder (he had long term symptoms of depression)
105. The existence of the above factors does not automatically mean that an ACCT should have been opened, and most of these factors had been present for some time before the man's death. However, in his final weeks, there is evidence that he was withdrawing more and spending most of his time in his cell. He had stopped attending his IT course and the recorded reason for this was that he was unwell but, in a telephone conversation with his mother, he said he had stopped attending due to his approaching move to a new prison. Some witnesses said that it was not in any case unusual for him to spend most of his time in his cell and no-one, including Listeners, members of the Samaritans, and his solicitor, believed that he might be about to harm himself.
106. The counsellor and Officer A appeared to have different understandings about the level of concern about the man on 24 July and how he presented. The officer thought that he was much the same person he had been since he had known him. The counsellor said he seemed different and very anxious. Although she later said she did not consider an ACCT needed to be opened, she was sufficiently concerned to say to him not to "do anything silly". She made no entries in either his P-NOMIS record or in the wing history record to support what she might have explained to the officer, so the level of concern she might have conveyed to him cannot easily be judged. Nevertheless, none of the people who knew him and saw him in the days before his death were concerned that he was at any risk of self-harm.
107. The clinical reviewer has pointed out that the relationship between the counsellor and the healthcare providers was informal and could have been benefitted from a more formal approach so that appropriate links between services were made.

The Governor and Head of Healthcare should ensure that external providers of counselling or other mental health linked services have a formal arrangement with prison healthcare to cover matters such as reporting, disclosure and supervision.

Emergency procedures

108. The man was discovered by an OSG. She radioed for help and tried to open her sealed key pouch but could not break the seal.
109. We understand from another recent investigation at Lewes that there is 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. Because the OSG used the term “hanging”, there was no confusion in the minds of response staff, even so we make the following recommendation:

The Governor should ensure that staff use an appropriate call code when radioing for emergency assistance.

110. The OSG had never previously had to break a key pouch seal and when she found herself in an emergency situation was unable to break the seal. The investigator asked Lewes’ Safer Custody Manager to allow the OSG to break a key pouch seal to allow her to understand the technique needed. Entering a cell in an emergency at night is a rare and stressful situation and the plastic seals can be quite difficult to break when officers are unused to doing so. (Using the anti-ligature knife which all officers should carry can be an effective way of cutting through the seal quickly.)

The Governor should ensure that night staff are practiced and confident in opening emergency cell key pouches.

Notification to family of the man’s death

111. The man had named his sister as his next of kin. It took around 15 hours for notification to be made as his sister was no longer at the address supplied and nor was his mother. When they failed to make contact that night, prison staff decided to try again in the morning. When his visitors’ records were checked in the morning an address in Cheshire was found. A visit by the Cheshire police to that address produced an address in North Wales where his mother was and she was told of the news at just after midday.
112. We accept that there was a degree of complication in finding an up to date address for the man’s family, but had all of his records been checked on the night of his death his family might have been informed a little earlier than was the case.
113. While we accept that the man had himself identified his sister as the person to be contacted in the event of an emergency, it is not clear why the prison did not make any attempt to contact his wife, particularly because of the difficulty in getting in touch with his sister or mother. Prison Rules 22(i) requires that “if a prisoner dies, becomes seriously ill, sustains any serious injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform that prisoner’s spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed”.
114. Ordinarily, notification of a death should be made by staff from the prison where the prisoner was located or, if distance is a factor, by staff from a prison local to the family home. Given a need for expediency, we accept that it was reasonable for Lewes to have asked the police to break the news.

The Governor should ensure that, following a death in custody, all steps are taken to notify a spouse or next of kin with the minimum of delay.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Governor should ensure that staff complete SIRs wherever suspicion that a prisoner has been involved in bullying or threatening behaviour is reported and wherever possible the prisoner is monitored and managed under the prison's violence reduction strategy.

Recommendation accepted:

A notice to staff will be published which will offer staff guidance on when to complete an SIR or monitor a prisoner under the prisons violence reduction strategy. Target for completion: 1 March 2013.

2. The Governor should ensure that staff note important information in prisoners' P-NOMIS records and/or the wing observation book as appropriate.

Recommendation accepted:

A notice to staff will be published to offer guidance on recording regular prisoner contact on P-NOMIS. Managers will incorporate this recommendation within their Quality assurance checks. Target for completion: 1 March 2013.

3. The Governor and Head of Healthcare should ensure that documented risk assessments are completed before prisoners are allowed medication in-possession.

Recommendation accepted:

The Medicines Management Group have ratified an in-possession medication risk assessment, this will be implemented. Target for completion: 1 March 2013.

4. The Head of Healthcare should ensure that healthcare reception interviews are conducted as required by Prison Service instructions.

Recommendation accepted:

A review of current practice has been carried out. Future healthcare reception interviews will be held in accordance with Prison Service Instructions. The Head of Healthcare will instigate a monitoring system. Target for completion: 1 March 2013.

5. The Governor and Head of Healthcare should ensure there is a robust process to identify prisoners who have a medical need for a single cell.

Recommendation accepted:

Following a review of PSI 11/2009, HMP Lewes will introduce an audit trail, that will evidence the decision making process. Target for completion: 1 March 2013.

6. The Governor and Head of Healthcare should ensure that external providers of counselling or other mental health linked services have a formal arrangement with prison healthcare to cover matters such as reporting, disclosure and supervision.

Recommendation accepted:

A review of information sharing protocols for providers of counselling and other mental health linked services, will be commissioned. Target for completion: 1 April 2013.

7. The Governor should ensure that staff use an appropriate call code when radioing for emergency assistance.

Recommendation accepted:

A Review of the Local Policy has been commissioned in line with the recently published PSI 03/2013 Medical Emergency Response Codes. Target for completion: 1 April 2013.

8. The Governor should ensure that night staff are practiced and confident in opening emergency cell key pouches.

Recommendation accepted:

The weekly night manager will ensure that all night staff are practiced and competent in the opening of sealed key pouches whilst on nights. The monthly diary will be used to record this training has taken place. Target for completion: 1 April 2013.

9. The Governor should ensure that, following a death in custody, all steps are taken to notify a spouse or next of kin with the minimum of delay.

Recommendation accepted:

A review of our current Local procedures will be commissioned to ensure we have the latest Next of Kin details. Target for completion: 1 March 2013.