

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr William Ansley a prisoner at HMP Lewes on 7 February 2019

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr William Ansley was found hanged in his cell at HMP Lewes on 7 February 2019, less than 15 hours after he had arrived. Mr Ansley was 65 years old. I offer my condolences to his family and friends.

Mr Ansley had been arrested at a well-known suicide spot and assessed at court as presenting a high risk of suicide. Although prison healthcare staff received information about his risk, this was not properly passed on to mental health staff.

I am also concerned that prison and healthcare staff placed too much emphasis on their perceptions of Mr Ansley's state of mind, and not enough emphasis on his known risk factors. This office has been saying for years that staff need to avoid making this basic error, and it is very disappointing to see it yet again in Mr Ansley's case.

It is also disappointing that we have once again identified deficiencies with the identification and management of a prisoner's risk on arrival at Lewes. The Prison Group Director of Kent, Surrey and Essex Group will need to address this issue urgently.

There was also a delay in the emergency response. While it did not affect the outcome for Mr Ansley, the Governor will need to address this.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**October 2019**

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# Summary

## Events

1. On 5 February 2019, Mr William Ansley was detained in police custody for alleged sex offences. Police records show that officers arrested him at Beachy Head, East Sussex, a well-known suicide spot.
2. At 10.17am on 6 February, a mental health nurse from the police court liaison and diversion service (PCLDS) reviewed Mr Ansley at court. He noted that Mr Ansley did not show concern about the charges he faced and appeared to mask his true feelings. The nurse asked for Mr Ansley to be assessed to see whether he needed to be detained under the Mental Health Act but the assessment team could not attend before court finished.
3. At around 4.45pm, Mr Ansley was remanded into custody. At 5.01pm, a Probation Service officer emailed HMP Lewes to say that Mr Ansley had not been to prison before and presented a high risk of suicide. Court officers completed a suicide and self-harm warning form, which was sent to Lewes with Mr Ansley.
4. At 5.17pm, the PCLDS nurse telephoned the healthcare inpatient unit at Lewes and relayed his concerns about Mr Ansley's risk of suicide to a healthcare assistant. The healthcare assistant reviewed the PCLDS nurse's risk assessment electronically and told two prison mental health nurses about their conversation. However, there is no evidence that the two prison nurses saw a copy of the PCLDS nurse's risk assessment.
5. At 6.25pm, Mr Ansley arrived at HMP Lewes. At 7.45pm, an officer conducted Mr Ansley's first night interview and noted that he had not been to prison before, did not have any concerns and did not report any thoughts of suicide or self-harm.
6. At around 9.00pm, a nurse conducted an initial health screen and recorded that Mr Ansley denied going to Beachy Head intent on committing suicide. He noted that despite feeling overwhelmed by what had happened to him, Mr Ansley presented as rational and repeatedly denied thoughts of suicide. There is no record that the nurse was aware of the PCLDS nurse's concern about Mr Ansley's presentation.
7. An officer unlocked Mr Ansley's cell at 8.35am on 7 February, and discovered him hanged. He asked a nearby officer to raise the general alarm and went into the cell. Staff tried to resuscitate him but paramedics declared shortly afterwards that Mr Ansley had died.

## Findings

8. Staff at Lewes did not adequately ensure that information about Mr Ansley's risk of suicide was shared with other members of staff. Although Mr Ansley had a number of risk factors, staff failed to start suicide and self-harm prevention measures, known as ACCT.

9. We have previously identified similar deficiencies in staff not identifying and managing risk when prisoners arrive at Lewes. Urgent action is needed to address the issue.
10. Staff did not immediately call a medical emergency code when Mr Ansley was found hanged, and this caused a short delay. Although it made no difference to the outcome for Mr Ansley, this could be critical in future cases.
11. We consider that it is important for staff who were involved in Mr Ansley's care to see the findings of and learn lessons from our investigation.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff identify and manage prisoners at risk of suicide and self-harm in line with PSI 64/2011 and PSI 07/2015. In particular, reception staff, healthcare staff, first night staff and all others who assess risk should:
  - recognise the additional vulnerabilities of newly arrived prisoners and have a clear understanding of their responsibilities and the need to share and record relevant information about risk;
  - start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions; and
  - document the information considered when deciding whether or not to start ACCT monitoring.
- The Prison Group Director of Kent, Surrey and Essex Group should write personally to the Ombudsman setting out what she is doing to satisfy herself that meaningful action is being taken to improve the assessment and management of the risk of suicide at Lewes.
- The Head of Healthcare should ensure that all healthcare staff are:
  - aware of the PCLDS's local policy for sharing concerns about suicide and self-harm; and
  - able to access the electronic medical record used by PCLDS staff.
- The Governor should remind staff of the procedure for conducting overnight checks on newly arrived prisoners in the first night centre.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to communicate the nature of an emergency.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator visited Lewes on 13 February. He obtained copies of relevant extracts from Mr Ansley's prison and medical records and interviewed two prisoners.
14. The investigator interviewed a member of staff from the East Sussex PCLDS by telephone on 6 March. He interviewed eight members of staff at Lewes on 19 March and 17 April.
15. NHS England commissioned a clinical reviewer to review Mr Ansley's clinical care at the prison. The clinical reviewer attended joint interviews with the investigator on 19 March and 17 April.
16. We informed HM Coroner for East Sussex of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. The Ombudsman's family liaison officer contacted Mr Ansley's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. His daughter wanted to know why the prison did not start suicide and self-harm procedures.
18. Mr Ansley's daughter received a copy of the initial report. The solicitor representing her wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed a factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

## Background Information

### HMP Lewes

20. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services. HMP Lewes has a healthcare centre with a full time senior medical officer. Healthcare is provided on a 24-hour basis; there is a 12-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics.

### HM Inspectorate of Prisons

21. The most recent inspection of HMP Lewes was in January 2019. Inspectors found that although arrival and first night procedures were generally good, some prisoners spent too much time waiting in reception. They found that first night centre interviews were conducted confidentially and that the assessment of risk was reasonable.
22. Inspectors noted that there had been five self-inflicted deaths in the three years since their previous inspection, and that despite comprehensive action plans in response to Prisons and Probation Ombudsman recommendations, most had not been satisfactorily implemented.

### Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 January 2019, the IMB expressed concern about prisoners having to wait a long time in reception for an initial health screen due to low staffing levels.

### Previous deaths at HMP Lewes

24. Mr Ansley was the eighteenth prisoner to die at Lewes since February 2016. Of the previous deaths, eleven were due to natural causes, two were drug-related and four prisoners took their own lives. We have previously made recommendations about identifying and assessing whether newly arrived prisoners are at risk of suicide and self-harm.

## Key Events

25. On 5 February 2019, Mr William Ansley was detained in police custody for alleged sex offences. Police records show that he was arrested at Beachy Head, East Sussex, a well-known suicide spot, where he told police, “I was going over the edge you know, this is only prolonging it.” Later that afternoon, a mental health nurse from the police court liaison and diversion service (PCLDS), recorded that Mr Ansley told her that he had no intention of taking his life and had gone to Beachy Head to “clear his head”.
26. At 10.17am on 6 February, a mental health nurse from PCLDS reviewed Mr Ansley at Crawley Magistrates Court. He noted that Mr Ansley did not show concern about the charges he faced or their potential impact on his life. Mr Ansley said that the remarks he made to the police at Beachy Head were flippant, and that he felt different after sleeping. He noted that although Mr Ansley denied thoughts of suicide or self-harm, he could not identify any substantial protective factors. He noted that Mr Ansley appeared to mask his true feelings and he asked for him to have an assessment to determine whether he should be detained under the Mental Health Act. However, the assessment team could not attend before the end of the court hours.
27. At around 4.45pm, Mr Ansley was remanded to custody for his own protection due to the seriousness of the alleged offences and the fact that he had gone to Beachy Head. At 5.01pm, a Probation Service Officer emailed a notification to HMP Lewes’ Offender Management Unit (OMU) to warn them that Mr Ansley was vulnerable, had never been to prison before and presented a high risk of suicide. However, the OMU office closed at 5.00pm and the notification was not seen until the following day. In the meantime, court officers sent Mr Ansley to Lewes, along with a suicide and self-harm warning form.
28. At 5.17pm, a nurse from the PCLDS telephoned the healthcare inpatient unit at Lewes to inform a nurse of his concerns about Mr Ansley, in line with local policy. No nurses were available so he told a healthcare assistant (HCA) that Mr Ansley had been arrested at Beachy Head and appeared to mask his feelings by saying that everything was fine. He said that he had completed a risk assessment and concluded that Mr Ansley posed a risk of suicide. At around 5.30pm, the HCA telephoned a mental health nurse who was working in reception to tell her about the nurse’s concerns and risk assessment. The HCA told the investigator that he also printed a copy of the nurse’s assessment. However, there is no evidence that he gave the document to healthcare or prison staff.
29. At 6.00pm, a mental health nurse arrived at the inpatient unit to start his shift. The HCA told him about his conversation with the nurse and he made his way to reception to take over from the other nurse. He told us that he was expecting a printed document from PCLDS with further information but he never received anything. He said that he did not have access to the PCLDS’s electronic medical records and such records could not be accessed in reception.
30. At 6.25pm, Mr Ansley arrived at HMP Lewes, where he was assigned a single holding cell.

31. At around 7.30pm, a supervising officer (SO) asked an officer to conduct Mr Ansley's first night interview as reception was particularly busy. The officer told the investigator that he had never done a first night interview before and had not been shown what to do. He said that he reviewed Mr Ansley's paperwork before collecting him from his holding room and noticed a suicide and self-harm warning form which indicated that the police had arrested him at Beachy Head.
32. At 7.45pm, the officer escorted Mr Ansley into a private interview room. He recorded that Mr Ansley had not been to prison before, had no concerns about being in prison and did not report any thoughts of suicide or self-harm. He told us that when he asked Mr Ansley what happened at Beachy Head, he said, "Nothing, I had no intention of killing myself." He said that Mr Ansley maintained good eye contact throughout the interview and did not appear distressed. He said that he told Mr Ansley that he could speak to the Samaritans and the Listeners (prisoners trained by the Samaritans to support other prisoners). He completed a cell-sharing risk assessment and assessed Mr Ansley as a standard risk.
33. At around 9.00pm, a mental health nurse completed an initial health screen for Mr Ansley. He told the investigator that he quickly established that Mr Ansley had not been in prison before and spent the first few minutes talking to him to establish a rapport. He said that Mr Ansley engaged well and presented as calm and lucid.
34. The nurse recorded in the electronic medical records that Mr Ansley had gone to Beachy Head but denied any suicidal intent. He told us that Mr Ansley said that he went for a drive after his wife asked him to leave the family home and ended up at Beachy Head. He noted that although Mr Ansley felt let down by his wife and overwhelmed by his sudden change in circumstances, he repeatedly denied thoughts of suicide or self-harm. He did, however, report unresolved issues following his daughter's death 10 years previously and agreed to be referred to the mental health team. There is no record that he considered the PCLDS mental health nurse's concerns about Mr Ansley.
35. At around 10.45pm, Mr Ansley was moved from reception to the prison's first night centre. An officer introduced himself and established that it was Mr Ansley's first time in prison. Mr Ansley declined his offer of a telephone call. Mr Ansley smoked so he gave him a vape pack (a supply of electronic cigarettes) and confirmed that he was happy to have a single cell. A prisoner who supported newly arrived prisoners in the first night centre spoke to Mr Ansley and gave him something to eat. Shortly afterwards, the officer locked Mr Ansley in his cell.
36. Around 20 minutes later, Mr Ansley pressed his cell bell and the told prisoner who supports newly arrived prisoners that he had difficulty using his vape. An officer unlocked his cell so that the prisoner could show Mr Ansley what to do. The prisoner told us that Mr Ansley did not report any other issues and appeared to appreciate his help. The officer locked the cell and did not check on Mr Ansley until the next morning.

## Events on Thursday 7 February

37. The officer started the morning roll check at around 5.15am on 7 February. CCTV footage shows that when he reached Mr Ansley's cell, he turned on the night light and looked through the cell door observation hatch. He told us that he could see clearly inside the cell and that Mr Ansley was in bed, asleep. There is no evidence that he conducted any other overnight checks.
38. At around 8.35am, while conducting the morning unlock of prisoners, an officer looked through Mr Ansley's cell door observation hatch and saw him hanging by a ligature from the toilet door. He shouted to another officer and asked her to raise the general alarm, which she did at 8.37am. He entered the cell, cut the ligature and laid Mr Ansley on the floor, with assistance from the other officer. CCTV footage shows him leaving the cell 20 seconds later and calling out to another officer who was making her way towards him. At 8.38am, the officer radioed an emergency medical code blue (indicating that a prisoner is unconscious or has breathing difficulties).
39. Two officers arrived within one minute and started cardiopulmonary resuscitation (CPR). Two nurses arrived shortly afterwards and asked officers to move Mr Ansley out onto the landing for easier access. CPR continued while one nurse applied a defibrillator which did not detect a shockable rhythm. At 8.46am, paramedics arrived and took over resuscitation efforts. At 9.08am, a paramedic pronounced that Mr Ansley had died.

## Contact with Ansley's family

40. Later that morning, the prison appointed the Head of Residence, as the family liaison officer. The family liaison officer and a prison chaplain visited Mr Ansley's sister, his named next of kin, at 1.30pm. They broke the news of Mr Ansley's death and offered support. Mr Ansley's sister confirmed that Mr Ansley and his wife remained on good terms. At 3.00pm, the family liaison officer and a prison chaplain visited Mr Ansley's wife but she was not at home. They waited until 4.15pm when she returned home. They told her that Mr Ansley had died and offered their support.
41. On 11 February, Mr Ansley's sister-in-law contacted the family liaison officer and told him that Mr Ansley's wife had died. The Coroner told the family liaison officer that Mr Ansley's daughter was his next of kin. The family liaison officer continued to support Mr Ansley's daughter until his funeral, which he attended with a prison chaplain, on 27 February. The prison contributed towards the cost, in line with national instructions.

## Support for prisoners and staff

42. After Mr Ansley's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
43. The prison posted notices informing other prisoners of Mr Ansley's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Ansley's death.

## **Post-mortem report**

44. The post-mortem report established that the cause of Mr Ansley's death was hanging. No substances were identified in routine post-mortem toxicology tests.

# Findings

## Identifying risk of suicide and self harm

45. Prison Service Instruction (PSI) 07/2015 on early days in custody requires staff to manage newly arrived prisoners at risk of suicide and self-harm appropriately. PSI 07/2015 also states that, all relevant information available about the prisoner must be noted in the appropriate record and shared with other staff as necessary.
46. A PCLDS nurse told a HCA by telephone that Mr Ansley appeared to be masking his feelings and presented a high risk of suicide. He passed this information on verbally to two mental health nurses but nobody recorded it. The HCA told the investigator that Mr Ansley did not have a prison medical record at the time and therefore he could not make a note. While we recognise that he printed a copy of the PCLDS nurse's risk assessment, we are concerned that he did not ensure that the document was shared with relevant members of prison and healthcare staff.
47. PSI 07/2015 also requires staff to start ACCT procedures if they receive information about a prisoner's risk of suicide or self-harm. The HCA told us that he did not consider initiating ACCT procedures as he had fully updated a nurse who was to review Mr Ansley in reception. We consider that the HCA should have started ACCT procedures as this would have ensured that there was a record of the PCLDS nurse's concerns.
48. Mr Ansley arrived at Lewes with a suicide and self-harm warning form which indicated that he had been arrested at Beachy Head. An officer appropriately discussed this with Mr Ansley during his first night interview but failed to initiate ACCT procedures. He told us that Mr Ansley did not report any thoughts of suicide or self-harm and gave no indication that he presented an immediate risk. He said that although he was aware of Mr Ansley's alleged offences and that it was his first time in custody, he did not consider ACCT procedures as Mr Ansley maintained good eye contact and displayed a positive demeanour throughout the interview.
49. A nurse did not assess Mr Ansley as presenting a risk of suicide. He told us that Mr Ansley presented as "perfectly rational" throughout his health screen and did not do or say anything to suggest suicidal intent. He said that he spoke to Mr Ansley about going to Beachy Head several times but was not aware of the PCLDS nurse's concerns about Mr Ansley. He told us that although Mr Ansley became upset when talking about his alleged offences and his relationship with his wife, he felt that his behaviour was a normal reaction to the situation in which he found himself and did not consider that ACCT procedures were needed.
50. Irrespective of the concerns identified by the PCLDS nurse, Mr Ansley had a number of risk factors for suicide and self-harm which are set out in PSI 64/2011. These included that it was Mr Ansley's first time in prison, he had been charged with sexual offences and he was estranged from his family. In this context, staff relied too heavily on Mr Ansley's calm presentation. Although a prisoner's presentation can reveal something of their level of risk, it is only a reflection of their state of mind at the time that staff assess their risk and should be

considered as a single piece of evidence. It is critical that all risk factors are considered to ensure that a prisoner's level of risk is judged holistically.

51. The clinical reviewer concluded that the clinical care that Mr Ansley received in prison was not equivalent to that which he could have expected to receive in the community. He considered that healthcare staff failed to consider all of Mr Ansley's risk factors and relied too heavily on his reassuring demeanour. The clinical reviewer was also concerned that a nurse did not have access to the PCLDS's electronic medical record and was not aware of the local PCLDS policy for sharing concerns about a prisoner's risk of suicide and self-harm.
52. In our thematic report about risk factors in self-inflicted deaths published in April 2014, we identified that reception assessments often place too much weight on staff's perception of the prisoner and they do not always consider all relevant information. We reinforced these messages in a learning lessons bulletin, issued in February 2016, about early days and weeks in custody. It is very disappointing to see such a basic failing being repeated yet again in this case.
53. We consider that prison and healthcare staff at Lewes missed three opportunities to initiate ACCT procedures. Had they done so, prison staff would have had to complete an immediate action plan and consider protective measures such as regular observations and cell sharing. We therefore make the following recommendations:

**The Governor and Head of Healthcare should ensure that staff identify and manage newly arrived prisoners at risk of suicide and self harm in line with PSI 64/2011 and PSI 07/2015. In particular, reception, healthcare, first night staff and all others who assess risk should:**

- **recognise the additional vulnerabilities of newly arrived prisoners and have a clear understanding of their responsibilities and the need to share and record relevant information about risk;**
- **start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions;**
- **document the information considered when deciding whether or not to start ACCT procedures.**

**The Head of Healthcare should ensure that all healthcare staff are:**

- **aware of the PCLDS's local policy for sharing concerns about suicide and self harm; and**
- **able to access the electronic medical record used by PCLDS staff.**

54. We have previously made recommendations to address Lewes's failure to identify effectively whether newly arrived prisoners are at risk of suicide and self-harm. In December 2018, we drew our concerns to the attention of the Prison Group Director for Kent, Surrey and Sussex. In response, the PGD said that she had reviewed the ACCT management process in June 2018 and a report, which contained findings and recommendations for improvements, had been "disseminated to all interested parties". As part of the review, she had provided

Lewes with guidance to remind staff that any relevant information received about a prisoner's risk should be shared with all relevant parties.

55. The prison said that the Group Safety Team conducted an ACCT quality assurance visit in December 2018 and a 'Bus to Bed' review, in January 2019. They said that the Group Safety Team had made several recommendations and were working with Lewes to implement the changes by May 2019.
56. However, we are concerned that failures to adequately identify and manage the risk of suicide in Reception at Lewes have continued despite this intervention and consider that urgent action is now needed. We make the following recommendation:

**The Prison Group Director of Kent, Surrey and Essex Group should write personally to the Ombudsman setting out what she is doing to satisfy herself that meaningful action is being taken to improve the assessment and management of the risk of suicide at Lewes.**

### Overnight checks in the first night centre

57. Lewes has a local policy that requires staff in the first night centre to conduct two overnight checks on newly arrived prisoners. An officer locked Mr Ansley in his cell after he was shown how to use his vape but did not check on him until the morning roll check. He told the investigator that the procedure which required additional monitoring had been in place when he worked in the first night centre around three years earlier but he had thought that it was no longer in place. While additional overnight checks would not have made a difference in Mr Ansley's case as he was apparently seen asleep at the morning roll check, they could be critical in future cases. We therefore make the following recommendation:

**The Governor should remind all staff of the procedure for conducting overnight checks on newly arrived prisoners in the first night centre.**

### Emergency response

58. Lewes's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.
59. An officer asked another officer to press the general alarm when he found Mr Ansley hanging by a ligature. This meant that the control room did not call an ambulance until another officer radioed a medical code blue, causing a delay of around 30 seconds. The first officer told us that he asked for a general alarm instead of a code blue because the other officer "might not necessarily have known what was going on", and he did not want to "get staff there in a heightened sense of shock".
60. We disagree and consider that a code blue should have been called immediately to communicate the nature of the emergency. While radioing a code blue earlier would not have changed the outcome for Mr Ansley, in other circumstances, a delay could be critical. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff promptly use an emergency code to communicate the nature of the emergency.**

61. We consider that it is important for staff who were involved in Mr Ansley's care to see the findings of and learn lessons from our investigation and we have written separately to the Governor about this.

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