

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brett Lowe, a prisoner at HMP Nottingham, on 18 July 2018

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



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Brett Lowe was seriously assaulted by his cellmate on 18 July 2018 in the induction unit at HMP Nottingham. Mr Lowe was taken to hospital, but he was pronounced dead soon after his arrival. He was 43 years old. I offer my condolences to Mr Lowe's family and friends.

In October 2020, Mr Ferencz-Rudolf Pusok was convicted of Mr Lowe's murder.

I am very concerned about the sequence of events in this case. Mr Lowe rang his cell bell in the early hours of 18 July to say that Mr Pusok had tried to strangle him while he was sleeping. Although staff made several checks on the cell during the night, the prisoners were not separated. I have also identified a worrying contradiction in the evidence given by staff that warrants a prison investigation.

There was a further missed opportunity to separate the prisoners when day staff arrived. Record keeping and staff communication on the risk to Mr Lowe was woefully inadequate and, although Mr Lowe asked to move cells, he was locked back in the cell with Mr Pusok.

As is usual in the case of a homicide, we had to suspend our investigation until all the legal proceedings had been completed and this explains the lengthy delay before we could produce this report.

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

February 2022

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	7
Findings	12

Summary

Events

1. On 17 July 2018, Mr Brett Lowe was remanded to HMP Nottingham charged with burglary and linked offences.
2. Another prisoner, Mr Ferencz-Rudolf Pusok, had arrived at Nottingham on 16 July, to serve a 10 week sentence for leaving a train while still in motion and resisting arrest. Mr Pusok shared a cell that night with another prisoner.
3. On the morning of 17 July, Mr Pusok and the other prisoner were separated. In a statement to the police, the other prisoner said that he had complained to staff that Mr Pusok had boiled the kettle several times during the night for no reason while looking in his direction and he feared that Mr Pusok might pour boiling water over him.
4. Mr Lowe and Mr Pusok began sharing a cell on the evening of 17 July. At 3.31am on 18 July, Mr Lowe rang his cell bell and told staff that Mr Pusok had tried to strangle him while he was sleeping. No action was taken, and no record was made.
5. On the morning of 18 July, Mr Lowe went to the wing office to ask to move cells. The officer dealing with cell moves told Mr Lowe that she would move him later that day, and he was locked back in with Mr Pusok just before 9.00am.
6. At 10.21am, a substance misuse worker went to conduct a routine check on Mr Lowe and saw him on the cell floor in a pool of blood. He called for help and officers responded and went into the cell. One of the officers radioed a medical emergency code and healthcare staff responded immediately. Staff began efforts to resuscitate Mr Lowe. Paramedics arrived and, at 10.54am, they gained a pulse. Mr Lowe was taken to hospital, but he was pronounced dead at 12.08pm.
7. Mr Pusok was arrested by police on suspicion of murder. He was found guilty of murder on 26 October 2020 and sentenced to life imprisonment with a minimum term of 20 years.

Findings

8. Staff failed to record that another prisoner reported strange behaviour by Mr Pusok on the night of 16 July and Mr Pusok's cell sharing risk assessment (CSRA) was not reviewed.
9. We are concerned that no action was taken when Mr Lowe told night staff that Mr Pusok had tried to strangle him. Staff did not radio the Night Orderly Officer (NOO) to report Mr Lowe's allegation. They also failed to record it in the wing observation book and failed to brief the morning staff about the allegation.
10. The staff on duty in the early hours of 18 July gave inconsistent accounts of the events that night.
11. There was a further missed opportunity to separate Mr Lowe and Mr Pusok on the morning of 18 July when he spoke to the movements officer and asked to move cells.

Recommendations

- The Governor should ensure that prison staff record all significant events and concerns about prisoner behaviour in the wing observation book and NOMIS records.
- The Governor should ensure that prison staff review CSRA assessments if evidence comes to light that might suggest an increased level of risk to other prisoners.
- The Governor should commission a disciplinary investigation into the contradictory reports from the night officer, the OSG and the Night Orderly Officer on the events of the night of 17/18 July and take appropriate action on the investigation findings.
- The Governor should ensure that staff act appropriately and separate prisoners whenever there is a significant altercation between cellmates.
- The Governor should ensure that night staff provide a full briefing of any significant events to the oncoming day staff at handover.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator visited Nottingham on 25 July 2018. She obtained copies of relevant extracts from Mr Lowe's prison and medical records. We suspended our investigation while Nottinghamshire Police completed their investigation into Mr Pusok's involvement in Mr Lowe's death, and then while the Crown Prosecution Service considered whether to bring any additional charges. We resumed our investigation in April 2021 after the conclusion of the criminal proceedings.
14. The investigation was then transferred to another investigator. He interviewed four members of staff in person at HMP Nottingham and HMP Ranby in August 2021.
15. NHS England commissioned a clinical reviewer to review the care provided to Mr Lowe and Mr Pusok at Nottingham.
16. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation and have sent him a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Lowe's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Lowe's sister said that her brother was vulnerable, and she asked why he was put into a cell with a prisoner who presented with risks and why he was not moved to a new cell when he asked to move. We have addressed her questions in this report.
18. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.
19. We also shared the initial report with the solicitors representing Mr Lowe's family. The solicitors raised several queries which we have addressed in separate correspondence.

Background Information

HMP Nottingham

20. HMP Nottingham is a local prison serving the courts of Nottinghamshire and Derbyshire. It holds just over 1,000 men and young adult males on remand, convicted or sentenced. Nottinghamshire Healthcare NHS Foundation Trust provides health services. The prison has 24-hour primary care cover with mental healthcare available Monday to Friday, 8.00am to 5.00pm.
21. D Wing is Nottingham's induction wing. The wing holds a maximum of 155 prisoners. All cells are designed for double occupancy.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons (HMIP) carried out an announced inspection of Nottingham in December 2017 and January 2018. The Chief Inspector noted that this was the third successive inspection where Nottingham had again failed to achieve sufficient standards on any of the four tests for a healthy prison.
23. The Chief Inspector wrote that he was most concerned about safety where, on all three of the inspections, Nottingham's rating was judged to be poor (the lowest assessment level). The Chief Inspector noted that many prisoners reported feeling unsafe at Nottingham with 40% saying that they felt unsafe on their first night, and 67% that they felt unsafe at some point during their stay.
24. The Chief Inspector wrote that underpinning several of the problems at the prison, was the inexperience of many staff and middle managers with about half of wing based staff being within their first year of service. The Chief Inspector noted that his team observed officers doing their best and trying to be helpful, but that too many staff were passive and lacked the confidence to confront poor prisoner behaviour and to deal with issues.
25. On 18 January 2018, HMIP invoked the Urgent Notification process which committed the Secretary of State to respond publicly to the concerns raised within 28 calendar days. The Secretary of State responded on 12 February 2018 with an action plan to deliver improvements. He said, among other things, that a process would be introduced to deal with prisoners identified as posing a risk of harm to others.
26. HMIP carried out its latest inspection of Nottingham in January 2020. Inspectors noted that the first night centre had moved from D Wing to F Wing, which was a better environment. Three additional welfare checks during prisoners' first night on F Wing had been introduced.
27. The prison's data showed that the levels of violence were still far too high and that the number of assaults between prisoners over the past six months was above average. Inspectors found that wing staff had failed to report some violent incidents to the safer custody team, but they were now confident that those reported to the team were all investigated.

Independent Monitoring Board

28. 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 annual report for the year to February 2019, the IMB noted that there had been five deaths in custody during the reporting year, including that of Mr Lowe. The IMB noted that violence continued to be a very significant problem. The IMB noted a large increase in reported incidents of violence compared to the previous year but acknowledged that the increase could be due to improved recording of incidents.
29. In its latest annual report for the year to February 2020, the Board noted that violence continued to be a significant source of concern, although the Board had received fewer complaints of violence and bullying from prisoners, both in writing and in person. The prison had made efforts to identify triggers and flashpoints but incidents of violence against prisoners had remained stubbornly high, with overall levels of reported violence against prisoners increasing during the year to 375 recorded incidents compared with 341 in the previous year.

Previous deaths at HMP Nottingham

30. There was a previous homicide at Nottingham, which occurred in December 2015. There were no similarities between Mr Lowe's death and the previous homicide.
31. Mr Lowe was the tenth prisoner to die at Nottingham since July 2016. Eight of the previous deaths were self-inflicted and one was drug related. In one of the self-inflicted deaths, we found that Nottingham failed to adequately assess the man's fear that he might be at risk of assault from other prisoners.
32. Since Mr Lowe's death, there have been a further eight deaths at Nottingham, three of which were self-inflicted (the last in December 2018) and five were from natural causes.

Cell sharing risk assessments (CRSAs)

33. Prison Service Instruction (PSI) 20/2015, *Cell sharing risk assessment*, says that a prisoner's suitability to share a cell must be assessed whenever it is proposed to locate him or her with another prisoner. It sets out the process to be followed based on research into risks where two prisoners are located together in a locked cell. The purpose of the risk assessment tool is to help staff to identify prisoners at risk of murdering or very seriously assaulting another prisoner in a closed space.
34. The PSI says that the CSRA should be seen as a live document and all staff should be encouraged to report changes in a prisoner's behaviour which affects the CSRA risk issues.

Homicides in prison

35. Homicides in prison remain relatively uncommon. Prisons contain many people who pose a serious risk of harm to others, but very few kill in custody. Learning can

be slow to emerge from these deaths because of the need to build, but not prejudice, a criminal case against those responsible.

36. The PPO can only complete an investigation once the criminal process has finished. Unlike a criminal investigation, the PPO's remit is to examine the circumstances surrounding the death and establish whether anything can be done to help prevent similar tragedies in the future.
37. To that end we have published two Learning Lessons Bulletins on homicides in prison. The first, published in December 2013, noted a common theme that staff did not always have access to, or fully consider, all relevant information in a prisoner's record. As a result, staff were not always aware of the information held about the risk a prisoner posed. We said that staff should be made aware of a prisoner's history of violence.
38. In a further Learning Lessons Bulletin, issued in September 2016, we identified the need to better manage violence and debt in prison, not least that associated with the use of drugs. We also said that when a prisoner is identified as potentially at risk of harm from others, action should be taken to ensure they are appropriately protected and located in a safe place.

Key Events

Mr Ferencz-Rudolf Pusok

39. On 13 July 2018, Mr Ferencz-Rudolf Pusok was convicted of leaving a train while it was still in motion and of resisting arrest. He was sentenced to 10 weeks imprisonment and sent to HMP Nottingham on 16 July.
40. Mr Pusok's cell sharing risk assessment (CSRA) was recorded as standard risk, which meant that he was deemed suitable to share a cell. At around 6.30pm, he was moved to cell 2-06 on D Wing (Nottingham's induction wing).
41. Another prisoner remanded into Nottingham on 16 July shared cell D2-06 with Mr Pusok that night.
42. In a statement to the police made three months later, the other prisoner wrote that during the night of 16 July, Mr Pusok boiled the kettle a number of times for no apparent reason and looked in his direction. The other prisoner feared that Mr Pusok might pour boiling water over him, and he deliberately remained awake through the night. When the cell was unlocked the following morning, the other prisoner packed his belongings and told a female officer about Mr Pusok's behaviour. He said that he wanted to move cells and if he was made to stay in the same cell he might react by assaulting Mr Pusok as the best way to defend himself. The officer said that there was nothing she could do as there was no space available. The other prisoner was locked back in the cell with Mr Pusok, but in the early afternoon he was moved to a different wing.
43. An entry was made in Mr Pusok's record on 17 July that he had completed the prison induction process. No record was made that the other prisoner had complained about his behaviour.

Mr Brett Lowe

44. On the afternoon of 17 July, Mr Brett Lowe was remanded to Nottingham charged with burglary, theft, and fraud through making false representations in attempting to sell stolen goods.
45. At Nottingham, a reception nurse noted that Mr Lowe engaged well and admitted to using drugs. A urine test proved positive for cocaine and opiates. Mr Lowe said that he wanted to engage with mental health services, and the nurse referred him to the mental health team, to the substance misuse team and to the smoking cessation service.
46. Later that day, a prison GP saw Mr Lowe and noted that he had drug withdrawal symptoms. The GP prescribed methadone for opiate withdrawal and also prescribed a food supplement for malnutrition.
47. On the same day, an officer completed part 1 of Mr Lowe's CSRA and a nurse completed part 2 to say that Mr Lowe had no medical issues to indicate that he might present a risk to others. Part 3 of the CSRA should have been completed by either an officer or a manager to authorise the sharing decision, but this section was left blank.

17 July to 18 July: evening and night

48. Mr Lowe was moved into cell D2-06 at just after 7.00pm and began sharing with Mr Pusok.
49. At 10.33pm, a substance misuse worker checked Mr Lowe for drug withdrawal symptoms and noted that he was watching television and had no concerns.
50. At 3.14am on 18 July, Mr Pusok rang the cell bell and the night officer responded. (The night officer was an untrained newly appointed officer who was shadowing night staff for experience.) Mr Pusok asked for paracetamol and the officer told him that he could not give him any but that if he began to feel worse, he should ring the cell bell again.
51. At 3.31am, Mr Lowe rang the cell bell. When the night officer responded, Mr Lowe told him that Mr Pusok had tried to strangle him. An Operational Support Grade (OSG) also came to the cell and Mr Lowe repeated what he had said to the officer and said he wanted to move to a different cell. The OSG told Mr Lowe that he did not have the authority to move him, but he would speak to the Night Orderly Officer (NOO - the senior officer on duty at night).
52. The night officer and the OSG returned to the wing office, which was on the same landing as cell D2-06 and directly opposite (a distance of around six or seven metres). The officer said that he asked the OSG whether they needed to make an entry in the wing observation book, but the OSG said that there was no need to do that but that he would speak to the NOO.
53. The OSG told the investigator that before he had a chance to contact him, the NOO came to the wing while doing his rounds of the prison. The OSG said that he told the NOO what Mr Lowe had reported. He said the NOO told him to keep an eye on the prisoners and to contact him if anything else happened and then he would move one of the prisoners.
54. The night officer told the investigator that he was in the wing office when the OSG told the NOO about what Mr Lowe had said. He said that the OSG and NOO agreed that the prisoners should be monitored for any further problems.
55. The NOO told the investigator that he gained temporary promotion to the position of custodial manager in February 2017 and worked regular shifts as a NOO from that time. He said that his practice at night was to visit all the prison wings even if nothing of concern was reported to him. He said that he always carried a radio so the OSG would have been able to contact him immediately to report any problems. He said that the OSG did not radio him that night and that when he visited D Wing, the OSG did not tell him about the problem with Mr Lowe and Mr Pusok.
56. The NOO gave the investigator an occurrence log completed by the OSG in which the OSG had noted that the NOO visited the wing at 4.00am but had not recorded any concerns about that visit. The NOO also gave the investigator an email that the Prison Officers' Association (POA) had sent to the OSG on 20 July. The POA asked the OSG whether he had any involvement in the circumstances leading to Mr Lowe's death and the OSG replied on the same day to say that he was not involved.

57. The NOO said that he would have taken action if he had been told of a problem with Mr Lowe and Mr Pusok and he gave the investigator details of an incident from the night of 16 to 17 July 2018 when he separated two prisoners after he was alerted about them having a heated argument. He said he had personally spoken to both of the prisoners and recorded details of the incident in his operational report of the night.
58. The investigator viewed CCTV for the night, and he identified an officer, who appears to be the NOO, visiting the wing office at 3.56am and then leaving the wing ten minutes later, without visiting cell D2-06.
59. The night officer and the OSG checked cell D2-06 several further times but no other incidents occurred. At 6.04am, the substance misuse worker checked Mr Lowe again and noted that he appeared to be asleep.
60. When the day staff arrived on duty, no one told them about the problems between Mr Lowe and Mr Pusok.

18 July: daytime

61. At 8.25am, Mr Lowe was let out of his cell to go to his prison induction interview. His induction was cancelled so he spoke to some of the other prisoners. One of the prisoners told the police that Mr Lowe told him that Mr Pusok had tried to strangle him.
62. A Supervising Officer (SO) wrote a statement to say that Mr Lowe had spoken to him while he was in the medication queue. Mr Lowe said that his cellmate had been acting bizarrely through the night and he wanted to move cells. The SO told Mr Lowe to speak to an officer who was co-ordinating cell moves that day.
63. At 8.35am, Mr Lowe went to the wing office. Other prisoners were waiting to speak to officers and Mr Lowe walked away. He returned to the wing office 10 minutes later and spoke to the movements officer. In a written statement and in two interviews with police investigators, she said that Mr Lowe reported telling the night officer of problems with his cellmate and said that he wanted to move cells. She said that there was nothing relevant in the wing observation book about any problems overnight and when she tried to get further detail from Mr Lowe on the problem with Mr Pusok, he did not elaborate. She explained to Mr Lowe that she would be arranging various cell moves later that day and she asked him if he was okay to remain in the cell in the meantime. She said Mr Lowe said that he was okay with that.
64. An officer told the police that he was in the wing office when Mr Lowe asked to move cells. He said Mr Lowe said that his cellmate had tried to strangle him the night before. The officer said that the movements officer had asked him to check the observation book. He told the movements officer that there was nothing relevant in the observation book and she then told Mr Lowe that she would try to move him if he was in danger. (The investigator was unable to speak to either the movements officer or the other officer as both had left the Prison Service by the time the Ombudsman's investigation resumed.)
65. A prison chaplain had been looking for Mr Lowe as part of the induction process and they met on the landing at 8.53am. Mr Lowe told the chaplain about Mr Pusok

and said that he had reported the attack to officers. The chaplain assumed that the matter was being dealt with and after speaking with Mr Lowe for around two minutes, he left to continue with his duties.

66. At 8.57am, an officer locked Mr Lowe into cell D2-06. He told the police that both Mr Lowe and Mr Pusok seemed in reasonable spirits. He said that Mr Lowe asked him what time association would be and he told him it would be in the afternoon.
67. At 10.21am, a substance misuse worker went to cell D2-06 to check if Mr Lowe had drug withdrawal symptoms. When he looked through the observation panel, he saw Mr Lowe on the cell floor in a pool of blood and he shouted for assistance.
68. Two officers and an SO were in the wing office and they responded to the call for assistance. One officer wrote that when she looked through the cell door observation panel, she saw Mr Lowe on the cell floor with a clear plastic bag over his head and a ligature around his neck. She unlocked the door and Mr Pusok was taken out of the cell. Another officer radioed a code blue emergency (to indicate a prisoner is unconscious or having breathing difficulties). The control room logged the code blue call at 10.24am and an immediate call was made to the ambulance service.
69. One officer pierced the plastic bag and started cardiopulmonary resuscitation (CPR) while another officer used a face mask to give emergency breaths.
70. Nurses arrived at 10.24am. One nurse wrote that when she reached the cell, she saw two officers attempting to resuscitate Mr Lowe. She asked them to move so she could check him. As she did so she saw a ligature concealed within Mr Lowe's skin which she only saw when pressing on his neck. She instructed one of the officers to cut the ligature. (From the various witness statements, it seems that Mr Lowe had had two ligatures around his neck. One was visible and as it was only loosely around his neck, the officers had not removed it before starting CPR. The other ligature was very tight and indented into Mr Lowe's neck.)
71. Once the ligature was removed the nurses took over CPR. They also checked Mr Lowe with a defibrillator which instructed that no shock could be given, and that CPR should continue. A first response paramedic arrived at 10.36am followed at 10.49am by more paramedics. The paramedics gained a pulse at 10.54am and at 11.46am Mr Lowe was taken to hospital. He suffered a further cardiac arrest at hospital and was pronounced dead at 12.08pm.

Contact with Mr Lowe's family

72. After Mr Lowe was taken to hospital, an officer was appointed as the family liaison officer (FLO). At 12.20pm, the FLO and a senior prison manager left the prison to visit Mr Lowe's ex-partner, whom he had listed as his next of kin. The FLO and senior prison manager arrived at the address at 12.40pm and told Mr Lowe's ex-partner that Mr Lowe was seriously injured. She asked to visit him. At this point, the senior prison manager received a telephone call from the prison to inform him that Mr Lowe had died, and he passed the news to Mr Lowe's ex-partner. She told them that Mr Lowe had three children: a minor daughter, of whom she was the mother, and an adult son and daughter from a previous relationship. They then visited the home of Mr Lowe's sister to inform her of the news.

73. Nottingham was unable to trace a record that they contributed to the cost of Mr Lowe's funeral, so we asked his sister whether they contributed. To date, she has not confirmed whether or not they did so.

Support for prisoners and staff

74. Nottingham's Head of Residence 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.
75. The prison posted notices informing other prisoners of Mr Lowe'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 Lowe's death.

Post-mortem

76. At the post-mortem examination, the pathologist identified a combination of blunt and sharp force injuries with extensive bruising and lacerations to the back of Mr Lowe's head. The pathologist noted that the injuries could have been caused by Mr Lowe's head striking the cell floor during a fall, but might have been caused by his head being forcibly struck against a hard surface. The pathologist noted that Mr Lowe had suffered a subarachnoid haemorrhage and a broken jaw and had lost several teeth.
77. The pathologist also found evidence of sharp force injuries consistent with the use of scissors, or an improvised implement, and which seemed most likely to have been inflicted by a third party. The pathologist noted that Mr Lowe's head injury would not necessarily have led rapidly to his death and he found, instead, that Mr Lowe died as a result of the combination of ligature and manual strangulation.
78. Toxicological examination found the presence of methadone, cocaine, heroin, dihydrocodeine and amitriptyline, but each at a low concentration.

Police investigation and trial

79. Mr Pusok was arrested on 18 July and charged with murder. Mr Pusok initially pleaded not guilty, but on 26 October 2020 he changed his plea to guilty. On 20 November 2020, Mr Pusok was sentenced to life imprisonment with a minimum term of 20 years.

Findings

Cell sharing risk assessment (CSRA)

80. Prison Service Instruction (PSI) 20/2015, *Cell Sharing Risk Assessment*, sets out the process for identifying prisoners at risk of seriously assaulting or killing a cellmate in a locked cell. A CSRA is completed for each prisoner during reception and their assessment identifies them falling into one of two risk categories. High risk prisoners are those where there is a clear indication that they may be severely violent to a cellmate or that a cellmate may be severely violent to them. Standard risk prisoners are those where, based on the available evidence, there is no immediate risk of cell violence.
81. PSI 20/2015 explains that there are static risk factors, such as prisoners who have previously committed an in-cell homicide, and dynamic risk factors where there are changes in a prisoner's behaviour which can lead to a review of their CSRA assessment. The PSI notes that one erratic episode in a prisoner's behaviour may not trigger a CSRA review. However, it is essential that knowledge of all such incidents is recorded.
82. When Mr Pusok arrived at Nottingham on 16 July he was assessed as standard risk. This was an appropriate assessment based on his known risk factors at that time and he shared a cell that night with another prisoner.
83. The other prisoner's evidence was that on the morning of 17 July, he complained about Mr Pusok's behaviour during the night when Mr Pusok repeatedly boiled the kettle and he feared he would be assaulted. There is no record of the other prisoner's alleged report in the wing observation book or in the electronic (NOMIS) records for either prisoner. We cannot therefore comment on the accuracy of the other prisoner's evidence. However, even if correct, it is unlikely that the other prisoner's report alone would have resulted in Mr Pusok's CSRA being raised to high risk, although we would have expected a record to be made of any such report.
84. While we cannot conclude conclusively that the other prisoner complained about Mr Pusok, we nevertheless make the following recommendations:

The Governor should ensure that prison staff record all significant events and concerns about prisoner behaviour in the wing observation book and NOMIS records.

The Governor should ensure that prison staff review CSRA assessments if evidence comes to light that might suggest an increased level of risk to other prisoners.

Staff response: night of 17/18 July

85. Mr Lowe rang his cell bell at 3.31am on 18 July and the night officer and an OSG responded. Mr Lowe told them that Mr Pusok had tried to strangle him while he was sleeping. Neither of the officers recorded the event in the wing observation book or elsewhere, but the OSG said that he would report the matter to the NOO. The OSG said that the NOO happened to come to the wing at around this time and he told him what Mr Lowe had said. The OSG said that the NOO told him to

monitor the situation. The night officer said that he was present at the time and he concurred with the OSG's evidence. (We note that the night officer and the OSG checked cell D2-06 several further times after the NOO's visit).

86. The NOO's evidence was very different: he denied being told about Mr Lowe's report and said he would have taken action had he been told, as he did the previous night when he separated two prisoners. He also gave the investigator a copy of an email that the OSG sent to the Prison Officers' Association on 20 July in which the OSG said that he had had no involvement in the events leading to Mr Lowe's death.
87. The investigator viewed the CCTV coverage for the night and identified an officer, who he thought was the NOO, visiting the wing office at 3.56am.
88. We are extremely concerned about the sequence of events and the contradiction in the evidence from staff. Where several staff are involved in an incident, it is usual for there to be some difference in the recollection of events between staff: there will often be disagreement on precise timings and the actions taken by the staff involved. However, the situation in this case is very different. If the evidence of the night officer and the OSG is correct, the NOO failed to take appropriate action to protect Mr Lowe and he gave misleading evidence to the police and to the PPO investigator. If the evidence of the NOO is correct, then the night officer and the OSG colluded to mislead the police and the PPO investigator and to deflect blame onto the NOO. Either would be a very serious matter.
89. We are also concerned that the OSG did not immediately radio the NOO to inform him about Mr Lowe's complaint and further concerned that he did not make an entry in the wing observation book (about which we have already made a recommendation).
90. We make the following recommendations:

The Governor should commission a disciplinary investigation into the contradictory reports from the night officer, the OSG and the Night Orderly Officer on the events of the night of 17/18 July and take appropriate action on the investigation findings.

The Governor should ensure that staff act appropriately and separate prisoners whenever there is a significant altercation between cellmates.

Morning handover: 18 July

91. The OSG acknowledged that he should have made an appropriate entry in the wing observation book and acknowledged that he should have briefed the day staff at handover. We make the following recommendation:

The Governor should ensure that night staff provide a full briefing of any significant events at handover to the oncoming day staff.

Staff response: morning of 18 July

92. At 8.45am on 18 July, Mr Lowe spoke to the movements officer to ask to move cells. She told police investigators that Mr Lowe did not mention that Mr Pusok had attacked him during the night, and he did not seem concerned when she told him that she would move him after lunch when she was due to make other cell moves.
93. Another officer told the police that he was in the wing office at the time and Mr Lowe did say that his cellmate had tried to strangle him. In addition to his recollection, we note that another prisoner and the chaplain also said that Mr Lowe told them that Mr Pusok had tried to strangle him. It therefore seems highly improbable that Mr Lowe would not have told the movements officer why he wanted a cell move, especially given that he knew that she was the officer responsible for organising cell moves that day. It is unfortunate that there was no entry in the wing observation book to reinforce the urgency to move Mr Lowe, but we are satisfied, on balance, that Mr Lowe did explain why he wanted to move and that the prisoners should have been separated immediately. We have already made an appropriate recommendation, so we do not repeat it here.

Whether there was a delay in the staff response on 18 July

94. A prisoner who was in cell D2-07, the cell adjoining D2-06 occupied by Mr Lowe and Mr Pusok, told the police that he heard a lot of commotion from cell D2-06 and then a cell bell, but that it was 15 to 20 minutes before officers responded.
95. The prison did not have a system at that time to record cell bell usage, but the police and the investigator reviewed the CCTV. The position of the cell and the quality of the CCTV footage in daylight made it difficult to determine if the cell light illuminated. However, cell D2-06 was very close to the wing office and several officers passed the cell during the period leading up to the discovery of the assault without any indication that anything untoward was occurring in the cell. On balance, we conclude that we cannot rely on the evidence of the prisoner in cell D2-07.

Mr Lowe's clinical care

96. The clinical reviewer found that the care Mr Lowe received at Nottingham was of a good standard and appeared equivalent to that which he could have expected to receive in the community. She noted that he was prescribed appropriate treatment for substance misuse and that the emergency response appeared to have been managed appropriately and professionally.

Mr Pusok's clinical care

97. The clinical reviewer found that the care Mr Pusok received at Nottingham was of a reasonable standard and appeared equivalent to that which he could have expected to receive in the community. She noted that he was referred appropriately to mental health services for his reported history of depression.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100