Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Hamilton Lee, a prisoner at HMP Lewes, on 16 May 2021

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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

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 Hamilton Lee died of a hypoxic ischaemic brain injury on 16 May 2021 after he was found hanged in his cell at HMP Lewes the previous day. He was 21 years old. I offer my condolences to Mr Lee's family and friends.

This was Mr Lee's first time in prison. Although Mr Lee found his first weeks in prison difficult, he appeared to settle into custody and began to receive positive reports from staff. Around a month before his death, his attitude appeared to change, and his partner telephoned Lewes to express concern for his safety. While these issues were addressed, each was considered in isolation and there was little consideration of their effect on his overall risk.

My investigation also identified a culture at Lewes of prisoners covering their cell observations panels at night, with little evidence of action taken to address the issue. As Mr Lee had blocked his observation panel on the night he hanged himself, this contributed to a delay in unlocking his cell and providing emergency assistance.

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 **March 2022**

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Summary

Events

1. On 23 December 2020, Mr Hamilton Lee was remanded in custody to HMP High Down. It was his first time in prison and Mr Lee said that he had taken an overdose two weeks previously. Prison staff started Prison Service suicide and self-harm prevention procedures (known as ACCT).

2. On 3 January 2021, Mr Lee told staff that he had crushed and "sniffed" his medication because he "wanted to die". On 20 January, he said that he had cut his arm because he was worried about an upcoming court appearance.

3. On 2 February, Mr Lee was transferred to HMP Lewes following a court appearance. Staff told us that Mr Lee appeared "down" in his few weeks at Lewes, and he was reportedly the victim of an assault. He was assigned a cell with a safer custody representative, and staff told us that Mr Lee began to gain confidence as he settled into the prison. On 25 February, prison staff stopped ACCT monitoring.

4. Over the following weeks, Mr Lee received positive reports from staff and began to work, painting and refurbishing his wing.

5. On 20 April, Mr Lee's partner telephoned Lewes and said that Mr Lee had said he would "kill himself". An officer spoke to Mr Lee about this and told us that Mr Lee appeared to find it funny and indicated he had only said this to affect his partner. The officer did not make a record of this conversation so other staff were not aware of it.

6. At around the same time, prison staff began to make negative entries about Mr Lee's work ethic and attitude. This culminated in him losing his job and, on 10 May, he moved to a different wing as a result.

7. On 13 May, Mr Lee was due to receive a 'wellbeing check' from a wing officer. There is no record that this happened or that anyone formally spoke to him to see how he had settled onto the new wing or whether he had any concerns.

8. That day, Mr Lee made over 50 unanswered telephone calls to his partner. He left two voicemail messages, in which he said that he had been urinating and coughing blood for several weeks and was very worried about this. Mr Lee said that he had not told anyone about this and indicated that he had tried to end their relationship because he did not want his partner to be hurt "if anything did happen".

9. At around 8.30pm on 15 May, a night patrol officer found that Mr Lee had blocked his cell observation panel. The night patrol officer did not immediately summon assistance and when officers opened the cell over seven minutes later, they found Mr Lee hanging. Paramedics were called and took Mr Lee to hospital, where he died the following afternoon.

Findings

10. Mr Lee had some risk factors for suicide and self-harm. While some were not known to staff, we are concerned that others were treated in isolation and better communication, or consideration of Mr Lee's changing behaviour, might have led to them being considered holistically.

11. At the same time, there is little evidence that prison staff had meaningful contact with Mr Lee after he moved wings in the week before his death. We are therefore concerned that staff did not give themselves the best opportunity to identify any issues that Mr Lee might have had.

12. On the night that Mr Lee died, several cells on his wing had their observation panel blocked. We were told that this was not unusual. The blockage, and lack of clear local policy to deal with such incidents, contributed to a delay of several minutes before Mr Lee's cell was unlocked.

Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and in particular the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

- The Governor should ensure that there is an effective key worker and wellbeing scheme which provides meaningful and ongoing support to prisoners.

- The Governor should ensure that:

    - prisoners who block their observation panels are challenged, blockages are removed, and frequent offenders receive appropriate disciplinary action or support; and

    - staff are aware of national guidance and understand their responsibilities when they find a cell observation panel obscured.

The Investigation Process

13. 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. He obtained copies of relevant extracts from Mr Lee's prison and medical records.

14. The investigator interviewed nine members of staff in July and August 2021. NHS England commissioned a clinical reviewer to review Mr Lee's clinical care at the prison. They jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the restrictions in place in response to the COVID-19 pandemic.

15. We informed HM Coroner for East Sussex of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Lee's mother and sister to explain the investigation and to ask if they had any matters they wanted us to consider. They asked some questions which we have addressed in separate correspondence, and the following questions which we have addressed in this report:

    - How long had Mr Lee been in his cell before he was found on 15 May, and what happened at that time?
    - Why did Mr Lee lose his job and move wings?
    - Should prison staff have been more aware of Mr Lee's mental ill-health and risk of suicide and self-harm and therefore done more to ensure his wellbeing?
    - Was there any evidence that Mr Lee was being bullied by other prisoners?

17. We shared the initial report with HM Prison and Probation Service (HMPPS). They identified two factual inaccuracies, which we have amended accordingly.

18. We also shared the initial report with Mr Lee's mother and sister. They did not make any comments.

Background Information

HMP Lewes

19. HMP Lewes is a local prison serving the courts of East and West Sussex, holding up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services and healthcare staff are on duty 24-hours a day.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Lewes was in January 2019. Inspectors reported that performance in terms of safety was poor and would reach the lowest possible level unless there was decisive intervention. They found that levels of self-harm were high and ACCT procedures were poor overall.

21. In December 2019, HMIP carried out an Independent Review of Progress, which followed up 12 of the 53 recommendations they had made after their January inspection. Inspectors reported that there had been reasonable progress against their recommendation that the prison should implement a strategy to reduce self-harm. They found that the number of incidents of self-harm had decreased by over a third in the six months before the inspection.

Independent Monitoring Board

22. 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 January 2021, the IMB reported that the severely restricted regime required by the COVID-19 pandemic, which meant that many prisoners were in their cells for 23 hours a day, had led to the prison becoming much safer for many prisoners due to a reduction in violence. The IMB reported that there had been a reduction in the number of incidents of self-harm, although ACCT procedures were started at around the same frequency as the previous reporting year.

Previous deaths at HMP Lewes

23. Mr Lee was the ninth prisoner to die at Lewes since May 2019, and the third to take his own life. Our investigation into the self-inflicted death of a prisoner in January 2021 found that prison staff did not properly assess his risk of suicide and self-harm. (The prison has not yet responded to this recommendation.)

Assessment, Care in Custody and Teamwork

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm.

Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

25. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

26. In September 2018, Mr Hamilton Lee was diagnosed with post-traumatic stress disorder (PTSD), when he described feelings of anxiety after being the victim of violence in the community. He told a doctor that he had occasional thoughts of self-harm but that he did not feel suicidal. The doctor prescribed antidepressants.

27. On 23 December 2020, Mr Lee was remanded in custody on a charge of false imprisonment. He was 21 years old, and it was his first time in prison. Court staff completed a suicide and self-harm warning form (to identify new prisoners at risk of suicide and self-harm) and recorded that Mr Lee said that he had taken an "overdose" two weeks earlier. They also recorded that Mr Lee was very upset and worried about going to prison and that he said he would not be able to cope.

HMP High Down

28. Reception staff at HMP High Down started ACCT procedures when Mr Lee arrived later that day. A nurse referred him to the mental health team and, the next day, a prison doctor prescribed a course of sertraline (an antidepressant).

29. On 24 December, an officer assessed Mr Lee's risk of suicide and self-harm. He recorded that Mr Lee described a history of PTSD, anxiety and depression and that his mood was very low. Mr Lee said that he had tried to hang himself in June 2020 after his father died and spoke about his recent overdose. Mr Lee said that he did not want to die but wanted to get out of prison to see his partner and her baby.

30. Over the following week, prison staff recorded that Mr Lee was doing "much better". He described his partner and her baby as protective factors and said that he would not hurt himself as he wanted to be with them when he was released.

31. On 31 December, a mental health nurse assessed Mr Lee. He recorded that Mr Lee was settled and that his mental state was stable with no indication of psychotic symptoms. Mr Lee said that he felt stressed and anxious because of his upcoming court case and the potential impact of a long sentence on his relationship. He requested an increased dose of his sertraline prescription. The nurse discussed a referral to a psychologist, which Mr Lee declined.

32. On 3 January 2021, Mr Lee told prison staff that he had crushed his medication and "sniffed" it because he "wanted to die". Prison staff increased the frequency of ACCT observations.

33. On 4 January, the mental health multidisciplinary team discussed Mr Lee's assessment. They incorrectly recorded that Mr Lee was not being managed under ACCT procedures. A prison doctor increased the dose of sertraline and the team agreed to discharge Mr Lee from their caseload.

34. On 18 January, Mr Lee's partner telephoned High Down and said that he had told her that he was not coping well and had self-harmed. Mr Lee's cellmate also told prison staff that Mr Lee had harmed himself.

35. On 20 January, Mr Lee told prison and healthcare staff that he had cut his left arm. He said that he was worried about an upcoming court appearance (on 2 February) and that this was affecting his sleep. A prison doctor prescribed a course of sleeping tablets.

36. On 29 January, Mr Lee told an ACCT case review that he was struggling with being in prison because he was not there for his family.

HMP Lewes

37. On 2 February, Mr Lee was transferred to HMP Lewes following a court appearance at which he was remanded in custody to await trial on 9 August.

38. A nurse assessed him on arrival, and recorded that Mr Lee said he was "always having thoughts of self-harm" but denied any current intention to harm himself. An officer conducted a first night interview and recorded that Mr Lee seemed "very down".

39. On 8 February, the mental health team met to discuss new referrals, including Mr Lee. They added him to the team's caseload for assessment.

40. That day, Mr Lee's sister telephoned Lewes and told prison staff that he said that he had been attacked in the showers. An officer spoke to Mr Lee as a result, who confirmed that the incident had happened but would not provide any further information about it. Mr Lee said that the matter was now resolved. The officer recorded that he had advised Mr Lee to report any future incidents to staff so that they could help him.

41. Shortly afterwards, Mr Lee began to share a cell with a wing safer custody representative. Staff recorded that he was more upbeat and positive as a result.

42. On 18 February, an assistant psychologist assessed Mr Lee, under the supervision of a clinical psychologist. She recorded that Mr Lee appeared low and tearful. He spoke about the death of his father and said that his partner was supportive but struggled with him being in prison. The assistant psychologist recorded that Mr Lee had been offered therapy but chose not to accept it. Mr Lee said that he did not find his medication helpful, and she referred him to the prison doctor for a medication review. The assistant psychologist recorded that Mr Lee said that he had some suicidal thoughts but no plans to act on them. She concluded that he did not require any further support from the mental health team and Mr Lee was subsequently removed from their caseload.

43. A Supervising Officer (SO) then led an ACCT case review, with the assistant psychologist providing feedback beforehand. (The assistant psychologist told us that she chose not to attend the case review as she did not think that revisiting the issues discussed in the assessment would be beneficial for Mr Lee as he had been tearful for much of it.) The SO recorded that Mr Lee was growing in confidence and settling on the wing, but that he still felt low.

44. On 19 February, Mr Lee declined to attend an appointment with the prison doctor. He told wing staff that he did not need to see the doctor.

45. On 25 February, the SO led an ACCT case review, with a mental health nurse and prison chaplain also present. Mr Lee said that he was struggling with his relationship as his partner had been unfaithful to him and that he worried about his partner's child, who he said had been born prematurely. He said that he had not harmed himself for some time and had many things to live for. Mr Lee also said that he had good support from his cellmate. The panel agreed to stop ACCT monitoring.

46. On 1 March, an SO completed an ACCT post-closure welfare check (conducted by a member of the Safety Team to check on how the prisoner is coping during the post-closure period). She recorded that Mr Lee had started work, painting and refurbishing the wing, which he enjoyed. Mr Lee spoke about aspects of his relationship with his partner that had caused him distress but said he would "get through it".

47. Over the following weeks, Mr Lee received several positive reports from staff about his work. They recorded that he was progressing well and had no concerns.

48. On 20 April, Mr Lee's partner telephoned Lewes and told a member of the safer custody team that they had argued on the telephone in the morning and that Mr Lee had said he would kill himself. The member of the safer custody team asked an officer, who worked on Mr Lee's wing, to speak to him about this. She recorded that the officer told her that Mr Lee had said that she was his ex-partner, that he was fine, and that he "couldn't care less" if prison staff telephoned her to report on his welfare.

49. The officer did not make a record of this conversation. He told us that he spoke to Mr Lee, who laughed and appeared to find it funny. He said that Mr Lee told him that he said he would harm himself because he wanted to "show" his partner and that he did not want to speak to her again. The officer said that Mr Lee did not seem fazed or upset.

50. The same day, an officer recorded that Mr Lee's work ethic had deteriorated significantly. He recorded that Mr Lee "rarely does the minimum" and asks others to do his work for him. The next day, another officer recorded that Mr Lee's behaviour and attitude had deteriorated and he did not appear to take any conversation about this seriously. She recorded that a supervising officer had warned Mr Lee that he would lose his job if his attitude did not improve.

51. On 23 April, Mr Lee declined an appointment with a prison doctor. He said that he thought the appointment was about his mental health medication and that he was happy with his current prescription. (The appointment was actually to review his acne medication.)

52. That day, an officer recorded that Mr Lee engaged well with prisoners and some staff, but sometimes displayed a poor attitude with other staff. He told us that Mr Lee got on well with some staff but not with others and that he could be immature and argumentative.

53. On 27 April, an officer recorded that Mr Lee was progressing well. He recorded that Mr Lee was helpful to new residents on the wing. He told us that when Mr Lee first lived on the wing, he appeared "down" and said that this was because he was

worried about his partner and her baby. He said that Mr Lee improved considerably over time and was always positive.

54. On 5 May, Mr Lee moved into a new cell on the same wing. An officer told us that his former cellmate (Mr Lee no longer shared with the safer custody representative) had said that Mr Lee had a difficult relationship with his partner and that their difficulties were impacting on him when he had his own problems to deal with. The officer said that Mr Lee appeared accepting of this and moved cell without complaint. He told us that there did not appear to be any ongoing problems between Mr Lee and the other prisoner after this.

Move to M Wing

55. On 10 May, Mr Lee moved to M Wing. The recent concerns about Mr Lee's attitude meant that he had lost his job and he therefore no longer fitted the criteria for A Wing. As all of the cells on M Wing are single cells, Mr Lee now lived in a cell on his own. All of the cells have an in-cell telephone.

56. During the COVID-19 pandemic prisoners on M Wing (and elsewhere in the prison) received a 'wellbeing check' once a week, to see how they are and whether they have any questions or issues. The day of the check depended on which cell they are allocated. Mr Lee's wellbeing check was scheduled for Thursdays. His first Thursday on M Wing was on 13 May but there is no record that a wellbeing check took place. An M Wing manager told us that short staffing meant that wellbeing checks were not always completed.

57. On 13 May, Mr Lee made 36 unanswered telephone calls to his partner from 9.05pm to 9.40pm. At 9.41pm, he left a voicemail message for his partner. In the message, Mr Lee said that he had been "lying" to his partner for a month and a half and was now calling to tell her the truth. He said that he had been "pissing blood" for a month and a half and felt light-headed and dizzy. He said that he had not told anyone about this. (All prisoners' telephone calls are recorded. Security staff listen to some calls at random or if staff have intelligence that might indicate information about the safety of individuals, or the prison has been discussed. Mr Lee's telephone calls were not listened to until after his death.)

58. From 9.50pm to 10.06pm, Mr Lee made a further 25 unanswered telephone calls to his partner. At 10.12pm, he left a voicemail message in which he said that he was "pissing and coughing blood". Mr Lee said that he would "get it checked out but it's getting worse". He said that he had tried to end their relationship because "I don't want to hurt you if anything did happen". Mr Lee asked his partner not to tell anyone else in his family. He said that he should have got it "sorted" sooner but felt like he was giving up and was "scared of what it could be". Mr Lee said that he would speak to his partner the following Tuesday (18 May) and reiterated that he did not want to hurt her. His telephone credit then expired.

15 May 2021

59. Due to COVID-19 restrictions, prisoners who did not work (such as Mr Lee) spent most of the day in their cells. A wing manager told us that prisoners on each landing would be unlocked for an hour in the morning for a domestic period in which

they could participate in activities such as exercise and showering. At lunchtime, prisoners collected a hot meal and a bag containing their evening meal and breakfast for the next day. They were then locked in their cells for the remainder of the day.

60. At around 8.30pm, the night patrol officer began a count of prisoners. CCTV footage shows that he spent 30 seconds at Mr Lee's cell. He told us that Mr Lee's observation panel was blocked and that he could not therefore see into the cell. The night patrol officer said that this was not an unusual occurrence and that there could be up to 16 cells with their observation panel blocked on any one night. He said that he could not get a response from Mr Lee and therefore continued to check the other cells on the landing.

61. Two and a half minutes after leaving Mr Lee's cell, the night patrol officer returned and spent around 17 seconds trying to look into it. He told us that he could see part of the bed by looking through a gap in the side of the door and that Mr Lee was not on the bed. He said that this made him more worried than previously.

62. The night patrol officer then went to the staff office, where he found an officer (who was not based on the wing overnight but had visited to drop off a piece of equipment for the night patrol officer). The officer radioed for assistance. He told us that local practice is that three members of staff should be present before a cell door can be unlocked in these circumstances.

63. A second officer responded. The three staff then went to and opened Mr Lee's cell, four and a half minutes after the night patrol officer had last left it. They found Mr Lee hanged from a ligature which he had made from a bed sheet and tied to the light fitting. The night patrol officer radioed a medical emergency code blue, indicating a life-threatening situation. The control room operator telephoned for an ambulance. The officers present removed the ligature and began cardiopulmonary resuscitation. Around three minutes later, a nurse arrived and took charge of the resuscitation efforts.

64. At 8.55pm, the first paramedics arrived. At 9.39pm, they took Mr Lee from Lewes to the Royal Sussex County Hospital. He died at 2.20pm on 16 May.

65. Prison staff found a note in Mr Lee's cell in which he wrote, "Tell [my partner] that I'm sorry but her and [her daughter] are better off without me, I'm not worth the hassle or time".

Contact with Mr Lee's family

66. On the night of 15 May, a prison family liaison officer tried to telephone Mr Lee's partner, his nominated next of kin, but the calls were unanswered. At around midnight, he contacted Hampshire Police to obtain the telephone number for a woman who was listed in prison records as Mr Lee's mother. At around 12.35am on 16 May, he spoke to the woman, who told him that she was Mr Lee's partner's mother. He explained the events, and Mr Lee's partner's mother said that she would inform Mr Lee's partner and biological mother. All of the family were with Mr Lee in hospital when he died.

Support for prisoners and staff

67. After Mr Lee's death, an operational 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.

Post-mortem report

68. A post-mortem examination established that Mr Lee died from a hypoxic ischaemic brain injury (lack of oxygen to the brain) caused by hanging.

Findings

Identifying the risk of suicide and self-harm

69. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Lewes should have recognised Mr Lee as at risk and begun ACCT procedures to support him.

70. Mr Lee had some risk factors for suicide and self-harm. It was his first time in prison, and he had been appropriately supported by ACCT procedures during his first weeks in custody while he settled into prison life. He had been the victim of an assault shortly after he transferred to Lewes. Mr Lee was prescribed antidepressants and had been diagnosed with PTSD following an assault in the community. Staff also knew that Mr Lee was worried about his relationship with his partner.

71. After some initial difficulties, Mr Lee appeared to settle well at Lewes. Staff took some positive action to support him, including allocating him a cell with a safer custody representative and identifying a job that gave him more time out of cell than many prisoners. As a result, staff began to write positively about his progress.

72. However, from mid to late April, prison staff began to raise concerns about a deterioration in Mr Lee's attitude and work ethic, which eventually resulted in him losing his job. At the same time, his partner identified that Mr Lee had threatened to take his own life. Although an officer spoke to Mr Lee about this, he did not record either Mr Lee's partner's concerns or the conversation he had with Mr Lee. This meant that other staff who worked with Mr Lee did not know about these events and their potential impact on his risk.

73. Significantly, the content of Mr Lee's voice messages to his partner shortly before he died indicates that he had been very worried about a physical health issue (that he had kept to himself) throughout this time.

74. While Mr Lee received some good support, we are concerned that the events of the month before his death were treated in isolation. Better communication might have led to his risk factors being considered holistically. While this would not automatically have led staff to start ACCT procedures, they should have considered this in the light of Mr Lee's increasing risk factors. We make the following recommendation:

    The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

Staff-prisoner relationships

75. Under the Offender Management in Custody model, each prison officer is the named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations with each prisoner. In March 2020, HM Prison and Probation Service (HMPPS) suspended key work due to the COVID-19 pandemic. On 12 May 2020, key work was reintroduced but delivered in a more limited way in line with an Exceptional Delivery Model, where priority prisoners received key work. Priority prisoners include those being monitored under ACCT procedures.

76. At Lewes, men such as Mr Lee who are not considered 'priority' prisoners should receive a wellbeing check once a week, in which a duty officer will speak to them and give them the opportunity to raise any issues or ask questions. On A Wing, Mr Lee received a wellbeing check most weeks.

77. Following his move to M Wing, Mr Lee's cell location meant he should have received a wellbeing check on Thursdays. There is no record of a wellbeing check on Thursday 13 May, or that anyone spoke to Mr Lee at any time following his move to the wing to see how he was settling or whether he had any concerns.

78. While we appreciate the pressures that prisons are under, we consider it vital that prisoners have the opportunity to speak to staff on a one to one basis through key work or wellbeing checks. Staff engagement is particularly important when a prisoner has moved to a new wing, particularly if the move was due to negative reasons such as the loss of a job. Without such contact, it is more difficult for staff to identify whether a prisoner has any issues or might be more vulnerable to suicide and self-harm. We make the following recommendation:

    The Governor should ensure that there is an effective key worker and wellbeing scheme which provides meaningful and ongoing support to prisoners.

Mental health care

79. The clinical reviewer considered that Mr Lee was appropriately referred to the mental health team on his arrival at Lewes and his medication was promptly identified and prescribed. Following assessment, Mr Lee was offered therapy, which he declined. The clinical reviewer concluded that Mr Lee received mental health care of a good standard and equivalent to that which he could have expected to receive in the community.

Emergency response

80. The night patrol officer told us that it was not unusual for prisoners to block their observation panels at night. He said that, in his experience, up to 16 cells on the wing could have their panel blocked on any one night.

81. Lewes does not have a local policy to tell staff what to do if they find a cell observation panel obscured. An HMPPS Safety Briefing on Observation Panels,

issued in February 2018, states that when staff discover that a panel has been blocked, and the prisoner does not comply with instructions to remove the blockage, they must take immediate action to remove the obstruction and check on the prisoner's welfare. In such circumstances, we would usually expect staff who cannot see or speak to a prisoner to radio for help from other staff and remain at the cell door. If they believe the prisoner may be at risk, they should assess the risk of opening the cell door before help arrives.

82. After first identifying that Mr Lee's observation panel was blocked, and not receiving a response, the night patrol officer continued his count of prisoners. When he returned to the cell, around two and a half minutes later, he was "more worried". He returned to the wing office, where a visiting officer radioed for assistance. Mr Lee's cell was opened when a third colleague responded, over seven minutes after the night patrol officer first discovered the blocked observation panel.

83. Our view is that the night patrol officer should have taken action to ensure that Mr Lee's cell observation panel was clear, including calling the Night Orderly Officer and, if necessary, opening the cell to remove the blockage and check Mr Lee's welfare. It appears that the culture at Lewes, where prisoners frequently block their observation panels with little consequence, contributed to his decision not to take more urgent action. We make the following recommendation:

The Governor should ensure that:

- **prisoners who block their observation panels are challenged, blockages are removed, and frequent offenders receive appropriate disciplinary action or support; and**
- **staff are aware of national guidance and understand their responsibilities when they find a cell observation panel obscured.**

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