

**Prisons &
Probation**

Ombudsman
Independent Investigations

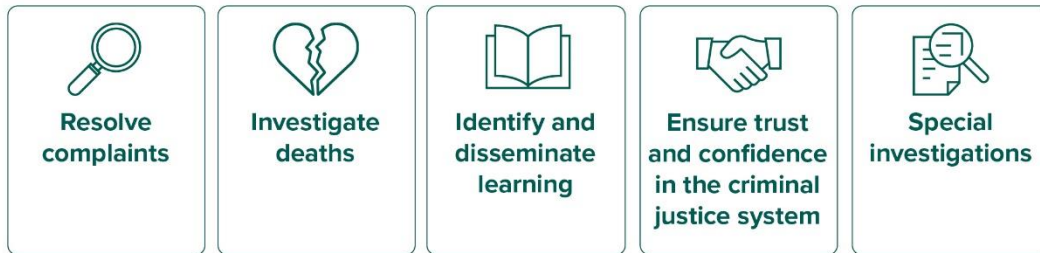
Independent investigation into the death of Mr Ricky Coombs, a prisoner at HMP/YOI Lewes, on 18 June 2018

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Coombs died on 18 June 2018 after being found hanging in his cell at HMP Lewes. Mr Coombs was 25 years old. I offer my condolences to Mr Coombs' family and friends.

Mr Coombs had only been at Lewes for six days before he died. He had recently tried to kill himself, was diagnosed with depression, had relationship issues, his licence had been revoked and he had been recalled to prison. There is no evidence that these risk factors were considered when he arrived at Lewes or that staff considered monitoring him under suicide and self-harm monitoring procedures (known as ACCT).

On 15 June, staff started suicide and self-harm monitoring when Mr Coombs said he was having suicidal thoughts. However, I am concerned that prison staff did not assess his risk properly or identify appropriate care map actions and that the ACCT was not managed in line with the correct procedures. Staff relied too heavily on Mr Coombs' saying that he had no suicidal intentions.

Our investigation has also identified deficiencies in healthcare procedures.

This is not the first time my office has identified concerns about the management of ACCT procedures at Lewes, and I have, therefore, escalated my concerns to the Prison Group Director responsible for Lewes.

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

April 2019

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Summary

Events

1. Mr Ricky Coombs was remanded into custody at HMP Lewes on 11 June 2018, charged with assault on a constable, driving while disqualified, threats to kill, criminal damage and assault. Mr Coombs had been released from custody in December 2017 on home detention curfew and at the time of his arrest was still subject to licence conditions which were due to expire on 1 July 2018.
2. At his initial health screen, a nurse recorded that Mr Coombs had depression, was prescribed antidepressant medication and had recently attempted to hang himself because of relationship problems. Mr Coombs said he had no current thoughts of self-harm. Escort officers passed Mr Coombs' court records to prison reception officers, which also recorded his recent suicide attempt and diagnosis of depression. Despite his recent history, staff did not start suicide and self-harm prevention measures and did not record the reason for this decision.
3. Mr Coombs was referred for a mental health assessment, but this was not prioritised and had not taken place before he died.
4. Mr Coombs was allocated a shared cell on the first night centre. Over the next two days, he refused to move to another wing because he said he had issues with other prisoners. This resulted in him being subject to disciplinary measures.
5. On 15 June, Mr Coombs told a member of the mental health team that he was having suicidal thoughts, so officers started suicide and self-harm procedures (known as ACCT). Mr Coombs said he had thought about hanging himself because he had his television removed when he refused to move wings. He said he would feel better if he could have his television back or be given a telephone call. Officers returned his television later that day.
6. Mr Coombs moved wings on 16 June and seemed to settle. On Monday 18 June, he did not want to leave his cell for exercise, but an officer told us that he seemed fine. He left his cell later that morning, spoke to prisoners on the wing and an officer told us that he seemed happy when he was locked back in his cell again.
7. At around 11.00am, Mr Coombs was found barricaded in his cell, and suspended by a ligature from cell furniture. Officers and nurses started cardiopulmonary resuscitation (CPR) and were assisted by paramedics, who arrived at 11.35am. Despite their best efforts, paramedics pronounced Mr Coombs dead at 11.56am.

Findings

8. We are concerned that reception staff did not consider starting suicide and self-harm monitoring procedures when Mr Coombs first arrived at Lewes or record their reason for not doing so. Mr Coombs told staff about several factors that increased his risk, including a recent suicide attempt, depression and relationship problems. These risk factors were also reflected in his court records.

9. When officers started ACCT monitoring four days later, Mr Coombs' caremap did not set out his individual risk or protective factors and did not meet the requirements set out in Prison Service instructions. A single supervising officer held case reviews, without consultation with other staff. It was not clearly recorded how frequently officers should check Mr Coombs and there were up to six hours between recorded checks.
10. We have made recommendations about the management of ACCT at Lewes before and now escalate the matter to the local Prison Group Director.
11. We also found deficiencies in healthcare procedures. Healthcare staff did not attend the first ACCT review and, although we were told Mr Coombs' mental health assessment would have been prioritised when an ACCT was opened, and that he would have been assessed within a week, we have seen no evidence that any arrangements were put in place for this to happen.

Recommendations

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- Staff identify, consider and record all known risk factors for a prisoner when determining their risk of suicide or self-harm.
- Where there are risk factors, but a decision is made not to begin ACCT monitoring, the reasons are clearly recorded.
- Staff set caremap actions designed to reduce the prisoner's risk of suicide and self-harm and reflect the current risks and review them at each case review to ensure actions are completed.
- Staff should complete all ACCT documentation accurately and legibly.
- Frequency of conversations and observations must be clearly recorded on the front cover and in line with agreed policy.
- ACCT reviews must be multidisciplinary, and no review should take place with a single member of staff.

The Prison Group Director for Kent, Surrey and Sussex should:

- Review the poor management of ACCT in respect of Mr Coombs; and
- Report back to the PPO, within three months of the issue of this report, on what he has found, including why Mr Coombs was not placed on an ACCT when he arrived at Lewes, and what actions he is taking to ensure that the ACCT procedures set out in PSI 64/2011 will be properly followed at Lewes in future.

The Head of Healthcare should establish why healthcare staff were not present for the first ACCT review and provide a report to the commissioners that provides assurance that healthcare staff will be involved in ACCT reviews in future.

The Head of Healthcare should put a process in place to ensure mental health assessments are prioritised for any prisoner placed on an ACCT and take place within one week of the ACCT being opened.

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 20 June. He obtained copies of relevant extracts from Mr Coombs' prison and medical records.
14. The investigator interviewed three members of staff and one prisoner at Lewes on 13 July.
15. NHS England commissioned a clinical reviewer to review Mr Coombs' clinical care at the prison.
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. One of the Ombudsman's managers contacted Mr Coombs' mother to explain the investigation and to ask if she had any matters the family wanted the investigation to consider. Mr Coombs' mother said that she was aware her son had been subject to suicide and self-harm monitoring, and asked the investigator to consider:
 - Why was he only observed three times during the day and three times at night?
 - Why was he moved into a single cell?
18. Mr Coombs' family received a copy of the initial report. The solicitor representing them 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.

Background Information

HMP Lewes

19. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 prisoners. Sussex Partnership NHS Foundation Trust provides primary care services. HMP Lewes has a healthcare centre with a full time senior medical officer, which makes use of specialist NHS facilities when needed. 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

20. The most recent inspection of HMP Lewes was in January 2016. Inspectors reported that the level of self-harm among prisoners was relatively low, but those at risk felt they did not receive sufficient support. Inspectors said that the suicide prevention management was poor, and prisoners said they did not feel well cared for. Caremaps did not reflect all issues identified during a prisoner's assessment, attendance at case reviews was poor, case managers were inconsistent and few caremaps were updated.

Independent Monitoring Board

21. 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 2018, the IMB reported that incidents of self-harm had increased nationally, and this was reflected at HMP Lewes. The Board was concerned about the increasing number of prisoners who were depressed, frightened and worried for their safety and wellbeing.

Previous deaths at HMP Lewes

22. Mr Coombs was the fourth prisoner to take his own life at Lewes since February 2016. In previous investigations, this office has been critical of failings in the suicide prevention procedures, including prison staff's failure to identify a prisoner's level of risk properly, inadequate observation levels and poorly completed caremaps. We have found several of the same failings in this investigation.

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular

multidisciplinary reviews and should not close the ACCT until all the actions are completed.

Key Events

24. Mr Ricky Coombs was remanded into custody on 11 June 2018, charged with assaulting a police officer, driving while disqualified, threats to kill, criminal damage and assault. Mr Coombs had been released from prison in December 2017 on home detention curfew (HDC) and at the time of his arrest was still subject to licence conditions which were due to expire on 1 July 2018.
25. When Mr Coombs arrived at Lewes, escort officers passed prison officers his records, including paperwork that had been completed while Mr Coombs was in police custody. The paperwork said that Mr Coombs had been observed every 30 minutes after he said that he had depression and thoughts of self-harm. In addition, the person escort record (PER), which accompanies everyone escorted between custodial environments, recorded in the risks section that Mr Coombs had previously tied clothing around his neck while in custody.
26. During an initial health screen, a nurse recorded that Mr Coombs said that he had no problems with illicit drugs or alcohol. He told the nurse that he had recently been diagnosed with depression and prescribed antidepressant medication. He also said that he had recently tried to kill himself but had been discovered by his girlfriend. Mr Coombs said that he had no current thoughts, plans or intent of harming himself.
27. The nurse sent a routine referral for Mr Coombs to be seen by the mental health team and indicated that he required antidepressant medication to be re-prescribed. (A matron told the clinical reviewer that the initial referral would have been triaged as medium to low priority, but once an ACCT was opened on 15 June, 'the priority would have changed to high', so Mr Coombs' mental health would have been assessed within a week.)
28. Although Mr Coombs talked about suicide during his health screen, neither the nurse nor reception officers started ACCT procedures and they did not record their reason for not doing so.
29. Mr Coombs was taken to the first night centre, where he was interviewed by an officer. The officer recorded that Mr Coombs was in good spirits and was happy to share a cell with someone he knew from the community, who was already on the first night centre.
30. On 12 June, an officer was working on the first night centre. An officer told the investigator that prisoners move onto from the first night centre to another wing after one night. She recorded that Mr Coombs was given the choice to move to either A or C Wing on 12 June, but he told her that he could not go to either wing as he had issues with some people already located there. He said he would move to M Wing. She said that staff arranged a place on M Wing, but when Mr Coombs was told to move, he refused and said that he had trouble on M Wing as well.
31. The officer said that she issued Mr Coombs with a form to apply for 'own protection' measures. Any prisoner can apply for these measures if he feels at risk from other prisoners. A prisoner subject to own protection measures is located with other vulnerable prisoners on a separate wing. She reminded Mr Coombs that it could be difficult for him if he later wanted to return to a standard wing. She said that Mr

Coombs' cellmate had also talked about wanting own protection measures and officers thought he had encouraged Mr Coombs to do the same. In the event, neither prisoner submitted the application.

32. On Wednesday 13 June, two days after he arrived at Lewes, the prison GP prescribed Mr Coombs antidepressant medication at the same dose as he was prescribed in the community. The pharmacy received the instruction too late for Mr Coombs to receive medication that day, and he was issued with medication on 14 June.
33. On 15 June, Mr Coombs and his cellmate both told staff that they would move to C Wing if they could share a cell. An officer said that she found a double cell on C Wing. Although initially happy, Mr Coombs and his cellmate eventually refused to move. They were placed on a disciplinary charge for refusing a direct order and had their television removed. The officer said that during the morning she had attempted to sort out Mr Coombs' PIN number to enable him to use the telephone. (His contacts were reviewed by the prison before his phone account was activated, to ensure that they did not breach any restrictions imposed by the court.)
34. At around 11.45am on 15 June, Mr Coombs asked an officer if he could speak to someone from the mental health team. A mental health nurse was on the wing at the time and agreed to speak to Mr Coombs. The nurse recorded that she had a brief conversation with Mr Coombs and informed him that he was on the in-reach mental health team waiting list. When she asked Mr Coombs why he had asked to be seen, he said that he was having suicidal thoughts. She told Mr Coombs that she would come back to speak to him after lunch and an officer started ACCT procedures.
35. Over lunch, an officer completed two ACCT observations on Mr Coombs. On both occasions, both Mr Coombs and his cellmate complained about having their television removed and the officer explained why this had been done. On each occasion, Mr Coombs said that, if he and his cellmate did not have the television returned, he would hang himself.
36. At 2.45pm, the mental health nurse returned and asked Mr Coombs whether he had a plan to self-harm. Mr Coombs said that he would do what he did last time (attempt to hang himself). She asked Mr Coombs why he felt like this, and recorded that Mr Coombs replied that his television had been taken and he had been given a 'nicking' (placed on a disciplinary charge). She asked Mr Coombs if there was anything that could be done to help him or prevent him from acting on his thoughts, and Mr Coombs said, "Give my television back or a telephone call."
37. That afternoon, officers recorded that both Mr Coombs and his cellmate kicked the cell door and threatened to self-harm if staff did not unlock them to collect their evening meals. An officer told the investigator that due to their disruptive behaviour, Mr Coombs and his cellmate had their meals taken to them at around 4.30pm. As both men were still agitated, a custodial manager (CM) explained the reasons they had been placed on report to them. He agreed that the television should be returned, because at that stage neither prisoner had been found guilty of any charge. Once the television was returned, both men settled down and officers recorded no further issues that evening.

38. On 16 June, an officer assessed Mr Coombs as part of ACCT procedures. The ACCT assessment requires the assessor to identify a prisoner's immediate issues and to inform the support plan. Mr Coombs said that he felt low after having his television removed, but this had now been returned. Mr Coombs said that he had not self-harmed recently but had previously tried to hang himself after discovering that his partner had cheated on him. He told the officer that he and his partner were still speaking to each other. When asked about his current thoughts, Mr Coombs said that he had previously had some suicidal thoughts but had not had any that day. When asked about support and methods of coping, Mr Coombs said that he was close to his family and that they would be devastated if he did anything to himself.
39. Following the ACCT assessment, Mr Coombs attended a case review with a wing supervising officer (SO). No other staff were present. He recorded that Mr Coombs said he was 'struggling' and he had spoken to staff from the mental health in-reach team, who had put him on their caseload. He recorded that Mr Coombs denied any thoughts of self-harm but said that he had been 'down' the previous day. He recorded that he considered Mr Coombs' risk of harm to himself as 'low' and that in his opinion the likelihood of further risk behaviours was also 'low.' He recorded that a further case review should take place on 24 June, and that a member of staff from the mental health team should be invited to attend. He recorded that, in the meantime, staff should record at least three conversations with Mr Coombs during the day, and he should be observed during the night, although he did not specify at what frequency.
40. Later that morning, Mr Coombs was found guilty of not obeying an order, and was given a suspended punishment of loss of canteen and told that he would need to move to C Wing, which he did that afternoon. Mr Coombs' cellmate remained on the first night centre as he was due for release.
41. A fellow prisoner and friend of Mr Coombs told the investigator that he had grown up with Mr Coombs and knew his family well. He was also located on C Wing. He said that he did not know Mr Coombs was in prison but saw him on the exercise yard from his window and spoke to him briefly. He said Mr Coombs had arrived on C Wing with another prisoner who was also an old school friend from the Crawley area, and they were placed in a cell together. However, he said that the other prisoner then moved in with another friend from Crawley, so Mr Coombs remained in a cell on his own. He said that Mr Coombs told him that he was looking at about 10 years in prison and seemed 'stressed out'.
42. The friend said that he did not know that Mr Coombs was subject to ACCT monitoring, but he knew that he had lots going on outside prison. He said that they spoke for some time and the conversation seemed to cheer Mr Coombs up a bit. Mr Coombs said he was having problems with his partner, and he had been trying to find out who had his little boy so that he could arrange for his sister to bring him to the prison for a visit. Mr Coombs told him that this was proving difficult. He said that Mr Coombs seemed a bit withdrawn about it all, and he did not come across as angry. He said that Mr Coombs did not mention harming himself or of having any thoughts of doing so.
43. On the morning of 17 June, an SO reviewed Mr Coombs' risk after another prisoner died at Lewes, in line with procedure. The SO told the investigator that he

completed the review on his own as there was no one else available. Mr Coombs said that he was fine and that he had not known the person who had died.

44. The SO recorded on the ACCT that Mr Coombs said that he was fine. However, he told the investigator that he was worried about Mr Coombs, even though he said he was fine, and that he put the ACCT to one side and asked Mr Coombs to talk to him about what was bothering him.
45. The SO said that Mr Coombs began talking about his family, how he felt 'very down' and that he had not expected to be remanded into custody. He said that he explained to Mr Coombs the support available on the wing. He said that although Mr Coombs seemed a bit down, he had only been in a few days and most prisoners felt that way at first. He asked Mr Coombs directly about any thoughts of suicide or self-harm. Mr Coombs said that he 'probably did not want to harm himself' and by the end of their conversation, Mr Coombs was looking forward to having contact with his partner and his family. He said that when they finished their conversation, Mr Coombs left the room quite happy.
46. The SO did not record his conversation with Mr Coombs on his ACCT document or update the caremap with Mr Coombs' family issues.
47. Officers recorded on the ACCT document that Mr Coombs spent much of 17 June mixing with other prisoners. When officers asked if he was alright, he raised no issues.
48. On Monday 18 June, an officer was on duty on C Wing and offered Mr Coombs exercise at about 7.50am, which he declined. He said that Mr Coombs seemed fine. He explained that, after exercise, all prisoners are unlocked for about half an hour, to shower, clean their cells and deal with applications. The officer said that he did not see Mr Coombs, but he was standing waiting for his cell door to be unlocked at the end of the half hour. He said that he spoke with Mr Coombs and asked him if he was alright, and he replied, 'Yeah, fine.' He said that he seemed very happy, he was polite and gave him no cause for concern at that time.
49. His friend said that he did not speak to Mr Coombs that Monday morning but had seen him on the wing. He said that Mr Coombs was talking with other prisoners that he knew from the Crawley area and seemed fine. The investigator viewed CCTV footage from that morning, and Mr Coombs was speaking to other prisoners between approximately 8.30am and 9.00am, when he went back to his cell. None of the prisoners could be identified from the CCTV and none came forward to speak to the investigator.
50. At around 11.00am, an officer went to unlock Mr Coombs' cell for lunch. When she looked through the observation panel, she saw Mr Coombs' cell furniture stacked behind the door, and Mr Coombs appeared to be behind it with what she thought was a ligature around his neck. She immediately alerted her colleague who was around 20 feet away.
51. The officer said that he immediately went across to the door. When he looked through the observation panel, he could see Mr Coombs standing with his back to the door, with what appeared to be an orange blanket around his neck. As the officer opened the door, the furniture (a table, locker and chair), started falling. Mr

Coombs fell down with the furniture and it was clear that he had used the stacked furniture as a ligature point. He thought that Mr Coombs had also stacked the furniture to stop people getting into the cell.

52. The officer said that he immediately removed the blanket from around Mr Coombs' neck. He felt for a pulse in his neck but could not feel anything and began cardiopulmonary resuscitation (CPR). The other officer radioed for emergency medical assistance.
53. A nurse was the first responder for medical emergencies on 18 June. He said that he received an emergency call on his radio at 11.10am, and immediately made his way to Mr Coombs' landing. On his way, he asked his colleague to assist him and to bring the emergency medical bag.
54. The nurse said that, when he arrived at the cell, Mr Coombs was lying on the floor and an officer was administering chest compressions. The officer told him that he had found Mr Coombs with a ligature around his neck, which he had removed. The nurse noted bruising around Mr Coombs' neck and confirmed that an emergency ambulance had been requested. He asked all available nurses to attend, before assisting with resuscitation attempts.
55. By 11.13am, there were six nurses treating Mr Coombs. A defibrillator was attached, and oxygen was used. Resuscitation attempts continued until paramedics arrived at the cell at 11.35am.
56. When paramedics arrived, Mr Coombs was moved onto the landing outside his cell to facilitate resuscitation. Paramedics inserted a cannula to administer drugs, but Mr Coombs did not respond. Paramedics pronounced Mr Coombs dead at 11.56am.

Contact with Mr Coombs' family

57. The prison's family liaison officer (FLO), Head of Residence, and an SO went to Mr Coombs' mother's house, but were told by her house-sitter that she was abroad and not due back for several days. The FLO confirmed that Mr Coombs' sister lived locally. The FLO called her and asked her to come to her mother's house. When Mr Coombs' sister arrived at her mother's house, the FLO broke the news of her brother's death to her.
58. The FLO said that Mr Coombs' mother flew back on 21 June, and he and the SO met her, her partner and her son the same afternoon. Mr Coombs' family visited Lewes on 26 June, and the prison contributed to Mr Coombs' funeral, in line with national guidance.

Support for prisoners and staff

59. After Mr Coombs' death, the duty governor 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.

60. The prison posted notices informing other prisoners of Mr Coombs' 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 Coombs' death.

Post-mortem report

61. The Coroner informed us that the cause of Mr Coombs' death was hanging and that no illicit substances were detected in his system.
62. An inquest was concluded on 3 November 2023. The jury gave a narrative verdict in which they said:

'...We the jury, in conclusion and having reviewed all the evidence during the week, Ricky's sad death was as a result of suicide. There were many contributory factors which might have brought about a different outcome if policies and procedures had been followed more stringently...'

Findings

Assessment of Mr Coombs risk

63. Prison Service Instruction (PSI) 64/2011 on safer custody lists risk factors and potential triggers for suicide and self-harm. Mr Coombs had a number of risk factors, including licence recall, a recent suicide attempt, depression and relationship problems.
64. When he arrived at Lewes, staff were provided with documentation setting out Mr Coombs' risk factors. He also disclosed his recent suicide attempt and diagnosis of depression to them. We are concerned that, despite this, neither reception officers nor the nurse started ACCT procedures, and no reason for this decision was recorded.
65. When Mr Coombs stated that he was having suicidal thoughts on 15 June, staff were quick to act, and appropriate monitoring was started. Mr Coombs continued to be monitored under ACCT throughout his time at Lewes, but we found deficiencies in the management of these procedures.
66. Prison Service Instruction (PSI) 64/2011 on safer custody says that ACCT reviews should be multidisciplinary. Mr Coombs' two reviews were conducted by single supervising officers. We also consider that, given Mr Coombs' risk factors, they made an error of judgement in assessing his risk of self-harm as low and in specifying a correspondingly low level of observations.
67. The PSI says that observations should be conducted at unpredictable times and the frequency of these should be clear and recorded on the front of the ACCT document. Mr Coombs' ACCT document indicated that staff should speak to him three times each day and conduct nightly observations. It did not specify the frequency of these observations and in some cases there were up to six hours between entries.
68. The PSI also says that ACCT caremaps must reflect the prisoner's needs, level of risk and the triggers of their distress. Each entry must reflect the identified issues, be tailored to meet the individual needs of the prisoner and be aimed at reducing risk.
69. Mr Coombs' caremap had a single entry which indicated that he needed to see the mental health team. This was not discussed as an issue in the assessment and only briefly in the case review on 16 June. Although a matron told the clinical reviewer that the referral 'would have' been made a high priority when the ACCT was opened, we have seen no evidence that this happened or that an appointment was made.
70. In addition, the caremap was not added to or updated, despite Mr Coombs telling the second SO about his concerns about family contact and his relationship.
71. When Mr Coombs initially moved onto C Wing, he shared a cell, but after his cellmate moved in with someone else on 16 June, he remained on his own. Locating someone on an ACCT in a shared cell can be helpful for some prisoners,

but it had not been identified as a protective factor for Mr Coombs. While a single cell might not have been unreasonable in Mr Coombs' case, staff should have considered the possible implications of a change from sharing a cell to single occupancy in the ACCT review held the same day.

72. We have made the following recommendations to Lewes on previous occasions, and we repeat them here:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **Staff identify, consider and record all known risk factors for a prisoner when determining their risk of suicide or self-harm.**
- **Where there are risk factors, but a decision is made not to begin ACCT monitoring, the reasons are clearly recorded.**
- **Staff set caremap actions designed to reduce the prisoner's risk of suicide and self-harm and reflect the current risks and review them at each case review to ensure actions are completed.**
- **Staff should complete all ACCT documentation accurately and legibly.**
- **ACCT reviews must be multi-disciplinary, and no review should take place with a single member of staff.**

73. As this is not the first time we have made these recommendations to Lewes, and as there seems to have been little progress since HMIP found deficiencies in suicide prevention procedures at Lewes in January 2016, we are escalating our concerns to the Prison Group Director responsible for Lewes. We recommend that:

The Prison Group Director for Kent, Surrey and Sussex should:

- **Review the poor management of ACCT in respect of Mr Coombs; and**
- **Report back to the PPO, within three months of the issue of this report, on what he has found, including why Mr Coombs was not placed on an ACCT when he arrived at Lewes, and what actions he is taking to ensure that the ACCT procedures set out in PSI 64/2011 will be properly followed at Lewes in future.**

Clinical care

74. The clinical reviewer concluded that the care Mr Coombs received was of a good standard and was equivalent to that which he would have received in the wider community. We do, however, have some concerns.
75. Mr Coombs was taking medication to treat depression when he arrived at Lewes on 11 June, and the reception nurse asked for this to be re-prescribed. However, the medication was not prescribed until 13 June, and because it was then too late for the pharmacy to action the prescription, Mr Coombs did not receive the medication until 14 June. Although the clinical reviewer does not believe that this contributed significantly to Mr Coombs' death, the delay in prescribing was poor

practice and meant that Mr Coombs was without his antidepressant medication for his first four days in prison.

76. We are also concerned that a nurse did not consider placing Mr Coombs on an ACCT when he arrived even though he presented with several risk factors including recall, depression and a recent suicide attempt.
77. We also share the clinical reviewer's concerns that no healthcare staff were present at Mr Coombs' first ACCT review – a mandatory requirement under PSI 64/2011. We recommend that:

The Head of Healthcare should establish why healthcare staff were not present for the first ACCT review and provide a report to the commissioners that provides assurance that healthcare staff are involved in ACCT reviews.

78. Finally, as healthcare staff did not attend the ACCT review, we are concerned that there is no evidence that healthcare staff reviewed Mr Coombs' priority for a mental health assessment when he was placed on an ACCT or that an appointment was made for him to have an assessment within a week. We, therefore, recommend that:

The Head of Healthcare should put a process in place to ensure mental health assessments are prioritised for any prisoner placed on an ACCT and take place within one week of the ACCT being opened.

Removal of the television

79. Although the removal of the television did not contribute directly to Mr Coombs' death as it was returned three days before he died, we are concerned that Mr Coombs television appears to have been removed by staff without due process. As a CM rightly recognised, the television should not have been removed because neither Mr Coombs nor his cellmate had been found guilty of any charge at the time.

Family liaison

80. The FLO told the investigator that the prison did not consider it appropriate to break the news of Mr Coombs' death to his mother over the telephone. Instead, he chose to inform Mr Coombs' sister in person. While we accept that this has caused his family some frustration, we consider that the FLO and the SO acted reasonably in difficult circumstances.

**Prisons &
Probation**

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