

**Investigation into the circumstances surrounding the  
death of a man  
at HMP Isle of Wight in May 2009**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**November 2010**

This is the report of an investigation into the circumstances of the death of a man in May 2009. He was found hanging in his cell at HMP Isle of Wight (Camp Hill site) at 00.35am, and sadly, he was pronounced dead by paramedics at 00.50am.

The man had transferred from HMP Lewes, where he had been for six months, to HMP Isle of Wight nine days earlier. This was his first time in custody. He was 24 years old.

I would like to offer this public expression of condolences to the man's family and friends on their loss. A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. His parents raised a number of matters with one of my family liaison officers and my colleague who carried out the investigation on my behalf. I hope my investigation begins to offer answers to their questions. It is with regret that this report has been delayed and I offer my sincere apologies for this.

The man spent the majority of his time in custody in HMP Lewes and the investigation has looked in detail at his time there as well as the nine days he spent at HMP Isle of Wight. Two separate clinical reviews were carried out and I am grateful to the Consultant in Public Health, and the Consultant Forensic Psychiatrist for looking at the clinical care at HMP Isle of Wight and HMP Lewes respectively. I would also like to thank staff at both HMP Isle of Wight and HMP Lewes for their co-operation with this investigation.

The man was a vulnerable prisoner with disabilities as a result of a severe life-threatening asthma attack in October 2005. He had made a serious self-harm injury within days of arriving at HMP Lewes and had periodically harmed himself again during his time there. Over time, he appeared to become more comfortable with the support of staff and, in particular, two prisoners. However, the nature of his transfer, which I believe occurred without sufficient warning and in a manner which was ill considered, is of concern. Sadly, he did not appear to settle at HMP Isle of Wight and died after nine days there.

In what is an upsetting story, the report contains 11 recommendations, many in relation to HMP Lewes. They concern looking after prisoners who are at risk of harming themselves, and those with disabilities. I also comment on transferring information and the importance of completing records correctly.

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

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**November 2010**

## **CONTENTS**

Summary

The Investigation Process

HMP Lewes

HMP Isle of Wight

Key Findings

Issues

Conclusion

Response to the draft report by the man's family

Recommendations

## SUMMARY

In October 2005, the man suffered a severe asthma attack which left him with disabilities. On 7 November 2008, he was arrested and remanded to HMP Lewes on 10 November. He declined to be located into healthcare where staff wanted to assess his physical capabilities and so was taken to an ordinary wing. In the early hours of 24 November, he seriously harmed himself by cutting his throat. He was taken to outside hospital where he remained until that afternoon. Upon his return an Assessment, Care in Custody and Teamwork (known as ACCT, which identifies, monitors and supports prisoners considered to be at risk of self harm/suicide) was opened and he was kept in the healthcare centre for four days.

Over time, the man appeared to settle with some select prisoners helping him with daily tasks on the wing such as collecting food. On 12 January, another ACCT was opened after he was found to have burn marks on his stomach. Also, he was unhappy with his cellmate and threatened to self-harm by cutting his throat. This was closed four days later without further incident. Again, on 15 February another ACCT was opened after he cut his neck. The ACCT was closed on 7 March without further incident although he had been placed on constant watch at court for a short time on 5 March whilst there to be sentenced. He received a three year sentence. Throughout his time at Lewes, he had a number of epileptic fits and suffered a number of injuries following falls as well as having an asthma attack. He always refused to move onto the healthcare centre preferring instead to stay on the wing.

On 16 April, the man cut his wrist but an ACCT was not opened by staff. A temporary Medical Record (MR) was opened by the attending nurse as the original one could not be found. (This record remained in circulation throughout the rest of his time in custody and travelled with him to HMP Isle of Wight [Camp Hill site].)

The man spent most of his time in a single cell either because of medical reasons or because he presented a high risk to others. On 30 April, a security report was logged. It was reported that there were suspicions that his medication was being taken from him by two prisoners who were recognised to help him on the wing and provide considerable support. In response, he was supervised whilst taking his medication. However, on 8 May, he moved into a cell with one of these prisoners.

On the evening of 11 May, the man discovered from another prisoner that he was to be transferred the following day to HMP Isle of Wight. It appeared that he received official confirmation of this move early the following morning. According to his cellmate, he was very distressed about the impending move and said that he would "just do myself in". In the morning the cellmate drew the senior officer's attention to this and the risk he thought such a move placed him under. However, after speaking with the duty manager, the senior officer continued with the planned transfer. Witnessed by a member of the Independent Monitoring Board (IMB, whose role is to ensure that the prison is properly run and that prisoners are treated decently), who became involved when the cellmate approached her, he was asked to come out of his cell under the pretence of speaking with the senior officer. He then tried to return to his cell which he was instructed not to do.

As a result, the man was restrained outside his cell before walking cooperatively to reception from where he was transferred to HMP Isle of Wight. These events were not recorded on the Prisoner Escort Record (known as the PER which is used to communicate important information between the various criminal justice agencies) and an ACCT was not opened.

Upon reception at the Isle of Wight, with incomplete medical records, the man was seen by a nurse who recognised that he was vulnerable and referred him to the doctor. However, she did not feel he was at risk from self-harm. He was taken to St Andrews wing. Two days later, he saw the doctor and the majority of the consultation was spent discussing his disclosure that he was withdrawing from drugs. This was the first time he had mentioned that he had been using illicit drugs at Lewes and there is no collaborative evidence. Again, the doctor felt him to be vulnerable but not at risk of self-harm.

The man telephoned his family five times over the next few days describing Camp Hill as a "shit hole". He seemed to have had little contact with staff or prisoners except to get a warning for smoking on 20 May.

On 21 May, the man was asked to turn his music down by the night staff at 11.20pm. At approximately 00.35am, hearing the music had been turned up again, an officer went to his cell and discovered him hanging. Within minutes, staff entered the cell but did not carry out cardiopulmonary resuscitation (CPR) as they believed he was dead. Paramedics arrived at 00.46am and pronounced him dead at 00.50am.

The man had complex needs which were difficult to manage in the prison environment. Whilst there is considerable evidence that staff supported him at Lewes, there are 11 recommendations in this report, two specifically in relation to the ACCT process at Lewes. A number of recommendations are directed at the Head of Healthcare at Lewes and concern how his physical difficulties were identified and communicated by staff.

## THE INVESTIGATION PROCESS

1. My colleague collected the documentation relating to the man from HMP Isle of Wight and opened the investigation in the days following his death. He met with senior prison managers. Notices were issued to staff and prisoners telling them of the investigation and offering the opportunity to speak with my colleagues. No one came forward as a result.
2. The investigator and another colleague visited Camp Hill on 18 June and interviewed five members of staff and a prisoner. Given that the man spent six months in Lewes, and was transferred nine days before he died, much of the investigation focused on his time there. Twelve interviews were conducted with staff by the investigator between 11 August and 24 September. A prisoner and a member of the IMB wrote to my investigator and, in addition to the statements they provided, they were also both interviewed on tape. One other prisoner at Lewes was interviewed. In addition, my investigator listened to the telephone calls the man had made from Isle of Wight.
3. My investigator contacted the local Primary Care Trust who agreed to prepare a clinical review regarding the man's time at Camp Hill. She conducted two joint interviews with the clinical reviewer appointed on 18 June. On 17 August, a review panel took place which she attended as well as a number of staff from the prison and the Primary Care Trust (PCT), and a full report is annexed to this report. The clinical reviewer did not consider it was appropriate to comment in detail on the man's time at Lewes.
4. The NHS and local Primary Care Trust agreed to prepare a clinical review for the man's time at Lewes and a second clinical reviewer carried this out on their behalf. Again, the report is attached. The clinical reviewer obtained the man's records from the community and his report contains useful background information. Both reports are referred to in the Issues section of this report.
5. A family liaison officer from my office made contact with the man's parents offering them the opportunity to meet with both herself and the investigator to discuss the purpose of the investigation and to raise any questions or concerns they had about the care he received whilst in custody. The investigator and family liaison officer visited the family home on 15 June. They specifically questioned:
  - The transfer to Camp Hill. They felt that he was settled at Lewes and would not have taken his life if he had remained there.
  - Why he was not considered a suicide risk at the time of his death given his history?
6. A copy of the draft report was sent to the Prison Service and their responses to the recommendation are repeated verbatim in the recommendations section. The response to the draft report by the man's family can be found on page 40.

## HMP LEWES

7. HMP Lewes is a small, old category B local prison holding remand and convicted prisoners and remand young adults, serving courts of East and West Sussex. It holds 558 prisoners in six units, three of which are residential wings (A, B and C), and also a first night centre and a small unit for vulnerable prisoners. In addition, there is a healthcare centre located in a separate building in the prison grounds. All responsibility for the delivery of the health service transferred to the primary care trust in 2005. There were three deaths at Lewes in 2008 and 2009. All were from natural causes.

8. The last announced HM Inspection took place in August 2007. It said:

“Lewes is a small, old local prison .... like many such prisons, the built environment and facilities are far from ideal: indeed, cells in one wing were barely fit for habitation and needed urgent refurbishment. However, relationships between staff and prisoners was extremely good, within appropriate boundaries. This was the prison’s great strength. There was evidence that staff knew about, and engaged with, the prisoners in their care, though this knowledge was not effectively put to use in resettlement and suicide prevention work.”

## HMP ISLE OF WIGHT

9. On 1 April 2009, Camp Hill merged with Albany and Parkhurst to become HMP Isle of Wight and is managed as a single unit. Camp Hill was built in the early years of the 20<sup>th</sup> century. It is a closed category C training prison holding adult men on short, medium and long sentences, received from the local prisons of Winchester, Lewes and the London area. It holds 595 prisoners in nine residential units including St Andrews and St Davids wings which are, respectively, the first night centre and induction unit. Given its distance from the mainland, and the expense of travelling there, Camp Hill is not popular with prisoners.
10. Health services at HMP Isle of Wight are commissioned by the local Primary Care Trust. The prison's healthcare is clustered with Albany and is provided by Parkhurst. Parkhurst provides healthcare to the 1500 or so prisoners on the island and has a 12 bed in-patient facility (mainly providing psychiatric treatment). Prisoners' medical needs are catered for by way of out-patients and core day primary nursing cover. There is no overnight healthcare facility at Camp Hill. If an incident should occur during the night, either the nursing facility at nearby Parkhurst are contacted for advice or the Accident and Emergency Department at the local hospital. If necessary the prisoner is taken there or collected by emergency ambulance.
11. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State.
12. HM Inspector of Prisons conducted an unannounced full follow-up inspection of Camp Hill from 9 to 13 February 2009. In her report, she wrote that the last inspection (August 2006) had revealed a prison lacking in direction and was not fulfilling its role as a training prison. However, the report did note that under better management:

“... there has been progress in all areas – but despite this the prison was still not performing sufficiently well in any of our four key areas: safety, respect, purposeful activity or resettlement. Six of our eight recommendations from the last inspection had not been achieved, and the other two achieved only partially.”
13. Camp Hill has had three self-inflicted deaths since 2007, one of these in February 2009. I have considered whether there are any similarities between this death and the others. I have found none of significance. To be clear which part of Isle of Wight prison is under investigation, I will refer to the prison as Camp Hill in the rest of the report.

## KEY FINDINGS

14. On 7 November, at 11.00pm, the man was arrested for an incident at his home which involved him self-harming and firing his air pistol from his window. He was said to have drunk a large amount of alcohol and to have been disappointed that a new girlfriend did not turn up to see him as expected. It is recorded that at one point he said that he wanted the police to shoot him.
15. The following day, whilst still in police custody, the man had a mental health assessment. The author reported that he always felt low but not suicidal. It said that he had suffered significant brain injury on top of a background of previous substantial substance misuse but there was no other evidence of any other significant major mental illness. His mother was contacted by the author for background information.
16. The man was taken to Magistrates Court on the morning of 10 November. The Prisoner Escort Record (PER) indicated that he had risk factors of “mental condition, violence, concealed weapons and suicide/self-harm”. The additional information about risk stated “caused cuts to arms/self-harmer, samurai swords, cross bows and air weapon at H/A [home address] threatened police with firearm/resisted arrest – 08/11/08”. The form indicated that he had had a mental health assessment and that the form was attached to the PER.
17. At 12.30pm, the man was assessed by a court diversion community psychiatric nurse (CPN) from the Mentally Disordered Offender Assessment and Diversion Scheme. The CPN opened a Suicide/Self-Harm Warning Form and assessed the frequency of observations needed to be ‘intermittent’. The form indicated that reception staff at Lewes prison were aware of his imminent arrival and that “he denies any current suicidal ideas or plans but has engaged in behaviour putting himself at risk”.
18. The man was remanded to HMP Lewes. In reception, his core record recorded his mother as his next of kin and that he had mental health issues. Section 2 of the Cell Sharing Risk Assessment (known as CSRA and used to assess the risk a prisoner may pose to themselves and others) stated “mental health issues, no (sic) very stable, in for fire arms”. He said that he did not have any concerns about sharing a cell and was not someone who got angry or frustrated easily. He was assessed as a ‘high’ risk to others indicating that there was a high level of risk that he might assault his cellmate. The same officer wrote in the history sheet  
  
“high risk for mental health grounds. In for fire arms offences (shooting at police). Some very strange answers and questions on the FNC [first night centre] interview, trying to get him to the health care for obs [observations], came in with sack of medication. High risk agreed by the Governor”.

19. Section 4 of the CSRA was completed by the Governor and he wrote "in reach referral" and "to be reviewed by in reach staff in 7 days". The First Night Centre Interview recorded the man as "cutting his arms at home on 6/11/08", but not feeling like self-harming now, had been treated for depression and he was NFA (no fixed address). The question about whether an ACCT was opened is not ticked as either yes or no.
20. Section 3 of the CSRA should be completed by a healthcare member of staff and usually by the same person who completes the First Reception Health Screen (FRHS). In the man's case, this did not happen. In response to being asked about the risk to others, the author has ticked that there was "insufficient evidence to give an opinion" and assessed him as a low risk. The author is also asked to assess whether there are any concerns about self harm and this has been ticked as no, although they recorded "history of self-harm with recent self-harm (07/11/08). To be referred to in reach".
21. A First Reception Health Screen (FRHS) was completed and the man gave details of his recent self harm. He said he usually drank heavily twice a week and was receiving medication for mental health problems. He said he did not feel like harming himself at that time. The author indicated that a referral to the doctor for physical health and substance use would be made as well as a referral to the mental health in reach team.
22. Corresponding notes were made in the Medical Record (MR). It was also recorded that the man "would not come to healthcare when offered so that we could assess his physical capabilities and how he would cope on the wing". He was located in an ordinary cell, K1-017 on his own, on the first night centre.
23. Although, there are numerous recordings of his recent self-harm, the man does not appear to have presented as at risk and there is no mention by staff of the suicide/self harm form completed by the CPN at court. An ACCT was not opened.
24. The following day, the man saw the doctor (GP). Although it is very difficult to decipher the writing, the GP concluded that "I think he will cope on ordinary location". A full medical history was not taken. His prescription charts were not given to my investigator and it is not entirely clear whether or not the man was prescribed the same medications he had in the community.
25. The man later saw Nurse A from the in reach mental health team. In interview, the nurse said that his physical problems made him appear as if he had a learning disability, which he did not, and the nurse was concerned that he would not cope on the wing. The nurse made an entry in both the history sheet and medical record. In the history sheet, he wrote "seen by mental health triage, no concerns re. mental state, however I have agreed to see him in 2 days time to see if he is coping on the wing (re. physical issues)". In the medical record, he recorded

“Seen for mental health triage, no evidence of mental illness. No thoughts of suicide or self-harm. Stated self-harmed a few days ago out of frustration. His issues are as a result of his physical problems which may cause him to be exploited on the wing, however he feels confident to be located on the wing”.

26. A Cell Sharing Risk Review (CSRR) was carried out the same day and he was assessed as a high risk of harming a cellmate. (Only one page of the two page document was given to my investigator.) He was moved to cell G1-013, again alone in the cell, on the induction wing.
27. On 12 November, the man was found in a collapsed state having suffered a fit. He had not lost consciousness and was assessed by a nurse. He was referred to see the GP the following day. Again the entry is difficult to read but it seems that there had been some gap in medication which was restarted. The GP concluded that he is “settling down in prison fine”.
28. Nurse A saw the man on 14 November and wrote “coping well no problems or concerns. No evidence of any mental health associated problems. No further action at this time”. On 18 November, he moved to cell C2-016 and the next day a further CSRR again assessed him a high risk (page two was missing again from the documents provided to my investigator).
29. At approximately 3.30am on 24 November, the man made a deep cut to the left side of his neck with a razor. Having pressed his cell bell, he was taken to outside hospital where he remained until the afternoon. He was placed in the healthcare centre upon his return in a dormitory with four others as he requested company. An ACCT was opened which recorded that he said that he did not want to die but wished to release his frustrations. On 25 November, he was visited by his mother which was said to lift his spirits. However, during the ACCT assessment interview later that day, he said that he did want to be dead and was disappointed that he was not. He had benefited from his mother’s visit.
30. A Risk Screening Assessment was completed by a member of the in reach team on 24 November. In relation to his mental health it is recorded:

“No evidence of mental illness. Says he has cut himself in the past to relieve anger/frustrations/stress caused by the physical disabilities and particularly being unable to be a ‘proper father’ to his 2 girls’. Says he has no wish to die, however when he cut his neck on 24/11/08 he felt he would be better off dead rather than being a ‘partial dad’ although he says that it was an impulsive action and on reflection a silly thing to do. No wish to dies or self-harm at present.”
31. It was also recorded that it was his first time in prison and “despite disabilities feels he will cope and not be subject to bullying. Feels he can “stick up’ for himself”.

32. The man remained in healthcare for four days and was generally settled. He returned to C wing on 28 December and was placed in cell C4-003 on his own. In his medical record, it is recorded that “nurse from the mental health in reach team has seen the man and agreed to take him on his case load”.
33. Two prisoners became aware of the man after this incident as they were wing cleaners and had cleaned up the cell after he was taken to hospital. According to them, and from accounts from staff, he began to spend a lot of time with them both. They generally looked after him on the wing, helping him get his food and other personal tasks and protecting him from any negative comments from others. (Prisoner A wrote an account of events from his perspective.)
34. Prisoner A, who was also a peer supporter (prisoners who volunteer to support other prisoners and are selected by staff) said in interview that they became very good friends. He said that the man needed people to approach him rather than vice versa.
35. On 1 December, concerns were expressed by staff that the man was losing his balance and falling over. He was seen by healthcare staff and it was recorded that “referred by staff to be manifesting strange behaviour”. The same day, Nurse A wrote  

“seen for follow up after being discharged from healthcare, he is settled on C wing. However, he is requesting to be moved to the 2s [second floor] landing due to mobility issues. On presentation, I did not feel he was expressing any suicidal ideation or intent and he denied any thoughts of self harm. He gave me a verbal agreement that he would ask for help if he felt he may self-harm. In-reach will support for the short term”.
36. The man fell on 2 December and was seen by the doctor. It is recorded in the medical record that he was now “flat located [on the ground floor] which should make things easier for him regarding mobility” and he moved into a different cell. An entry in his history sheet, says that “advised via healthcare that he has asked to share a cell. The doctor has taken him off medical single but obviously care must be taken when allocating a cell mate”. Nurse A wrote in his medical record on 3 December that “requesting to have his medical single status removed as he was lonely. Dr removed the single cell status. From my point of view I said that sharing a cell may provide him with a sense of friendship”. He moved into cell C2-001.
37. On 3 December, Nurse A completed a care plan. He wrote that “in reach will provide the man with weekly support on the wing in order to build a rapport and gain a wider view of the social pressures he is under”. The next day, a cell mate moved in with him, and continued to share with him for a month.
38. Two days later, on 5 December, the ACCT was closed with a post closure review booked for 12 December. At the review, the man said that he was

settled on the wing and had no thoughts of suicide or self-harm. He also said he was getting on well with his cell mate.

39. It is recorded in his medical record that the man collapsed again on 10 December. He was assessed by healthcare and advised to contact staff if he felt unwell again. On 12 December, Nurse A saw him and recorded that he was “coping well, glad to be sharing a cell ... no worries/concerns raised”. Another Risk Screening Assessment was completed and the management plan concluded:

“No current mental illness and no suicidal ideation.

His problems are primarily to do with poor physical health and inability to deal with stress and failure to get his perceived needs met – has declined admission to HCC [Healthcare Centre].

Very low key Inreach involvement.”

40. On 13 December, a Report of Injury to Prisoner form was completed indicating that “whilst escorting the man to reception to collect his property he became unstable and fell forward to the floor. He appeared to have grazed both hands”. This incident is not recorded in any other document including the medical record. An entry in his medical record on 15 December recorded that he did not feel he needed any additional services.
41. On 16 December, the man fell down the stairs and was assessed by medical staff. They concluded that he had no ill effects or injuries. There is a mention that he had taken four Clonazepam tablets rather than two that morning. (Prescription charts from a later period show that he was being given four Clonazepam daily which may have been meant to be taken in two separate doses.) Four days later, he had an asthma attack and the emergency healthcare nurse attended. The nurse stayed with him for over an hour until the symptoms passed. Again, he declined admittance to the healthcare centre for observations.
42. Officer A wrote in his history sheet on 25 December “still unsteady on his feet, has moments when he just stares into space, HCC (healthcare centre) are aware, I feel he would be better suited to HCC than normal location and have said as much to HCC”. In interview, she said that she had chosen for him to be in the cell opposite the servery to reduce the amount of walking he had to do. She described other prisoners as looking after him in a protective way and helping him with tasks.
43. Nurse A saw him on December 29 and recorded:

“Seen on the wing, appears bright in mood and no problems or concerns raised. He and I spoke about discharge from the in reach caseload, he was happy to be discharged however I felt that maybe he should be jointly assessed by another member of the team as he was expressing vague suicidal ideation, I was unable to gain any evidence

of any active intent on examination. I will see him with another member of the nursing team before discontinuing any care plans.”

44. The next day, Nurse A tried to see the man with a colleague but he refused as he was watching television and did not want to miss a particular programme.
45. On 3 January 2009, the man’s cell mate changed. Later, he rang the cell bell as his new cell mate was hearing voices and sitting in corner shaking. The cell mate was taken to the healthcare centre and did not return to the cell.
46. An entry in his history sheet on 6 January says that “the man seems to have settled down recently. He is still unsteady on his feet. He is genuinely polite to staff and follows wing regime. Staff still keep an eye on him but we are less concerned with him of late”. Later that day, he had a fit. He had slept through the collection of medication earlier in the day and wing staff were asked to monitor him and wake him overnight for his medication.
47. On 8 January, a new cell mate started to share with the man. An incident occurred on 12 January at 1.15pm and the following was recorded in his medical record by Nurse B:

“Seen in response to an urgent request by officers on C wing. The man had refused to his cell (shared) as he was demanding a single cell and threatening to cut his throat if his demands not met. Situation gradually diffused and he agrees to return to cell, (unable to decipher writing) whilst situation further discussed and resolved. As he has complex physical health problems due to acquired brain injury he was offered a bed in HCC to monitor his physical health and maintain personal safety – poor balance, epilepsy etc; he adamantly refused to come to HCC stated his needs were not severe enough – see report on file by doctor re his ability to make decisions re his care. Assessed as high risk by officers and needing single cell. Discussed my reservations re his physical health safety in a single cell with a colleague and we agreed that there were no grounds to forcibly move him to HCC + he has capacity to make decisions re his care ie. Not being admitted to HCC despite being advised to. He is not currently mentally ill and is not expressing any suicidal ideation or intent. His problems are connected with his physical illnesses and poor coping skills linked with anger + frustration when he does not get his perceived needs met. In reach will continue low key monitoring.”

48. Another CSRR was carried out and again the man was assessed as being a high risk to others. Further details (which had been missing from previous documentation) recorded that he had threatened to set a fire in his cell. The form recorded that “he is of low intelligence and has trouble interacting with others. He has had previous issues with other cell mates”. It concluded that he should be in a single cell. Due to his fits and asthma, he was to be monitored and his cell bell should be answered as soon as possible due to his medical history. The duty governor commented that there should be a further review in a week to see if a suitable cell mate could be found.

49. At 3.30pm, one of his personal officers opened an ACCT as he had burn marks on his stomach made with a lighter. In interview, she recalled him saying that he had burnt himself because he was bored. She explained that she would have to open an ACCT and he told her that she did not need to as he was not going “to do anything stupid” (meaning harm himself again).
50. Officer B carried out the ACCT assessment interview on 13 January. He recorded that the man would not talk about the burn marks but had told him that he had done them a few nights earlier. The ACCT was closed on 16 January after no further incidents or concerns about self-harm. At this review, it was recorded that “the man categorically states that he has no intentions of self harming or suicide. He now has a single cell and accepts that he will be sentenced soon and then would like to go to HMP Camp Hill which is where his brother is. Document closed”. (The man’s mother told my investigator this was not the case. His brother had previously been at Camp Hill but had transferred to another prison some weeks before.) A review was carried out on 23 January.
51. On 17 January, the man fell in his cell and medical staff attended to treat his hand, which was swollen. His history sheet records that on 19 January “the man has spent the last couple of days in bed, since he had a fall on Saturday. He was seen by healthcare. He remains polite to staff, does have to be chased up to go behind his door”. On 25 January, healthcare said that it was unsafe for him to use the stairs and so he needed to exercise in the healthcare centre yard if the lift was broken.
52. The man spoke with his personal officer again on 3 February (they were meeting bi weekly). She described his mood as being “very up and down of late”. An entry in his medical record on 4 February, indicated that he had not requested any support from the in reach team for a while and consequently he was discharged from their caseload.
53. On 5 February, the man appeared at Crown Court and pleaded guilty to the charges. A Pre-Sentence Report was requested for the next hearing in a month’s time. Another CSRR was completed and again it was recorded that he ‘has threatened cell mate and attempted to set fire to them’. The author wrote that the man “does talk to me but sometimes it’s difficult to know if he understands what is being said”. It concluded that he was to remain on his own as “there is a perceived risk to cell mate”. Also, the form said he suffered from asthma and panic attacks (this is the one and only entry in all the documents about panic attacks).
54. The man cut his neck again with a razor blade on 15 February and an ACCT was opened. The injury was skin deep and he would only let healthcare cover it with a dressing. He wanted to speak with his friend, Prisoner B, who persuaded him to have some sutures put in. He was placed in a cell overnight with the prisoner “to keep an eye on him”. During his ACCT assessment interview, he said that boredom was his main problem and that he did not want to kill himself. He was described as a “serial self-harmer”.

Staff were going to try and give him work whenever possible. A referral for a psychiatrist's assessment was completed that day so that he could discuss his anti-depressants which he said were not helping him.

55. In interview, Prisoner B remembered this incident. He said that the man was worried that if he went over to the healthcare centre for treatment he would be kept there. The prisoner said that he did not want to go because he was a smoker and smoking is not allowed in healthcare. Having gained reassurances from staff that he would come back to the wing, the prisoner managed to persuade him to go and have some treatment. He was then allowed to stay overnight in the prisoner's cell.
56. On 16 February, the Disability Liaison Officer conducted a Disabled Prisoner Care Plan. The purpose of the assessment was to consider whether any "reasonable adjustments" were needed to accommodate the man in his every day life. His 'disability' was described as "he has got brain damage due to lack of oxygen. He is a bit slow but has no memory loss. He has a tendency to self harm". It concluded that he needed no assistance in any areas.
57. Officer C had a routine meeting with the man on 16 February. He told the officer that he gets bored and would like a wing job and she wrote that staff would look into the matter and see what they can do. She also recorded that he was very close to Prisoners A and B who "tend to be able to keep his spirits up." In interview, my investigator asked if he appeared depressed:

"No, not very often; most of the time he was happy. Sometimes he'd spend a couple of days in bed and then you'd go in there and sort of will him to get up because obviously he was having bad days and I think it was times around his birthday or his children's birthdays he'd mentioned that he was feeling quite low. So obviously I mean the staff got on really well with him on C wing, we got to know him quite well. So if we couldn't wheel him out of bed then we'd obviously speak to the two prisoners because they used to go up there and go and have words with him, see if they could get him up."
58. A referral to the mental health in reach team was completed on 16 February as the man made a superficial injury to his neck the day before.
59. An ACCT review took place on 22 February at 2.30pm. The case manager was a senior officer from another wing who had not met the man before and was involved solely because he was the duty manager that day. In the review, he described finding the support of Listeners helpful (there is no record of him requesting Listeners in his on-going record although he was spending time with Prisoner A who was a peer listener) and had good eye contact and interaction throughout. (Listeners are prisoners trained by the Samaritans and are available at all times for prisoners to speak with.) Again, they spoke about getting work and him being bored. There is a record in his on-going ACCT document at 11.20am on 23 February of him saying that he told his solicitor that "if he gets a custodial sentence, he will kill himself".

60. Another ACCT review took place on 1 March, again with two discipline staff, but the man refused to take part. It was reported that he had spoken to his personal officer, Officer C, and that he had “no intention of self-harming”. SO A, who was acting as the case manager, spoke to him in his cell and he said he was “feeling ok” and reiterated what he had told Officer C. He said he was looking forward to going to court later in the week.
61. On 2 March, Officer D wrote in his history record: “The man is still quite shaky physically and has had his stitches in his neck removed. He does not engage in conversation with me but spends a lot of time with Prisoners A and B who look after him”.
62. The man appeared at Crown Court on 5 March 2009, to be sentenced for the offences of possession of a firearm/imitation firearm with intent to cause fear of violence and possession of a bladed article. The Pre-Sentence Report (prepared between 5 February and his court date) said “The man informed me that should he receive a custodial sentence he would kill himself. He also expressed that he was unable to cope with the daily battle of life anymore”. At 12.15pm, whilst at court, he was placed on a constant watch as he was very distressed following a visit by his solicitor. At 12.50pm, he had a closed visit with his parents and appeared more settled and was taken off constant watch at 2.00pm. He then appeared in court and was sentenced to three years imprisonment. Upon his return to Lewes, he was again placed on constant watch for an hour and 40 minutes. He then told staff that he was fine and had no thoughts of self-harm. He declined to see a member of healthcare and was taken off constant watch.
63. On 7 March, at an ACCT review, again with two discipline staff and those who carried out the first review, the man said he was in full time education. He also said he “has been sentenced now and is happy with the result as he only has a year to do”. He spoke of his family support and the drawings he received from his children. The ACCT was closed. At the post closure review on 14 March, he said he was well.
64. An entry in the wing observation book the same day says that the man rang his cell bell, saying he thought he was going to have a fit soon. Healthcare staff were contacted but wing staff apparently were told that they would not intervene with any one having a fit. He was to be advised to lay on his bed.
65. The man had a regular meeting with Officer C on 16 March and said he had been quite happy during the past week. He was attending education and mixing with a few other prisoners on the wing. The next day , 17 March, he tripped and fell when leaving the servery. On 30 March, it is recorded in his history sheet that he remained polite to staff and was still attending education. There were no concerns about him.
66. On 31 March, another CSRR was carried out and the same information repeated about previous threats to cell mate. The author concluded that “given his unpredictable nature I feel it would be wise to move him to medium risk. Should he find a suitable cell mate who he wished to share with then his

CSRA can be reviewed. However due to his previous history, the risk should be fully explored”.

67. At his bi-weekly meeting with Officer C on 13 April she said that there was no change but she believed he used his illness as an excuse to do as he pleased. In interview, she explained that he could be quite cheeky and child-like. She spoke about how settled he appeared at Lewes.

“I can remember coming in the day after he’d done it (self-harmed on 24 November) and that was the first time I met him or a couple of days after he’d done it and that’s the first time I’d ever met him. And from the first time I met him up until when I went onto nights he was completely different person. He’d sort of settled right into the wing, he knew the staff extremely well, he knew that he could talk to us about anything and he also liked, say came really good friends with Prisoners A and B. And I think he was quite settled and he could accept his prison sentence being in an area he felt comfortable. So I should say from when he first came he was feeling very low and withdrawn and probably at more risk than he had been the whole time he was at Lewes.”

68. An entry in the wing observation book on 13 April at 5.50pm, says that “staff to monitor closely has previously self harmed by cutting throat. Advised by Prisoner A that the man is down in the dumps and should be watched by staff”. Another entry at 6.30pm, says “Prisoner A put in cell C2-01 to speak to him. Concerns raised as he may self-harm. Agreed by Oscar 1 [duty manager]. Prisoner A returned to own cell at 7.20pm stating the man ok.”
69. On 16 April an entry in observation book says “rang bell. He sat on bed, had made slight cut across L wrist, N/O [night orderly officer who is the most senior member of staff at night] and H/C [healthcare] informed and attended. No ACCT opened”. At 8.25pm, Nurse C recorded in the medical record “called to C wing, he had cut his left wrist small clean cut cleaned and dressed. Razor blade removed from cell. To see GP tomorrow for assessment ? taking medication”. There is also a note saying “can’t find IMR” and the front of the medical record it is written “original IMR not found – temporary file”. (This file became his on-going medical record.)
70. In interview, Nurse C recalled dressing and cleaning the wound and said that the man spoke about his family and that he harmed himself to relieve stress. When asked about opening an ACCT, she said;

“We can, yes. I didn’t feel at the time that it was, because so many of them just do it for stress related, we don’t open one for everyone. The officers, if they, felt needed one they could have opened one as well, I don’t remember any discussion about it actually, that night. And in fact, yes I suppose in retrospect, but even the following day the doctor didn’t feel the necessity, after he spoken to him.”

71. Nurse C remembered the man from February when she had attended after he cut his neck and she had referred him to the in reach team. She felt the previous self-harm had been more severe and that the discussion with him felt very different from before.
72. SO A was the night orderly officer (duty manager) that night but in interview could only recall the incident vaguely. Asked about why an ACCT was not opened he said:
- “Well, everybody is trained to a certain level within the establishment. I would assume that the OSG (night staff) who found him with an injury would have instigated opening an ACCT, if not healthcare since they go back and write the reports for the doctor the following day. They would have opened an ACCT because they are privy to far more information than our uniformed staff are and individuals.”
73. He also did not recall having a discussion with staff about opening an ACCT.
74. There is a further entry which is unsigned and not dated which may have been written that day which reads “feeling quite low - not a suicide attempt ... refer to in reach”. In interview, Nurse C said this was written by the doctor the following day.
75. It is noted in the medical record on 17 April that a fellow prisoner reported that the man had fallen down stairs and had a bump on his head and elbow. Four days later, in reach staff attempted to see him but he was at education. On 19 April, it is recorded that he asked for and saw a Listener.
76. On 30 April, a prisoner passed a note to Officer D saying that “Prisoners A and B were taking four Clonazepam off the man every morning”. In interview, she said that she completed a security report and instructed that he was to be supervised by healthcare when taking his medication. This is recorded in his medical record as “phone call from wing – he’s being bullied for his medication. Clonazepam to be supervised at hatch and taken over in evening”.
77. In interview, Prisoner A said that he was aware that people had suggested that he was involved in taking medication from the man. He denied this. He said that he knew what medication the man was prescribed. He and Prisoner B would tell him to take it on a couple of occasions they had seen piles of pills in his cell which he had not taken.
78. On 3 May, an entry in the man’s history sheet said “needs chasing from time to time and relies heavily on Prisoners A and B – these two look out for and after him on the wing. Has his ups and downs and seems to be ‘up’ at the moment, needs to be monitored easily falls into self-harm”. The next day, there is an entry in the wing observation book which said that he was distressed about something another prisoner had said to him but he would not repeat what it was. He asked to see the in reach team and a message was left for them.

79. Two days later, an entry in the medical record recorded “form from gym re fitness for gym. Is epileptic and asthmatic – severe. GP appt given for Monday 11 May 09. Dr to assess fitness for gym”. On 7 May, an entry by Nurse B, from the in reach team, said “seen flowing a referral...no indication of any severe/enduring mental illness – appeared to have mild LD [learning difficulties] and some reactive depression – he’s worried about future, does not like prison and feels lonely. No current suicidal ideation or intent ... regularly attends gym and education – he feels that he is ‘okay’ at present and does not need any help. No further action.”
80. The man’s MR says he is “fit for transfer” on 8 May as recorded by Nurse D. In interview, she explained this as a simple paper process which involves checking whether the prisoner has any outstanding hospital appointments or any other medical reason for holding them at Lewes. It does not involve interviewing the prisoner and is usually carried as one of the night duty activities.
81. The man started to share his cell with Prisoner A on 8 May. In interview, the prisoner said that they began sharing because both of them were in single cells and it was likely that he would be moved from his. He says he suggested to him that they share and staff agreed.

## **12 May**

82. Given that the man was a sentenced category C prisoner, he was eligible for transfer. According to Prisoner A, who was sharing a cell with him, he became aware that he was being transferred the night before when another prisoner came into the cell to say that he had seen his name on the transfer list in the wing office. The prisoner said that the man had not received a notification slip which they usually get with at least 24 hours notice. He said that his face dropped when he heard the news and so he told him he would speak to staff. The prisoner approached the office but was told that it would be something to be looked at in the morning because it was about 6.30pm and the day staff were not there.
83. Prisoner A said that the man was very distressed during the night and said that “I’ll just do myself in”. He said that he tried to reassure him that he would see the senior officers in the morning and that he would be able to sort it out. In interview, he said that because of the man’s history of self-harm they were sure they would stop the move. Early that morning, he says a slip was put under the door about the transfer. He says that as soon as they were unlocked he went to the office and spoke to SO A who said “I know what you are going to say and there is nothing I can do”.
84. SO A recalled Prisoner A coming to see him and showing concern regarding the man. In interview he said:

“I have been trying to remember, he was concerned, he felt that it wasn’t good for him to go there because you know people here were looking after him, he would be on his own down there. It would

probably put him back two steps from how much he's advanced since he'd been at Lewes, because yes he did quite well here, I know he self harmed a couple of times but he was out and about, he was cleaning, he seemed a little bit better and so he came to speak for him. Because Prisoner A's been in a long time, he knows the system better than most people and he's had a couple of good responsible jobs on the wing."

85. The SO was unable to recall whether or not he spoke directly to the man at this point about what he thought about the transfer. In terms of what exactly Prisoner A said about his worries about the man in relation to the risk of self-harm/suicide, SO A said:

"I wish I could sit here and say I remember clearly what was said in that office, I don't recall those words but then again if he had those concerns I'm sure he would have said it. I'm not saying he didn't say it, it's just I can't sit here and honestly say to you hand on heart I remember him saying to me he's going to do this or that or the other, but if he had those concerns I'm sure he would have said it, I'm no doubt he would have said it if he had those concerns."

86. Prisoner A said that SO A said he needed to hear from the man himself and according to him the man did tell the SO. The prisoner described him as becoming bashful and in quite a state with a stutter and twitch which he said got worse the more stressed he became. He said that he asked for in reach to be called to come over and assess the man. SO A could not recall if the man was with Prisoner A in the office.

87. SO A said that he contacted the duty manager (Oscar One) to get advice about what to do in the circumstances. He was unable to recall exactly what was said "I don't recall exactly what I said but any concerns that I would have had about potential of, any sort of self-harm I would have passed onto Oscar One". My investigator asked if he considered opening an ACCT:

"Well no he was going to be transferred that morning, the concerns that I had passed to Oscar and then Oscar 1 deals with him how they deal with it within their control. He had already been cleared by healthcare to be transferred so, like I said before, I play a very small part in the whole process of being transferred. Nine times out of 10, if not more, I don't even get involved."

88. Prisoner A in interview said that later he was on the telephone and saw someone from the Independent Monitoring Board (IMB). A member of the IMB was on the wing at the time with a colleague who was being inducted. In interview, she said the prisoner approached her and told her that the man had had a note slipped under his door that morning about being transferred to Camp Hill and that he was very agitated.

89. She went into the cell to see him, who was lying on the lower bunk bed and, having knelt down, she introduced herself and asked him some questions. She said that he did not respond and was "just lying there not looking at me at all, not looking at anyone, just lying there". The prisoner told her that the man

was a self-harmer who had attempted suicide before and that as long they were together, he would not attempt suicide.

90. She felt that she needed to find out more information about the situation and why the man had not been given more notice about the transfer. She approached Officer A in the office, which was a very short distance from the man's cell. She said that Officer A told her that it was a good thing that he was being moved because there was a suspicion that Prisoner A was taking his drugs. Officer A confirmed this in interview with my investigator. She said that the move to Camp Hill would be in his best interest so that he could get his medication. There is no evidence to support that healthcare had been contributed about his move. At this point, they were interrupted by a "kerfuffle" behind them and the IMB member looked round to see the man being taken to the ground by officers. She retreated at this point to observe what was happening. She said she heard Officer A telephone healthcare to ask for two nurses come to reception urgently.
91. In interview, Officer A said that she thought the decision had been made not to tell the man too far ahead about the move. SO A said that staff were watching the relationship between the man and Prisoners A and B carefully but there was no proof that bullying for his medication was taking place. He thought that they looked after him, taking him food and generally helping him out. He felt that the suspicion about bullying would not have been the reason for the transfer which would have been routine. If bullying had been the case there would have been a number of options that they could have taken place such as moving him to another wing or, (as is policy) moving the perpetrators. He said that some staff were surprised that he was being moved but was unable to expand on this. He could not recall any discussion about staff agreeing not to tell him in advance of the transfer.
92. SO A said that he wanted the man to be transferred with the least amount of trouble. In interview, he said  

"... I knew he had to go so I had to try and think of a way of trying to get him in to the office so I could talk to him and say look you're going and that's it, so I asked staff to ask him to come and see me under the pretence that he was just going to come and talk to me. I didn't want it to get heated and turning into an argument or potentially you know even worse, and sort of like Prisoner B getting involved and the man getting you know sort of upset like about everything, I wanted to keep it calm and low key, so that's why I wanted to separate them."
93. The SO asked Officer E to take the man out of the cell by saying the SO wanted to see him in his office. In interview, the officer described knowing the man quite well as a very polite individual who did not mix with many people. He said staff took "quite a caring role with him, sort of looked after him" probably because he "was that little bit more vulnerable". The officer said he "seemed to become very, very settled in the end; he was very comfortable on the wing".

94. Officer E said that, having got the man out of the cell, he then attempted to go back to the cell and was told he could not. He was shouting through the door to Prisoner A about what was happening. The officer said that, despite being asked to come away from the door, he ignored the instructions of the staff. He was heard to say that he wanted to say goodbye to Prisoner A. Three officers were then involved in restraining him. Officer E was asked about the decision to restrain him. He said:
- “Yes, I wouldn’t say restrain him. Basically Officer F pulled him away from the door to which then he started to get quite agitated. Myself and Officer G then took one arm each, then he went down onto the floor. We didn’t take him down to the floor, he went down to the floor of his own accord.
- We just literally held them [his arms]. He then struggled and sort of lowered himself down to the floor, at which point we attempted to put him into an arm lock for control.”
95. Officer E explained that the arm lock position which the man was placed in was an alternative to his arms failing about and instead they were put in to the back hammer position. However, he explained;
- “.. as we attempted to do this he said ‘ow, ow, my arms don’t bend that way’. At that point all locks were completely released and he was helped to his feet and subsequently he was walked down to the section under no formal restraint whatsoever and he walked willingly down to reception. The whole incident was witnessed by the IMB as well.”
96. The IMB member followed them to reception. Officer E and G said that the man was crying as they walked but he could not recall any conversation. In reception, the IMB member asked the healthcare staff if he had taken his medication and they told her he had. Nurse D was one of two nurses who attended reception and she recalled asking him if he was okay to which he answered he was fine. The IMB member approached him and, after introducing herself again, asked if he had any concerns about being transferred. She said he did not answer her. She remained for a short while and then left reception.
97. The IMB member wrote to Prisoner A later that day which read “The man was taken to reception this morning and was supervised by HCC. He was calm, after an initial struggle. He was compliant about being moved to Camp Hill and will be medically supervised when he gets there.”
98. Officer E returned to the cell and Prisoner A packed up the man’s possessions. The officer then returned to reception where the transport was waiting to take the prisoners. Officer F, who had been involved in the restraint, processed the possessions through reception. He said that by the time the man got onto the van he seemed fine.
99. Prisoner A commented that he had heard that the man was only transferred because another prisoner had managed to avoid going and the man went in

his place. My investigator could find no evidence to support this having examined the list of transfers.

## **Camp Hill**

100. The risk categories for violence, conceals weapons and suicide/self-harm were ticked on the PER which accompanied him to Camp Hill had. Under the section of further information about risk is written "closed ACCT. Threatened police with firearms/resist arrest 08-11-08. Conceals weapons – samurai swords, cross bows and air weapons at H/A". Under the section about medical risks, the form indicates that there are no known risks. Also, there was no mention of the control and restraint used at Lewes immediately prior to the transfer.
101. The man arrived at Camp Hill at 2.28pm. Staff Nurse E conducted the medical screening when he arrived. The medical records which travelled with him were incomplete because the original had been lost and a temporary file had been generated. In essence these were the medical records from 16 April to 8 May.
102. The nurse, in interview, said she spent about 30 minutes with him. He told her of a history of drug misuse and that, prior to coming to prison, he drank eight cans and a bottle of spirits daily. She said "he presented as quite anxious. He had a lot of trouble with his speech, he would start to talk to me and then he would actually stop and then restart again and then going through his medical history I discovered why he was like that". She asked him directly about whether he thought about harming himself and he said that he was not. She referred him to the doctor for a medical review.
103. The nurse decided that he should have a single cell for medical reasons because he said that he was up quite a lot during the night and disturbed people. She assessed him as medium risk because of the previous self-harm and thought that it needed to be reviewed. He was located on the ground floor due to his mobility difficulties.
104. The medical notes received at Camp Hill were incomplete although the prison did receive the man's self harm history. Nurse E arranged for a GP consultation with the prison doctor due to the nature of his conditions.
105. Following the meeting, Nurse E discussed the man with a member of the Mental Health In Reach Team (MHIRT). They agreed that a routine referral was appropriate (which was outstanding when the man died. It is usual for a referral to take a few weeks to be processed).
106. That evening, Prisoner A said that he wrote to the man trying to reassure him. He still had a "few bits of his belongings as he had only two minutes to pack it all up, and to keep his chin up".
107. On Friday 15 May, the prison doctor assessed the man. He was not the usual doctor at Camp Hill but she does drug misuse work there. Her colleague was

away and she agreed to see him because Nurse E told her that he had a complex medical history. The nurse did not want to wait until after the weekend for him to see the doctor. She said that Nurse E was “not concerned about his immediate safety but she was worried about him, she felt he was quite vulnerable in the prison, that he had a lot of complex problems and felt that we ought to be aware of him sooner rather than later”.

108. The doctor said that she spent about 25 minutes with him and the first part of the consultation was spent talking about his drug use. He said he had been using heroin and snorting Subutex until the point of transfer and had last used three days before. His withdrawal appeared to be largely over by the time of their consultation but she did prescribe symptomatic relief for the symptoms although he did not collect this medication. He said he was “comfortable”. After the consultation, she referred him to the Substance Misuse Nurse Lead.
109. In interview, the doctor described an in-depth discussion with the man about his drug use and the problems he had since the severe asthma attack. She has a special interest in mental health and said “I very much hoped I would have picked up (depression) at that point. I mean you can never be 100% sure about people, but he was communicating, he maintained eye contact, he was happy to answer questions, I felt that he had engaged with me”. She described there being “an air of sadness” about him. She said it did not occur to her to open the ACCT procedures. She said that the subject of his drugs withdrawal dominated the consultation and they did not explore his self-harm history in any detail.
110. The doctor said that the man told her that he was okay at Camp Hill and they discussed whether he wanted to share a cell. She recalled that he preferred to remain in a single cell.
111. A prisoner on the wing who worked as an orderly (cleaner) recalled the man coming onto the wing. He described him as very quiet and, although he spoke when spoken to, he did not volunteer any information or engage with people. He said that the man would come out at association (time out of cell to mix with other prisoners) and watch people play pool although he did not see him playing. The prisoner described the staff on the wing as helpful and sympathetic but said the regime was poor and prisoners spent a considerable amount of time locked in their cell.
112. The man wrote Prisoner A a short letter (postmark on envelope 15 May) saying that it was a “shit hole” there, that he missed them and that some of his stuff was missing. He asked him to write back soon. (Some items were left in the cell at Lewes and were sent later to Camp Hill to be sent to his parents.)
113. A prison chaplain saw the man on 16 May in his cell as part of the induction process for any registered Catholic prisoners. She spent about 15 minutes with him and they spoke of his children and his accommodation needs upon discharge. She said he was not very communicative or forthcoming but she did not have any concerns about self-harm or suicide risks. She did, however, mention to a member of staff that she felt he might need some extra

help on the wing but she could not recall who she spoke to. There is no mention in the wing observation log book.

114. On 18 May, a CSRA was completed which stated that the man was to be "locate flat and single cell" with the reason given as "high/medical single."
115. Two days later, on 20 May, he was issued with a warning for smoking two days earlier whilst on association, a routine response to anyone who smokes outside the designated areas. The warning was issued by Officer H and countersigned by SO B. In interview, the SO recalled the officer reporting that the man had been very polite when he was issued with the warning which he felt was unusual under the circumstances.
116. The same day, Nurse E recalled a very quick conversation with the man when he came to the medication hatch in the afternoon. She thought from his brief encounter that he said he was fine and she did not have any concerns about him.
117. The man made five telephone calls to his parents between 14 and 19 May. He described life at Camp Hill as a "shit hole" and "worse than anything he has ever known". My investigator listened to the calls and felt that he sounded relatively upbeat and his parents said they were not unduly concerned about him. They discussed him getting a visiting order (VO) and he spoke of it being returned because he needed their dates of birth. On 20 May, at 6.19pm, he made his last telephone call to a female friend and they spoke for about five minutes. She asked what it was like there and he replied "shit" and, when asked whether he had made any friends, he said no. He gave the address of Camp Hill so she could write in and he could send her a VO. She told him about going to Canada for a couple of weeks and the conversation ended quite abruptly when he said he had to go. (These calls were routinely recorded and would not have been listened to at the time.)
118. OSG A was on night duty starting at 8.45pm on 18 May. At the start of the shift, there was a handover from day staff but nothing was reported about the man. During the night, the OSG's duties included checking any prisoners on ACCTs, answering cell bells and carrying out roll checks [counting all the prisoners] at the start and end of the shift. At 11.20pm, he became aware that the man's television was turned up quite loud so he went to his cell. He said that the man was sitting on the bed and when he asked him if he would turn the volume down. He did so, without comment, and the OSG thanked him and walked away. The prisoner in the neighbouring cell confirmed that he had heard the volume of the television go up and the man being asked to turn it down.
119. At 12.05am, the Orderly Officer, SO C, came onto the wing as part of his night time checks of the prison and he and the OSG sat in the office talking until 12.30am. (The Orderly Officer is the most senior member of staff on duty at night and is responsible for the prison. Both are permanent night staff and have been employed for a considerable time.) At approximately 00.35am when the Orderly Officer left, the OSG noticed that the volume of the man's

television was up again and returned to his cell. He looked through the observation flap and saw him sitting on the floor, with his head bent forward. The OSG then noticed the noose attached to the top bunk. The OSG was only steps away from the office and returned there to telephone the control room to tell them a prisoner was hanging. (The OSG was carrying a radio but said he was so near the office that it was his first response was to use the telephone in there.)

120. The control room radioed the Orderly Officer who arrived at the cell very quickly, having only just left the wing to return to the segregation unit a couple of minutes earlier. The segregation unit is approximately 30 yards from the cell and he ran, accompanied by at least two other officers. SO C opened the cell door and staff quickly cut the ligature and laid the man down. The SO said that the man's face was bright red and he was cold to touch with a degree of rigor mortis. He made a number of checks for a pulse but could not locate one and asked the control room to call for an ambulance. The staff did not attempt cardiopulmonary resuscitation (CPR).
121. According to the ambulance report, the paramedics were called at 00.41am, were at the man's side by 00.46am and certified his death at 00.50am. He had left a short note addressed to his parents by his side and placed a photo of his children next to it.
122. The prison contacted the police who agreed to go to the home of the man's parents to break the news. This was at about 4.00am. Very soon after this visit, his mother contacted Camp Hill and spoke with a governor. Later that afternoon, Officer I, from the Safer Custody Team, contacted the man's mother in his role as family liaison officer. He offered to collect her so that she could come to Camp Hill and also to see her son at the Chapel of Rest. She declined the offer but did agree to a visit from the FLO a few days later. The prison offered the cost of the funeral.

## ISSUES

123. The man had both complex physical and emotional difficulties. Whilst there was not a clear understanding of his needs, there is significant evidence of staff at Lewes interacting in a meaningful and supportive way towards him. They were helped by some prisoners. Staff tried to persuade him on a number of occasions to be moved to the healthcare centre but he always declined. He made three further self-harm attempts after his initial serious attempt in November, but these were less severe. I am particularly impressed by the regularity of his contact with his personal officer which is something not often seen in other establishments. However, there are a number of areas in which staff at Lewes performed disappointingly.

### ACCT management at Lewes

124. In his clinical review, the clinical reviewer discusses the man's acts of self-harm;

“on each occasion that he cut himself, an assessment of the event and of his intent to attempt suicide or harm himself again was made. Separately, these assessments all indicated low risk. Each individual assessment following self-harm was adequate. However, there appeared to be no attempt made to understand the triggers for him harming himself, the circumstances of these incidents and whether a theme or pattern would be established. I observed that in his case, each individual assessment was conducted carefully and came to a reasonable conclusion, but each focused only on the most recent episode of self-harm.”

125. The man was on three ACCTs during his time at Lewes. Although he was in contact with the mental health in reach team, and with medical staff for his many physical needs, none of the reviews included any staff other than discipline staff. These reviews should be multi-disciplinary especially when the prisoner is already involved with medical staff. In each individual ACCT there was no consistent case manager and rarely the same two staff conducting the reviews. Although he was known to staff on his wing and they would have been familiar with him, a case manager with an overview of him should have been at each review. This indicates some poor practices in the general management of the ACCT process.

**The Governor of HMP Lewes should issue repeat guidance about the management of ACCTs, ensuring multi disciplinary case reviews and a consistent approach in the case manager role. The ACCT must be monitored for quality.**

126. On 16 April, staff attended to the man after he cut his left wrist. None of the staff involved, which included a nurse and the duty manager, considered, or even discussed, opening an ACCT. The guidance from Prison Service Order 2700 (Suicide prevention and self-harm management) is very clear:

“All acts of self-harm or statements of intent to self-harm must always be taken seriously no matter what the perceived reason for the self-harm is. Attitudes that see some people who self-harm as “genuine” and others as “manipulative” are dangerous and should not be tolerated by managers. Where the self-harm is goal-oriented, the prisoner should be helped to find a more constructive way to meet their underlying need.

### **13.2 Follow-up actions and care for prisoners who have self-harmed**

*In the event of any incident of self-harm staff must (where there is not one open already) open an ACCT Plan. This must be done no matter what the reason for the self-harm. Opening an ACCT means that the individual will be interviewed by an ACCT Assessor who will talk with them about what led up to the incident, what they were trying to achieve and why and how they think further self-harm could be avoided or reduced in the future. The care plan for someone whose self-harm was not suicidal in intent will be different from one who is determinedly suicidal, but they still require care.”*

127. The ACCT process is not only a tool for those with active suicidal intentions, but also for those who harm themselves. An ACCT should have been opened regardless of how the action was perceived by the nurse, who felt that it was not a serious attempt. The duty manager should have checked that an ACCT was opened.

**The Governor of HMP Lewes should remind all staff of the PSO guidance in relation to when an ACCT must be opened.**

### **The man’s physical health care needs**

128. In his clinical review, the clinical reviewer comments that:

“The medical record is replete with accounts of the man falling, collapsing, suffering from an epileptic fit and – on one occasion – having an asthma attack. I found no information to indicate that his risk from collapse (from fits or falling) and poor mobility were addressed comprehensively.

Addressing his physical problems and managing him in a more appropriate environment may have improved his physical and mental well-being. I acknowledge that this is difficult in a prison environment.”

**The Head of Healthcare at HMP Lewes should ensure that staff adequately identify and manage physical health care needs and communication difficulties for prisoners.**

## **Identification of the man as a prisoner with disabilities**

129. The man was identified as a prisoner with disabilities and, on 16 February, the Disability Liaison Officer at Lewes completed a Disabled Prisoner Care Plan. By this stage, he had been in custody for two and a half months. The assessment concluded that he needed no assistance in any areas. Given the help he was receiving on the wing from prisoners and staff this does not seem to accurately reflect his situation. It is not clear from the form whether any supporting information was sought from staff or healthcare and gives the impression that the assessment may be a formality rather than an in-depth enquiry.

**The Governor of HMP Lewes should ensure that the Disabled Prisoner Care Plan is completed in a timely fashion and with attention given to all available records.**

130. During his telephone calls to his family, the man described Camp Hill as a “shit hole” and mentioned that he needed their dates of birth so he could send out a visiting order. This appeared to be holding up his application and preventing him from sending out a visiting order. Given that all this information was already recorded in the system as his parents had visited before, it seems an unnecessary demand on prisoners to provide this repeatedly and particularly for him something he would have found difficult to recall. Such a request would have impacted disproportionately on him and, had he been more systematically identified as a prisoner with disabilities, I hope that he would have received help from staff.
131. Unfortunately, the man’s parents received a visiting order six days after he died and understandably were very upset by this. My investigator spoke with the liaison officer at Camp Hill who looked into the matter and found that the man had sent the order out on 20 May, the day before he took his own life.

## **The man’s medical record**

132. The man arrived at Camp Hill with a temporary medical record. On 16 April, a new medical record was started as the original one appeared to have been lost. This second record remained in circulation and was the document which travelled with him to Camp Hill. The investigator asked staff to see if they could search for the original medical record and it was found in the archived medical records file. (The record was sealed and had written on the outside “released 3/01/09. However, the last record in it is recorded as 17 February.) It is hard to believe that this action could not have taken place before his transfer and, at the very least, upon his transfer. I do not know how regularly misfiled medical records are but I would suggest that the Head of Healthcare give some guidance to staff about what measures should be taken to find one should it go missing.

**The Head of Healthcare at HMP Lewes should remind all staff of the importance of filing records correctly. In the event of a missing medical record, guidelines should be issued about how to search for them.**

133. One of the responsibilities of the healthcare staff is to complete the medical section of the Prisoner Escort Record. This is usually a task done during a night duty and involves checking their medical record. When the man was transferred to Camp Hill, the PER said that he had no medical issues. Given the extent of his extensive difficulties, it is difficult to understand how this can have happened and I am disappointed the PER was not fully completed in this area.

**The Head of Healthcare at HMP Lewes should issue local instructions on the correct procedures to be followed when a prisoner is transferred and the information that should be made available to the receiving prison on the PER form.**

134. Given the complexity of the man's medical difficulties and the numbers of incidents of fits and falling he had had whilst at Lewes, it would have been very beneficial if medical staff at Camp Hill had been provided with a summary of his needs.

**The Head of Healthcare at HMP Lewes should ensure that proper written handovers are given to any receiving prison, especially when a prisoner has ongoing medical issues.**

#### **Cell Sharing Information records**

135. The man's Cell Sharing Risk Assessment was marked with a comment that he had threatened to set fire to his cell mate. My investigator has been unable to find out what this refers to as there is no other record and none of the staff interviewed knew what it meant. The comment contributed to him being identified as being high risk, although he does appear to have been allowed to share with prisoners after this incident. The information was passed onto Camp Hill, even though it may have been inaccurate, and although he was identified as high risk and did not want to share, it may have penalised him unnecessarily.

**The Governor of HMP Lewes should remind staff of the importance of completing records accurately.**

136. A security report had been completed on 30 April following a prisoner telling staff that two prisoners were taking his medication from him. As a result, the man was supervised when taking his medication. On 8 May, he was allowed to share a cell with one of these prisoners. Although this was a move which he agreed to, it does appear a somewhat risky policy. I make no recommendation but the Governor will wish to consider whether any action should be taken to ensure that prisoners do not share cells with a possible bully.

## **Transfer from HMP Lewes to HMP Camp Hill**

137. Once the man was sentenced and categorised as a category C prisoner, he became eligible for transfer out to Camp Hill. The timing of the transfer is organised by the OCA (Operations, Categorisation and Allocations department) and staff on the wing are informed accordingly. From Lewes, the transfer day to Camp Hill often occurs on a Tuesday and notification to the wing can take place on the previous Friday or the Monday. Depending on which member of staff my investigator spoke to they explained that prisoners are informed of the move by being handed a slip in person or posted under their door. At least 24 hours warning is given, although it can be longer, and this allows a prisoner the opportunity to speak with staff if they are unhappy about the transfer. Staff said that the objection can be expressed to a governor for them to deal with. It seems that he received his slip on the morning of the transfer after hearing of the move the night before from another prisoner. It is not clear whether this was a deliberate action on the behalf of staff or an oversight. For the man, it meant he was not given the appropriate amount of time to launch any objection to the move.
138. He was not an unknown quantity to staff on C wing at Lewes. They knew of his self-harm history, his physical difficulties and how both he and staff relied on other prisoners to help him. On the morning of the transfer, the view was taken that he would resist going to Camp Hill and a situation developed where use of force was used. (Staff completed the use of force paperwork.) The senior officer wanted the transfer to happen without any problems and I believe that the man was “tricked” into coming out of his cell. This meant that he also did not have time to pack up his own things or say goodbye to his friends. I do not believe that this situation was dealt with in an appropriate or fair manner.
139. Despite being aware of his history and the concerns being expressed by Prisoner A, an ACCT was not opened by staff at HMP Lewes even though this would not have prevented the move or held up the transport van. Also, no information was recorded on the PER to relay that use of force had been used. Consequently, staff at Camp Hill were unaware of what had taken place during that morning and his distress about being moved.

**The Governor of HMP Lewes should issue local instructions on the correct procedures to be followed when a prisoner is transferred and the information that should be made available to the receiving prison on the PER form.**

## **Clinical care**

### **HMP Camp Hill**

140. Unusually, there are two clinical reviews attached to this report. The first clinical reviewer’s review looks at the man’s time at Camp Hill and the second clinical reviewer reviews his time at Lewes.

141. The first clinical reviewer's review discussed two main points. Firstly, the man did not attend for his supervised morning medication on 16,17, 18 or 20 May at Camp Hill and although healthcare staff say that they rang the unit but he refused and only attended evening sessions, their calls and his response were not recorded anywhere. It was confirmed that a policy, prompted by his death, was in the process of being written. The pharmacist present at the panel review suggested that the implications of him not taking his medication would be that he was more likely to suffer from a fit after two or three days. Missing his anti-depressant medication would have had a long term effect.
142. Secondly, staff indicated that healthcare staff would normally inform wing staff if a prisoner suffers from epilepsy, asthma or diabetes. The man's form, available to discipline staff, had 'serious medical issues' but they were not specified.
143. Both these concerns were addressed with the one recommendation made by the clinical reviewer and panel;

**The Primary Care Trust should draw up a policy to identify prisoners at HMP Isle of Wight who miss their medical appointments and medication appointments. This is also to include identifiable conditions such as epilepsy, diabetes and asthma.**

144. The first clinical reviewer concluded that, in relation to Camp Hill, the man received "equitable care as that received within the community".

### **HMP Lewes**

145. The second clinical reviewer's review contains a number of recommendations which can be read in full in the annexe. For the purpose of his review, he spoke with the nurse consultant in Forensic Mental Health at HMP Lewes. For his review, he obtained the man's medical notes from the community and wrote:

"Access to these records would have enabled the prison health service to appreciate the man's history of self-harm and substance misuse prior to his respiratory arrest and his complex problems that followed his respiratory arrest, both physical and psychological, in response to dramatic changes in his circumstances as well as hypoxic brain damage'.

146. The clinical reviewer makes the following recommendation in relation to this which I fully endorse;

**HMP Lewes' mental health service should request mental health records for prisoners with a history of contact with mental health services.**

147. Among his comments, the clinical reviewer suggested that 'the provision of a key nurse may have enhanced the clinical team's understanding of the man's circumstances, contributed to the clinical formulation, and provided him a

single point of contact, a nurse with whom he could develop a therapeutic relationship’.

148. The clinical reviewer made some very interesting comments about the identification of mental disorder, the transfer from Lewes to Camp Hill and drawn some conclusions. I repeat them here.

“A historical occupational therapy/speech and language therapy report dated 2007 – available in the prison record – noted that the man had difficulty planning and organising information and in social interaction and behaviour, where he had a tendency to push boundaries. This may indicate the presence of frontal lobe pathology, which may also have had a bearing on his apparent tendency to emotional instability and poor impulse control at times when he harmed himself. This is suggested by his appearing to harm himself in response to relatively trivial matters and frustrations when his demands were not met.

This would have presented particular difficulties with management, as hypoxic frontal lobe damage is likely to have been irreversible at this stage. However, treatment could have aimed to control the external environment and provide appropriate, consistent support and boundaries. A management plan formulated to minimise external pressures would have been difficult to implement within a prison setting, but a care plan designed to keep external stresses at a minimum and provide a consistent clinical team may have been beneficial.

An assessment by a psychiatrist would have provided the opportunity to collate the man’s history and perform a mental state examination to produce a comprehensive clinical formulation to inform management.

I discussed this with a colleague. At the time of the man’s imprisonment at HMP Lewes, there were only two sessions of consultant and two sessions of specialist registrar clinics weekly. This dedicated that only prisoners with the most severe disorders or acute presentations could be assessed by and receive aftercare from a psychiatrist. My colleague agreed that it would have been highly desirable for the man to have been assessed by a psychiatrist, in order to collate a detailed history and produce a comprehensive clinical formulation to inform management. He has been implementing a commissioning review with the result that a new consultant has been recruited to provide seven clinical sessions at HMP Lewes. He anticipates that this will provide sufficient resources to enable the clinical assessment and management of more prisoners, including those with complex presentations like that of the man.

Regarding equivalence of care, my colleague was of the opinion that HMP Lewes had been able to provide a high standard of care, but this would not have been as comprehensive as a community mental health

team would have been able to provide because of the lack of a psychiatrist and multidisciplinary team.”

149. With regard the transfer, the clinical reviewer wrote:

“The inmate medical record and the community mental health team and substance team notes from Bognor Regis indicate that the man found it difficult to adjust to new circumstances. Transferring him from HMP Lewes to HMP Camp Hill may have resulted in his experiencing considerable stress. That he was transferred nine days prior to his death may well be significant.

A complete clinical formulation may have alerted prison mental health staff to the possibility that he could tolerate transfer poorly. The provision of a keyworker who had developed a therapeutic rapport with him may have enabled its anticipation.

The transfer of vulnerable prisoners with poor coping mechanisms should only take place when absolutely necessary, and with adequate support structures in place.

My colleague said that his clinical team would have no influence over the transfer of a prisoner, except if they expressed a ‘grave concern’, for which they would have to provide evidence.”

150. The clinical reviewer makes 15 recommendations which should be considered by the Head of Healthcare at Lewes. He concludes his report:

“While the man’s attempting suicide may not have been predictable in the days before his death, there are a number of issues that could have been addressed at an earlier stage in his imprisonment that may have reduced the risk of his acting thus.

The absence of a mental illness does not necessarily equate to a low risk of attempting suicide, particularly when a number of psychological and social factors and stressors combine. Together, these can engender a sense of hopelessness and futility. This is especially hazardous in an individual with a propensity to risk-laden acts rather than a tendency to approach staff to discuss unpleasant feelings and ideas of self-harm.”

151. The man’s disclosure to the prison doctor at Camp Hill that he had been withdrawing from drugs during his first few days at the prison is a puzzling revelation. There is no evidence of this other than his own disclosure. Neither Prisoners A or B indicated when asked that they had known him to use drugs. I am unable to draw any conclusion except that, if he was withdrawing, this would have affected his mood.

## **The discovery of the man**

152. There is no inpatient healthcare facility or any healthcare staff available in Camp Hill during the night. Two senior officers work alternate permanent night shifts and, at the time of the man's death, only one was first aid trained. SO C was not up to date with his training (which has to be refreshed every three years) and was not CPR trained although he described himself as competent and knowledgeable. Upon discovering the man, he assessed his condition and believed that all the signs indicated that he was dead. In interview, he was asked about his understanding of when staff should or should not attempt CPR. He responded:

“The first aid side of life is quite simple and it's if a person shows no signs of life via heartbeat or via breathing, then CPR should be used until medical, proper qualified medical attend and I've got no problem with that whatsoever. But not being trained, not being qualified then it's not my place to actually carry it out apart from obviously if I thought that I could do it. But if it was blatantly obvious, which unfortunately it was that the person was beyond resuscitation which in opinion, unqualified that he was, there was no point to it whatsoever which the ambulance crew when they arrived confirmed. If some degree of life or recent life had been there then I would have had no problem whatsoever in doing it but unfortunately he was beyond that, in my opinion.”

153. Despite his lack of up to date first aid training, I believe that SO C's actions were entirely appropriate. Following the man's death, both permanent night staff have now been trained in CPR. Had this not been the case, I would be making a recommendation to this effect.

## **Family Liaison**

154. The man's parents were told at 4.00am of his death by police officers from West Sussex. It is preferable for staff from the prison, or alternatively, staff from the nearest prison to the family home, to break the news to the family in person and this is policy guidance. A report into the death of another prisoner in 2009 resulted in a recommendation regarding how best to inform the next of kin. Given the time of night, and the limited number of staff on duty at night in any establishment, it is understandable that Camp Hill made these arrangements with the police. However, it should be noted that generally the expectations are that prison staff will inform the next of kin.

## CONCLUSION

155. At Lewes, the man appeared to settle and staff, recognising his vulnerability, supported him very well. Whatever the motives of Prisoners A and B, it was recognised that they consistently provided help and support for the man. Staff often called on them on both a daily basis and when he was in particular difficulty and at risk of harming himself. Having self-harmed very seriously two weeks after his first remand to Lewes, he appeared to become more comfortable and settled. The good practice at Lewes was tragically undermined by the apparently unplanned transfer to Camp Hill. Lewes prisoners regularly move to Camp Hill but I find it unfortunate that no exception was made for a vulnerable prisoner such as the man. Furthermore the transfer was carried out in a fundamentally flawed way. Not only was he deprived of his opportunity to appeal the move, pack his belongings or bid farewell to his friends, but he was moved after what can only be described as a trick which persuaded him to come out of his cell. Then, and making matters considerably worse, force was used to make him leave. Finally, none of this was reported to Camp Hill and so no one there knew about the traumatic experience that he had experienced. Sadly, at Camp Hill without his friends and amongst staff who were unfamiliar to him and how he presented, he was isolated and vulnerable.

## **FAMILY RESPONSE TO DRAFT REPORT**

156. The man's family received a copy of the draft version of the report as part of the consultation period. His family told my family liaison officer that they were angered and saddened by the findings and that it had been simply too painful to read the report and annexes in their entirety. They feel he required specialist help and the system failed to provide this. They feel that a lack of information sharing between staff meant their son received inconsistent and inadequate care and that little effort was made to understand his disabilities and to engage him in activities he was physically able to do. They were further concerned about the management of his medication and the decision to transfer him to a prison that did not provide 24 hour healthcare, the rationale being that this was not something he had relied on in the community. His family strongly disagree. They explained that although he craved independence, his disabilities prevented him from living independently in the community. He lived in adapted housing where he relied on visits from carers at least three times a day and daily help from his family. The family feel it is apparent that he was deemed 'fit for transfer' without due consideration of his healthcare needs or the ongoing support he required. The family were also shocked to learn that prison officers are not required to have mandatory first aid training despite being responsible for large numbers of prisoners. They welcome the subsequent decision to provide CPR training for permanent night staff at Camp Hill. The family feel that the way in which he was tricked out of his cell prior to being transferred to Camp Hill was reprehensible and a serious breach of his rights as a prisoner. They feel strongly that this can only have added to his feelings of vulnerability, isolation and despair.

## RECOMMENDATIONS

All recommendations, with the exception of number 7, were accepted. Number 7 was partially accepted. The proposed action is written in italics following each recommendation.

1. The Governor of HMP Lewes should issue repeat guidance about the management of ACCTs, ensuring multi disciplinary case reviews and a consistent approach in the case manager role. The ACCT must be monitored for quality.

*ACCT management monitoring procedures are already in place including post closure reviews and a further assessment during the Safer Custody meetings. Multi disciplinary reviews will be further promoted by within the Safer Custody Strategy and regular Safer Custody meetings.*

2. The Governor of HMP Lewes should remind all staff of the PSO guidance in relation to when an ACCT must be opened.

*We will re-publish guidance on ACCT management. This will be further supported by referral to the Safer Custody Toolkit, now accessible by all staff electronically. All ACCT training to reinforce instruction on when an ACCT must be opened.*

3. The Head of Healthcare at HMP Lewes should ensure that staff adequately identify and manage physical health care needs and communication difficulties for prisoners.

*Each prisoner entering Lewes will receive a full health screen. Any issues identified will be followed up through Mental Health, Drugs and Alcohol or Primary Care Services. All care plans and referrals will be tracked through the System One electronic medical records system now in place at HMP Lewes. All referrals to the Mental Health In-Reach Team are now scrutinised by our resident consultant psychiatrist.*

4. The Governor of HMP Lewes should ensure that the Disabled Prisoner Care Plan is completed in a timely fashion and with attention given to all available records.

*Disability Officer to be provided with sufficient opportunity to complete care plans in a timely fashion including sufficient access to necessary and available records where appropriate.*

5. The Head of Healthcare at HMP Lewes should remind all staff of the importance of filing records correctly. In the event of a missing medical record, guidelines should be issued about how to search for them.

*All medical records are now maintained electronically utilising System One; all paper received is scanned into the system.*

6. The Head of Healthcare at HMP Lewes should issue local instructions on the correct procedures to be followed when a prisoner is transferred and the information that should be made available to the receiving prison on the PER form.

*Local healthcare protocol will be produced stating what health information must be included on each Prisoner Escort Record.*

7. The Head of Healthcare at HMP Lewes should ensure that proper written handovers are given to any receiving prison, especially when a prisoner has ongoing medical issues.

*When a receiving prison is 'live' with System One Electronic Records, there is no need for a written paper transfer sheet – as records are electronically 'push-pulled' from one establishment to another. In the absence of System One, a full summary extracted from System One will be printed and sent with the prisoner.*

8. The Governor of HMP Lewes should remind staff of the importance of completing records accurately.

*Notice To Staff (NTS) to be published reminding staff on the importance of completing records accurately.*

9. The Governor of HMP Lewes should issue local instructions on the correct procedures to be followed when a prisoner is transferred and the information that should be made available to the receiving prison on the PER form.

*Instructions to be provided to those working in Reception on the use of the PER, including the assurances required that all necessary and relevant information is accurately documented.*

10. The Primary Care Trust should draw up a policy to identify prisoners at HMP Isle of Wight who miss their medical appointments and medication appointments. This is also to include identifiable conditions such as epilepsy, diabetes and asthma.

*Guidelines are in draft form. Further amendments are in the process of being included which will then be agreed for working draft. Full discussion at management meeting 24 November 2010 for working draft to be implemented.*

11. HMP Lewes mental health service should request mental health records for prisoners with a history of contact with mental health services.

*When a prisoner is identified, through first-night reception healthcare screening processes to have had previous contact with the mental health services, the Mental Health In-Reach Team will make a determined effort to obtain previous records and information. The Nurse Consultant for Mental Health is currently in communication with the neighbouring Mental Health Trust to gain access to Electronic Care Planning Approach (ECPA).*