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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP Lewes in  
July 2012**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanging in his cell at HMP Lewes in July 2012. He was 36 years old. I offer my condolences to the man's family and friends.

A clinical review of the man's clinical care and treatment was carried out on behalf of West Sussex Primary Care Trust. Lewes prison co-operated fully with the investigation.

The man spent over seven months at Lewes during two separate spells. In between, he spent six weeks at an NHS mental health unit. He had been charged, and was later convicted, of the murder of his partner.

The man said he was actively considering suicide for much of his time in prison and he was monitored under Prison Service self-harm and suicide prevention procedures for his entire time at Lewes, and he remained a patient in the healthcare centre. He was regarded as a high risk of suicide and for long periods was constantly supervised. He made a serious attempt on his life by drug overdose during his stay in the mental health unit, and appears to have taken two overdoses at Lewes. However, after his conviction in late June he began to speak more positively about the future and his likely move from Lewes. Because of this, his level of self-harm and suicide monitoring was reduced and he was moved to a new cell in a quieter part of the healthcare centre that gave him a better environment.

It is possible that the man gave staff false reassurances about his state of mind and his intentions in order to improve his chance of killing himself. Prison staff considered this, but judged that it was appropriate to make adjustments to allow him an improved quality of life. Although certain aspects of Prison Service procedures for those at risk of suicide were not followed, in many respects he received very good care. Ultimately it is very difficult to prevent someone who makes a reasoned decision to kill himself from carrying out that plan, without making living conditions so restrictive as to be inhumane. Accordingly I do not criticise the decision to relax the level of the man's observations.

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.

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## SUMMARY

1. The man was remanded to HMP Lewes in October 2011, charged with the murder of his partner. He told prison staff that he had previously attempted suicide by taking a drug overdose two years earlier and that he had suicidal thoughts. Staff opened an ACCT<sup>1</sup> and he was held in the healthcare unit for enhanced support.
2. The man remained at the prison for the next two months before being transferred to a medium secure mental health unit just before Christmas 2011, because of concern about his continued low mood and expressions of ongoing suicidal thoughts. He had remained on an ACCT and in the healthcare unit throughout his two months at Lewes.
3. The man made a serious attempt on his life by taking a drug overdose at the mental health unit. After six weeks at the unit, he returned to Lewes in mid February 2012. No formal diagnosis of a mental health illness had been found. In a discharge letter a psychiatrist said that the man's low mood and suicide risk were very much associated with his circumstances and that he posed an ongoing risk of suicide.
4. The man moved back to a high observation cell in healthcare and another ACCT was opened. He continued to report thoughts of suicide. At the end of June he was convicted of murder and sentenced to life imprisonment with a minimum term of 17 years. At first he said he was not sure how he would be able to deal with such a long period in custody, but within a week or so he began to speak in more encouraging terms including talking about identifying a suitable long-term prison for him to move to.
5. Two significant adjustments were made to the man's management during July. One was a reduction in the level of his ACCT observations and the other was to agree his request to move from the main healthcare unit to the healthcare lower floor which houses prisoners with less intensive needs. Some of the staff were sceptical about his apparent increased optimism, but staff were also mindful of trying to improve his quality of life by allowing him a degree of privacy that he had not been able to have so far during his time at Lewes in a high observation cell.
6. At the end of July, the man's ACCT plan included hourly checks at night. He was apparently asleep in bed when checked at 2.00am on a morning in July, but at 3.00am the nurse who checked him noticed he was sitting slumped behind the privacy screen in his cell. Staff entered the cell and found that he had a noose attached to the privacy screen support. Resuscitation was attempted by prison staff but was unsuccessful. The man was pronounced dead at 3.35am. He was 36 years old.
7. The investigation found that the man received a good level of support from a dedicated group of staff. While the outcome might not have been affected, the

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<sup>1</sup> ACCT stands for Assessment, Care in Custody and Teamwork. It is the process through which support is given to prisoners deemed at risk of self-harm or suicide.

investigation found that the ACCT procedures were not in line with national guidance, including enhanced case review procedures for those with enduring suicidal thoughts and on constant supervision.

## THE INVESTIGATION PROCESS

8. The investigator visited HMP Lewes on 2 August 2012, and met the Governor, a representative from the Prison Officers' Association and a member of the Independent Monitoring Board. He visited the man's cell and the wing where he lived. He obtained copies of his prison and health records. Notices were issued to staff and prisoners informing them of the investigation and inviting them to contact the investigator if they wished to be involved. One prisoner came forward in response.
9. The investigator subsequently interviewed 13 members of staff and one prisoner.
10. The investigator contacted the Coroner's officer and a copy of this report has been sent to the Coroner to assist his enquiries.
11. A consultant forensic psychiatrist carried out a review of the man's clinical care and treatment on behalf of West Sussex Primary Care Trust.
12. One of the Ombudsman's family liaison officers (FLOs) spoke to the man's grandmother, his next-of-kin, to inform her of the investigation and to allow her to identify areas she wished the investigation to cover. She said that she had no concerns about the care her grandson had received at Lewes. She considered that he had been well looked after in the circumstances and was very positive about the sensitive support she had received from the prison's family liaison officer.

## **HMP LEWES**

13. HMP Lewes is a Victorian prison which holds up to 723 remand and convicted male prisoners. It consists of five main residential units. Healthcare is commissioned by East Sussex Downs and Weald Primary Care NHS Trust

## **HM Inspectorate of Prisons**

14. HM Chief Inspector of Prisons last inspection of Lewes before the man's death was in May 2010. The reports of a more recent inspection in November 2012, has yet to be published. The Chief Inspector's 2010 report included:

“... This prison has ... sustained its strong emphasis on safety and good staff prisoner relationships ... this inspection has been able to confirm that Lewes is an improved and improving prison.

“The suicide and self-harm policy was under active review ... ACCT self-harm monitoring documents were of a reasonable standard, with some good examples of engagement, care and compassion. The quality of case reviews was generally good but many were insufficiently multidisciplinary ...”

## **Independent Monitoring Board**

15. The IMB is made up of independent, unpaid members of the local community who help ensure standards of care and decency are maintained. In their last report for the period ending January 2012, the IMB noted:

“With the emphasis now that all staff have to be trained in the use of ACCTs [suicide and self-harm prevention measures] and in the operation of the review system concerning prisoners identified as being at risk of self-harm/suicide, a greater awareness of the importance of a 'safer custody' in the prison is being created.”

## **Previous deaths in custody at Lewes**

16. There have been four self-inflicted deaths at Lewes in the five years preceding this man's death, including one earlier in July 2012 and one just three days before the man's death. The investigator reviewed the circumstances surrounding these other deaths. In all three cases the deceased's offences had been against family members. Although the circumstances were quite different, the man who died a few days before this man was also charged with homicide against a family member. All three prisoners were found hanging, and we comment about using an effective emergency response code in each of the investigations.

## KEY EVENTS

17. The man was arrested on the night of 16 October 2011 and charged with the murder of his partner. He stayed in police custody until 20 October, when he went to court and was remanded into HMP Lewes. The documentation from his time in police custody indicated that he was at risk of suicide and needed to be monitored closely.
18. Staff at Lewes opened an ACCT and moved the man to a high observation cell in the healthcare unit where he was placed on constant supervision. (Constant supervision is where a member of staff observes and supports a prisoner at all times in order to help reduce the risk of suicide.)
19. A community psychiatric nurse (CPN) assessed the man and noted that he was generally calm, but became emotional when speaking about his young children. The man told the CPN that he had previously worked as a police officer and was concerned about his safety in prison. He said that he had attempted suicide by drug overdose two years previously after his father was murdered. He said he felt actively suicidal at the time. The records show that his previous suicide attempt had been pre-planned and he had concealed medication in his home over a period of time for that purpose.
20. As part of the ACCT process five triggers that might cause the man to harm himself were identified. These were his current charges, his symptoms of depression, the impending anniversaries of his father's birthday and death, his son's impending birthday and when he realised he would be likely to have to plead guilty to murder. An officer carried out an ACCT assessment interview that afternoon.
21. At the assessment, the man said that he felt very highly depressed. He said that he had not decided whether he wished to live or to die but reported feeling supported through being constantly supervised.
22. The man attended his first ACCT case review on 21 October, which was chaired by the healthcare manager, accompanied by a doctor. The healthcare manager noted the man said he had no suicidal thoughts and felt well supported in healthcare. Observations were reduced from constant to every 15 minutes and staff were required to record interaction with him four times during the day and four times at night.
23. The ACCT Caremap to identify actions to support the man noted a need to ensure his safety in prison because of his previous profession and the nature of his offence. The plan was to keep him in the healthcare centre and transfer him to the vulnerable prisoners' wing. (Vulnerable prisoners are those who might be at risk from other prisoners and kept apart from them, usually due to the nature of their offence). The man always expressed great reluctance to move out of the healthcare centre and this move never happened.
24. The healthcare manager explained to the investigator that at Lewes, prisoners in the healthcare centre assessed as at risk of suicide or self-harm are managed through a dual process combining the prison ACCT process and the PCT's

therapeutic observation policy. As a result, when the man was removed from constant supervision, he was still observed four times every hour under the PCT policy. He said that the instruction on the ACCT document that there should be four daily contacts and four nightly contacts did not reflect the actual level of support and supervision. The healthcare manager said that healthcare staff were not confused by the operation of both these policies together.

25. On 24 October, a nurse made the following entry in the man's clinical record:

"... [the man] spoke about how his thoughts surrounding suicide fluctuate throughout the day and he feels certain times i.e. nights are more difficult to cope with. Talked about how he realises that it's up to him to make the decision that he will be around for his trial date in April 2012 and what his life may be like after this. Talked about his children and how he has asked that they go to his late [partner's] family ... spoke about wanting to do the best for his children ... Stated ... that he feels safe [in healthcare] and would happily stay here until his trial in April ..."

26. The nurse had a lot of contact with the man and told the investigator that when the man first arrived at Lewes he was shocked and distressed and often spoke about how much his life had changed in such a brief period of time. He talked about how he had lost his family, his home and his lifestyle, but then began to settle into the prison regime. The nurse said that she and the man had a good relationship and he spoke to her about his career, about the impact of his father's death and how the only support in his life was his grandmother. She said that he was selective about the people he would engage with and was also selective about what he would disclose. However, he consistently said that he was taking each day as it came and he always kept as an option that he might one day choose to take his life.

27. On 31 October, one of the man's friends telephoned the prison with a warning that a potential trigger for his friend to take his life would be if he were to be advised by his legal team that he would have no option but to plead guilty to murder. Staff at Lewes recorded this in the ACCT plan. A prison psychiatrist saw the man that day and recorded:

"... [the man] stated that he continued to be low in mood with intermittent suicidal ideation. He finds it hard to believe the situation he is in and feels he has lost everything ... Past history of contact with mental health services ... in 2009 following the murder of his father ... Took an overdose [two months] after this ... compliant with [consultation] with good eye contact and good rapport ... Mood objectively and subjectively depressed ... Suicidal thoughts around 20 times per day but denied active plans as does not feel there is currently any opportunity. Stated that he tries to get through each day as it comes and feels that it is an achievement when he wakes up in the mornings ..."

28. The psychiatrist saw the man again on 11 November and noted:

"Reviewed in the light of hearing the news that his 2 year-old son has heard about his mother's death. He has spent time talking with nursing staff on the

landing. He remains ... low in mood. He stated that he is dealing with each day at a time, simply getting through it but does not know whether he will have the mental strength to get through. In one way he wants to get to the trial ... but in another way, he feels he has nothing left to live for as he has lost everything – his [partner] and children ... he describes suicidal ideation ... He kept repeating “It’s up to me” and stated he may well reach a point when he feels he cannot go on but is not at that place yet.”

29. The man refused to take any meals on 14 November. He had previously refused an occasional meal and after 14 November there were several days when again he refused all meals and some days when he refused individual meals. He explained that sometimes he simply did not feel like eating. Staff opened food monitoring forms to document his food intake and by the end of November no further food refusal was recorded.
30. ACCT reviews were held at five to seven day intervals and the man’s level of observation remained the same. At an ACCT case review on 17 November, the man said that he had: “... 99% given up”. He would not say whether he had any set plan to end his life at that time. He was reminded that staff were available to talk with him at any time. The nurse who chaired the review noted the man’s clinical record that he said that he could not face ten years or so “in a place like this”. The action points on his Caremap were for him to maintain safety while in prison, to receive support with bereavement issues, for him to receive one to one support to minimise the risk of suicide, for him to be encouraged to eat and for him to be referred to a psychiatric unit.
31. Healthcare staff discussed transferring the man to a psychiatric unit for a period of assessment with him. At an ACCT case review on 30 November he said that he thought about suicide most of the time and it was noted that he had scratched his wrist and neck using a toothpaste tube. He agreed that a transfer to a psychiatric unit might be a beneficial move.
32. On 5 December, the man was assessed by two psychiatrists from a mental health unit. The next day, three nurses from the clinic saw him to conduct a psychological assessment. During this assessment, he was described as having “strong suicidal ideation” and said that he wanted to die as he could see nothing to live for and was feeling hopeless about his future.
33. The prison psychiatrist saw the man on 9 December after the mental health unit had accepted him as a patient. He told the psychiatrist that he thought this was the right decision for him but also said that he felt hopeless about his future. He told the psychiatrist that he had no clear explanation for his minor acts of self-harm a few days before other than he was bored. He spent most of his time reading in his cell.
34. On 12 December, the man’s grandmother telephoned the prison to say that she had received a letter from him telling her that he had “had enough and wanted to end it all”. A member of staff from the prison’s safer custody team spoke to the man and entries about this were made both in his ACCT and in his clinical records.

35. A nurse spoke to the man on the evening of 15 December when another prisoner reported concerns about his safety. The nurse noted in the man's ACCT and his clinical record that he had said this had been his worst day since coming to prison.
36. At an ACCT case review on 20 December, the man said that he continued to have suicidal thoughts. He said that he had no fixed suicide plan, but added that he would not reveal such a plan to staff in any case.
37. The man transferred to the mental health unit on 22 December and remained there for the next six weeks. While there he took a drug overdose in a planned attempt at suicide. He had managed to hide medication while under constant observation. In a discharge letter to Lewes dated 8 February 2012, a consultant forensic psychiatrist from the clinic explained:

"[The man] ... was ... transferred to the ... [mental health unit] ... for assessment of low in mood and suicide risk ...

"[The man] managed to take a serious overdose on [26 January 2012] ... he [lost consciousness and was admitted to intensive care] ...

"... we now have him on [two to one] nursing observation at all times, and with an increasingly restrictive care plan. This means he has a poor quality of life here ... We are unlikely to be able to do much that is therapeutic with him, because of the risk of him escaping or attempting suicide again.

"... it was agreed ... that [the man] is remitted back to HMP Lewes and that he will then be assessed by [high security psychiatric hospital] ...

"We had not reached a formal diagnosis. His low mood and suicide risk seem very much associated with his circumstances. He does not have marked biological symptoms of depression ... Clearly he poses an ongoing risk of suicide in the future ..."

38. On his arrival back at Lewes on 9 February, the man was put back on constant supervision. The psychiatrist at the prison assessed him and said:

"... I agree with [the mental health unit] that his depression is reactive to his current situation. There is no evidence of psychosis. [He] currently seems keen to portray that he is a compliant and safe prisoner (including his agreement to take antidepressants which he has [previously] refused) but I worry that this could be part of a plan to reassure us so that he can act on his suicidality. After all, he showed ingenuity in obtaining tablets and creating an opportunity to take them whilst on [constant] observations. It remains my opinion that he is at high risk of completing suicide and that the most appropriate place for him is in hospital. It will be hard to envisage him [having] any quality of life whilst we maintain his safety in the prison system."
39. A psychiatrist from a high security psychiatric hospital assessed the man the next day. Her report was later discussed by an admissions panel which

concluded that it was not appropriate for him to be admitted to a high security unit such as this one.

40. At an ACCT review with two members of staff on 11 February, the man said he had no current thoughts of suicide. He said that he had his children to live for and he was keen to go to trial to explain his side of matters at court. The review panel noted that the psychiatrist was doubtful about the man's motives for making such comments and they kept him on constant supervision.
41. The psychiatrist reviewed the man again on 13 February and noted that he "seemed brittle in mood and close to tears at times". He said that this was the first time since his offence that he had had no thoughts of suicide. He added that he was preparing for his court case and was looking to the future even though he was anticipating a sentence of 15 to 20 years imprisonment. The psychiatrist's opinion was that the man's denials and assurances were unconvincing. She recommended that he should remain on constant supervision and added that staff would need to be highly vigilant.
42. At an ACCT review on 20 February, the panel acknowledged that the man had engaged with the review but that he also appeared flat in mood and guarded at times. The panel agreed to reduce the level of supervision to four times an hour when he was in his cell but to maintain constant supervision when he was out of his cell. The healthcare manager told the investigator that the reason for this was that there could be around 18 prisoners out of their cells during association periods which might allow the man an opportunity to acquire medication to take another overdose if he was not closely observed.
43. At a consultation with another of Lewes' psychiatrists, on 28 February, the man reported feeling more relaxed now that he was at a lower level of observations. The psychiatrist tried to explore how he had acquired medication to take an overdose while in hospital but he said that he had previously told others how he had done it and he would not do so again. The psychiatrist's opinion was that the man was "... calculated, selective and manipulative in information sharing".
44. Entries in the man's clinical records over the following fortnight indicated that he appeared stable in mood and was telling staff that he was "taking one day at a time".
45. On the morning of 16 March, a nurse was called to the man's cell as he failed to respond when asked if he wanted to go outside for exercise. He was lying on his bed and she noted that he was very hot and he had involuntary movements in his arms and legs. She recorded his blood pressure and pulse and asked him if he had taken an overdose. He nodded to indicate that he had, but he could not explain what and how much he had taken. He was taken to hospital. The escorting officers said that he appeared high in mood and was talking nonsense.
46. The man returned to the prison healthcare unit on the afternoon of 18 March. He was noted to be a little confused and still had a hand tremor but denied that he had taken an overdose. A discharge summary from the hospital noted that an ECG showed some abnormalities, and the diagnosis was one of "unspecified

overdose". Blood tests taken at the time of the hospital admission showed no specific toxins.

47. A nurse spoke to the man the next day and he again denied taking an overdose. All that he could explain was that he had started to feel unwell on the evening of 15 March with symptoms of headache and nausea. That morning, the level of observations were raised from four times an hour to constant supervision.
48. At an ACCT case review on 20 March, the man reiterated that he had not taken an overdose but accepted that he continued to have suicidal thoughts.
49. The prison psychiatrist spoke to the man on 21 March who was adamant that he had not taken an overdose. He said that he had felt unwell the day before and on the day of his collapse had had a small supper before taking his prescribed medication. He had no recollection of anything else until he woke in hospital. He denied feeling suicidal, and said that he was eager to get his court case out of the way. The psychiatrist noted that she found it difficult to gauge what had happened. She could not rule out an overdose, but there was the possibility that the man had had an adverse reaction to his prescribed medication. She noted that a referral had been made for a neurological assessment.
50. On 2 April, at the prison psychiatrist's request, a consultant forensic psychiatrist based at an outside hospital assessed the man for a second opinion on his risk of suicide and to consider how he should be managed in prison. The consultant forensic psychiatrist did not consider the man to be clinically depressed at the time, but noted that he had demonstrated a propensity to depressive episodes. He considered that the man would remain a long term risk of suicide although he also believed that continuing constant supervision would be detrimental to his mental state. He considered that the man's risk of suicide would increase after his trial and closer observation would be appropriate at that time. He advised that the man should remain in the healthcare centre until the conclusion of his trial and that in the case of him being convicted, that Lewes transfer him as soon as possible to an appropriate prison away from his home area.
51. In the following weeks, the man continued to maintain that his collapse had not been caused through an overdose and he said that if he wanted to kill himself he would "just go ahead and do it". Entries in his clinical records indicate that he became increasingly frustrated with being constantly supervised. His professional relationship with his primary nurse broke down in the middle of April. He told the healthcare manager that the nurse had promised him that he would be moved to the lower floor of the healthcare centre but this had still not happened. The healthcare manager arranged for a different nurse to be the man's new primary nurse.
52. The man had remained on constant supervision for a month. On 18 April, his level of supervision was reduced to four times an hour while he was in his cell, but one-to-one supervision when he was out of his cell. Arrangements were made for him to start attending the gym again which he had not done for six months. The entries in his records suggest that his mood began to improve, although he told his new primary nurse that he would not tell staff if he had thoughts of self-harm or was planning to take his life.

53. During a consultation with his primary nurse on 10 May, the man mentioned that one of the prisoners in the healthcare centre had asked him for help with reading and writing. The nurse referred him to the Toe-by-Toe reading scheme where prisoners help others improve their literacy. The man's records show that he spent a lot of time reading and he also spent time associating with other prisoners in healthcare. He attended some education classes, but was surprised at how basic the classes were.
54. After an ACCT case review on 16 May, a prison psychiatrist noted in the man's clinical records that there was a forthcoming hearing to deal with the custody of his two youngest children. The children were likely to be placed with their maternal grandparents and the man believed that was in their best interests. The psychiatrist noted that the man had commented previously that he would kill himself when he knows his children were "all right". She also noted that his trial was approaching and wrote: "Review his observations with low threshold for increasing observations to [constant] after court cases if distressed and bearing in mind that he can present well and manipulate in order to act on his suicidal ideation as [happened at the [mental health unit]]".
55. On 25 May, the man was taken to hospital for investigations into the possible cause of his recent blackouts. He was told that the hospital would contact the prison healthcare unit with an appointment for further investigations.
56. At 5.00am on 18 June, a nurse said he heard a thud coming from the man's cell and he found him collapsed on the floor. The nurse called for assistance and, he and a colleague, helped the man onto his bed. The nurse noted that the man was dazed and was not fully responsive to stimuli. An ambulance was called and he was admitted to the local intensive treatment unit for two days. Toxicology results showed that his collapse had been caused by him having taken two non-prescribed sedatives.
57. The man returned to Lewes on 20 June and his primary nurse spoke with him that evening at an ACCT review. She asked him if he had taken medication as an attempt on his life or as an act of self-harm but he denied taking any medication. He said that he had stored up some medication a few weeks earlier, but had flushed this down the toilet. His observations were kept at four an hour.
58. On 26 June, the man pleaded guilty to murder and was convicted and sentenced to life imprisonment with a minimum period to serve of 17 years before he could be considered for release. When he returned to the prison, a nurse noted the man's records to say that he had asked for some time to himself to adjust to his new circumstances and that not too many people should question him about his feelings and how he would cope with the sentence. The ACCT observations were maintained at four each hour when in his cell with constant supervision when he was out of his cell.
59. A nurse told the investigator that he and the man had a number of shared interests, such as keep-fit and reading, and that they had quite a good relationship. However, he said, that the man began to disengage from staff at

around this point, which he assumed then to have been because he knew he would be moving on to a new prison.

60. At an ACCT case review on 27 June, the man denied having any thoughts of suicide or self-harm and said that he would like to speak to someone who dealt with prison transfers so he could consider his options. A prison psychiatrist saw him that day and she noted that he seemed relieved that the legal process was over.
61. At his next ACCT review on 1 July, the man said his sentence was in line with what he had been expecting, but he was still adjusting to it and acknowledged that he would experience some “ups and downs”. It was noted that he continued to engage in unit activities. The record of the review was marked to indicate that the frequency of observations had been adjusted, but it was unclear what this adjustment was.
62. On 2 July, the man’s primary nurse noted in his clinical record that she had spent time catching up with him as she had been on leave the previous week. She said the man had said that he was unsure how he would manage with his sentence but would take: “each day as it comes until he is moved [to a new prison] and can adapt to a new environment”. She noted that he was aware that his time at Lewes was potentially the worst time he could have in the prison system because of the limited activities available to him as well as living in a high observation cell.
63. On 4 July, a prison psychiatrist discussed plans for the man with Lewes’ Safer Custody Manager and the man’s original primary nurse. The psychiatrist noted that he appeared settled since sentencing and the plan was to “cautiously reduce observations and increase structured activities”. It was agreed to move him to a “downstairs cell” when one became available. The healthcare centre has a separate unit on a lower floor which is used for patients with less acute problems. It is quieter than the main unit but further from the nurses’ station. The man had been asking to move to the lower unit for some time as he said he felt the main unit was noisy and disruptive.
64. Also on 4 July, the man had a “post-sentence” interview with an offender supervisor. The man said that he had found it hard spending the previous nine months in the healthcare unit so was anxious to move to a prison for life-sentenced prisoners. He told her that the overdose he had taken at the mental health unit had been a serious attempt at taking his life.
65. At a consultation with his primary nurse on 9 July, the man re-iterated, as he had on many previous occasions that he still could not see a future for himself. However, he also said he hoped to move to a new prison soon. The nurse noted that the man: “... openly spoke about the fact that he has sorted out all of his personal affairs and that everything is in order should he decide in the future [to take his life]”. She also noted that she and the man: “Discussed activities and at this time he still has limited motivation to attend the gym again, he hopes to build up to this next week, continues to read ... as well as use exercise ... yard ... talked about how he does not get close to people as he knows they are going to move on.”

66. On 11 July, the man moved from the main healthcare unit to a new cell on the lower floor. His nursing observations were reduced to two per hour from four. The level of his ACCT observations at this time are unclear.
67. The safer custody manager told the investigator that he had a reasonable amount of contact with the man, particularly in relation to what he termed “complex case reviews”. He said that the ACCT process is designed to support people going through a period of crisis. The man differed from the norm, however, as he had a long term intention to take his life so the crisis would never avert. The safer custody manager said that it would have been inhumane to have kept him under constant supervision for an indefinite period. The approach that was taken therefore was to balance the management of his risk against improving his quality of life. One such improvement was to cover the night light in his cell with a red filter which made it easier for him to sleep at night. Similarly, staff eventually agreed to the man’s request to move to the healthcare lower landing and at the same time the level of ACCT observations were reduced. (As stated above, the exact frequency of ACCT observations at that time is unclear.)
68. The man declined to attend ACCT reviews on 15 and 22 July as he said there were no changes in his circumstances and that he was content with his new living arrangements on the lower floor of the healthcare unit. Entries in his clinical records at this time indicate that he appeared settled in his new location. A nurse told the investigator that her understanding was that the man had said all that he had wanted to say at the time he had been on an ACCT so there was nothing for him to add.
69. The man’s next ACCT review was on 28 July (this review was scheduled for 29 July, but it was brought forward by one day due to a death in Lewes of another prisoner). The review was chaired by a senior officer and the man’s original primary nurse attended. The senior officer noted that the man initially resisted attending the review as he “thought we were going through the same process and as he stated on [the] last two reviews, nothing has changed”. When the reason for the review that day was explained, the man agreed to take part and he appeared to engage well. He talked about his reduced level of risk and said that he was looking ahead to moving to a new prison. The senior officer noted that the issues on the man’s Caremap had all been dealt with and unless anything arose in the meantime, the ACCT could be closed at the next review. The next review was scheduled to take place on 2 August. Later that day, a CPN noted in the man’s clinical record that he was asking questions about the death of the other prisoner.
70. Entries in the man’s ACCT plan and clinical records on 29 July refer to him spending time associating with other prisoners and indicate that this was an uneventful day for him.
71. Another prisoner told the investigator that he was also an ex-policeman and he and the man talked to each other about their common backgrounds. He thought that the man had taken his sentence well, and he had mentioned that he had researched the best options for his next prison. He said that the death (by

hanging) of another prisoner at Lewes on 27 July had upset the man, even though he did not know him. The prisoner said that he and the man had spent time together during association on 29 July. The man seemed fine and after collecting his evening meal had said he would see him in the morning.

72. A healthcare assistant<sup>1</sup> told the investigator that she always made a point of having “a bit more of a lengthy chat” with the prisoners on the lower landing because their cells are more isolated than those on the main healthcare unit. She said that she chatted with the man about various day to day topics. She said that at around 8.30pm on 29 July she and the man discussed the Olympic Games which he had been watching to help pass the time. She said that he seemed “absolutely fine”.
73. At midnight on a night in July, a nurse noted in the man’s ACCT to say that he appeared to be asleep and that she had seen him move. She told the investigator that he always slept on his left-hand side facing the wall. He tended to cover his head with his bedding and he was a very still sleeper. She said that her practice when doing checks at night was to hold her torch on him until she observed some movement.
74. The next ACCT entry was made at 2.00am the following morning by the healthcare assistant. The entry stated that the man “appears to be asleep on his left side”, but there was no reference to any movement. She told the investigator that although her record did not mention movement, she had watched him until she had observed movement as this was what she always did.
75. A nurse made the next check at 3.00am. When she shone her torch at the man’s bed she saw that it looked strange and realised it had been tampered with to make it look as though it was occupied. When she shone her torch around the rest of the cell she saw that the man was slumped on the floor behind the toilet privacy screen. She called to her colleague to radio for urgent assistance and collect emergency equipment. An ambulance was called when the alarm was raised.
76. The Night Orderly Officer (NOO)<sup>2</sup> told the investigator he was close by when the emergency call was made and he opened the man’s cell door within a minute of the call being made. The NOO and an officer found the man partially suspended from a twisted bed sheet around his neck and tied to the privacy screen. The officers cut the sheet and the nurses started cardiopulmonary resuscitation (CPR). The nurses checked him with a defibrillator<sup>3</sup>, which advised to continue with CPR which they continued with until relieved by paramedics who arrived at 3.10am. Efforts to resuscitate the man were unsuccessful and he was pronounced dead at 3.25am.
77. One of Lewes’ family liaison officers (FLOs) was contacted at home and arrived at the prison at 5.15am. The Coroner’s officer and two police officers had also arrived and they discussed contacting various family members. The police said

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<sup>1</sup> Healthcare assistant carry out basic clinical tasks and caring duties but are not trained nurses.

<sup>2</sup> The Night Orderly Officer is the officer in operational charge of a prison at night time.

<sup>3</sup> A defibrillator measures electrical activity in the heart and gives audible instructions on management of the patient such as whether or not an electrical shock should be given.

that they would contact the man's partner's parents who were caring for his children (their grandchildren), while the family liaison officer should contact the man's nominated next-of-kin, his grandmother. The FLO and a colleague arrived at his grandmother's home just after 8.00am and broke the news of his death. The man's cousin was also present and the family liaison officer explained the protocols surrounding a death in prison custody. At the request of the man's grandmother, the family liaison officer also informed one of her grandson's friends of his death.

78. The family liaison officer telephoned the man's grandmother the next day and agreed to liaise with her grandson's friend about the funeral arrangements. She and a colleague attended the funeral and the prison contributed to the costs in line with national guidance.
79. A hot debrief meeting was held on the morning of the man's death to allow staff involved to talk about what had happened. Staff were informed about the support available through the care team.
80. The man's friends in the healthcare unit were told in person about his death. Other prisoners on open ACCTs were reviewed.

## ISSUES

### Assessment of risk

81. When the man arrived at HMP Lewes in October 2011, he had been charged with the murder of his partner. The documents from his time in police custody indicated that he was considered to be at risk of suicide and that he needed to be monitored closely. Staff at Lewes opened an ACCT and he was constantly supervised in a cell in the healthcare unit. The next day his level of observation was reduced to four times an hour in line with the local healthcare protocol.
82. The man remained in the healthcare unit and was monitored under ACCT procedures throughout his time at Lewes. The only break from this was for a six week period from late December 2011 to early February 2012 while he was being assessed at a hospital psychiatric unit. His level of observations was raised to constant supervision when he returned from hospital on 10 February and he remained constantly supervised for more than two months. This level of supervision began to be reduced slightly from 18 April, although he was still constantly supervised when he was out of his cell. By this time, he had been convicted and sentenced to life imprisonment with a minimum term of 17 years. He had pleaded guilty to the charge of murder so his sentence and conviction were not a surprise to him.
83. The man's ACCT plan remained open throughout his time at Lewes because of his clearly stated intention and thoughts of suicide. He said many times that he had lost everything after the death of his partner and indicated that he was unsure whether he could face a long period in custody. He appears to have taken two drug overdoses at Lewes and he took another at the psychiatric unit. He often said that he was "taking one day at a time", indicating that he was uncertain whether he wished to live or die.
84. After his conviction, the man expected to transfer to a different prison with programmes suited to life-sentenced prisoners. He began to indicate that he was keen to make this move to "get on with his sentence". For some time before his trial he had been asking to move to the quieter environment of the lower floor of the healthcare unit. As this was further away from the nurses' station, at first this was not agreed as it was recognised that he might be at increased risk up to and during his trial. After he was sentenced at the beginning of July, he was moved to a new cell on the lower floor. At the same time, his level of ACCT interactions and observations were lowered as he began to indicate an intention to move to a new prison and to get on with his sentence.
85. The investigator explored with witnesses whether the man might have been deliberately trying to mislead them into thinking his risk had diminished in order to improve his chances of a successful attempt on his life. Lewes' Safer Custody Manager said he had been sceptical about any of the man's assurances that he would not harm himself but also said it was important to try to improve the man's quality of life.
86. The man had been managed under the ACCT process for the whole of his time at Lewes, and for a long time he was constantly supervised. Local guidance at

Lewes recognises that for the great majority of people, suicidal crises are short-term. Support available through ACCT is designed mostly to help people through a crisis period, but the guidance also recognises that there are a small number of people, often those who have carried out particularly disturbing crimes, who make it clear at an early stage that they have no intention of serving out their sentence. Although the man was often ambivalent or inconsistent about his intentions he spoke frequently about keeping all options open. It seems likely that he increasingly moved to the view that he did not wish to spend many years in prison.

87. In assessing his risk, the prison, while initially cautious, accepted the man's expressions of increased optimism. To improve his quality of life he was moved to a better environment and the level of required ACCT interactions and observations were reduced. Although the assessment of his risk proved to be incorrect we consider this was a humane and reasonable approach. Ultimately, it is very difficult to prevent a person who makes a reasoned decision to kill themselves from doing so, especially when they indicate otherwise.

### **ACCT procedures**

88. The healthcare department at Lewes operates a process known as the therapeutic observation policy devised by the local primary care trust (PCT). This means that inpatients in the healthcare unit who are considered at risk of suicide or self-harm are managed jointly through the Prison Service ACCT procedures and the local PCT procedures. In this man's case this resulted in a number of apparent anomalies including potentially confusing instructions about the levels of interactions and observations and ACCT case reviews occurring less frequently than should have been the case and with fewer than the optimal number of appropriate staff. Constant supervision was used for an extended period of time, without enhanced case reviews, although some sporadic "complex case reviews" were held which resulted in care plans.
89. Instructions about the management of the ACCT process in Prison Service Instruction (PSI) 64/2011 include specific guidance for prisoners subject to constant supervision. This includes that for the first 72 hours multi-disciplinary case reviews must be held daily and while prisoners remain under constant supervision they must be seen by a doctor at least once in every 24 hour period. This did not happen with the man.
90. The PSI also requires the use of the enhanced case management process for difficult to manage prisoners such as those who have expressed prolonged active suicidal intent, or who have been subject to constant supervision for eight days or more. The PSI explains that:

"The Enhanced Case Review Team will involve all relevant disciplines and include more specialists and a higher level of operational management than a typical ACCT Case Review Team ... The essence of case management is to provide a flexible but consistent approach to achieve the desired changes in a prisoner's behaviour."

91. The PSI makes clear that for prisoners located in healthcare, the ACCT plan should be managed in line with the procedures set out in the PSI.
92. Had the man been managed by an Enhanced Case Review Team, this would have brought together multi-disciplinary team members with broader experience of dealing with complex cases. There would have been a clearer and more focussed approach to his management.

**The Governor should ensure that there is no confusion between ACCT and other observations for prisoners monitored under ACCT procedures in the healthcare unit and that ACCT plans are managed in line with the requirements of PSI 64/2011.**

93. The man's ACCT record shows that his night time observations were often made at precise and regular intervals: for instance 9.00pm, 12.00am (midnight) and 2.00am were frequently listed as the times of his checks. PSI 64/2011 requires that ACCT observations should be at unpredictable times.

**The Governor and Head of Healthcare should ensure that staff make ACCT observations at irregular and unpredictable intervals.**

94. The last entry in the man's ACCT before he was found hanging at 3.00am was a check at 2.00am by a healthcare assistant who noted at that point that he "appears to be asleep on his left side". Instruction to staff making ACCT observations makes clear that when prisoners are apparently asleep, evidence must be included in the ACCT entry to indicate signs of life, for instance observation of breathing or of movement. The healthcare assistant told the investigator that her practice when making ACCT checks always was to remain at the cell door until she had seen such evidence and she acknowledged that she understood the need to have made a record of this.

**The Governor and Head of Healthcare should ensure that staff always record evidence of observed life when making ACCT observations at night.**

### **Clinical support**

95. The clinical reviewer is a consultant forensic psychiatrist. She considered that the standard of psychiatric care provided to the man was appropriate for his needs. In reaching that assessment, she referred to the early recognition of the man's need for psychiatric support, to the referral made for hospital support, to the degree of mental health input within the prison's healthcare unit and to his regular consultations with the same consultant psychiatrist.
96. The clinical reviewer considered it appropriate that when the man appeared to begin to settle after his conviction staff began to normalise his situation. This was aimed at helping him progress with his sentence, which is what he indicated he wished to do. She did not consider that the man's death, on the day it happened, was something that the staff could have predicted.

## **Emergency response**

97. When a nurse saw the man slumped behind the privacy screen in his cell she immediately summoned assistance. She and her two nursing colleagues collected emergency equipment and officers, including the NOO, arrived in less than a minute. The nurse told the investigator that although she had a cell key, she thought it appropriate to wait for the officers as the man was known to be trained in martial arts and previous intelligence had suggested he might be an escape risk while he was in the psychiatric unit.
98. Nurses in prisons are not trained in techniques such as control and restraint. The man was only partly visible behind the cell privacy screen and it was not clear that he was hanging. As officers were available so quickly, we do not consider it unreasonable in the circumstances for the nurses to have waited for support from officers before going into the cell.
99. However, the emergency call simply called for “urgent assistance”. Most prisons operate a code system to alert staff to the type of emergency and for the control room staff to call an ambulance in life threatening situations. We have made recommendations to Lewes about this in recent investigations and repeat it here.

**The Governor should ensure that staff use an appropriate call code when radioing for emergency assistance.**

## RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Governor should ensure that there is no confusion between ACCT and other observations for prisoners monitored under ACCT procedures in the healthcare unit and that ACCT plans are managed in line with the requirements of PSI 64/2011.

***Recommendation accepted:***

*The Head of Healthcare and the Safer Custody manager have commissioned a review of the ACCT processes within the Healthcare setting. This will ensure compliance with PSI 64/2011.*

*The Safer Custody manager will carry out weekly quality assurance on ACCT documents and provide the results to the Head of Healthcare. These results will also be monitored at the safer custody meeting. Target for completion: 1 March 2013.*

2. The Governor and Head of Healthcare should ensure that staff make ACCT observations at irregular and unpredictable intervals.

***Recommendation accepted:***

*A notice to staff will be published to all staff. Target for completion: 14 March 2013*

3. The Governor and Head of Healthcare should ensure that staff always record evidence of observed life when making ACCT observations at night.

***Recommendation accepted:***

*A notice to staff will be published to all staff. Target for completion: 14 March 2013.*

4. The Governor should ensure that staff use an appropriate call code when radioing for emergency assistance.

***Recommendation accepted:***

*A Review of the Local Policy has been commissioned in line with the recently published PSI 03/2013 Medical Emergency Response Codes. Target for completion: 1 February 2013 in line with the release of the new PSI.*