

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Ryan Trimmer a prisoner at HMP Lewes on 26 April 2017

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration departments.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ryan Trimmer was found hanged in his cell at HMP Lewes on 22 April 2017 and died in hospital four days later. He was 29 years old. We offer our condolences to Mr Trimmer's family and friends.

Although Mr Trimmer was monitored under Prison Service suicide and self-harm prevention procedures throughout his time at Lewes, he self-harmed on a number of occasions before he was found hanged. We found deficiencies in the management of those procedures. Staff did not properly assess Mr Trimmer's risk of suicide and self-harm and, for the majority of the time he was being monitored, staff failed to identify appropriate actions to support him and reduce his risk.

We are concerned that Prison Service guidance on the use of constant supervision and alternative clothing was not followed.

We are also concerned that there was a delay in staff entering Mr Trimmer's cell when he was found, which resulted in a delay in the resuscitation attempt.

It is troubling that many of our recommendations repeat those we made in a previous investigation into a death at Lewes. The Governor should take vigorous and demonstrably effective steps to ensure that they are properly acted upon.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**December 2017**

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# Summary

## Events

1. Mr Ryan Trimmer was remanded to Lewes prison on 4 March 2017, for charges of assault and criminal damage. Reception staff noted that Mr Trimmer had a history of attempting suicide and self-harm, and they started suicide and self-harm monitoring procedures (known as ACCT). Mr Trimmer was allocated a single cell in the prison's First Night Centre.
2. An officer checked Mr Trimmer that evening at approximately 7.50pm, to find him with three ligatures tied around his neck. Staff called an ambulance and Mr Trimmer was taken to hospital. He was returned to the prison later that night and was allocated a cell in the healthcare department.
3. On 6 March, Mr Trimmer was found in his cell with a ligature around his neck. Staff started constant supervision, which continued for three days. Mr Trimmer continued to be monitored under ACCT procedures for the remainder of his time in custody.
4. On 24 March, Mr Trimmer was sentenced to eight months imprisonment. He was moved out of the healthcare department on 29 March.
5. Mr Trimmer self-harmed on 30 March and, on 20 April, he was found unresponsive, with a ligature around his neck. He was returned to the healthcare department so that he could be monitored more closely.
6. On 22 April, at 9.27pm, a nurse checked Mr Trimmer and found him suspended by a ligature. She radioed a medical emergency code but did not enter the cell until officers arrived. Staff carried out cardiopulmonary resuscitation (CPR) until paramedics arrived and took over his care. The paramedics detected a response and Mr Trimmer was taken to hospital, but he died at 12.06pm on 26 April.

## Findings

7. We found deficiencies in the prison's management of ACCT procedures. Mr Trimmer's level of risk was not adequately assessed, prescribed timescales were not adhered to, observations were often at predictable times and paperwork detailing the level of observations was not completed correctly.
8. There was no evidence that the prison's use of constant supervision and alternative clothing was authorised and managed in line with Prison Service instructions.
9. We are concerned that, despite a recommendation by a nurse that Mr Trimmer should share a cell because of his risk of suicide and self-harm, he was allocated a single cell when he first arrived at Lewes.
10. We are also concerned that healthcare staff seemed unaware of the process for entering a cell when a prisoner's life is in danger. This led to a short delay in accessing Mr Trimmer and administering CPR. Aspects of the nurses' life support attempt also troubled the clinical reviewer.

11. There was an unacceptable delay in notifying Mr Trimmer's family that he had been taken to hospital.

## Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
  - Staff identify, consider and record all known risk factors for a prisoner when determining their risk of suicide or self-harm.
  - Staff set caremap actions designed to reduce the prisoner's risk of suicide and self-harm, review them at each case review and ensure actions are completed.
  - Staff vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.
  - Staff should complete all ACCT documentation accurately.
  - Staff should record the reasons for placing a prisoner on constant supervision and reassess daily.
  - Staff should use alternative clothing as a last resort and if used, staff should record the reasons and hold an enhanced case review.
- The Governor should ensure that wherever possible, prisoners are allocated to shared cells when this has been advised as a protective measure against suicide and self-harm, and where a shared cell is not allocated, staff record the reasons.
- The Governor and Head of Healthcare should ensure that all staff understand the importance of entering a cell without delay when a prisoner's life is at risk, when it is safe to do so.
- The Governor and Head of Healthcare should ensure that all staff are trained or receive refresher training in basic life support.
- The Governor should ensure that staff inform the next of kin of seriously ill prisoners promptly.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Trimmer's prison and medical records.
14. The investigator interviewed 12 members of staff at Lewes on 31 May and 5 June.
15. NHS England commissioned a clinical reviewer to review Mr Trimmer's clinical care at the prison. The investigator and clinical reviewer interviewed healthcare staff jointly.
16. We informed HM Coroner for East Sussex of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Trimmer's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Trimmer's partner said the prison knew Mr Trimmer was vulnerable, but failed to keep him safe. She was also concerned about the prison's emergency response. Mr Trimmer's family received a copy of the initial report. They did not raise any further issues or comment on the factual accuracy of the report.
18. The initial report was shared with HMPPS. They did not find any factual inaccuracies.

## Background Information

### HMP Lewes

19. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services.

### HM Inspectorate of Prisons

20. The most recent inspection of HMP Lewes was in January 2016. Inspectors reported that the level of self-harm among prisoners was relatively low, but those at risk felt they did not receive sufficient support. Inspectors said that the suicide prevention casework management was poor, and prisoners said they did not feel well cared for. Care plans did not reflect all issues identified during a prisoner's assessment, attendance at case reviews was poor, case managers were inconsistent and few care plans were updated. In addition, there was little mental health input for prisoners with mental health needs.
21. The inspectors also found that staff in the healthcare inpatient unit provided prisoners with complex health needs with care, but a lack of custody staff affected the development of a therapeutic regime.

### Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2017, the IMB reported that suicide monitoring procedures were poorly managed and corresponding paperwork completed incorrectly.

### Previous deaths at HMP Lewes

23. Mr Trimmer was the third prisoner to take his own life at Lewes since February 2016. In a previous investigation, we were critical of failings in the suicide prevention procedures, including prison staff's failure to identify a prisoner's level of risk properly, inadequate observation levels and poorly completed caremaps. We repeat a number of the same recommendations in this investigation.

### Assessment, Care in Custody and Teamwork

24. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT until all the actions are completed.

## Key Events

25. On 4 March 2017, Mr Ryan Trimmer was remanded to Lewes prison on charges of assault and criminal damage. He arrived with a Person Escort Record (PER) that noted he had a history of attempting suicide and self-harm, most recently in August 2016, which included self-strangulation and cutting.
26. A nurse saw Mr Trimmer in reception for an initial health screening. She noted that Mr Trimmer had cut his wrists four or five times in 2016, and had taken overdoses of paracetamol and antidepressants. Mr Trimmer was stressed about his relationship with his partner, with whom he had a young baby, and said he could not understand why he was not allowed to communicate with her. She started suicide and self-harm monitoring (known as ACCT), noting that Mr Trimmer needed to share a cell. She completed a Concern and Keep Safe form (part of the ACCT) and noted that Mr Trimmer was agitated, had a history of self-harm and that when he felt 'disturbed' he harmed himself, although he was 'not keen' on being referred to the mental health team.
27. A Safer Custody manager completed Mr Trimmer's Immediate Action Plan in the ACCT. He completed a routine referral to the mental health team and put Mr Trimmer on hourly observations until he was assessed. Mr Trimmer was allocated a single cell (despite the nurse's note) in the First Night Centre (FNC). When the nurse saw Mr Trimmer in the FNC a little later, she told an officer that Mr Trimmer needed to share a cell. The officer said she would see who he could share with, as he had a previous conviction for racism.
28. Mr Trimmer telephoned his partner. A little later, a member of staff passed a message to an officer saying that his partner was annoyed Mr Trimmer had telephoned her, as she had a restraining order against him. The officer telephoned Mr Trimmer's partner to seek clarification, and she told him that she was in the process of getting a restraining order against Mr Trimmer. He told Mr Trimmer, who was unhappy with this.
29. The Safer Custody manager spoke to Mr Trimmer in his cell at 7.00pm and asked him if he was okay alone in a cell. Mr Trimmer said he wanted to be on his own and that he would not self-harm. He added that he was frustrated about his earlier telephone call to his partner.
30. An officer carried out an ACCT check on Mr Trimmer in the FNC at 7.00pm, and went to check him again at 7.50pm. She could not see him, so shouted to him and banged the cell door. She had no response so she radioed for the night manager. Another officer heard the call, attended and opened the cell. Mr Trimmer was behind the toilet's privacy curtain with three ligatures tied around his neck. The officer cut the ligatures and began cardiopulmonary resuscitation (CPR). The night manager arrived and radioed an emergency code blue (indicating that a prisoner is unconscious or not breathing). After a couple of minutes, Mr Trimmer began to breathe. He was taken to hospital by ambulance and discharged later that evening. He arrived back at the prison at 11.40pm and was placed in a high visibility cell (with a perspex screen) in the healthcare department with observations set at every 15 minutes.

31. In the early hours of 5 March, a nurse carried out a mental health assessment of Mr Trimmer in his cell in the healthcare department. Mr Trimmer said that he had not made a serious attempt to take his life, but was frustrated that he could not speak to his partner. The nurse checked Mr Trimmer throughout the night. He noted that Mr Trimmer was very anxious and said that he had acted impulsively due to family issues.
32. A nurse assessed Mr Trimmer later that morning, as part of an inpatient care plan. She noted he had concerns surrounding his family and his current offence and he said he had self-harmed in the past. She noted that Mr Trimmer would remain in the healthcare department, continue to be monitored by the ACCT process and that a psychiatrist would review his mental health.
33. Mr Trimmer spent the day either asleep or watching television. He said he was frustrated that he could not smoke in the healthcare department and declined nicotine patches and lozenges. Later in the evening, he asked about telephoning his partner again, but a nurse told him to speak to an officer. An officer telephoned Mr Trimmer's partner to ask whether she would accept a call from Mr Trimmer. She explained that she should not speak to him as she was arranging an injunction against him, but would write to him explaining the situation. Staff decided to tell Mr Trimmer the next morning, but there is no record that anybody did. Mr Trimmer continued to ask to telephone his partner.
34. A psychiatrist tried to assess Mr Trimmer on 6 March, but he refused to be seen.
35. An officer carried out an ACCT assessment on the afternoon of 6 March. Mr Trimmer said he had suicidal thoughts all the time, and his partner and child were his only reasons for living. The officer recorded that he would speak to a member of the mental health team and arrange contact with Mr Trimmer's family. It was also agreed that Mr Trimmer would be moved from healthcare to a residential wing (but there was no mention of him being moved to a shared cell and he remained in a single cell in healthcare).
36. A nurse checked Mr Trimmer at 10.15pm. She then heard him moving around his cell, so checked him again five minutes later. Mr Trimmer was sitting on the floor with a ripped sheet tied around his neck, attached to a door handle. He said he had images of his mother, who he had found dead a few months earlier. He also said he was frustrated that he could not contact his partner. Mr Trimmer was placed under constant supervision. He was also given anti-rip clothing (although there is no record of when he was given anti-rip clothing, or the reasons for doing so).
37. The first ACCT case review was held the following morning, 7 March. The case manager and representatives from the safer custody department, healthcare and the offender management unit attended. Mr Trimmer said he was concerned about his lack of contact with his partner. He had been told that he was not permitted to contact her due to a restraining order. Mr Trimmer said there had been a mix up and the restraining order was for a previous partner and staff agreed to try to clarify the situation. Mr Trimmer said he was impulsive, had previously attempted suicide and wanted to die. Mr Trimmer became abusive when staff told him they still considered him a high risk of suicide or self-harm and he refused to engage in the review thereafter. Mr Trimmer remained under

constant supervision and continued to wear anti-rip clothing. They all agreed to review Mr Trimmer's ACCT the next day. The case manager completed Mr Trimmer's caremap issues and actions.

38. On 8 March, the case manager held the second ACCT case review, with Mr Trimmer and safer custody staff. Healthcare staff did not attend, but contributed verbally before the review. Staff continued to assess Mr Trimmer's risk as high because he had still not had contact with his partner (staff had telephoned her on five occasions, but her telephone had been engaged each time). Later that day, the case manager facilitated another call to Mr Trimmer's partner. This time Mr Trimmer managed to speak to her and the call went well. Mr Trimmer's observations were reduced to every 15 minutes, his own clothing was returned to him, and he was given a television. The level of observations was not recorded on the front of the ACCT document.
39. A third ACCT case review was held as part of the psychiatry ward round in healthcare on 9 March, and attended by a nurse and the psychiatrist. Mr Trimmer's risk was reduced from 'high' to 'raised' and observations were reduced to every 30 minutes. The psychiatrist concluded that Mr Trimmer did not have a thought disorder, and had no thoughts of self-harm or suicide. Mr Trimmer recognised he had anger issues, which he attributed to his childhood and alcohol, so agreed to explore treatment. Mr Trimmer explained that he was extremely anxious about something happening to his partner while he was in prison, he spoke about his offence and excess drinking. Mr Trimmer said he felt very angry and agreed to be referred to RAPT (Rehabilitation for Addicted Prisoners Trust) to help him manage his emotions.
40. On 12 March, Mr Trimmer became rude and aggressive because he wanted to make a telephone call to his partner, but could not as his telephone calls had not yet been cleared on the prison's PIN phone system. A nurse telephoned Mr Trimmer's partner and asked her whether she could pass on her love to him. She agreed and Mr Trimmer seemed happy to hear this. The ongoing record in the ACCT document showed that at this point Mr Trimmer was observed twice per hour, although this was not noted on the front of the document. Observations were carried out at regular, and therefore predictable, 30-minute intervals.
41. A fourth ACCT case review was held a day late, on 14 March. A nurse and a healthcare assistant attended the review with Mr Trimmer and noted his risk was raised. Mr Trimmer said he was very upset because he had telephoned his partner and she had hung up on him. He was given permission to telephone her again, but she did not answer. Mr Trimmer refused to engage in the review and returned to his cell in the healthcare department. His level of observations was not recorded in the ACCT, but the ongoing record showed he was checked at regular and predictable 30-minute intervals.
42. On 15 March, the case manager chaired Mr Trimmer's fifth ACCT review in the healthcare department. He remained on 30-minute observations with a requirement for six daily conversations. Mr Trimmer said things had improved with his partner and that he felt ready to move from the healthcare department. The case manager noted that Mr Trimmer must share a cell when he moved from

the healthcare department. Mr Trimmer's next review was scheduled for 20 March (but not carried out until 22 March).

43. On 21 March, Mr Trimmer was upset that he could not get through to his partner. He was tearful and said he would do 'something stupid'. This persisted throughout the night. A night manager telephoned his partner, but told Mr Trimmer the call had gone straight to answerphone. Mr Trimmer questioned this and said he remained concerned.
44. A sixth ACCT review was held on 22 March. Mr Trimmer said he was still having difficulty contacting his partner and that he felt suicidal, although he had no plans to take his life. Mr Trimmer's risk was assessed as low and his observations were reduced to six daily and six nightly.
45. Later that day, Mr Trimmer smashed up his cell. Healthcare staff said he had been in a 'foul mood' because he said his partner 'had dumped him'. Mr Trimmer became more agitated during the day and, that evening, threatened to kill himself and made ligatures. Staff removed all items from his cell, put him under constant supervision and held another ACCT review at 11.00pm. Mr Trimmer's risk of suicide and self-harm was assessed as raised. In the early hours of 22 March, Mr Trimmer was abusive, threatened staff and to self-harm. Mr Trimmer spat at staff from a hole in the perspex cell door, while banging the door and shouting. He told staff he wanted to die because his partner did not want to be with him.
46. Staff held another ACCT case review on 23 March. Mr Trimmer's level of risk remained raised and he remained under constant supervision.
47. On 24 March, Mr Trimmer was sentenced at Crown Court to eight months for assault and criminal damage. Mr Trimmer could apply for Home Detention Curfew (HDC) (which he subsequently did) from 5 May, otherwise his release date was 4 July.
48. Mr Trimmer had an ACCT case review on 29 March. He reported feeling calmer, said he had resolved some issues with his partner and had not recently self-harmed. He was moved to a cell on A Wing (it is not clear whether Mr Trimmer shared a cell, despite a manager's note that he should be not be in a single cell when he moved to a wing). The ACCT remained open but his observations were reduced, although this was not noted in the ACCT. The ongoing record showed he was checked five times during the night.
49. On 30 March, Mr Trimmer cut his arm several times with a razor. One cut measured seven centimetres and was described as 'gaping'. Mr Trimmer said he had been thinking about his mother and was fearful of prisoners on the wing who had assaulted him. Mr Trimmer's observations were increased to five observations during the night. This was evident from the ongoing record in the ACCT, but nowhere else. Mr Trimmer was moved to C Wing on 1 April.
50. Mr Trimmer had an ACCT review on 5 April. Healthcare staff were invited to attend, but they declined, as they said he was not on their caseload. Mr Trimmer said he was having problems with prisoners on C Wing and it was agreed he would move to M Wing, also called the Sussex Unit. Mr Trimmer's risk was assessed as low but his level of observations was not recorded.

51. Mr Trimmer had an ACCT review on 12 April on M Wing. He said all his issues stemmed from a lack of contact with his partner and he found this stressful. He said he had settled on the wing. A Supervising Officer (SO) said he was concerned that Mr Trimmer was in a cell on his own after he had attempted to hang himself, but Mr Trimmer said he had acted out of frustration and had not intended to kill himself, and confirmed he was happy in a single cell. Mr Trimmer spoke about his two children for whom he said he was responsible and had caring responsibilities. They agreed the ACCT would remain open but observations were reduced to three daily conversations and three nightly observations. For the first time, Mr Trimmer's observations were noted on the front page of the ACCT.
52. Mr Trimmer had another case review on M Wing on 19 April. He told staff that he felt quite settled and was looking forward to his release on HDC. Mr Trimmer admitted he thought about harming himself, but attributed this to difficulties with his partner. A probation officer said he would contact the prison's mental health team to arrange an appointment. There is no record of this referral being made in the ACCT documentation. Mr Trimmer said he appreciated the support he received while on an ACCT, so it remained open. The level of observations remained the same but it was noted, incorrectly, on the front page of the ACCT document that observations had been reduced to two conversations and two observations.
53. On 20 April, at approximately 9.20pm, Mr Trimmer asked to speak to a Listener. Two officers unlocked the Listener and escorted him to Mr Trimmer's cell. They found Mr Trimmer lying unresponsive on the floor with his belt tied around his neck. An officer immediately radioed a code blue. A nurse attended and believed Mr Trimmer was faking, as he was easily rousable and able to sit in a chair. A paramedic arrived at the cell and agreed that Mr Trimmer did not need any treatment. Mr Trimmer told the nurse that he was worried his partner would leave him and he had had trouble contacting her. She arranged for Mr Trimmer to move to the healthcare inpatient department. Staff checked him hourly until another case review the next afternoon.
54. During 21 April, Mr Trimmer was warned for smoking in the healthcare department. An officer told Mr Trimmer if he continued to smoke he would remove his television. Later that day Mr Trimmer refused to see a psychiatrist. During the afternoon, Mr Trimmer attended another ACCT case review. He told staff that he had put a ligature around his neck as a 'cry for help'. He was assessed as being at low risk and his observations were reduced to three a day and four (noting movement) during the night. His next ACCT review was scheduled for 28 April.
55. On 22 April, Mr Trimmer called his partner four times between 9.34am and 10.23am, but did not manage to speak to her.
56. At approximately 9.27pm on the night of 22 April, a nurse found Mr Trimmer suspended behind his cell door with a ligature tied around the side of the door and through the observation panel. She called a code blue and cut the ligature from outside the cell. Another nurse also on duty in the healthcare department

responded to her colleague's call for help, but told the investigator that nurses were not permitted to go into a cell at night and had to wait for a prison officer.

57. The night manager responded to the code blue. It took him approximately one minute to get to the healthcare department, along with an officer. Two more officers also responded to the emergency call. They managed to push open the door (as Mr Trimmer was lying against it) and immediately checked him for signs of life. They found none, so pulled him onto the landing outside the cell to give them more space to carry out CPR. The night manager carried out continuous chest compressions, while two officers took it in turns to administer air through a mask. A nurse used the defibrillator four times and each time the machine instructed to continue CPR. She said they did not administer any oxygen, despite it being in the emergency bag in the healthcare department, as all the staff had been carrying out other aspects of CPR.
58. Paramedics arrived at Mr Trimmer's cell at 9.32pm and took over Mr Trimmer's care, assisted by staff. Paramedics managed to detect a response from Mr Trimmer and he was taken to hospital by ambulance at 10.05pm, accompanied by an officer. Mr Trimmer failed to regain consciousness and died in hospital at 12.06pm on 26 April.

#### **Contact with Mr Trimmer's family**

59. The prison appointed an officer as a family liaison officer on the morning of Sunday 23 April. He and another officer visited Mr Trimmer's partner at 1.00pm, told her what had happened and took her to the hospital. The prison contributed to Mr Trimmer's funeral, in line with national guidance.

#### **Support for prisoners and staff**

60. After Mr Trimmer's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Staff discussed the need to identify a family liaison officer at the earliest opportunity. The staff care team also offered support.
61. The prison posted notices informing other prisoners of Mr Trimmer's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Trimmer's death.

#### **Post-mortem report**

62. The preliminary post-mortem report concluded Mr Trimmer died from hanging. The toxicology report is still awaited.

# Findings

## Management of Mr Trimmer's risk of suicide and self-harm

63. Prison Service Instruction (PSI) 64/2011 on safer custody, lists risk factors and potential triggers for suicide and self-harm. Mr Trimmer demonstrated a number of risk factors, including previous suicide attempts, a history of self-harm and substance misuse, and significant ongoing relationship problems.
64. When he arrived at Lewes, staff correctly identified that Mr Trimmer was at increased risk of suicide and self-harm and started ACCT procedures. Mr Trimmer continued to be monitored under ACCT throughout his time at Lewes, but we found deficiencies in the management of these procedures.
65. We are concerned that Mr Trimmer's risk was not properly assessed throughout his time at Lewes, and in particular in the two days before he was found hanged.
66. For example, Mr Trimmer was originally allocated a single cell after reception, despite a note in the ACCT advising he should share a cell and despite exacerbated concerns about his relationship with his partner. He self-harmed that night and was taken to hospital. On 21 March, he was tearful and upset all night about not being able to contact his partner and said he would do something "stupid" and at the ACCT review the following day he said he was still having difficulties contacting his partner and felt suicidal. Despite this his risk was assessed as low and his observations were reduced at the ACCT review.
67. On the evening of 20 April, Mr Trimmer asked to speak to a Listener and shortly afterwards, was found on the floor of his cell having tied a belt around his neck. At his ACCT review the next day, Mr Trimmer said this was a cry for help and that his partner was refusing contact because she thought he had cheated on her. Staff continued to assess Mr Trimmer as low risk and reduced his level of observations. We consider they were wrong to do so. Difficulties in Mr Trimmer's relationship with his girlfriend were an ongoing issue for him, and we consider that the statements he made at his ACCT review and the fact that he had tied a ligature around his neck the previous day, indicated that his risk of suicide and self-harm had increased rather than reduced.
68. We found that staff failed to adhere to the prescribed ACCT timescales. The ACCT assessment interview and the first case review should both be conducted within 24 hours of the ACCT being opened. In Mr Trimmer's case, the assessment interview took place on 6 March, two days after the ACCT was opened, and the first case review was not until 7 March. One of the ACCT case reviews, scheduled for 13 March, was not completed until 14 March, and another scheduled for 20 March, was not carried out until 22 March, with no explanation. ACCT paperwork was also not completed correctly. In particular, Mr Trimmer's level of observations was not added to the front of the ACCT document until 12 April, over a month after the ACCT was opened and it was not always updated correctly.
69. Observations should be conducted at unpredictable times. We found many instances where Mr Trimmer's ACCT checks were completed at regular and

therefore predictable intervals, for example on 14 March, Mr Trimmer was checked repeatedly on the hour and half-hour.

70. PSI64/2011 instructs that ACCT caremaps must reflect the prisoner's needs, level of risk and the triggers of their distress. Each entry must reflect the identified issues, be tailored to meet the individual needs of the prisoner and be aimed at reducing risk. Mr Trimmer's caremap was not updated with any actions after 11 March, despite a further ten case reviews, and did not include an officer's intention to refer Mr Trimmer to the prison's mental health team on 19 April. Neither was it recorded in Mr Trimmer's healthcare record.
71. PSI64/2011 says that constant supervision is a response to an immediate suicidal crisis and is therefore intended to be in place for the shortest time possible, that it should be authorised by a manager or senior clinician and the decision for constant supervision should be recorded in the ACCT. We found no evidence that the constant supervision of Mr Trimmer had been authorised, and there was no record of the reasons and justification for this decision. The use of constant supervision should be reviewed daily. A nurse told the investigator that doctors, nurses and officers did so, but there was no record that these reviews took place.
72. Staff gave Mr Trimmer anti-ligature clothing while he was on constant supervision, although the reason for this, and who made this decision, was not recorded. PSI64/2011 says that alternative clothing must be used as a last resort and for the shortest possible time and the reasons why the clothing was needed should be recorded in the ACCT. The PSI says that placing an at-risk prisoner in alternative clothing must trigger an enhanced case management review. There is no evidence that an enhanced case review was conducted.
73. When a nurse opened an ACCT for Mr Trimmer, she recommended that he should be allocated a shared cell. Despite this he was given a single cell in the FNC, where that night he self-harmed resulting in a hospital admission. It is important that where a shared cell has been recommended in order to mitigate the risk of suicide and self-harm, staff allocate a shared cell wherever possible.
74. The healthcare department at Lewes has single cells only. This means that the risk of being in a cell alone must be balanced against the risk of self-harm and being visible in a small unit. As well as ACCT checks, healthcare staff carry out their own hourly checks on prisoners in the department, so it was reasonable for Mr Trimmer to be located there (on occasions in a constant supervision cell). During his time on A and C Wings, Mr Trimmer shared a cell.
75. A PPO publication on self-inflicted deaths of prisoners on ACCTs, published in April 2014, found that too often staff failed to properly assess risk, failed to identify appropriate caremap actions and carried out predictable ACCT observations. This was the case for Mr Trimmer. We make the following recommendation:

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

- **Staff identify, consider and record all known risk factors for a prisoner when determining their risk of suicide or self-harm.**
- **Staff set caremap actions designed to reduce the prisoner's risk of suicide and self-harm, review them at each case review and ensure actions are completed.**
- **Staff vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.**
- **Staff should complete all ACCT documentation accurately.**
- **Staff should record the reasons for placing a prisoner on constant supervision and reassess daily.**
- **Staff should use alternative clothing as a last resort and if used, staff should record the reasons and hold an enhanced case review.**

**The Governor should ensure that wherever possible, prisoners are allocated to shared cells when this has been advised as a protective measure against suicide and self-harm, and where a shared cell is not allocated, staff record the reasons.**

### **Entering Mr Trimmer's cell**

76. A nurse discovered Mr Trimmer hanging from a ligature on 22 April, and although she cut the ligature from outside the cell, she did not enter and attend to Mr Trimmer until prison officers arrived. Another nurse who was with her at that time, told the investigator that nursing staff never went into a cell without an officer. However the inpatient manager said that although nurses cannot enter a cell for any general reason during patrol state (when all prisoners are in their cells and the prison is in lockdown), if it is required for any clinical reason (such as an emergency) then a nurse can go into the cell. She said this is covered by the NMC (Nursing and Midwifery Council) code of practice and in a safe system of work joint policy between healthcare staff and the prison. A Notice to Staff (NTS) 033/2017, issued in March 2017, says that the decision to enter a cell or not is taken by the individual.
77. The delay in entering Mr Trimmer's cell meant a consequent delay in starting CPR. While we cannot say whether this delay impacted on the eventual outcome for Mr Trimmer, it is imperative that in future medical emergencies, staff enter the prisoner's cell without delay so they can start resuscitation attempts immediately if required. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff understand the importance of entering a cell without delay when a prisoner's life is at risk, when it is safe to do so.**

78. We are troubled by some aspects of the emergency response. Officers were carrying out CPR for Mr Trimmer while a nurse used the defibrillator. Although the officers used an Ambu-bag to administer air to Mr Trimmer, oxygen was available but was not used despite it being in the nurses' emergency bag. A

nurse told the investigator that as she asked whether she should get the oxygen out, the paramedics arrived. The clinical reviewer concluded that the use of oxygen is part of life support (the Life Support Algorithm) which should have been followed in this instance. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff are trained or receive refresher training in basic life support.**

#### **Delay informing Mr Trimmer's next of kin**

79. Prison Rule 22 requires a prisoner's next of kin to be informed at once, if a prisoner becomes seriously ill. Mr Trimmer was discovered in his cell at approximately 9.27pm on 22 April, and left the prison in the ambulance at 10.05pm. The prison did not appoint a family liaison officer (FLO) that night, but waited until 8.30am the next morning. This delay is unacceptable given the seriousness of Mr Trimmer's condition. We make the following recommendation:

**The Governor should ensure that staff inform the next of kin of seriously ill prisoners promptly.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations