

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Dean Barrell a prisoner at HMP Lewes on 13 February 2017

**A report by the Prisons and Probation Ombudsman**

## 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 centres.

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

Mr Barrell was found hanged in his cell at HMP Lewes on 13 February 2017. He was 34 years old. I offer my condolences to Mr Barrell's family and friends.

There were no obvious signs to indicate that Mr Barrell was at imminent risk of suicide and self-harm at the time of his death. It would have been difficult for staff at Lewes to have predicted or prevented it.

We are concerned that the officer who found Mr Barrell hanging failed to give an accurate account of the circumstances that led to Mr Barrell's discovery. His retirement means that the reasons for his actions remain unclear. We are troubled that a frontline officer may not have been issued with anti-ligature cutting tools despite it being a mandatory requirement. The Governor should address this.

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

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**                      **December 2019**

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# Summary

## Events

1. Mr Barrell was released on licence from HMP High Down on 26 January 2017 after serving three months of a six-month sentence for theft and possession of a knife. He failed to report to his offender supervisor and was recalled to custody. He was arrested on 6 February and was remanded to HMP Lewes on 7 February.
2. Mr Barrell said he had been drinking alcohol daily since his release from High Down. He had been prescribed anti-depressants in the past and had a history of taking heroin and crack cocaine but had not recently self-harmed and had no thoughts of taking his life. Mr Barrell was admitted to the drug stabilisation unit and started an alcohol detoxification treatment programme. His referral to the mental health team due to a history of psychosis was put on hold until his detoxification was completed. He was told he would be released on 27 April.
3. Mr Barrell wrote several letters to his mother, which she received the day after his death. He said he felt unwell, was hearing voices, had sold his food for tobacco, felt alone and had thoughts of ending his life. He did not tell nursing staff, officers or his cellmate how he was feeling.
4. On 13 February at about 10.00am, a psychologist from the mental health team saw Mr Barrell. He told her that he wanted medication for anxiety but did not elaborate. He said he was not feeling suicidal. Mr Barrell's cellmate was moved to another wing at about 11.00am as he had finished his detoxification treatment. Mr Barrell collected his lunch and was last seen by an officer at 12.05pm locked in his cell, sitting, eating his meal.
5. A psychosocial caseworker went to Mr Barrell's cell between 12.30pm and 1.30pm to ask him to complete some paperwork but when he looked in the cell and could not see Mr Barrell, he assumed he was in the toilet and told the officer on duty he would return later.
6. At about 2.00pm, an offender manager told the officer on duty that she needed Mr Barrell to sign his licence recall documentation (for his revised release date of 17 February) but when she had looked through the door observation panel of his cell, she could not see him. The officer remarked that she was the second member of staff to make the same comment. He opened the cell door and found Mr Barrell hanged in the toilet.
7. The officer was not carrying a ligature-cutting tool. He radioed for assistance. Staff responded quickly and began cardiopulmonary resuscitation. Paramedics arrived, examined Mr Barrell and at 2.59pm recorded that he had died.

## Findings

8. Mr Barrell's clinical record recorded that he had tried to take his life in the community on at least three occasions since 2005, the most recent attempt in October 2016. His Person Escort Record flagged up issues of depression and anxiety and on arrival, he said that he had been prescribed medication. However, there was no obvious indication that he was likely to take his life and at an initial

health check, he denied suicidal intent. With the benefit of hindsight, he could have had a more in-depth assessment of his risk given that he was undergoing detoxification and he had been recalled to custody, factors that heightened his risk of self-harm, but there was little to suggest that staff should have begun ACCT procedures.

9. Mr Barrell was appropriately identified as suitable for alcohol detoxification. He was placed in a residential unit dedicated for drug and alcohol stabilisation and received appropriate care equivalent to that which he could have expected to receive in the community.
10. The officer who found Mr Barrell hanging was not carrying a ligature-cutting tool. He gave the investigator unsatisfactory, inconsistent, incomplete and misleading accounts of his actions that day but has since retired.

## **Recommendations**

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
  - All uniformed staff in contact with prisoners are issued with a personal ligature-cutting tool and that it is worn at all times while on duty.
  - All staff in contact with prisoners are trained in suicide and self-harm prevention procedures with appropriate refresher training.
  - Staff ensure they receive a response from prisoners if they are not visible or otherwise enter the cell.

## The Investigation Process

11. 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. She wrote to two prisoners asking for information. One prisoner responded.
12. The investigator visited Lewes on 16 February 2017. She obtained copies of relevant extracts from Mr Barrell's prison and medical records
13. The investigator interviewed 12 members of staff and one prisoner in April, May and July 2017. The Governor was provided with feedback about concerns about ligature-cutting tools and said that he would arrange an audit. We understand that this has been completed.
14. At our request, a member of the Independent Monitoring Board examined the small observation windows in each cell which allow staff to check whether a prisoner is in the toilet area. They found the observation windows blocked in nine of the eleven cells.
15. NHS England commissioned an independent clinical reviewer to review Mr Barrell's clinical care at the prison. The clinical reviewer joined the investigator for 11 interviews and interviewed one member of healthcare staff by telephone.
16. We informed HM Senior Coroner for East Sussex of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Barrell's sister, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. His sister said that Mr Barrell had written several letters to their mother, which arrived the day after his death. In the letters, Mr Barrell spoke of feeling cold, hearing voices in his head, suicidal feelings and selling his food to obtain tobacco. His family also wanted to know:
  - Whether his post should have been checked by staff before it was sent;
  - Whether he had moved cells during his stay;
  - Whether his physical and mental healthcare were appropriate;
  - Whether he saw a psychiatrist and what was discussed;
  - Was he being bullied;
  - Whether the work sheet found in his cell after his death about his mental health had been seen by staff;
  - Whether it would have made a difference if he had been told his new release date; and
  - Why he was left in a cell by himself on the day he died.

18. Mr Barrell's family was given a copy of the initial report. Their legal representative responded that the first night risk assessment was not adequate, the investigation did not consider the delay of an urgent mental health assessment until detoxification was completed, his bathroom door could be closed from the inside preventing him from being viewed and staff should have realised his mental health was deteriorating. We have responded to their concerns in separate correspondence.
19. HMPPS was also provided with a copy of the report. They pointed out that there was only one member of staff who had not been issued with an anti-ligature tool not several. The Chief Executive of HMPPS wrote to the Acting Ombudsman in June 2018 that he was unable to accept one of our initial recommendations about the cost and privacy of restoring clear observation ports in cell toilet areas. Our revised recommendation that staff should enter a cell if they do not receive a response from prisoners who are not visible has been accepted. Their action plan is included as an annex to this report.

# Background Information

## HMP Lewes

20. HMP Lewes is a local prison serving the courts of East and West Sussex. It holds up to 692 sentenced or remanded men. Sussex Partnership NHS Foundation Trust provides the primary healthcare. RAPt are responsible for substance misuse services. Lewes was designated a failing prison in December 2016 and placed in special measures.

## The Drug and Alcohol Stabilisation Unit

21. The drug and alcohol stabilisation unit, also known as K wing, holds up to 22 prisoners in double cells. The purpose is to provide support for at least five days for newly arrived prisoners who have used alcohol or drugs until they are stable or in recovery. It is staffed by prison officers and by specialist substance misuse nursing staff. It was run by a drugs and alcohol recovery team (DART) until October 2016. It is now managed by RAPt, a rehabilitation charity organisation.

## HM Inspectorate of Prisons

22. HMP Lewes was inspected in January 2016. Inspectors reported that first night support was inadequate and prisoners at risk of self-harm did not receive sufficient support. Some staff did not carry anti-ligature knives at night and could not provide assurances that they would act appropriately if there was a serious self-harm incident. Self-harm was lower than in similar prisons, prisoners reported feeling relatively safe and there appeared to be good staff-prisoner relationships. A third of prisoners sampled said they felt depressed or suicidal on arrival but the safer custody team was not functioning effectively due to a lack of staff. There had been no ACCT refresher training for staff for three years. The most recent inspection took place in January 2019. The Chief Inspector's report described Lewes as deeply troubling and indicative of systemic failure despite having been in special measures for two years which were intended to promote improvement. It concluded that there was a great deal of urgent work required in respect of safety.
23. Healthcare and substance misuse services were generally good and effective. Psychosocial care was provided by a highly competent group of staff.

## Independent Monitoring Board

24. 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 2016, the IMB reported that Lewes had run a severely restricted and inconsistent regime in the previous 12 months. The standard of its suicide and self-harm support documents was poor but prisoners with healthcare needs were treated fairly with recognition of their individual needs.

## **Previous deaths at HMP Lewes**

25. Mr Barrell was the tenth of 11 prisoners to die in the custody of Lewes since 2015, three deaths being apparently self-inflicted. In a previous self-inflicted death in 2016, a community GP had prescribed medication for depression but a reception nurse who conducted an initial health screen did not review the prisoner's previous history or properly consider his risk of suicide and self-harm. Prison staff missed several opportunities to recognise that another prisoner who died in 2016 was the victim of bullying.

## **Assessment, Care in Custody and Teamwork (ACCT)**

26. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm.

## Key Events

27. On 28 October 2016, Mr Dean Barrell was sentenced to six months in prison for theft and possession of a knife. It was his first custodial sentence although he had a history of offending from 1999, linked to heavy alcohol use. He was sent to HMP High Down. Mr Barrell was released on 26 January 2017 with licence conditions that required him to live at an agreed address and report to his offender supervisor when required. He was recalled to custody on 3 February after failing to comply with his licence conditions and was arrested by police on 6 February.
28. On 7 February, he was sent to HMP Lewes. Mr Barrell was taken to the First Night Centre where all newly received prisoners are interviewed using a standard induction record. He told an officer that he was expecting to return to prison, had accepted it and did not have any concerns about being in prison. He said he had attempted to hang himself when he was homeless but did not feel like self-harming. He asked whether he would be able to telephone home and was allowed to make a call after the induction process was explained. The officer asked Mr Barrell whether he had any current thoughts of self-harm and he said he did not. The officer noted from Mr Barrell's records that he had a history of self-harm but Mr Barrell did not give him immediate cause for concern. Mr Barrell was given a smoker's pack (tobacco, a lighter, filters and cigarette papers).
29. A sentence planning document in Mr Barrell's records prepared by his offender supervisor said that Mr Barrell had tried to hang himself twice in 2003, he had taken an overdose in 2006 and in 2012 he had hanged himself from a tree but the branch broke. It was unclear whether Lewes had access to this information at the time he was received into custody. His Person Escort Record (which accompanies a prisoner on all journeys between police stations, courts and prisons to communicate risk factors) flagged up that he suffered from depression and anxiety and had tried to hang himself with wire.
30. Mr Barrell told the nurse who carried out an initial health screen that although he had a history of smoking heroin and crack cocaine, he had only done so once since he left High Down and his main problem was alcohol which he drank daily (more than 50 units) and a heavy cigarette smoker. The nurse assessed him and noted that he had mild symptoms of alcohol withdrawal including tremors, nausea and anxiety.
31. Mr Barrell told a nurse he was concerned he had a chest infection. The nurse referred him to see a GP and to the mental health team due to his history of drug induced drug or alcohol-induced psychosis. He noted that Mr Barrell had a history of overdoses and attempts to hang himself though when asked, he said he had no ideas to harm himself.
32. A GP working with substance misuse patients talked to Mr Barrell about his initial substance misuse assessment. He said he had anticipated being able to control his urge to drink but he had drunk as soon as he was released from High Down. He agreed to undergo an eight-day alcohol detoxification programme and was taken to K wing, the drug and alcohol stabilisation unit. He was allocated the top

bunk in cell K1-14. A nurse noted in his clinical record that he had several prolonged bouts of coughing during the night and he said been feeling like that for about a week, as he had been homeless. She gave him some herbal tea bags and boiled sweets to ease his throat. He shared the cell with a cellmate and remained there until his death.

33. On 8 February, a prison GP examined Mr Barrell. His clinical notes described Mr Barrell's throat as red with large lumps of mucus. He prescribed antibiotics, a steroid medication to treat inflammation and an inhaler to assist his airways to remain open.
34. A prisoner who worked as a wing cleaner recognised Mr Barrell as someone he had previously shared a house with in Portsmouth. He thought Mr Barrell seemed low in mood and 'not himself' but Mr Barrell said he was alright.
35. Mr Barrell's health was monitored daily by substance misuse nurses for withdrawal symptoms and physical health who updated his clinical records. On 9 February, a Community Psychiatric Nurse from the mental health team noted that Mr Barrell's referral would be put on hold until he had completed his alcohol detoxification. Mr Barrell asked an officer if he could have a telephone call. The officer noted that Mr Barrell had already been offered a free two-minute call to his family and was not eligible for another. On 10 February, the mental health team manager met the substance misuse nurse practitioner to discuss Mr Barrell's case. They agreed that there was no current sign of psychosis and his detoxification could continue but that the substance misuse team would alert the crisis team if he had any mental health concerns.
36. A psychosocial caseworker with RAPt met with Mr Barrell on 10 February to discuss consent to future substance recovery treatment. Mr Barrell said that he had tried to take his life in October 2015 but did not give details. The caseworker gave him a three-page work sheet with different sections to complete in his own time, detailing his history of substance misuse, health and offending behaviour, which they would discuss in private at their next session. Mr Barrell described his physical health as 'no good', his mental health as 'bad' and that he self-harmed sometimes. The worksheet was found in his cell after his death.
37. On 12 February, a nurse met with Mr Barrell for a five-day review of his detoxification treatment. She noted that he had tachycardia (rapid resting heart beat) which could have been related to his throat infection. He had moderate tremors, mild pins and needles and numbness, which were normal symptoms.
38. Mr Barrell wrote to his mother on 12 February. He said he had been moved to the healthcare centre as he was struggling with pneumonia and bronchitis and feeling cold all the time. (In fact, he did not move and remained in the same cell on K wing until his death. His clinical record noted that he was coughing periodically in his sleep but he remained on K wing.) He wrote that he had not seen anyone from the mental health team and still had voices in his head. He asked his mother to send him some money, as he had sold his food for tobacco and he needed to pay back a prisoner who had given him some tobacco. He described the prison as hard and said he did not like it. The letter had a drawing of a tombstone with his name and the dates 1982 to 2017 written on it and a noose. He apologised to his mother for comments he had made in the past and

said he needed 'a hug'. Staff do not read the contents of outgoing letters unless specific restrictions have been put in place. No such restrictions were in place for Mr Barrell.

39. Mr Barrell's cellmate told the investigator he had seen Mr Barrell eating his meals and was not aware of him giving food to other prisoners. An officer told the investigator he has come across bullying for tobacco on K wing in the previous 15 months but not in relation to Mr Barrell. The safer custody manager told the investigator he had not received any reports of bullying in relation food or tobacco on K wing in the past year.

### 13 February

40. Mr Barrell's cellmate told the investigator that they got on well and wanted to go to C wing together when their detoxification treatments ended. Mr Barrell's cellmate did not find the staff on K wing particularly approachable. Mr Barrell's smokers pack had run out within two or three days and he kept asking other prisoners for tobacco. His cellmate told the investigator he thought officers had spoken to Mr Barrell in a threatening way on two occasions. The first, which his cellmate overheard, was when a male officer whose name he did not know said to him "keep going round asking for roll ups and I'll put you on A wing" which was regarded by prisoners as the worst wing. His cellmate said this upset Mr Barrell and he stopped asking other prisoners for tobacco. On the second occasion, Mr Barrell told him he cut the sleeves off an item of clothing and an officer had spoken to him about it. It is unclear why Mr Barrell objected to this.
41. Mr Barrell asked the prisoner he had shared a house with, how he could speak to someone from the mental health team. He said he should speak to a nurse or an officer and asked Mr Barrell if he was alright. Mr Barrell replied "yeah, just need to see someone". We do not know if he spoke to a member of staff about his mental health.
42. A counselling psychologist with the mental health in-reach team spoke to Mr Barrell privately in a side office at about 10.00am. He told her he wanted medication for anxiety and described it as 'something to take the edge off' but would not be more specific. She got the impression that he did not want to be assessed. He seemed settled and said his sessions with RAPt were fine. She described their conversation as rational. He made good eye contact and talked about his tattoos. She noticed some old scars and asked him about his risk of self-harm. He said he had taken an overdose five years ago but did not elaborate. She did not see anything in their conversation that made her concerned about his safety.
43. Mr Barrell's cellmate said an officer opened their cell door and, without warning told him to pack his belongings as he was moving to C wing. The officer told the investigator that he had unlocked the wing at 8.00am as usual. He recalled Mr Barrell as he saw him with prison-issue T-shirt that looked like it had been customised. He asked Mr Barrell if he had cut the arms off. Mr Barrell had replied that he found it like that, which he accepted. Mr Barrell asked for some writing paper and envelopes, which the officer gave him. About 11.00am, the officer took Mr Barrell's cellmate to another wing. An officer locked the prisoners in their cells after they collected lunch from the servery at about 12.00pm. He

asked Mr Barrell if he was all right, as he knew his cellmate had moved and Mr Barrell replied 'yeah, fine Guv.' The officer counted the prisoners once they had been locked in. He saw Mr Barrell at about 12.05pm sitting on a chair in his cell eating his lunch.

44. Between 12.30pm and 1.30pm, when the wing was locked up for lunch, the psychosocial caseworker returned to K wing because he had a form for Mr Barrell to sign. He told the investigator that he looked into Mr Barrell's cell through the door observation panel and heard loud music playing but could not see him in the cell. He told the officer on duty, he assumed that Mr Barrell was in the toilet and he would return to see him later that day.
45. At about 2.00pm, an offender manager arrived on K wing to ask Mr Barrell to sign his licence recall papers, as his new release date would be 17 February. She told the investigator that she told the officer on duty that Mr Barrell needed to sign the papers. He replied that the wing was in lockdown. She suggested that she could push the documents under Mr Barrell's door and, if he had a pen, he could sign them and push them back to her. The officer agreed and the offender manager went to Mr Barrell's cell door but she could not see him inside. She knocked and called out his name. She could hear loud music coming from inside but he did not respond. After standing at the door for a minute or so, she returned to the officer saying that she thought he was in the toilet. The officer responded that Mr Barrell had to be there but someone else had told him earlier that they could not see him in the cell either. The offender manager offered to open the cell door and talk to Mr Barrell but the officer said he would go with her and he would unlock the door.
46. The offender manager said the officer went into the cell while she stood in the doorway, looking into the cell. The officer went into the toilet area and shouted out the name of a prisoner who she presumed was a cleaner. A prisoner appeared on the landing straightaway and walked towards Mr Barrell's cell. The offender manager said 'quick, the officer needs you' and he went into Mr Barrell's cell. She saw Mr Barrell's head being laid on the cell floor and heard the officer radio for staff assistance, which arrived within a minute. A supervising officer (SO) cut the ligature from Mr Barrell's neck and began cardiopulmonary resuscitation until further healthcare assistance arrived.
47. The offender manager returned to the offender management unit and told her manager what had happened. She told the investigator that the officer telephoned her later that afternoon and said he needed to talk to her when no one else was around. She did not return his call or see him again before going on maternity leave two weeks later.
48. The prison communications room incident log records the officer radioed for staff assistance at 2.09pm. Lewes called an ambulance at 2.10pm. Two ambulances arrived at 2.20pm and 2.26 pm. Ambulance staff tried to resuscitate Mr Barrell but he was pronounced dead at 2.59pm.
49. The investigator interviewed the officer who found Mr Barrell on 24 April and 5 July. He gave conflicting accounts of how he came to discover Mr Barrell hanging and who was present in the cell when he found him. He initially insisted that he was by himself when he discovered Mr Barrell. He later said that that the

offender manager had been on the landing with some paperwork she wanted to give to Mr Barrell but said she could not see him in his cell. He said he did not recall when she left the wing. He was asked whether he called out to anyone on finding Mr Barrell. At first, he said he did not, then that he might have shouted out to someone such as one of the nurses, but he could not remember. The officer eventually disclosed that there were two prisoners unlocked on the wing when it was in lockdown; one was painting a cell and the other was cleaning the showers. The officer called one of them to assist him. Asked why he had been adamant that he had not called for a prisoner to assist him, he said he did not want to get the prisoner into trouble and said he did not remember seeing him in Mr Barrell's cell. It is unclear why the officer gave conflicting accounts of events, nor did he fully explain why he wanted to speak with the offender manager about the incident in private. The officer did not have a ligature-cutting tool because he had not been issued with one and although he had been a prison officer for 25 years, had no idea whether it was a mandatory requirement. The officer has now retired from the Prison Service.

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

50. Mr Barrell had named his mother, who lives in Hampshire, as his next of kin. As both of Lewes' family liaison officers were unavailable, HMP Ford's family liaison officers offered to assist. They arrived at Mr Barrell's mother's home at 6.45pm and broke the news of his death. Lewes contributed to the cost of Mr Barrell's funeral in line with national policy.

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

51. Managers debriefed the staff involved in the emergency response and offered support. Staff notified prisoners of Mr Barrell's death and offered them support. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case the news of Mr Barrell's death had affected them. Mr Barrell's cellmate said prison staff told him of Mr Barrell's death two days later.

### **Post-mortem report and inquest**

52. The post-mortem report gave the cause of death as hanging. Toxicology tests showed that Mr Barrell had benzodiazepines (chlordiazepoxide from the alcohol detox and diazepam) in his bloodstream and urine at the time he died in small quantities.
53. An inquest took place in September 2018. The finding was that of suicide with the following factors causing or contributing to his death:
  - His increasing risk of self-harm and suicide was not recognised by staff
  - lack of an open ACCT
  - he was unaware of his release date
  - Lewes lacked an effective policy for getting a response from a prisoner
  - error in smoke alarm design (not in PPO remit)

# Findings

## Assessment of risk of suicide and self-harm

54. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff in reception and in the first night centre at Lewes should have recognised Mr Barrell as at risk of suicide.
55. The PSI lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, previous self-harm, substance misuse and mental illness. Staff in reception should assess new prisoners' risk of suicide and self-harm and be alert to any increased risk, and address any concerns, including opening an ACCT if necessary
56. Mr Barrell arrived with some risk factors: his escort record noted he had depression and anxiety. When he arrived at Lewes, he acknowledged he had harmed himself in the past and told two nurses and an officer that he had no thoughts of suicide or self-harm. He gave similar answers three days before his death to his psychosocial caseworker and only hours before he was found, to a psychologist who probed why he wanted medication for anxiety. Only his letters to his family, to which staff were not privy, revealed the inner distress he was feeling. Outwardly, he appeared normal in mood to staff and his cellmate. We are satisfied that staff considered his risk and it was reasonable for them to conclude that Mr Barrell did not need to be monitored under ACCT procedures and he could be safely left in a cell by himself.

## Management of safer custody procedures

57. PSI 64/2011 sets out the roles and responsibilities of Governors and other staff in risk management and the preservation of life. Following the officer's disclosure that he was not carrying an anti-ligature cut-down tool when he found Mr Barrell, the investigator communicated to the Governor our concern that such a situation could arise. We understand that the Governor asked a senior manager to carry out an audit of anti-ligature cut-down tools, which is underway. The senior manager told the investigator that the database of ligature-cutting tools had been poorly maintained. The officer had been a workshop instructor when the anti-ligature cutting-tools had first been introduced and it had been decided at that time that workshop instructors did not need to be issued with such tools but that this decision would be reviewed. The investigator returned to Lewes in July to re-interview the officer. He said that he had not received ACCT training and still was not carrying a cut-down tool. It is unacceptable that an officer was dependent on the arrival of a colleague to remove the fabric from the prisoner's neck, or that he would remain on duty without a cut-down tool for next five months.

58. HM Inspectorate of Prisons report on Lewes in 2016 also flagged up these worrying issues. Chapter 1 of PSI 64/2011 states *“All uniformed staff in closed and semi-open establishments must be provided with and carry (whilst on duty) their own personal issue cut-down tool ... staff other than discipline staff may also carry cut-down tools, if it is decided locally to be necessary/desirable ... Governor/Directors must carry out a risk assessment to decide which other staff, including healthcare staff, must carry their own personal issue cut-down tool.”*

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

- **All uniformed staff in contact with prisoners are issued with a personal ligature-cutting tool and that it is worn at all times while on duty.**
- **All staff in contact with prisoners are trained in suicide and self-harm prevention procedures with appropriate refresher training.**
- **Staff ensure they receive a response from prisoners if they are not visible or otherwise enter the cell.**

## **Healthcare**

59. After Mr Barrell was released from High Down, he had been consuming large amounts of alcohol every day and was homeless. When he arrived at Lewes, he was feeling physically unwell. The clinical reviewer concluded that the healthcare he received was equivalent to that which he could have expected to receive in the community. He was promptly assessed for substance misuse issues and given a bed immediately in a specialist unit. He saw a GP promptly and was prescribed appropriate medication for his throat infection. His responses to the detoxification programme were regularly monitored. He was referred to the mental health team and a counselling psychologist from the team visited him. There were no obvious omissions in the care he received and, unfortunately, he chose not to disclose his thoughts or feelings about ending his life.

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