

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Deejay Blampey, a prisoner at HMP Exeter, on 2 February 2021

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO



WHAT WE VALUE



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

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

Mr Deejay Blampey, a prisoner at HMP Exeter, was found hanged in his cell on 2 February 2020. He was 27 years old. I offer my condolences to his family and friends.

At the time of his death, Mr Blampey was appropriately being monitored under suicide and self-harm prevention procedures (known as ACCT). However, I am concerned that on the day that his cellmate transferred to another prison, no one considered whether Mr Blampey's risk of suicide and self-harm had increased and whether to increase the level of ACCT monitoring.

I am also concerned about the use of inappropriate language made by a member of staff soon after Mr Blampey's second ACCT document was opened and about the delay in calling an ambulance after Mr Blampey was found hanged.

Although the clinical reviewer concluded that, overall, the clinical care that Mr Blampey was of a reasonable standard, she raised some concerns about referrals to the mental health team, the need for them to be carried out in private and for nurses to respond to emergencies with the correct equipment.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

September 2022

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Summary

Events

1. On 11 January, Mr Deejay Blampey was remanded to HMP Exeter. He had a history of depression and anxiety and had previously served time in prison.
2. When he arrived at Exeter, staff started suicide and self-harm monitoring procedures (known as ACCT) and although they were stopped on 12 January, they were started again on 21 January, after Mr Blampey told staff that he felt suicidal.
3. During his time at Exeter, Mr Blampey had contact with the prison's mental health team and was supported by the prison's chaplaincy. Mr Blampey appeared to have settled at Exeter, was given a job, which gave him additional time out of his cell, and he got on well with other prisoners, including his cellmate. On 2 February, Mr Blampey's cellmate was transferred to another prison.
4. On the evening of 2 February, during an ACCT check, an officer found Mr Blampey unresponsive in his cell, with a ligature tied around his neck. Nurses and officers tried to resuscitate him, and they were later assisted by paramedics. Their attempts were unsuccessful, and paramedics confirmed Mr Blampey's death at 11.44pm.

Findings

5. Although staff appropriately started ACCT procedures on two occasions when Mr Blampey was at Exeter, we are concerned that when his cellmate was transferred, no one re-assessed his risk of suicide and self-harm or considered if his observations needed to be increased.
6. We are also concerned about the inappropriate use of language by prison staff shortly after Mr Blampey was monitored under ACCT procedures for the second time.
7. We are concerned that there was a delay in calling an ambulance after the emergency code blue was called.
8. The clinical reviewer concluded that the care that Mr Blampey received at Exeter was of a standard equivalent to which he could have expected to receive in the community.
9. However, the clinical reviewer identified several concerns in Mr Blampey's care, including the need for mental health assessments to be completed privately, that urgent mental health referrals are carried out within 48 hours and the need for emergency response nurses to take with them appropriate emergency equipment. The clinical reviewer also highlighted several learning points about record keeping and the correct use of personal protective equipment (PPE) during the COVID-19 pandemic.

Recommendations

- The Governor should ensure that a multidisciplinary ACCT review is held when there is evidence of a significant change in circumstance and that the frequency of observations should reflect a prisoner's risk and be adjusted when that risk changes.
- The Governor should ensure that staff are reminded not to use inappropriate or insensitive language towards prisoners, particularly, those being monitored under ACCT procedures.
- The Governor should ensure that control room staff call an ambulance as soon as they receive a medical emergency code.
- The Head of Healthcare should ensure that, wherever possible, consultations and assessments with prisoners are carried out in private and if this cannot happen, the reason is clearly documented.
- The Head of Healthcare and Mental Health Clinical Manager should ensure that referrals to the mental health team, reporting that a prisoner feels suicidal, prompts an additional mental health assessment within 48 hours.
- The Head of Healthcare should ensure that nurses respond to emergency code blue incidents with the relevant emergency equipment, including a defibrillator.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Blampey's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Blampey's clinical care at the prison.
13. The investigator interviewed nine members of staff and three prisoners at Exeter on 25 February, 4, 8, 9 March and 4 May, some jointly with the clinical reviewer. All the interviews were conducted remotely either by video or by telephone because of the restrictions imposed as a result of COVID-19.
14. The investigator also spoke to Mr Blampey's cellmate who had transferred to another prison.
15. We informed HM Coroner for Exeter and Greater Devon of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
16. We contacted Mr Blampey's family to explain the investigation and to ask if they had any matters that they wanted us to consider. They asked if Mr Blampey had left a suicide note.
17. Mr Blampey's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Exeter

18. HMP Exeter holds up to 431 adult men and young offenders, and serves the courts of Devon, Cornwall and Somerset. GP and primary care health services are delivered by Practice Plus Group, formerly known as Care UK. Devon Partnership NHS Trust provide mental health services and substance misuse services are provided by EDP Drug and Alcohol Services.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Exeter in May 2018. Inspectors reported that despite a significant increase in staffing levels since their last visit in 2016, there had been a further sharp deterioration at the prison.
20. However, inspectors found that the quality of ACCT assessment and case management reviews for prisoners was better than they normally saw at other prisons and that there were some positive initiatives, including a log of triggers that could affect prisoners in crisis and weekly meetings to discuss complex cases, but that care plans remained underdeveloped and did not place sufficient emphasis on the need to offer prisoners meaningful activity.
21. Inspectors reported that the prison's chaplaincy had a high profile, that chaplains knew prisoners well and were well integrated, attending safer custody meetings and providing excellent pastoral support to prisoners.
22. Inspectors reported that substance misuse provision was good, health services had improved and mental health services comprised a rich skill mix, including psychology services, despite some staffing shortages.
23. Inspectors reported that the prison was significantly less safe than at their last inspection, and their overall assessment of the prison was "poor". Following the inspection, HM Chief Inspector of Prisons invoked the urgent notification protocol and wrote to the Secretary of State in May 2018, setting out his concerns about the treatment of prisoners.
24. HMIP carried out an independent review of progress in April 2019. They found that progress had been good or reasonably good in almost half of the recommendations they had made since their inspection in 2018. They noted that relationships between staff and prisoners were improving and there were credible plans to make further improvements.
25. HMIP carried out a scrutiny visit to Exeter in March 2021 during the COVID-19 pandemic. Inspectors reported that there had been little progress in addressing long-standing deficiencies in the care of prisoners at risk of suicide and self-harm. Inspectors reported that time out of cell for most prisoners was limited to about 90 minutes on most days and less at weekends and work opportunities were confined to essential roles only.

26. Inspectors reported a lack of confidence among staff, many of whom were inexperienced and they noted that relationships between staff and prisoners were lacking, including insufficient care for prisoners at risk of suicide and self-harm. Inspectors reported that despite recommendations made by the Prisons and Probation Ombudsman about the quality and effectiveness of the ACCT process, they found that the quality of many ACCT documents was poor and prisoners at risk of suicide and self-harm were not adequately supported.
27. Inspectors reported that due to the suspension of the keyworker scheme, daily wellbeing checks had been introduced in December 2020 for prisoners assessed as vulnerable and that these generally took place.

Independent Monitoring Board

28. 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 December 2020, the IMB reported that they continued to have some concerns about ACCT case management. The IMB reported that during the COVID-19 lockdown, arrangements were in place for staff to visit the most vulnerable prisoners daily and that the Chaplaincy had maintained a presence during the pandemic, providing bereavement and pastoral support.
29. The IMB reported that overall, the standard of healthcare provision that prisoners received was equivalent to that available in the community but COVID-19 had curtailed the operation of some specialist clinical services. The IMB reported that it had been a difficult and busy year for the mental health team, as many prisoners had struggled with mental health problems during the restricted COVID-19 regime.
30. Since Mr Blampey's death there has been a further IMB report for the year to December 2021. In their latest report, the IMB reported that a number of prison processes and programmes, including the keyworker scheme, continued to suffer due to COVID-19. The IMB reported that there had been strenuous efforts to ensure that ACCT reviews were multidisciplinary. The IMB reported that prisoners continued to struggle with their mental health as a consequence of COVID-19.

Previous deaths at HMP Exeter

31. Mr Blampey was the fourteenth prisoner to die at Exeter since January 2019. Three of the previous deaths were self-inflicted, ten were from natural causes and there was one non-natural death. In our report into the self-inflicted death of a prisoner in July 2019, we made a recommendation about the need for mental health assessment to be carried out privately and not during ACCT reviews.

Assessment, Care in Custody and Teamwork

32. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. As part of the process, a risk reduction plan, also known as a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be

closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

33. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

COVID-19 restrictions

34. On 24 March 2020, in response to the COVID-19 pandemic and in line with Government advice, HMPPS issued an instruction to all prisons to introduce social distancing and a restricted regime for staff and prisoners, wherever possible. On 27 March, HMPPS issued operational guidance to prisons on exceptional regime and service delivery, which reflected Government restrictions following the national lockdown of 23 March. This guidance resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent much of their day locked behind their cell doors.

Keyworker scheme

35. The keyworker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversation with each of their allocated prisoners.
36. The key worker scheme was suspended across the estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, such as those who were at risk of suicide or self-harm, the Prison Service introduced the Exceptional Delivery Model for keywork in May 2020 which required officers to have a weekly conversation with prisoners identified as vulnerable.

Key Events

37. On 11 January 2021, Mr Deejay Blampey was remanded to HMP Exeter, charged with actual bodily harm. It was not his first time in custody. He had a history of depression and anxiety, for which he had previously been prescribed antidepressants.
38. Mr Blampey's person escort record (a document that accompanies prisoners between police custody, courts and prisons and sets out their risks) noted that Mr Blampey was at risk of suicide and self-harm, that he had tried to kill himself in December 2019 after the deaths of his brother, who had died in prison, and his daughter.

HMP Exeter

39. When Mr Blampey arrived, an officer noted that Mr Blampey was polite. He concluded that Mr Blampey should initially be supported under suicide and self-harm monitoring procedures, known as ACCT. The officer explained to Mr Blampey the dangers of taking drugs in prison and explained the prison's new restricted regime as a result of the COVID-19 pandemic. Mr Blampey said that he was happy to share a cell with another prisoner.
40. A nurse completed an initial health screen and a prison GP saw Mr Blampey. It was noted that Mr Blampey had a history of anxiety, drug and alcohol misuse and denied thoughts of suicide and self-harm. He was referred to the prison's mental health and substance misuse teams.
41. On 12 January, a Supervising Officer (SO) completed the ACCT assessment. Mr Blampey said that he felt "pretty good", despite being in prison, and was managing to "sort his life out". Mr Blampey told the officer that he "absolutely" denied thoughts of suicide or self-harm, but that he had tried to take his life in April 2019 after the deaths of his brother and daughter. Mr Blampey told the SO that he had been diagnosed with severe anxiety but had stopped taking his medication as he did not need it.
42. A second SO chaired Mr Blampey's first ACCT review. A mental health nurse and the prison chaplain attended. The first SO did not attend but told the second SO about his earlier assessment. Mr Blampey said that he felt that they had started ACCT monitoring due to his suicide attempt in 2019, which was a low point in his life but he had turned his life around since then and had made good progress. Mr Blampey said that he wanted to address his use of cannabis and his anxiety. Further referrals to the mental health and substance misuse teams were made. Mr Blampey denied thoughts of suicide or self-harm and it was agreed that ACCT monitoring would end.
43. During the ACCT review, the mental health nurse, completed a mental health assessment for Mr Blampey. She noted on 14 January that he had appeared well kempt and engaged well. Mr Blampey told her that his history of depression mostly related to his life circumstances, and that he had managed the physical symptoms of anxiety through substance misuse. Mr Blampey said that the memories of his brother's death sometimes caused him distress and he had received counselling in

the past. She noted that Mr Blampey displayed no evidence of psychosis, that he wanted to engage with the prison's substance misuse team and was "very keen to engage in something to help him manage his anxiety in a more constructive way".

44. During the day, Mr Blampey told the prison chaplain that he wanted to attend his grandfather's funeral. The chaplain made further enquiries on Mr Blampey's behalf to find out if he could attend remotely.
45. On 13 January, an officer completed Mr Blampey's prison induction.
46. A member of staff from the prison's substance misuse team assessed Mr Blampey who said that he wanted to engage.
47. On 15 January, Mr Blampey attended his grandfather's funeral remotely. A pagan chaplain noted that he was grateful to staff for arranging for him to attend. An officer noted that Mr Blampey was distressed but was coping as well as could be expected.
48. A recovery worker from the prison's substance misuse team, assessed Mr Blampey. She noted that he was humorous, motivated and wanted to better understand his substance misuse and to develop coping mechanisms. Mr Blampey set himself goals such as going abroad and getting a promotion at work. He agreed to work with her and to complete workbooks.
49. Mr Blampey told the recovery worker that he had tried to take his life when he was a teenager and had received counselling. He said that he randomly got fleeting suicidal thoughts and that he had last tried to take his life in 2019 after he was sectioned for three days. Mr Blampey denied thoughts of suicide and self-harm. He said that watching television and keeping busy made the thoughts less frequent.
50. Mr Blampey was discussed at the mental health team's multidisciplinary team meeting. They noted that no further action was needed.
51. On 16 January, Mr Blampey told the prison chaplain that he was grateful for being able to attend his grandfather's funeral and was thankful for the support that he had received. The chaplain told Mr Blampey that he would accompany him to the chapel in memory of his grandfather.
52. On 18 January, the mental health team wrote to Mr Blampey to tell him that his mental health needs would best be met by a prison GP and that he might find it helpful to work with the substance misuse team, chaplaincy and other support services. They told him that he could ask to be referred to them again if his mental health needs changed.
53. That day, the pagan chaplain spoke to Mr Blampey. She noted that he said that he was as well as could be expected and was making plans for the future.
54. On 19 January, an officer who was a physical education instructor, completed a post-closure ACCT review. She noted that Mr Blampey said that he was happy to talk about his life experiences and that although staff had been very helpful, he wanted bereavement support. Mr Blampey denied thoughts of self-harm. The decision was taken with Mr Blampey that ACCT procedures should remain closed.

55. That afternoon, Mr Blampey asked his keyworker, about accessing personal clothing while in prison and he explained the process.
56. On 20 January, Mr Blampey made an application to ask for mental health support as he had frequent worrying thoughts which were getting stronger.
57. On 21 January, Mr Blampey told staff that he felt suicidal and that he had been sitting in his cell, thinking of places to ligature from. He said that he wanted to speak to the mental health team about being prescribed medication. An officer started ACCT monitoring. Mr Blampey was put on hourly observations and it was noted that there should be medical intervention. An officer referred Mr Blampey to the mental health team.
58. That evening, it was noted that Mr Blampey had said that he felt better and had “just had a bad day”. His cellmate told staff that he would look out for Mr Blampey and not let him do anything stupid.
59. On 22 January, an officer completed the ACCT assessment. Mr Blampey told her that he had had a “wobble” the previous day, he had not taken medication for depression and anxiety for over a year and felt that counselling would be beneficial. Mr Blampey also told her that he had not appreciated that an officer had come to his cell door the previous day, and said, “you are still alive then”, as he had not wanted his cellmate to know that he was being monitored under ACCT procedures. Mr Blampey told the officer that it had taken him a lot to confide in staff, only then to be mocked by them. Despite this, he said that he felt that he could still speak to them. The officer noted that Mr Blampey would need a GP referral for depression and would be supported under ACCT procedures.
60. An SO chaired Mr Blampey’s first ACCT case review. A mental health nurse, and the pagan chaplain attended. It was noted that Mr Blampey had said that he had grieved a lot over the previous few years due to close family bereavements and he needed support. The pagan chaplain told Mr Blampey that the chaplaincy would provide bereavement support.
61. The nurse noted that Mr Blampey had acknowledged his poor impulse control and that he wanted to change this and be more positive. She offered Mr Blampey therapy sessions with the psychology team, and told him that this might take two weeks to arrange. Mr Blampey said that he would wait as talking helped. He said that he would rather have therapy than take medication. The nurse added him to the psychology team’s waiting list. Mr Blampey denied thoughts of suicide and self-harm. His risk was assessed as low and his observations were reduced to three at night.
62. On 23 January, officers noted that Mr Blampey was in good spirits, had spoken about his brother who had died in prison and how he wanted to help other prisoners with drug problems to use their time wisely in prison. That evening, he told an officer that he was comfortable asking staff or his cellmate for a chat. The following day, it was noted that Mr Blampey planned to buy some items from the canteen (prison shop), was upbeat, got on with his cellmate and said that he wanted to get some sleep and get back to work in the community.

63. On 25 January, an officer told Mr Blampey that he had to move cells. Mr Blampey initially refused to move as he was concerned that he would have to share a cell with a prisoner who took drugs. He later agreed after the officer reassured him that his new cellmate did not take drugs.
64. The pagan chaplain later met Mr Blampey. She noted that he felt positive about his cell move. That evening, he thanked the officer for giving him a “decent” cellmate and that staff had “picked a good one”.
65. On 26 January, a prison GP, diagnosed a cyst on Mr Blampey’s testicle. That evening, Mr Blampey spoke at length to an officer about his offence and the length of sentence he might receive. The officer noted that Mr Blampey felt positive, talked about his brother and life outside prison and how the prison would help him stop misusing alcohol.
66. On 27 January, an officer completed a wellbeing check on Mr Blampey as the safer custody team had identified him as at risk. She noted that Mr Blampey said that he was coping well and appeared positive. Mr Blampey later told the officer that he was getting on well after his cell move, that it was quieter and he was happier as he knew more prisoners.
67. The third death anniversary of Mr Blampey’s brother was on 28 January. During a wellbeing check, the officer noted that Mr Blampey had engaged in the prison regime, continued to maintain family contact and appeared positive after his cell move. Mr Blampey later told her that he had applied for a job as he did not like being locked up all day. She told him that she would tell colleagues about his polite, compliant and respectful behaviour. She also asked Mr Blampey how he felt about his cellmate leaving the following day. Mr Blampey said that he did not know how he felt. (Mr Blampey’s cellmate did not move until 2 February.)
68. On 29 January, an officer noted that Mr Blampey seemed positive. However, that afternoon, it was noted that he was “not happy” but would not say why.
69. A SO chaired Mr Blampey’s second ACCT review. The pagan chaplain attended. A member of the mental health team provided a verbal report, confirming that Mr Blampey remained on the waiting list for psychology. The SO noted that Mr Blampey was positive, engaged with wing staff and talked about getting a job on the wing the following week. Mr Blampey talked at length with the pagan chaplain about bereavement counselling, which she told him would be followed up on 4 February. Mr Blampey said that the substance misuse team had not returned to see him, and the SO told him to make further contact by completing an application, which Mr Blampey agreed to do. The decision was made that ACCT monitoring would remain open to ensure that the support already offered to Mr Blampey continued. His risk was assessed as low and he remained on three observations at night. A further case review was scheduled for 6 February.
70. On 30 January, Mr Blampey told an officer that he had “had a wobble” but was now over it and had a job which would keep him busy. Mr Blampey later told an officer that he had no thoughts of suicide or self-harm.
71. On 31 January, Mr Blampey told an officer that he “could not wait” to start his job the following day. That afternoon, the officer asked Mr Blampey about the goals in

his ACCT caremap. Mr Blampey told him that he had a meeting with the chaplaincy on 4 February, that the substance misuse team has spoken to him once and that further contact was being arranged. Mr Blampey thanked the officer for showing concern and told him that it meant a lot.

72. That afternoon, Mr Blampey made several phone calls to a friend and to his sister. Mr Blampey told his friend that he would pay money into his bank account as he was "just doing a bit of business in here". In the telephone call to his sister, Mr Blampey asked about clothes being sent into him and that he "was making a little bit of money in prison".
73. That evening, an officer asked Mr Blampey how he was and if he needed anything. Mr Blampey said that he was good and thanked the officer for asking. The officer noted that Mr Blampey was laughing with his cellmate.
74. On 1 February, Mr Blampey told an officer that he was "doing really well right now". The officer later noted that he was still in good spirits but not very engaging as Mr Blampey had nothing new to say. That evening, the officer noted that Mr Blampey was more engaged as he had been out to work which had kept him busy and that he had mixed with other prisoners, he had had a shower and was making full use of his time out of his cell.
75. Mr Blampey made several phone calls to his friend in which they talked about money and bank accounts. In calls to his sister, Mr Blampey again talked about clothes being sent to the prison and of payments to bank accounts. Mr Blampey made a further call to his friend at 7.52pm and told him that he would call him at the weekend for a good chat as he had to limit his telephone credit. At 8.42pm, Mr Blampey spoke to another of his sisters, and again talked about clothes being sent in. He ended the call by telling her that he loved her.
76. An intelligence report submitted about his telephone calls noted that Mr Blampey was likely involved in the illicit economy at Exeter and that other prisoners were likely paying him for items.
77. A prisoner said that he had spoken to Mr Blampey when they worked together but did not know him well. He said that Mr Blampey never talked about self-harm or seemed upset but had mentioned that his brother had died in prison.
78. At around 9.00am on 2 February, Mr Blampey's barrister visited him. He reported after Mr Blampey's death that when he met him, there "wasn't the slightest sign of problems or depression or anxiety" and that Mr Blampey's death had come as a "terrible shock".
79. At around 10.25am, an officer noted she had spoken to Mr Blampey who told her that he was much happier as he had a routine, carrying out volunteer work on the wing pending clearance for a full-time job. Mr Blampey told her that he was waiting for his clothes to be sent to the prison, he had got on well with his previous cellmate and really well with his new cellmate as he did not take drugs. She spoke to Mr Blampey about his family's support.
80. The officer asked Mr Blampey about his mental health and how he felt about being monitored under ACCT procedures. He told her that he hoped ACCT monitoring

would end soon as he was doing much better and was having a bad day when an ACCT document was opened for him.

81. At 11.52am, an officer noted that Mr Blampey had been unlocked for work and seemed in relatively good spirits.
82. Mr Blampey's cellmate, said that he and Mr Blampey got on very well and they would often sit up until the early hours, talking. He said that Mr Blampey got on well with other prisoners and there was no indication that he was being bullied. He said that Mr Blampey never talked to him about self-harm but he had once punched the kiosk out of frustration.
83. The cellmate said that he was told that day that he was to be transferred to another prison. He said that he told Mr Blampey when he returned from work and they agreed to keep in contact. He said that Mr Blampey did not seem happy about the transfer.
84. At 2.30pm, an unidentified officer noted that they had spoken to Mr Blampey and that he had told them that he was happy to have a job and wanted to progress to other jobs in the prison.
85. At around 7.00pm that evening, Mr Blampey was locked in his cell. At around 7.22pm, an officer checked on Mr Blampey and checked that the cell door was locked.
86. At 7.27pm, Mr Blampey telephoned his sister. They discussed clothes that she was sending him, and Mr Blampey talked about his telephone contract debt. He told her that his phone credit was running out, that he loved her and that they would speak again in a few days.
87. An officer arrived for his night duty at around 8.00pm. He said that he received a handover from staff but that Mr Blampey was not mentioned. During the roll check at 8.08pm, the officer checked Mr Blampey's cell. He said that he saw Mr Blampey but could not recall what he was doing. He noted the check in Mr Blampey's ACCT document at 8.20pm.
88. At 10.51pm, the officer went to Mr Blampey's cell to carry out the first of three ACCT checks that night. He looked through the observation panel and saw Mr Blampey hanging from the cell's window bars, from a ligature made of bed sheets. The officer shouted to colleagues nearby for assistance, called a medical emergency code blue (used when a prisoner is not breathing and triggers an automatic request for an ambulance and for healthcare staff to attend) and went straight into the cell. (The incident log shows that an ambulance was called at 10.52pm while ambulance service records show that it was called at 10.56pm.)
89. Two officers who were nearby, responded immediately and went into the cell. An officer cut the ligature from Mr Blampey's neck and the officers lay him on the floor. An officer said that Mr Blampey was cold and although he believed that Mr Blampey might have already died, he and an officer instinctively started and continued cardiopulmonary resuscitation until two nurses arrived soon afterwards. Having checked for signs of life, and found none, the nurses and officers continued with their attempts to resuscitate Mr Blampey.

90. At 10.56pm, a nurse left the cell and returned two minutes later, with further emergency equipment. He left the cell again at 11.00pm to collect a defibrillator and returned at 11.02pm. The defibrillator was attached but advised no shock.
91. Paramedics arrived at around 11.03pm and continued resuscitation efforts. They were unsuccessful and at 11.44pm, they pronounced that Mr Blampey had died.

Contact with Mr Blampey's family

92. On 3 February, the Governor and the Head of Business Assurance, confirmed Mr Blampey's death in person to his next of kin. The prison contributed to funeral expenses in line with national instructions.

Support for prisoners and staff

93. A governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
94. The prison posted notices informing other prisoners of Mr Blampey's death and offered support. We understand that staff reviewed prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Blampey's death.

Post-mortem report

95. A post-mortem examination found that Mr Blampey died from compression of the neck as a result caused by suspension from a ligature. The toxicological tests did not identify any illicit substances in Mr Blampey's body.

Findings

Reassessing risk

96. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff who have 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. The PSI lists several risk factors and states that potential triggers should be continually assessed. PSI 64/2011 says that in addition to planned ACCT case reviews, a case review must be held where an ACCT trigger is activated or there are other concerns.
97. Although Mr Blampey was being monitored under ACCT procedures, none of the prison staff we interviewed considered that he was at an increased level of risk of suicide or self-harm in the days leading to his death, and we are satisfied that he gave no indication to staff that his risk of suicide or self-harm had increased significantly.
98. However, on 2 February, Mr Blampey's cellmate was transferred to Channings Wood. While we recognise that prisons must be able to move prisoners as they see fit, we are concerned that there is no evidence that anyone spoke to Mr Blampey after his cellmate had moved or that his change in circumstances was brought to the attention of managers. Staff missed an opportunity to hold an ad hoc case review to reassess Mr Blampey's risk and consider the impact on him and protective measures to implement, particularly as he had had got on well with his cellmate.
99. Had an ACCT review taken place, it might have also identified that Mr Blampey's risk had increased as it was the third anniversary of his brother's death.
100. With the benefit of hindsight, there was a missed opportunity to have reassessed Mr Blampey's risk. However, we do not consider that prison staff could reasonably have predicted his actions given the information available to them at the time, taking into account the progress that Mr Blampey had made and his positive outlook on the future. However, we make the following recommendation:

The Governor should ensure that a multidisciplinary ACCT review is held when there is evidence of a significant change in circumstance and that the frequency of observations should reflect a prisoner's risk and be adjusted when that risk changes.

Inappropriate comments

101. On 21 January, Mr Blampey alleged that an officer had made inappropriate comments to him while he was being monitored under ACCT procedures. He was upset that after he had confided in staff about his suicidal thoughts, he felt "mocked".
102. We consider that the officer's comment was insensitive, unprofessional and showed poor judgement, even if no malicious intent was meant and it had been considered as "banter". However, we do not consider that the remarks had a bearing on Mr

Blampey's subsequent actions as he told an officer that he still felt that he could speak to staff and this is evidenced by his subsequent interactions during ACCT reviews and numerous conversations with other members of staff who appear to have been supportive. Despite this we make the following recommendation:

The Governor should ensure that staff are reminded not to use inappropriate or insensitive language towards prisoners, particularly, those being monitored under ACCT procedures.

Delay in calling an ambulance

103. PSI 03/2013 on medical emergency response codes requires staff to radio a code blue in a medical emergency and for the control room to call an ambulance immediately when an emergency code is used. Exeter has a local policy which reflects the requirements of the PSI. This requires that staff should radio a code blue when a prisoner has difficulty breathing or is unconscious and ensure that an emergency ambulance is automatically called. The PSI is clear that prisons should not wait for healthcare staff or a duty manager to decide whether an ambulance is needed and that an ambulance can be cancelled later if not needed.
104. Although an officer called an emergency code blue on finding Mr Blampey at 10.51pm, the control room did not call an ambulance until 10.56pm according to ambulance service records. Any delay in calling an ambulance can have a significant impact on a person's chance of survival. In this case, there was a delay of five minutes which would probably not have changed the outcome for Mr Blampey. However, in another emergency, such a delay could be critical. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance as soon as they receive a medical emergency code.

Clinical care

105. The clinical reviewer concluded, overall, that the substance misuse support, mental and physical healthcare that Mr Blampey received at Exeter was of a standard equivalent to that which he could have expected to receive in the community. However, the clinical reviewer made a few recommendations which the Head of Healthcare will need to address.

Mental health assessments

106. Mr Blampey had a history of depression and anxiety and was referred to the mental health team. A mental health nurse attended Mr Blampey's first ACCT review and completed his mental health assessment during the review.
107. As we identified in our investigation of a man who died at the prison in July 2019, we do not consider that it is good practice for mental health assessments to take place during ACCT reviews. Mental health assessments should be completed separately from ACCT reviews and in private. We repeat the recommendations we made in July 2019:

The Head of Healthcare should ensure that, wherever possible, consultations and assessments with prisoners are carried out in private and if this cannot happen, the reason is clearly documented.

108. On two occasions, Mr Blampey reported to staff “worrying” and suicidal thoughts. The clinical reviewer reported that these reports should have prompted urgent mental health assessments, within 48 hours, but this did not happen and there was no evidence that referrals were considered or actioned. We make the following recommendation:

The Head of Healthcare and Mental Health Clinical Manager should ensure that referrals to the mental health team, reporting that a prisoner feels suicidal, prompts an additional mental health assessment within 48 hours.

Emergency equipment

109. The clinical reviewer reported that when the nurses responded to the emergency code blue, they did not bring all the relevant emergency equipment so a nurse had to leave to collect further equipment, including the defibrillator. This led to a delay. The clinical reviewer was not able to conclude whether the outcome would have been different if they had taken all the equipment with them but noted that all nurses should be aware of the importance of doing so. The Head of Healthcare confirmed that this issue had also been identified in a local review. We make the following recommendation:

The Head of Healthcare should ensure that nurses respond to emergency code blue incidents with the relevant emergency equipment, including a defibrillator.

COVID-19 restrictions

110. COVID-19 restrictions in place resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent up to 23 hours a day locked behind their cell doors.
111. At the time of Mr Blampey’s death, prisoners at Exeter were allowed out of their cells to exercise, have time in the fresh air, have a shower and mix with other prisoners on the wing. When prisoners were locked behind their cell doors, officers checked on them during daily roll and welfare checks. In addition to this Mr Blampey had additional time out of his cell as a wing worker.
112. The exceptional regime and service delivery operational guidance required prisons to make every effort to ensure resources were available to support prisoners subject to ACCT procedures as prolonged periods in cells increase the risk of suicide and self-harm.
113. It is difficult to determine what effect the COVID-19 restrictions may have had on Mr Blampey and how it affected his wellbeing and mental health. However, we are satisfied that prison staff at Exeter had frequent interactions with Mr Blampey which were clearly recorded.

Learning lessons

114. We have identified a significant number of concerns in this report. We consider that it is important for staff to learn from our findings, and make the following recommendation:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Inquest Verdict

115. The inquest hearing into the death of Mr Blampey was held on 8 July 2024. It confirmed that the medical cause of Mr Blampey's death was compression of the neck from suspension by a ligature.

**Prisons &
Probation**

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