Investigation into the death of a man whilst in the custody of HMP & YOI Exeter in May 2010

Report by the Prisons and Probation Ombudsman for England and Wales

March 2011

This report considers the circumstances surrounding the death of the man at HMP & YOI Exeter. The man was found hanging in his cell at 9.00pm. He was 46 years old.

I offer my sincere condolences to the man's family and all those who knew him.

The investigation was conducted by one of my investigators on my behalf. I would like to thank the governing Governor and his staff for their co-operation. I also extend thanks to the staff, who liaised with my office. In addition, I thank the clinical reviewer, who conducted a review of the man's clinical care. He was appointed by Devon Primary Care Trust.

The man was remanded to Exeter in January 2010. He remained there until his death in May. During February, he was considered at increased risk of suicide, but this was thought to be resolved. However, he remained unhappy about his personal relationships and especially the restrictions placed on his contacts outside the prison. It seems that he took advantage of being alone in his cell, on an evening when prisoners were locked up for longer than usual, to end his life.

This is the seventh self-inflicted death at Exeter since 2004, when my office began investigating all deaths in prison custody. Before the man's death, the last such death occurred in November 2009.

My investigation has looked into the suicide monitoring process, food refusal, restrictions on contact, clinical care, the D wing regime, the evening of 20 May, the emergency response, closed circuit television (CCTV), support for staff and prisoners, and family liaison. I make eight recommendations and endorse two further recommendations made by the clinical reviewer.

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

Jane Webb
Acting Prisons and Probation Ombudsman **March 2011**

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SUMMARY

The man appeared at Sedgemoor Magistrates' Court on 8 January 2010 and was remanded to HMP & YOI Exeter. He was assessed by medical staff who noted that he suffered from epilepsy. However, the man said he would not take his medication whilst in prison. He was initially accommodated on B wing, then moved to A wing and subsequently D wing a few days later.

Concerns were raised about the man's attempts to contact his partner, who was the alleged victim of his offences. His ex-wife also wrote to Exeter to ask that he was not permitted to contact her. The restrictions on the man's mail and telephone calls were explained to him, and he was angry that such measures had been taken. On 31 January, the man told the chaplain that he was distressed and had not eaten for five days. The Assessment, Care in Custody and Teamwork (ACCT, used to support and monitor prisoners judged to be at risk of harming themselves) process was started the next day after the man said he would kill himself if he could not speak to his ex-wife. He was admitted to the prison's healthcare unit and returned to D wing the next day.

During the time that he was subject to the ACCT monitoring, the man told members of staff that he would refuse food if restrictions on his mail and telephone calls were not lifted. However, members of wing staff reported that he was taking his meals. The man also tried to circumvent the restrictions by sending letters to other people with the intention of them reaching his partner and his ex-wife.

Reviews of the man's ACCT were held on 9, 16 and 23 February, at which point the document was closed because he was eating and drinking, and had no thoughts of self-harm or suicide. There was also concern that he had been manipulating the ACCT process in order to have restrictions on his contact removed.

The man sent a letter in March suggesting that if things went badly for him, he would kill himself on his partner's birthday, 21 June. On 14 April, he was seen by a nurse after concerns were raised by wing staff. Consideration was given to restarting the ACCT process, but there was some confusion about whether this was possible. The nurse consulted a number of people but did not open an ACCT despite her concerns about the man's well-being. The man was admitted to the healthcare unit for observation but was discharged the next day.

On 16 April, the man attended Taunton Crown Court and pleaded guilty to the offences with which he had been charged. He was returned to Exeter to await sentencing. After pleading guilty, the man was allowed to resume contact with his partner, and he started to telephone her several times daily. He also sent numerous letters to her. This continued throughout April and May.

The telephone calls between the man and his partner were generally friendly until 19 May, when there was a change in the relationship. The man's partner had learned about further allegations that had been made against him, and she accused him of lying to her.

On the morning of 20 May, the man left a number of voicemail messages for his partner saying he hoped she would visit him as planned. He also asked the chaplain to telephone her and ask if she intended to visit. The chaplain made the call and told the man that his partner was going to visit him that afternoon. The same morning, the man's cellmate moved to another cell, leaving the man alone.

The man's partner visited him on the afternoon of 20 May with a friend. They stayed for almost two hours. When the man returned to the wing, two prisoners noticed that he was very upset. He told one of them that his partner had ended their relationship. The man telephoned the friend who had accompanied his partner. He asked to speak to his partner but she refused. The friend told the man that the relationship was probably over.

Prisoners on D wing, including the man, were locked in their cells at 5.30pm. Almost an hour later, another prisoner looked into the man's cell and saw what he thought was the man sitting awkwardly on the lower bunk of the bed. At 7.50pm, a prison officer completing the roll count saw the man in the same position. His cell was unlocked for the overnight period in accordance with usual D wing practice.

At 9.00pm, the man's former cellmate visited his cell and found that he was suspended from the top bunk, having used a piece of bed sheet as a ligature. The prisoner immediately alerted members of staff, who went to the man's cell and called for assistance. However, it appeared that he had been dead for some time and cardio-pulmonary resuscitation (CPR) was not attempted. The man's death was declared at 9.15pm by the paramedics.

I have investigated issues around the ACCT suicide monitoring process, food refusal, restrictions on contact, clinical care, the D wing regime, the emergency response, closed circuit television (CCTV), support for staff and prisoners, and family liaison. I make eight recommendations and endorse a further two recommendations made by the clinical reviewer. I attach particular importance to the recommendations about family liaison.

THE INVESTIGATION PROCESS

1. One of my senior investigators opened the investigation and visited HMP & YOI Exeter on 28 May 2010. He met two officers and collected copies of all documents relating to the man's period in custody between January and May 2010. Notices of my investigation were sent to the prison for distribution and display.

2. During his opening visit, my investigator saw D wing, although the man's cell remained sealed at the time to preserve evidence. He spoke to wing officers about the overnight arrangements for the unit, and about how the man had presented on the day of his death.

3. My investigator returned to Exeter on 14 and 15 June. He conducted interviews with six members of the prison's staff, and with three prisoners. The interviews were recorded and transcripts are included as annexes to this report. During this visit, my investigator also saw the man's cell and spoke informally to a number of other staff members.

4. In addition to the interviews and conversations conducted on 14 and 15 June, my investigator received written reports from members of staff who were working in the visits area on 20 May. He also reviewed CCTV footage of the visit the man had with his partner and her friend that day, and listened to the recordings of 222 telephone calls that the man made between 6 and 20 May.

5. My investigator was given a disc thought to contain CCTV footage of the emergency response on 20 May, but the disc was blank. It seems that errors made whilst creating the disc also led to the footage being deleted from the computer's hard drive.

6. One of my family liaison officers (FLOs) contacted four different branches of the man's family to explain the purpose of my investigation and provide them with an opportunity to raise any issues or questions about the care the man received in prison. My family liaison officer and my investigator subsequently met with three of these parties. A number of questions and concerns were raised during these meetings, most notably:

    - Why was the man in a single cell?
    - Why was he not considered at risk of suicide or self-harm, particularly after specific at-risk dates had been identified?
    - What procedures are in place for monitoring and supporting people who are distressed and at risk of suicide?
    - Had the man previously self-harmed whilst in prison?
    - Was he considered to be a vulnerable prisoner? If not, why not?
    - Was the man considered as a potential healthcare inpatient?
    - Why was he not considered at risk of suicide, when his letters clearly indicated that he was planning to take his life?
    - What were the restrictions placed on the man's contact, and why were his family members not notified when these were lifted?

- Did the man receive a large sum of money whilst in prison? If so, what happened to it?
- Was the man able to access sufficient legal support and guidance ahead of changing his plea?
- What happened on the last day of the man's life? Did he receive any visits, make any telephone calls, or appear distressed to staff or other prisoners?

7. In addition to these questions, there was unanimous concern about the family liaison from Exeter following the man's death. All three parties were dissatisfied with and upset about the way in which the news was conveyed. There was also concern about the quality of ongoing contact with Exeter.

8. I do my best to answer the family's questions in my report, which I hope will help them to better understand the circumstances of the man's death.

9. Devon Primary Care Trust (PCT) appointed the clinical reviewer to conduct a review of the man's clinical care whilst in custody. The purpose of a clinical review is to examine the medical care that a prisoner received in custody, which should be an equivalent standard to what might have been expected in the community. The clinical reviewer consulted the man's medical records and interviewed one of the prison's doctors. He also had access to the transcripts of the interviews that my investigator conducted with other members of the prison's staff. His findings are summarised in this report and the full clinical review is included as an annex.

Responses to the draft report

10. As part of the consultation period, the three family parties mentioned above each received a copy of my draft report. In their response, two of the parties said they were content with my findings, but reflected on the continuing anguish caused by not knowing the reasons behind the man's actions, something they acknowledged would, sadly, never be known. No further comments were raised by the third family party in response to the findings of the investigation.

11. The National Offender Management Service (NOMS) and HMP Exeter considered the draft report and identified no omissions or factual inaccuracies. They accepted my 10 recommendations, and the responses to these recommendations are summarised on pages 53 and 54.

HMP & YOI EXETER

12. HMP & YOI Exeter can accommodate up to 533 prisoners. It serves the courts of Cornwall, Devon and West Somerset, and holds remanded and convicted adults and young adults. The prison has four residential wings, three of which (A, B and C wings) were originally built in the 1850s. A fourth wing (D wing) was added in the 1960s. D wing is a three-storey building housing vulnerable prisoners. It has no in-cell sanitation (toilets, showers or wash basins) and operates a privacy locking system, allowing prisoners to leave their cells and access the toilets during the night.

13. Healthcare services at Exeter are commissioned by Devon Primary Care Trust (PCT) and provided by Devon Partnership Trust. There is an inpatient facility offering 24-hour healthcare, as well as outpatient services on the residential wings.

Performance

14. The Ministry of Justice provides quarterly assessment figures for all prisons in England and Wales. Every establishment is given a rating between 1 and 4 based on 34 agreed performance indicators (with 1 meaning serious concerns about performance, and 4 indicating exceptional performance). The most recent figures available at the time of writing are for quarter 4 of 2009-2010 (January, February and March 2010). For this period, Exeter received a rating of 3, showing good performance. This was the same rating received during the three preceding quarters, meaning that Exeter showed good performance throughout the 2009-2010 reporting period.

15. HM Chief Inspector of Prisons inspected Exeter in October 2009. Her report acknowledged that the prison "has to manage a wide range of needy and transient prisoners in elderly, overcrowded and often inadequate conditions". Whilst there were relatively few incidents of self-harm, the suicide prevention co-ordinator was "often redeployed to other tasks". Concern was also raised about the ability to effectively monitor prisoners overnight on D wing. This was due to the landing gates being locked so that prisoners could use the communal toilet facilities. As a result, it was difficult for members of staff to check prisoners who were thought to be at risk of self-harm or suicide.

16. The HM Chief Inspector of Prisons found that little had been done to follow up PPO investigation reports and recommendations following deaths in custody. There was no evidence of formal action plans or concerted efforts to make changes in response to recommendations. I am disappointed to learn that this was the case.

17. An Independent Monitoring Board (IMB) is made up of volunteers from the community in which the prison is located. IMBs must satisfy themselves as to the humane and just treatment of people held in custody, and they report to the Justice Secretary annually. At the time of writing, the most recently published report for Exeter covered the period November 2008 to October 2009. The IMB noted that the prison was overcrowded and accommodated a

> "We are not convinced that the … arrangements for night-time toilet access for prisoners are safe. Individual prisoners report irregular night-time behaviour, which is not always observed by current staffing deployment, and claim that they are fearful and feel intimidated by a minority of D wing prisoners. The physical environment presented by D wing is poor; to compound this with behaviour management issues is unacceptable."

Previous deaths at HMP & YOI Exeter

18. The Ombudsman's office has been responsible for investigating deaths in custody since April 2004. Prior to the man's death, six apparently self-inflicted deaths have been investigated. One occurred in 2004, one in 2005, two in 2007, and two in 2009. Aside from the method used (hanging by ligature is the most common form of self-inflicted death in prisons), there were few similarities between the man's death and those of other prisoners. The PPO report into one of the deaths in 2007 made a recommendation about closed circuit television (CCTV). The most recently issued report, following a death in November 2009, made a recommendation about family liaison. Both of these issues are also relevant to the current investigation.

Assessment, Care in Custody and Teamwork (ACCT)

19. The National Offender Management Service (NOMS) uses the ACCT process as a way of monitoring and providing support to prisoners identified as being at risk of self-harm or suicide. This is used in all prisons and young offender institutions across England and Wales. All members of staff should receive basic ACCT training and be able to open a document, as well as make appropriate entries in the ongoing record. The process encourages staff to work together to tailor individual care to prisoners in distress. Regular checks and reviews of the prisoner's situation are part of the ACCT process. Case reviews should comprise no fewer than two members of staff and also involve the prisoner subject to the ACCT document. These reviews should also, ideally, be multi-disciplinary. When staff members conducting a review determine that risk has been significantly reduced or is no longer evident, and it is felt that further intensive support and monitoring is not required, the document can be closed. A post-closure review should take place seven days later to confirm that risk remains reduced. Ideally, this review should also be multi-disciplinary.

Personal Identification Number (PIN) telephone system

20. All prisons operate a PIN telephone system. Prisoners have a personal account and can make telephone calls to authorised numbers. When prisoners wish to add new telephone numbers to their account, they must make an application. There is no limit to the number of telephone numbers that can be authorised. However, certain telephone numbers may be blocked if there are issues relating to, for example, victim harassment or witness intimidation. Prisoners are able to transfer money from their personal spending accounts to purchase credit for the PIN telephone system. All telephone calls are automatically recorded, though they are not routinely monitored unless there is a specific reason to do so. This report makes a number of references to telephone calls made by the man. All of these calls were made through the PIN telephone system at HMP & YOI Exeter.

KEY EVENTS

21. The man appeared at Sedgemoor Magistrates' Court on 8 January 2010 and was charged with violent and serious sexual offences. All of the offences were alleged to have been committed against his partner. He pleaded not guilty. His case was committed to Taunton Crown Court for trial, and he was remanded into HMP & YOI Exeter, arriving at 7.45pm.

22. A 'first reception health screen' was completed upon the man's arrival at Exeter. This is a short assessment completed for all prisoners. It is intended to gain a brief medical history to help ensure that prisoners receive appropriate medications and, if necessary, referrals to other services. The person completing the health screening wrote on the form that the man suffered from epilepsy and was prescribed Epilim (a brand name for sodium valproate, a medication used to treat epilepsy). However, he refused to take this medication whilst in prison. Further information about this issue was noted in the man's clinical record. He told healthcare staff that, during previous periods of imprisonment, he had refused to take his medication because he wanted to take it at 10.00pm and the prison's regime did not allow this. The man said he would prefer to have a seizure than comply with an earlier medication regime. He was offered Epilim at 8.25pm, but declined. Although advised to sleep on a lower bunk, the man said he would sleep where he wanted to, which was the top bunk.

23. The man's health screening also noted that he drank alcohol socially and had not used illegal drugs in the preceding month. He said that two years previously, he had attempted suicide by hanging. The health screening document states that in these circumstances, prisoners should be referred for a mental health assessment. However, there is no evidence that this happened in the man's case.

24. A cell sharing risk assessment (CSRA) was also completed for the man. The CSRA process is primarily intended to identify the risks a prisoner might pose to other prisoners. It takes into account previous violence and its context. The man was low risk, meaning that there was no indication or evidence of any risk, and he was suitable for sharing a cell.

25. The man spent three nights on B wing, which usually accommodates newly arriving prisoners. He moved to A wing, one of Exeter's standard residential units, on 11 January.

26. The next day, 12 January, prison Doctor A wrote in the man's clinical record that he refused to take his Epilim despite the risks associated with his condition having been explained to him. He also made a note of this on the man's prescription chart, which showed that he had not collected his Epilim since arriving in prison. On 14 January, an entry in the man's clinical record noted that he had been referred for a secondary health screening (a more detailed assessment of health needs) but had said he did not want to see anyone else for healthcare advice.

27. An anonymous note detailing the sexual offences and locations of various prisoners on A wing was left in the unit office on 15 January. The man's details were amongst them. It was alleged that these prisoners, including the man, were being threatened by other prisoners on the wing. The man and the other prisoners were asked if they wanted to be considered for vulnerable prisoner status, and the man completed an application form at 7.00pm on the same day to this effect. (Prison Rule 45 allows Governors to remove prisoners from normal association with others, to maintain good order or discipline, or in prisoners' own interests. Prisons usually have a separate unit for those considered vulnerable.) He wrote on the form that he was applying for vulnerable prisoner status due to the nature of his offence, and because he feared for his own safety on A wing. The application was approved. The man moved to B wing as an interim measure on the same night, and then to D wing, which is used to accommodate vulnerable prisoners, the next day.

28. On 18 January, the man signed to indicate that he had read and understood the rules and regulations of D wing. Two days later, he received a visit from his solicitor. On 24 January, the reverend wrote in the chaplain's journal, saying that he had telephoned the man's ex-wife at his request. The man's ex-wife had said during the call that she had written to him, telling him that the relationship was over. She asked not to be called again. The next day, the man's ex-wife wrote to the prison. She said that despite telling him that she did not want him to telephone or write to her, he had continued to do so. She asked Exeter to ensure that he was not allowed to contact her, otherwise she would take legal action for harassment.

29. An entry in the man's clinical record on 26 January noted that he was still refusing to take his prescribed medication for epilepsy. The next day, Exeter's public protection unit (PPU) began monitoring the man's mail and telephone calls, in response to the letter from his ex-wife. A comprehensive entry in the PPU electronic contact log explained the reasons for the monitoring. In addition to the letter from the man's ex-wife, there were concerns about him contacting his partner, also the victim in the ongoing case against him. Two letters to the man's ex-wife and two letters to his partner were stopped. Telephone numbers for his partner and ex-wife were also barred, in addition to another number which the man had registered as belonging to his brother, but which was in fact for his partner.

30. The man's offender supervisor introduced herself to the man as his offender supervisor on 28 January. (An offender supervisor usually works for the prison's PPU and offender management unit (OMU) and has various responsibilities, including sentence planning and liaison with external probation services.) She wrote in the PPU contact log that the man was extremely angry about his mail being monitored and stopped. When the man's offender supervisor returned the letter he had written to his ex-wife, he tore it up. The man's offender supervisor wrote that the man was "undoubtedly angry with [his ex-wife] and blames her for the subsequent barring of his other numbers". She explained to him that numbers he had been using to contact his partner had been barred. This was because she was the alleged victim of his offences, and had nothing to do with his ex-wife's

31. On 29 January, the day after the mail monitoring and restrictions had been explained to the man, the PPU intercepted two letters intended for his partner. One was addressed to her and had been written before the restrictions were put in place. The second letter was sent to a different name and address, but it was clear from the content that the man's partner was the intended recipient. Both letters were returned to him.

32. The next day, according to the man's property record, he received through the post a cheque from Scottish Widows for £3,703.44.

33. The man requested a visit from the chaplain on 31 January. He was seen by Reverend B, who wrote in the chaplain's journal that the man was very distressed and said he had not eaten for five days. He asked the Reverend to telephone his ex-wife and tell her that he wanted to re-marry her if she was willing. However, because of the nature of the previous telephone call, the man's ex-wife was not contacted.

34. The next day, 1 February, the man's offender supervisor wrote in the PPU contact log, explaining that she had spoken to the police domestic violence unit (DVU) about her concerns over the man's attempts to contact his partner. The address to which the man had attempted to write three days earlier was confirmed as belonging to his partner's parents. There were also concerns that he was attempting to contact his ex-wife and his partner through his son. The man's offender supervisor wrote that she was unable to stop the man's calls to his teenage son unless this was requested by the boy's mother. The man's ex-wife also telephoned the prison to say that she had received another letter, and that the man was sending them to other people who were then giving them to her.

35. Later the same day, the man's offender supervisor spoke to the police officer investigating the man's alleged offences. He confirmed that the mother of the man's son had asked for her number to be barred, as the man had made a number of telephone calls to his son asking him to pass on messages to his ex-wife and partner.

36. The man's offender supervisor wrote in the PPU contact log that "given that this was a clear breach of mail restrictions, and done within a day of being told, [the man] has been placed on report". This meant that he was accused of breaking one of the Prison Rules and referred to an adjudicating governor. The notice of report was issued to the man at 7.30pm on 1 February, explaining that he was alleged to have broken Prison Rule 51, paragraph 2. This rule relates to the disobeying of any lawful order. The man's offender supervisor outlined the circumstances of the alleged offence (attempting to circumvent mail restrictions by sending a letter to his partner via her parents) and explained that his case would be heard on 3 February at 10.00am.

37. On the same day, but before the man's offender supervisor issued the notice of report, healthcare staff were asked to see the man. An entry about this was made in the clinical record, though it is unclear who wrote it because the staff member's name was not clearly printed. The entry notes that the man had been found collapsed on the floor of his cell. He was conscious and alert, although he said he felt weak and had not eaten "since Sunday" (the day before). The member of healthcare staff wrote that the man was known to be epileptic but was refusing to take his medication, and also continued to sleep on the top bunk despite being advised to move. He said he would kill himself unless he was able to talk to his ex-wife, and could not accept that this would not be allowed.

38. Following the healthcare visit, the man was made subject to self-harm monitoring under the Assessment, Care in Custody and Teamwork (ACCT) process. The first stage of this process is to complete a Concern and Keep Safe Form. This was done at 5.59pm, but it is unclear from the record who completed it. The nature of the concern was indicated as 'suicide attempt or statement of intent to kill self'. The person completing the form wrote that the man became upset with the news that he could not contact his son or his ex-wife, he had not eaten for three days, he felt very weak and was lying on the floor of his cell. He found it difficult to accept that his family members did not want him to contact them by telephone.

39. An Immediate Action Plan was formed. This is intended to keep the prisoner safe until an assessment interview and a first case review take place within 24 hours. The action plan included the man sharing a cell, and staff holding conversations with him at least three times daily and observing him three times overnight. He was made aware of telephone access to the Samaritans, and encouraged to speak to a Listener (a trusted prisoner trained by the Samaritans) if required. It appears that this plan was formed on the evening of 1 February, though it was not signed by the unit manager until the following morning at 8.00am.

40. An entry in the man's clinical record, written by the same person who had completed the Concern and Keep Safe Form and the Immediate Action Plan, gave similar information. The man was unwilling to give any reassurances about his future, and it was noted that he had attempted to hang himself two years earlier. He also reported his mood on a scale of one to ten (one being unhappy, and ten being happy) as zero. In addition to the actions already identified on the Immediate Action Plan, The man's food and fluid intake would be monitored. He would also be admitted to the healthcare unit and reviewed by the doctor.

41. At 9.45pm, a further entry was made in the clinical record. The man was seen on D wing and said he had not eaten for five days, and was on hunger strike after not being allowed to contact his partner, ex-wife and son. When asked "where his anger will go tonight" he said, "I want to tell you, but if I don't do it tonight then I will do it tomorrow night or the night after." The person writing the entry suggested that the man should be admitted to the healthcare unit, accommodated in a single cell, issued with alternative clothing (designed not

42. An inpatient unit admission assessment form shows that prison Doctor B admitted the man. The reason given for admission was “food refusal and threats of suicide”. Although the admission form comprises eight pages, there is no further information given.

43. At 6.00am on 2 February, an entry was made in the man’s clinical record, chronicling the events of the previous night. After being admitted to the healthcare unit and provided with alternative clothing and bedding (designed not to tear), the man had initially appeared restless, then moved his mattress to an upright position so that he could not be seen. He said this was because the cell was covered by a closed circuit television (CCTV) camera, which was a violation of his human rights. It was explained to the man that the purpose of the camera was to help ensure his safety and if he could not be seen, it would be necessary to disturb him periodically during the night. Although he seemed to accept this, the man covered the camera with wet toilet paper approximately one hour later. He refused to remove it when asked, but eventually removed it after speaking to the night orderly officer (the person in charge of the prison overnight). The man spent the night doing a jigsaw and went to sleep around 4.00am, after accepting two large cups of tea. These incidents were also documented in the ongoing record section of the man’s ACCT document.

44. At 8.50am on 2 February, an entry was made in the ongoing record of the man’s ACCT document. It is not clear which member of the healthcare staff wrote the entry, but they noted that the man was “rude and obstructive [and] would not engage other than to say he wouldn’t take meds [medicines] or breakfast”.

45. An ACCT assessment interview was conducted at 10.15am by Senior Officer (SO) A (who is also a nurse) and Nurse A. Whilst any member of staff can initiate the ACCT process, assessment interviews are conducted by designated members of staff who have received more comprehensive training. During the interview, the man described his main problem as the restrictions that had been placed on his outside contact. He said that as he was not allowed to contact his son or partner, he had no way of conducting his affairs. He went on to say that he had not harmed himself and had no intention of doing so. The man said he had not eaten anything since 27 January but was drinking tea and water.

46. When discussing his mental health, the man said he was frustrated about not being able to contact his partner. He was sleeping normally and had a normal appetite, although he was refusing to eat as a deliberate strategy. SO A and Nurse A wrote that the man showed no signs of depression. However, he was vague about his reasons for living. He said he would eat when he returned to D wing.

47. After the assessment interview, the first review of the man's ACCT document took place at 10.50am. This was attended by the man, SO A, Nurse A and prison Doctor A. The man asked to go back to D wing as he said his cellmate was a useful source of support. He also said he would start to eat again when he was on D wing. The man's domestic situation had been discussed with the chaplaincy team, who would liaise with his offender supervisor. It was agreed that the man could return to D wing, but he would continue to be reviewed by medical staff as an outpatient. He also remained subject to the ACCT process, and a further review was arranged for 9 February.

48. Prison Doctor A wrote in the clinical record at 11.20am that the man's problems were personal and that he had talked them through. He reiterated that the man was very keen to leave the healthcare unit and return to D wing.

49. Also on 2 February, Reverend B wrote in the chaplain's journal that the man was in the healthcare unit and was still on hunger strike. When seen, the man asked if Reverend B could obtain his brother's telephone number from his partner. There was nothing to indicate whether or not this request was acted upon.

50. At 12.30pm, Nurse B wrote in the ongoing record of the ACCT that the doctor had authorised the man's return to D wing. Although he was still not eating, the man was drinking adequate amounts of fluids. He was keen to return to D wing so that he could smoke. (Smoking was prohibited in the healthcare unit.)

51. The man returned to D wing the same afternoon. At 5.15pm, Officer A wrote in the ongoing record that he had declined his tea meal, and appeared to be in a "calm but sullen" mood. Officer B added at 7.50pm that the man had been very quiet, but appeared to be happier now that he was back on D wing.

52. An incoming letter was logged on the mail monitoring record the same day. The letter appeared to be from the man's partner, who said she knew that he had been in contact with his ex-wife and ex-partner, and that she had "done with him and his lies". It is unclear when the letter was given to the man, and whether the possible effects were considered in light of its content.

53. The next day, 3 February, the man attended the adjudication hearing (after the offender supervisor's notice of report two days earlier). Officer D from D wing wrote a conduct report, saying that the man was clearly frustrated about his situation, but "takes this out on staff with offensive language and churlish behaviour". The man admitted that he had written letters in contravention of the restrictions, and explained that he was having a bad day and wanted to get the attention of a governor. As punishment, the man was given five days' cellular confinement, suspended for three months, and 14 days' forfeiture of canteen privileges. This meant he would not be allowed to make purchases from the prison shop for two weeks. The cellular confinement aspect of the punishment was suspended, and so would not be imposed if the man did not break the Prison Rules again for three months.

54. At 11.45am, Officer D wrote in the ongoing record that the man seemed much more positive in conversation and said he was going to eat normally. On the same day, he wrote a letter to his brother asking for a telephone number and for contact details for another two of his brothers.

55. Officer A noted at 5.40pm that the man had spoken to him about changing his offender supervisor. He was advised that he would need to submit an application to one of the governors. The man took his evening meal and ate it, and seemed to be in a positive state of mind. At 7.45pm, Officer A wrote that the man had spent most of the association period (a period of time during which prisoners have the opportunity to be out of their cells and associate with others) in his cell and had only been out a couple of times.

56. Although my investigator has not had sight of an application form, it appears that the man did ask to change his offender supervisor. An undated response from Acting SO B referred to an application submitted on 3 February. Acting SO B asked the man to reply, giving the reasons why he felt he could not work with the offender supervisor. The Acting SO B went on to say that, having read through the notes, he was confident that the members of staff dealing with him had acted professionally and appropriately.

57. Members of staff continued to write entries in the man's ongoing record over the next four days. On 4 February, he had a healthcare review and said he was coping well with the support of officers on the wing. The next day, Officer D wrote that the man had declined exercise but had collected all his meals. This happened again on 6 February. The man seemed to spend most of his time in his cell, talking to his cellmate, but there were no major concerns about his well-being. Officers reported that he was taking his meals and appeared settled.

58. At 9.25am on 8 February, Officer A wrote in the man's ongoing record that he was "up and about, had breakfast this morning, seems calm and shows no signs of recent self-harm". Later that morning, however, at 11.00am, the man saw the offender supervisor, and his behaviour was described in the ongoing record as "very rude and obnoxious".

59. The offender supervisor wrote in the PPU contact log that she had visited the man to tell him about a letter from one of his ex-wife's neighbours. The neighbour explained that the man had sent a letter to him with the intention of it being passed on to his ex-wife. In his letter to the prison, the neighbour made it clear that he did not want any further correspondence from the man. In addition, the man's ex-wife had written to the prison, asking for her mobile telephone to be returned. It had been in the man's possession when he was remanded. He refused to release the telephone and suggested instead that his ex-wife should cancel her contract. The offender supervisor wrote to the man's ex-wife the same day to inform her of the situation.

60. Officer A wrote in the man's ongoing record at 5.11pm that, apart from the issue with the offender supervisor, the man's day had been quite settled with "no major dramas or dilemmas". During interview with my investigator, Officer

> "He was continually locking horns with the Public Protection Unit who were telling him about restrictions that were being put on him with regard to contact with members of his family, and he reacted very aggressively towards them … he was verbally very aggressive and I recall on a couple of occasions him returning from interviews with [offender supervisor] and throwing things around in his cell."

61. Officer E, based on D wing, also recalled during interview that the man could be very difficult, refusing to engage or even make eye contact with people if he thought they were trying to "tell him how he should conduct himself with his family or things outside".

62. An ACCT review was held on 9 February, attended by the man, SO C, Officer F and Officer D. The SO wrote on the review form that the man continued to have difficulties coming to terms with the fact that he could not contact his partner or ex-wife. He said that if the situation was not resolved within a week, he would "go back on hunger strike, including fluids". The man remained subject to the ACCT process, and a further review was arranged for 16 February. In addition to the review, he was asked to nominate his next of kin. A full-page notice in the ACCT document states that this should be done within 24 hours of opening the ACCT, but by 9 February, the man had been subject to the ACCT process for eight days. He gave his ex-wife's details.

63. On 10 February, offender supervisor returned a letter that the man had written to his ex-wife's neighbour. Because he had written it before being told that contact was prohibited, no action was taken against him. The offender supervisor wrote in the PPU contact log that the man had a much better attitude and said he thought there had been a "personality clash".

64. The man's cellmate was released from Exeter on the same day, and a different prisoner moved into the cell. Entries in the ongoing record on 10, 11 and 12 February noted that the man was upbeat, had eaten his meals, had attended the library and was getting on well with his cellmate.

65. The offender supervisor wrote in the PPU contact log on 12 and 15 February about ongoing problems concerning the mobile telephone that was stored at Exeter. The man's ex-wife was keen for it to be returned to her, was having difficulty cancelling the contract, and was accruing outstanding bills. The man refused to authorise the return or take responsibility for paying the bills.

66. The man's property record shows that, on 15 February, he posted the cheque from Scottish Widows (received on 30 January) out to someone else, although there is no detail about the intended recipient.

67. An ACCT review was held on 16 February at 11.00am, and was attended by the man, Acting SO D and Nurse C. The man said in the review that he was not eating and from midnight that night would cease taking in any fluids. He

68. At 12.40pm, an entry was made in the ACCT ongoing record, noting that the man had refused his lunch. A further entry half an hour later said "he will refuse food and liquids until something can be done about contact with his son". It went on to say that the man was not in a good mood after his ACCT review and did not want to speak about it.

69. The mail monitoring form kept by the PPU shows that, on the same day, the man sent a letter to one of his sisters, asking her to tell his mother that he would pay back the money he owed to her. He enclosed a copy of his bank statement, showing that he had £3,000 available, and the letter from his ex-wife confirming that she did not want any contact with him.

70. A further entry was made in the man's ongoing record at 5.30pm. The name of the person making the entry is not legible. The entry said that the man had decided not to go on hunger strike after receiving good news in his mail. It went on to say that he was a lot brighter and in good spirits. It is unclear what this good news was.

71. The next day, 17 February, the man sent another letter to his sister. The mail monitoring record described the content of the letter as "generally feeling sorry for himself". The entry goes on to read that the man "says it's been a real wake-up call and he won't be coming back".

72. At 5.00pm the same day, Officer D wrote in the ongoing record of the ACCT document that the man was "doing well". He had taken all his meals and had spent most of the day watching television with his cellmate. The next morning, Officer A wrote that the man appeared calm and settled.

73. On 19 February, the offender supervisor wrote on the mail monitoring form that an item of post had arrived for the man from his partner. An envelope was enclosed with an upsetting message and a torn up Valentine's card. There was an indication that the man had sent a card to his ex-wife as well as his partner. Neither of the cards were recorded in his outgoing post, and so the offender supervisor surmised that the man must have enlisted another prisoner to send them out for him.

74. It is unclear whether this item of post was given to the man. The offender supervisor wrote that she "alerted staff as [he is] on an open ACCT", which suggests the letter was passed to him. There was no mention of this in the ongoing record section of his ACCT, which said he had a good day with no major concerns or issues.

75. Officer D wrote in the man's ongoing record on 20 February that he was "still vocal and abusive about his ex-partner but says he's okay". He was reported to be in good spirits on 21 and 22 February.

76. An ACCT review took place at 3.30pm on 23 February. It was attended by the man, SO C, Officer B and the offender supervisor. SO C wrote on the review form:

> "The man is a very manipulative/controlling individual. His behaviour and attitude comes out in interview. Since coming into custody a number of restraints have been placed on the man which have taken control away from him. His offence is domestic violence related. I believe that this ACCT document was further evidence of his manipulation. ACCT closed."

77. SO C added the following to the reverse side of the form:

> "He is eating and drinking. When questioned he stated that he has no intention of self-harm or suicidal tendencies."

78. As a result of this review, the man was no longer subject to the ACCT processes. This meant that reviews no longer took place, and his conversations with officers were no longer recorded.

79. The offender supervisor wrote a long entry in the PPU contact log after attending the man's ACCT review. She said: "ACCT review today and decided to take him off (though without informing him)." This suggests that the man did not know that he would no longer be subject to the ACCT process, though he was present at the review. My investigator spoke to the offender supervisor about this issue, and she recalled that the senior officer thought the man might behave more appropriately if he believed he was still subject to the ACCT process. She could not recall how the practicalities of this worked, given that the man was present at the review.

80. The offender supervisor also noted in the PPU contact log that, although The man said he was not eating or sleeping much, this was disputed by wing officers. She mentioned that he was concerned about his cheque and whether it had gone to the bank, and angry about the lack of contact with his son, blaming "her in Bristol". The offender supervisor said that although she had explained that the contact had been stopped because he had been trying to relay messages to his partner, he continued to blame his ex-wife.

81. In the same entry, the offender supervisor wrote that the previous day, she had received a telephone call from the man's sister, who was concerned because he had told her that he had not eaten since 28 January. The offender supervisor had explained to her that the man was monitored closely and he would be treated by the healthcare team if there was a problem. The offender supervisor wrote that the man's sister "understood this and it would appear that she is used to his behaviour".

82. On 25 February, the offender supervisor wrote on the mail monitoring form that the man had received a letter from a recently released prisoner. Four days later, on 1 March, the man wrote back. The offender supervisor noted that the letter said he was missing "the love of his life" and his children, and that he was on hunger strike. He also enclosed a stamped addressed

83. On the same day, an ACCT post-closure review was held in the D wing office. The purpose of such a review is to examine what has happened since the closure of the ACCT, and to decide whether it should remain closed or be re-opened. The man, SO C and Officer A attended. SO C wrote on the review form that the ACCT would remain closed. He said the man would be seeing his solicitor the following day, who would hopefully provide some answers about his personal problems and the chances of bail.

84. The man received a letter from his partner on 8 March. The offender supervisor wrote on the mail monitoring form that the man's partner said that if he was going to "do the right thing" in court she would be there so that he could talk to her in person. She also provided a new address and telephone number for the man to contact her. On the same day, the man sent a letter to one of his ex-wife's neighbours, saying that he missed his ex-wife and blamed his partner for his situation. The offender supervisor returned the stamped addressed envelope that the man had tried to send out the previous week. He said he was not bothered about this and would be getting bail soon.

85. The man tried to send a letter to his partner on 10 March, using the address that she had supplied. He had also tried to add the mobile telephone number to his list of authorised numbers. The letter was returned to him. The offender supervisor explained that, even though his partner had contacted him, he was not allowed to contact her because his court case was ongoing. The man suggested to the offender supervisor that he would still try to contact his partner.

86. On 12 March, the man sent a letter to some friends, asking them to collect some property that was being stored at the prison. Three days later, he sent a letter to Scottish Widows. On 17 March, the man sent another letter to friends and talked mostly about his partner. There was some concern because the address was very close to his partner's parents and another address that he had previously used to try and contact his partner. However, as the letter genuinely appeared to be for his friends, it was sent.

87. The man wrote to an address in Cambridge on 19 March. He suggested that "if things went badly for him" he would kill himself on his partner's birthday, 21 June. The offender supervisor was notified, and the entry on the mail monitoring form noted that there was "no suggestion that he is planning to do it straightaway but ACCT may be necessary nearer the time".

88. Nothing further was recorded on the mail monitoring form until 30 March, when the man wrote to his friend. He said he wanted to meet her friend, with whom he had fallen in love after seeing a photograph. Similar sentiments were expressed throughout the letter. On the same day, a letter arrived from Scottish Widows, advising that they would be sending another cheque soon.

89. The man received a letter from his ex-wife on 1 April. She also sent in £50 as she had sold his bicycle and had moved house. On the afternoon of 4 April, Officer D wrote in the electronic wing record that the man had said he planned to stop taking fluids from the following night. Officer D reported this to Nurse D, who saw the man and recorded his weight in the clinical record as nine stones exactly. The nurse informed wing staff of her concerns and referred the man to the doctor for review.

90. The next day, the man received a cheque from Scottish Widows for £3,704.44. This was placed with his securely stored property.

91. On 7 April, the man sent three letters, all to the same friends. In the first letter, he asked his friends for bank details and for their friend to give him a chance. He asked for more photographs of the friend. The mail monitoring form described the letter as "very obsessive" about the friend. In a second letter, the man talked about the friend said he had drawn a picture of her, and asked if she wanted to get engaged. The third letter was described as confusing, and included an envelope that was not addressed to anyone. This envelope had a torn letter from his ex-wife, which he said was proof that the relationship was over.

92. The man completed a request form on 12 April asking for his cheque to accompany a letter he was sending to Scottish Widows. He sent a letter to his brother asking him to visit. He also wrote to his friends, and concern was noted on the mail monitoring form that this and previous letters had been intended for his partner. The police officer who was investigating the man's case was consulted, and advised that the letter should be allowed to go, because the man would be appearing in court four days later and would be allowed to resume contact if he pleaded guilty.

93. The next day, 13 April, the man posted out his cheque to Scottish Widows. On the same day, Officer D wrote in the wing record that the man said he had not eaten for 16 days. Officer D reported this to Nurse E, the primary healthcare manager.

94. At 8.55am on 14 April, Nurse F saw the man on D wing after concerns were raised by wing staff. (The nature of these concerns was not recorded, but could have related to Officer D's report the previous day.) The man told Nurse F that he had not eaten solid food for three weeks, was refusing to eat for his own reasons, and did not want to divulge them. He said he was drinking five or six cups of tea with milk per day, but was not taking in any other fluids. The man told Nurse F that he would stop drinking tea when he decided to, and knew what the result would be. Nurse F took the man's blood pressure and again measured his weight as exactly nine stones. The man refused to provide a urine sample and did not want any medication. Nurse F wrote in the clinical record that the man looked thin and did not maintain eye contact.

95. Over the course of the morning, Nurse F explored the possibility of re-opening the man's ACCT document. She spoke to Nurse E about this, and wrote in

> "Any ACCT re-opening needs to be undertaken by officer who had indicated that had heard prisoner threaten self-harm on wife's birthday."

96. Nurse F spoke to prison Doctor C who said that the man needed to be admitted to the healthcare unit for closer monitoring of his eating habits and weight.

97. Around midday, Nurse F spoke to officers on D wing, but could not identify who had heard the man threaten to harm himself. As a result, she wrote in the clinical record: "ACCT not able to be opened??"

98. The man moved to the healthcare unit the same afternoon. At 3.45pm, prison doctor A wrote in the clinical record: "Does not want to be here. He sends out mixed messages regarding his liability to self-harm. Says he will not take fluids. He has the capacity [meaning the mental capacity] to make decisions." Nurse E wrote at 6.00pm that the man had spent time resting on his bed and, although he had raised no issues, he had declined food. The man spent the night in the healthcare unit.

99. The next morning, 15 April, prison Doctor A wrote in the clinical record:

> "He sent a letter four weeks ago saying he would harm himself on anniversary of his ex-partner in June. He has capacity to refuse food. The risks of refusing food explained to patient and he comprehends. Staff to ensure that June date is in prisoner's wing file. Discharge healthcare unit."

100. The man moved back to D wing the same day. The offender supervisor wrote in the PPU contact log that he had spent the night in the healthcare unit and had been advised that he needed to eat. She also noted that the man had said he would kill himself on his ex-wife's birthday in June.

101. On 16 April, the man wrote a letter to his friends that was described on the mail monitoring form as obviously being for his partner. He said that after his court appearance, he would be able to write and telephone. He also said he wanted to marry her, and repeatedly apologised for what he had done in the past. On the same day, the man attended Taunton Crown Court and pleaded guilty to the offences. His case was adjourned for sentencing and he returned to HMP & YOI Exeter.

102. The man's prisoner account statement shows that, on 20 April, he received £3,703.44 through the post. No further information was given, but the man had posted out a cheque for the same amount one week earlier.

103. The offender supervisor wrote in the PPU contact log on 22 April that she had spoken to the police officer who was investigating the man's case about the

104. On the same day, the man moved into cell D2-17 and began sharing with another prisoner. During interview with my investigator, the man's cellmate said he had moved to D wing that day, and the man helped him to get accustomed to the wing's regime. He said they got along very well and there were no problems between them. In terms of the man's problems, the man's cellmate said:

> "He was obviously stressed out because he wasn't allowed to speak to his partner or have any contact with her but he always said … that if he didn't have [his partner] then he had nothing to live for."

105. Whilst he was aware of the man's problems, the man's cellmate said he did not think of him as someone likely to harm himself. He also said that, during the time they shared a cell, the man was eating properly. He recalled that the man ate breakfast, and usually had a salad with chips or potatoes for his evening meal.

106. Between 22 and 27 April, the man sent four letters to his partner. He talked about getting married and wanting to win custody of his son. He continued to apologise and to say he would have no further contact with his ex-wife. A letter sent on 27 April was described on the mail monitoring form as "emotional blackmail", as he told his partner that he would go back on hunger strike if she did not maintain contact with him.

107. The man sent two letters to his partner on 29 April, asking for another chance and offering to buy her an engagement ring. He said he was sorry and wanted to be a role model for his partner's children. On the same day, a letter arrived from his partner. She said she was unwell, and that she was also facing homelessness. She went on to say that, having made a number of "empty promises" in the past, she did not expect the man to help.

108. On 4 May, the man again wrote to his partner. This was described on the mail monitoring form as being "pages and pages" in length, telling her that he would provide for the family and would send money out to help with her accommodation. The man apologised for "bullying and abusing" his partner in the past and said this would never happen again. He sent a similar letter the next day, and another three letters on 7 May.

109. The man made eight telephone calls on 6 May. He left five voice messages about his partner for their mutual friend, saying he loved and missed his partner and was "lost without her". At 2.33pm, the man spoke to the friend,

110. The man made five telephone calls to his partner on 7 May, leaving four voice messages. They were all very similar, with the man saying he loved his partner and missed her. On the morning of 8 May, the man left a voice message for his partner. Just before 10.30am, he spoke to her very briefly during two telephone calls. Between 10.30am and 11.03am (a 33-minute period) he left eight voice messages. They were all very similar in nature, with the man telling his partner that he loved and missed her, and asking her to take his calls. During one of the voice messages (left at 10.49am) he said: "I need to know what I'm doing, whether I've got a lady and two kids, or I have nothing and therefore I've got no reason to stay on this … planet." He said that if he did not "do it" in prison then he would "do it" at an address outside. As the messages continued, the man began to sound angry, saying: "Pull your socks up, get your head out of your arse, playtime is over." In addition to these eight voice messages, he left another message at 11.20am when he was crying and said he could not take any more.

111. The man continued to use the telephone in the afternoon. At 1.41pm, he left a voice message for his partner saying he had stopped eating and would never eat again. By 1.56pm, he had left three further messages asking his partner if their relationship was over. During one of them, the man said he would "end it" and would not leave prison alive if he did not have his partner. He then spoke to their mutual friend and said he was worried about not being able to contact his partner. Their friend said his partner was at work. Two hours later, the man called the friend again, who said she had not been able to contact his partner either. The man asked her if his partner was seeing someone else. Their friend said she was not, and that she loved and missed him. The man left one further voice message for his partner.

112. The next morning, 9 May, the man left four voice messages for his partner between 8.14am and 11.31am. They were similar in content and tone to the previous day's messages, with the man professing his love and asking if the relationship was over. During one of the messages, he said he was eating so she should not worry. He also said he was sending out a cheque for £2,500 and would follow this with another one for £1,000. The man spoke to his partner at 11.57am and again at 3.40pm. She said she did not want his money but he insisted that she should have it. He said he had sent her a list of how she should spend the money.

113. The man wrote two letters to his partner on 10 May. They were similar to the previous letters, and he said he was upset that she was not writing to him or answering his telephone calls. On the same day, the man filled in a form asking to send a cheque for £2,500 from his account to his partner. His

114. On the same afternoon, the man made four telephone calls to his partner. They talked about the cheque that he had sent out, and about his sentencing. His partner questioned why he was giving her the money, and he said he was not going anywhere. They also spoke about the list that the man had sent with the letter. He encouraged her to choose and buy an engagement ring.

115. The next day, the man telephoned his brother to make arrangements for some of his possessions to be moved to his partner's house. In the afternoon, he spoke to his partner for more than half an hour. He talked about how he had previously circumvented the restrictions on his post, and said his offender supervisor was a "stuck up little cow". The man's partner said he needed to go to anger management and resolve his issues around violence and women. He said he was already doing so in prison. He also said that if he received a lengthy sentence, he would "be dead within a week".

116. On 12 May, the man sent a letter to his partner. The entry on the mail monitoring form noted that the man said he was pleased to have spoken to her, loved her, and insisted that she did not speak to anyone else. He spoke to her twice more in the afternoon and talked about a letter that she had written to the judge about his sentencing. The man also let his partner speak briefly to his cell mate, who said he was "like an agony aunt" for the man.

117. The next morning at 8.05am, the man spoke to his partner for almost 13 minutes. He said he was being interviewed by the police that day but did not know why. His partner suggested that it might be about his ex-partner, and asked the man if he had sexually assaulted her in the past. He said that he had not. He went on to say that he was worried about his contact with his partner being stopped. At 4.36pm, the man again spoke to his partner. He said he had been interviewed by the police in the presence of his solicitor, and they were investigating an assault against his ex-partner. The man also said that his ex-partner was taking his son away to live in Ireland, and he seemed upset about this. The conversation was strained, with the man's partner saying they would never be free of his ex-partners. He said the assault was invented and untrue.

118. The man left voice messages for his partner at 4.52pm and 4.53pm. He said he loved her, wanted to be with her, asked her not to be angry and said he had done nothing wrong. Between 5.16pm and 5.22pm he left four further voice messages along the same lines.

119. Also on 13 May, the man's prisoner account showed a sub-account transfer for £900. There was no further detail given about what happened to the money, though the man mentioned it in subsequent telephone calls to his partner.

120. The man left two voice messages for his partner on the morning of 14 May. These were much the same as previous messages. He spoke to his partner twice in the afternoon. She sounded upset and told him she was feeling unwell.

121. During two telephone calls to his partner on 15 May, the man apologised, said he was proud of her, and told her that he loved her. He later left a voice message saying that he had sent money out for her.

122. The man made four telephone calls on 16 May. He spoke to his brother in the morning, arranging for his partner to collect some belongings. He then had two friendly, pleasant conversations with his partner. The man disclosed that he had not been taking his medication since being in prison. He also said he had tried to hang himself (although there is no evidence of this) and mentioned that the prison was aware of 'at risk' dates and might decide to admit him to the healthcare unit. The man later spoke to his partner's son.

123. On 17 May, the man sent three letters to his partner, promising to love her and keep her safe. The same day, the offender supervisor wrote in the PPU contact log that she had seen the man briefly and had asked how things were going. He told her he was fine. When the offender supervisor asked if he had a court date for sentencing, the man said he had the date but that she did not need to know. She noted that he continued to be very uncooperative.

124. The same day, the man spoke to his partner by telephone. This was a happy exchange during which they laughed and joked, talking about the planned visit three days later. The man said he had sent instructions with the money, and reminded his partner to choose an engagement ring. He left two voice messages and spoke briefly to his partner's son.

125. The man placed 81 telephone calls on 18 May. He did not receive an answer or leave a message in 55 cases. He left 18 voice messages for his partner, three messages for their mutual friend, spoke to the same friend twice, to another friend once, and to his partner's son once. On one occasion, the call was answered but nobody spoke. The voice messages were all very similar in content and tone. The man repeatedly said he loved his partner, missed her, was sorry for what he had done, and was worried about her. As the day went on, he sounded increasingly desperate to speak to his partner, contacting their friend to ask where she was and when she would be at home.

126. On the morning of 19 May, the man left four voice messages for his partner between 8.07am and 9.16am. He said he had not lied to her since he had been allowed to call and write, and wanted her to trust him. He said he was guilty of what he had done, wanted her to visit him, and asked her to speak to him. The man repeatedly said he loved his partner and did not want to lose her.

127. At 9.47am, the man made a 17-minute telephone call to his partner. This was, for the entire duration, a difficult, strained and unpleasant conversation. The man's partner was angry and upset that the police had contacted her

128. Two hours later, the man made a further telephone call to his partner. This was very similar to the previous call, with the man protesting his innocence. His partner said he was angry and controlling, and had not changed. He then suggested that she could change him, and she replied that she had tried for three years.

129. Over the course of the afternoon and evening, the man left four voice messages for his partner. He said many of the same things as during the earlier calls, asking her to visit, professing his love, and saying that the allegations against him were “all lies”.

20 May

130. At around 8.30am on 20 May, the man was seen at breakfast by another prisoner, who worked as a servery orderly, meaning that he served the food to other prisoners. He was also responsible for asking prisoners, on every third day, for their choice of meal from a set menu for the next two days. During interview with my investigator, he recalled that the man went through a period of not eating, which he estimated was around six to eight weeks before his death. He said that, as time went on, the man began to order meals as normal. He recalled that the man would always order option 5, a salad. He knew the man on a social basis but did not know him well enough to be aware of what problems or issues he might have had. When he saw the man on the morning of 20 May, he was not concerned about his appearance or presentation.

131. Between 8.21am and 9.06am, the man made four telephone calls to his partner. He did not speak to her, but left three voice messages. They were very similar in content and tone. The man repeatedly told his partner that he loved her and that he hoped she would visit that afternoon.

132. The other prisoner who was the servery orderly saw the man again at around 11.00am on the D wing landing. They exchanged pleasantries but had no further conversation. He said he had no reason to be concerned about the man.

133. Reverend C wrote in the chaplain’s journal that he saw the man on 20 May. My investigator confirmed with Reverend C that this happened at around 11.30am. He recalled that the man asked him to telephone his partner, to make sure she would be visiting him that afternoon. Reverend C made the

134. The man's cellmate told my investigator that, on the morning of 20 May, a single cell had become available on D2 landing and he had asked if he would be able to move into it. He explained that he got on well with the man, and his intention to move was not prompted by any problems or issues between them. He said that as the man smoked and he was a non-smoker, he preferred to have his own cell. He told my investigator that after lunch, the man helped him to move some of his possessions to his new cell, then shortly after 2.00pm left the wing to meet his visitor.

135. The man used the telephone to leave a voice message for his partner at 2.09pm. He asked her to talk to him, said he was about to go to the visits hall, and feared he would look foolish if she was not there to see him.

136. Officer G told my investigator that she escorted two women to see the man in the visits hall. She said that she thought one of them was very nervous, and she reassured her that the visit could be ended at any time. SO F was in charge of social visits, and told my investigator that his colleague received a telephone call from the visits centre, asking staff in the hall to keep a close eye on the visit. This was after a request from the visitors, though no reason was given.

137. The visits hall is covered by CCTV with video but no sound. According to the timestamp on the footage, the man arrived at 2.27pm. At 2.49pm, an officer spoke to the man for approximately 30 seconds, and at 2.52pm his visitors arrived. The visits log showed that the visitors were the man's partner, and the friend to whom he had been writing with the intention of the letters reaching his partner. During the course of the visit, the man seemed sometimes agitated, and his partner appeared upset. Shortly before his visitors left, the man began pointing at his partner and leaning across the table. The two visitors left at 4.34pm. He also left the table with them, but returned, alone, one minute later. He did not look upset, but did appear somewhat pensive. Two minutes later, he too left the table.

138. SO F told my investigator that, as requested, he monitored the visit closely. He said that it passed without incident, and whilst the conversation sometimes appeared strained, this was not uncommon on social visits. He said:

> "There were no signs to indicate that it was a particularly upsetting visit. There were no raised voices, no tears or anger. At times there was laughing, smiling and what appeared to be good-natured banter."

139. SO F also mentioned that the visitors stayed until the end of the session. Officer H, who was also working on visits, recalled that the man had a small argument with his visitors towards the end of the session. Officer F said that at the end of the visit, the man's visitors were keen to leave the area quickly.

140. The man's cell mate recalled during interview that, whilst the man was having the visit, he helped some older prisoners to move their possessions from D2 to D3 landing. He was doing this when the man returned to the wing. A prisoner from D2 landing, told my investigator that the man was visibly upset and asked where the man's cellmate was. The prisoner from D2 wing explained that he was helping other prisoners to move, and the man then used the telephone.

141. The PIN telephone system's time is clearly set differently to that of the CCTV system. Although the man left the visits hall at 4.37pm according to the CCTV system, the PIN telephone system records him making a call from D wing at 4.34pm. Between 4.34pm and 4.46pm, the man made four telephone calls. He did not speak to his partner but left three voice messages. He was crying during the calls and kept repeating the same things: that he loved his partner, he was sorry, he wanted another chance, and he would call her the next day at 2.00pm. During a message left at 4.46pm, the man said: "I wish they had the electric chair with a lethal injection, because I'd take it right now if it made you happy."

142. At 5.18pm, the man made another call, leaving a further voice message along the same lines as those he had left earlier. One minute later, he made a call to a mobile telephone number and spoke to the friend who had visited him with his partner. The call lasted two minutes and 25 seconds. The man began by asking how his partner was, and saying he would call her at 2.00pm the next day. After being told that she probably would not speak to him, the man asked if he had "lost her". The friend said she was not sure, but thought he had. The man repeatedly asked to be given another chance, and asked a number of times if he had lost his partner. The friend did not confirm this definitively, but suggested that the relationship was over. The man did not speak to his partner at any point during the telephone call.

143. Towards the end of the call, the man asked to speak to his partner, but the friend told him she would not speak to him. He then said: "What happens tonight, I've got to do it then." The friend did not appear to hear what he had said, but he did not repeat himself.

144. The prisoner from D2 wing said that when the man had finished using the telephone, he went into his cell. The prisoner from D2 landing then made a personal telephone call. When the man's cellmate returned to the landing at around 5.25pm, the prisoner from D2 wing told him that the man was in his cell, appeared upset, and had asked to see him. The man's cellmate said that when he went into the cell, the man was very upset and was crying. He told the cellmate that his partner had ended their relationship. The man's cellmate recalled that the man was distressed and angry, and was punching the furniture in his cell. A few minutes later, the man's cellmate left to collect his evening meal from the servery area. He told the man that he would look in on him around 9.00pm. The man did not collect a meal, and remained in his cell.

145. At around 5.30pm, the prisoners on D wing were locked in their cells in accordance with the wing regime. Officer I told my investigator that he had a

146. The prisoner who was the servery orderly visited each prisoner on D wing to ask them for their meal choices for the next two days. The other prisoners remained locked in their cells during this time, and the prisoner who was the servery orderly was able to talk to them through observation panels in the cell doors. He arrived at the man's cell around 6.25pm. He said that, although it was daylight outside, the cell was relatively dark. He knocked on the cell door and asked the man for his meal choice, but received no response. When he looked through the observation panel, he noticed the man in what he described as an unusual position. He said:

> "He was sat on the floor with his back, the back of his neck was on the bottom bunk and he was like that but his hands were down on either side. He had his head lifted over to his left hand side, the back of his neck was on the bottom bunk bar, his behind was on the floor and as I say his head was leant back over onto the left-hand side of his body."

147. The man's cell was at the end of D2 landing, so the layout was slightly different to most of the others. The window was on the side wall of the cell, with the bunk bed across the back wall. He was facing towards him, with his legs and feet towards the cell door.

148. The prisoner who was the servery orderly thought that the man was sleeping, although he said it looked like an unusual and uncomfortable position to sleep in. As the man always chose the same meal, he decided not to disturb him, and continued with his rounds. During interview, he said that although he had not noticed anything specifically wrong, he started to wonder about what he had seen, and worried about the man's well-being. However, after returning to his cell he did not report his concerns to officers, and said he did not want to cause trouble if there was nothing wrong.

149. The published D wing regime states that, on Mondays to Thursdays, there is an association period between 6.00pm and 7.30pm. However, during interviews with my investigator, several officers said that it was often cancelled due to staff shortages. The officers explained that members of staff from D wing would often be called upon to work in other areas of the prison, and this did not leave enough officers on D wing to allow association to take place. As a result, prisoners were locked in their cells during the evening association period.

150. On the evening of 20 May, association did not take place on D wing. The regime states that a final roll check should take place at 8.45pm, when overnight staff begin their work. A roll check essentially involves counting the

151. Officer J told my investigator that he arrived on D wing at 7.45pm, though his shift was not scheduled to begin until 8.30pm. He realised that there were only two officers - Officers K and L - on D wing and so there had been no evening association period. As the prisoners had been locked in their cells for more than two hours, Officer J decided to complete the roll count early. This would allow D wing to move to the night state, with the cells unlocked and the prisoners using the privacy locking system.

152. Officer J explained that one of the other officers unlocked each cell, whilst he followed and counted the prisoners. He started with D3 landing, then moved down to D2. He reached the man's cell at around 7.50pm. Officer J recalled that the man was alone in a double cell, and so he checked that there was nobody else present. He said the man was sitting almost on the floor of the cell, either on the lower bunk bed or perhaps on a box. Having satisfied himself that the man was alone in the cell, Officer J moved on and continued his roll check. He did not go inside the cell. At 7.55pm, he finished counting the prisoners, ensured that the numbers were correct, and withdrew from the landings to the secure area of the wing.

153. At 8.00pm, Officer M arrived to begin his overnight shift. Officer J told him that the roll check had been completed and the cells had been unlocked for the night-time arrangements. As D wing is staffed by two officers overnight, Officers K and L, who were covering the evening period, then left the wing to finish their shifts.

154. Shortly after his cell was unlocked, the man's cellmate went to the prisoner from D2 landing's cell to talk to him. Around one hour later, at 9.00pm, he left the prisoner from D2 to see the man, as he had promised earlier. When looking through the observation panel, the man's cellmate saw that the cell was in complete darkness. The door was closed but unlocked. He went into the cell and saw that the man was suspended from the top bunk, having used a piece of a bed sheet as a ligature. The man was facing the door of the cell, with his legs and feet on the floor. The man's cellmate noticed that he was grey in colour.

The emergency response

155. The man's cellmate immediately made his way to the gate at the end of D2 landing. Officer J saw him approaching on the CCTV monitor. The wing office is located on D2, so the two officers were very close to the gate. The man's cellmate rattled the gate and asked for Officer J, then told him that he thought the man had hanged himself in his cell.

156. Officer M explained to my investigator that the normal procedure for dealing with such a situation would be to wait for the night orderly officer to arrive. He went on to say, however, that "our first thought was to get in there to see if we could save life". The officers were easily able to access the landing as they both had complete sets of keys. (Overnight, officers exchange their keys for sets that only allow them access to their immediate areas of work. On D wing, one officer carries a key for the landing gates, and the other officer carries a cell key. However, the key exchange was not due to happen until 10.00pm.)

157. Officers J and M and the man's cellmate went quickly to the man's cell at the end of the landing. Officer M recalled that it was in semi-darkness and that the man appeared to be sitting on the lower bunk. Officer J went into the cell first and said that, as he approached the man, he saw that he was suspended from what he described as "a thin sliver of bed sheet" that had been tied to the metal guard rail of the upper bunk. Officer J used his anti-ligature knife (a tool carried by all prison officers) to cut the ligature. The two officers lowered the man to the floor, and Officer M checked for signs of life. He told my investigator:

> "I checked carefully for a carotid pulse from the neck, I checked for any respiration … there was none. The eyes were the biggest giveaway, they were just, sort of like fixed, the pupils were dilated and almost sort of glazed and there was no reaction to any light or touch."

158. In addition to checking for signs of life, Officer M said the man felt cold to the touch, and that blood had started to pool in his hands, which were close to the floor. He said:

> "When the heart stops functioning the blood tends to drain from the upper body, particularly if the body is sat upright as the man was, and pools in the lower extremities. Because his arms were down by his side you could see that there was a purplish crimson tinge to the bottom edges of his hands where the blood had started to pool down the lower extremities. It's usually a sign that somebody's been dead for a while."

159. Officer M told Officer J that he did not think the man could be resuscitated. He said during interview that "to attempt resuscitation at that stage would have been undignified for the man". He used his radio to relay a 'code blue' message (a radio call sign indicating that someone is not breathing) and asked for urgent medical assistance.

160. The man's cellmate was, at this time, standing outside the man's cell. After Officer M had checked for signs of life and asked for urgent assistance, Officer J took the man's cellmate back to his own cell and locked him inside. The two officers then proceeded to lock the other prisoners on D2 landing in their cells.

161. The night orderly officer on 20 May was SO G. She had started work at 8.00pm, and one hour later was on A wing. She told my investigator that at 9.04pm, she heard an alarm sound over her radio. This was a high-pitched beeping noise intended to alert all members of staff in the prison to an urgent situation. The alarm was immediately followed by a message from Officer N in the prison's communications room. He reported a 'code blue' situation on D wing, and asked 'Oscar 1' to acknowledge the message. 'Oscar 1' is the radio call sign for the night orderly officer. SO G acknowledged the message and ran to D wing. On her way, she saw the assistant night orderly officer. SO G asked the assistant night orderly officer to go to the healthcare unit, collect the nurse and escort her to D wing. SO G continued to D wing and said she arrived around one minute after receiving the urgent radio message.

162. When SO G arrived at D wing, Officer M shouted to her that she was needed on D2 landing. She went up the stairs and found that the officers had already unlocked the gate to the landing and secured the prisoners in their cells. SO G told my investigator that when she went into the cell, the man appeared to be in a sitting position, facing the door of the cell, with his back against the lower bunk. She checked for signs of life but found none, and concurred with Officer M's assessment that the man could not be resuscitated. She said she closed the man's eyes and, around one minute later, the nurse arrived.

163. Nurse F told my investigator that she started work in the healthcare unit at 8.00pm. She was 'Hotel 1', a radio call sign for the medical response to any urgent situations. Nurse F went on to explain that during the night, she only carried keys to the rooms within the healthcare unit. To leave healthcare, she would need to be escorted by a prison officer. She recalled that around 9.05pm, she heard the radio alarm and the 'code blue' message from the communications room. Nurse F was then asked over the radio if she had access to the main prison, and replied that she did not. She made her way to the gate at the end of the healthcare unit as she knew that someone would be sent to escort her to D wing, and assistant night orderly officer arrived two or three minutes later.

164. During interview with my investigator, Nurse F said she knew from the initial radio messages that she was responding to "a severe emergency". She knew that bags of emergency medical equipment were kept on the wings and so did not have to take one from the healthcare unit. She ran with the assistant night orderly officer to D wing, collecting a defibrillator (a piece of medical equipment designed to analyse a patient's heart rhythm and administer an electric shock, if required) en route. When she arrived at D wing, Nurse F picked up an oxygen cylinder from the medical treatment room, and made her way to the man's cell. She told my investigator that it took around four minutes to get from the healthcare unit to the man.

165. When Nurse F arrived, SO G said she thought the man had been dead for some time. Nurse F told my investigator:

> "I felt his skin, he was cold … and his hands were sort of mottling white and blue and … I was going to start doing some emergency work on him but really it was quite futile, I saw it was quite futile to do this."

166. Nurse F went on to say that, had she thought resuscitation was viable, she would have made efforts immediately. She was confident about performing cardio-pulmonary resuscitation (CPR), had done so many times, and had received life support refresher training.

167. Officer J decided to check on the man's well-being. He was concerned about him being left on his own in a cell, and asked him if he wanted to speak to a Listener. The man's cellmate did not want to do so, but was very shaken. Officer J did not want to leave him in a cell alone, and asked if there was anyone with whom he wanted to share temporarily. The man's cellmate suggested the prisoner on D2 landing, who was in the adjacent cell. Officer J moved the man's cellmate, explained the situation to the other prisoner, and made a cup of tea for the man's cellmate. SO G also visited the man's cellmate to check on his well-being.

168. A report completed by the paramedics from the South Western Ambulance Service NHS Trust recorded the time of the 999 call as 9.07pm. They arrived at the prison at 9.10pm and were with the man two minutes later. The paramedics attached an electrocardiograph (ECG) machine (used to monitor heart rhythms) to the man. No heart rhythm was found. The paramedics did not attempt resuscitation and, at 9.15pm, declared that he had died.

169. Officer M told my investigator that when he was leaving the cell, he saw that there was a note on the table. He did not read it or remove it from the cell, but left it for the police. My investigator obtained a copy of the note, which the man had written to his partner. He said she was to have all his belongings, including those at his brother's house. He went on to say that his partner was to keep the money he had sent to her. The man wrote: "I love her, I wouldn't have ever hurt her again. She is my next of kin."

Events after the emergency response

170. SO G confirmed with Officer N that he was contacting the necessary people in accordance with the contingency plan, and that the duty governor was on the way. She also instructed the assistant night orderly officer and the other overnight staff to check the well-being of the prisoners subject to the ACCT process. Officer M said he checked the one prisoner on D wing who was subject to ACCT monitoring, but he was on D1 landing (one floor below) and was not aware of what had happened. Officer M then spent time with the man's cellmate, whom he described as feeling very guilty about moving out of the cell earlier in the day. The man's cellmate stayed in the cell with the prisoner from D2 landing until about 1.30am, when he returned to his own

171. Officer J told my investigator that, although prisoners on D2 landing knew what had happened, those on D1 and D3 were not formally told of the man's death that night. However, if individual prisoners asked what had happened, they were told.

172. The duty governor arrived at the prison at 9.30pm. He checked the well-being of the members of staff who had been involved, as well as asking about the emergency response. A member of the Independent Monitoring Board (IMB), did the same when she arrived at 10.10pm.

173. On the morning of 21 May, Officer J unlocked the servery area of D wing so that that the prisoner who was the servery orderly could attend to his duties. He asked him if he had heard about the man. During interview, prisoner who was the servery orderly told my investigator that he immediately knew what Officer J was going to say, because he had been concerned after seeing The man lying in an unusual position. He told Officer J what he had seen, and then reported it to the other wing officers. (On 2 June, he made a written statement after this was requested.)

174. The prison's deputy governor, and the head of residential care, travelled to Bristol on the morning of 21 May to inform the man's ex-wife about his death. When they arrived at the address that the man had provided prior to his death, the prison deputy governor and the head of residential care found that the man's ex-wife had moved. They established the new address and visited the man's ex-wife. They found, however, that the coroner had already telephoned and informed her of his death.

175. A post-mortem examination was carried out 25 May, concluding that the cause of death was hanging**.** The man's funeral took place on 2 June in Bath.

ISSUES

Assessment, Care in Custody and Teamwork (ACCT)

176. The ACCT process is used by prisons to provide additional support and monitoring to prisoners considered at increased risk of suicide or self-harm. The process was started for the man on 1 February 2010 after he was found collapsed in his cell. He told staff that he was not eating and would kill himself unless he was able to speak to his ex-wife.

177. An assessment interview took place on 2 February, and this was followed by a review. Further reviews took place on 9, 16 and 23 February, at which point the ACCT process was discontinued. Over this period of time, useful information about the man was recorded in his ongoing record. His primary concern seemed to be re-establishing contact with his partner, ex-wife and son, and although he made threats about refusing to eat and drink, he was observed to be doing so by members of staff.

178. The ACCT document contains a form for next of kin details. A full-page notice states that this should be completed within 24 hours of the document being opened. In the man's case, it was completed on 9 February, eight days after the process was started.

The Safer Custody manager should remind staff to complete all elements of the ACCT process, including obtaining next of kin details, within the published timescales.

179. The ACCT document was closed on 23 February. SO C wrote on the review form that the man was "a manipulative and controlling" person, and that the ACCT document was further evidence of manipulation. The man was reported to be eating and drinking, and had "no intention of self-harm". The offender supervisor, who attended the review, wrote in the PPU contact log that the man was not told that he was no longer subject to the ACCT process. She told my investigator that SO C thought the man might behave more appropriately if he believed he was still subject to ACCT. It is not clear how this worked in practice, given that the man was present at the review.

180. The prisoner is central to the ACCT process, and the purpose is to provide additional support during a time of increased risk. When a prisoner is no longer thought to be at risk, the process can be stopped. However, the prisoner should contribute to this decision or at least be aware of it. I believe that it is dishonest and potentially dangerous to create a situation whereby a prisoner believes that he remains subject to the ACCT process when in fact this is not the case.

The Safer Custody manager should remind all staff that prisoners should be kept informed about their ACCT status.

181. Whether or not the man was aware of the closure of his ACCT document on 23 February, he must have known about it by 2 March, when he attended a

182. I am satisfied that there is nothing to suggest that the decision to close the ACCT was unreasonable. The man attended a number of reviews and was monitored closely by unit staff. He was observed to be eating and drinking, and did not show any further signs that he intended to harm himself.

183. On 14 April, consideration was given to re-opening the man's ACCT document. He told Nurse F that he had not eaten solid food for three weeks and also alluded to ending his life by refusing to drink fluids. Nurse F was clearly concerned about the man's well-being. She updated the clinical record throughout the day, and spoke to a number of staff members, including SO E from the Safer Custody department. Nurse F wrote in the clinical record that she had been told that the ACCT would need to be re-opened by the person who had heard the man threaten self-harm. Although she attempted to locate this person, Nurse F was unsuccessful and the ACCT was not re-opened.

184. Prison Service Orders (PSOs) provide instructions to prisons about procedures that must be followed. PSO 2700 relates to suicide prevention and self-harm management. Paragraph 1.2.2 states that:

> "Suicide prevention is the responsibility of all staff. Whenever any member of staff believes a prisoner is at risk of suicide or self-harm they must open an ACCT Plan following the procedures set out in Annex 8G."

185. Annex 8G goes on to explain in more detail exactly how to start the ACCT process, who to inform, and what steps to take. Any member of staff can open an ACCT document regardless of whether or not the prisoner has previously been subject to ACCT. Nurse F was clearly concerned about the man and, if she had reason to believe that he was at risk of suicide or self-harm, should have opened the ACCT document herself. It seems, however, that she was not fully aware that she could do this.

The Safer Custody manager should remind all staff at Exeter that anyone can and should open an ACCT document if they believe a prisoner poses a risk of suicide or self-harm.

186. As a result of the concerns raised by Nurse F, the man was admitted to the healthcare unit. However, prison Doctor A was more sceptical about him, and wrote in the clinical record that "[h]e sends out mixed messages regarding his liability to self-harm". The man was discharged from the healthcare unit the next morning and returned to D wing. Prison Doctor A wrote in the clinical record: "He [the man] sent a letter four weeks ago saying he would harm himself on anniversary of his ex-partner in June."

187. The letter to which prison Doctor A referred was sent on 19 March and was noted on the mail monitoring form. The man was not subject to ACCT at that time, and it is unclear how widely the information from the letter was disseminated. I do not think that any further action was appropriate.

Clinical care

188. The clinical reviewer was appointed by Devon Primary Care Trust (PCT) to review the man's clinical care. The clinical reviewer found that, although the man did not have a great deal of involvement with medical staff at Exeter, there was evidence of good practice. Repeated efforts were made to try and convince the man to comply with his medication for epilepsy, though he refused to do so. In addition, there were a number of interventions relating to food refusal.

189. When the man arrived at Exeter on 8 January 2010, an initial health screening was carried out. He said that two years earlier, he had attempted suicide by hanging. The screening document states that in such circumstances, prisoners should be referred for a mental health assessment. However, there is no evidence that this happened. The clinical reviewer made the following recommendation, which I endorse.

The healthcare manager should ensure that, in accordance with the initial health screening document, all prisoners who declare previous mental health problems have the more detailed mental health questionnaire completed.

Food refusal

190. There were clear issues around food refusal. The man first mentioned that he was not eating on 1 February, and he continued to make similar claims as time went on.

191. A document entitled 'guidelines for the clinical management of people refusing food in immigration removal centres and prisons' was published by the Department of Health in August 2009. It states that:

> "Prisoners and detainees have the legal right to refuse food and fluid, as does anyone receiving treatment in the community. Although all efforts should be made to persuade individuals to eat and drink, feeding against the will of anyone who is competent to make their own decisions can be considered assault."

192. The document goes on to say that food refusal should be managed by way of weekly reviews to consider the prisoner's physical and mental state as a result of malnutrition. Reviews can be held more frequently if this is necessary. Consideration should also be given to the use of an ACCT document.

193. ACCT documents must be opened following any act of self-harm. However, guidance regarding food refusal is different. Exeter's food refusal guidance states:

> "Although food refusal is self-injurious, the prisoner may not be refusing food *primarily* to self-harm". Therefore it is not mandatory to open an … ACCT Plan … in every case of food refusal. The final decision on whether or not to open an … ACCT Plan … lies with the establishment."

194. The guidance also says that food refusal should always be taken seriously, and that "if the food refusal lasts more than a short time, it will be essential that the person is managed using a multi-disciplinary care plan". The guidance says that food refusal should be recorded on food refusal sheets.

195. The man was not subject to a specific care plan regarding food refusal. However, there is also evidence to suggest that he did not refuse food and fluids on an ongoing basis. Between 1 and 23 February, The man was subject to the ACCT process. He told members of staff that he was not eating and, although he declined some meals, he accepted others. Whilst the man regularly threatened to refuse food in attempts to resume contact with his relatives, unit staff reported that he was eating meals.

196. Although the man did not appear to refuse all food, staff and prisoners reported during interview that he looked thin and appeared to have lost weight. Officer E recalled that, when he returned to work after a short period of leave, he noticed that the man appeared to have lost weight. However, when the man was actually weighed, this turned out not to be the case. Officer E also said during interview:

> "He went once or twice and refused a meal but I can't remember, honestly, him actually having a sustained period of that. We all have days when we don't want to eat, I mean I think there was a couple of occasions where he was in a bit of a temper about something and decided that he'd rather stay in bed but I don't remember any sustained period."

197. Officer D said that the man "lost a lot of weight". He went on to say:

> "We were assured by the man on occasion, but more regularly by his cellmate, that he was taking occasional food so it wasn't a huge concern, although it was something that we kept asking him about, and even when he was declining food we were going and checking that he really didn't want to go for food. I remember on a couple of occasions going to his cell and trying to encourage him to take food."

198. The prisoner from D wing, told my investigator that, until April, he was responsible for asking prisoners for their meal choices. He said that the man would often decline to order any food. On these occasions, he would order the most popular choice for the man, but he did not know if he then ate his meals. He said the man lost a lot of weight during his time in prison. The man's cellmate, who shared a cell with the man from 22 April to 20 May, said the man was eating normally towards the end of his life and he did not have any concerns about his food intake.

199. In terms of the formal monitoring and recording of the man's food refusal, Officer D said:

> "We were concerned on a number of occasions that he wasn't eating properly and he announced during a couple of the outbursts against probation that he was going on to hunger strike because he felt things weren't going his way, although … during these periods he was observed to take occasional food and certainly he was taking liquids, so I'm not sure how well documented any hunger strike, as he called it, would have been. I'm certainly not aware that he was formally on hunger strike."

200. Indeed, there did not appear to be any formal monitoring of the man in terms of food refusal. No food refusal sheets were completed, and there were no reviews outside those provided as part of the ACCT process. The man's weight was recorded as exactly nine stones on 4 and 14 April. However, as his weight was not recorded at the time of his arrival in January, it is impossible to calculate how much weight he may or may not have lost. The pre-printed 'first reception health screen' form has a space for weight to be recorded, though it was not completed for the man. It is important to have a baseline weight for prisoners so that any weight loss or gain can be accurately recorded.

The healthcare manager at Exeter should remind clinical staff to record a prisoner's weight as part of the initial health screening.

201. The man made regular threats to refuse food and fluids, often in the context of trying to have restrictions around family contact lifted. Although he refused some meals, there is little if any evidence to suggest that he made a concerted effort to withdraw from food or fluids. The man's contact with healthcare professionals was minimal, and he did not see any clinical staff between 15 April and his death on 20 May. This was, of course, his choice. Prison Doctor A was clear in his entries in the clinical record that the man had the capacity to make his own decisions regarding his intake of food.

202. Although there was some evidence to suggest that the man was eating, prisoners and members of staff thought he lost a lot of weight during his time at Exeter. This could not be verified because his weight was not recorded on a regular basis. When a prisoner claims to be refusing food, it would be beneficial for their weight to be recorded at regular intervals, so that any weight loss can be properly monitored. The clinical reviewer agreed, and made the following recommendation which I endorse.

The healthcare manager should ensure that prisoners who are refusing food and/or fluids have their weight recorded on a weekly basis.

Monitoring of and restrictions on mail and telephone calls

203. There were a number of issues with regard to the man's contact with his relatives. His ex-wife contacted the prison to make it clear that she did not

204. Separately, the man was not allowed to contact his partner because she was the victim of the offences and, at that point, he had not been convicted. However, the man tried to make contact with his partner through his teenage son. The man's ex-partner (the mother of his son) requested through the police that he was not allowed to telephone or write to his son because he was trying to have messages passed to his partner. These restrictions were put in place.

205. The man was very keen to contact his partner, ex-wife and his son, and he did not seem willing to accept the reason for the restrictions being put in place. He continually tried to circumvent these restrictions, writing to other people in the hope that they would pass on letters, and asking other prisoners to send out letters for him.

206. Restrictions on mail and telephone calls can have a potentially detrimental effect, because they close off avenues of support that prisoners might have in the wider community. However, I am satisfied that the reasons for restricting The man's contact were sound. He was able to remain in contact with other people, such as his siblings, whilst he was in prison.

207. A comprehensive log of mail items was kept, with details of the content and the intended recipient. However, it seems that not all of the man's mail was screened. His sister received a number of letters that do not appear in the mail monitoring log. The man sent a number of letters to a friend in early April. Whilst they were clearly intended for his partner, the staff members involved in monitoring the man's mail did not seem to realise this for several days.

208. There were inconsistencies in the approach that was taken to restricting the man's mail. On 12 April, a letter that was clearly intended for his partner was allowed to be sent after the offender supervisor contacted the police officer was investigating the man's case. The advice to allow the letter was based on the fact that the man would be appearing in court four days later, and would be allowed to resume contact if he pleaded guilty. However, at this point he had not appeared in court and, as far as he was aware, the restrictions remained in place. Given that the man frequently questioned the rationale behind the restrictions and tried to circumvent them, it would have been sensible and good practice for Exeter to maintain a consistent approach until such time as the circumstances had changed.

209. After the man appeared in court, he was allowed to resume telephone contact with his partner, although it continued to be monitored. My investigator listened to more than 200 telephone calls that the man placed between 6 and 20 May, and there may be issues of harassment to consider. He sent many letters to his partner and made a great number of telephone calls. As well as speaking to her, he left many voicemail messages. On 18 May, for example, the man placed 81 telephone calls in attempts to contact his partner.

210. Although the man's partner did not make a complaint about the letters, telephone calls and voicemail messages, she told my FLO and investigator that she felt overwhelmed by them. This is, I accept, a difficult issue for a prison to monitor. The man was allowed to contact his partner, and she did not seek to restrict his letters or telephone calls. However, his mail and telephone calls remained subject to monitoring, and so the extent of the contact was known. I do not make a recommendation in this area, although the Governor may wish to consider what action could reasonably be taken should similar circumstances arise in the future.

211. The man's ex-partner (the mother of his son) told my FLO and investigator she had not been informed that the man had been to court and that the contact restrictions around his partner had been lifted. His ex-partner had initially asked the police to restrict the man's contact because he was trying to pass messages to his partner via his son. As he was allowed to contact her freely after his court appearance, there was no need for continued restrictions around contact with his son. The man's ex-partner said she thought the prison should have made her aware of this.

212. The request from the man's ex-partner about restrictions on contact was made through the police. It was probably not feasible for the prison to make the link that there was no need for the restriction after he was allowed to contact his partner. As the request had been made through the police, the man's ex-partner could have sought updates about the case from the investigating officer. However, such matters are beyond my remit.

D wing regime and staffing

213. During interview with my investigator, several members of staff raised concerns about the staffing levels on D wing. Officer M talked about the importance of working on a wing regularly, of getting to know the prisoners and having some understanding of the problems they might be facing. He mentioned that Officers L and K, who were staffing D wing on the evening of 20 May, were not regular D wing officers, and so would probably not have had an in-depth knowledge of the prisoners accommodated there. Officers E, and J also spoke about the staffing on D wing, and said that staff shortages in the prison were often managed by removing members of staff from D wing. This meant that the evening association period for D wing was either shortened or cancelled entirely.

214. The D wing regime for Mondays to Thursdays includes an evening association period between 6.00pm and 7.30pm. Officer D explained that "there are no facilities for D wing to have association, so their association consists of being unlocked … so they [can] have contact with others on the wing". If members of staff from D wing are re-assigned to work in other areas of the prison, or if D wing is short-staffed for some other reason, then the evening association period will be reduced or cancelled. On the evening of 20 May, only Officers L and K were working on D wing. For the association period to take place, three officers were required. As a result, prisoners on D

215. My investigator obtained the records of evening association periods for the dates 11 April to 27 May inclusive. There is no evening association period on Fridays, and there was one bank holiday during this time, and so there were 27 days on which evening association was scheduled to take place. On 11 of these days, D wing prisoners did not have an evening association period. There was only one week (beginning 18 April) during which D wing had evening association on all the scheduled days. During two of the weeks, D wing prisoners had evening association on only one day.

216. The Governor will already be aware of these matters and, whilst I do not make a recommendation in this area, I draw his attention to the issues I have raised.

The evening of 20 May

217. At around 6.20pm on 20 May, the prisoner who was the servery orderly visited the man's cell to ask for his meal choices. As previously mentioned, he recalled that the man was sitting in an unusual position and appeared to be asleep. Although he said that he started to wonder about what he had seen, and was concerned about the man's well-being, he did not report his concerns to officers because he did not want to cause trouble if there was nothing wrong.

218. Around 7.50pm, Officer J looked into the man's cell as part of the roll check. He was aware that the man was alone in a double cell and so checked that there was nobody else present. Officer J observed the man sitting in his cell with his legs outstretched, and did not notice anything out of the ordinary. He explained that the purpose of the roll check was "purely to check that there are the right number of people in the cell, that they're present and that they're visible". He said that there was no requirement to solicit a verbal response from prisoners unless they were thought to be at risk.

219. Local Instructions are issued by prison governors and provide written guidance about various subjects. Local Instruction 2.05 refers to roll checks at Exeter, and paragraph 13 states: "Where a roll check is made, each prisoner must be seen. In cases where the observation glass is covered, the prisoner inside must be made to remove the obstruction." The instruction makes no mention of obtaining a verbal response from prisoners. Officer J saw that the man was in the cell and, believing that nothing was amiss, continued with his roll check. He told my investigator that, if he saw that someone appeared to be dead or in distress during his roll count, he would go into the cell immediately and call for help.

220. When the man was found by his cellmate, he was in the same position. Both the prisoner who was the servery orderly and Officer J accepted during interview that the man may have been dead when they saw him earlier in the evening. Officer J said that only when he was in the cell could he see that the man was suspended by "a very thin sliver of bed sheet", and that this was not visible from outside the cell. I accept that neither the prisoner who was the servery orderly nor Officer J saw anything unusual and I do not criticise them for not raising the alarm.

The emergency response

221. When the man's cellmate raised the alarm shortly after 9.00pm on 20 May, the response was swift and organised. Officers J and M went to the man's cell and entered it immediately, without waiting for other officers to arrive. Officer J cut the ligature, and Officer M checked for signs of life.

222. Officer M is not a medical professional. However, during interview he gave a comprehensive account of the different checks that he made to look for signs of life, and what the man's appearance might mean in terms of how long he had been dead and whether CPR was viable. He did not think CPR could be effective, and this assessment was supported by both Nurse F and the paramedics when they arrived.

223. There is, of course, further evidence (as outlined above) that the man had been dead for some time when the man's cellmate discovered him at 9.00pm. I am therefore satisfied with the decision taken in respect of CPR. To attempt resuscitation in those circumstances would have been unnecessarily distressing for the members of staff involved and undignified for the man.

Closed circuit television (CCTV) footage

224. The D wing landings are covered by CCTV. The cameras allow members of staff, who do not routinely enter the landings overnight, to monitor prisoners on the wing. The footage is recorded.

225. My investigator was given a DVD that was thought to contain CCTV footage of the emergency response on the night of 20 May. However, there was no footage on the disc. It transpired that human error in creating the disc had also led to the footage of the emergency response being deleted from the main computer's hard drive.

226. If a CCTV system is to be effective, it must be able to display and retain footage. Members of staff must also be able to retrieve footage of significance for evidential purposes. One of my investigators previously encountered difficulties obtaining CCTV footage when undertaking an investigation at Exeter following a death in September 2007. At that time, a recommendation was made about ensuring that the CCTV system was regularly maintained and was working effectively.

The Governor should ensure that the CCTV system is properly maintained and appropriate members of staff are fully trained in its use.

Support for staff and prisoners

227. I have found that support for members of staff and prisoners on the night of 20 May was good. My investigator was told by several members of staff that the duty governor was very supportive and took the time to speak to them about what had happened and how they had responded. The man's cellmate was moved to share a cell with the prisoner from D2 wing and was allowed to remain there until he felt comfortable about returning to his own cell. All prisoners subject to the ACCT process were checked. Prisoners on D wing who asked what had happened were told, and all other prisoners were informed of the man's death the following morning.

228. PSO 2710 refers to the actions that should be taken following a death in custody. Paragraph 5.3 states:

> "Debriefings are generally found useful after a death in custody if they provide an opportunity to share experiences, dispel inappropriate feelings of guilt and self-blame and provide reassurance that stress is normal in these circumstances. There must always be a hot debrief immediately after the incident and provision for this should be made in local contingency plans. A senior member of staff must act as debriefer and a duty care team member must also attend."

229. Hot debriefs are commonly conducted in a group setting. However, this would not have been feasible on the night of 20 May, when the staffing level was already minimal. As such, duty governor acted appropriately in speaking to each member of staff individually. Whilst the member from the IMB also offered support to members of staff, no duty care team members attended. The acting SO B from Exeter's care team, sent an email the next morning to the members of staff involved. She was on annual leave but provided her mobile telephone number and the name of the person who was leading the care team in her absence.

The Governor should ensure that Exeter's contingency plan for deaths in custody includes a requirement for a duty care team member to attend.

230. During interview with my investigator, the man's cellmate said he had been asked if he wanted to see a counsellor, and that this had been arranged. He also said that, shortly after the man's death, he had submitted an application to the Governor to ask if he would be allowed to attend the funeral. He told my investigator that, at the time of interview (14 June 2010) he had not received a response to his application and did not know if the man's funeral had taken place. A member from Exeter's business management unit confirmed to my investigator that the man's cellmate's application had not been answered. He eventually received a reply to his application, but only after intervention from my investigator. Whilst I do not make a

Family liaison

231. When my investigator and FLO visited the man's partner, sister, and his ex-partner and son, they expressed concern and disappointment about the family liaison provided by the prison.

232. During his time at Exeter, the man had given his ex-wife's name and address when asked to provide next of kin details. He did this on more than one occasion. As a result, the prison initially treated the man's ex-wife as his next of kin, and travelled to Bristol on 21 May to inform her of his death. Efforts to inform other parties, such as the man's partner, ex-partner, son, sisters and mother were made by telephone.

233. When speaking to my investigator and FLO, the man's ex-partner (and the mother of his son) was particularly disappointed with the way in which she was informed of the man's death. She explained that she had missed a telephone call from the prison chaplain at 1.00pm, and that a further call was arranged for 6.00pm, when she would be home from work. However, before the second call, the man's ex-partner received a telephone call from his ex-wife, who informed her of his death. The man's ex-partner felt strongly that such news should be delivered in person rather than over the telephone, and that the prison should not have allowed a situation to arise whereby she was informed by a third party.

234. The man's sister recounted a similar experience. She said that one of her sisters was informed of the man's death by his ex-wife, and in turn told her mother. She told my investigator and FLO that it was very distressing and hurtful for them to find out about the man's death from his ex-wife rather than from the prison directly.

235. The man's partner was also informed of his death by telephone. She told my investigator and FLO that the prison chaplain left a message for her at 10.00am on 21 May, and later telephoned to break the news of the man's death. She said she was not given any details of how he had died, and nobody from the prison spoke to her again until four days later.

236. PSO 2710 covers deaths in custody. Paragraph 4.2 states that the Governor must:

> "Arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened."

237. There is detailed supplementary guidance about liaison with bereaved family members. Paragraph 4.7 of this document states that:

> "There are opposing views … but the vast majority believe that the first contact must be made directly by the establishment so that the family recognise that the death is a matter of great concern to the establishment."

238. Paragraph 4.9 goes on to outline the recommended option for informing family members. It says that family members should be informed, in person, as soon as possible after the death. Paragraph 4.13 states: "Using the telephone is too impersonal … in delivering news of a death to the family and should only be used as a last resort."

239. Whilst the prison made efforts to inform the man's ex-wife in person, they did not do so for the other parties. With regard to the man's partner, the prison had access to all of the information they needed to inform her in person. The man had written her address on the note that was left in his cell, and it was clear (from the note itself and from his letters and telephone calls, which had been monitored) that they were in a relationship.

240. The situation with the man's ex-partner and with other members of his family was less straightforward, as the prison did not have such easy access to their addresses. The mail monitoring forms contained the relevant information, though it seems this was not considered at the time. There were, however, other options that the prison could have explored, such as attempting to obtain addresses via the police.

241. I accept the difficulties that exist in trying to inform different branches of a family of such difficult news in a sensitive and timely way. However, it does not appear to have been very successful in this case. The guidance for family liaison is clear that the telephone should only be used as a last resort, and there is no evidence that more suitable alternatives (such as deploying staff from a prison closer to the family members) were considered. The prison cannot, of course, control the actions of family members and who else they might tell after they have been informed, though this serves to highlight the importance of delivering news in a timely manner.

242. Although the circumstances were different, my investigation following a death at Exeter in November 2009 highlighted problems with relaying the initial information to family members.

The Governor should ensure that, wherever possible, the initial breaking of news to family members is done in person by prison staff.

243. SO H and SO I were appointed as FLOs on 25 May. On the same day, SO H spoke to the man's ex-wife, his partner and his sister. On 26 May, the two FLOs met with one of the man's sisters after she had identified his body at the hospital. There was initially some confusion about the man's next of kin because, although he had named his partner in the note that he had left, staff at the prison did not know if this was legally binding. SO I telephoned the coroner and was informed that the man's son was his legal next of kin.

244. On 27 May, SO I spoke to the man's partner to inform her that she was not his legal next of kin, and that his property would be given to his son. The man's partner told my investigator and FLO that she did not have any further contact from the prison, despite her ringing and asking someone to contact her. She was left without any information about the specifics of the man's death. My investigator spoke to Exeter about this issue. Exeter sent a letter to the man's partner on 24 August, inviting her to visit the prison.

245. The man's partner and his ex-partner were critical of the efforts made by the prison in terms of ongoing family liaison. The man's ex-partner said that the FLOs had visited once to return property to his son, but otherwise, contact had been minimal. She was also disappointed to find that the information provided by the prison about bereavement support services contained outdated and incorrect telephone numbers.

246. The man's sister said her experience of the ongoing liaison with Exeter had been more positive. She was invited to visit the prison and offered assistance with the funeral costs.

247. The guidance for family liaison officers (supplementary to PSO 2710) contains a section about who should be considered family. Paragraph 3.1 states that:

> "The term 'family' can include 'chosen' as well as 'biological' and can include: husbands, wives, partners, significant others, parents, siblings, children, guardians and others who have had a direct and close relationship with the deceased."

248. Paragraph 3.4 goes on to say:

> "The family may be large, split geographically [or] at odds amongst themselves. Many modern families are split by divorce or separation and there may be several branches all with equal rights to information. The FLO may be able to get the family to nominate a single point of contact who undertakes to keep other family members up to date. This may not always be possible, or may not work in practice, so the FLO should be prepared to deal with different section of one family if necessary."

249. The man's partner, ex-partner and son did not feel supported by the prison, and there is no evidence of ongoing liaison with these parties.

The Governor should ensure that, in accordance with the published guidance (supplementary to PSO 2710), family liaison officers maintain contact with different sections of the family when necessary.

Issues raised by the man's family

250. The man's sister asked my investigator whether the man was able to access sufficient legal support and advice before changing his plea from not guilty to guilty.

251. Until April 2010, the prison employed a legal services officer, whose role was to provide legal advice to prisoners and advise them on who they could contact regarding legal representation. The man was able to see the legal services officer, though there is no evidence to suggest that he did so. However, the man was represented by a solicitor.

CONCLUSION

252. The man was remanded to HMP & YOI Exeter on 8 January 2010. Soon afterwards, he was prevented from contacting his partner, ex-wife, ex-partner and son. The ACCT process was started on 31 January after the man said he would kill himself. He threatened to stop eating if contact restrictions were not lifted, but there is little evidence that he made a concerted effort to refuse food. The ACCT process was closed on 23 February.

253. In April, The man pleaded guilty to the offences with which he had been charged, and returned to Exeter to await sentencing. He was allowed to resume contact with his partner.

254. On 20 May, a number of seemingly unrelated happenings led to the man taking his own life. His cellmate moved out, leaving him alone in the cell. He had a difficult visit from his partner. The evening association period on D wing was cancelled. Nevertheless, the man was not considered to pose a risk to himself, and so I am satisfied that there was no reason for members of staff to monitor him more closely than other prisoner.

255. My recommendations relate to the ACCT process, initial health screenings, food refusal, CCTV and family liaison.

RECOMMENDATIONS

Assessment, Care in Custody and Teamwork (ACCT)

1. The Safer Custody manager should remind staff to complete all elements of the ACCT process, including obtaining next of kin details, within the published timescales.

   The recommendation was accepted. Exeter's governor published a notice to staff on this issue in December 2010.

2. The Safer Custody manager should remind all staff that prisoners should be kept informed about their ACCT status.

   The recommendation was accepted. Exeter's governor published a notice to staff on this issue in December 2010.

3. The Safer Custody manager should remind all staff at Exeter that anyone can and should open an ACCT document if they believe a prisoner poses a risk of suicide or self-harm.

   The recommendation was accepted. In addition to the governor's notice to staff issued in December 2010, the point will be reiterated in ACCT foundation and case manager training.

Clinical care

4. The healthcare manager should ensure that, in accordance with the initial health screening document, all prisoners who declare previous mental health problems have the more detailed mental health questionnaire completed.

   The recommendation was accepted. The healthcare manager will ensure that all prisoners declaring previous mental health problems have the more detailed questionnaire completed.

5. The healthcare manager at Exeter should remind clinical staff to record a prisoner's weight as part of the initial health screening.

   The recommendation was accepted. The healthcare manager will ensure that the weight of prisoners is recorded as part of initial health screenings.

Food refusal

6. The healthcare manager should ensure that prisoners who are refusing food and/or fluids have their weight recorded on a weekly basis.

   The recommendation was accepted. The healthcare manager will ensure that this is incorporated into care plans.

Closed circuit television (CCTV)

7. The Governor should ensure that the CCTV system is properly maintained and appropriate members of staff are fully trained in its use.

The recommendation was accepted. CCTV in all areas will be included in the weekly management check. Key personnel will also be trained in the use of the CCTV system.

Support for staff and prisoners

8. The Governor should ensure that Exeter's contingency plan for deaths in custody includes a requirement for a duty care team member to attend.

The recommendation was accepted. Exeter's contingency plan states that a staff care team representative should be present at the hot debrief.

Family liaison

9. The Governor should ensure that, wherever possible, the initial breaking of news to family members is done in person by prison staff.

The recommendation was accepted. This is now part of the death in custody contingency plan.

10. The Governor should ensure that, in accordance with the published guidance (supplementary to PSO 2710), family liaison officers should maintain contact with different sections of the family.

The recommendation was accepted. This will be included in the terms of reference for family liaison officers.