Investigation into the death of a man at HMP Exeter in July 2009

Report by the Prisons and Probation Ombudsman for England and Wales

June 2010

This is the report of an investigation into the circumstances surrounding the death of a man. He was found hanging in his cell and died four days later without regaining consciousness. He had been in prison for less than a fortnight. I offer my sincere condolences to his family. I apologise for the delay issuing this report and any additional distress it may have caused them.

The man had struggled with alcohol and substance misuse for several years. His addiction was at the root of his offending behaviour and he was not a stranger to prison. His addictions also affected his health. He suffered from depression and attention deficit hyperactivity disorder (ADHD) and in 2008 he required hospital treatment for an infection in his heart.

The investigation was led by one of my colleagues. The Ombudsman's appointed a family liaison officer. She acted as a contact point for the man's mother during the investigation.

A clinical reviewer from the local Primary Care Trust undertook a clinical review into the medical care received by the man in Exeter. I am grateful to him for his assistance. I am also grateful to the liaison officer for Exeter prison and to the staff and prisoners at Exeter for their co-operation with this investigation.

The man received a high standard of care while at Exeter. I am pleased to say that the emergency aid offered to him was exemplary. I am however critical of the unacceptable standard of family liaison provided by Exeter. I make five recommendations and highlight two areas of good practice.

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

Jane Webb
Acting Prisons and Probation Ombudsman **June 2010**

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SUMMARY

The man was a 37 year old man who had been addicted to alcohol and illegal substances for many years. He suffered from attention deficit hyperactivity disorder (ADHD) and depression. He was arrested on 22 June 2009 and remanded into HMP Exeter on 24 June. He had three children. At the time of his arrest he was not allowed access to his children, a fact which distressed him greatly.

In Reception at Exeter the man expressed anxiety that he would be at risk from other prisoners. He explained that he had given evidence at a trial several years ago in his local community and he was worried that he would be regarded as a ”grass”. He remained anxious about this for the duration of his time in Exeter.

The man was located in cell B3/1. This cell is close to the wing office and allowed staff the opportunity to observe him. Wing staff told the investigator that they did not see any other prisoners go to his cell or harass him in any way. One officer who had known him on previous sentences told the investigator that his behaviour was very different on this sentence. He described him as very anxious, with obsessive and paranoid thoughts. He had not tried to harm himself when he was in prison before.

A prisoner who spent the most time with the man between 24 June and 4 July, told the investigator that the man was anxious to obtain a newspaper clipping that he said proved he was not a ”grass”. He said the man was worried about other prisoners but he had not thought he was at risk of harming himself.

The man was examined by three doctors and four members of the primary care nursing staff during the 12 days he spent in Exeter. The clinical review concludes that the clinical care he received was appropriate. The review makes a single recommendation about the legibility of entries in the clinical record.

At about 3.45pm on Sunday 5 July, the man was found hanging from his cell light by his shoelaces. Staff responded in a timely and highly effective manner. He was not breathing when he was found but staff and paramedics managed to re-start his heart. He was taken to hospital but sadly he died there without regaining consciousness.

Wing staff and prisoners on B wing reported that they had received appropriate support in the aftermath of the man’s death. I raise a concern that healthcare staff may not have the same level of care extended to them.

I am satisfied that the man was looked after well by wing staff and healthcare staff. I conclude that his attempt to hang himself could not have been reasonably foreseen or prevented by staff. Unfortunately the liaison provided to the man’s mother by the prison was not of a high standard. The family found it hard to contact their liaison officer and a delay in the prison paying for the funeral meant they were subjected to unwelcome intrusion from the undertakers at a very difficult time for them. I make a recommendation that I hope will help to prevent such events from occurring after any future deaths at Exeter.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 9 July 2009. The investigation was allocated to an investigator the same day. Notices were issued to staff and prisoners at Exeter telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. She wrote to the Coroner and spoke to a Detective Sergeant from Exeter CID.

2. The investigator visited Exeter on 15 July. She met with the Governor, the prison liaison officer, and a Detective Sergeant. She visited the cell where the man hanged himself and spoke informally to staff. She collected copies of his prison record and copies of other records associated with his death.

3. The investigator returned to Exeter on two occasions in July and November 2009 and interviewed 13 members of staff and three prisoners. She also spoke by telephone to a substance misuse nurse who had worked with the man in the community.

4. A clinical review of the man's medical care was commissioned from the local Primary Care Trust (PCT). The clinical reviewer, a General Practitioner employed by the PCT, undertook the review. His report appears as an annex to this report.

5. One of the Ombudsman's family liaison team contacted the man's mother by telephone. She explained the nature and purpose of the investigation and invited the family to ask any questions or raise any issues about the man's time in Exeter prison. The man's mother did not raise any concerns about his treatment in Exeter but said she was upset, angry and frustrated by the failure of services in the community to section him under the Mental Health Act for his own safety. She said that prior to being sent to HMP Exeter she had been extremely concerned about his mental health.

6. The man's mother said she was upset that no member of staff from Exeter had attended his funeral. She had found the contact she had with one of the prison chaplains at the hospital very helpful. She also experienced great difficulty in contacting the prison to arrange payment of the funeral expenses. The prison had properly offered to meet the cost of the funeral but a subsequent lack of communication from the prison family liaison officer led to her receiving frequent and distressing requests for payment from the funeral directors. Despite the best efforts of the Ombudsman's family liaison officer to contact the prison family liaison officer the situation was only resolved when another of my investigators who was visiting the prison spoke directly to him.

7. In response to the draft report, the man's mother commented that she felt strongly that information highlighting that he was at risk of self-harm should have accompanied him to prison. The family believe that this lack of information sharing was a significant failing on the part of the community agencies involved with his care.

HMP EXETER

8. HMP Exeter is a Victorian prison dating back to 1850. It is located near the city centre and holds adult male remanded and convicted prisoners and young adult males between the ages of 18 and 21 on four wings. The prison has an operational capacity (maximum overcrowded capacity) of 533. It is designed in the Victorian radial style with wings going out from a 'centre'. There is an office on the centre that is used by the orderly officers who are responsible for the daily operation of the prison. B wing, where the man was located, is the induction and first night centre. There is a large purpose built healthcare centre with 21 in-patient beds.

9. In her report of an unannounced follow up inspection in October 2007, Her Majesty's Chief Inspector of Prisons found that Exeter was experiencing many of the pressures of an overcrowded prison system. She reported that population pressures meant that not all new prisoners could be held on the first night centre. The investigator found that staff continued to be frustrated by this in July 2009. They were concerned about the impact overcrowding was having on their ability to keep new prisoners properly supported during their initial period in custody.

10. In their 2008 report (the most recent one published) the Exeter Independent Monitoring Board (IMB – a group of independent volunteers who monitor life in their local prison), concluded that there were a number of dedicated and professional staff working at Exeter and that staff/prisoner relations were good. The IMB remarked too that the combination of Victorian buildings and high prisoner numbers provided enormous challenges for staff to keep prisoners safe and purposefully occupied.

11. There have been six apparently self-inflicted deaths at Exeter since the Ombudsman assumed responsibility for investigating all deaths in prison in 2004. One of these occurred since the man died, in November 2009. In the reports of the two apparently self-inflicted deaths immediately before his death, in 2007, I recommended that a hot debrief be held in the aftermath of a death in accordance with PSO 2710 and PSO 8150, an emergency code system be introduced and that prisoner's previous medical records be sought to improve continuity of care. I am pleased to see that all three happened in this case.

KEY EVENTS

12. The man was arrested on 22 June 2009 and taken to a Police Station. He appeared at Magistrates Court on 24 June. The prisoner escort record (PER) form showed risk indicators for drug/alcohol addiction, self-harm, violence and health. The explanation section reads, “previous for self-harm, claims to be on Warfarin”. (Warfarin is an anticoagulant used to prevent blood clots.) The man was remanded into custody and taken to Exeter prison the same day.

13. On arrival at Exeter, the man was taken to Reception where a nurse completed his first reception health screen. He told the nurse that he had been homeless for the previous year. He had last been in Exeter in June 2008. The man said that he had seen a doctor and was being treated for depression and ADHD. He said he was taking dexamphetamine (for ADHD), aspirin and Warfarin. He said that his community nurse worked at the headquarters of the Drug and Alcohol Team.

14. The man had a black eye and told the nurse that this had happened during his arrest by police. He also reported chest pain and said this was because he had a “hole in his heart valve”. He told the nurse that he had spent a month in hospital because of his heart problems. Despite this he is recorded as saying that he had no concerns about his health. He admitted to drinking four to six litres of cider daily but said he no longer used drugs. He said he was not receiving any medication for any mental health problems and said that a psychiatrist had confirmed he was of sound mind at a child custody hearing on 17 June.

15. The man said he was very angry but denied any suicidal thoughts. The nurse recorded, “inmate appears angry at present, difficult to express his feelings”. In the planned action section (of the first reception health screen), he referred the man to the prison doctor (because of his physical health) and to CARATS (counselling, advice, referral and throughcare service – the service which provides the non-clinical treatment needs for prisoners with substance misuse issues) for his substance misuse. The nurse wrote that the man could share a cell but “with discretion as angry at present”.

16. The nurse and an officer completed a Cell Sharing Risk Assessment (CSRA) form for the man. The officer wrote that the man was fearful for his own safety and feeling stressed and agitated. He was offered the opportunity to be located on the vulnerable prisoners wing but declined. The officer concluded that the man presented a high risk to anyone sharing his cell. The nurse also concluded that the man presented a high risk to a cellmate. He wrote on the form that he appeared very angry, feared for his own safety and wanted to be located as a vulnerable prisoner. Because of the high risk rating the form was then referred to the duty reception officer. The duty reception officer concluded that the man needed a period to calm down as he was very angry and could be a danger to others. He was recommended for a single cell.

17. Also whilst he was in Reception, the man signed a consent form allowing staff in the Devon Prison Health Partnership to contact agencies in the community and obtain information about his healthcare prior to entering prison.

18. Immediately afterwards the man was reviewed by a prison doctor. The doctor completed an initial medical assessment form. He wrote that the man had drunk to excess for "a long time". The man told him that he had suffered fits when he had stopped drinking previously. The man said that he had a hole in one of the valves in his heart and had suffered "mini strokes" in 2008. He said that he was taking Warfarin (but did not know the dose), aspirin and dexamphetamine. He described the Warfarin capsules as green and yellow. The doctor wrote on the record that this did not sound like Warfarin. He diagnosed the man with an apical systolic murmur. (Heart murmurs are relatively common but can indicate heart disease. It is not clear from the records what grade of murmur he had.) The doctor recorded that the man had a black eye and bruising to his cheek. He wrote on the record, "not suicidal" and "says he has worries about other inmates".

19. The doctor also made an entry on the man's continuous clinical record. He prescribed a week of alcohol detoxification and asked for his heart problems and the information he had given about his prescriptions for Warfarin and dexamphetamine to be confirmed with agencies in the community.

20. The man was then taken to the First Night Centre where a second officer completed the remainder of his first night reception documentation. He said that he had self-harmed two years previously by attempting to drown himself. He said that he felt at risk of self-harm and was very concerned about being in custody. The officer noted that he became agitated when talking about other prisoners being "after him". She asked him whether he wanted to be located on the vulnerable prisoners wing but he declined. She made an entry in his wing history file:

    "Very angry and agitated. Claims he gave evidence against someone years ago and now everyone from Cornwall is after him. Could not give any names …"

21. The next day, on 25 June, a third officer wrote on the wing history sheet that the man appeared to have calmed down but had re-iterated his concerns that he was at risk from other prisoners.

22. The man completed his day one induction. As part of his induction he was interviewed by a worker from the CARATS drug and alcohol service. He also spoke to a woman from Choices Consultancy which is a voluntary organisation that provides family services in the Devon cluster of prisons. Volunteers speak to prisoners on first reception to identify any family issues and offer appropriate support. The third person he spoke to was a Listener. (Listeners are trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress. In Exeter Listeners are deployed in the First Night Centre as part of the prison's suicide prevention strategy.) The man told the woman from the consultancy that he had given evidence against a man 14 years previously and

other prisoners had already approached him about this. The Listener wrote that there were "no concerns" raised by his conversation with the man.

23. The man was located in cell B3/1. Staff told the investigator that they allocated that cell because it was near to the office and gave them more opportunity to observe him and to see whether he was bothered by other prisoners. The cell contains a camera which transmits pictures to an office on the 'centre'. This office is not routinely occupied except by the Night Orderly Officers and there is no guarantee that anyone will be looking at the pictures transmitted from the cell. Staff told the investigator that the man was told that the camera was not watched. There is a sign on the wall below the camera in the cell that explains this.

24. Also on 25 June, the substance support nurse manager received a fax from the man's community nurse. She had sent the fax late in the afternoon of 24 June, after the nurse manager had finished his shift. She said that the man was prescribed 60ml of dexamphetamine daily and he had last collected his prescription for doses for 20 and 21 June, on 20 June. She said that he had suffered form endocarditis (an inflammation of the inner layer of the heart) in December 2008 and had been an inpatient at hospital. However, he had missed several outpatient appointments. His local doctor prescribed him aspirin and Ramipril (used to treat hypertension and congestive heart failure) daily and he had received a 28 day supply of these medicines on 23 June. She added that he had "stated suicidal intentions" when he was remanded on 24 June.

25. The nurse manager made a record of the information received in the man's continuous clinical record. He telephoned the community nurse the same morning. She told him that the man had episodes of impulsive aggression and was therefore always visited by two staff. The nurse manager noted the man's continuous clinical record, made an entry in the significant events section and put a red star on the front of the clinical record to indicate that he might be a risk to staff.

26. At 2.30pm the same day, the man had an appointment with a second prison doctor. This was made following confirmation from the community nurse that he had been prescribed dexamphetamine in the community. However, the doctor wrote on the clinical record that she was unable to prescribe dexamphetamine because he had not been given a urine test on reception. He was given a urine test at 4.30pm and then saw the doctor again. He told the doctor that dexamphetamine made him less paranoid and analytical and he was able to 'switch off' better. He thought that he last took a dose of dexamphetamine on 21 June. The doctor wrote that his urine had tested negative for amphetamines and prescribed a dose building up to his previous level over the next four days. The doctor also wrote that he told her he was anxious and worried about being on the main wing. However, he was able to 'keep to the interview' and had no psychotic symptoms.

27. On 28 June, the man completed a wing application form. He asked to see the Governor as soon as possible. He wrote:

> "My mental health is in a state, inmates are tormenting me and I think staff are great, but I still think things will happen to me I do not deserve. Of course I'm paranoid as I've seen what happens in prison. I have a heart condition spent 2 months in hospital recently, 37 years old."

The form shows that it was passed to the Mental Health In-reach Team and was received by them on 29 June.

28. Also on 29 June, the man was interviewed by the Offender Management Unit as part of the Protective Factors Interview/Custody Plan. This document is designed to ensure that assessments are completed on prisoners within five days of coming into custody with a view to identifying appropriate positive supports. The conclusions of the interview are entered on an electronic tracking system. According to the form completed on him his mental health "anxiety" was noted but not considered to be a "pathway concern" (meaning it did not warrant further action by Offender Management). His use of alcohol was considered to be of concern and it was noted that he had been referred to CARATS.

29. The following morning on 30 June, the man attended a Well Man Assessment with a Healthcare Assistant (HCA). The HCA wrote that he was "feeling really low and tearful". She referred him to the cardiac clinic, the prison doctor and (again) to CARATS. At interview she was unable to remember him.

30. That afternoon the man was interviewed by a second CARATS worker. She recorded that he, "seems very stressed about his whole situation". He told her he thought he was coping "OK". He said that landing staff thought he was paranoid about other prisoners accusing him of being a "grass". He told her that the wing staff kept asking him if he was going to hurt himself. He also told her about his heart complaint. She contacted healthcare and was told that he was due to be seen in the cardiac clinic shortly. After the interview she asked wing staff about his concerns about other prisoners and they told her that they had seen no evidence that he was being bothered.

31. At 4.00pm, shortly after the second CARATS worker spoke to the man, he was examined by the nurse manager and a nurse in his cell. He had failed to attend his appointment in the cardiac clinic in healthcare that morning and so they visited him in his cell. The clinical record shows that wing staff had told the nurses that they felt that he was "not well". The nurse manager wrote that the man presented initially as calm and settled but became more agitated when discussing his stay in prison. He said the man expressed paranoid thoughts but was "able to rationalise the process" behind his thoughts. He became more agitated when explaining that the wing officers did not believe he was at risk from other prisoners. The nurse manager concluded that the man did not present paranoid ideation without apparent evidence. He also completed the final reply section of the application form completed by the man on 28 June. He said the man had been seen in his cell and a note made in his clinical record.

32. On 3 July, the man attended court and was again remanded to custody. When he returned to Exeter he said his solicitor had advised him to ask to see a member of healthcare staff. A Registered Metal Health Nurse (RMN) interviewed

him. She wrote in the clinical record that he told her he had received threats to kill him on the wing and could not return there. He said he was feeling stressed but had no thoughts of suicide or self-harm. She said he appeared calm when discussing his problems. At interview she told the investigator that he appeared relaxed and made good eye contact. She checked his pulse and remembered that he did not feel clammy. She did not think he had any medical need that meant he should be located in the healthcare centre. She discussed his situation with discipline staff afterwards and thought that they located him in a camera cell on B wing. In fact he returned to cell B3/1 where he had been located since arriving at Exeter.

33. During the afternoon of the next day, Saturday 4 July, the third officer and a Senior Officer (SO) became especially concerned about the man's mental health. The officer told the investigator that he remembered the man from previous sentences he had served at Exeter. He said that his behaviour was very different to how he remembered him. The man seemed paranoid that other prisoners were "out to get him" and obsessed with the need to get hold of a newspaper clipping that proved he was not a "grass". The officer said that the man had been much more distressed since returning from court on 3 July and he was especially concerned by his behaviour on 4 July. The SO said that the man could not tell him who wanted to harm him or whether they had approached him. He told the SO that he did not feel safe and wanted to be transferred to the vulnerable prisoners wing. However he changed his mind when he realised that even as a vulnerable prisoner he would not be moved from B wing. (Because of overcrowding and the number of vulnerable prisoners, the vulnerable prisoner wing was full and the overspill was being located on B wing.)

34. The third officer discussed the man's behaviour with the SO and they decided to ask a third prison doctor to come to the wing to examine him. By coincidence, before he went to see him, the doctor asked the RMN where he could find the man's clinical record and she was able to tell him about her interview with him the previous day.

35. The third prison doctor talked to the man in his cell at 3.30pm. He wrote in the clinical record that he did not display any signs of acute psychosis. He had some paranoid thoughts but these were grounded in rational feelings. The doctor said the man had no thought disturbance but asked to speak to him again the following week so he could decide whether a referral to the psychiatrist was appropriate. The doctor spoke briefly to the third officer to tell him that he felt the man was suitable for normal location and did not require any intervention from healthcare.

36. At approximately 1.50pm the following afternoon the third officer asked the man if he wanted to come out of his cell for the exercise period. He said he did not and the door was closed. At approximately 3.44pm, the officer began unlocking the cells on B wing for prisoners to collect their teatime meal. When he looked through the observation flap of the man's cell he saw him suspended from the light switch with his feet off the floor.

THE PRISON'S RESPONSE TO DISCOVERING THE MAN HANGING

37. The incident log shows that the SO made an emergency call from B wing at 3.44pm. He said the emergency was Code Blue which means someone is having difficulty breathing. The call was acknowledged immediately by a PO (the orderly officer) and the duty governor. At 3.46pm an ambulance was called and it arrived at the prison gate at 3.52pm. By 3.54pm the ambulance was in B wing yard and the paramedics were in the man's cell.

38. When he saw the man hanging, the third officer shouted for assistance and entered the cell. He supported the man's weight and a fourth officer cut through the shoelace the man had used as a ligature using his cut down tool. The officers laid him on the cell floor and the fourth officer used his knife to remove the rest of the ligature from the man's neck. The fourth officer said that the man's body was lifeless and he was blue in colour. He said he could not detect a pulse. A second SO had arrived in the cell by this time and he started emergency breaths while the fourth officer started chest compressions. The officer thought that he had gone through about ten to 15 cycles of compressions when the nurse entered the cell and took over from him.

39. The nurse said that he was working in the C wing treatment hatch when he heard a Code Blue call to his call sign on the radio. He immediately closed the hatch and used his radio to verify the exact location of the emergency. He said he realised that the incident must be serious because the prisoners were being asked to return to their cells. The nurse arrived at the man's cell and felt his brachial artery for a pulse. (The brachial artery is in the arm above the elbow joint. The nurse felt there for a pulse because there had been trauma to his neck.) The nurse could not feel a pulse. He then took over chest compressions from the fourth officer while the second SO continued emergency breaths through a mask. The nurse said they worked in a cycle of 30 compressions to two breaths at a rate of 100 compressions per minute.

40. A second nurse said she was working in A wing treatment hatch when she heard a Code Blue emergency call on her radio. Shortly afterwards she heard a call for A wing prisoners to be returned to their cells and realised that there must be a major incident. The Primary Care healthcare manager told her that he would collect the emergency bag and so she collected the defibrillator from the centre and went to B wing. On her way she saw the first nurse running up the spiral staircase ahead of her. The healthcare manager arrived at the man's cell almost at the same time and oxygen was given to the man using an ambu-bag. The second SO then attached the defibrillator to him and the machine advised to continue with CPR. (A defibrillator will only advise a shock if a heart rhythm can be detected.) The nurse and the SO continued CPR until the paramedics arrived and took over from the SO. After several more cycles of CPR a pulse was registered and the nurse stopped compressions. Oxygen was continued and the man was taken to hospital by ambulance.

41. The Principal Officer (PO) was the orderly officer on Sunday 5 July. He said that he was on the centre with two SOs when he heard the Code Blue on the radio. He said he immediately sent both of them to B wing. He used the tannoy system

to request that all prisoners be returned to their cells. He then went to B wing where he found staff giving the man emergency aid. The nurse told him that the man was not breathing so he used his radio to order a 999 call for an ambulance. He left the cell when the paramedics arrived and made arrangements for two officers to escort the man to the hospital. He then checked that the two officers were alright before returning to the centre and ordering staff on A and C wings to resume unlocking prisoners for their teatime meal.

42. Although the man was alive, his condition was critical and so the prison's death in custody contingency plans were followed. All the relevant people in the National Offender Management Service (NOMS) were contacted.

43. Once prisoners on A and C wings had eaten their meal and been given their medication, staff were sent to B wing to help give those prisoners their meals and medication. A chaplain visited two prisoners who were in the cell opposite the man and who had witnessed him hanging when the third officer opened the cell. A count of all the prisoners was agreed and the duty governor supervised a hot debrief for staff who had been involved in the discovery and resuscitation of the man. All prisoners on open ACCT forms (the document used by NOMS to monitor prisoners thought to be at risk of suicide and self harm) were checked later the same evening.

44. Contact with the man's next of kin was discussed by the duty governor and the chaplain. As he was still alive it was decided to ask the family's local police to visit them as soon as possible. The police eventually contacted his mother in the late evening and she and his two sisters travelled to the hospital as soon as possible. A second chaplain visited the hospital daily and spent time with the man's family. The Governor also went to the hospital on two occasions but unfortunately missed the family on both occasions.

45. The second chaplain was with the man's mother and sisters when he died. On the following Sunday he incorporated a memorial service for him into the regular service in the prison chapel.

WHAT OTHER PRISONERS SAID

46. A prisoner said he had occupied the cell next door to the man until 4 July. He thought he was the prisoner who had been closest to him during his time in Exeter. He said that he had said hello to him when he arrived on the wing. He saw other prisoners giving the man "bad looks" and thought that this was because someone had spread a rumour that he was a "grass". The prisoner said he had spoken to the man about these rumours and said that he did not believe they were true. He said the man had spent some time and energy arranging for his ex-wife to send a newspaper clipping into the prison that he thought proved that he was not a "grass". He said that the man had asked him to show the clipping to other prisoners but had actually done so himself.

47. The prisoner said he and the man used to sit in his cell and share cigarettes. He said the man showed him pictures of his children. He said he thought the man was upset about his poor relationship with his "missus" as this meant he had trouble seeing his children. The prisoner said that the man obviously thought the world of his children.

48. The prisoner described the man as a "nice fellow" and said they got on very well. He knew he was "down" but did not know what about, apart from the gossip and not seeing his children. He said he thought the man felt he was at risk of being "jumped by kids from Redruth" but did not think he was at risk of self-harm. He said the man never talked to him about "topping himself" and his death had come as a great shock to him.

49. The prisoner said there was a camera in his cell on B wing. He said there was a notice on the wall below it that made it clear that the camera was not being watched all the time. He said staff had also explained this to him when he was in that cell. He did not remember the man talking about the camera in his own cell. The prisoner said he was very sorry that the man had killed himself and said he would like his condolences to be passed on to the family.

50. A second prisoner said it was his first time in prison and he had only been in the prison some two weeks before the man attempted to hang himself. He said that as far as he could remember he had not seen or spoken to him on the wing. He was not aware of any rumours about him or bad feeling towards him. The prisoner said he occupied the cell opposite the man on B3 landing. He shared this cell with another prisoner.

51. On 5 July 2009, the second prisoner said an officer unlocked his door and then unlocked the man's cell. He heard the officer call for assistance. He looked across and saw the man hanging from the light fitting. The prisoner said that very quickly his own door was shut and the observation flap was closed. He said he could still see out of his cell through a gap in the door and he saw officers working on the man giving him CPR.

52. The second prisoner said that "the female chaplain" had come to see him later that day and that B wing officers asked him regularly "for several days after" if he was alright. He said he felt he had been adequately supported. He could not

remember how other prisoners were told about the man's death but said that the wing was kept up to date with his condition in hospital.

53. A third prisoner said he had been in the cell opposite the man on B3 landing for about a week. He said he had spoken to him and he had seemed "alright but sometimes a bit distant". He said he thought the man had seemed a bit "up and down" in his moods. The prisoner said he had heard a rumour about the man but he had not seen any other prisoners picking on him or arguing with him. He thought that he had seemed "a bit paranoid". He saw him once in his cell sitting on the bed rolling a cigarette and looking miserable. The prisoner said he had thought the man might not have been alright on 5 July because he said he had not wanted any dinner or exercise. He also thought there was something "up with him" because he was in a single cell with a camera and close to the wing office. He spoke to him during the morning of 5 July about his canteen sheet and described this as a "normal interaction".

54. On 5 July, the third prisoner said he remembered the third officer unlocking his cell and then going over to the man's cell. He said the officer looked through the man's observation flap, shouted "he's topped himself", used his radio to call a Code Blue and then unlocked his cell and went inside. The prisoner said he saw the man hanging from the light in his cell. He said he thought he was "gone". He said he saw his bin lying on its side and rubbish over the floor of the cell. He said he saw the officer support the man and another officer cut him down. He saw the officer start to work on the man's chest. When other officers arrived on the wing he was locked in his cell. He said he thought that the officers had "done a good job" trying to revive the man.

55. The third prisoner said that the staff at Exeter had been "brilliant". Two nurses and a vicar had seen him the same day and the wing officers still asked him if he was alright. He said he had seen a chaplain again only two days before the investigator interviewed him.

ISSUES CONSIDERED DURING THE INVESTIGATION

The management of the man's risk

56. A number of documents in the man's prison record indicate that he was at risk of self-harm or suicide. The PER form completed by the police for transfer from the police station to the magistrates court informs us that he said he had attempted to kill himself two years previously by drowning. As far as I have been able to establish, this is the only reference to an attempt of self-harm or suicide in his history. During his previous sentences at Exeter he had no history of such behaviour and had not been identified as at risk in prison.

57. Apparently the man spoke to someone at court on 24 June and told her he felt suicidal. I have not seen a PER for his journey from court to prison on 24 June but this was referred to by the community nurse in her fax of 24 June. Unfortunately the member of staff in question went on long term sick leave shortly afterwards and the investigator did not speak directly to her. The investigator did speak to the community nurse who reported that her colleague had said that the man was anxious about going to prison. She had known the man for several years but had no knowledge of any attempt by him to drown himself. She said that he had a history of unpredictable behaviour and mood swings but not of self-harm or suicidal thoughts.

58. The man was consistent in his responses to the question of whether he felt like harming himself. He told the nurse and the first prison doctor at his reception healthscreen that he was angry, stressed and anxious about being in prison but denied he was suicidal. The first night paperwork completed by the second officer indicates that he was feeling suicidal and he told her that he had tried to drown himself two years previously. However, the discussion was overwhelmingly about his anxiety about other prisoners and shortly afterwards he raised no concerns with either the volunteer from Choices Consultancy or the Listener in Reception. He was reviewed during the remainder of his time in Exeter by two other doctors, three other nurses and a healthcare assistant. He was also interviewed by a CARATS worker and trained ACCT assessor. She in effect took him through a basic ACCT assessment in this interview. She also spoke to wing staff and healthcare staff immediately afterwards. This is good practice. On each occasion he was spoken to, he denied feeling suicidal. I am therefore satisfied that his actions on 5 July could not have been foreseen or prevented.

The CARATs worker follow up of the man's concerns (with wing staff and healthcare staff) is good practice.

59. At every opportunity, whether talking to staff or prisoners, the man said that he was anxious about being in prison because he felt other prisoners were "out to get him". He put this down to the fact that he had appeared as a witness in the trial of a man from his community some years previously. At no point did he name any of the prisoners who he thought were after him nor did he mention any specific incidents when he had been threatened, harassed or bullied. Neither the prisoner who spent most time with him in Exeter nor wing staff ever witnessed

any such incidents. He might have had good reason to be concerned for his safety but I have seen no evidence to suggest that any other prisoners posed a threat to him.

60. There is evidence that staff took the man's anxieties seriously. They put him in a cell that was easily observed from the wing office and made efforts to check if anyone approached his cell. Despite the issues of overcrowding at Exeter and the pressure on places on B wing, he was kept in the same cell throughout his time at Exeter.

61. When he returned from court on 3 July, the man discussed accepting vulnerable prisoner status. After discussion with B wing staff it was thought that it was better to keep him close to the staff who knew him. In his application form of 28 June, he acknowledged that staff were "great". He told his CARATS caseworker on 30 June that wing staff asked him regularly if he was going to hurt himself. I am satisfied that staff exercised their duty of care to him and that it was reasonable to assess that he was not at risk of suicide.

62. There appears to be some confusion among healthcare staff about the use of the in-cell cameras on B wing. Wing staff are clear that, although his cell contained a camera, he was not placed in that cell for that reason but because of its proximity to the wing office. The first prisoner, who occupied the cell next to him, which also contained a camera, told the investigator that it had been explained to him that the camera was not watched and there was a sign below it that made this clear.

63. I have seen no evidence that the man thought that he was being monitored for his own safety. (He did tell the second nurse and the nurse manager on 30 June that he thought he was being watched through his toilet screen but was vague about who was watching him and whether he was being watched all the time.) The RMN appears to have been left with the impression that he was being monitored in a camera cell after she spoke to staff in reception when he returned from court on 3 July. The clinical reviewer was also under the impression after interviewing the doctors that the man was being monitored in a camera cell. The SO told the investigator that he had had to explain to healthcare staff on past occasions that the cameras were not used to watch prisoners thought to be at risk.

64. In order to make informed decisions about the safety of prisoners' healthcare staff need to be aware that the cameras in the cells on B wing are not routinely used to monitor prisoners.

I recommend that the Head of Healthcare issues a notice to all healthcare staff informing them that the cameras on B wing are not routinely used for monitoring prisoners and the cells are not used as 'camera cells' or specifically for prisoners thought to be at risk of self-harm or suicide.

This recommendation was accepted by NOMS at draft report stage.

The clinical care offered to the man

65. The clinical reviewer's review appears in full at annex one of this report. The doctor praised the admission process at Exeter and the fact that his exact medication was confirmed before he was prescribed any drugs. He also concluded that the man was reviewed a number of times by healthcare staff in Exeter and therefore there was ample opportunity for him to share his feelings with staff. He makes two recommendations which I endorse.

66. I should like to add that I was impressed by the number of times the man was reviewed by healthcare staff during a relatively short period. The quality of the entries in the clinical record made by the nursing staff was also high. In particular I consider it was good practice for the nurse manager to telephone the community nurse after receiving her fax. Although the fax contained useful information, the telephone call elicited even more – including the fact that the man was subject to impulsive outbursts of aggression and was always visited by two members of staff together. Although he did not present a threat to staff in Exeter it is nevertheless important that staff are aware of this type of behaviour, not only for their own safety but also for that of the prisoners in their care, some of whom might be expected to share his cell.

    The telephone call from the nurse manager to the community nurse was good practice.

The response to finding the man hanging

67. I am satisfied that staff responded appropriately to the discovery that the man had attempted to kill himself on 5 July. The third and fourth officers acted promptly to remove the ligature and place him on the floor. The fourth officer Winfield, the second SO Cole and the nurse provided emergency aid in accordance with the latest guidance from the Resuscitation Council. Chest compressions and breaths must be done properly to stand any realistic chance of reviving a person whose heart has stopped. The fact that the man's heart was restarted is testimony to the high quality of emergency aid given by Exeter staff. Unfortunately it appears his brain had been without oxygen for too long for him to have survived.

68. All the emergency equipment was in working order and was taken to the man's cell in a timely manner. Paramedics were at his cell only ten minutes after he was discovered. I am satisfied that the prison staff did all that was possible to save his life.

69. I consider that the management of the emergency on 5 July by the duty governor and the PO was efficient and timely. Staff reported that it was very difficult to be expected to complete their shifts before being allowed home. I have great sympathy with them. Unfortunately, when emergencies of this nature occur at weekends or at night, current staffing levels do not allow for cover to be provided. Neither is it within my gift to remedy this situation. It is therefore very important that staff are properly supported in the aftermath of these traumatic events. I am pleased that all the discipline staff told the investigator that they had felt

appropriately cared for by colleagues, the chaplaincy and the care team. All the staff found the hot debrief led by the duty governor very helpful.

70. I am disappointed however that this level of support does not appear to have been extended to all the healthcare staff who tried to save the man's life. One nurse said she had spoken to the first SO and the PO on the day but had not been approached by the care team or by managers then or in the days following. Unfortunately, I have heard the same experience reported in other cases investigated by the Ombudsman.

    I recommend that, in the light of the feedback received from healthcare staff during this investigation, the Governor and the Head of Healthcare ensure that systems are in place to offer appropriate support to all staff involved in fatal incidents.

    This recommendation was accepted by NOMS at draft report stage.

71. I am also pleased that the prisoners on B wing interviewed by the investigator told her that they had been kept informed of the man's condition and had regularly been asked about their wellbeing. I note too the active role of the chaplains in offering support to staff and prisoners after the sad events of 5 July.

72. The exception was the prisoner who probably spent most time in the man's company in Exeter. He was moved to a different wing the day before the man attempted to kill himself. When the investigator interviewed him he told her he had been unaware of his death until he received her letter inviting him for interview.

73. The prisoner was on an open ACCT form for reasons unrelated to the man's death. He was understandably upset by the manner he heard about his death. I understand that the acquaintance between the man and the prisoner was recent and of short duration. I also understand that in a busy and overcrowded local prison where there is huge pressure on spaces in the first night and induction centre, it is impossible for staff to keep track of every prisoner friendship. However, 12 days is long enough on one wing for prisoners to form bonds. Also the man was a local man in a local prison where he had served sentences before and therefore it is likely that he may have had other friends of longer standing elsewhere in the establishment. It is important that news of a death in custody is disseminated throughout the wider prison.

    I recommend that the death in custody contingency plan at Exeter is amended to ensure that the Governor's notice to prisoners informing them of a death is put up on every wing.

    This recommendation was accepted by NOMS at draft report stage.

74. In previous reports into two apparently self-inflicted deaths at Exeter in 2007 the Ombudsman made three recommendations which are relevant to the circumstances of the man's death. The first was that the healthcare manager and PCT initiate a procedure for obtaining a prisoner's consent to the disclosure

of confidential medical information about them, secondly a colour code system was to be introduced for use in emergency situations and finally that a hot debrief should always take place after a death. I am very pleased to see that all of these measures were in place in this case.

Family liaison and issues raised by the man's family

75. The man's mother told the Ombudsman's family liaison officer that she had a number of concerns about the treatment her son had received in the community. She said that she had been extremely worried about her son's mental health in the period leading up to his remand in custody. She had tried to persuade community mental health staff to have him compulsorily admitted to hospital under the Mental Health Act for his own safety. She said that they had told her that her son would be safe in prison. They said that he would be put on suicide watch and checked every 15 minutes. Their actions are outside my remit and I have not investigated these comments. The Coroner may wish to address the man's mother's concern about those actions at the inquest.

76. The man's mother told the family liaison officer that she had great difficulty in contacting the prison's family liaison officer. She was disappointed that no one from the prison attended the funeral. She said that the chaplain had been a great comfort to the family while they were with her son in hospital and when he died. The investigator spoke to the chaplain and he expressed regret that he could not attend his funeral. He said he had telephoned the man's mother to apologise and to ask about the service. Another chaplain commented to the investigator that, after being very involved with the emergency on 5 July, she had felt "out of the loop" in the following week. She thought that a lack of direction and central point of contact had contributed to, amongst other things, the fact that no staff had attended his funeral.

77. The lack of a central point of contact was an issue that other staff expressed to the investigator. The duty governor, who was in charge on 5 July, went on annual leave the day afterwards and it does not appear to have been made clear to staff who would assume responsibility for taking overall control in his absence. I expect too that this was felt more keenly because it was some days before the man died. I draw this to the attention of the Governor for learning purposes.

78. When the man died the prison properly agreed to meet the costs of his funeral. Unfortunately, the bill was not paid to the funeral directors until 23 November – almost five months after he died. Both the man's mother and the Ombudsman's family liaison officer found it extremely difficult to contact the prison liaison officer. The situation was only resolved when another of my colleagues visited the prison on a different matter.

79. This delay is unacceptable and can only have added to the man's mother's distress. I understand that the prison's family liaison officer had a family bereavement. I am sympathetic to his personal circumstances but consider that if he was unable to fulfil his responsibilities he should have been replaced. This was an issue for his management. The role of family liaison officer is hugely

important and there must be measures in place to make sure that it is properly fulfilled.

I recommend that the Governor of Exeter satisfies himself that there are effective management structures in place to ensure that the prison family liaison officers are properly fulfilling their role.

This recommendation was accepted by NOMS at draft report stage.

CONCLUSION

80. I am satisfied that the care received by the man in Exeter was of a high standard. I do not consider that his death comes into the category of so called preventable deaths where a risk was not identified. All the decisions made about his care and the nature of his risk were reasonable. The emergency aid given to him was exemplary and the incident management on the day of 5 July was highly organised and efficient. There is evidence that most wing staff and most of the key prisoners received proper support.

81. Unfortunately the family liaison provided to the man's family did not reach the heights of the care given to him. I am also disappointed to hear a familiar complaint from healthcare staff that the care offered to them was not consistent with that offered to discipline staff. The management of healthcare in prisons is no longer the direct responsibility of the Governor and therefore it is important that further divisions between discipline and healthcare staff do not occur. The clinical review at annex one also references communication between discipline and healthcare staff.

82. In common with other local prisons Exeter prison is struggling with overcrowding. There are more vulnerable prisoners than can live on the designated wing (D wing) and the overspill means that places on B wing (designated as first night and induction wing) are at a premium. Staff expressed their concern to the investigator that they could not properly look after new receptions as there was little chance of retaining them on B wing. This is not a situation that I (or anyone at Exeter) can remedy but, in writing these reports, I am constantly reminded that overcrowding in prisons increases the stresses and demands on staff and has implications for the safety of prisoners.

RECOMMENDATIONS

1. I recommend that the Head of Healthcare issues a notice to all healthcare staff informing them that the cameras on B wing are not routinely used for monitoring prisoners and the cells are not used as 'camera cells' or specifically for prisoners thought to be at risk of self-harm or suicide.

2. I recommend that there should be an improvement in the legibility of the doctor's entries in the clinical record and that all entries should be signed and the name of the doctor printed under the signature.

3. I recommend that, in the light of the feedback received from healthcare staff during this investigation, the Governor and the Head of Healthcare ensure that systems are in place to offer appropriate support to all staff involved in fatal incidents.

4. I recommend that the death in custody contingency plan at Exeter is amended to ensure that the Governor's notice to prisoners informing them of a death is put up on every wing.

5. I recommend that the Governor of Exeter satisfies himself that there are proper management structures in place to ensure that the prison family liaison officers are properly fulfilling their role.

From the clinical review:

1. The use of Camera surveillance in the prison cells. There seems to have been a breakdown in communications between the Prison Staff and the Health Care Staff regarding the use of the cameras in camera cells. The medical staff seemed to think that the cameras should be monitored regularly but in fact they were not monitored at all and there are signs in the cells explaining this to prisoners. I recommend the two services should start regular liaison meetings with the aim of improving working relationships between the two sides.

2. Routine health checks for prisoners entering custody. These were all performed at the correct time but some of the entries were illegible and the signatures were not recognisable. I recommend that there should be an improvement in the quality of the entries in the IMR and that all entries should be signed and the name of the clinician printed under the signature.

Good practice:

The second CARATS worker follow up of the man's concerns (with wing staff and healthcare staff) was good practice.

The telephone call from the nurse manager to the community nurse was good practice.