Investigation into the circumstances surrounding the death of a man in August 2007 whilst a prisoner at HMP Exeter

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is the report of an investigation into the death of a man who died at the Royal Devon and Exeter Hospital on, 17 August 2007 whilst a prisoner at HMP Exeter. He was aged 42. I apologise for the delay in publishing this report.

I wish to offer my sincere sympathy and condolences to the man's family for their loss.

This investigation was conducted by one of the Ombudsman's Senior Investigators.

I would like to extend my thanks to the Governor and his staff at Exeter for their help and co-operation during this investigation. I also thank the prisoners who agreed to take part in the investigation process.

A clinical review of the care and treatment received by the man whilst at Exeter was conducted by a panel convened by the Devon Primary Care Trust. I am grateful to the clinical reviewer and her team for their report.

This report highlights a theme common to many of the investigations carried out by the Ombudsman's office, that of medical confidentiality. As will be seen there is now plenty of advice and guidance available to allow the sharing of confidential information if it is likely to reduce risk of harm. The challenge appears to be to spread the word at the grass roots level so that it can be done both properly and in the best interests of the prisoners.

I have made three recommendations, which should be read in conjunction with those made by the Clinical Review Panel.

Jane Webb
Deputy Prisons and Probation Ombudsman **July 2008**

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SUMMARY

The man was charged with a sexual offence and remanded into custody at HMP Exeter on 20 April 2007. He had been at Exeter on previous occasions and was known to many of the staff.

The man had a history of self-harming by cutting which he disclosed during the reception process upon arrival at the prison. He also told staff that he drank a bottle of spirits every day. As a result he was put on a Librium detoxification programme. The doctor noted that he was mentally stable, not suicidal and had no thoughts of self-harm.

The man applied for Rule 45 status, meaning that he wanted to be treated as a vulnerable prisoner because of the nature of his charge.

Three days after arriving at Exeter the man cut his right forearm and wrist. He told the doctor that he was angry about his charge and being back in prison. The doctor opened an ACCT document and moved the man into healthcare. (An ACCT document is part of a system that that supports and cares for prisoners who are considered to be a risk of suicide or self-harm.)

There were no further acts of self-harm and the ACCT document was closed on 7 May. However, on 9 June, the man cut his right forearm, wrist and torso. He told the officer who found him that he wanted to kill himself and that the television was telling him to harm himself. Another ACCT document was opened which would remain open until his death.

On 22 June, the man cut his neck and left arm. He told staff that he had been frustrated by some legal documents he had received. He was later seen by the prison doctor who found no evidence of any psychotic illness or suicidal intent.

Four days later another prison doctor referred the man for further mental health assessment. That night the man smashed up his cell, claiming that he had read his legal documents again. The following morning he told staff that his television was talking to him which was why he smashed it. That evening the man began to damage his cell again after arming himself with a chair leg. He was removed to the Care and Separation Unit.

On 28 June, prison staff intercepted a letter the man had written in which he referred to killing himself. Later that same day an adjudication was held in relation to the cell damage. It was adjourned for the man to seek legal advice, but not before he had started to use foul language towards the governor's 'Pudsey bear' mug which was on the desk. He said that he thought the mug was talking to him.

The man was seen by a psychiatrist on 4 July, who found no evidence of thought disorder, delusions, hallucinations, cognitive disturbances or suicidal thoughts. That afternoon the previous week's adjudication was resumed and the man was punished by three days cellular confinement, seven days loss of earnings and canteen and 14 days loss of television.

The man self-harmed again on 8 July and 19 July and returned to Healthcare. He returned to normal location and the next few days passed without incident.

Staff discovered the man on 30 July when he used a towel as a ligature and suspended himself from the cell window. He was discovered by staff and cut down. He had no injuries and apparently suffered no lasting effects. He was returned to Healthcare.

On 10 August, the man moved back to D wing having applied again for Rule 45 status. His television was removed and he put in a complaint form asking for its return. On 15 August, a senior officer returned the complaint form to the man with his explanation as to why he could not have a TV at that time. One of the reasons given was the number of TV's that the man had damaged at Exeter during his various periods of custody there.

The following day the man was not let out of his cell for evening association because he had defaced the complaint form with foul language and put it under his cell door. A prison officer checked his cell again and was sworn at and told to go away. A few minutes later the same officer saw the man hanging behind his cell door.

Staff entered the cell and called for medical assistance. Cardio pulmonary resuscitation (CPR) was performed until the paramedics arrived and took over. After about 20 minutes the defibrillator showed a faint output from the man's heart and he was transferred to the Royal Devon and Exeter Hospital. The man was pronounced dead at 11.17am the following day.

THE INVESTIGATION PROCESS

1. The investigation was opened at HMP Exeter on 24 August 2007. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were displayed around the prison to inform both staff and prisoners of the investigation.

2. A meeting was arranged with the investigating officer from Devon and Cornwall Police. My investigator was able to discuss the progress of their investigation and obtain copies of the statements they had taken.

3. My investigator formally interviewed a number of members of staff and prisoners regarding the man's death. The transcripts of those interviews are attached at the end of this report.

4. One of the man's brothers contacted my office shortly after his death. One of my family liaison officers followed this up. She offered the opportunity to meet with her and the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. The man's parents, who reside outside of the country, further responded and became the main point of contact for the man's family. They have since appointed a solicitor to act on their behalf.

5. My investigator contacted Her Majesty's Coroner to inform her of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist with her enquiries into the man's death.

6. The Devon Primary Care Trust was asked to prepare a clinical review of the care that the man received whilst at Exeter. A panel, chaired by the Commissioning and Development Manager for the PCT, examined the man's medical record and other documents and produced a report of their findings. One particular issue in their report, that the man changed his method of self-harm from cutting to the use of a ligature, was also noted by my investigator. I have chosen not to duplicate the panel's recommendation on this matter but I wholeheartedly support it. The panel made nine recommendations and highlighted several areas of good practice.

HMP EXETER

7. The prison is located within the city of Exeter and was built around 1850. It currently has four accommodation units and a healthcare facility. Exeter holds adult male remanded and convicted prisoners committed to custody from Cornwall, Devon and southwest Somerset. Additionally it holds young men between the ages of 18 and 21.

8. Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, writes in the foreword to her December 2004 inspection report of Exeter,

> "In an overcrowded, pressurised prison system, it is commendable that managers at Exeter had succeeded in embedding the positive developments we recorded at the last inspection, and had also achieved considerable improvements in healthcare and resettlement. The main focus of their attention now should be to improve both the amount and the quality of activity available to prisoners".

9. Later in her report when commenting on self-harm within the prison she writes,

> "The safer custody committee monitored self-harm and suicide matters and acted to adjust policies and practice when required. Scrutiny of F2052SHs revealed that initial care plans were meaningful and drew on a good range of available resources, including psychiatrists, mental health workers, chaplains, the Samaritans and Listeners and CARAT (counselling, assessment, referral, advice and throughcare) workers. Reviews were held punctually, were multidisciplinary and were again meaningful. The quality of daily observation entries was mixed, with some informative comments demonstrating good interaction and others merely stating that the prisoner had been seen and appeared to be all right. Night entries were not of a high standard, with some recording of movement but none of interaction; many simply said 'checked'. The timing of night observations was generally at set intervals rather than random."

10. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor the day-to-day life in their local prison or removal centre and ensure that proper standards of care and decency are maintained. The IMB produces an annual report on their prison. In the executive summary of the latest report for Exeter, 2006-2007, the chairperson wrote:

> "There are some very dedicated, professional staff working in Exeter Prison.
> Relationships between staff and prisoners are very good. Prisoners generally feel safe in custody. However, we would like to see a more purposeful and constructive use of prisoners' time through the extension of education, skills and leisure opportunities. The challenges of operating within predominantly Victorian buildings designed for another age are immense. The pressure of very high prisoner numbers adds to the

difficulties and requires continuous attention to the maintenance of clean and safe living and working environments. As monitors, we expect to see creative management solutions to these problems in the coming year. The IMB has full access to all prisoners and all areas of the prison."

11. Since the Ombudsman was given responsibility for investigating deaths in prisons in April 2004, there have been three deaths at Exeter prior to that of this man. Two were apparently self-inflicted deaths and one man died from natural causes. In two of those previous cases I made similar recommendations for a coded radio system for use in medical emergencies.

KEY FINDINGS

12. The man was arrested on 19 April 2007, on suspicion of burglary of a neighbour's flat. He was charged with a sexual offence at a Police Station on 20 April. The Prisoner Escort Risk form (PER) had medical condition, violence, sex offence and suicide/self-harm ticked as risk factors. In the further information section the police officer had written, "violent, self-harm, sexual, heart complaint, depression". (The PER form is used to communicate perceived risk about a prisoner as he or she moves between police stations, courts and prisons.)

13. The man appeared at a Magistrates Court later that day and was remanded to HMP Exeter. Upon arrival at reception the man was taken through the normal reception procedures. He told the reception officer that he had no next of kin and that there was no one to contact in an emergency. He said that he was unemployed. Answering questions for the Cell Sharing Risk Assessment form (CSRA), the man told the officer that he had abused alcohol and was currently dependent on alcohol.

14. The man was then seen by a health care worker who completed the First Reception Health Screen. The man confirmed that he was not prescribed any medication and had no injuries. He claimed to drink a bottle of vodka, rum or wine a day but stated that he did not abuse drugs. The man was asked about his mental health. He said that he had received psychiatric treatment outside prison, citing the causal factor as his time in the prison in 2005. He said that he had never received any medication for mental health problems and admitted to self-harming by cutting his arms when he was in Exeter again in November 2006. The man denied feeling like self-harming at the present time. The healthcare worker noted that he seemed stable and aware of time and place. He was referred to see the doctor for his alcohol misuse.

15. A prison doctor saw the man and noted that his general health was satisfactory but that there was evidence of heavy drinking, again citing the man's assertion that he drank a bottle of vodka daily. The prison doctor noted that the man was mentally stable, not suicidal and having no ideas of self-harm. The doctor prescribed Librium for alcohol detoxification.

16. The man was taken to B wing, the First Night Centre/detoxification wing. This is a section of the prison where most new reception prisoners spend the first few days as their needs are assessed and they are inducted into prison life.

17. The man applied for Rule 45 status, meaning that he wanted to be treated as a vulnerable prisoner. Exeter houses Rule 45 prisoners on D wing and part of B wing as overspill. The man gave his reasons for wanting Rule 45 as being the nature of his offence and the fact that he had been on Rule 45 in the past.

> "Prison Rules 1999 as amended states: 'Removal from association 45. - (1) Where it appears desirable, for the maintenance of good order or discipline or in his own interests, that a prisoner should not associate with

other prisoners, either generally or for particular purposes, the governor may arrange for the prisoner's removal from association accordingly."

18. On 23 April, the man was seen by a probation officer working in the Offender Management Unit. Her role was to conduct a basic needs analysis, assessing concerns about debt, housing, drugs and alcohol. The man told the probation officer that he had been staying with a friend but was unable to return as his offence had taken place at a neighbour's flat. She noted that he appeared not to have had a settled address for a number of years following the breakdown of relationships. He said that he had five children but was not in contact with any of them, adding that his parents were living abroad. The man said that he had neither been working nor claiming any benefits recently and now had some debt. My investigator asked the probation officer about the level of debt she believed the man to have, but she was unable to recall any details.

19. The probation officer recorded that the man was detoxifying from alcohol and at times was quite tearful. During interview she said that was not unusual as people newly into prison are often low and the man told her that he was having problems coping with his thoughts without alcohol. He said that he felt that he saw and heard messages and connections in what he saw and heard around him. The probation officer spoke to him about what he should do if he felt very low and the man said that he understood. The probation officer referred the man to the housing advice officer, Action 4 Employment, CARATS regarding his alcohol use and the prison healthcare unit. (CARATS stands for 'Counselling, Advice, Referral, Assessment and Throughcare'. CARAT workers act as keyworkers and coordinate the care of those prisoners on their caseloads; workers can also provide basic information about drugs and their effects and ways to reduce harm; they may offer some structured one-to-one support and group work to prisoners who want to give up or cut down on their misusing. They can also refer a prisoner to a drug treatment rehabilitation programme.)

20. Later that day, at 1.00pm, the man was seen by the second prison doctor. The man had made lacerations to his right forearm and wrist. He told the doctor that he was angry at the charge and having to return to prison. He added that he had been taking a vast quantity of alcohol for the last few weeks due to not being able to settle in the community. The man told the second prison doctor that he felt he got very little support from his family, whom he thought judged him.

21. The man said to the second prison doctor, "I don't want to be here". During his interview with my investigator the doctor said,

> "That might literally mean I don't want to be in prison but it also might mean I don't want to be in this life and I take statements like that seriously. That might indicate thoughts of suicide. People might find it hard to say I am going to kill myself and they put it in a covert way but the seriousness of that remark shouldn't be underestimated. If people say that when they are harming themselves, are withdrawn, having the body language of being down and out, you shouldn't underestimate it."

22. The second prison doctor opened an ACCT plan. (ACCT stands for Assessment, Care in Custody and Teamwork. The plan encourages staff to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis or to help individuals with long-term needs, such as those with a pattern of repetitive self-injury, to better manage and reduce their distress.)

23. The man was located in a single cell in healthcare. The immediate action plan stipulated that the man was not to have a television or his shoelaces but could access a telephone or talk to a Listener. (A Listener is a prisoner who volunteers to be trained by the Samaritans to provide a similar confidential service to other prisoners.)

24. It was noted in the ACCT assessment interview that the man,

> "Presents as quite incongruent – feels that he would like to have cut a vein today but also would like to attend video link 24.4.07. Does not express any plans to further self-harm or take his life."

25. The video link referred to above is a video link from the prison to a Magistrates Court in Devon.

26. The man passed a quiet night, but at 8.45am on 24 April he was caught trying to conceal his medication. It was noted that he was cross at being caught. At 9.10am he attended the video link and his case was remanded until 22 May.

27. At 12.20pm the man spoke with the third prison doctor saying that he could not cope either in or out of prison and that he wished to die. The doctor noted that he should remain in healthcare at that time, that he accepted all his meals and interacted well with others during association. Later that day the man told staff that he regretted saying that he wanted to kill himself and had been angry when he said it.

28. The next few days passed without incident and on 30 April the man attended an ACCT review. The prison doctor decided to discharge him from the healthcare unit but to keep him on the ACCT plan. A nurse noted on the review that the man's presentation was that of a quite truculent man who, unless he was gaining what he wanted, declined to interact much. The man was moved to D wing and into a double cell. It was later recorded on his ACCT plan that the man had a good evening and was mixing well with his cellmate.

29. The man was monitored on the ACCT plan over the next week. He appeared to be in good spirits, watching television and interacted well with staff and other prisoners. On 7 May, another ACCT review was held. A senior officer recorded on the case review sheet that the man was,

> "a completely different man from the last time we met. He is currently presenting as bright, cheerful, positive and has different outlook on his future. Good eye contact and is sleeping and eating well. Is completely finished his detox and is feeling much better. All in agreement to close ACCT."

30. Seven days later on 14 May, at an ACCT post closure interview, the man told the staff that he was coping well and was happy with the way things were going for him. Everyone present agreed that the ACCT plan should remain closed.

31. The man appeared to settle well into prison life for a while. An entry in his main record for 20 May states,

> "Good humoured and sociable on the wing. No episodes of paranoia, as encountered during previous custody."

32. Seven days later, on 27 May, an officer wrote in the man's main record that there was no change from the previous entry (above) and that the man seemed to just want to serve his sentence as quietly as possible.

33. On 9 June, shortly after 6.00pm, the man rang his cell bell to be allowed out to use the toilet as there are no in cell facilities on D wing. The second prison officer thought that the man was taking a long time so he went to check. He found the man in the toilet area and saw that he had cut himself. The man had apparently taken a disposable razor and used the blade to harm himself. He offered the blade to the officer when he was found. The second prison officer summoned medical aid and a nurse attended. She wrote, both in the medical record and the main record, that the man had deep lacerations to his inner right forearm as well as cuts to his wrist and torso. The man was tearful and said, "I want to kill myself". He also said that the television was telling him to harm himself.

34. The man's wounds were dressed and he was taken to healthcare. The out of hours doctor service was contacted as the man's cuts required stitching. The second prison officer opened another ACCT plan for the man as the result of the self-harm. He wrote that the man said that he wanted to kill himself because he could not cope with being "inside or outside".

35. The out of hours doctor treated the man's cuts and he was admitted to healthcare. At 2.30am the following morning the man asked for and was given two paracetamol tablets for pain in his arms. It is recorded that the man was abusive and verbally aggressive at 8.30am and remained so for the rest of the day. The nurse wrote in the ACCT plan that she was unable to carry out the assessment interview due to the man's fractious nature. She had attempted to check his wounds but was met with abuse. The man's cuts were re-dressed by another nurse but he again became aggressive and abusive afterwards, punching the hatch as staff tried to talk to him. It was decided that two Control & Restraint officers should be present whenever the man was unlocked.

36. The nurse conducted the ACCT assessment interview on 11 June. The man told her that he had not been coping on the wing due to his current situation (in prison for the current charge). He said that he made the cuts on his arm because he did not want to carry on, but he went on to say that he was relieved that he did not die. The nurse, who is a registered mental health nurse, recorded her thoughts about the man's current mental state, saying that he was very stressed, anxious and emotional. He was not hearing voices or having hallucinations nor reporting panic attacks. The man stated that he was not currently thinking about self-harm or suicide and had no plans to harm himself.

37. On 12 June at 11.15am, the man was seen by the prison doctor in healthcare. The man wanted to be discharged from healthcare and the doctor agreed. He prescribed a short course of chlorpromazine to help with the man's anxiety.

38. The man returned to D wing and the shared cell he had previously occupied. Later that day an officer noted that the man was happy to be back on D wing with his cell mate and that his medication was having a profound effect as he was very cheerful.

39. On 18 June, the man refused to go to education and according to staff, was in quite a belligerent mood. He also put in an application to come off Rule 45. By the afternoon it was recorded that the man had calmed down and he apologised for his behaviour. An ACCT review was held at 3.45pm. The man said that he was feeling a lot more settled although he was still having mood swings. It was decided that the ACCT plan should remain open.

40. Two days later whilst at a class, the man became very agitated and began to cry when he was asked to write a short life history. The senior officer contacted the mental health in-reach team who agreed to see him. The next morning the man was very agitated, tearful one minute and angry the next. The senior officer referred him to healthcare because of his surly behaviour and attitude. The man was seen by a nurse at 3.20pm. She wrote that he was very angry and agitated but was unable to identify a specific reason for his feelings. He blamed the police, his family and the prison staff for his situation. He was tearful and frustrated but denied any immediate thoughts of self-harm. The man agreed to daily outreach with healthcare staff and agreed that he would tell them if he did not want to talk. Both the nurse and the senior officer were concerned for the safety of the man's cell mate due to the man's anger. The senior officer reviewed the CSRA and made it "high". The nurse discussed the man's case with the second prison doctor who agreed for him to move into a single cell.

41. At 9.00pm that night the officer spoke with the man. The man said that he was a lot happier on his own.

42. At 11.45am on 22 June, staff noticed marks on the man's neck. When he was asked about them he said that he had cut his neck and left arm due to frustration after receiving some legal documents the day before and then 'not

being right'. Healthcare staff were called to clean and dress his wounds. The healthcare worker recorded in the medical record that the man claimed to have caused the wounds the previous afternoon. She referred him to the doctor.

43. The man was seen by the prison doctor at 6.35pm. The man told him that he did not like the wing and that people were saying things about him and an officer who was friendly to him. He was also worried about his case. The prison doctor recorded that he found no evidence of any psychotic illness or suicidal intent.

44. On 23 June, the D wing officer wrote in the main record that the man's behaviour was becoming increasingly erratic and bizarre. At 4.00pm, a third senior officer made a similar entry in the ACCT plan, adding that he felt staff should be cautious when working with the man.

45. Three days later, on 26 June, the man was seen by a fourth prison doctor. She referred him to see the prison in-reach mental health team. The doctor wrote the following on the referral form,

> "Inmate presents as agitated and troubled. He is possibly confused; he sometimes feels he is getting messages from the TV. His speech is thought disordered at times. He becomes distracted and loses eye contact. He has self-harmed – cuts to neck and forearms. Currently taking chlorpromazine 25mg. He needs further mental health assessment."

46. At 10.30pm staff heard noise coming from the man's cell. Upon investigation they found that he had "smashed up" his cell. The man said that he had done it because he had read his reports again.

47. On 27 June at 8.00am, the D wing officer noted both in the ACCT plan and the main record that the man was extremely volatile when his cell was opened. The man was claiming that the previous night his television was talking about him, which was his reason for smashing it. He also accused other prisoners of stealing his tobacco and talking about him. At 10.55am, the man was found damaging his cell again. On this occasion, he had armed himself with a chair leg. At 12.15pm, the man was moved to the Care and Separation Unit because of his behaviour. He was put in one of the cells with an in-cell camera which allowed staff to view him more easily. The camera did not however record the images.

48. When a prisoner is located in the Care and Separation Unit (also known as the segregation unit or the 'seg') an initial safety screen form must be completed, part of which is a segregation safety algorithm. The segregation nurse completed the algorithm on this occasion at 12.30pm. Her decision was that there was no healthcare reason for the man not to be segregated. My investigator asked the segregation nurse during her interview if she had any concerns about the man being segregated. She replied,

> "No, if I had I wouldn't have made him fit for cellular confinement. I spoke to the man on that occasion, I was present when he was taken from the cell on D Wing and taken to the Separation and Care Unit, I was present all the way with him. He was very angry, very verbally abusive, didn't co-operate very well at all with the Officers during the move, so it was quite difficult for them as well. And when he was located in the cell in the Separation and Care Unit I went in and spoke to him. I asked him if he had injuries, if he wanted to report anything to me and he just said, 'no'. He had calmed down and he said no and on that occasion I didn't feel that he was mentally unfit to be able to be located in the Separation and Care Unit."

49. At 12.45pm a governor checked and signed the form as required by the protocols. It was also decided that the man could be allowed tobacco and a lighter in his cell and standard furniture.

50. The prison doctor saw the man in the Care and Separation Unit at 3.35pm. His assessment was "behaviour rather strange – showing no evidence of psychotic illness. I feel his behaviour is not compatible with medical illness."

51. At 5.00pm that day an ACCT case review was held. The man was not present, because of his previous volatile behaviour. It was noted that the man was calm at that time and that another review would take place after the adjudication to be held the next day. The remainder of the day passed without incident.

52. When a prisoner breaks the prison rules an adjudication takes place with a prison governor acting as the adjudicator. The governor hears the evidence against the prisoner, gives the prisoner the opportunity to put his case and then makes his/her decision. If the case is proved the usual punishments are loss of privileges and or earnings.

53. The following morning, 28 June, a letter written by the man was intercepted by correspondence staff. In the letter, which does not have an addressee's name, the man wrote about killing himself. A Security Information Report (SIR) was submitted and a number of relevant people were informed, including the fourth prison doctor, healthcare, and the Safer Custody Unit.

54. At 1.00pm, another governor held the adjudication. The governor explained some of what took place during his interview for this investigation,

> "I opened the adjudication and the man requested contact with his legal representative for advice. The norm is to allow them seven days to do that, that is either by mail or preferably they can get a phone call to their solicitor. So it appears that the man requested contact with his solicitor which I granted, I allowed him seven days but during the adjudication process he became aggressive and the proceedings were halted and he was returned to his cell, in the Separation and Care unit. As a result of that plus what the original offence, alleged offence of him being there I didn't deem it appropriate for him to return to ordinary location and

therefore I signed him on good order or discipline for an initial period of 72 hours".

55. Good order or discipline, also known as GOOD, is Prison Service Rule 45 which states,

> "Where it appears desirable, for the maintenance of good order or discipline or in his own interests, that a prisoner should not associate with other prisoners, either generally or for particular purposes, the governor may arrange for the prisoner's removal from association accordingly."

56. Another officer gave another view of the man's behaviour during the adjudication in his interview,

> "Okay, I think he had two charges for disorder and damages which is the charge we lay for breaking prison property, I think it was threatening and abusive behaviour towards the staff who tried to intervene, the previous afternoon he had calmed down considerably, I don't think I had a problem out of him all the evening. So the following day eight o'clock we start, the adjudication starts about ten o'clock, I don't think there was a problem with him in the morning, when he came into the governor about ten o'clock, he wasn't in familiar surroundings, he wasn't just speaking to me or my colleague in his cell, he was now in a different room within the unit, talking to the governor. He wasn't familiar with the governor because halfway through the adjudication he started talking to the mug on the table which was a Children in Need Pudsey Bear mug, he thought that the bear was talking to him. He was trying, he was about to start to have an argument with the mug, saying that the mug was looking at him, and he has got no right to look at him. I think he was using foul and abusive language towards the mug, at which point the governor I think said that he was unfit to carry on in adjudication, so me and my colleague just escorted the man back to the cell and it was as if nothing had happened, he just went back into the cell and was calm again."

57. Another ACCT review was held at 2.30pm. The man said that he did not have any self-harm thoughts at that time. The review officers were aware that he had been allowed seven days to take legal advice. It was decided to keep the ACCT open.

58. On 29 June, the man was seen by a nurse from the mental health In-reach team. It was recorded that he was hostile during the interview but not distressed. There was evidence of possible paranoid thoughts as the man felt that he could talk to the programmes on the television. The entry ended with the nurse saying that the man needed to see the psychiatrist on Wednesday morning (4 July).

59. At lunchtime on 30 June, the man refused his lunch and then began head butting the cell door. He blocked the toilet with a towel, which was removed by staff. Later that afternoon he was reported as having a very aggressive

and angry hour, refusing his medication and being extremely abusive to staff. He also refused his evening meal.

60. The man appeared to have a peaceful night, but the following day he would not communicate with staff and he refused breakfast and lunch. His tea meal was placed in his cell as he had not eaten all day. The man did say that he would take his medication as well when the nurse came.

61. On 2 July, an officer wrote in the ACCT plan that after having his cell camera lens unblocked twice, the man had a very aggressive and angry morning. The man had ripped his clothing off, tried to flush it down the toilet, put his head into the toilet bowl, banged his head, punched the cell door and screamed abuse. That lasted about 30 minutes then the governor spoke with the man and he calmed down. The rest of the day was calmer with staff reporting that the man had been compliant, had taken his medication and left his cell to collect his tea.

62. The following day staff reported that the man was well behaved, calm and that he took his meals.

63. On 4 July, at 9.45am the man had a psychiatric review with a doctor. The doctor recorded in the man's medical record that he found him coherent, relevant and lucid. He found no evidence of thought disorder, delusion, hallucinations, cognitive disturbances or suicidal thoughts. The man said that he felt okay now and did not have any mental health or health problems.

64. That afternoon the man attended his adjudication (a day early because of the weekend). It is not recorded whether he had spoken to his legal representative since the last hearing. The governor decided to impose a punishment of three days cellular confinement, seven days loss of earnings and canteen and 14 days loss of television.

65. On 5 July, a segregation officer recorded in the ACCT plan that the man had said that he felt a lot better, was happier and engaging more with staff. The officer acknowledged that the man did look better and seemed happier. Later that day at 7.30pm the same officer noted that the man had had his best day for quite a while, including joking with staff.

66. At 2.55pm on 6 July, another ACCT case review was held. It was noted that the man had come a long way during the last few days. The man said that it was his birthday the next day and that was no longer an issue for him. He said that he had no more thoughts of self-harm and did not want to go backwards. Although both staff and the man agreed that the ACCT should be closed, it remained open and the observations continued.

67. Just before 6.00pm that evening, the man moved back to B wing. He had completed his cellular confinement days. The man's birthday passed without incident, but the following day, 8 July, it was recorded that he was feeling low again.

68. At 2.00pm, an ACCT case review was held. The man presented as very confused and rambled a lot about the cause of his stress. It was noted that he was unable or unwilling to elaborate on what he was saying. He kept talking about the voices in his head, but became increasingly angry when asked what could be done to help him. Eventually, the man left the review in an agitated state and returned to his cell. The senior officer who had conducted the review, increased the perceived risk from 'low' to 'raised'. He spoke with a nurse about the man seeing a doctor.

69. Before that could happen the man self-harmed again. At 3.45pm, a B wing officer opened the man's cell and noticed blood on the floor. The man was in the toilet area and out of sight. The officer asked what had happened and the man said that he had fallen over. The officer then approached the man in the toilet area and saw that his arms were covered in blood from cuts to his arms. The man was holding a razor blade which he put in the sink when he was asked.

70. The man was taken to healthcare where his wounds were cleaned and dressed. The wounds did not require sutures. He was admitted to healthcare. As a healthcare in-patient on an ACCT, the man would have been observed five times an hour as well as casual observations by staff going about their routines. As one member of staff explained in her interview with my investigator, the only higher level of observation is a constant watch, which as it suggests means continuous observations by a member of staff. The man settled into the regime in healthcare.

71. On 10 July, the man explained to the doctor that his thoughts were racing and that he found relief from his anxiety and anger by self-harming. This was recorded in his medical record.

72. During the afternoon of 11 July, after a healthcare team discussion it was decided to allow the man to have a television.

73. On 13 July at 12.07pm, a healthcare nurse recorded in the ACCT plan that the man had attended association that morning but had not been in a good frame of mind. At 5.00pm, the man asked to speak with a Listener as he did not wish to talk to staff.

74. At an ACCT case review held on 14 July, the man talked freely about how he felt and explained that he self-harmed to cope with things in his past. He said that he became homeless, got in with the wrong crowd, and drank heavily then his mental health went down. The man told the staff that he felt safer in healthcare and only had occasional thoughts of self-harm. He said that he found talking with a Listener very beneficial and he was finding it difficult in prison this time.

75. The man appeared to be settled for a couple of days, although when the healthcare nurse asked him if he was okay at lunch on 16 July, he replied that he was not. He would not elaborate but said that he just wanted to eat his lunch. A little later he threw some water and punched his television. Later

that day it was recorded that the man was much calmer and that he had said, ”I was just pissed off this morning”. He also said that he was trying to give up smoking.

76. At 11.30am on 17 July, the man attended another ACCT review prior to being discharged from healthcare. A governor, the segregation nurses and both the third prison doctor and the prison doctor were at the review. It was reported that although the man felt more settled whilst in healthcare he acknowledged that it was not appropriate for him to remain there. The man said that he wanted to come off Rule 45 as he did not wish to return either to D wing or B4. The man agreed that he would seek help or support either from the landing or healthcare staff. In turn, the man was told that appropriate healthcare support would be put into place to help him on the landing. As part of the new care plan it was decided that any superficial self-harm should be dealt with on the wing.

77. My investigator asked the segregation nurse why the man could not simply remain in healthcare as it appeared to suit him better than the wings. She replied,

> “Because as far as we were concerned from the entries that we had made, there was no need, the man was not self harming, he was not being a management problem, he wasn’t having any medical intervention that he couldn’t receive on ordinary location which could be provided through Outreach, so the nurse could go and see him. The mental health team could go and see him on the ordinary location. He didn’t need to be in a hospital environment, his needs could be met on the landing, so we don’t keep people in healthcare for their sentence. Once they are settled, they are telling us that they are ready to move back on to the wings. Then we will put in place in their ACCT documents if they are on one, and we also do if they are not on an ACCT document, we do a discharge plan which goes in the front of their IMR which the nurses on Out-patients can read, tells them a little bit about why they are in healthcare and how they should be looked after initially on their discharge.”

78. An officer who works in healthcare noted in the man’s main record that the man became truculent when he was told that he was being discharged from healthcare. Whilst out of earshot of the staff he threatened one of the orderlies. However he was moved to B wing without incident. At 5.20pm, he declined both his medication and his food and did not reply to the officer who asked how he was. The officer wrote, “Perhaps he is not happy being on B wing, would probably prefer to have remained on HCU.”

79. At 10.00am on 19 July, the man made multiple cuts to his right forearm, some through the full skin thickness and others to the right side of his neck. The second prison doctor thought the cuts were potentially serious and admitted him to healthcare. The man’s injuries were treated with ‘steri-strips’ and dry dressings. It is clear from the second prison doctor’s entry that he did not have either the ACCT or medical record to hand when he saw the man. The second prison doctor explained during his interview that the man was

bleeding when he was brought to him. The second prison doctor said that he would not have expected staff to worry about the paperwork under those circumstances.

80. The man settled back into life in healthcare. On 20 July, a third prison doctor and the nursing team agreed that the man could return to normal location and to a shared cell, subject to a satisfactory risk assessment. On 24 July, following an ACCT review, the man relocated to C wing. During the review he expressed a wish to share a cell and he was advised to speak with the wing staff. There is no record of him asking to share a cell but in any case the Cell Sharing Risk Assessment was marked as high due to his unpredictable behaviour.

81. The next few days passed without incident. On 30 July, the man spoke to one of the landing staff. The officer tried to put the man at ease but recorded later that the man thought the staff might be trying to catch him out. The officer told the man that the staff were always available to him and that seemed to reassure him. Another officer spoke with the man a couple of hours later, at 7.30pm. The officer felt that he seemed a little uptight, saying, “You guys know what is up, you are always asking me.” The man then assured the officer he was alright. However the officer was not happy and decided to check the man again 15 minutes later.

82. At 7.45pm, the officer returned to the man’s cell with a colleague and found the man hanging from the cell window. He had used a towel as a ligature. The officers cut the ligature. No resuscitation was required and there was only a mild irritation to the man’s neck. He was seen by the prison doctor, who admitted him to healthcare once again. The man had written a suicide note which the officer described as rambling. The officer told my investigator that he took the note to healthcare with the man but since then the note appears to have been lost. The note is not mentioned by any of the staff who cared for the man after this act of self-harm.

83. The following morning at 9.00am, the man told staff that he was okay, but later was seen punching his pillows and was generally angry. It was noted that he was ”rude and truculent” when seen by the doctor. At 4.00pm, a senior officer from the wing noted that the ACCT review was to be deferred until 1 August due to the man’s uncooperative presentation.

84. At 3.00pm on 1 August, the man attended an ACCT review. He told the staff that he had tried to hang himself because he felt like he was going mad. He said that he did not know if it was because of the way he was being treated or because he had lost control. The man said that he self-harmed due to uncertainty about his case and his previous charges. He repeated that he harmed himself out of anger and frustration.

85. After the review the man spent the afternoon associating with the other prisoners without problems. The healthcare nurse recorded that later, whilst waiting at the treatment hatch, the man became very angry about something.

When she asked him what the problem was he stormed off without giving her an answer.

86. On 2 August, the nurse asked the man how he was feeling, to which he replied, “Do you really care miss?” She told him that she did. Later, at 12.44pm, the healthcare officer spoke at length with the man. He told the officer that he was finding it very difficult to cope with prison this time. He said that he had received threats whilst on the wing as the result of previously being on Rule 45, and that other prisoners questioned him too much about his offence. The officer noted that the man did not mention any intention to self-harm but did say that he had difficulty coping with being angry and was impulsive.

87. The man remained generally calm and settled until 8 August, when he went to Exeter Crown Court. Initially he was talking and responding to staff but later became quiet and withdrawn. The man said that he thought that the staff were laughing at him and he also got upset with his barrister during a legal visit. He arrived back at Exeter at 2.15pm when it was recorded that he was ”not happy – very quiet”. The man remained settled and calm for the next 24 hours.

88. At 3.30pm on 9 August, an ACCT case review was held prior to the man being discharged from healthcare. Earlier he had made an application to return to Rule 45. He wrote his reason for the request as ”vulnerable prisoner”. His request was agreed by a governor. He was to remain in healthcare until space became available on D wing. At the review it was noted that the man had been in healthcare since 30 July and had not self-harmed or threatened to during that time. It was agreed by the review team that once he was discharged the man would be re-admitted on a crisis intervention basis for an overnight stay unless the reason for admission was severe. Superficial acts of self-harm were to be treated on the wing.

89. The man moved to D wing at 4.30pm on 10 August. The senior officer recorded the prison doctor’s instructions that the man’s cell was to be kept available should he need to go to healthcare following an act of self-harm. The man’s television was removed from his cell when he arrived back on D wing. My investigator was told that the man had broken several televisions during his time in custody and there was also concern that on occasion he would tell staff that the set was talking to him. The man put in a complaint form that day stating,

> “Regarding TV removal when I arrived back on D wing, Fri 10th. Previously on healthcare 9 days and C wing prior, so alright with TV in presence.”

In the section “What would you like to see done about your complaint?” he wrote, “TV returned and trusted with appliance”.

90. The next two days passed without incident. On 12 August, the man was seen by the senior officer for the purposes of carrying out a Cell Sharing Risk

review. It was recorded again on that form that the man had broken six television sets. The senior officer decided that the man remained a high risk to a cell mate.

91. The senior officer spoke with the man the following afternoon and wrote in the ACCT record that he "had great difficulty elucidating any real information from the man due to his incoherent rambling". Later however, the man mixed well with the other prisoners during association.

92. During the day of 14 August, the man was recorded as being unhappy. He asked about coming off Rule 45 and declined lunch, but took his tea meal and medication later. The last ACCT entry that evening reads, "Has been in a strange mood during the evening, talking to himself a lot. Left him lying on his bed."

93. On 15 August, an officer made two entries in the man's ACCT record, and one in his main record.

> "12.30 – At times has a normal conversation and at other times goes on rants about cameras watching his every move – unpredictable.
>
> 17.30 – Improved as day went on, though quiet, seemed in a better mood.
>
> Has been behaving in strange manner over the last couple of days. No control problem at present, but needs watching."

94. During the day the senior officer returned the complaint form that the man had submitted on 10 August. He wrote in the response section,

> " I have informed you of the reason why you currently do not enjoy the privilege of an in cell TV. To date you have destroyed <u>six</u> televisions. Your actions have a knock on effect of depriving the next person who is located in your cell of a TV. As the D wing manager and a crown employee I have a duty and responsibility to ensure public property is looked after. Your damage of six TV's demonstrates to me you are unable to treat prison property with the respect it deserves – I would also remind you that the damage you inflicted on each of the six appliances rendered them beyond repair. I am not ruling out you being supplied with one in the future but your current unpredictability precludes you from the facility of a TV at present."

95. At 8.00pm, the D wing officer wrote in the ACCT record, "A bizarre evening behaviour, talking to empty cell D1 – 9. Otherwise quiet, prefers to remain in cell."

96. The following morning the man was let out of his cell so that he could get the equipment to clean it. He got into a confrontation with another prisoner. The man accused the other man of staring at him. He became very aggressive and began shouting at the other prisoner. An officer defused the situation and the man returned to his cell. The man told the officer that there were too

many cameras on the wing and that people were staring at him. When asked what could be done to help, the man said that he wanted to come off Rule 45 and go back into the main prison.

97. The man attended another ACCT review at 10.05am on 16 August. The senior officer was the case manager and two other officers were present. The senior officer wrote on the review form that the man had much recent evidence of self-harm on the inner aspect of each forearm. The man said that he did not need to be on the ACCT. The officers felt that the majority of the review was taken up with the man's incoherent ramblings and claims of hearing voices. In his interview with my investigator, the senior officer said that the man claimed that Fearne Cotton was talking to him from the television.

98. The senior officer concluded the review record by writing, "The H.C.U claim he is not mentally ill but, but those present are of the opposite opinion. It was felt that, all things considered, he should stay on this ACCT."

99. At 12.20pm, the D wing officer noted in the ACCT record that the man's primary concern was to move back to the main prison. He added that the man insisted he was okay.

100. In fact the man had put in an application to come off Rule 45 and move back to the main prison, stating his reason as "hopefully feel comfortable on the main now. Came back to D wing after being released from hospital wing. To adjust etc."

101. A principal officer approved the man's application at 2.30pm, noting that the man was aware of the inherent risks and that he had been on normal location before. The man was to move to C wing the following day. The risk that the principal officer was referring to was the possibility of a negative reaction from other prisoners. (A lot of prisoners think of those on Rule 45 as being sex offenders and do not want to associate with them.)

102. At 2.17pm and 2.28pm, the man tried to telephone his brother, first on his home and then his mobile number, but neither call connected. During his time at Exeter, the man attempted to make 13 calls but did not actually speak with anyone. Exeter's pin phone clerk checked the man's record and confirmed that at the time he had credit on his account and so there was no obvious reason for the last two calls not to go through.

103. As part of the investigation process notices were placed around the prison to notify prisoners of the investigation. Two prisoners on D wing asked to speak with my investigator although only one prisoner wished to go on the record.

104. The prisoner said that he was the man's friend, although they had only known each other since he had been at Exeter. On the afternoon of 16 August, the prisoner spoke with the man on D wing. He said that the man was really edgy and anxious. The man had received the reply about his television and was not happy about it. The man was at his cell door and said to the other

prisoner, “That’s it; I’m going to kill myself tonight.” The prisoner said, “What?” The man said, “No, no, I’ve had enough, I ain’t staying here no longer. That’s it, I’m going to do it tonight”. The prisoner said that the man then shut his cell door and locked it, ending the conversation.

105. At 4.35pm the primary healthcare manager visited the man to check on how he was settling in on the wing. In his interview with my investigator, the manager described the man as,

> “Appearance wise he was quite relaxed, pleased to see me. We basically had a chat about how things were going and I could see from the cell that things were tidy. He had no recent self-harm or any injury that I could see to him at that time, he gave me no cause for concern with his appearance or anything in his behaviour or conversation really.”

106. My investigator said to the healthcare manager, “Thinking back on your earlier interview, can you think of anything that gave you any sort of indication at the time?” the manager replied,

> “No, the most surprising thing for me is that one minute I was having a chat with him and a few hours later it was such a fatal situation. There was nothing that I could have picked up in anything that he said or was doing or how he appeared in front of me. There were no visual clues to anything being untoward for him.”

107. When the primary healthcare manager left the man’s cell, the prisoner took the manager into his cell to speak with him. The prisoner told my investigator,

> “So I grabbed the healthcare team, talked at teatime as I was getting my meal, I pulled him in my cell, he was there for a good five minutes. I said, I’m really concerned about him over there, he’s going downhill, somebody needs to do something with him and I told him straight there and then, I think he’s going to kill himself, well he’s threatened to kill himself.”

108. The prisoner said that the healthcare manager assured him that he would take on board what he had told him.

109. The conversation with the prisoner was not recorded, neither was it mentioned to my investigator during his interview with the primary healthcare manager. The manager later verbally confirmed that he had spoken with the prisoner about the man that day but said that the prisoner had not told him about the man’s intention to kill himself.

110. At 5.30pm the senior officer recorded on the ACCT document that the man had taken his tea meal and appeared to be chatty and his usual self. (At Exeter prisoners eat their tea meal while locked in their cells.)

111. The D wing officer said in his statement to the police that he last saw the man at 6.00pm when he did his final roll call before going off duty. The officer said

that the man was lying on his bed reading a book and that he gave a 'thumbs-up' when the officer looked in.

112. At 6.27pm (time from CCTV), the officers on D wing began to open the cell doors for the association period. A prison officer was about to open the man's cell door when a prisoner asked him if he was sure he wanted to do that. At that time the officer noticed a sheet of paper that had been slipped under the cell door. The prison officer looked at the paper and realised that it was a complaint form. It was, in fact, the form that the man had submitted asking for a television. The officer saw that 'fuck off pig' had been written on the bottom of the form and the senior officer's reply had lines across it.

113. A prison officer described the sequence of events in his interview:

> The prison officer: "…Through the spyhole, I hadn't unlocked the door. The man was acting peculiar in the cell, he was acting … my concerns at that point were compounded by the other prisoner stating that, you know, are you sure you want to unlock the prisoner, and to explore it further, I made a decision at that point not to unlock the man. I went to speak to the other officer, raised my concerns, we agreed not to unlock him at that point, to just monitor for a while.
>
> Investigator: You said that he was acting peculiarly in the cell, can you …?
>
> The prison officer: He was just fidgety, maybe agitated, non-committal, wouldn't speak to me, look at me, things to that effect.
>
> Investigator: So then you had gone back and spoken to another officer and decided not to open him up just at that point …
>
> The prison officer: Just at that point, yes. Didn't mean he wasn't going to be opened up, not just at that point. However when I went back to see him at 1900 hours (CCTV shows 18.38) once again on his bed reading a book and he told me to 'fuck off' at that point, rather aggressively, so I wasn't going to unlock him at that point. We also had another prisoner come into the office and made a statement to the effect that there had been some problem on the landing and again some of the prisoners were concerned in, I wouldn't say frightened, of his behaviour. So we both took the decision not to unlock him. We continued to monitor him. Which I did."

114. At 7.13pm (CCTV time) the prison officer returned to check on the man. He found that his view into the cell through the door hatch glass was mainly blocked. He saw the man's back high up on the door and thought he was suspended. The officer returned to the landing office and told the other officer that he thought the man was hanging.

115. The other officer rang the control room and asked for Hotel one (the emergency healthcare response officer) to come to the landing as there was a medical emergency. The officers locked the prisoners back into their cells and then entered the man's cell at 7.15pm (CCTV time).

116. The officers had to force their way into the cell as the man's body weight was against the door. They found the man hanging off the ground, suspended by the neck from an overhead pipe. He had tied socks together to make the ligature.

117. The prison officer used his personal issue anti-ligature knife, referred to as a 'fish knife' due to its shape, to cut through the socks while the other officer supported the man's body weight. Once the ligature was cut, the man's weight proved too much for the officer but nevertheless he managed to manoeuvre him onto the bed. Both officers then put the man onto the cell floor. The prison officer, who was First Aid trained, checked for a pulse but found none.

118. When the officers laid the man on the cell floor they placed him, they believed, in the recovery position. Very shortly after, at 7.18pm (CCTV time), a nurse arrived at the cell. The nurse was 'Hotel one' that day, but did not know what kind of emergency he was attending. He had queried the emergency call as he was busy in Reception and had been told that it was urgent but no more.

119. The nurse found the man lying flat on the floor, not in the recovery position. He turned the man onto his back and checked for signs of life. He did not find any and he noted that the man's face and hands were blue in colour. The nurse started cardio pulmonary resuscitation (CPR) by means of chest compressions. He applied a resuscitation mask over the man's mouth and nose and used that to blow air into the man's lungs.

120. Whilst carrying out CPR, the nurse told the two officers to call for an ambulance urgently and to get the fourth prison doctor, who was in reception. At 7.21pm, the officer in the control room was informed by the other officer that the man had attempted suicide and an ambulance was required.

121. The CCTV shows the fourth prison doctor arriving at the cell at 7.24pm. She assisted the nurse with CPR until the paramedics arrived six minutes later, at 7.30pm.

122. Some water had been spilt on the floor of the cell so the paramedics decided to move the man out onto the landing to get him clear of the water. The paramedics attached a defibrillator to the man's chest but the machine did not register any cardiac output. The man was intubated (a tube was placed into the man's throat to ensure a clear airway) and adrenaline was administered. CPR continued. At about 7.50 pm, the defibrillator showed spontaneous activity from the man's heart. The paramedics decided to move him to a local hospital and at 7.55pm the ambulance left Exeter and took the man to the Royal Devon and Exeter Hospital.

123. No suicide note was found either at the time or when the police arrived later.

124. Just after 8.00pm, the senior officer arranged for the D1 landing prisoners to be let out of their cells. He spoke with the prisoners, advising them what had

happened. He also told them that Listeners were available if any of them were traumatised or distressed.

125. The staff involved were spoken to by the staff care team that evening but no 'Hot' debrief took place and no other debriefing session involving the staff has been held since. (The purpose of a 'Hot' debrief is to acknowledge what happened, acknowledge the role of the staff involved, normalise the situation and ensure that immediate needs of the staff have been met.)

126. One of the prison chaplains was notified and he went to the hospital to be with the man. After some difficulty, due to the lack of next of kin information, one of the man's brothers was contacted by the police and he and his wife arrived at the hospital at 12.15am. The Governor of Exeter was also present. He and the prison chaplain spoke to the man's relatives. The prison chaplain later prayed with the family before leaving them to be with the man.

127. At 11.17am the next day, a doctor certified that the man had died in the Intensive Care Unit.

ISSUES

Television

128. I believe it was clear from the time the man first arrived at Exeter that he might be a challenging prisoner to care for. He was already known by some of the staff from previous periods at Exeter. The man's reputation for smashing televisions emanated from those times in custody, and no less than seven security reports relating to smashed televisions have been located in earlier records.

129. The fact that the man had smashed a number of televisions was recounted to my investigator by a number of officers during the investigation. The impression given was that it had happened during his most recent time in custody, yet when the documents were checked the only mention of him damaging prison property was on 26 June. There was one record of him punching his television (no damage recorded) on 16 July. It is clear from the records that the man could sometimes have an unusual relationship with his television, saying that he could talk to the programmes or that they were talking to him. Those factors and the self-harm danger from broken parts, taken together, would easily justify removing the television. However, a lot of the time when it was recorded in the ACCT document that the man was calm, the observation was also made that he was watching television.

130. I am not convinced that a prisoner's current care should be unduly influenced by damage to a television or a number of televisions during previous times in custody.

Change of self-harm method

131. The man was known at Exeter as a man who would self-harm by cutting, yet on 30 July he was found hanging from the window in his cell. The man did not self-harm by cutting again. Although it is not clear if the healthcare staff or other staff were aware of the suicide note I believe the change of method should have been noted and should have triggered a mental health review. This view was shared by the Clinical Review Panel, who have made the following recommendation.

When there is a change in a prisoner's pattern of self-harming, such as application of a ligature rather than cutting, this should trigger a review and a reassessment of the individual by a psychiatrist.

Sharing confidential information

132. This investigation has once again highlighted a divergence between the medical staff and the discipline staff at prisons. The man was assessed by a psychiatrist, three doctors and other healthcare staff. In their opinion the man was not mentally ill. Very often non-medical staff find it hard to know how best to handle and care for prisoners like the man. After what was the last

ACCT review on 16 August, the senior officer wrote, “The HCU claim he is not mentally ill but those present (at the review) are of the opposite opinion.”

133. Very often during my investigations discipline staff complain of the lack of feedback they receive after they bring any health concerns, particularly about mental health, to doctors or nurses. My investigator was told that there is no formal documented pathway for those concerns to be passed, with a phone call or chance meeting on the wing being the usual method. It is not unusual for discipline staff to be waiting eagerly for a psychiatrist to assess a prisoner about whom they have genuine mental health concerns. The assessment is duly carried out but nothing is fed back to the wing staff who have 24 hour responsibility for that prisoner.

134. Medical confidentiality is usually the reason cited by healthcare staff for the lack of information given to discipline staff. There appears to be a belief by the staff (not only at Exeter) that they are not allowed to share medical information. In his introduction to ‘Safe and Secure’ – Guidance for healthcare staff on information sharing’ Head of Offender Management Partnerships – Department of Health and Director of Health and Offender Partnerships – National Offender Management Services wrote:

> “Although staff from all organisations involved with justice and secure care systems have always been willing to cooperate with and assist each other where possible, concerns over unlawful disclosure of sensitive and personal data have constrained sharing of information with, at times, tragic results. Whilst concerns to stay within the laws and guidance governing disclosure of information are justified and laudable, they have at times been misplaced.”

135. A review of patient-identifiable information was commissioned by the Chief Medical Officer for England as a result of increasing concern about the ways in which patient information is used in the NHS, and the need to ensure that confidentiality is not undermined when information is passed between NHS organisations or between the NHS and other organisations. The report of the review – the Caldicott Report – was published in December 1997. Following the report there has been a requirement for each NHS organisation to nominate a senior person, preferably a health professional, to act as a guardian to be responsible for safeguarding the confidentiality of patient information. These guardians have become known as “Caldicott Guardians”.

136. Caldicott Guardians act as a focus for information sharing issues which relate to patient information that has been provided in confidence. The responsibility for protecting and using patient information continues to lie with the whole organisation. The Caldicott principles which govern the use of confidential information are as follows:

- Justify the purpose(s) for using personally-identifiable information.
- Only use when absolutely necessary.
- Use the minimum that is required.

- Access should be on a strict need to know basis.
- Everyone should be aware of their responsibilities.
- Understand and comply with the law.

137. Another important recommendation of the Caldicott Committee was that protocols should be developed to protect the exchange of patient-identifiable information between NHS and non-NHS bodies.

138. The Devon PCT code of confidentiality (June 2007) lays out clear guidelines for when confidential medical information can be disclosed and to whom. At present there is no specific section dealing with prison discipline staff but I believe that they could be classified as 'carers without parental responsibility'. The guidelines for disclosure to those persons are as follows,

> "Only information essential to a patient's care should be disclosed and patients should be made aware that this is the case. However, the explicit consent of a competent patient is needed before disclosing information to a carer. The best interests of a patient who is not competent to consent may warrant disclosure."

139. The code sets out what is required for "explicit consent" as follows,

> "When seeking explicit consent from patients, the approach must be to provide:
> - Honest, clear, objective information about information uses and their choices – this information may be multi-layered, allowing patients to seek as much detail as they require,
> - An opportunity for patients to talk to someone they can trust and of whom they can ask questions, reasonable time (and privacy) to reach decisions, support and explanations about any form that they may be required to sign,
> - A choice as to whether to be contacted in the future about further uses, and how such contacts should be made, and
> - Evidence that consent has been given, either by noting this within a patient's health record or by including a consent form signed by the patient.
>
> The information provided must cover:
> - A basic explanation of what information is recorded and why, and what further uses may be made of it,
> - A description of the benefits that may result from the proposed use or disclosure of the information,
> - How the information and its future uses will be protected and assured, including how long the information is likely to be retained, and under what circumstances it will be destroyed,
> - Any outcomes, implications, or risks, if consent is withheld (this must be honest, clear, and objective – it must not be or appear to be coercive in any way), and

- An explanation that any consent can be withdrawn in the future (including any difficulties in withdrawing information that has already been shared).
- The information provided must allow for disabilities, illiteracy, diverse cultural conditions and language differences.

Any consent obtained must be recorded with details of:

- Who gave consent
- When it was given
- What purposes
- Any limitations to the consent."

140. Whilst I am not suggesting wholesale disclosure of confidential medical details, I do believe that when the need arises prisoners should be asked to sign a consent form allowing information to be shared with senior wing staff. Having a clear policy for disclosure would help prison healthcare staff to recognise that in certain circumstances such disclosure is both lawful and beneficial. Prison Service Instruction (PSI) 25 of 2002 'The Protection and Use of Confidential Health Information in Prisons and Inter-agency Sharing' (still in force) laid much of the groundwork for such a policy, but it is clear that in the six years since its introduction the mindset of the majority of prison healthcare professionals has not been changed.

141. I am pleased to see that the latest version of Prison Service Order (PSO) 2700 published in October 2007 highlights this issue in Section 6,

> "There are strong links between self-harm and mental ill health, drugs/alcohol problems, and experience of abuse. Other problems such as bereavement and, especially for women, the loss of children to the care system are common causes of distress to prisoners. All are issues that staff caring for prisoners need to be aware of and watch for; both in terms of the related risks to the prisoner, and around what specialist support is available to help the prisoner. Also, the often repeated findings from PPO investigations into deaths in custody and HMIP reports cannot be emphasised enough, concerning the need for <u>healthcare staff to share risk and basic care information with discipline staff who manage a prisoner</u>" (emphasis in the original).

142. In May 2008, the Director of Offender Health, Department of Health, NOMS, wrote a letter to PCT Prison Health Leads, Prison Governing Governors and others. He wrote about ten best practice issues from 120 PPO reports. Number 8 in the list was;

> "**Promoting an integrated approach to the care of people in prisons**
> The reports have demonstrated some differences in the aims and cultures of NHS and Prison Service at local level that may compromise working relationships on the ground. For example, evidence exists in the care of people with mental illness that a lack of willingness to share information may reduce opportunities to identify significant changes in mood and warning signs of decline in mental health".

The Healthcare Manager together with the Devon PCT should draw up and publicise widely a procedure for healthcare staff at Exeter to implement a clear policy for the obtaining of consent and the subsequent disclosure of prisoners' confidential medical information to realise both the letter and spirit of Section 6 of PSO 2700. The effectiveness of the new arrangements should be formally reviewed within six months of their introduction.

Conversation between a prisoner and the Primary Healthcare Manager

143. When the primary healthcare manager was interviewed by my investigator he did not mention that the other prisoner had approached him after he left the man's cell on the afternoon of 16 August. The prisoner said that he had spoken to the healthcare manager and expressed his concerns about the man after he had said that he intended to end his life that day. When my investigator spoke with the manager again he agreed that the prisoner had spoken to him about the man but that the conversation centred on the prisoner's concern that the man would start getting angry in the food queue at tea time.

144. There was obviously a conflict between the two accounts. If the prisoner's account was correct the manager, a registered mental nurse, should have realised the import of what the prisoner had told him and taken action. For that reason and in line with my terms of reference the Governor was told of the situation and then the investigating police officer was informed and given copies of the interviews.

145. Both parties were interviewed by the police. I understand the prisoner did not repeat that he had actually told the manager that the man had said he intended to kill himself that day. The police investigation has been reported to HM Coroner and, together with my report, will form part of the evidence available at the inquest.

Emergency radio system

146. I investigated the death of another man at Exeter in January 2005. One of the recommendations in that report was that the Healthcare Manager should consider introducing a coded radio system for alerts. Many prisons have introduced such a scheme where, for instance, a medical emergency involving blood is a code red, one involving a prisoner not breathing or having trouble breathing a code blue, etc. Such a coded system has the advantage of alerting all staff to the type of situation they may find upon arrival at the given location.

147. In the man's case, the nurse was busy in Reception when he received the call over his radio. Even when he queried the nature of the call, the control room officer was unable to give the nurse any details as he himself had not been given any.

148. Finding a person hanging is a stressful experience and often staff find it difficult to recall times and exactly what they said or did. A coded system would ensure that the essential information was conveyed quickly. It would also allow the medical staff to arrive at the location with the relevant staff and equipment. The nurse would have brought a defibrillator to the man's cell if he had known the kind of emergency he was attending, although in this case I do not believe the lack of equipment had a negative impact. Ideally an ambulance would have been called as soon as the man was discovered hanging and would have been if the control room had the specific information from the outset.

The Governor together with the Healthcare Manager should introduce a radio colour code system for use by staff in medical emergency situations.

Lack of hot debrief

149. Neither the staff who found the man in his cell on 16 August nor those subsequently involved were asked to attend a 'hot' debrief that evening or any other debriefing session later. This is in contravention of the guidelines laid down in Prison Service Order (PSO) 2710 and PSO 8150. I am aware that a 'hot' debrief was not held after another man died at Exeter by his own hand, in September 2007.

"PSO 2710 paragraph 5.3 states: *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.* (Italics in original) The purpose is not to analyse or re-live the incident. Nor is it an opportunity to apportion blame or pre-judge investigation findings. The hot debrief should focus on reassurance, information sharing, normalisation and how staff can support each other. Particular reassurance is needed when the prisoner died after unsuccessful resuscitation attempts, when staff involved are more likely to feel a sense of failure. Staff wanting but unable to attend the debriefing should be followed up, as a group or individually. Refer to PSO 8150 for guidance about Critical Incident Debriefs and longer-term support and specialist treatment."

Section 1 and 6 of PSO 8150 states:
"1. Immediately following a potentially traumatic incident- identify, inform and debrief. In the immediate aftermath of the incident, before the staff involved go home, it is important that managers identify all staff who were involved and provide them with a short debrief, known as a "Hot" debrief. Within 5-10 days of a potentially traumatic Incident- Critical Incident Debrief.

6.1The purpose of a Critical Incident Debrief is to:

- Give staff involved in an incident the opportunity to discuss the personal impact of the incident with others involved.
- Encourage and enhance mutual support.

- Provide information on the effects of Post Trauma Stress.
- Normalise Post Trauma Stress reactions.
- Encourage coping strategies and support networks.

6.2 A Critical Incident Debrief will automatically be offered when the Incident is categorised as potentially traumatic and when there are more than 2 members of staff affected. When only 1-2 members of staff are affected, they can be referred (if necessary and with their consent) to Employee Support for an individual support."

The Governor should ensure that the relevant sections of PSO 2710 and PSO 8150 are complied with in relation to debriefing sessions following a death in custody.

RECOMENDATIONS

1. The Healthcare Manager together with the Devon PCT should draw up and publicise widely a procedure for healthcare staff at Exeter to implement a clear policy for the obtaining of consent and the subsequent disclosure of prisoners' confidential medical information to realise both the letter and spirit of Section 6 of PSO 2700. The effectiveness of the new arrangements should be formally reviewed within six months of their introduction.

2. The Governor together with the Healthcare Manager should introduce a radio colour code system for use by staff in medical emergency situations.

3. The Governor should ensure that the relevant sections of PSO 2710 and PSO 8150 are complied with in relation to debriefing sessions following a death in custody.

Recommendations from the Clinical Review Panel

1. Where patients report positive responses to questions on the secondary health questionnaire, then action and consideration by an appropriate health practitioner should be recorded in the patient's notes.

2. The use of a summary sheet to record major events should be maintained and include incidents of self harm, and prison health care unit in-patient admissions.

3. When calling healthcare to an emergency on the wings they should be made aware if it is a suspected suicide.

4. When there is a change in a prisoner's pattern of self harming eg application of a ligature rather than cutting, this should trigger a review and reassessment of the individual by a psychiatrist.

5. Care plans for reviewing patients following admission and/or requiring continuing wing support, should clearly state the frequency and objective of future consultations, with a clear criteria for discharge and readmission.

6. Assessment proformas should be comprehensively completed by staff.

7. Discipline staff who discover a casualty not breathing and with an absent pulse should be appropriately trained to initiate CPR, whilst specialist assistance is summoned.

8. When a serious incident occurs which could result in a death in custody the Primary Care Trust Commissioner should be informed the next working day via the healthcare manager or their deputy.

9. A mechanism should be in place to request a prisoner's previous GP records via the PCT for prisoners serving a sentence of longer than six months.

Good practice identified by the Clinical Review Panel

- A comprehensive discharge plan was prepared by healthcare staff, summarising recent care and future care needs.

- The time between a primary care referral and assessment by a psychiatrist was appropriate and timely.

- Resuscitation is particularly traumatic in a prison setting; the extensive efforts of the attending nurse and paramedics in supporting this prisoner should be noted and commended.

- The level of support which was provided from the multidisciplinary team should be commended.