# The Investigation into the circumstances surrounding the death of a man in custody at HMP Exeter on 14 August 2004

**Report by the**
**Prisons and Probation Ombudsman**
**for England and Wales**

**March 2005**

This is the report of an investigation into the circumstances surrounding the death of a man on 14 August 2004 at HMP Exeter. The investigation was carried out under the transitional arrangement for investigating deaths in custody agreed between my office and the Prison Service, and which ran until 30 November 2004. The investigation was conducted by the Deputy Governor of HMP The Verne, and overseen by a member of my team.

A clinical review of the care and treatment received by the man was undertaken by the Medical Officer HMP Dorchester. He concluded that "*such an unfortunate incident could not have been predicted. I would commend Healthcare Staff for the clarity and methodical way the Inmate Medical Record (IMR) was maintained throughout this period"*. I agree with his views.

I would like to thank the Governor of Exeter for making the necessary arrangements to accommodate the investigation team. Additionally I wish to thank the Principal Officer and the Head of Business Development for their assistance as liaison officers.

The report makes six recommendations for the prison and identifies one area of good practice.

The loss of any family member is tragic, but especially so whilst they are in custody. I offer my sincere condolences to the man's family and friends. His children have now lost both parents. No words of mine could capture the sadness of their young lives.

**STEPHEN SHAW CBE**
**Prisons and Probation Ombudsman**

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## SUMMARY

1. The man was remanded into custody on 24 May 2004 by the Central Devon Magistrates' Court, having been charged with murder. Upon his initial reception, he was allocated to the prison Healthcare Centre for observation and assessment. This is normal practice for someone facing such a serious charge. The assessment identified an earlier suicide attempt (1981) and, due to concerns about his children and raised risk of self-harm, the nurse completed the Self-Harm at Risk Warning form, F2052SH. The F2052SH is used by the Prison Service to identify anyone who may be at risk of self-harm and to monitor their behaviour, moods and comments. It is a multi-disciplinary document and involves holding a case conference, with the prisoner in attendance, and identifying any support mechanisms that need to be in place. In the man's case, the document was later closed on 13 June following a case conference.

2. Following the hospital assessment period, the man was moved into the main prison and accommodated in a single cell. He was allocated work in the reception area, which is a highly trusted position for any prisoner to work in and a measure of how well he had settled down.

3. On the morning of 14 August at 6:25am, the man was discovered hanging from the window bar by an officer who was checking the wing roll. Medical assistance was requested. The prison doctor pronounced him dead at 7.10am.

## INVESTIGATION PROCESS

4. Terms of Reference were issued and the Deputy Governor of HMP The Verne was commissioned to carry out the investigation, with support from one of my investigators.

5. The investigation began by my investigator meeting the Deputy Governor of HMP The Verne and the Governor of HMP Exeter. The Governor briefed the team about what had occurred. A Principal Officer was appointed by him to act as Liaison Officer.

6. My investigator and the Deputy Governor of HMP The Verne met with a member of the Independent Monitoring Board and Prison Officers' Association and explained how the investigation would proceed.

7. The Principal Officer had produced a comprehensive document containing all the necessary information relating to the man. He also arranged for facilities to be available for the investigation team.

8. The area where the man died was visited and examined. Following this, the team released the cell back to the Governor. The area of the prison where the man worked was also visited.

9. All available documentation was examined. A list of key staff who attended to the man and of prisoners was drawn up in readiness for interviewing.

10. My investigator met with the Coroner and later with the man's mother and sister at the family home. His family were given the opportunity to raise any concerns that they might have. No concerns were raised. They asked my investigator to return and brief them on the findings, once the report was available.

11. The Deputy Governor of HMP The Verne was briefed as to how the investigation should proceed. Under the transitional arrangements for investigating deaths in custody, he took over responsibility for the investigation, overseen by my investigator.

## THE MAN

12. He was born on 9 January 1957 and was one of two adopted children. He had an adopted sister, who now lives in the Midlands. His mother still lives in the Exeter area. The man was educated at boarding school and local authority education schools in the Exeter area. He left school at the age of 16 and joined a local factory, where he remained until leaving to become a welder. He later returned to the factory where he had begun work after leaving school and gained a supervisory position on the production side of the factory.

13. The man had been married for 17 years and had two children aged 13 and 11 at the time he was arrested. The marriage was going through an unsettled period and his wife had begun divorce proceedings. He was aware that his wife had been seeing another man, but did not know who.

14. On 21 May at 8.03pm, the police received a telephone call via 999 from the man to say that he had stabbed his wife at the home address in Devon. The police responded and initially arrested him on suspicion of wounding. Once it had been established that his wife was dead, he was arrested on suspicion of murder. He was taken to hospital for treatment to a stab wound on his left leg and right hand. Following treatment, he was taken to Exeter Custody Centre for questioning.

15. His period of custody did not cause any concern to staff. He was described by staff and prisoners as very polite and quiet. The wing files did not have any recorded negative entries or warnings. The Security File had one entry indicating that he was a potential suicide risk. This had been obtained from the initial assessment files raised following his initial reception into custody and was not new information.

**HMP EXETER**

16. The prison is located within the City of Exeter and was built around 1850. The Certified Normal Accommodation is 314 and the Operational Capacity 533. The prison holds both adult male remand and convicted prisoners committed to custody from Cornwall, Devon and South West Somerset. Additionally it holds young men between the ages of 18 and 21. On 14 August, the population was 502.

17. The Healthcare Centre has one Principal Officer and one Senior Officer. The nursing staff complement is : One H Grade, one F Grade, 11 E Grade (full time), two E Grade (part time), one D Grade, and one B Grade. The Healthcare Centre has a “Green Light” assessment and is staffed 24 hours.

18. The Standards and Security Audit carried out in May 2003 assessed the prison as “Good”.

## FINDINGS

19. The man died on August 14 whilst in Exeter Prison. The autopsy report, produced by the Home Office Pathologist for Devon and Cornwall Constabulary, identifies the cause of death as hanging.

20. He had been remanded into custody by the Central Devon Magistrates' Court on 24 May 2004 for an offence of murder. Following his remand into custody he was transferred to Exeter Prison. He was further remanded by Exeter Crown Court on 2 June and 6 August. The Police National Computer (PNC) printout shows that he was not known previously to the police.

21. On his arrival into custody, he was allocated initially to the prison Healthcare Centre and discharged into the main wing accommodation by the prison doctor on 31 May. He underwent assessment by Healthcare staff as a potential risk of self-harm or suicide, which resulted in a Self-Harm at Risk Form (F2052SH) being opened by an Healthcare Officer. The form was subsequently closed on 13 June following a multi-disciplinary team meeting, which the man attended. He was noted as being positive and speaking openly about the offence and fully accepting his responsibility. The review summary noted that the man stated that he was not suicidal.

22. The prison's local procedures for dealing with the F2052SH system were audited by the Standards Audit Unit in April/May 2003. The overall marking was 83 per cent, which gave an assessment of "Good". An examination of the F2052SH file opened on the man shows a number of entries where the authors have not printed their name and simply signed the entry, making it difficult to audit. This is contrary to the document instruction. It was also found that a number of entries have gaps between them, which is poor practice and both findings require correction.

    **The Governor should remind staff that all entries into the F2052SH document clearly identify the person making the entry with printed name, signature, and time. Additionally, there should be no gaps between entries.**

23. As the man was facing a mandatory sentence for his offence, an Officer interviewed him as a potential life sentence prisoner on 27 May. The report noted that the man had said that he did not require any support as he preferred to keep his thoughts to himself. The Officer did not raise any concerns regarding him.

24. All prisoners arriving into custody for the first time are assessed by the "First Night" staff and a Cell Sharing Risk Assessment carried out to assess the level of risk to others. The man was assessed as low risk. The Case Management Record indicates at section E that he had made a self-harm attempt in 1981, due to domestic reasons. It does not identify how the self-harm attempt was made. Section F notes specific concerns raised by him regarding sleeping and his children.

    **The Governor should remind staff that the Case Management Record identifies how any previous self-harm/suicide attempt was carried out and when.**

25. Following the man's transfer from the Healthcare Centre to normal location, he was allocated work within the prison reception. He remained working in the reception department up until his death.

26. On 13 August, he attended his work place as usual and remained in the department until approximately 9.00pm. He had given no cause for concern to either the reception staff or other prisoners working in the area. The Reception Officer said in his statement that there was no indication that anything was wrong and that the man did not seem to be down in the dumps.

27. A prisoner who worked with the man, said that he was positive when he returned to the wing the evening prior to his death. Another prisoner employed in the reception area, said that the day was normal and that he had been talking to the man through the window the evening prior to his death and had said that he would see him in the morning. The man had not given either of the prisoners any cause for concern

28. The man returned to his cell, A4:36, at approximately 8.00pm following completion of his work in the reception department. He had been allocated to this cell since his transfer from the prison hospital on 31 May. The cell was a single occupancy room. When he returned to the cell he found a letter on his bed from a firm of solicitors which had been posted in by his own solicitor. The letter explains to his solicitor the legal position regarding his property and future maintenance contribution for his children. Prison staff delivered the letter to his cell for him to read on his return. As the letter was from a solicitor, it would not be routine for prison staff to read the contents. The staff therefore would not have realised the significance of the contents.

29. The Senior Officer said that at 5.00pm he had been having a drink of tea with the man and that he appeared quite happy. Once he had been made aware that the man had died he spoke to other prisoners who worked in the reception area. They said that the man informed them that he had a letter and gave a facial expression of not being too happy. They did not see him again.

30. An Operational Support Grade (OSG) carried out a roll check of A4 landing at 8.54pm and said that she observed the man looking out of the window. He did not acknowledge her. The wing has a movement detector sensor which then operates a video camera. Unfortunately, the detector located at the area the man was allocated to failed to work. However, the video evidence does show that the OSG began her roll check at 8.56pm on the left side of the landing. When she entered the far left hand side the image disappears and does not re-appear until she activated the detector in the lower right side of the landing. The fault has since been corrected.

**The Governor should introduce a regular auditable maintenance check to test the cameras and sensor operation.**

31. On 14 August at approximately 6:25am, the OSG carrying out a roll check discovered the man hanging from the window bars of cell A4:36. Roll checks are undertaken to establish that the prison population agrees with the recorded total and to ensure that individuals are safe and secure. The man was at the window of the cell and the OSG could observe a ligature around his neck. He summoned assistance from the

communications room and from staff within the unit. Staff attended soon after his request for assistance. The OSG was unable to open the cell door, as his normal duty was to patrol the external area of the prison and therefore he was not permitted to carry a cell key with him.

32. The prison Incident Log shows that at 6.25am a radio message was received from call sign "November two" requesting "Hotel one" to attend A4:36. Hotel one is the call sign of the Healthcare staff.

33. The Orderly Officer, radio call sign "Oscar one", acknowledged at 6.28am by radio that he was on his way to collect a Nurse from the Healthcare Centre. Once the Orderly Officer had been informed that the incident was one of a prisoner hanging, he requested an ambulance to be called. The control room staff made a 999 call at 6.29am.

34. The cell door was unlocked and opened by a Senior Officer. Another OSG assisted the Senior Officer with lifting the man and removing the ligature. This OSG, who is a Paramedic Reservist in the Army, checked for vital signs, carotid pulse, eye movement, breathing and chest noise. He was unable to find any indication. He said that he had found Rigor Mortis and the eyes to be fixed and dilated. The skin was cold and clammy with the limbs extremely stiff.

35. A nurse arrived shortly after. Having assessed the body, the nurse concluded that it would be inappropriate to attempt resuscitation. The Clinical Review agrees with this view. The nurse was on duty in the Healthcare Centre when the urgent message call was transmitted. As he was on night duty, he did not have keys available to him to allow him access into the incident area. The procedure for obtaining medical assistance during the night is that the Orderly Officer has to escort the nurse to the incident scene. In this case the short time delay was not relevant. However, due to the nurse having to wait for the Orderly Officer to attend, it is possible that valuable time could be lost in giving medical aid. This requires reviewing.

**The Governor should review the procedures and carry out a risk assessment for accessing urgent medical assistance during the night time.**

36. The prison doctor pronounced the man dead at 7.10am. The cell was then locked and a member of staff positioned outside the door to prevent entry and protect the evidence.

37. The prison contingency plans for dealing with a death in custody were activated. The Duty Governor was telephoned at home and informed of the death. He attended the prison promptly. When he arrived at the scene, the cell door was locked and he gave instructions that the door should not be unlocked until the police arrived as it was a potential crime scene. However, the Chaplain requested to say a prayer over the body of the man, which the Duty Governor allowed and the cell door was unlocked. This was a compassionate and decent thing to agree to, and I make no criticism of the action. However, as a potential crime scene the door should not have been unlocked until the police had given authority.

**The Governor should ensure that all staff are aware that a potential crime scene should not be entered until authority has been given by the police. This should be entered into the local contingency plans.**

38. The ligature was found to be a form of nylon "Baler" twine as used in the prison reception and clothing exchange area. An Officer explained in his statement how the towels arrive bound by the twine and the method of disposal. The investigator concluded that the control and disposal of the twine was not sufficiently robust and alerted the Deputy Governor to this fact.

**The Governor should introduce a system to account for the twine.**

39. As well as the solicitor's letter identified at paragraph 15, two further letters written by the man and dated 13 August were found. One was jointly to his mother and sister.

40. The Governor, Family Liaison Officer and Chaplain were very supportive to the family, which is to be commended. On 15 August, the man's sister wrote to the Governor thanking him and the staff. The letter suggests that the final straw for her brother was receiving the solicitor's letter.

41. The Chaplain had spoken to the man previously and had never had any cause for concern regarding his welfare. The Chaplain took the funeral service and also arranged for a memorial service to take place in the prison chapel, which prisoners and staff could attend. The service was held on 25 August.

42. My investigator met the man's sister and mother and they suggested that he had never come to terms with being adopted. They also suggested that, as he had attempted suicide previously, he would be well aware of how to hide his feelings and disguise his true intentions and that nothing could have prevented him committing suicide. They spoke very highly of the prison and the care and attention afforded them.

43. The investigation found that the man was well cared for and appropriately supported during his time in prison.

## RECOMMENDATIONS

1. The Governor should remind staff that all entries into the F2052SH document clearly identify the person making the entry with printed name, signature, and time. Additionally, there should be no gaps between entries.

2. The Governor should remind staff that the Case Management Record identifies how any previous self-harm/suicide attempt was carried out and when.

3. The Governor should introduce a regular auditable maintenance check to test the cameras and sensor operation.

4. The Governor should review the procedures and carry out a risk assessment for accessing urgent medical assistance during the night time.

5. The Governor should ensure that all staff are aware that a potential crime scene should not be entered until authority has been given by the police. This should be entered into the local contingency plans

6. The Governor should introduce a system to account for the twine.

## GOOD PRACTICE

1. The Governor should commend Healthcare Staff for the clear and methodical way the Inmate Medical Record was completed.