

**Investigation into the death of a man whilst in the  
custody of HMP Dartmoor on 25 October 2006**

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

**July 2008**

This is the report of an investigation into the circumstances surrounding the death of the man at HMP Dartmoor in October 2006. The man was found in his cell, apparently dead. A post mortem examination conducted by a Home Office registered pathologist, confirmed that he had died as a result of a heroin overdose. The man was aged 27.

I offer my sincere condolences to the man's uncle and aunt, and to his many friends, for their loss. I must apologise for the considerable delay in issuing this report.

The investigation was carried out by one of my investigators. I also commissioned an independent clinical review of the management of the man's health needs while he was in custody. This was conducted on behalf of the Exeter Primary Care Trust. I am grateful to the clinical reviewer for his contribution.

On 28 November, my investigator and one of my family liaison officers met the man's uncle and aunt to find out what matters they wanted the investigation to address. The concerns they expressed have been examined in the pages that follow.

I would like to express my appreciation to the Governor of Dartmoor and her staff for their help and co-operation during the investigation. I am particularly grateful to the prison liaison officer and to his assistant.

My investigation has found that the man was offered appropriate support in his quest to end his use of drugs. Sadly, despite the best efforts of staff, he continued to succumb to temptation.

It is particularly disturbing to investigate a death from a drugs overdose that has occurred whilst someone is in prison custody. I hope the recommendations I and the Primary Care Trust have made in this report will help prevent a further similar tragedy occurring at Dartmoor or elsewhere.

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

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**July 2008**

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## SUMMARY

The man was sentenced to three and a half years imprisonment at Crown Court for possession of drugs with intent to supply. He was taken to HMP Blakenhurst that day. The man had a history of drug abuse and had been in prison many times before. However, he had no apparent self-harm history.

The man spent a little over four months at Blakenhurst before being transferred to HMP Exeter on 2 December 2005. Three weeks later he was transferred to HMP Dartmoor as a category C prisoner.

Upon his arrival at Dartmoor, the man underwent a reception health screen during which his weight - 25 stones - was noted as a particular problem. His history of drug abuse was also noted, and as a result he was referred to the Counselling, Assessment, Referral, Advice and Throughcare (CARATs) service. He seemed highly motivated then and, for most of his time at Dartmoor, to put his drug abuse behind him.

In his early days at Dartmoor, the man was employed as an Insider - a prisoner trained to assist less experienced prisoners to adjust to prison life. In May 2006, he applied to join the Resettlement Unit (RSU). This unit assists prisoners to prepare for their release through the provision of opportunities to undertake work outside the prison after a six month period of assessment. The unit regime also requires prisoners to remain drug free.

As soon as he had been accepted for the unit, the man turned it down, telling staff he preferred to remain an Insider. However, a month later he changed his mind. He was soon employed as an orderly on the unit servery. By all accounts, the man settled well in the unit and felt generally content with his environment. He soon joined courses to help him gain employment on release. He planned to buy his own property using capital left to him from the sale of his mother's house. He undertook voluntary drugs tests that indicated he was drug free. All the signs were that he was making best use of the opportunities available and that his morale was high.

However, on 17 October 2006, staff suspected the man of attempting to send money to the girlfriend of another prisoner to pay for drugs and alcohol to be brought in to the prison. Two days later, he anonymously wrote a poem for his female drug worker to read. He wrote that he was feeling emotional about his mother's death, especially at night. He also said he sometimes wished he was dead.

The drug worker, recognised that the poem had been written by the man and saw him straightaway in the company of a prison officer. After seeing him, they decided to open an Assessment, Care in Custody and Teamwork (ACCT) form. (This is a means by which prisoners considered to be at risk of self-harm or suicide can be monitored and assisted to reduce their risk.) I am impressed by the speed of response by the drug worker and the officer and commend them both for their initiative.

The risk management plan for the man included seeing a bereavement counsellor and a doctor, a referral to the Mental Health In-Reach Team, and using the Listeners on his wing. With the man's agreement, an appointment was made for him to see a doctor on 26 October 2006 at 3.30pm. The ACCT form remained in force until the man's death.

On 24 October, the man asked to be removed from the Resettlement Unit. He told staff he wanted to be able to share a cell, something he could not achieve in the RSU. Despite being told this would be difficult because of the scarcity of double cells, he insisted on being allowed to move. Although his motives were considered to be dubious, his request was granted and he was placed in a shared cell on the uppermost landing in D Wing (the Induction Unit), where he had been an Insider at the beginning of his time at Dartmoor. The man's cellmate who was already in that cell, was initially reluctant to agree to share with the man. However, the cellmate was persuaded to do so when the man suggested to him they could smoke heroin together. Because of his weight, the man occupied the bottom bunk.

According to the cellmate, both prisoners smoked heroin through the night. Although routine checks were made on them, they were not caught. The investigation failed to ascertain the time at which they fell asleep. Although the cellmate was awake when officers carried out security checks of the cell during the next morning, the man remained passive. The cellmate, like the staff and other prisoners who visited the cell, assumed he was asleep. None of the staff made any attempt to gain a response from the man, in spite of the fact that he was subject to self-harm monitoring procedures.

It was not until 1.35pm on the day that an officer discovered the man was dead. A post mortem examination showed he died as a result of a heroin overdose.

During the course of the investigation, a prisoner confessed to my investigator that he had passed to the man the heroin that killed him. Although the police investigated, and the Crown Prosecution Service considered whether he should be charged with supplying a Class A drug, the case was not brought to trial because the prisoner's confession was considered to be unreliable and because of the absence of corroborative evidence. I have chosen to withhold the name of the individual concerned.

The investigation found that the man's healthcare needs were appropriately managed at Dartmoor. He was given every support in his apparent quest to avoid the use of drugs. Unfortunately, he did not make best use of that support.

I express my concern at the complacent approach of those staff who failed to gain a response from the man during that morning. However, I do not blame them for his death. I am not prepared to speculate as to when he died or whether an earlier intervention would have prevented it from happening. The investigation could not determine whether he died as a result of an accident or because he committed suicide.

I am critical of some aspects of the self-harm and suicide prevention procedures applied to the man. In particular, I draw attention to the failure to set out clear instructions for the frequency of required observations during the last night of his life.

I examine the physical and procedural security measures in place at Dartmoor at the time of the man's death as well as measures that have been taken since. I argue that the Governor's local policies for the reduction of the supply of and demand for, illicit drugs, are thorough, comprehensive and well thought out. However, the ability of her staff to combat the introduction of contraband into the prison is limited by poor physical security at the perimeter where, I believe, the cost of making effective improvements would be prohibitive.

This report makes a number of recommendations that I hope will help to minimise the risk of another death occurring in similar circumstances at Dartmoor or any other prison.

## **INVESTIGATION PROCESS**

1. The investigation was opened on 30 October 2006 when my investigator, met the Governor of Dartmoor, the Chairman of the local branch of the Prison Officers' Association, and a representative of the Independent Monitoring Board. Three members of the Devon and Cornwall Police also attended the meeting. My investigator briefed those present on the nature and scope of the investigation. On the same day, notices were issued to staff and to prisoners inviting anyone with concerns relating to the man's death to make themselves known to my investigator.
2. I also commissioned an independent clinical review of the management of the man's health needs while he was in custody at Dartmoor. This was conducted by the clinical reviewer of the Exeter Primary Care Trust.
3. On 28 November 2006, my investigator and one of my family liaison officers met the man's uncle and aunt who had been listed as his next of kin. They raised a number of concerns that have been addressed in this report.
4. On 12 December 2006, the investigation was temporarily suspended to allow the Devon and Cornwall Police to make their own enquiries into matters uncovered during an interview with a prisoner. The investigation was reinstated on 4 January 2007. Twenty members of staff and seven prisoners were interviewed.

## HMP DARTMOOR

5. HMP Dartmoor is in Princetown, Devon. It is currently used as a category C training prison for up to 625 adult male prisoners. Its cellular accommodation comprises six wings, including an induction unit, a vulnerable prisoners unit, and a resettlement unit. The establishment was given the outstanding Public Service Team award for 2004-05, and the Most Improved Prison award for 2005.
6. At the time of the investigation, healthcare at Dartmoor was provided by the Prison Service. The healthcare centre has no inpatient facilities. Prisoners requiring a stay in hospital are normally transferred to a nearby NHS hospital or to the Healthcare Centre in HMP Exeter.
7. Dartmoor was most recently inspected by HM Chief Inspector of Prisons in February 2006, eight months prior to the man's death. In the introduction to her report of that inspection, she wrote:

“This is the third inspection of Dartmoor since I became Chief Inspector in 2001. It describes a prison that has been transformed during those five years. Dartmoor was a prison stuck in a time-warp – over controlled and disrespectful, and offering scarcely any positive benefits to prisoners. It is now recognisably a 21<sup>st</sup> century training prison with good and improving resettlement opportunities for prisoners.”
8. In respect of resettlement, the Chief Inspector's report commented that a number of improvements had been made since the previous inspection in 2003 and that the prison was performing reasonably well. The drug strategy document had been revised and there was a separate alcohol strategy. The range of available courses had been extended and included PASRO (Prisoners Addressing Substance Related Offending). Good links had been established with drug agencies in the community.
9. In their report on Dartmoor for the period 1 October 2005 - 30 September 2006, the Independent Monitoring Board (IMB) also commented positively on many aspects of the prison. The Resettlement Unit, where the man spent much of his time, was described as having processed more than 1,400 successful temporary releases. The IMB reported that the healthcare department had been through a period of major change. They thought the security department was a well organised unit that had kept drug problems under control. No comments were recorded about suicide prevention.
10. I have investigated only one previous apparently self-inflicted death at Dartmoor. The recommendations I made in my report of that investigation are not relevant here.

## **KEY EVENTS**

11. The man was sentenced at Crown Court to three and a half years imprisonment for possession of drugs with intent to supply. He was taken to HMP Blakenhurst that day.

### **Blakenhurst: 28 July to 2 December 2005**

12. Upon arrival at Blakenhurst, he underwent a reception health screen during which he manifested no risk of self-harm. However, he was referred to a doctor about his substance misuse.
13. Shortly afterwards, the man had an OASys (Offender Assessment system) interview. In the subsequent report, he was described as having no difficulties coping with imprisonment. He was not depressed nor socially isolated, and there were no psychiatric problems. The man told his interviewer that, although he had felt depressed after his mother's recent death, he had not seen a doctor and had not, therefore, taken any medication. The man said he had never self-harmed or attempted suicide. The interviewer concluded that there were no risk indicators of self-harm. The report recorded that, although the man had abstained from drug and alcohol abuse for two years, he needed to remain clear of both if he was to live a normal life.
14. A week later, the man was transferred to the voluntary drug testing unit where he was required to remain drug-free. On six occasions between August and November 2005, he undertook voluntary urine tests that indicated he was clear of drugs.
15. In early October, the man was released into the custody of police in Taunton in relation to alleged offences already under investigation. He later returned to Blakenhurst.
16. On 2 December, the man was transferred from Blakenhurst to HMP Exeter to appear at Taunton Magistrates' Court to face further charges. He was sentenced to a consecutive period of six months imprisonment for burglary and taking without consent. After his court appearance, he returned to Exeter.

### **Exeter: 2 December to 22 December 2005**

17. During the reception procedures at Exeter, it was noted the man had no history of self-harm. He told staff that, although he was a drug addict, he had been clear of drugs since November 2003. He confirmed he did not currently feel suicidal. He said he would let his uncle know where he was. Three weeks later, the man was transferred as a category C prisoner to HMP Dartmoor.

## **Dartmoor: 22 December 2005 to 25 October 2006**

18. The Prisoner Escort Report (PER) for the journey between Exeter and Dartmoor indicated no risk of self-harm but noted drugs were a risk factor.

### ***Reception Health Screen***

19. Upon his arrival at Dartmoor, the man underwent a reception health screen. This was undertaken by a nurse who recorded that the man had no physical ailments or mental health problems, although, at 25 stones, he was grossly overweight. The nurse also recorded that the man did not have any self-harm history. She noted in his medical file that he had previously used drugs, and had asked to be allocated to a drug-free wing. She referred him to the CARATs service.
20. A first night checklist described the man as appearing “anxious, depressed or withdrawn” yet able to cope. He told the induction staff he had no immediate concerns or problems. He took up the offer of a first night telephone call.
21. On 6 January 2006, a second officer assessed the man’s suitability for open conditions. The second officer wrote:

“The man arrived at Dartmoor on 22 December 2005. He is currently on his induction programme. His wing/prison history from Exeter does not state that he has done anything in the area of offending behaviour work to reduce his risk. Has completed ETS (Enhanced Thinking Skills) course which is not offence related. Nothing completed in custody to reduce the risk of reconviction. To remain Cat C.”
22. Three days later, the man was assessed by healthcare staff regarding his obesity. However, he was found to be in good health.

### ***Application to join the Resettlement Unit***

23. At the beginning of May 2006, the man applied to join the Resettlement Unit. The purpose of this unit is to assist and encourage selected prisoners to prepare themselves for living in the community after release. The resettlement process includes, for the most trusted prisoners, a chance to do paid work outside the prison. Before being granted such a privilege, prisoners are required to undergo a period of assessment for about a month before joining the unit and for up to six months after joining it. This period is known as Resettlement Stage One.
24. A third officer interviewed the man in order to initiate the Stage One process. The officer recorded that he was pleased with the man’s attitude and motivation. The man had completed an enhanced thinking skills course during the previous year and had attracted good reports. He had completed a relapse prevention

course in April 2006, as well as a course in Literacy and Numeracy. It was known that the man had no employment arranged for his release but he had inherited enough money in his mother's will to enable him to buy his own house. The officer recorded that the man was due to start a substance misuse course imminently, and that the successful completion of that course would mark the achievement of all his offending behaviour work. The officer wrote that the man was an enhanced prisoner who was eligible for parole from June 2007 and who was, in his view, worthy of a place in the Resettlement Unit.

25. After the man had been told he was to be accepted, he wrote the following letter to the unit staff:

"To whom it may concern"

"I would like to thank you for offering me a place on the resettlement wing and I am grateful for the time and consideration it's taken to assess me and find me suitable. However, I unfortunately have to decline at the present time. I realise that I did apply for resettlement in the first place and it's not that I don't want to move because I do. It's just that when I applied I was under the impression that there was a long waiting list and I didn't think I would get a place so soon.

"I currently have over 12 months left until my parole date and 20 months left until my non-parole release date, which would be a nice long time to spend on resettlement. I was hoping to spend my last 6 months on resettlement so that anything I was to learn or gain from my time over there would be more helpful/effective for when I go back into society.

"I currently have a job as an insider [a prisoner trained and trusted to help new prisoners adapt to prison life] on D Wing as well as doing the PASRO (substance misuse) course but I've only started my job as an insider last month and I feel I would be letting members of staff down if I gave up my job now as another insider would have to be found and trained to replace me and there aren't many inmates who would want to do the job and the ones who do are not suitable. So I would like to carry on doing my job as an insider if possible. I have gained a lot from my time in prison over numerous sentences and being an insider gives me chance to give something back. I have spoken to members of staff and I feel that the best thing I could do at this point in time is to carry on as I am. I hope this won't be held against me and I am sorry if I have wasted anyone's time, but I think that it is the right thing to do.

“However, I hope that if I reapply to go onto resettlement in another 4 or 5 months the opportunity would still be available, but if there were no spaces then I would understand and realise that I might have turned down the only chance I had of moving to resettlement.

“Thank you once again. The man”

26. However, the man later changed his mind and, on 13 June 2006, joined the Resettlement Unit. He was soon employed as an orderly on the unit servery. He was described by a fourth officer as a quiet and polite man. By all accounts, the man settled well in the unit and felt generally content with his environment. He had already begun an information technology course and had indicated an interest in preparing for employment on release as a HGV driver. He was confident he could, nearer the time of his release, plan to buy his own property using capital left to him from the sale of his parents’ house.

27. On 14 June, the man wrote the following letter to his Probation Officer:

“Dear Probation Officer,

“Just thought I’d write to you to let you know how things are going down this neck of the woods. Well, I’m a few months closer to my release from when I last wrote and time seems to be going really fast, but more importantly I’m now on the resettlement wing here at Dartmoor which I consider to be a BIG step in the right direction. I’m still drug free, which I’m really pleased about because I thought that when I came back to prison I’d end up getting involved with heroin again, as prison is where I first tried heroin and I know how easily available it is in prisons. But like I said, I’m still drug free and I’ve been doing voluntary drug testing for most of my sentence now. All negative.

“I’m behaving myself as well which is another step in the right direction (I wouldn’t have been allowed to move onto this wing if I wasn’t behaving.). I’m still on enhanced and I haven’t had any adjudications [disciplinary hearings] whatsoever.

“I’ve just finished a course called PASRO (substance misuse) and I’m told that you are invited to the review, either in person or over the phone so hopefully we can have a little chat about things then.

“Also, I’m due to have my sentence plan reviewed in a few weeks and I have the option of inviting someone to be present, so I would like to invite you so you can see how I’ve been doing, and give any feedback as to what you might think I may need to do, etc, etc.

"I look forward to hearing from you soon.

"Yours, the man."

28. The man's prison record shows that, although he made a slow start in settling into the wing regime, he later gave the impression of having a positive attitude about how best to benefit from his time inside. On 10 July 2006, he began work in the prison laundry. On the same day, he was assessed again by healthcare staff about his obesity. Two days later, he underwent an electrocardiogram. No abnormalities were found. At this time, the man had complained of a back pain. This was attributed to his weight. He was given advice about diet and exercise.
29. In August, the man expressed an interest in taking part in a Victim Awareness Course, although this did not materialise as the course was not available at Dartmoor. In September, he received a certificate for completing a two day Alcohol Awareness course.
30. On 25 September, only a month before he died, the man wrote the following letter to the psychology department at Dartmoor:

"Dear Psychology department,

"It is part of my sentence plan that I should be assessed for the CALM [Controlling Anger and Learning to Manage it] course. Would it be possible for someone to come and assess me in the near future as I need to meet my targets on my sentence plan before I can be considered for ROTL [release on temporary licence] Cat D, parole etc. I hope you can get back to me soon. Yours, the man"

31. A trainee psychologist at Dartmoor, told my investigator that the member of staff who ran the CALM course was ill at the time this letter was written. It remained unanswered as it was not discovered in the psychology department until after the man died.
32. At the end of September, the man was awarded a certificate to show he had attended a half-day Crack Cocaine Awareness course. However, two weeks later, the fourth officer noted the man appeared to seek the reassurance of staff and needed to take responsibility for his own actions.
33. On 17 October 2006, the officer made the following entry in the man's wing history sheet:

"The man sending £30 to a friend of a friend. When interviewed not forthcoming. Tried to be clever and devious."

34. At interview, the fourth officer told my investigator the man completed a cash disbursement form so that a sum of money - he thought it was £30 - could be sent to the girlfriend of another prisoner. The officer said he asked the man to indicate who this person was. The man told the officer the money was for the purchase of flowers for his uncle and aunt. The officer thought the cash transaction was possibly a payment for drugs or for whisky. The officer also told my investigator that, some time later, a mobile telephone was found in the possession of the same prisoner.

### ***ACCT form opened***

35. On 19 October, the man's friend handed to the drug worker, a PASRO facilitator at Dartmoor, an envelope containing a long poem written anonymously by the man in which he described his feelings about the loss of his mother. The man also wrote that he sometimes wished he were dead.
36. At interview, the drug worker and the officer who accompanied her said the man's friend did not know what was in the envelope and did not say who it was from. However, the drug worker said that, as soon as she read the poem, she could tell it was from the man because she knew he wrote poems and because of the references to his mother. After reading the poem, the drug worker went straight to the Resettlement Unit to talk to the man. Initially, she spoke to him alone. But because she was concerned to ensure the wing staff were aware of how the man was feeling, she asked the officer to join them.
37. The man spoke to the drug worker about his difficulty coping with his mother's death and said he was considering self-harm. He told her he was "feeling down" and was crying a lot at night when he thought about his mother. He also disclosed he had recently been involved in a "security matter" but gave no further details. When the officer joined them, the man refused to disclose exactly what he meant by "a security matter". Later, he admitted he had recently acquired some alcohol. Consequently, that evening, the officer and the resettlement unit manager, searched the man's cell. They found no contraband of any kind.

### **Referral to bereavement counsellor**

38. The drug worker was so concerned about the man that she sent the following letter to the bereavement counsellor:

"On 19 October, I went on request to the RSU to speak with the man. At this time, he informed me that he has difficulty dealing with previous bereavement issues. He said that in the past he has been able to deal with it but at this present time it is at the forefront of his mind and he is feeling quite down. I informed him that I would go and check he is ok until you are able to see him but that I can only listen and am not in a position to give advice. He has also informed

the RSU staff of his problem and is considering accessing the Listeners scheme. I would be grateful if you could go and see him as soon as possible as he has mentioned that he is feeling like self-harming. He is slightly reluctant to open up to people about his problems. Therefore it may take him some time.”

39. The drug work and the officer also decided to open an ACCT form. ACCT procedures require a number of actions to be taken as set out below.
40. First, a concern and keep safe form should be completed as soon as possible. This form enables staff to record the concerns that led to the opening of the ACCT document. Once completed, it should be passed to the person responsible for keeping the prisoner safe. This is normally the manager of the unit in which the prisoner is located.
41. The officer who had accompanied the drug worker completed a concern and keep safe form for the man. He wrote on it as follows:

“Called to interview with PASRO this morning. The man’s mood and speech were a cause for concern. The man stated he has/is considering self-harm due to inner feelings he is having trouble dealing with. PASRO is contacting the bereavement counsellor to assist the man to come to terms with the recent death of his mother. The resident Listener who was the man’s friend too has had an initial talk with the man and is staying with him.”
42. The officer who had accompanied the drug worker later explained that the man’s friend saw the man as a friend rather than in his role as a Listener.
43. The second step under ACCT is that an immediate action plan should be completed. The purpose of this plan is to prompt staff to consider the most appropriate environment and regime required to support the prisoner prior to the first case review.
44. The officer devised the man’s immediate action plan. He recorded that the man was happy to remain in his own cell in the Resettlement Unit (RSU). Staff were to monitor him throughout the day. As the RSU was on an all-day unlock, this would help staff to make unobtrusive observations. The man declined an opportunity to make a call to the Samaritans and told the officer there were no family members to whom he wished to speak. Also recorded was the comment that the man was not in possession of any medication.
45. The next step is that an assessment interview should be conducted within 24 hours of concerns being raised. The interview is to enable staff to gather information relevant to the risk the prisoner presents of self-harming. The

chaplain one of the trained assessors at Dartmoor, conducted an assessment interview with the man that day. He wrote:

“The man states, ‘I am alright during the day. It is at night when I get time to think. It is nothing to do with prison. It is the outside things I think about. I recently lost my mum. I have only an aunt and an uncle.’

“No act of self harm committed. Has never self-harmed. Feeling down. Upset that he has been put on the ACCT. At night when he’s alone, he wonders whether it’s worth carrying on. Reasons for living and coping resources: Support for PASRO. Bereavement counselling. Hoping for parole next June.”

46. ACCT procedures also require that a care map should be drawn up. The care map is designed to ensure that staff identify the level of risk the prisoner presents, the problems that are causing him the most pain, and the resources that have most potential to support him. It is expected that a small number of achievable targets will be set for the prisoner to achieve, with the support of staff, in order to reduce the level of risk. The following care map was set out for the man:

Issues	Goals	Action required	By whom and when	Status of action
Bereavement problems	To receive counselling	Contact HCC	SO 20.9.07	Contacted 11.37 20.10.07
In reach team	Interview with in-reach team	Contact in-reach	SO 20.9.07	Contacted 11.37 20.10.07
HCC	Possible medical attention	Dr’s appointment	SO 20.9.07	Contacted 11.30 20.10.07
Listeners	As when the man requires help	Call out Listener when need arises	Prisoner-ongoing	

The man signed the care map to signal that he had agreed its contents.

47. A first case review should take place within 24 hours. This and any subsequent reviews held are designed to ensure that the level of risk presented by the prisoner is monitored and reviewed, the goals set out in the care map are reviewed, and clear records are made of the details discussed. Review panels should be multi-disciplinary and the prisoner should be encouraged to attend.
48. At 9.30am on 20 October, the first ACCT case review was held in the Resettlement Unit. The review was chaired by a senior officer and attended by the chaplain. The man was also present. The review was summarised as follows:

“The chaplain and I had a long discussion with the man. The following was decided:

1. Bereavement counselling
2. HCC [Healthcare Centre] - doctor appointment
3. In reach
4. Use Listeners on wing”

49. The man’s risk of self-harm was judged as ‘raised’. The next review was to take place on Tuesday 24 October at 9.30am. No mention was made in the ACCT document of the frequency of observations required for the man. However, between 3.30pm on 19 October and 1.05pm on 25 October, entries were made in the ACCT ongoing record at irregular intervals. They showed that the man remained subdued on some occasions but brighter on others.

### ***Assessment by Registered Mental Nurse***

50. On 22 October, the man was assessed by a registered mental nurse. The registered mental nurse made the following entry in the ongoing record in the man’s ACCT file:

“Seen by RMN this morning. Quite tearful during chat. Obvious unresolved issues surrounding mother’s death. Says he is unable to see a future on release in eight months. Will be first time out without mum being alive. Unable to pinpoint precipitating factor for low mood. Says feels suicidal at times but no plans at present and does not feel like self-harming. To see bereavement counsellor as soon as possible.”

51. The registered mental nurse also made the following entry in the man’s medical record the next day:

“Asked to see by RSU. Placed on an ACCT on 19 October following drop in mood. Had written a letter to PASRO which talked of suicide and his mother’s death July 2005. When I saw him he became quite tearful when talking about his mum. He lived alone with her. She died suddenly. He found her dead in her bed. He came to prison just weeks afterwards. He said he felt tearful during the last year but has coped. His low mood has passed. He now has eight months of his sentence left and feels he has no future without his mum being there. He has a house and money and there is a belief by staff that he is involved in security issues which may have resulted in him being bullied for money although he denies that there are any issues on the wing.

“He obviously has unresolved grief issues surrounding his mother’s death which have resulted in his low mood. He denies any thought of DSH [deliberate self-harm] although he says he thinks of suicide - but has no plans - it seems to be more in the way of wishing he was dead than any active plans.

“Mood certainly appears low although is sleeping and appetite not affected. Plan: refer to bereavement counsellor; speak to doctor re anti-depressant commencement.”

The registered mental nurse spoke to a doctor the following day to arrange an appointment for 26 October.

52. At 7.15pm on 23 October, a member of the RSU staff made the following entry in the ACCT ongoing record:

“Spoke to the man. He is afraid that he will be ‘two’d up’ and moved off the unit because he is on an ACCT plan. I stated that this was very unlikely to happen for that reason. He left the room in a brighter mood, looking forward to his pre-release session tomorrow.”

53. At 9.00am on 24 October, the drug worker saw the man in the unit. She recorded her discussion with him as follows:

“I came down to speak to the man as a follow up from the initial concerns that were raised. The man still said he was feeling low but this was not better or worse than when we had spoken a few days before. He explained he has seen the mental health nurse and is considering anti-depressants. The man said he had nothing he wished to discuss. It was agreed that I would ring the bereavement counsellor to chase up the memo I’d written on Wednesday and it is likely he will be seen tomorrow afternoon.”

54. At 9.30am, an ACCT case review took place in the Resettlement Unit as planned. The ACCT form presented to my investigator did not include a summary of this review. However, the chaplain explained that he attended the review, and that it was chaired by the senior officer who chose to use the ongoing record to record his views as follows:

“ACCT review: Not much progress made. States that he is feeling down/low still. Very one-sided conversation. He will not talk to discipline staff. On the landings he is just as ‘normal’. He will see bereavement counsellor. Mental Health Nurse will arrange Dr’s appointment.”

The registered mental nurse arranged for the man to see a doctor on 26 October.

55. At 11.45am, the senior officer also made the following entry in the ongoing record:

“Seen at lunchtime roll-check. Seems ok in himself. I informed him that he would be seeing a doctor on Thursday 26.10.06 at 3.30pm. Happy with this.”

***Request to leave the Resettlement Unit***

56. At 2.30pm on the same day, the man's friend, approached the resettlement unit manager to ask if the man could move out of the Resettlement Unit. At interview, the resettlement unit manager told my investigator he thought it more appropriate for the man to make the application in person.
57. The resettlement unit manager said that, a short time later, the man and his friend came to see him together. The man told him on he wanted to move so that he could share a cell. The resettlement unit manager explained that the only area of the prison where there were double cells was D Wing, the induction unit. He said the man told him he was depressed about his mother's death and had been thinking about her mostly at night. The resettlement unit manager told the man he could not guarantee finding him a double cell because of the overcrowding situation in the prison. The man replied that he “just wanted off the wing”.
58. The resettlement unit manager then put to the man the suggestion that, if he wanted to leave the wing irrespective of the availability of double cells, there must have been other reasons for wanting to move. The resettlement unit manager told my investigator he suspected that the man was either being bullied or that “there was something available off the unit that wasn't available in it”. He asked the man if he was being bullied. The man told him he was not. The resettlement unit manager again asked the man why he wanted to leave the resettlement unit. According to the resettlement unit manager, the man “just shrugged”. The resettlement unit manager therefore confronted the man with the suggestion that if he was not being threatened on the unit, “there must be something available on the main that might not be obtained in the RSU”. The man replied by saying, “You can think what you want. I have told you the reasons. Why won't you help me?” The resettlement unit manager told the man he would try to find him a cell elsewhere because the only prisoners who were to remain in the RSU were those who wanted to be there. The man reiterated his desire to move. The resettlement unit manager then asked the senior officer to find a double cell. The senior officer confirmed there was a cell available in D Wing and arranged for the man to move that afternoon. The resettlement unit manager made a record of this development in the man's ACCT ongoing record. The man moved at 3.45pm into cell D5 -14, the uppermost landing in the wing.

59. At interview, the man's cellmate told my investigator he thought the man said he had come from the resettlement unit because he had either been self-harming or had actually self-harmed. The cellmate said he was upset by that and went to the office to complain. He told the staff he had two different cellmates in two weeks and would rather "go to the block" (the segregation unit) than stay in the cell with the man. The cellmate returned to his cell to pack his belongings. He said that, as he was doing so, the man approached him and asked him not to move. The cellmate said it was not the man's fault he did not want to share his cell. He just wanted to be on his own. The man then told him it would be to his advantage if the two of them shared the cell. When the cellmate asked the man to explain what he meant, the man asked him if he smoked heroin. The cellmate told the man he used heroin outside. According to the cellmate, the man then said the story about self-harming was just an excuse to get off the resettlement wing. The man told my investigator he was in two minds as to whether to stay in the cell with the man but decided to stay "for a smoke". Although the cellmate knew this was a stupid thing to do, he went to the office and told the staff he was happy to stay.
60. The cellmate explained what happened at the end of that afternoon. He said:
- "We was banged up just before tea. We had a bit of a smoke, you know, made some foil out of some tobacco pouches and had a smoke ... We was unlocked for tea, came out and for some reason he gave me a bag for free, a bag of heroin for free. Then I went out of the cell and I smoked that with a friend of mine on the 4's landing. I just came back upstairs and at that time he was just talking to a few of his friends, I don't know who they were and then we were just locked up for the night again, about half seven."

### ***Events during the night of 24 October***

61. At approximately 7.30pm, an Operational Support Grade (OSG), began his night shift in D Wing. The OSG told my investigator he was the only member of staff on duty in the wing. It fell to him to familiarise himself with the details of any prisoner subject to self-harm monitoring procedures by looking at the ACCT form. The OSG said he knew the man was subject to ACCT. He said he therefore read the document and saw that it contained no instructions as to how frequently the man was to be observed. The OSG rang the control room to seek advice. It was decided that, in the absence of any clear instructions, the man should be observed every hour.
62. The next task for the OSG was to carry out a roll check of the wing to ensure the number of prisoners in the wing tallied with the number found by the staff who had conducted the last daytime roll check. The OSG told my investigator he carried out his check and found nothing amiss. He remembered checking the man's cell and seeing him watching television.

63. At interview, the OSG said he observed the man every hour and at the same time each hour during the night. He recognised that the man and his cellmate would thus have known both when they were to be observed and when they were unlikely to be disturbed. The OSG made a record of his observations in the man's ACCT form. Those entries are repeated here:

8.10pm: "Sat on bed with cup of tea talking to cell mate. Says he is fine. No problems."

1.00am: "Appears asleep lying on his right side."

3.00am: "Ditto."

5.00am "Appears asleep. Lying on his left side."

6.00am "Appears asleep. Lying on his left side. No problems all night."

64. The OSG was adamant that, although he made these entries at the times shown, he observed the man every hour. He was equally adamant that, on each occasion, the man was as he described him. He could remember seeing the man lying on his right side at 1.00am and again at 3.00am. The OSG could also remember seeing the man on his left side at 5.00am and again at 6.00am.

65. The cellmate gave my investigator his version of events that night. He said:

"That night, well we got banged up about half past seven, quarter to eight I think it was. He [the man] gave me a cup of coffee, I can remember that, he made me a cup of coffee and he got the foil back out again and he put about two grams of heroin on it and we started smoking that and then after smoking that he made another cup of coffee and drank that again. We were talking in between so this was like taking about half an hour with a smoke. He again put about another two grams back on the foil again. We smoked that and time is now about half past nine. I then started feeling sick, started vomiting, I was like continuously vomiting and I could feel a migraine coming on as well, so I just got onto my top bunk and tried to go to sleep. Cos the light is right above the bunk, it is like hurting my eyes, so I sat round and asked him to turn the light off after I stop making the bags, cos he was making some bags up so he could sell for the next morning and the last thing I remember was going to sleep, waking up in the middle of the night and finding the light was off, the TV was off and basically he was asleep."

### ***Events during the morning***

66. Before he went off duty, the OSG handed over to the officer who was first on duty that day. The officer began an all-day shift in D Wing just before 7.00am. The officer said the OSG told him there were two prisoners in D Wing who were subject to ACCT procedures, one of whom was the man. The officer was not told

how many times it was necessary to observe the man and saw no instructions to that effect in the ACCT form.

67. The first officer on duty that day completed the first roll check of the day and found everything in order. In interview, he remembered checking the man's cell at 7.00am. This check was completed without the door being unlocked. The officer wrote in the man's ACCT form that he appeared to be asleep. Afterwards, the officer moved down onto the second landing in D Wing, where he remained until lunch time when he was detailed as the patrol officer for the wing.
68. At about 8.00am, the first officer on the scene carried out checks he unlocked the man's cell so that he could carry out a further check of the occupants. At interview, the officer explained that he opened the cell door and looked in. He said to my investigator:
- "... the fabric of the cell was fine, just, you know, nothing was on the back wall, or any problems like that. It was only a quick visual check but there were two people in there. There was movement in that cell but I can't state whether it was the man or the other chap on the top bunk because I didn't know who was who really."
69. The officer remembered seeing a large man on the bottom bunk but he did not know it was the man. When asked what the purpose of entering the cell was, the officer said,
- "It was a body count really because I haven't got a lot of time to engage every single prisoner. I have got to unlock and get back to the office to start taking prisoner applications. I have only got half an hour to do that."
70. The first officer on the scene explained that he did not have any conversation with either of the two occupants. After he had checked the cell, he left the door open and moved on. He said the door would have been left unlocked until approximately 8.30am. This would have enabled the occupants to leave the cell to make applications or to speak to landing officers. The officer was adamant that neither the man nor the cellmate left the cell. He said he had no reason to believe anything was wrong in the cell. He said it was "not uncommon for prisoners on the induction landing to just put a blanket over their head and don't even want to speak to you." The officer was not aware that anyone entered the cell during this period. He said he locked the cell door at 8.30am.
71. The first officer on the scene said that, at some time between 8.30am and 9.30am, he unlocked the door again to complete a fabric check of the cell. He entered the cell and told the two occupants he was about to complete a fabric check. There was no response from either prisoner. The officer saw that the prisoner on the bottom bunk was lying on his right side. The officer checked the

walls, the door and the floor. He then checked the window bars and the locks on the door. He said there was movement in the cell but none from the bottom bunk. He did not ask either of the two occupants to move from their bunks so that he could check the fabric of the wall behind them. He then left the cell and locked the door.

72. At 11.00am, the first officer on the scene unlocked all the cells on D5 landing for association – a period when prisoners are allowed to mix with each other if they wish to do so. The officer said he unlocked the man’s cell door and pushed the door open and immediately moved on towards the next cell without stopping. He later saw a number of prisoners enter the man’s cell. He said the prisoners were in the man’s cell “for a fair while”.

73. The cellmate gave the following account of what happened that morning:

“We was unlocked about, I think it was quarter past eight in the morning and as soon as the door was unlocked, someone, one of the other prisoners walked straight in and tried waking the man up, well started shouting his name. I don’t know who he was - he was just one of the man’s friends. He then left, cos we were both still in bed and I still felt groggy form the night before. He [the visiting prisoner] said, ‘do you want the door closed?’ so he has closed the door behind him.

“I don’t know if the man was alive then, he was, cos he was only in there for, I don’t know what his sleeping habits was like. He didn’t say anything.”

74. When asked whether he could hear the man breathing or snoring, the cellmate replied:

“No, no, nothing like that.”

75. My investigator interviewed another prisoner who gave the following account of what happened that morning:

“At 11.15am we finished PASRO and I’ve come back to the wing and when I’ve gone up to the fives, where his cell was. There were about nine or ten people in the cell and I’ve gone in the cell and I’ve seen him lying in his bed. He was covered from foot to head, facing the wall. But as I said, there was about nine or ten different people in the cell and I cleared the cell. I said, listen man, the man’s asleep, get out of his cell, leave him alone, do you know what I mean? So I pulled his cellmate and I say, what’s all that about and he say I don’t know they just wanted to speak to the man and that. So I’ve gone in the cell speaking to his cell mate and I’m

sitting on the chair. His cellmate jumped up on the top bunk because he was on the top bunk and we were talking and that and a couple of times I've looked over but there was no movement from the man at all. Whilst I was sitting in there, a few boys were standing outside the cell door and what have you and a third officer he came along to the door and just called the man. I personally said to the officer his cellmate said he's been up all night. I think he's sound asleep. Can't you come back later and the officer, ok fair enough walked off. They are called for dinner. I said to his cell mate listen I'm going down for dinner, when the man gets up tell him I've been up to see him and make sure he's alright and that and tell him his friend was thinking of him. I went down for dinner, had my dinner, got banged up and the next thing I know I don't know what happened, whether the officers realised something was up or just trying to get him up to go and do something. I don't know. The next thing I know the whole wing was locked down and rumour had it that he had died."

76. When asked if there was anything to suggest the man was not alive, the prisoner said:

"There was nothing in the cell. It may be a comment of one of the boys I can't even remember who it was. One of the boys said, yeah I've been in there and I've tried to shake him to wake him up but he didn't stir. When you've got nine people in your cell and they are not very big cells, for somebody not to even stir, I suppose, because I said to some how long had they been there, they said they had been coming in and out all morning. I said why and he said I don't know and so that's when I've gone in there. I'm not saying I'm bigging myself up or anything but I was well known on D Wing. Respected to a degree you know what I mean. So I said listen boys out of his cell, if you want to speak to him wait till he gets up. Now really I suppose that should have raised my suspicions. But I would have thought if anything his cellmate would have been the one to know, do you know what I mean? But he said to me he was fine so it didn't really raise my suspicions at all and when the third officer, I'll come back later, even an officer didn't wasn't privy to the fact that he was dead, he just assumed he was asleep. You know admittedly he wasn't snoring because he was a big boy, he was a big man."

77. At his interview, the third officer said he came on duty in D Wing at 7.45am. At that stage he did not know the man was back on the wing. At the morning meeting in the wing, he and his colleagues were told by the senior officer that the man was on an ACCT form. The officer confirmed he was given the form.

During the course of the morning, the officer made the following entries in the form:

8:10am "Unlocked. Appears asleep on right hand side. Asked if he was OK. No reply but was breathing."

11:20am "Still appears asleep on right hand side. Several other prisoners in cell. They stated he was ok but asleep."

12:00am "Did not take lunch. Stayed in bed."

78. The third officer told my investigator that, before he made these entries, he had no knowledge of what had gone before. Neither did he know how often he was supposed to observe the man. However, after he made his first entry he read the document in detail. He said he saw a policy note to the effect that observations should be unobtrusive. The man said that, from the information he had read, he considered that the man was not a high risk of self-harm and so decided to observe him three times in the morning and three times in the afternoon. The third officer was aware that the policy at Dartmoor was that the required frequency of observations should be shown on the front cover of the ACCT form.
79. The officer explained that he made the entry at 8.10am because it was part of his normal duty to undertake such checks at the outset of his shift. He said that, with hindsight, he should have made the comment "appears to be breathing" rather than "was breathing".
80. When asked why he felt it necessary to make such a comment at all, the officer said:

"On that occasion, you know he was on his side, asleep. I looked at him because he didn't answer when I spoke to him ... I just thought he was asleep. I thought I'll just check and at the time I thought he was breathing."
81. The officer also told my investigator he checked the man again at about 8.45am. He said that on this occasion he was not carrying out an ACCT check. The officer entered the cell and said, "Hello, what are you doing back here?" The officer said there was no reply.
82. The officer explained that it was not unusual for prisoners in the induction unit to stay in bed for long periods. He thought there was nothing about the man to suggest there was anything wrong with him. When asked whether staff at Dartmoor were required to demand a response from prisoners subject to ACCT procedures, the officer said:

“Well we, having checked the ACCT, when I checked the ACCT it did say he wasn’t a self-harmer and that he hadn’t self harmed in the past. I do now make sure I get a response from them.”

83. My investigator asked the officer whether this change of practice was related to the man’s death. He replied:

“It’s nothing I’ve been told but since his death I’ve reflected on things that I could have done differently and I do try to get a response.”

84. However, the officer was of the view that it was important not to be intrusive, especially in relation to prisoners who were not high risk.

85. The officer told my investigator that, at about 10.30am, he went back to the man’s cell to see the cellmate who was required to move that day to A wing. The officer made it clear that he did not check on the man on that occasion as the sole purpose of his visit was to see the man.

86. He next went to the man’s cell at about 11.20am. He gave the following account of events:

“We open up all the people that are locked up during the morning. We tend to try to open them up about 11:00am. This gives them a bit of time out of cell before lunch. The cell had been opened and I went down to my ACCT checks and there was definitely a prisoner was seen at the head of the bed, then a prisoner was standing in the doorway, just inside the door. The cellmate was on his bunk and I’m not sure whether there was another or not. I seem to remember there was another in the cell but I don’t know his name. Now I said, is he still asleep and the prisoner sitting in front said, yeah, yeah gov, yeah, yeah, he’s a lazy sod isn’t he? And I said no really he’s sleeping, he said yeah yeah yeah, he’s alright, he’s fine, he just had a late night ...”

87. The third officer confirmed that on this occasion there were other prisoners in or near the man’s cell. My investigator asked if, with the benefit of hindsight, he thought the presence of so many other prisoners might have indicated something was wrong. The third officer replied:

“Well, with the benefit of hindsight and also the talk on the wing from so many different prisoners. I’ve been told since he died he was dead in the morning and I could probably agree with that. I’ve been told by several different prisoners that they were disgusted because they said he was dead in the morning and the prisoners that were there in the cell were waiting for drugs.”

88. My investigator asked the officer if there was anything about the demeanour of those prisoners that might have indicated they wanted him to leave the cell. The officer replied as follows:

“Only with hindsight. At the time, everything was fine, amicable and light-hearted. There was nothing to indicate there was a problem at all. I was waiting with the first officer on the scene on the landing. I said to him, ‘what do you think about putting the man in a single cell because he might prefer it?’ The first officer on the scene said that it’s better to leave him in the double cell while he’s on the ACCT because at least there is someone to keep an eye on him and I agreed. I said I’m just going to ring the RSU to find out why he’s over here. I spoke to an officer. I don’t know who the officer was. He said it was his choice he had come over to the main prison. I said, ‘He’s been in bed all morning’ and he said it doesn’t surprise me because it is more of a relaxed regime and he’s a lazy sod. He said, ‘The best thing you can do is get him a job, get him out of bed in the morning and try and motivate him because he’s lost his confidence and he’s got no motivation.’ I said, ‘What, a wing cleaner’s job?’ He said, ‘No, a job off the wing preferably where he’s actually got to go to work in the morning.’ ”

89. The officer explained that at midday he was at one end of the man’s landing and noticed the man did not come out of his cell to collect his lunch meal. The third officer made his last entry in the ACCT form to record this. He could not remember whether he went in to the man’s cell to observe him.
90. During his interview with my investigator, the cellmate gave his version of events. When the cell door was unlocked (at about 11.00am), he got out of bed and went out onto the landing. He said:

“... I was still feeling unwell from the night before. I didn’t want lunch but shouted out the man’s name a few times. I said to the man, ‘it is lunch time’, you know and he still didn’t wake up and at this point a lot of other boys just walked in to the cell as well and they were trying to wake the man up. Like just shouting, ‘wake up’ and I thought, I assumed all these boys knew the man from before or something and I walked out of the cell to fill up my hot water flask and as I went round the corner of the landing I could see a few other boys were going to go into the cell again. Then I went back to the cell thinking there might still be a bit of tobacco or something, I don’t know, I’ve gone back to the cell and I see them all in there, just sitting there just like waiting for him to wake up or get up or something like that and they have asked me the question as to what time, you know, what happened last night, what time did you

go to sleep, and I said, I assumed the man was still asleep, he was tired and he just wanted didn't want to talk to them. I said he had gone to sleep at six o'clock in the morning, cos I assumed, do you know what I mean, cos he didn't move and he wasn't paying any attention to them I thought he was must just be laying there, pissed off thinking why have they all come in trying to wake him up? So I told them, do you know what I mean, he went to sleep at six o'clock, no one was basically taking, paying any attention to me anyway. Some other boy he came back into the cell as well, he came into the cell and he shouted out the man's name a few times, I can remember, and then still no reaction from the man and the prisoner has told, like, cos the prisoner knew the man from before something, I don't know and the prisoner has told everyone else to get out of the cell. Then the prisoner ... gave me a note to give to the man. He said, 'Look take this note and give it to the man for when he wakes up' so I took the note and just put it in my pocket, I put it in my pocket and that was it, then the officers came and closed the cell door behind me, that was it. Then I went back to sleep again. Well, on the top bunk, I went to sleep again, I fell asleep, woke up at one o'clock to find an officer come into the cell and he shouted the man's name about twice, three times. He called his name and he looked up at me and said, 'Has he been like this all morning?' I said, 'Yeah guv, he has not moved an inch' and the officer has bent over, leant over to see the man to try to wake him up. The man wasn't waking and from what I gather he must have put a pulse off him and, I don't know, must have felt his skin that was cold or something and he has got back up and he has looked at me and he goes, 'Get out of the cell'. I got out of the cell and then he has come back out on the landing. The officer has started shouting for assistance ..."

The cellmate confirmed that the officer concerned was the first officer on the scene.

91. In a statement written to the Governor after the man's death, the first officer on duty that day wrote:

"At approx 1300 hrs on 25 October 2006, I was lunchtime patrol on D Wing. I checked upon the prisoners who were on active ACCT forms. The first being [name withheld] located in D1-24. He was sat on his bed and said to me, 'Alright boss.'

"Then I walked up to the 5s landing and checked upon the man in cell D5-14. He was sharing the cell with the cellmate. When I opened the flap, the cellmate was lying stretched out on his bed resting on his elbow. He looked towards me when the flap was

opened. The man was on the bottom bunk with his bed covers over him, so I couldn't see his face. It looked as if he was with his head nearest the window. The vision into the cell was not very good as the light was off and the sky was overcast and raining. He appeared to be sleeping. However, I thought that I saw him making a breathing movement. I then shut the flap and returned to the 2's to fill in the ACCT booklets."

92. At 1.05pm, the first officer on duty that day made the last entry in the man's ACCT ongoing record. The officer wrote, "Under blanket, moved, appears asleep." At interview, the officer said he thought he saw the man move, as if he were breathing. He said he was sure the man was alive at that time, although he recognised that "the observation flap can play tricks with the eyes." He told my investigator he had no reason to suspect anything was amiss in the cell because of the presence of the cellmate, who was not behaving as one would expect if he knew that his cell mate was lying dead on the bottom bunk.
93. At midday, the wing manager had asked the first officer on the scene to fetch the man at 1.30pm and to take him to the Healthcare Centre for an appointment with the bereavement counsellor.
94. At approximately 1.35pm, the first officer on the scene unlocked the man's cell as requested. The officer said in interview that he shouted to the man to get up. He noticed the man was lying on his right side with his head nearest the back wall of the cell. He was covered by his duvet. After getting no response from the man, the officer tapped his foot, the only part of his body not covered by the duvet. The officer noticed that the man's foot was very cold. There was still no response. The officer then turned to the cellmate on the top bunk and asked if he had spoken to the man that day. The cellmate said he had not. The officer shook the man's shoulder, but again there was no response. The officer noticed the man's shoulder was very cold despite it being covered by the duvet. At this point, the second officer, aware of the possibility that there was something seriously wrong with the man, felt for a pulse. He could find none.
95. The second officer immediately shouted for help from other staff in the wing. The first to respond was the second officer on the scene. At interview, the second officer on the scene said he remembered the first officer on the scene looking pale, as if in shock. The first officer on the scene said to the second officer on the scene words to the effect, "I think he's dead", pointing towards the man's cell.
96. The second officer on the scene accompanied the first officer on the scene went into the cell and told him to pull the man's duvet back and to check for signs of life. He could find none. At interview, the first officer on the scene said he found signs of stiffness in the man's limbs. The second officer on the scene told my investigator that, as soon as he arrived at the cell, he asked the first officer on the scene what checks he had made. The second officer on the scene said that the

first officer on the scene confirmed he had checked to see whether a ligature was attached to the man and whether he had a pulse. The second officer on the scene and the first officer on the scene checked for a pulse again and could find none. The second officer on the scene said both he and his colleague thought the man was dead. The second officer on the scene escorted the cellmate to a nearby cell. He then returned to the cell to find that other staff had arrived. These included the first nurse on the scene who later made the following entry in the man's medical record:

“13.40 Urgent assistance called for on D Wing over the radio.  
13.45 Arrived on D Wing with all medical equipment. On entering the man's cell, he was found on his bed on his right side under his duvet. He appeared cold and rigid cyanosis of peripheries. We were unable to move him off the bed onto the floor. He was curled up on his right side facing the wall. There was no pulse and no heart beat. The second nurse on the scene examined his neck but there appeared to be no signs of a ligature. The second nurse on the scene was unable to open his mouth to examine as his jaw was clenched tightly. There was evidence of pooling in all four limbs and back and buttocks. It appeared that he had been dead for some time. Therefore the second nurse on the scene and myself took the decision that further medical intervention would be inappropriate. Ambulance was called. It was decided by the Governor to seal the cell and the second nurse on the scene and myself were asked to leave to allow this to happen. Approx 14.30 the Governor called paramedics up to the cell to examine body. They stated after examination signs of life extinct. Paramedics needed to turn body over to examine right side. I assisted with this. I then left the area.”

97. The man was pronounced dead at 2.35pm by the paramedic. In the opinion of the paramedics, rigor mortis was present.
98. When the police later examined the man's cell they found amongst the contents a quantity of white powder.

#### ***Staff and prisoner support***

99. The Governor issued a Notice to Prisoners to inform them of the man's death. The cellmate was placed in a cell with another prisoner so that he had company at a time of distress.
100. Those staff involved in the discovery of the man were called to a debrief at 5.10pm. The purpose of the debrief was to allow staff to explain the role they had performed and for support to be offered to them. Members of the prison's care team were also present to offer their support.

### ***Informing the next of kin***

101. The man's uncle and aunt were listed as his next of kin. As the address recorded for them in the man's record showed they lived in Birmingham, A second Governor was asked at approximately 3.30pm to contact HMP Birmingham and arrange for a senior manager there to inform the family. The incident log compiled at Dartmoor shows that, about ten minutes later, the Duty Governor at Birmingham agreed to place someone on standby to carry out this request. At 4.22pm, confirmation was received from Birmingham that their family liaison officer would break the news of the man's death to his aunt and uncle. At 4.29pm, the second Governor rang him to brief him, but his number was engaged. The second Governor tried again at 4.50pm and this time was able to pass on the relevant details. However, it was later discovered that the man's aunt and uncle had moved from the address given to him. The log shows that the family liaison officer called Dartmoor at 7.00pm to confirm that they had been informed. No reference was made in the log to the means by which the news was communicated. However, the man's uncle later telephoned Dartmoor himself.
102. The following day, the Governor wrote a letter of condolence to the man's aunt and uncle. In her letter, she said she would have preferred the news of the man's death to have been given to them in person. She explained that the address given to the prison by the man showed them as living in the Birmingham area. Consequently, arrangements had been made for a governor at HMP Birmingham to break the news at the address given. The Governor said she understood that they had recently moved to Honiton.
103. The Governor offered to visit the family at their home in the company of her family liaison officer. She briefly explained the circumstances in which the man was found the day before and that a post mortem examination was to be carried out on 27 October. The Governor offered the family the contact details of an organisation which provided emotional and practical support in such circumstances. She invited members of the man's family to visit the prison to see the cell where he died, if they wished to do so.
104. The Governor also offered the family financial support in relation to the cost of the man's funeral. At consultation stage, the man's uncle and aunt said that although they were told they were to be invited to a memorial service at the prison, this did not materialise. They said they were never told if the service took place. However, they did visit the prison and met prisoners who had known the man. They found this helpful. The man's uncle later rang the prison to say he had received the proceeds of a collection held at the man's funeral service and wanted to donate the money to a young offender's charity. He was given appropriate advice by the prison.

## ISSUES

Here I provide answers to the following questions:

- *Were the man's physical and mental health needs properly identified and met?*
- *Was his risk of self-harm properly assessed, monitored and managed?*
- *Was the man's own drug addiction properly assessed and managed?*
- *How did the man acquire the drugs that killed him?*
- *Were adequate measures taken to prevent the supply of illicit drugs to prisoners at Dartmoor?*
- *Could the man's life have been saved?*
- *Were appropriate courtesies offered to the man's next of kin after his death?*

### ***Were the man's physical and mental health needs properly identified and met?***

105. The only health problems presented by the man upon his reception into prison in July 2005 were his drug abuse and his obesity. At that time, the man weighed 25 stones. Reception health screens were conducted at Blakenhurst and Dartmoor and appropriate referrals were made. The clinical reviewer, author of the clinical review of the management of the man's health needs, confirms that few requests were made for treatment from primary care services except in relation to his obesity.
106. The clinical reviewer reports that the reception health screen form included in the man's medical file was incomplete and there was no evidence that a full physical examination was carried out. I suspect that, had the form presented to the clinical reviewer been complete, it would have shown that a physical examination did take place.
107. I believe that the standard of care given to the man so far as his physical health was concerned was satisfactory. I discuss the man's drug abuse separately below.
108. I also judge that the man's mental health needs were appropriately managed. When he entered prison on this occasion, he had no mental health history. Neither did he present with any existing problems.

109. As soon as he began to demonstrate signs of depression and suicidal thoughts, the man was referred to and seen by appropriate agencies, including the mental health team. He was also referred to a bereavement counsellor. Indeed, the officer who discovered the man had gone to his cell to take him to see the bereavement counsellor. The man was also due to see a doctor to discuss a regime of anti-depressant medication.

**I am impressed by the manner in which the man's drug worker, reacted when she received the poem written by the man. Her swift intervention caused the ACCT form to be opened immediately. I commend her and the officer who had accompanied her.**

110. However, the clinical review appended to this report makes the following recommendations with which I concur:

**The reception proforma used at Dartmoor should contain a prompt to explore substance misuse related health issues.**

**Obese prisoners should be offered a care plan with regular reviews to encourage weight control.**

**Obese prisoners' needs should be considered as part of a disability assessment.** (I would add that had this been done in the man's case, he might not have been placed in a cell on the fifth landing in D Wing at Dartmoor.)

**Appropriately calibrated scales should be made available in reception so that the weight of obese prisoners can be accurately measured and recorded.**

**When a mental health assessment is required as part of the ACCT process, the observations should be recorded both in the ACCT document and the patient's medical record.**

**Medical records should be kept in chronological order to permit contemporaneous recording in the history sheets.**

***Was the man's risk of self-harm properly assessed, monitored and managed?***

111. Prior to his entry into prison in July 2005, the man had no history of self-harm or suicide attempts. During his reception health screen at Blakenhurst, he did not present as being at risk of self-harm or suicide. This was also the case when he transferred to Exeter on 2 December 2005, and again at Dartmoor three weeks later.
112. The first indication given by the man that he was at risk of self-harm was on 19 October 2006 when he wrote a poem in which he hinted that he wanted to die.

The drug worker and the officer decided to open an ACCT form after learning from the man that he had been depressed about his mother's death and had spent a lot of time crying in his cell by night. The man told the drug worker and the officer he had been considering harming himself. Once the ACCT form had been opened, the drug worker also took the precaution of referring the man to a bereavement counsellor.

113. An immediate action plan was set out for the man and an ACCT assessment interview was conducted within prescribed timescales. The record of the assessment interview shows the man felt alright during the day but at night, when he had time to think, he felt low. It was at night that he wondered "whether it was worth carrying on". He told the chaplain, who conducted the assessment, that he was upset he had been placed on an ACCT form.
114. On 20 October, the first case review was conducted. The man himself was present. A care map was drawn up in which appropriate goals were set for Robbie to achieve with the support of staff. However, no mention was made in the ACCT document of the frequency of observations the man required. This serious omission was to cause confusion amongst staff as to how often the man needed to be observed during the last hours of his life.

**The Governor should ensure that clear instructions on the frequency of observations of at-risk prisoners are set out in their ACCT documents at all stages.**

115. On 22 October, the man was seen by a registered mental nurse, in keeping with his care plan. Registered mental nurse thought the man's risk related more to a wish that he was dead rather than to any active plan to kill himself. However, the registered mental nurse decided to refer the man to a doctor so that the need for anti-depressant medication could be assessed. An appointment had been arranged for 26 October. The entries made in the man's ACCT record show no sign that he was actively contemplating self-harm or suicide.
116. The OSG Operational Support Grade on duty in D Wing during the night of 24/25 October, told my investigator he knew an ACCT form had been opened for the man but was not clear how often he was expected to observe him. The entries OSG made in the ACCT ongoing record were at 8.10pm on 24 October, and 1.00am, 3.00am, 5.00am and 6.00am on 25 October. The OSG was adamant that he actually observed the man at hourly intervals. He also admitted that his observations were predictable, and that both the man and his cellmate would therefore have had a good idea when each observation was likely to be made and when they were unlikely to be disturbed.
117. If prisoners can predict the times at which they are likely to be observed, the point of observing them is weakened: during the periods when they are not observed they are free either to misbehave or to self-harm undetected.

**The Governor should ensure that observations of prisoners at risk of self-harm or suicide are not carried out at predictable intervals.**

118. The clinical review comments that a mental health nurse assessed the man three days before his death. Whilst his low mood was a matter of concern, no acute risks of suicide were observed.
119. The investigation found no direct evidence to establish whether the man died as a result of a deliberate act or by mischance.

***Was the man's drug addiction properly assessed and managed?***

120. The man had been sentenced for possession of drugs with intent to supply. Upon his arrival at Blakenhurst on 28 July 2005, he admitted he had been addicted to drugs but said he had abstained from drug abuse during the previous two years. The nurse who carried out the reception health screen referred the man to the prison doctor in relation to his drug abuse history. His clinical record contains no evidence to clarify whether he saw a doctor, but a week later the man was placed in the voluntary drug testing unit where he undertook a number of urine tests that showed he was clear of drugs. In the short time he was at Exeter in December 2005, no entries were made in his record in relation to drug abuse.
121. Upon his arrival at Dartmoor on 22 December, the man asked to be placed on a drug free wing and was referred to CARATs service who allocated the drug worker as his caseworker. The drug worker kept in touch with the man throughout the ten months he was at Dartmoor before his death.
122. I consider that the support given to the man to assist him to remain drug-free was appropriate. Despite this support, it is clear that the man did have access to drugs and that during the night of 25/26 October 2006 he took a fatal dose of heroin.

***How did the man acquire the drugs that killed him?***

123. On 11 December 2006, my investigator was told by a prisoner whose name I have chosen to withhold that, on the day before the man died, he passed him a quantity of heroin that had recently been brought into the prison. The prisoner said that before the man left the unit for D Wing that day, he (the man) said to his friend words to the effect, 'I can end it all now'. The prisoner told my investigator that, after the man left the Resettlement Unit, he (the prisoner) went to the staff office to report what the man had said. The prisoner said to the senior officer and another member of staff whose name he did not know were in the office. The prisoner said he told the senior officer that the man had left the wing in possession of half an ounce of tobacco. The prisoner explained that the word

'tobacco' was a code word for heroin and that staff knew this. He said he chose not to refer to heroin directly lest other prisoners in the vicinity should hear him. He said he told the senior officer that the man was capable of "doing something". By this he meant that, as the man was subject to ACCT procedures, he might harm himself. The prisoner alleged that the senior officer did nothing about what he had told him.

124. Upon receipt of this information, my investigator reported the matter to the police who advised that the investigation should be suspended in order to enable them to make enquiries of their own. The prisoner was subsequently transferred to another prison where he was formally interviewed by the Devon and Cornwall Police. A case was submitted to the Crown Prosecution Service for them to consider prosecution. The CPS advised that, in view of the unreliability of the prisoner's confession and the absence of any corroborative evidence, no further action should be taken.

125. My investigator interviewed the senior officer and put to him the allegations the prisoner had made. The senior officer told my investigator he knew nothing of the alleged use of the word 'tobacco' for heroin. The senior officer was also asked the following question:

"Were you given any information of any sort by the prisoner on the evening of 24 October last year that indicated to you that the man had drugs and wanted to end it all and was going to do it in D Wing?"

The senior officer said he was given no such information.

126. My investigator then said to the senior officer:

"Can you comment as to whether the prisoner or anybody else gave you information about the man that would normally cause you to follow up that information and check up on him in D Wing?"

The senior officer again said he was given no such information.

127. Shortly after the interview with the senior officer, the chaplain at Dartmoor, volunteered information to my investigator. The chaplain said he visited the Resettlement Unit at about 6.30pm on the day the man died. The purpose was to check on the morale of some of the prisoners there in the aftermath of the man's death. The chaplain accompanied a member by a volunteer within the chaplaincy. Together they saw three prisoners, including the one referred to above. The chaplain explained that the volunteer had already seen the prisoner earlier that day and wanted to make sure he was alright.

128. The volunteer was asked to give an account of the conversation he had with the prisoner. He said:

“... He was pretty upset, had his head in his hands, from memory a few tears, I think and he surprised me by saying he was blaming himself for not taking the drugs off the man. Now at that stage I had absolutely no idea what had caused the man’s death in any way shape or form and so we talked generally about you not being upset, and don’t blame yourself and I am sure you did all you could etc. But I did go back in the conversation to say, you know what do you mean by this, because obviously my ears pricked up slightly and I was half listening to something that might be useful information. He then told me that some time earlier and I don’t know how earlier, alcohol was brought into the Resettlement Unit. Specifically that it had been brought in for the man’s use. But he, as I said, had thought that the man ought not to get involved in these things and he told me that he had spoken to an officer about it. I remember him asking which officer was involved and he said he didn’t think I needed to know that and I agreed with him. But I went back again to the drugs thing and he then, and my recollection is fairly clear on this, he told me that he knew drugs had come into the prison but he didn’t want to go back to an officer again because he had half sensed that possibly the fact that the alcohol had been discovered might have been traced all back to him and clearly he had his eyes on not being seen as a grass or anything similar ...”

129. Towards the end of his interview with the volunteer, my investigator put to him the following:

“In my interview with the prisoner which took place some time ago, he said to me that he told a named member of staff on the evening of 24 October, in other words the day before the man died, that he knew the man had drugs and suggested to the named member of staff that he needed to keep an eye on him because the man was on an ACCT form and might kill himself. Now what you told me flies in the face of that. Do you want to comment?”

The volunteer replied:

“That is a surprise to me because, as you say, it flies in the face of what I’ve just told you and my recollection is that he was blaming himself for not taking the drugs off the man and also I remember asking which officer was involved and he didn’t want to tell me and he indicated that if everything was tracked back to him he really would be seen as a grass.”

Later, he concluded:

“... So from what you say to me now, I think, yes, I suppose with all you've said so far, this is a transference of guilt. Is it the prisoner thinking, my goodness, it was me and all this about telling an officer the night before is that a way of perhaps shifting blame from himself ...”

130. I am of the view that the statements above cast serious doubt on the veracity of the prisoner's claim that he alerted the senior officer to the fact that the man was in possession of drugs, and suggested he keep an eye on the man because he was likely to kill himself with the drugs he had acquired. However, there is no further evidence to resolve the conflicting statements.

***Were adequate measures taken to prevent the supply of illicit drugs to prisoners at Dartmoor?***

131. Prison Governors are required to put in place a local drug misuse strategy for:

- reducing the supply of drugs
- reducing the demand for drugs
- reducing the health risks associated with drug misuse
- staff training.

132. The policies in place at Dartmoor at the time of the investigation are summarised below.

*Reducing the supply of drugs*

A comprehensive strategy for the reduction of drug supply was evident. The following targets were pivotal:

- All prisoners were to be strip searched as part of the reception procedures.
- All visitors were to be subject to a 'pat down' search before entering the visits hall.
- 10% of prisoners were to be strip searched before returning to their units from the visits hall.
- The prison perimeter was to be patrolled frequently.
- Appropriately trained dogs were to be used, when available, to search visitors and prisoners on a random basis, and all areas of the prison.
- Staff were to be searched on a random basis when entering the prison.
- Closed circuit television (CCTV) was to be used to deter and detect the passing of drugs between visitors and prisoners. The police were to be involved whenever there was CCTV evidence indicating the possession or passing of drugs on visits. Visitors caught passing drugs to prisoners were to be banned from further visits for an appropriate period of time.

- All mail for prisoners was to be checked for enclosures and was to be checked by drug dogs when available.
- Mandatory drug testing was to be carried out on 9.5% of the prisoner population at any one time on a random basis.
- Voluntary drug testing was to be offered to all prisoners. (The Resettlement Unit was designated as a drug free unit.)
- Dogs were to be used to screen prisoners returning from periods of temporary release, outside working parties and court appearances.
- Every effort was to be made to ensure that those attempting to smuggle drugs into the prison were prosecuted.

### *Reducing the demand for drugs*

The following measures were in place for reducing the demand for drugs:

- PASRO

This is a five week programme delivered by prison staff and community based drug workers. The programme seeks to help prisoners to:

- increase their motivation to reduce their drug misuse
- attain self-control skills in relation to their drug dependency
- use those skills for relapse prevention
- think about changing their life styles.

- CARATS

This facility is available in all prisons. It involves teams of staff from the prison and community work who work together to:

- help prisoners avoid the use of drugs in prison
- offer counselling on a one-to-one or group basis
- give advice on communicable diseases
- provide rehabilitation programmes
- draw up release and through care plans.

### *Reducing the health risks associated with the misuse of drugs*

An integral feature of Dartmoor's drug misuse strategy is helping prisoners to reduce the health risks associated with the misuse of drugs. A protocol agreed between health care staff and the CARATs team is included in the strategy document. The protocol is designed to ensure that all prisoners presenting at the healthcare centre with problems relating to drug addiction are offered appropriate support and, if necessary, referral to the CARATs team.

Also in place is a protocol for the prescription of opiate based analgesia. The protocol is based on the premise that most prisoners presenting with drug misuse

problems on reception are likely to use opiates. The protocol therefore sets out to avoid any prescription of opiate based analgesics unless it is specifically clinically indicated as being necessary. The protocol also sets out the local approach towards the management of opiate withdrawal and detoxification regimes.

### *Staff Training*

The local strategy document sets out targets for training staff:

- to develop an in-house drug awareness course for staff
- to improve drug awareness
- to improve addiction awareness
- to improve health education amongst staff in relation to communicable diseases.

133. The measures included in Dartmoor's strategy for the reduction of the supply of and demand for drugs and for the reduction of the health risks associated with drug misuse are consistent with national guidelines for the management of drug misuse in prisons. I believe Dartmoor's local strategy document is thorough, comprehensive and well thought out. However, the investigation found security weaknesses that could be exploited by prisoners determined to bring drugs and other contraband into the prison.
134. HMP Dartmoor is surrounded by a high stone wall along its entire perimeter. The wall is illuminated throughout its internal side. The exterior is illuminated only by the occasional street lamp. There are houses near some parts of the wall, whilst in other areas there is open wasteland. Closed circuit television cameras are installed within the prison at selected sites. This equipment offers staff a limited opportunity to monitor the internal side of the prison wall and, to a lesser degree, the external side. However, there are inevitable blind spots on the external side that can be exploited by those intending to pass contraband into the prison.
135. The internal and external sides of the perimeter are patrolled on an ad hoc basis throughout the day by dog handlers. By night, the exterior is not patrolled. Occasional intelligence-led patrols are mounted by security staff in support of dog handlers.
136. My investigator was taken around the internal side of the prison perimeter. He was shown a means by which it was possible for drugs and other contraband to be thrown over the wall for prisoners to collect. The area most used for this purpose was adjacent to a small compound used by the establishment for the storage and processing of re-cycled rubbish. My investigator was told that prisoners used to be able to work unsupervised in this compound but that this practice had ceased. He was told that members of the public would often throw parcels over the wall towards the compound. Prisoners in the adjacent wings would help ensure the parcels followed an accurate trajectory by communicating with those delivering the goods using mobile phones smuggled in to the prison. I believe every effort was made by staff to intercept parcels, but the ingenuity of prisoners was such that they would find ways of defeating staff initiatives to curtail the smuggling.

137. My investigator was also told that, when prisoners returned to the prison from their work outside, they were collected by an Operational Support Grade who took them from the gate area to the end of the Resettlement Unit. Here an officer would give them a full search during which they were required to remove their clothes. However, the investigation found that on occasions the number of prisoners returning from work was such that it was possible for the staff to be distracted. This created the chance for some prisoners to avoid a proper search.
138. Notwithstanding the security weaknesses to which I have referred, it was not possible during the investigation to discover how the drugs that killed Robbie were smuggled into Dartmoor..
139. Before completing this report, my investigator asked the Head of Prison Operations, what steps had been taken to tighten up security in the aftermath of the man's death. The Head of Prison Operations confirmed that measures had been put in place straightaway to ensure that a maximum of two prisoners are taken from the gate to the Resettlement Unit upon their return from external employment. This has significantly reduced the opportunity for distractions and consequent lapses in security. She also confirmed that more recently, all category D prisoners had been removed from Dartmoor to open prisons. Although this measure was unrelated to the man's death, it nevertheless has had the effect of bringing to a halt the capacity of prisoners in the Resettlement Unit to work outside the prison on projects and full-time employment. She told my investigator the number of drug related incidents in the prison had reduced as a result.
140. A significant proportion of the prison population have been convicted of crimes that are directly or indirectly related to drug abuse. Their demand for drugs does not cease when they go into prison. The capacity of prisoners to overcome the most sophisticated security procedures and systems is such that it is unrealistic to expect prisons to be completely drug-free. This would call for draconian measures such as intrusive searching and closed visits for everybody, thereby denying physical contact between prisoners and their visitors. A balance has to be struck between deploying robust security measures and maintaining a humane environment that supports the wider rehabilitation of offenders and the maintenance of family ties.
141. I believe the measures already in place at Dartmoor to limit the supply of drugs, as well as those taken since the man's death, are the best that can reasonably be expected in the circumstances. The cost of taking measures to strengthen the physical security of the perimeter of the prison, such as increasing the provision of CCTV or building an external road or pathway on which to mount vehicle patrols, would likely prove prohibitive. I therefore make no recommendations on these matters.

### ***Could the man's life have been saved ?***

142. The paramedic team who attended the man confirmed that rigor mortis was present when they found him. This suggests the man was dead well before 1.35pm. I am concerned that, during the entire morning period, no one knew for certain whether he was asleep, unconscious, dying or dead.
143. It is known that the man was seen alive by the OSG at 8.10pm on 24 October. The OSG said that the man was sitting on his bed, drinking tea and talking to the cellmate. The OSG told my investigator he also saw the man lying on his right side at 3.00am the next morning but on his left side at 5.00am. If the OSG's memory was correct, it means the man turned over and adopted a new sleeping position at some time between 3.00am and 5.00am. It is safe to assume that, having taken his lethal dose of heroin before then, the man's condition could have started to deteriorate at any time that night. Although the man must have been alive when he turned over, it does not follow that he had not reached a point where he was lapsing into a coma.
144. The evidence provided by the man's cellmate offers a graphic account of what actually took place in his cell during the last hours of the man's life. It is clear that the cellmate had no idea of the state the man was in between the time the cellmate woke up on the morning of 25 October and the confirmation of the man's death at 1.35pm that day. The cellmate said the man went to sleep as late as 6.00am. However, in view of his admission that both he and the man had taken large quantities of heroin earlier that night, I question the reliability of that claim.
145. OSG told my investigator he checked the man every hour through the night. He made a record of only those observations he made at 1.00am, 3.00am, 5.00am and 6.00am. At each of those observations, the OSG thought the man was asleep. As the OSG had no cause for concern, he had no reason to enter the cell.
146. The first officer who was on duty that day also thought the man was asleep when he checked his cell for the roll check at 7.00am. The roll check procedure does not require staff routinely to enter a cell. The officer therefore only looked through the observation panel in the cell door for the purpose of carrying out his check.
147. The Prison Service's National Security Framework sets out general guidance for security but devolves to Governors the responsibility for drawing up specific security policies for their own establishments. Where roll checks are concerned, the National Security Framework sets out the times at which checks should be made but does not dictate the method.

148. My investigator examined the instructions in place at Dartmoor for the conduct of roll checks. Although the times at which roll checks were to take place were made clear in the instructions, they made no reference to the manner in which they were to be carried out. As a result, there was no clear onus on staff to check the wellbeing of each prisoner during roll checks. While there was an implicit expectation that staff should check that the correct number of prisoners were in their cells, there was no explicit instruction requiring them to assess their wellbeing.
149. I understand the Prison Service recognises roll checks are normally conducted in a manner that prioritises security over the wellbeing of prisoners. Thus, if staff do not demand a response from each prisoner they check, it is possible for them to fail to spot prisoners who may be unwell, dying or dead.
150. I do not criticise the officer who was first on duty that day for not obtaining a response from the man at 7.00am on 25 October. He carried out his roll check in the manner to which he was used. Neither am I prepared to speculate as to what, if any, difference it might have made to the man's chances of survival if his wellbeing had been checked at that time. However, I believe there is a case for roll checks to meet both security and health requirements.

**The Governor should consider reviewing the policy for the conduct of roll checks to ensure that staff are required to gain a response from prisoners, at least at the first daytime check.**

151. The next person to see the man was the first officer on the scene who unlocked his cell door at 8.00am to carry out a further security check. He opened the door and looked in. He saw there were two prisoners present and there was movement but he did not know "who was who". The officer remembered seeing a "large man" on the bottom bunk. He quickly left to check the other cells on the same landing. He said he did not have a lot of time to engage with prisoners because he had half an hour to check the whole landing, get back to the office and take prisoner applications. He therefore had no conversation with the two occupants. The officer said he had no reason to believe there was anything wrong in the cell. It was not uncommon for prisoners on the induction landing not to want to speak to staff. He said he locked the cell door at 8.30am.
152. The third officer said that when he saw the man at 8.10am he made an entry in the ACCT form to indicate that he appeared to be asleep and was breathing. The officer explained that he made the entry because it was part of his normal duty to undertake such checks at the outset of his shift. He said that, with hindsight, he should have made the comment, "appears to be breathing" rather than "was breathing".
153. The first officer on the scene said he saw the man again between 8.30am and 9.30am when he returned to his cell to complete a fabric check. The officer

completed this check without asking either occupant to move so that he could inspect the section of the cell wall hidden by their presence in their respective bunks. He said he told them what he was doing but there was no response. As a result of the fact that the officer did not ask the man or the cellmate to move, an opportunity to assess the state of the man's health was lost. However, once again I am reluctant to speculate as to the man's likely condition at that juncture.

154. The third officer told my investigator he checked the man again at about 8.45am. He said that on this occasion he was not carrying out an ACCT check. The officer entered the cell and said, "Hello, what are you doing back here?" The officer said there was no reply. He said it was not unusual for prisoners in the induction unit to stay in bed for long periods. He thought there was nothing about the man to suggest anything was wrong with him. When asked whether staff at Dartmoor were required to demand a response from prisoners subject to ACCT procedures, the officer said that he now makes sure that he gets a response. My investigator asked whether this change of practice was related to the man's death. As noted earlier, he replied that he had not received a specific instruction, but had reflected on things he could have done differently.
155. The third officer said he went back to the man's cell at 10.30am to see the cellmate who was required to move that day to A wing. The officer made it clear that he did not check on the man on that occasion as the sole purpose of his visit to the cell was to see the cellmate.
156. Yet another opportunity to check on the man's condition arose at about 11.00am when the first officer on the scene unlocked all the cells on D5 landing for association. The officer said he unlocked the man's cell door and pushed it open, and immediately moved on towards the next cell without stopping. He later saw a number of prisoners enter the man's cell. The officer said the prisoners were in the man's cell "for a fair while".
157. My investigator was told by Devon and Cornwall Police that they interviewed a number of prisoners who may have entered the man's cell. The police found no incriminating evidence in relation to those they interviewed.
158. The third officer on duty that day said he next went to the man's cell at about 11.20am. He said there were other prisoners in the cell besides the man and the cellmate. One of them told the officer that the man "just had a late night", was still asleep and was alright.
159. By this time, the man had been checked to one degree or another on six separate occasions by two members of staff. On each occasion it was assumed the man was asleep. On none of those occasions was any attempt made to demand a response from him. On the last occasion, the word of the other prisoners in the cell was taken as fact.

160. I believe staff should have been more proactive in their monitoring of the man that morning, particularly as he was subject to ACCT procedures. It seems they made assumptions, rather than personal knowledge, in deciding how to react to the man's passivity.
161. At 1.05pm, the first officer on duty that day made the last entry in the man's ACCT ongoing record. At interview, he said he thought he saw the man move, as if he were breathing. He said he was sure the man was alive at that time, although he recognised that this could have been mistaken. He told my investigator he had no reason to suspect anything was amiss in the cell.
162. Whilst I have some sympathy with the officer's reading of the situation, I believe that he, too, should have demanded a response from the man rather than simply accepting that he was asleep. I am sure he must have been mistaken (either in recollection or at the time) in thinking that the man was breathing at 1.00pm.
163. Each failure by staff to demand a response from the man that day is suggestive of some complacency. When combined, they suggest a culture that allows prisoners to remain passive in their cells rather than being challenged and encouraged to engage in positive activities. I am disappointed that this could be the case in a wing designated as the induction unit at Dartmoor.
164. The investigation could not determine when the man died. It would therefore be unfair to suggest that any individual member of staff could have saved his life had there been an earlier intervention. Even the cellmate, who was in the cell throughout the morning of 25 October, thought the man was asleep. However, I believe more could have been done to monitor the man in the last hours of his life.

**The Governor should take steps to ensure that wing and unit staff do not allow prisoners, especially those subject to ACCT procedures, to remain passive in their cells for long periods of time. Those subject to ACCT procedures should be required to give a verbal response to staff responsible for checking them during the day.**

***Were appropriate courtesies offered to the man's next of kin after his death?***

165. I am satisfied that proper arrangements were made for the man's uncle and aunt to be informed of his death as soon as possible on the day he died. This was despite the fact that they had recently moved from the address listed in the man's file.

## **RECOMMENDATIONS**

- 1. The Governor should ensure that clear instructions on the frequency of observations of at-risk prisoners are set out in their ACCT documents at all stages.**
- 2. The Governor should ensure that observations of prisoners at risk of self-harm or suicide are not carried out at predictable intervals.**
- 3. The Governor should consider reviewing the policy for the conduct of roll checks to ensure that staff are required to gain a response from prisoners, at least at the first daytime check.**
- 4. The Governor should take steps to ensure that wing and unit staff do not allow prisoners, especially those subject to ACCT procedures, to remain passive in their cells for long periods of time. Those subject to ACCT procedures should be required to give a verbal response to staff responsible for checking them during the day.**
- 5. The reception proforma used at Dartmoor should contain a prompt to explore substance misuse related health issues.**
- 6. Obese prisoners should be offered a care plan with regular reviews to encourage weight control.**
- 7. Obese prisoners' needs should be considered as part of a disability assessment.**
- 8. Appropriately calibrated scales should be made available in reception so that that the weight of obese prisoners can be accurately measured and recorded.**
- 9. When a mental health assessment is required as part of the ACCT process, the observations should be recorded both in the ACCT document and the patient's medical record.**

### **Commendation**

**I am impressed by the manner in which the drug worker, the man's drug worker, reacted when she received the poem written by the man. Her swift intervention caused the ACCT form to be opened immediately. I commend her and Officer Fergus.**

**At consultation stage, the Prison Service accepted all the above recommendations except recommendation 7. This was partially accepted. In its response to this particular recommendation, the Prison Service said,**

**“Obese prisoners may not believe that they have a disability and may therefore not declare it under DDA. We have no right to enforce the marking of disabled on any obese prisoner. This would be a clinical judgement that would advise the establishment of any appropriate needs.”**