Investigation into the circumstances surrounding the death of a man at HMP & YOI Exeter in November 2009

Report by the Prisons and Probation Ombudsman for England and Wales

July 2010

This is the report into the circumstances surrounding the apparently self-inflicted death of a man who had been remanded to HMP & YOI Exeter less than 24 hours earlier. He was 36 years old when he died. I offer my sincere condolences to the man's family.

The investigation was carried out by one of the Ombudsman's investigators. I would like to thank the Governor and his staff for their co-operation during the investigation. Particular thanks go to the investigation liaison officer.

Devon Primary Care Trust (PCT) commissioned a doctor to conduct a review of the clinical care the man received while at Exeter. I am grateful for his timely review.

The man had been at Exeter for a very short time before he died and, in that time, he gave staff no indication that he was vulnerable or struggling to cope. I find that staff completed their assessments of him properly and that his death was not foreseeable or, for that reason, preventable. The man was not able to telephone his family, because of one of the offences he was alleged to have committed. However, there is no evidence to suggest that he was unduly concerned by this decision.

The clinical reviewer makes one recommendation, which I endorse, about referring newly arrived prisoners for further mental health intervention. I make two more recommendations, the first concerning allowing prisoners to inform next of kin of their whereabouts and the other contact with the bereaved family following a death in custody. I have raised several other points for the Governor's consideration.

The man's is the fifth apparently self-inflicted death to occur at Exeter since the Ombudsman took over responsibility for investigating deaths in custody in 2004. There is only one issue which has been raised several times in the previous investigations (concerning the use of prescribed radio call signs in an emergency) which has also been noted in this investigation, although it has not led to a formal recommendation on this occasion.

The man's family commented on the draft version of this report and I am grateful for their contribution. The Prison Service has also responded to the recommendations made. Some changes have been made to the report to reflect the feedback received.

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

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

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SUMMARY

The man was arrested by the police early on 6 November 2009, following a car accident. While in police custody he underwent a risk assessment during which he said he was prescribed anti-depressants but had not been taking them. He told police he had never tried to harm himself before and had no such thoughts at the time.

The following day, Saturday 7 November, the man appeared in the magistrates' court charged with several offences, including breach of a non-molestation order. He was remanded him into the custody of HMP & YOI Exeter until 11 November. Staff responsible for escorting him to court and then to prison had no concerns about him while he was in their care.

The man arrived at Exeter at 1.30pm. He was one of three prisoners to arrive that day. He told reception staff he had been in prison once before. He said he received a cut to his face during a fight with his wife but did not mention that he had crashed his car. He said he was not dependent on drugs or alcohol and had no concerns about being in prison.

While in reception, the man was told that because he had been charged with breaching a non-molestation order, he would not be able to make any telephone calls until the subject of the order had been identified the following Monday. The man expressed no concerns about this.

Shortly afterwards, the man's immediate physical and mental health needs were assessed by a nurse. He told the nurse that he had a history of depression and was prescribed anti-depressants. He said he had not been taking them for three weeks because he felt better. The nurse had no concerns about his mental or physical health and, consequently, did not refer him to the doctor or any other service.

A volunteer from the Choices Consultancy Service (who provide support to prisoners and their families at Exeter) saw the man. The man said that no one knew he was in prison and he would like to speak to his mother. Having been told by reception staff, he knew that he would not be able to make any telephone calls himself. At the time, neither Choices volunteers nor prison officers could make telephone calls to next of kin on prisoners' behalves (since the man's death the policy has been amended). The man said he had no particular concerns about being in prison and gave the volunteer no reason to worry about him.

The man also met a prison Insider (a prisoner trained to provide useful information about life at Exeter to other prisoners) and a first night officer. He gave neither any cause for concern.

The man was allocated a double cell with a bunk bed on the designated first night wing, but had the cell to himself. At 5.00pm, prisoners were locked in their cells for the night. During the first roll check of the day at 5.45am on 8 November, a member of staff found the man hanging by a ligature attached to the top of the bunk bed. Staff went into the cell but it was clear that he had been dead for some time and so

they made no attempts to resuscitate him. An ambulance arrived shortly afterwards and the paramedics confirmed that the man had died.

I make three recommendations. The first concerns referring new prisoners for further mental health intervention, the second allowing prisoners to inform their next of kin of their whereabouts and the third concerns how news of a death should be passed to the bereaved family. I conclude however that staff assessments of the man risk to himself were reasonable and that his death could not have been foreseen.

THE INVESTIGATION PROCESS

1. The Ombudsman was notified of the man's death on 8 November 2009. The investigation was allocated to an investigator, the following day. The investigator visited Exeter on 16 November to open the investigation.

2. The investigator issued notices inviting staff and prisoners to contact her with any information they thought might be relevant to the investigation. There was no response to these notices. The investigator was provided with copies of the prison records relating to the man's time at Exeter, including his medical record. She conducted interviews with staff and prisoners at Exeter in January 2010.

3. Devon PCT commissioned a doctor to conduct a review of the clinical care the man received at Exeter. The investigator and the clinical reviewer conducted joint interviews with members of healthcare staff at the prison. The clinical review is attached to this report as annex 1.

4. HM Coroner for Exeter and Greater Devon was notified of the investigation and will receive a copy of the report to assist with her enquiries.

5. The Ombudsman's senior family liaison officer invited members of the man's family to be involved in the investigation. They raised no specific questions or concerns but I hope this report provides them with a picture of his brief time at Exeter.

HMP & YOI EXETER

6. HMP & YOI Exeter was built in the 1850s and is a local category B prison serving the courts of Cornwall, Devon and south-west Somerset. It can accommodate up to 533 unconvicted or convicted adult male prisoners and young offenders.

7. The National Offender Management Service (NOMS) publishes quarterly performance ratings of prisons in England and Wales, with each prison being assessed across a number of set indicators. For the past four published quarters, Exeter's performance has been judged "good" (with other possible assessments being exceptional, requiring development or serious concerns).

HM Inspectorate of Prisons (HMIP)

8. HM Inspectorate of Prisons conducted an announced inspection of the prison in October 2009. The Inspectorate recognised that Exeter "has to manage a wide range of needy and transient prisoners in elderly, overcrowded and often inadequate conditions". Reception and first night procedures were found to be "satisfactory" and most prisoners surveyed by the Inspectorate said they were well treated in reception. Interactions between reception staff and newly arrived prisoners were "relaxed and friendly".

9. The first night centre was described as "welcoming" with plenty of information on display. Prisoners were interviewed by first night officers, the Choices Consultancy Service (who focus particularly on helping prisoners maintain family and social relationships throughout their time in prison) and prison Insiders. The Inspectorate noted, however, that the interviews were not conducted in private.

10. New prisoners were allocated cells on B wing, the first night wing, if there was space, or other wings across the prison if not. First night support once prisoners had left the first night centre was "not so well organised". Although a list of new prisoners was produced, there was "little evidence" that particular checks were made of them overnight.

11. The Inspectorate noted that there had been three self-inflicted deaths since the last inspection in 2004 but that little had been done to follow up investigations. The suicide prevention co-ordinator was "often redeployed to other tasks" and safer custody meetings were not well attended. However, levels of self harm in the prison were low and prisoners at risk received "reasonable personal support".

Independent Monitoring Board (IMB)

12. Each prison in England and Wales is also monitored by an IMB, the members of which are volunteers from the local community. Members of the Board have full access to every part of the prison and each prisoner held there. The IMB produce annual reports for each establishment, and the latest available for Exeter covers the period November 2007 to October 2008.

13. The IMB noted the "dedicated and professional" staff working at Exeter and the positive relationships between them and prisoners. However, the lack of

activities available for prisoners was criticised. The difficulties of managing a growing population in old and unsuitable buildings were also recognised.

Cell Sharing Risk Assessment (CSRA)

14. The CSRA primarily assesses the risk a prisoner poses to other prisoners and whether they are suitable for sharing a cell. The level of risk can be low, medium or high. One section is completed by a discipline officer, the other by a member of healthcare staff. The form contains a series of questions relating to previous and current offences and any history of anti-social behaviour. Staff complete the form based on information gathered from relevant paperwork and what the prisoner tells them. The assessment also provides an opportunity to consider whether the prisoner poses any risk to him/herself.

KEY EVENTS

15. During the early hours of 6 November 2009 the man was arrested by the police following a car accident and taken to the local police station. On his arrival, he underwent a risk assessment. The police officer noted that the man had a cut to his left cheek (which had been treated by paramedics at the scene of the accident) but no other known physical health problems. The man said that he was prescribed anti-depressants. He denied having consumed any alcohol or drugs within the last 24 hours or being dependent on any substances. He said he had never tried to harm himself or take his own life and that he currently had no such thoughts.

16. At 4.25am he was assessed by a doctor at the police station. The doctor also recorded that he had a cut to his left cheek, bruises to his left shoulder, left eye socket and across his body where he had been wearing a seat belt. The man told the doctor that he had a history of depression, had been prescribed anti-depressants but had not been taking them as directed. Again, he said he had not drunk alcohol or taken any drugs prior to the accident. The doctor noted that the man was "not mentally impaired" but was shivery and shaken. He took samples of the man's blood so that it could be tested for the presence of alcohol or drugs. The man was considered "fit to be dealt with" and did not require a mental health assessment. The doctor assessed the risk of him attempting to harm himself as "standard".

17. The following morning, Saturday 7 November the man appeared at a local magistrates' court charged with three offences, including breaching a non-molestation order. At 8.10am, Reliance (the private company responsible for escorting prisoners from police custody or prison to and from court in the south west of England) collected the man from the police station. The Person Escort Record (PER) which accompanied him was completed by a police officer in the custody suite. It recorded that the man posed no known risk, either to himself or to others. (The PER provides details of the risks the escorted person might pose, including whether they might try to harm themselves or someone else and whether they have any health or substance misuse problems. It also serves as a record of their time in the custody of the escort service.)

18. The man arrived at the magistrates' court at 8.40am, appearing in court at 10.02am when he was remanded into the custody of HMP Exeter until 11 November. He was placed on the escort van at 12.30pm, arriving at Exeter at 1.30pm. Reliance provided the investigator with statements completed by staff who collected the man from the police station and had contact with him during the day. They agreed that the man's PER indicated that he posed no known risks and that his demeanour during the day caused them no concern. He was one of three new prisoners to arrive at Exeter that day.

19. Shortly after he arrived an officer completed the first part of the Cell Sharing Risk Assessment (CSRA) with him. The officer recorded that the man had never abused alcohol or drugs and was not currently dependent on either. He was not being monitored under any suicide or self harm procedures and had no concerns about sharing a cell. The man said he was not someone who got angry or

frustrated easily. Nonetheless the officer assessed the man as posing a "medium" level of risk to other prisoners (the other options being low or high).

20. The investigator interviewed the officer. He recalled the man as compliant and confident during the reception process. On arrival at Exeter, most new prisoners are issued with a unique code they can use to make telephone calls (this is known as the PIN phone system). However the man had been charged with breaching a non-molestation order, the subject of which was not yet known. Staff explained to him that he would not be issued with a code number until the prison's Public Protection Unit (PPU) had checked the order the following Monday. The officer said the man accepted this.

21. While in reception the man removed a bandage from his face. He told reception staff he had been injured during a fight with his "missus". The officer completing the CSRA had not seen any of the accompanying paperwork and so did not know that he had been in a car accident. The man told the officer that he had no thoughts of harming himself and no history of doing so. The officer said that he considers other factors, such as the prisoner's body language, when assessing their risk. He saw no reason to be concerned that the man might try to harm himself.

22. The officer who completed the CSRA was asked why he had assessed the man as medium risk. He explained that he is not comfortable assessing any new prisoner as low risk in reception as he does not know them but knows that prisoners are particularly vulnerable during their first days in prison. Despite this precaution, the officer was unsure whether assessing new prisoners as medium risk meant that any more comprehensive checks or assessments are carried out.

23. The man was then taken to the first night centre. At 2.54pm a nurse completed the First Reception Healthscreen with the man. (The purpose of the First Reception Healthscreen is to identify any immediate physical or mental health problems requiring referral to the doctor or other specialist service in the prison.) The man told the nurse that he had been in prison previously in 2005. He said he was registered with a doctor in the community and had been assessed recently because he was suffering with depression. He told the nurse that he was being prescribed anti-depressant medication, but he did not know which one. He said he had not taken any for three weeks. The man said he had never tried to harm himself and had no such thoughts currently.

24. The nurse was interviewed as part of the investigation. He said that the man told him he no longer felt depressed which was why he had not taken his medication over the previous three weeks. The nurse told him that healthcare staff would contact his community doctor the following Monday to seek extra information about his medical history and confirm his prescription.

25. The man told the nurse that he had been assaulted by his wife the previous day and had injuries on his face, arms and body which were treated by ambulance staff. Otherwise, he reported no physical health concerns. The nurse recorded that the man drank alcohol "socially" and did not use drugs. The man did not think he needed to see the prison doctor and the nurse made no referral to either

the doctor or any other specialist service. The nurse recorded that the man could be given a cell on one of the prison wings and was fit for work.

26. According the guidance contained in the First Reception Healthscreen, the man should have been automatically referred to the mental health team because he had been treated for depression. The nurse did not do so and was asked about this in interview. The nurse explained that the man gave him no cause to be concerned about his mental health. He said that he uses his judgement as an experienced nurse to decide whether a prisoner needs further mental health intervention. On this occasion, he concluded that the man did not currently require support from the mental health team.

27. The nurse said that when assessing a prisoner's mental health and risk to self, he considers not only what they say but also their body language, level of eye contact and other non-verbal signs. He explained that often vulnerable prisoners are "vague or avoiding the issues" when they answer the questions. The nurse said that, if he has any worries about a prisoner, he opens an ACCT document. (Assessment, Care in Custody and Teamwork [ACCT] is the prison service process by which prisoners at risk of harming themselves are monitored and supported.)

28. After completing the healthscreen the nurse spoke to the prison doctor on duty in the first night centre. He told the doctor that the man was prescribed anti-depressants but had not taken them for three weeks. He said he had left instructions for staff to contact the man's community doctor on Monday. The prison doctor gave the nurse some paperwork relating to the man, including the ambulance service log of the treatment given to him following his car accident. In interview, the nurse said he realised that the man had not mentioned being involved in a car accident and that the ambulance log stated he had crashed into a wall. He explained that this was not particularly unusual as prisoners often did not "tell the truth". He said that the man's failure to mention the accident did not cause him concern. The nurse and the prison doctor read the police doctor's record and were satisfied that they had no reason to worry about the man. The nurse also completed the healthcare section of the CSRA, assessing the man as a low risk to other prisoners.

29. Each new prisoner sees an Insider in the centre who provides them with useful information about Exeter. The Insider on duty saw the man on his arrival and completed the Insiders checklist. The Insider noted that he provided the man with information about what he could expect from his first 24 hours in the prison, as well as using the telephone, writing letters and receiving visits. They also discussed the prison's anti-bullying and violence reduction policies, race relations, using the emergency cell bell (located in every cell and used to attract staff attention) and accessing Listeners or the Samaritans. (Listeners are prisoners trained and supported by the Samaritans to offer a confidential listening service to other prisoners. They can be accessed by any prisoner at any time of day or night. Prisoners are also able to make free telephone calls to the Samaritans using a dedicated telephone.) The man told the Insider that he had no concerns that needed to be addressed urgently.

30. The Insider was interviewed during the investigation. He remembered the man as quiet but seeming to understand all the information he was given. He noticed that the man had an injury to his face, but did not think it was appropriate to ask about it. The Insider had no concerns about the man. He said that if he had any concerns about a prisoner he would record them on the checklist, which is passed to an officer, and also discuss his worries with staff.

31. The Choices Consultancy Service also provides a service to new prisoners. A volunteer speaks to every new prisoner who comes through the first night centre. Their role is to check whether the prisoner has any family or relationship based concerns. The service provides ongoing support and assistance to both the prisoner and his family and friends. The volunteer on duty on 7 November completed the Choices information sheet with the man.

32. The volunteer was interviewed by the investigator. He described the man as quiet, calm and "level headed" during their meeting. The man told the volunteer that no one knew he was in prison. The volunteer asked him if anyone needed to know where he was and said that the man did not reply. He then asked the man if he intended to telephone anyone and let them know. The man said he was not sure he would be able to because of what he had been told in reception. The volunteer told him that the first night officer, who he was seeing next, would be able to give him more information.

33. The volunteer said he knew that prisoners who are not allowed to contact family or friends during their early days in custody might be more vulnerable. He told the man that he, or another Choices volunteer, would return to see him the following Monday and check whether he needed any help contacting his family. At this point the man told him that the only person he really needed to speak to was his mother to get a list of his family and friends' telephone numbers.

34. The investigator asked the volunteer if Choices volunteers were able to make telephone calls on a prisoner's behalf if they are not allowed to make the call themselves. He explained that, at the time, volunteers could not do so until the PPU had made the necessary checks. The volunteer explained that, since the man's death, the policy had changed. Staff are now able to make one telephone call on the prisoner's first night in prison to let their next of kin know where they are. The investigator was provided with a copy of the Governor's Order 42/09, dated January 2010, which confirms this is the case.

35. After the man had seen the volunteer an officer completed the first night centre checklist and risk assessment. The officer was also interviewed as part of the investigation. He explained that the first night interview is designed to gather as much information as possible about the prisoner. The officer said that the reception and first night process for new prisoners who arrive on a Saturday is the same as for those arriving on a weekday.

36. The first night officer noted on the checklist that the man had no thoughts of harming himself and was not withdrawing from alcohol or drugs. The officer recorded that the man appeared self-confident and co-operative, was of "middle" mood and did not seem aggressive. The man told him he was in full time

employment but had debts. The officer noted that the man had been charged with a violent offence against a family member. (In fact, none of the offences he had been charged with were violent and, at the time, prison staff did not know who the victim was.) The man said he had no concerns or worries. The officer recorded that the man had been given his identity card and written information about the prison regime. The officer wrote that the man had not been given any telephone credit "due to the nature of [his] offence". He said that he and the volunteer agreed that they could not make a telephone call on the man's behalf until the situation had been discussed with the PPU.

37. In interview the officer said that the first night interview usually lasts about 20 minutes. However, because it was quiet that afternoon, he remembered spending about 45 minutes with the man. He said that the man had good body language and although he "obviously wasn't happy to be in prison", he did not seem "sad". The officer described him as an "intelligent man" who said he owned two businesses. He said the man gave the impression of having "a lot to live for".

38. The investigator asked the first night officer if the man appeared to have any concerns about the offences he had been charged with. The officer remembered reading some of the paperwork accompanying the man's which mentioned that he had crashed his car into a wall. The man told the officer that the police had accused him of "trying to hurt … himself … or his wife or something like that". However, while the man mentioned having "problems with his wife", the officer did not consider it his place to "pry" further. The man said nothing more about the nature of the alleged offences.

39. Several of the questions on the first night assessment checklist form are highlighted and the officer was asked why. He explained that answering positively to those questions might indicate the prisoner posed a greater risk to himself. The officer answered the majority of those questions negatively. When asked if he had any concerns about the man, he replied "quite the opposite".

40. The first night officer allocated cell B4-21, on the designated first night wing, to the man. The cell is designed to accommodate two prisoners and contains bunk beds. However the man was a non-smoker and there were no single cells or spaces in cells with other non-smokers which were available. As a result he had the cell to himself that night. The officer explained that he thought the man was happy not to be sharing a cell. The officer found a spare television and said that the man seemed pleased.

41. Prisoners are served their evening meal at about 4.15pm on Saturdays. A second Insider based on B wing took the man to collect his food. This Insider told the investigator that the man was "chatty" and seemed not to have any worries. The Insider offered his support if the man needed anyone to talk to but he said he was fine. The second Insider said that, had he any concerns about the man, he would have suggested that he should share the cell that night. He explained that Insiders often offer to share cells with new or vulnerable prisoners if they want company and support during the night and that staff are happy to arrange this.

42. At 5.00pm on Saturdays, all prisoners are locked in their cells for the night. Two roll checks are carried out during the evening (when each prisoner is checked and counted), at 8.45pm and 10.00pm. The roll was correct at 8.45pm and staff reported no concerns about the man. (After his death, staff who conducted this roll check told the senior officer on duty that night that the man was writing a letter when they looked into his cell. Devon and Cornwall Police provided the investigator with a copy of a letter found in the man's cell after his death. It is not a suicide note and contains no references to his mood or intentions.)

43. An operational support grade (OSG) member of staff was on duty overnight on 7 November and conducted the 10.00pm roll check. (OSGs are employed to complete a variety of duties across the prison. They do not undergo the same training as prison officers and generally have fewer responsibilities.) In interview the OSG explained that to carry out the roll check, the member of staff looks through the observation hatch in every cell door making sure the right number of prisoners is in each cell. She said that, although staff try to check the welfare of each prisoner, this can be difficult if they have already gone to sleep. She explained, however, that at each check staff must get a response from all prisoners on an ACCT document. The OSG could not recall checking the man at 10.00pm that night but said if she had any concerns about a prisoner she would always raise them with more senior members of staff on duty.

44. At 5.45am on 8 November the OSG began to carry out the first roll check of the day on B4 landing. On reaching the man's cell, she looked through the observation panel in the door and saw that he was not in bed. She turned the cell light on, using the switch located outside his cell door. The OSG kicked the cell door, thinking the man might be using the toilet. When she heard no response, she shone her torch into the cell and saw him at the back of the cell. She saw that he had a bedsheet tied around his neck and to the top rail of the bunk beds.

45. On finding the man the OSG used her radio to call for assistance. She told the investigator she requested "urgent assistance" and said that using the word "urgent" indicated that it was an emergency. Very quickly the senior officer (SO) (the Night Orderly Officer in charge of the prison that night), an officer and two other OSGs arrived at the cell.

46. The SO explained that all staff on duty at night carry a cell key in a sealed pouch which can be used in an emergency. (Cells should not normally be unlocked overnight so the use of sealed pouches means there is an audit trail if cells are opened.) He said that OSGs are not expected to enter cells alone in an emergency if they do not feel comfortable doing so and certainly should not go inside without informing the orderly officer.

47. The SO and the officer unlocked the man's cell and went in. As they did so, the SO used his radio to alert the control room to a "Code Blue" situation, indicating a medical emergency where a prisoner is not breathing. Staff in the control room called for an ambulance.

48. The officer used his anti-ligature knife (which is specially designed to safely cut ligatures) to try to cut the bed sheet but, because it was too thick, was unable to so. Instead the SO untied the ligature from the bed rail and lowered the man to the floor. The officer checked the man for a pulse or any signs of breathing, but found neither. His body appeared rigid and cold to the touch. It was clear that he had been dead for some time so staff did not attempt cardiopulmonary resuscitation. Both the SO and the officer said that, had they thought it appropriate, they would have been confident attempting resuscitation. The officer told the investigator he had completed a first aid course very shortly before the man's death.

49. Soon after the two officers had placed the man on the cell floor another officer arrived at the cell. The SO asked him to go to the healthcare centre to collect the nurse. The SO explained that the nurse on duty at night is locked inside the healthcare centre and does not carry keys so cannot move around the prison unless escorted by a member of staff who is carrying keys. (For the majority of the night, the orderly officer and his assist are the only people who carry keys. At the time the man was discovered, the D wing officer had just collected his set of keys as the early morning tasks were about to begin.)

50. The SO escorted the OSG who found the man to the main gate so she could collect a set of keys and bring the ambulance to the wing when it arrived. While he was doing so the nurse arrived at the man's cell with the emergency medical equipment. On checking him, the nurse established that there was nothing she could do to resuscitate him. She and the officer then left the cell. (The nurse no longer works in the prison and was not available for interview as part of the investigation.)

51. At 5.50am, the ambulance arrived at the prison. The paramedics were escorted to the man's cell and carried out checks on him. Finding no signs of life, they pronounced his death shortly afterwards.

Contact with the man's family

52. The duty governor that morning asked the local police to break the news of the man's death to his mother, his nominated next of kin, who lived approximately 40 miles from Exeter. According to Prison Service Order (PSO) 2710, Follow up to a death in custody, where possible, news of the death should be broken in person by prison staff. The investigator asked the duty governor why this had not happened. He explained that it was his first experience of dealing with a death in custody. As the incident manager, he knew he had a number of responsibilities. He said he wanted the man's family to be told as soon as possible and so decided to ask the police to visit.

53. At 11.00am that day, the prison governor and the duty governor visited the man's mother. The man's mother told his estranged wife of his death who then rang the police for confirmation. After discussions between the prison and the police, the police contacted his wife to give her further information.

54. A member of the prison's chaplaincy team was appointed as the prison family liaison officer and maintained contact with the man's family and wife. The prison made an offer of financial assistance towards the cost of the funeral. This is in line with the guidance contained in Prison Service Order 2710.

Support for prisoners

55. On learning of the man's death on the morning of 8 November two members of the chaplaincy team visited the wing. Having said prayers in the man' cell, they informed other prisoners on the wing of his death and offered their support. As it was Remembrance Sunday, they also informed those prisoners who attended services that day. All prisoners on ACCT documents were checked during the day.

56. The two Insiders told the investigator they had been very well supported by prison staff following the man's death. Both had been offered counselling by the chaplaincy team and said they found this very useful.

Support for staff

57. The duty governor chaired a hot debrief at 7.00am. (This is when all staff involved in a serious incident gather together to discuss their roles. Its primary purpose is to offer support but it may also help to identify any immediate learning points. Holding a hot debrief is a requirement of PSO 2710.)

58. All staff interviewed said they were contacted by the prison Care Team and knew where to access support if they needed it.

ISSUES

59. The man had been in prison for less than 24 hours when he died. This investigation focuses on whether those who came into contact with him during his short time at Exeter adequately assessed the risk he posed to himself.

60. Prior to arriving at Exeter the man was held in police custody after a car accident. During the first night interview with a prison officer on 7 November the man said that the police thought he had crashed his car to hurt himself or his wife, who was the passenger. However, the paperwork completed by the police and the police doctor while he was in their custody did not indicate that there were any concerns about his risk to himself. Reliance staff who looked after him at court on 7 November said he gave them no reason to worry.

Clinical assessment of the man's risk to himself

61. The clinical reviewer considered the nurse's assessment of the man. The man had a cut on his face which he told the nurse had been inflicted during a fight with his wife. He told the nurse that he had a history of depression and was prescribed anti-depressants. However, he said he had not taken the medication for the previous three weeks because he felt better. During the healthscreen the nurse also assessed the man's body language and other non-verbal signs which can indicate a prisoner is vulnerable. The man answered the questions put to him clearly and maintained good eye contact throughout. The nurse had no concerns about the man following the assessment. The nurse left instructions for healthcare staff to contact the man's community doctor the following Monday to check his medical history and prescriptions.

62. After completing the healthscreen the nurse discussed his assessment of the man with the duty doctor. The doctor gave the nurse paperwork relating to the man which had accompanied him into the prison. The paperwork included the paramedics' log of treatment provided following his car accident the previous day and the police doctor's report. On reading them, the nurse realised that the man had not mentioned being involved in a car accident. However, the nurse told the investigator that prisoners do not always tell the truth. The man's decision not to tell him about his car accident did not strike the nurse as particularly strange or concerning. I am satisfied that the man's decision not to mention his car accident to the nurse and to other staff was not, in itself, a reason for them to think he might be at risk of harming himself.

63. However, the first reception healthscreen document contains an instruction that any prisoner who has received treatment for a mental health condition should be referred to the mental health team. The nurse did not make such a referral, explaining that he used his clinical judgement to decide whether a prisoner needed further mental health assessment. He concluded that, on the information available to him, there was no reason to refer the man to the mental health team. This approach was endorsed by the prison's Head of Healthcare.

64. The clinical reviewer concludes that the nurse's assessment of the man's mental state was appropriate. He notes that "at no time had the man indicated or had there been any information that he was likely to try to self harm". Given that the nurse was seeking further clarification of the man's mental health problems and treatment, he concludes it was reasonable to delay the referral until the additional information had been received. He recommends however, and I endorse his view, that healthcare staff clearly record the reason for any delayed referral on the healthscreen.

The Head of Healthcare should ensure that, where an instruction on the First Reception Healthscreen is not being followed or is being delayed, healthcare staff clearly record the reason why.

How discipline staff assessed the man's risk to himself

65. Prisoners who have been charged with or convicted of violent offences against a member of their family or their partner are known to be particularly vulnerable. Prison staff had not received official confirmation of the victim of the man's offences, but it appears to have been his wife. However, in my view, the nature of his offences would not, on their own, place him in this at-risk group.

66. The man was also assessed by two prison officers. In addition the Choices volunteer and an Insider spent time talking to him. All four were interviewed as part of the investigation. None had any concerns that he might have been thinking of harming himself. The man, who had been in prison before, denied ever having tried to harm himself in the past and said he currently had no such thoughts. I think staff assessments of his risk and vulnerability were reasonable. There were no indications that an ACCT document should be opened.

67. One of the officers, who carried out the CSRA, assessed the man as medium risk to other prisoners. This was despite the man having no history of violent offending, no history of dependence on substances, not being monitored on an ACCT and saying he had no concerns about sharing a cell. In my view, there was no evidence to support the judgement that he should be medium risk.

68. In interview the officer was asked about his decision making. He explained that, when completing the CSRA, he was reluctant to assess any new prisoner as low risk. He said this was because he did not know very much about them or the potential risks they might pose to other prisoners or themselves. He knew, however, that prisoners could be particularly vulnerable during their first days in prison. As a result, he said he usually assessed new prisoners as medium risk. However, the officer did not know whether any more detailed assessments or checks were made as a result. The nurse assessed the man as low risk.

69. The officer's approach did not impact on the later decision to allocate the man as the sole occupant of a double cell (which was made on the basis that he was a non-smoker and there was no space in a non-smoking cell). However, I think it displays some uncertainty about the purpose of the CSRA and how the form should be completed. I make no formal recommendation, but the Governor may

wish to remind staff of the correct process, to fulfil his obligations under PSO 2750 Violence Reduction.

Making a telephone call on his first night in custody

70. Under chapter four of PSO 4400 Prisoner communications, which covers prisoners' use of telephones, prison governors must make arrangements to allow all prisoners to make a call to their next of kin within 24 hours of their arrival at the prison.

71. On his arrival at Exeter, staff noted that the man was charged with breaching a non-molestation order, a civil injunction. However, staff were unsure about the order and subject of it. They told him that he would not be able to make a telephone call to anyone until the PPU had clarified the situation. The man arrived on a Saturday, and the PPU is not open over the weekend. As a result, he would not have been able to make a telephone call for over 24 hours.

72. Chapter six of the Public Protection Manual provides guidance on the circumstances under which prisoners with existing civil injunctions against them are given access to the prison telephone system. On arrival, the prisoner must nominate the people he or she wishes to have contact with and the prison must check their status (to confirm they are not the victim or subject of the existing order) before allowing any contact.

73. Safer Custody and Offender Policy (SCOP, the department in the National Offender Management Service responsible for developing policy relating to prisoner safety) provided guidance on this issue. They note that, in applying the procedures outlined above, the prison should also take account of the potential impact of refusing a prisoner access to the telephone. For example, raising the risk of anxiety might increase the risk of self harm. SCOP advocates that a member of staff makes a telephone call on the prisoner's behalf, in their presence. This might help to alleviate the prisoner's concerns until the necessary checks have been made.

74. At the time of the man's death, staff said they were unable to make a telephone call on the prisoner's behalf without PPU's permission. Since then, the Governor has issued an instruction allowing staff to make one call to the prisoner's next of kin to inform them that the individual is in prison. I am pleased that the Governor has introduced this sensible measure. Not being able to contact someone during the early days in prison may well increase a new prisoner's anxiety and vulnerability. At the draft report stage the man's mother commented that she was pleased the policy change had been introduced, although she was sad that it had taken her son's death for this to happen.

75. However, this is not the first time that an investigation into a self-inflicted death has found that a prisoner was not allowed to make a telephone call on his arrival in prison. I think this merits urgent consideration by the Prison Service.

The Prison Service should ensure that all prisoners are able to inform their next of kin of their whereabouts when they come into prison or that this is done on the prisoner's behalf, preferably in the presence of the prisoner

76. The man's mother was particularly concerned that her son had not been able to speak to someone after he arrived. She urges the Prison Service to take urgent action in response to the recommendation.

The emergency response on 8 November

77. At about 5.40am on 8 November an OSG was conducting the roll check on B wing and found the man suspended from a ligature in his cell. She used her radio to alert the orderly officer to the emergency. The OSG said she used the words "urgent message" to convey the seriousness of the situation. The senior officer told the investigator that he used the words "Code Blue" when he used his radio to call for medical assistance.

78. The different radio calls might have led to a delay in a member of staff being dispatched to collect the nurse from healthcare. On hearing the OSG call, a number of staff went to the man's cell, but it was only once the SO put out the "Code Blue" call that it was clear medical assistance was required. The SO then sent an officer, who had arrived at the cell, to collect a nurse (who was not carrying keys at the time). On this occasion, I do not believe the delay in healthcare staff reaching the man made any difference to the outcome, but it might do in other circumstances. This matter has been raised in previous investigations into deaths at Exeter. While I make no formal recommendation, I am sure the Governor will wish to remind staff of the correct procedures. It might also be sensible to task a specific member of staff (for example the Assist Night Orderly Officer) to collect healthcare staff in such a situation. On receipt of the draft version of the report, the man's mother commented that action was needed to ensure staff responded promptly and appropriately.

79. The OSG did not unlock the cell when she found him hanging, choosing to wait until other more senior staff had arrived. The SO explained the cell entry protocol during the night. Staff should always inform the orderly officer if they go into a cell, but they should only do so if they are happy to. I think it is understandable that the OSG did not go into the man's cell immediately she found him.

80. When the SO and an officer went into the cell, they checked the man's pulse and for signs of breathing. Both realised that he had been dead for some time. The officer told the investigator that rigor mortis had already set in. Because they were sure nothing could be done to revive him, they did not attempt cardiopulmonary resuscitation. When the nurse arrived, she agreed and also did not attempt to resuscitate the man. The paramedics reached his cell within

about ten minutes of him having been found. They quickly pronounced that he had died.

81. Both the SO and the officer said that, had the situation been different, they would have been confident commencing CPR. I am pleased this is the case, but agree that, on the evidence available, it was appropriate to decide not to attempt to resuscitate him.

Contact with the man's family

82. On the morning of 8 November, local police visited the man's mother, who lived about 40 miles from Exeter, to tell her of her son's death. PSO 2710 directs that it is most appropriate for staff from the prison to break the news of the death in person to the nominated next of kin. Asking the police to do so should only happen in specific circumstances.

83. The duty governor on 8 November and made the decision to ask the local police to visit the man's mother. He told the investigator that he wanted to ensure that she was told as quickly as possible. I accept that the reasons behind his decision were well intentioned. I am pleased that he and the Governor visited the man's mother later that morning. However, I think the Governor should remind all governor grade staff of the family liaison guidance contained in the PSO.

    The Governor should remind all governor grade staff of the guidance contained in PSO 2710, particularly where it relates to contact with the bereaved family.

CONCLUSION

84. The man arrived at Exeter at 1.30pm on Saturday 7 November. At 5.40am the following morning, he was found dead in his cell, having apparently taken his life. During his short time at the prison, he was separately assessed by a nurse and two officers and spoke with a prison Insider and a volunteer from the Choices Consultancy Service.

85. Although he admitted a history of depression and said he was prescribed anti-depressants, he also said he felt better and had not been taking the medication for three weeks. He denied ever having tried to harm himself in the past and repeatedly assured staff he had no such thoughts currently. Staff received no other information from outside sources to suggest that he might be at risk. This investigation has found staff's assessment of the man's risk to himself to have been reasonable.

86. I make one national recommendation to the Prison Service concerning allowing all prisoners to inform their next of kin of their whereabouts. I also make one recommendation to the Head of Healthcare concerning the First Reception Healthscreen instructions, and one to the Governor of Exeter concerning contact with a bereaved family. While I think none would have prevented the man's death, his mother believes that had he been able to make a telephone call, he might not have taken the action he did. .

RECOMMENDATIONS

All of the recommendations were accepted at the draft report stage.

To the Head of Healthcare:

1. The Head of Healthcare should ensure that, where an instruction on the First Reception Healthscreen is not being followed or is being delayed, healthcare staff clearly record the reason why.

To the Prison Service:

2. The Prison Service should ensure that all prisoners are able to inform their next of kin of their whereabouts when they come into prison or that this is done on the prisoner's behalf, preferably in the presence of the prisoner

To the Governor:

3. The Governor should remind all governor grade staff of the guidance contained in PSO 2710, particularly where it relates to contact with the bereaved family.