Investigation into the circumstances surrounding the death of a man at HMP Dartmoor in January 2009

Report by the Prisons and Probation Ombudsman for England and Wales

March 2010

The man was 38 years old when he died in January 2009, in his cell at HMP Dartmoor. He was found hanging. He had been treated at HMP Exeter for schizophrenia until a week beforehand. The investigator and Family Liaison Officer join me in offering our sincere condolences to his family and friends for their sad loss.

I wish to thank the Governor of Dartmoor and the Deputy Governor for making the necessary facilities and information available to the investigator. I also thank the prison Liaison Officer for his assistance.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment the man received in custody. A clinical reviewer was appointed by the local Primary Care Trust to undertake a clinical review on my behalf. He was assisted by a Consultant Psychiatrist. I am extremely grateful for their assistance and report.

For the purpose of this report, I have concentrated on the time from when the man first arrived at Dartmoor in July 2008. In October he cut his wrist and from then on he was monitored under the suicide and self harm procedures, until his death three months later. I make 11 recommendations including a commendation for an officer who placed his own health at risk whilst attempting to resuscitate him.

I must apologise to the Coroner and the man's family for the delay in producing this report.

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
Deputy Ombudsman **March 2010**

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SUMMARY

The man had a long history of mental health problems, for which he had received treatment and hospitalisation whilst in the community. When he arrived at prison, his medical history was noted and a number of support mechanisms put into place.

After arriving at Dartmoor in July 2008, it was noted by healthcare staff that the man had been diagnosed with paranoid schizophrenia. He was prescribed a number of different medications to help his symptoms.

In October, the man cut his wrist and from then on, suicide and self harm monitoring began. (The procedure for monitoring is known as Assessment, Care in Custody and Teamwork (ACCT) which I explain in greater detail later in the report.) As well, due to concerns about his mental health, he was transferred to Exeter as an in patient in the prison hospital. His condition became worse and then improved. He continued to receive support from mental health in-reach staff and a psychiatrist. (In-reach forms part of the community mental health team and offers support to prisoners.) In January 2009, he was deemed well enough to return to Dartmoor and when he arrived there, he was allocated to A wing.

Six days later, in January, the man's behaviour became a cause for concern and in order to keep him safe, Exeter healthcare were asked whether they were able to take him back. Unfortunately, there were no beds available and he remained at Dartmoor.

That evening, an ACCT case review took place and consideration was given as to whether the man should move to a safe cell. He was unhappy about moving and so staff considered whether force should be used. However, the manager considering the option was unable to find any guidance. Instead, he remained in his cell and was monitored every hour. Shortly after midnight, whilst carrying out a routine check, he was found hanging in his cell.

I make ten recommendations aimed at improving systems at Dartmoor and one which commends an officer. Five recommendations refer to Dartmoor's suicide and self harm procedures, five are intended to improve healthcare arrangements and one recognises the efforts made to resuscitate the man.

THE INVESTIGATION PROCESS

1. When the Ombudsman's office was notified in January 2009 of the man's death, the investigation was allocated to a Senior Investigator. He contacted the Governor and arranged to travel to the prison to meet him and his team for the purpose of opening the investigation.

2. In February, the investigator met the Governor as arranged. The investigator also met the Deputy Governor, the prison's liaison officer to the investigator, a representative of the Independent Monitoring Board, a representative of the local Prison Officers Association, the Devon PCT Patient Safety Quality Manager for Commissioning, the Healthcare Services Governor for Devon Partnership andthe prison coordinating chaplain.

3. Following the meeting, the investigator and the healthcare team went to the cell where the man had been found hanged. They were able to view the inside of the cell and see where the ligature was attached. After viewing the cell, the investigator arranged to return at a later date, to continue with the investigation.

4. In February, the investigator returned to the prison to begin interviewing staff. At the end of the week, he met with the Governor and gave feedback about his initial findings and likely recommendations. He later followed this up in writing. Before leaving the prison, he arranged to return at a later date to carry out joint interviews with the clinical reviewer.

5. Four days later, the Ombudsman's family liaison officer spoke to the man's mother who was his listed next of kin. This was to inform her about the investigation and provide her with an opportunity to raise any concerns or issues she wished to be explored as part of the investigation. His mother raised a number of issues including wanting to know why her son was able to take his own life, given that he was being monitored. Additionally, she was concerned that his medication had been changed whilst in prison and had tried to discuss the issue with prison staff. His mother said that when she telephoned the healthcare department, she was told they could not discuss it due to patient confidentially.

6. His mother said she had spoken to her son on the day he died and described him as being exhausted. She asked whether prison staff tried to help him. Additionally she asked why he was moved from healthcare to a prison wing and whether prison staff had recognised his distress.

7. The investigator has considered and attempts to answer these questions within the report. I am very grateful to the man's mother for her assistance at what was a very difficult time. A copy of this report will be shared with his family. I hope the findings of this investigation help them better understand the events leading to his death.

8. In April, the investigator returned to Dartmoor with the clinical reviewer to continue his interviews. The clinical reviewer was assisted by a Consultant Psychiatrist. The following day, the investigator fed back his findings to the Deputy Governor, and followed this up by writing to the Governor explaining what he had told the Deputy Governor. At the time of writing this report, I have not received a response to the feedback from the Governor.

9. As part of the normal process for investigating deaths in custody, a clinical review report was requested from the local Primary Care Trust, and they commissioned a clinical reviewer. In July, the investigator received the report.

10. In preparation for this investigation the Clinical Lead, Devon Prisons Health Partnership, submitted a report to the investigator for inclusion in the investigation. I have used some of the information from his report to help fill in any gaps in the clinical review report.

11. After issuing the draft report, I received feedback from the Prison Service. They told me that with the exception of one, all recommendations had been accepted. The Prison Service did not feel it necessary to make clearer the transfer arrangements between Dartmoor and Exeter or to provide clear care plans in the medical records.

12. Additionally, I received feedback from the man's mother. In her response to the draft report, she said she was concerned that staff had not entered his cell straight away, particularly given his long history of mental health problems. She also reiterated her concerns about changes to his medication, in particular a reduced dose of diazepam.

13. The man's mother added that she was concerned that he had been asked, rather than being told to move to a safer cell. Additionally, she said prison staff should have varied the times of observations. She said she felt it unsatisfactory that the prison had been unable to accommodate him properly. She said she was satisfied with the report and agreed with the recommendations.

HMP DARTMOOR

14. The prison is situated close to the village of Princetown in Devon. Originally built in 1809, the prison has undergone extensive refurbishment and modernisation. Accommodation is provided for adult sentenced males.

Her Majesty's Chief Inspector of Prisons

15. Her Majesty's Chief Inspector of Prisons reports on all prison establishments. The majority of inspections are announced and allow the prison being reported on to prepare for inspection.

16. In the introduction to her latest report on Dartmoor, following an announced inspection during 11 – 15 February 2008, she said it was disappointing that the inspection found that progress identified previously had not been maintained and that the prison had slipped back noticeably. However, she acknowledged that it was still considerably better than it had been in 2001.

17. She went on to say that the prison was not unsafe. She said that with the exception of one wing (A wing), the inspectors found staff who were engaged, committed and often overworked.

18. In the final paragraph she said:

> "It is always disappointing to report on a prison which has not been able to maintain promising progress. Dartmoor had significantly slipped back from the prison we inspected in 2006. It will require renewed and much more robust management to reverse this trend, to support and encourage committed staff, and to ensure that Dartmoor once again fulfils its role as an effective training prison".

19. Within the main report, she said vulnerable prisoners were held on F and G wings. She said prisoners there said they felt safe and that staff were generally helpful. She added that staff appeared aware of potential bullying and risks and that "Staff – prisoner relationships were mixed, but insufficiently proactive, except on the resettlement and vulnerable prisoner wings".

20. Under the heading of self harm and suicide, she said there was an appropriate system to manage self harm and suicide, but the quality of interventions varied across the prison. She said the information was not well reviewed during safer custody meetings and that management checks did not include an assessment of quality. She went on to make seven recommendations.

21. In relation to health services, she said that mental health provision was satisfactory, but there was a lack of multidisciplinary working. She went on to say there was no formal mental health awareness training for prison staff. She made 19 recommendations about health provision.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) made up of members of the public and their role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. In the first instance, the Board report to the Governor, or, if considered necessary, it can report directly to Parliament. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.

23. In its latest report, covering the period from 1 October 2008 – 30 September 2009, the Board said that in the first quarter of the reporting year, the prison continued to perform poorly and had dropped from a level three prison, to two. (The National Offender Management Service rates prisons using four levels, with level four being the highest and best performing.) However, following the arrival of the Governor, the Board were pleased to note that the performance had gone back up to three. The Board went on to say that the appointment of the Governor had brought strong leadership and that he was developing a clear strategy for the prison and challenging unacceptable behaviour.

24. Under the heading of mental health issues the Board said

> "Probably the biggest challenge faced in regard to diversity is the acceptance and understanding of staff in how to respond to those prisoners who have mental health issues.
>
> There is an overarching assumption that all prisoners can be expected to and should respond in a similar way. Training is required to challenge these assumptions. An awareness in how to deal with different mental health conditions…
>
> Mental health interventions provided through healthcare are severely reduced at present".

Healthcare provision

25. Dartmoor forms part of the healthcare cluster between Exeter and HMP Channings Wood. Neither Dartmoor nor Channings Wood has any facilities to care for prisoners requiring a hospital bed. In cases where a prisoner requires a hospital bed either because they are ill, or require constant observation, there is a protocol in place which allows for prisoners to be transferred to Exeter healthcare.

26. The Clinical Lead is based at Exeter and is the Clinical General Practitioner Lead for the Cluster. He oversees the protocol for all three prisons. He attends Dartmoor on Mondays remaining there all day, whilst on Fridays he attends for the morning only. For the remainder of the week, doctor cover at Dartmoor is carried out by locums.

27. At the time of the man's death there were nine general nurses and two healthcare assistants at Dartmoor. Included within the nine general nurses were three mental health nurses. Additionally, there was a visiting nurse specifically employed to work with prisoners with learning difficulties.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document should be available to all staff where the prisoner is located. Within 24 hours of the document being opened, the at-risk prisoner will be interviewed by a trained ACCT assessor. The ACCT assessment section has eight questions which are used as a reminder to the assessor of areas to be covered. The assessor's role is to consider the questions and if necessary expand the questioning, recording their comments in the ACCT document. Following the assessment a case review meeting is held, which is a multi disciplinary meeting and meant to involve sufficient numbers of staff to make an informed decision. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers take on the role of case manager, oversee the management of the ACCT document and attend case reviews. Regular case reviews are held until it is felt the prisoner is no longer at risk and that the ACCT document can be finally closed. In the meantime, prisoners are monitored. Monitoring can be anything from constant observation to intermittent.

Care team

29. Each prison has its own care team. Care team staff are drawn from all areas of the prison and trained specifically to help and support prison staff. Following any serious incident, they provide an invaluable role to any member of staff who requires support.

Emergency response codes

30. In the event of urgent medical assistance being required, a number of prisons have chosen to adopt codes to alert medical staff to particular incidents. The most common code used is code red and code blue, although some prisons have opted for code one and code two.

31. Code red or one informs the medical staff that the patient is bleeding. Code blue or code two alerts them that the patient is in breathing difficulty. At Dartmoor the code used is red and blue.

32. In prisons where codes are used the healthcare departments have created emergency response bags which contain the necessary equipment to deal with the particular incident. This ensures that medical staff takes the correct emergency equipment with them and helps provide the necessary medical care as quickly as possible.

Police investigations of deaths in custody

33. With all deaths in prison custody, the police are notified by the prison as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that the Ombudsman's investigators begin their own investigations.

34. At the meeting with the investigator in February, the officers confirmed that the man's death was not being treated as suspicious and that no final note had been found in his cell. The officers also agreed that the investigator could enter the man's cell for the purpose of familiarising himself with the layout. The investigator shared with the officers a copy of the Memorandum of Understanding between the Ombudsman and the Association of Chief Police Officers.

Prison officer grades

35. There are three levels of uniformed prison officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

36. Senior Officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.

37. Principal Officers (POs) are the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

38. In addition to prison officers, there are a group of staff known as Operational Support Grades (OSGs). OSGs wear prison uniform and carry keys but do not carry out the same function as prison officers. Their role is to support the areas of the prison that have little or no prisoner contact, for example, the gate. Additionally, they carry out night patrol duties. These duties often mean they have indirect contact with prisoners, which is limited to seeing and talking to them through a hatch in a cell door.

Prison Service Orders (PSO)

39. At the time of the man's death, Prison Service Orders were in use. They contain long term mandatory instructions which are intended to last for an indefinite period. Any mandatory instructions to Governors or Directors of contracted prisons are written in italics. Each PSO is given a title and unique reference number.

PSO 2700. Suicide Prevention and Self Harm Management

40. PSO 2700 provides instructions on identifying prisoners at risk of suicide and self harm, and on providing the subsequent care and support for prisoners. Included within the PSO are mandatory instructions, with an implementation date of 30 April 2008.

Personal Issue Cut-down tool (PSO 2700 section 11.3.3) "Fish Knife"

41. Contained within PSO 2700 is the following mandatory instruction:

> "All unified and uniformed staff in closed and semi-open establishments must be provided with and carry on duty their own personal issue cut-down tool."

42. Personal issue cut down tools are specially designed anti ligature knives, commonly referred to as "fish knives" because of their shape, which are used in an emergency to remove a ligature. The knives have a concealed blade which is placed against a ligature and which can be pushed forward to cut it without harming the prisoner.

Safe Cells

43. Although not a recognised term by the National Offender Management Service, Dartmoor has five cells that they call "safe cells". The cells are designed to have fewer ligature points and furniture with rounded edges. They are intended to be used as a short term method of supporting prisoners who are at risk of harming themselves. Once the prisoner is no longer deemed to be at risk, they return their own cell and the safe cell is expected to remain empty and available for use as necessary.

Sealed cell key

44. Unlike the officers on duty during the day time periods, night patrol officers are not issued with any security keys. Instead, they are issued with a cell key, which is kept secure in a sealed leather pouch, secured to the officer and only opened in the event of an urgent need to enter a cell. The officer must first of all be satisfied that it is safe to unlock the door and enter the cell. If they judge that it is not safe, then they must wait for assistance to arrive.

KEY FINDINGS

July 2008

45. In July, the man transferred from HMP Gloucester to Dartmoor. In his clinical review, the clinical reviewer said there was an appropriate healthcare screen carried out when he arrived at Dartmoor. It had been noted that the man had been diagnosed as suffering from paranoid schizophrenia for which he had been prescribed olanzapine, Venlafaxine and Diazepam.

46. In his report, the Clinical Lead said that when the man arrived at the prison, he was on a reducing dose of Diazepam. He added there had been a lengthy discussion with the man about reducing the medication, although he does not say who it was that had spoken to him.

47. Whilst in Gloucester, the man had been assessed by the psychiatric in-reach team and arrangements had been made for his case to be reviewed by the Dartmoor team. In August, the man was seen by a member of the in-reach team at Dartmoor and a gradual withdrawal from Diazepam was recommended.

48. The clinical reviewer said the man had been well up to September. However, when he was seen and assessed by Consultant Psychiatrist that day, he noted that his paranoid ideas had become more troublesome. The doctor noted him as being “low in mood, but having no suicidal thoughts”. The Consultant Psychiatrist adjusted the man’s medication and started him on a course of Risperidone, an antipsychotic drug. The following month, a further review was carried out and the Risperidone dosage increased.

49. In October, the man harmed himself by cutting his wrist. He was assessed by prison healthcare staff and his injuries treated. As a result of the self harm and him telling the officer that he would “dangle himself”, he was moved to a safe cell and an ACCT document opened and monitoring started. The level of monitoring was set at twice hourly. He told the officer that he was hearing voices and that staff and prisoners were laughing at him. (The document remained open through to the time of his death.)

50. At the ACCT assessment interview carried out the next day, the man said he felt everyone was talking about him and that he was hearing voices. He said that cutting his left wrist was a genuine attempt to end his life. It is noted in the assessment section that he was feeling low and had broken down in tears during the meeting. He was apparently observed shaking and repeating that the voices made his head hurt. He went on to say that he planned to hang himself from the cell window bars and that he wanted to go to sleep and not wake up.

51. During the assessment, the man was seen by the Clinical Lead. The doctor assessed him as being “very paranoid” and arranged for him to be

transferred to HMP Exeter that day as an in patient. The reason for the transfer was so that his condition could be stabilised.

52. In October, the man was assessed by members of Exeter's medical team with a view to returning him to Dartmoor. A psychiatric review took place and recommended that he remain at Exeter due to his deteriorating mental state and increased risk of harming himself.

53. The clinical reviewer said that the man's medical record notes that healthcare nursing staff had recorded him as being settled. The doctor said this was in direct contrast to psychiatric nurses who had written that the man was "quite paranoid and unwell".

54. In November, a further psychiatric review took place. The Exeter psychiatric in-reach team decided that the man's mental state had deteriorated to the point where admission to an external hospital should be considered. Before organising admission, they asked his previous in-reach team from Gloucester to see him.

55. The next day, the first ACCT case review took place attended by two members of staff and the man. The ACCT record notes that he was emotional and tearful during the review and as a precaution he was placed on "intermittent supervision" and remained in the healthcare unit.

56. In his report, the Clinical Lead said that, in November, the man had been seen by a Consultant Psychiatrist. He said the Consultant Psychiatrist adjusted the man's medication, increasing the dosage of the Venlafaxine and, starting him on Quetiapine an antipsychotic drug whilst stopping the Risperidone.

57. In November, a second ACCT case review was held. Once again the man attended the review and was noticeably tearful and anxious about his future. It was noted in the ACCT document that he had a fear of not getting better. The case manager also noted that the man had good insight into his illness and was complying with his medication regime. The level of observation remained unchanged at intermittent.

58. Seven days later, the third ACCT case review was held. On this occasion the man was recorded as saying he felt settled at that time and was much more confident. The case manager said the man felt able to interact with staff and peers and kept the level of observation as intermittent. He told the case manager that he had no thoughts of harming himself and was looking forward to the future.

59. In November, as a result of the request made earlier in the month, a Consultant Psychiatrist reviewed the man. His assessment of the man's condition was:

    - "Chronic schizophrenia with some ongoing symptoms

- Chronic substance misuse. (Currently abstinent in a controlled environment.)

- Current risk of suicide considered low. However, the doctor added that the man's history predicted a long term risk of impulsive deliberate self harm at times of stress."

60. The Consultant Psychiatrist said that, in his medical opinion, he did not consider that the man required admission to hospital. He said he appeared to be taking his medication. Additionally, the doctor considered the risk of suicide as low. The doctor increased the Quetiapine prescription to the maximum recommended level. In his clinical review, the clinical reviewer said the prescription appears to have been slow in being actioned, as it was not supplied until November, three days after being authorised.

61. In November, the fourth ACCT case review was held. The case manager noted that the man was continuing to take his prescribed medication. He went on to say that he was aware of the signs and symptoms related to his illness. It was also noted that he had said he was "feeling a bit paranoid", but had no thoughts of harming himself. The case manager left the level of monitoring as intermittent.

62. The nursing entries in the man's medical record describe a settled period. In December, following a mental health review, it was thought that he had recovered sufficiently for him to be transferred back to Dartmoor. It was also noted that he should be allocated to a vulnerable wing as it was thought he might relapse if not. (Vulnerable wings are normally used to accommodate prisoners who, due to their offence, may be at risk from other prisoners. They are also used to accommodate prisoners who might be susceptible to bullying or have difficulty coping in prison. Vulnerable wings are generally much quieter and offer a more relaxed calming atmosphere, which is why it was recommended for him.)

63. In December, the fifth ACCT case review took place. The case manager wrote a positive summary of the meeting. In it, he describes the ma as focusing positively on his future and gaining confidence. As before, the level of observation remained as intermittent.

64. Eight days later a further ACCT case review was held. Like the one held the previous week, the summary was positive in that the man's confidence had increased and he was able to interact. Similarly, the seventh case review held noted that he was settled and sociable. At the end of the review, another was arranged for January 2009, with the level of observation remaining as intermittent.

65. In the meantime and, before arranging the transfer back to Dartmoor, the prison was contacted to ensure they were able to take the man. At that point, the vulnerable wing at Dartmoor prison was full and so Exeter was asked to allow him to remain there until after the New Year, which was agreed.

2009

66. In January, an ACCT case review meeting was held. At that meeting it was noted that the man had been upset when told that his mother had telephoned the prison enquiring how he was. He became tearful and it was noted that he was not doing as well as he had been presenting. It was agreed that he should be seen by an in-reach worker and that the level of observation remain as intermittent. Also discussed was whether his transfer back to Dartmoor should be deferred.

67. The following day, a Registered Mental Nurse saw the man and recorded in his medical notes that he wanted to die. He had told the nurse that he had been looking for ligature points in his cell and had said he would make a noose.

68. In his clinical review, the clinical reviewer said a psychiatric review was arranged by the Consultant Psychiatrist who in turn arranged for a twice weekly psychiatric review. The clinical reviewer adds that in January, the man's medication was increased. He points out that, despite this, the Clinical Lead had written in the man's medical notes "Awaits transfer to Dartmoor".

69. In January, another ACCT case review meeting was held. The man was described as having a positive and settled attitude, but was concerned about the possibility of relapsing. The level of observation remained as intermittent.

70. The clinical reviewer said that by January, the man's medical notes refer to him as being settled and that his paranoid ideas were declining. However he adds that the nurse had made an entry to say that the stress of returning to Dartmoor may cause a relapse, but felt the additional support would aid his recovery.

71. The final entry in the medical notes, before the man returned to Dartmoor, was made by the nurse. She said that he was allegedly secreting medication. The file does not say who was making the allegation. At interview, the nurse said the man had not taken his medication as he had a stomach upset and had not been storing medication. She added that he was reminded of the importance in taking his prescription.

72. In January, two ACCT case reviews were held, with the first one being at 9.25am whilst at Exeter, the second was held at Dartmoor. At the first review, it was noted that he was nervous about returning to Dartmoor. The case review manager added that he was not thinking about harming himself. He made a note to say that the ma was experiencing some mental health issues, but does not say what they were. He went on to say that they were not as severe as those he had experienced previously. The man agreed to continue with the support of in-reach and was reminded of the

need to take his medication. It was agreed that the level of observation should remain as intermittent.

73. Later that morning, the man returned to Dartmoor. When he arrived there he was seen by one of the healthcare staff. She made a note in his medical file which said he was happy to be back at the prison.

74. Another person to see him that day was an officer. The officer said he met the man as part of the normal procedure for settling new prisoners into the wing. As well as this and along with another officer, a further ACCT review was carried out. The man attended the review meeting and asked if the ACCT document could be closed. The officer told the investigator that the request was declined as it was felt a further assessment should be carried out. He said the man accepted the decision and was calm throughout the meeting. He left the level of observation as intermittent.

75. Four days later, in January, the man attended another ACCT case review. The case manager summarised the meeting saying that the man was "very relaxed". The manager noted that he said he was relieved to have been allocated to the vulnerable prisoner unit and had settled in well. It was also recorded that he was still in contact with in-reach.

January

76. In January, the man was expected to attend a doctor's appointment, but did not attend. The clinical reviewer is unable to say why he failed to attend the appointment, but notes that a new appointment was made. He also did not collect his morning medication from the prison dispensary and it is recorded in his medical notes that he refused to take his medication.

77. During the early part of the afternoon and shortly before making a telephone call, the man approached an officer, who was in the wing office. He began talking to the officer about his medication. Although initially calm, his voice became louder and louder. He told the officer that the doctors and his own family wanted to kill him.

78. Prison telephone records show that at about 2.30pm, the man made the first of four telephone calls. As there was no requirement to monitor his telephone call, he was able to make normal telephone calls. The call lasted for just under seven minutes. The investigator has listened to the conversations and summarised the content.

79. The investigator believes the call was answered by the man's mother. The man spoke very quietly and told her that he was exhausted and that he "had had enough". After a few minutes, the call was passed to another female, believed to be his grandmother. He spoke mainly about his medication and told the lady that he was due to see a doctor the following day. He repeated that he had had enough and said he had "told them". He also complained about lack of sleep.

80. The man told his grandmother that when he first went into prison he was fine, but then adds that his medication was being “messed with” and said he was paranoid. She suggested that he should see a doctor and he replied saying “they are all in it”. He went on to say that he has “horrible feelings and paranoid”.

81. During the conversation, the man said he was going to “string himself up”. He again said that he had had enough. At this time, his voice has became raised and agitated, with his language becoming abusive. He went on to say that he was going to “smash up” and that he had “gone weird”.

82. At this point, his mother returned to the telephone. The man was still aggressive, kept repeating himself over and over and was asked to calm down. He described his feelings, and once again said he would “string himself up”. He then said that he felt trapped and was “too scared to move”. He ended the call abruptly by saying he did not know if he would telephone again.

83. The man made his second telephone call at 3.16pm to a different number, with the call lasting for four and a half minutes. The remaining two were made to the same telephone number.

84. The telephone call was answered by a lady and begins by a general discussion regarding a letter. After a short time, the man said that he had had enough and said he did not “feel right”. He repeated what he had said in his earlier call and said he would smash up his cell. The woman asked him if he was taking anything for his paranoia, and he said that he was not, adding that he was not eating. He told her that his medication was not for the treatment of paranoia. He went on to say that he would string himself up and that there were 130 people in the wing talking about him. He said he was unable to take any more and that he could not speak to anyone in the prison. Once again, he said he would smash up his cell and go to the segregation unit adding that “there was no one to talk about him”. He also said he felt trapped. The woman asked him if he was taking valium. At his point he ended the call saying she and his mother were “probably in it as well”, he then replaced the handset.

85. Shortly after, two officers went to the man’s cell to speak to him. At interview, one officer said the man told him that he was a paranoid schizophrenic and healthcare staff were “messing with his medication”. The man went on to say he had read an article in a magazine, which told him that his medication was for the treatment of bi-polar disorder. The officer said he then showed him the article. The officer said the man had misread the article and it was in fact written about the treatment for those who have used LSD.

86. The officer handed the investigator a report which he had prepared following the man’s death. He said he had made the note the following day. In his report, the officer noted that throughout the conversation the man was displaying mood swings. He said the man alternated between

talking quietly and then shouting, becoming excited and tense. He told the officer how he was feeling. The officer noted that he said "I feel like all the stuff is pouring out of me, everyone is talking and laughing at me, do you think I like feeling like this". The officer went on to say that the man would turn his head away and ignore him if he or the other officer were not saying what he wanted to hear. The officer also noted that he said "you want me to commit suicide, well I will". The officers told him that they would arrange for him to be seen by a nurse, which the officer said had the effect of calming him down.

87. After about 30 minutes, the officers left the man's cell and went to healthcare and spoke to a nurse. At that time the nurse had a patient with her. They interrupted her and asked if she would see him as soon as she was finished. Both officers then returned to F wing.

88. At 3.42pm, the man made a third telephone call, which was answered by another woman. He told her that his medication was for the treatment of bi-polar disorder and not paranoia. He said that he had stopped taking his medication saying it was a "conspiracy". He said he was unable to speak to anyone as "they" were all talking about him. The woman told him "not to do anything silly". He told her he was unable to take any more and wanted to talk to someone, but "they were all in it together". He said "they do not want me to get better" and at this point he ended the call abruptly.

89. At about 3.45pm, the nurse arrived at the wing regarding an unrelated matter. The two officers saw her and took the opportunity of speaking to her again about their concerns for the man. In his report, the officer said the nurse asked them to take him to the treatment room, but to allow her about ten minutes so that she could read his medical record before meeting him.

90. About 15 minutes later, the officers took the man to the treatment room. In his report, the officer noted that the nurse saw the man, but once again his mood swings were evident. The officer said the nurse showed the man a copy of the British National Formulary (which lists prescribed medications) and the section relating to the medication that he had been prescribed. The officer said he read the document and then became angry, saying the staff were against him, after which he left the room and returned to his cell.

91. In his report, the officer said that he and the other officer decided to speak to the wing manager and the SO. He said they told both managers of their concerns and it was decided that the SO would hold an ACCT case review meeting to discuss the man later that day.

92. At interview, the SO said that at about 4.30pm he went to speak to the man about his behaviour as he had been told that he was aggressive towards staff. He went to his cell and spent about ten minutes talking to him. The SO said he was complaining about his medication, saying that the treatment was wrong. He showed the SO the same article that he had earlier shown to the officers. The SO told the investigator that the article

had appeared in a magazine called FHM. He said the man showed him a section in the magazine relating to the same type of medication that had been prescribed to him. The SO said the man told him that the report stated that the medication was for the treatment of bi-polar disorder. The SO said the reason for the man being angry was because he was not bi-polar and that he believed healthcare had deliberately given him the wrong treatment.

93. After speaking to the man, the SO decided that he needed to leave the cell and seek further advice. He said that when he left the cell, the man was much calmer.

94. Having left the cell, the SO spoke to the nurse and the officer about holding an ACCT case review meeting. The SO said the nurse told him that she would speak to someone in HMP Exeter healthcare, because the man had a mental health issue and she wanted to see if they would take him back.

95. In his clinical review, the clinical reviewer said the man had been expressing a view that all nursing and medical staff were against him and that he wanted to kill himself. He adds that, although she had no mental health training, the nurse tried to explain to him what his medication was used for.

96. At interview, the nurse said she telephoned the healthcare department at Exeter to enquire whether they had a bed available for the man. She said the person she spoke to felt it unlikely, as they were expecting new prisoners.

97. The nurse tried to contact the Clinical Lead for his advice. When she eventually made contact with him, the doctor said he would review the man the next day, but said he felt he would be all right overnight. However, in his report, he said:

> "… if the condition necessitated and she was very concerned regarding self harm he [should] be admitted to the healthcare unit at Exeter".

98. Following her conversation with the Clinical Lead, the nurse recommended that the level of ACCT observations be increased to maximum, which she said was every 15 minutes. She also recommended that an ACCT review should take place the next day.

99. In the meantime, the SO read the man's ACCT document. At interview he said the purpose for doing this was to read the entry of the previous case review and the reason why he was subject to ACCT monitoring.

100. At about 5.30pm, the SO went to speak to the man about the case review. The SO asked him if he had used the telephone which he confirmed, saying that he had spent about ten pounds on the telephone. The SO asked him who he had spoken to and what he had talked about. He told him that he had spoken to his friends and his sister. The SO asked him if

he had spoken to his parents. He said he had not as they did not get on. He also told the SO that he was looking forward to being released in four months. He then said "don't worry I will not be a problem to you tomorrow". The SO asked him to explain what he meant and was told that he was intending to "smash up" his cell with a view to getting out of Dartmoor.

101. The SO said he spoke to the man about the possible consequences of his actions. He tried to persuade him that it would be better to remain where he was, as he would have access to every day items such as television. They also discussed the possibility of him being moved into a safe cell within the wing and increasing the level of observations. The SO said the man resisted the idea of moving and told him that he would have to be forcibly moved into a safe cell. The SO said the man appeared to understand why he was suggesting a move of cell and increased ACCT observations, but that he was unhappy with the prospect. He went on to say that the man felt healthcare staff were against him.

102. After leaving the cell, the SO spoke again to the nurse. She told him that Exeter would not take the man back, as the prison was full.

103. In the meantime, at 6.19pm, the man made what was to be his final telephone call. The call was answered by a man and the man asked for a woman. He told her that he had spoken to staff about his medication and also that his purchases from the prison shop were wrong, adding that it was all a "conspiracy".

104. At this point the man became much angrier, saying he would be taken to the segregation unit. He began shouting and, from what could be heard in the background, it would appear that he was being abusive to someone in the wing. The man said people were shouting and that it echoed in his ears. He said he had had enough, could not sleep and was exhausted.

105. Towards the end of the conversation, the woman asked the man to telephone his mother. He said no and told her that this was the last telephone call he would be making. The call was then taken over by the man who originally answered. The man began to repeat himself and talk about his medication. The man tried to reason with him and told him to concentrate on his artwork. The man talked over him and said "tell Lisa I love her". At that point, after seven minutes and 23 seconds from when the call began, it was terminated by the man.

106. As part of this investigation, the clinical reviewer and his assistant have listened to the telephone calls. In his clinical review, he said:

> "… it is clear he was feeling isolated and his thought processes were deteriorating quite quickly over this time. He also had lost confidence in the doctors who were looking after him. Despite pleas from his family to talk to the staff about his worries, the man did not do so."

107. The SO told the investigator that, before organising the ACCT case review meeting, he sought advice from the prison Suicide Prevention Co-ordinator. He said the purpose of speaking to him was to discuss what options were available. The SO told him that the man was refusing to move to a safe cell and so he wanted the Co-ordinator's opinion on the level of observations appropriate to the man's needs. The SO went on to say that the man told him that he did not want an increase in observation levels because he said he was a paranoid schizophrenic. The SO said the man felt that people would be looking at him which he felt would make him even more alarmed.

108. After speaking to the Co-ordinator, the SO returned to the man's cell to discuss the arrangements for the review. He told the SO that he did not want to leave his cell because he did not like people. He said he did not like being looked at and that the wing was too big for him. The SO said the man told him that he did not like the unit and wanted to get out of the prison. During the conversation, the SO attempted to engage further with him by suggesting he played a game of pool or chess. However, although he appeared to appreciate what was being said to him, he repeated his wish to leave Dartmoor.

109. In the meantime, the Co-ordinator considered what options were available to keep the man safe. His first thought was to move him to cell G 106, which the SO said was a safe cell, although he was unsure whether he would move willingly. Due to his uncertainty, the SO looked at PSO 2700 to see if it contained any information about moving someone by force if necessary. He said he was unable to find any information to advise him. The Co-ordinator went on to say that he later discovered that cell G 106 was unavailable as another prisoner was located there. He said the prisoner in the cell was not "at risk" and he was there was because a decision had been taken to use the safe cells as part of the Certified Normal Accommodation (CNA) figures. (CNA is the minimum amount of bed space available in the prison.) He said he did not know who had made the decision, but added that following the man's death, the Governor had removed the safe cells from the CNA. I deal with this later in the report.

110. One of the options available was for the man to be monitored constantly by a member of staff outside his cell. The investigator asked the Co-ordinator if this was something which had been considered and whether to do so would cause operational difficulties. He said it would cause problems because an extra officer would have to be called in to sit outside the cell. Additionally, he said there is no facility at Dartmoor for constant watch and anyone requiring such a level of observation would require an immediate transfer to Exeter healthcare. He went on to say there is no gated cell facility at Dartmoor, or clear fronted gated cell where somebody can be observed constantly and no 24 hour healthcare facility available at the prison. (A gated cell is one with bars which does not obscure the view, rather than a solid door, which does.)

111. The investigator asked the Co-ordinator what the scenario would be if, during the night, there was an urgent need to monitor a prisoner who

required constant observation, but could not be moved straight away to Exeter. He said he would have to call in an extra member of staff to cover the work.

112. At about 7.25pm and what was to be the final ACCT case review meeting took place, which the man attended. Chairing that meeting as case manager was the SO and also present were the nurse Harris, the officer Denny and the Co-ordinator.

113. In the case review summary, the SO noted that the man had been "unwilling to engage" in the review until they went to his cell. He told them that there was a conspiracy against him and said healthcare "were playing with his medication". When asked if he felt suicidal, he did not answer. However, he did say "don't worry you will not have a problem tomorrow". Although it was recorded in the review that the panel were concerned at what he had said, they felt he was trying to manipulate the situation. As a precaution and due to him having previous a history of cutting himself, the SO suggested that the cell should be checked and any razor blades removed. (Prisoners are allowed to have razor blades unless it has been decided that they should not. In this case, he was allowed to have a razor blade in his possession.) The level of ACCT observations was increased from intermittent to hourly. A further case review meeting was scheduled.

114. At about 7.45pm, an OSG began her duty in F wing as the night patrol officer. Also starting duty at a similar time was a night officer. She was the night patrol officer on G wing, which is adjacent to F wing, and jointly they were responsible for G and F wings.

115. At interview, the night officer said that when she arrived into the wing, she did so at the same time as officers were going into the man's cell to remove his razor blades. The officer said she was told that the level of ACCT observations on him had been increased to hourly. The night officer went on to say that, before the day staff left the wing for the evening, she asked one of the officers what his mood was. She said an officer told her that he was fine.

116. The OSG said that when she arrived into F wing, the SO told her that the level of observations on the man had been increased to hourly. Having received a handover from the SO, she began her patrol.

117. At about 8.00pm as part of the ACCT monitoring, the OSG looked into the man's cell and saw him. She said he did not speak to her, as he was using the toilet. About an hour later the OSG carried out a further ACCT observation and on this occasion he was watching television.

118. The next ACCT observation was carried out at 10.00pm by the night officer. At interview she said when she looked into the cell the man was watching television. She said she spoke to him and he said he was okay. The investigator asked the officer if she had any concerns about him at that time, and she said that she did not.

119. One hour later, at 11.00pm, the OSG made a further ACCT observation. She said the man was still watching television and, although he did not speak, he did look at her. This would appear to be the final occasion that he was seen alive.

January

120. At about midnight, the night officer went to the man's cell to carry out the next ACCT observation. When she looked into the cell, she saw his face squashed against the door observation glass. The officer said there was a green sheet around his neck.

121. Unsure about what she had seen, the officer went to the wing office and asked the OSG to assist her. Before returning to the cell, the OSG used her prison radio and asked the radio operator to contact the night manager for his assistance. Satisfied that help was on the way, she and the night officer went to the man's cell.

122. When they arrived at the cell, the OSG unlocked the cell door. However, as they were unsure about whether the situation was real or not, they did not go inside, deciding to wait for assistance. At interview, the OSG said the man's skin colour was grey and there was no movement. She said her instinct was that he was dead.

123. Following the request for assistance, the radio operator asked the night manager to go immediately to F wing. The operator told the night manager that a prisoner was hanging.

124. The night manager was an Acting Senior Officer (ASO). At interview, the ASO said he began making his way to F wing and as he was doing so, he received a further message from the radio operator. The radio operator asked for permission to break the emergency cell key seals and gate key seals, which he agreed to.

125. As well as the ASO hearing the message, all those on duty with a radio heard the request for assistance. One of those was an officer. At interview, the officer said that when he heard the radio message he did not hear what was happening as there was a lot of background noise. Sensing that something was wrong, he asked the radio operator if he was required and was told of the situation in F wing. The officer then made his way to the wing.

126. When he arrived he saw the night officer and OSG outside the man's cell and could see his face against the observation glass. As his body was against the door, the officer had difficulty opening it and had to push at the door to gain entry.

127. The officer said that, when he went inside the cell he realised that the man was hanging. A ligature was round his neck and had been attached to the

window bars. The officer took the weight off the ligature by lifting and supporting his body. Following him into the cell was the night officer, who used her anti ligature knife to cut the ligature. Once it had been cut, they laid him onto his back, and began checking for signs of life.

128. Those checks included pinching the man's ears and listening for his breathing, although they did not check for a pulse. The officer said the man's skin was clammy and colder than what would normally be expected of someone alive.

129. Unable to detect any signs of life, both officers began Cardio Pulmonary Resuscitation (CPR) at a ratio of 30 breaths to two chest compressions, which is the correct procedure. Although he had a mouth guard, the officer felt it hindered his ability to perform CPR and so discarded it, preferring instead to give direct mouth to mouth breathing. He said he could see the man's chest rising and falling as he did so. Whilst he was performing mouth to mouth resuscitation, the night officer administered the chest compressions.

130. In the meantime, the ASO had arrived into the wing, where he met the OSG. She told him that it was the man who had been found hanging and then directed him to his cell. When he got to the cell he saw both officers performing CPR.

131. The ASO told the investigator that the night officer was tiring as a result of doing the chest compressions and so he took over from her. The ASO and the other officer continued CPR, although he said the ratio was ten compressions to one breath. No longer required to assist with CPR, the night officer went to the gate to help with the emergency access for paramedics.

132. At about 12.30am, paramedics arrived and were taken to F wing. Once at the cell, they began carrying out their own checks and setting up their own emergency equipment. Sadly, they were unable to resuscitate the man and, at 12.50am, they confirmed that he had died.

Following the man's death

133. The Co-ordinator told the investigator that following the man's death, all prisoners being monitored under the ACCT arrangements were reviewed. He said this was done to ensure they were supported and to identify anyone who may have adversely been affected by the death. He went on to say that notices had been displayed around the prison, explaining what had happened.

134. I understand from the man's mother that her family were told of the death by the prison chaplain, adding that he had been very supportive. She said the Governor had paid for his funeral and representatives from the prison had attended.

135. I have been pleased to learn from prison staff that they have felt supported by the Governor and his managers. Members of the local care team made themselves available to any member of staff affected by the death.

ISSUES

Assessment, Care in Custody and Teamwork (ACCT)

136. In October 2008, an ACCT document was opened and remained open until the man's death three months later in January 2009. The initial assessment of his problems is well documented and contains a comprehensive report for case managers to consider.

137. During the time that the document was open, there were 13 case review meetings held, all of which the man attended. The ACCT record shows that there was a multi disciplinary approach to each case review and there were well documented summaries of the meetings. It is clear from the records that a great deal of effort went into his care, alternative support mechanisms were considered and where necessary, action was taken.

138. Despite all the efforts made to keep the man safe, sadly he went on to end his own life. I am satisfied that the ACCT procedures including the assessment and case reviews were generally well structured and that he had every opportunity to engage further with the procedure.

139. One of the expectations is that all case managers are appropriately trained. In January, although not trained, the SO chaired a case review meeting. Additionally, although I have not examined this, I understand there are other managers who have not been trained to case manage, but are apparently doing so. This, if correct, is contrary to correct procedure. PSO 2700, section 1.3.1 states:

> "All Senior Officers, Principal Officers and Operational Managers (F and above), including Governors and Directors, must be trained to at least ACCT Case Management level".

The Governor must ensure that ACCT case managers have received the necessary case management training and are competent to act as case managers.

140. I am also concerned about the ACCT monitoring in January. From 8.00pm on a date in January until the man was found hanging, the ACCT observations were predictable, in that they were on the hour, every hour. Whether the man recognised this is not known, but it is possible. Therefore he would have known that, after the 11.00pm check, he was unlikely to be disturbed much before midnight. Although I make no criticism of the staff concerned, I believe the Governor should remind his staff of the need to vary their observations.

The Governor should remind his staff that ACCT observations should be varied and not predictable

Prisoners requiring constant observation

141. The Co-ordinator said prisoners requiring a level of constant ACCT watch would be transferred to Exeter, adding that there are no facilities at Dartmoor. He went on to say that arranging constant observations would cause operational difficulties, because additional staff would need to be called in to cover the task.

142. Whilst I make no criticism of the SO, constant watch is not an issue which should or can be influenced by the need to call extra staff in. Clearly, if there is a requirement to remain with someone to ensure their safety, then it should be done without hesitation, and if necessary, less important work should be stopped.

The Governor should ensure that constant ACCT observations are provided if they are necessary to ensure a prisoners safety.

Suicide Prevention and Self Harm Management (PSO 2700)

143. During the investigation, it became evident to the investigator that there had been difficulties at the prison prior to the Governor's arrival relating to the implementation of PSO 2700.

144. In April 2009, the investigator met the Area Safer Custody Manager, and asked him for his views. (He is responsible for coordinating the South West Area safer custody policy.) He said there had been poor management of the implementation of the PSO at Dartmoor, along with a lack of management support. He went on to say that he had raised his concerns with the area manager in early 2008, who, in turn had asked the then Governor for an action plan. He said there had been some improvement, but added there was, at that time, a lack of management support from some managers at the prison.

145. He said that, since the Governor had taken over, there had been an improvement and that he (the Area Safer Custody Manager) was content with the implementation. He stressed there was still more work to do, but that the changes were being managed effectively by the Governor and Area Manager.

Safe cells

146. The investigator asked the Area Safer Custody Manager about safe cells at Dartmoor. He said safe cells form part of the certified normal accommodation and are meant to be used as normal accommodation. He added that, although aware that some cells at the prison are referred to as safe cells, they do not meet the correct specification. He had previously told the prison managers that they should not be referred to as safe cells.

The Governor should satisfy himself that Dartmoor prison staff fully understand and are able to identify any cells which meet the criteria to be referred to as either safe, or safer cells. If there are no such cells at the prison, then this should be made clear to all staff.

Personal issue cut-down tools (anti ligature knives)

147. Although anti ligature knives had been received at the prison in 2008, they were not issued until the Governor instructed that they should be. The Area Safer Custody Manager said the failure to issue the knives was part of the problem with what he said was a "dysfunctional approach" by a manager at the prison, who was unhappy at applying the mandatory instructions. I am satisfied that the Governor has resolved the problem and anti ligature knives have been issued.

148. I have carefully considered the historical problems identified in implementing PSO 2700. Although I recognise that the current Governor has given a clear message to ensure the provisions of the PSO are in place, I am of the opinion that a recommendation would support him.

The Governor should ensure that the mandatory instructions contained within PSO 2700 are in place.

The night officer

149. Although he had a mouth guard to protect him from coming into direct contact with the man, the officer felt it was hampering his resuscitation attempts and, in an act of unselfishness, he discarded it. By doing so, the officer placed himself at risk of accidentally ingesting body fluid and potentially causing harm to himself.

150. Prison staff deal with a number of difficult and dangerous individuals and do not always receive the credit they deserve for doing this difficult job. Sadly, I have investigated a large number of prison deaths and am often impressed at the lengths some staff will go to rescue those in their care. This case highlights another example where an officer placed his own health at risk in order to do his best for a prisoner. The officer's actions are a credit to the service and I believe that his unselfish behaviour should be commended.

The National Offender Management Service should commend the officer for his actions in attempting to resuscitate the man.

Clinical care

151. In his clinical review, the clinical reviewer said his recommendations should not imply criticism of the nurse or the RMN. In his opinion, the nurse acted in an appropriate way yet found herself in an isolated professional position without sufficient clear cut support mechanisms. He adds that the RMN appears to have had the confidence of the man and recorded her views

accurately in his medical notes. However, he went on to say that, because of the way the notes are structured, this important information seems to have been overlooked subsequently.

152. The clinical reviewer confirms that there is a higher incidence of mental health problems in the prison population that the general population. A large number of prisoners will therefore have mental health needs and all the nursing staff should be equipped to assess these requirements, especially as they are expected to work in a professionally isolated way and with a good deal of autonomy. He makes the following recommendation, which I endorse:

All nursing staff at Dartmoor should receive training in assessing the mental health of prisoners.

153. The clinical reviewer said it had been difficult to extract the key entries from the man's medical notes. He believes the information would be more easily communicated if a clear summary and risk history was clearly accessible. He makes the following recommendation which I endorse:

Healthcare should introduce a robust system for documenting key information which will ensure it can be extracted quickly in emergency situations by all healthcare staff.

154. The clinical reviewer believes that, once the decision was made to transfer the man back to Dartmoor, medical staff at Exeter seemed intent on pursuing this path. This, he adds, was despite the clear opinions from the psychiatric nurses there that the man was still psychotic and would not cope with a transfer at that point.

155. Additionally, the clinical reviewer added that the transfer back to Dartmoor in January, and the initial first few days back at the prison, should have been better managed. He said there should have been more effort made to follow up a patient who had been very ill during his stay in the healthcare unit at Exeter. He makes the following recommendations:

The transfer arrangements between Dartmoor and Exeter must be much clearer and there should be clear care plans recorded in the medical notes.

Healthcare plans should, as a minimum, have a summary of progress while in Exeter healthcare, including the drugs and dosages taken on discharge and the arrangements for aftercare and follow up.

There should be a contingency plan in place to show what should happen if the patient's condition deteriorates. The plan should clearly note relapse indicators, and when a patient should be returned to Exeter.

CONCLUSIONS

156. The man had a number of mental health issues when he went into prison and which had been identified when he arrived into custody. His medical record shows that he received a number of mental health interventions and medication designed to help his symptoms.

157. That said, there is a question mark over the assessments by psychiatric nurses at Exeter regarding the man's condition and the healthcare staff there wanting to transfer him back to Dartmoor. It does appear there was some disagreement about what was best for him and, in the clinical reviewer's view, "intent by healthcare staff to transfer the man back to Dartmoor". Additionally, the clinical review shows that the care plan for him was not clear and, there was no plan in place should he relapse.

158. The man also had a long history of being at risk of suicide and self harm and had been monitored by the ACCT procedure for several months before he died. I have considered the ACCT document and am satisfied that when he first showed signs of harming himself, a file was opened and remained in place until he died. I am satisfied that the ACCT assessment was thorough, with regular case reviews taking place, all of which appear to be well recorded.

159. I am often told that it takes but a few seconds to become unconscious once a ligature is tightened around the neck and, unless interrupted, the outcome is usually inevitable. In this case, the ACCT observations on the evening in January were predictable. Although I cannot be sure, it is entirely possible that the man came to the conclusion that he would not be disturbed for at least an hour and acted in the way he did.

160. Clearly, the man had been considered to be at risk for some considerable time. From what the investigator has read and heard, there were extensive efforts made to keep him safe. Other than constantly watching someone deemed at risk, the next best thing is to observe them frequently but intermittently. However, on this occasion, he was monitored regularly and hourly.

161. It is clear that the man's behaviour in January had deteriorated and had been recognised as such. A great deal of effort went into protecting him but, oddly, the question of constant watch appears to have been something which was problematic. In the absence of an urgent transfer to Exeter, I am of the opinion that constant watch that evening would have been appropriate. Regrettably, it was not arranged.

162. I am satisfied that there was a quick recognition by the nurse at Dartmoor that the man's condition was a cause for concern, and that extensive efforts were made to transfer him to Exeter. Unfortunately, Exeter was unable to take him that evening. I agree with the clinical reviewer in that there should be systems in place to transfer prisoners who are deemed to require full time medical care to Exeter.

RECOMMENDATIONS

1. The Governor must ensure that case managers have received the necessary case management training and are competent to act as case managers.

   The Governor has accepted the recommendation.

2. The Governor should remind his staff that ACCT observations should be varied and not predictable.

   The Governor has accepted the recommendation.

3. The Governor should ensure that constant ACCT observations are provided if they are necessary to ensure a prisoners safety.

   The Governor has accepted the recommendation.

4. The Governor should satisfy himself that Dartmoor prison staff fully understand and are able to identify any cells which meet the criteria to be referred to as either safe, or safer cells. If there are no such cells at the prison, then this should be made clear to all staff.

   The Governor has accepted the recommendation.

5. The Governor should ensure that the mandatory instructions contained within PSO 2700 are in place.

   The Governor has accepted the recommendation.

6. The National Offender Management Service should formally commend the officer for his actions in attempting to resuscitate the man.

   The National Offender Management Service has accepted the recommendation.

7. All nursing staff at Dartmoor should receive training in assessing the mental health of prisoners.

   The recommendation has been accepted.

8. Healthcare should introduce a robust system for documenting key information which will ensure it can be extracted quickly in emergency situations by all healthcare staff.

   The recommendation has been accepted.

9. The transfer arrangements between Dartmoor and Exeter must be much clearer and there should be clear care plans recorded in the medical notes.

   The recommendation has not been accepted. The action plan states “Care plans are already in place in the medical records. Patients are regularly accepted from other Devon prisons where beds are available”.

10. Healthcare plans should, as a minimum, have a summary of progress while in Exeter healthcare, including the drugs and dosages on discharge and the arrangements for the aftercare and follow up.

    The recommendation has been accepted.

11. There should be a contingency plan in place to show what should happen if the patients condition deteriorates. The plan should clearly note relapse indicators, and when a patient should be returned to Exeter.

    The recommendation has been accepted.