

**Investigation into the death of a man
in August 2011, while in the custody of HMP Exeter**

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

October 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Exeter, who died in August 2011, after he was found hanging in his cell. He was 24 years old. I extend my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. Devon Primary Care Trust commissioned a clinical reviewer to carry out a review of the clinical care the man received in custody. Exeter prison cooperated fully with the investigation. I apologise for the late issue of this report.

The man had been arrested on 17 June 2011 in possession of an imitation firearm; he had also cut his wrists. A psychiatrist saw him while he was in police custody and recommended that a full psychiatric assessment be carried out. This information was not passed to the prison, although he was subsequently remanded for psychiatric reports. Nevertheless, when he arrived at Exeter, prison staff were concerned about his previous self-harm and put in place suicide and self-harm monitoring and support procedures. These were closed just two weeks later, on 5 July 2011, following a review that found he was more settled and appeared to have no further thoughts of harming himself.

I share the clinical reviewer's concern that prison and healthcare staff did not have access to key information about the man's mental health, both from the psychiatrist who saw him in police custody and from his community GP records. However, even without this information, the investigation raises concerns over the assessment of the man's level of risk which led to him not being subject to self-harm monitoring at the time of his death and regarded him as low risk when he was being monitored.

Assessing the risk a prisoner poses to himself is not an exact science and involves balancing demeanour and behaviour against known risk factors. While the man seemed settled and caused staff little concern, it appears that too much reliance was placed on his personal presentation rather than an objective assessment of other risk factors, including the fact that this was his first experience of prison, that he had only recently attempted several serious acts of self-harm and that his mother had voiced her concerns about his state of mind shortly before his death. Sadly, we cannot know that the outcome would have been any different had all the relevant information been available and acted upon.

The recommendations made in the draft report has been accepted by HMP Exeter. I have included the prison's response to the recommendations at the end of 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.

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Prisons and Probation Ombudsman

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SUMMARY

1. The man was born in 1987. He was 24 years old when he died in August 2011 at HMP Exeter.
2. On 17 June 2011, the man was arrested by police for possession of an imitation firearm. While he was in police custody, the man was visited by a psychiatrist who recommended a full psychiatric assessment.
3. On 18 June 2011, the man was remanded into the custody of HMP Exeter. The information from the psychiatrist who saw him in police custody was not shared with the prison.
4. During his initial health screen interview, it was recorded that the man had previously been treated for depression. He told prison staff he had recently taken an overdose and cut his wrists. He explained that he had been arrested when he had brandished an imitation gun hoping that the police would shoot him. A self-harm observation and support plan was started but this was closed on 5 July, when the man appeared more accepting of his situation and the risk of self-harm was thought to have reduced. A post closure review took place on 12 July. Throughout the monitoring process his risk had been assessed only as low, despite his recent active self-harm and other evident risk factors.
5. The man was initially held in the healthcare centre at Exeter before moving to a shared cell on a general residential wing. At around 10.00am on a day in August, while carrying out routine cell checks, prison officers found the man unconscious and suspended by a ligature made from clothing tied to his bed. His cell mate was not in the cell at the time. Officers cut the ligature and summoned medical assistance. Healthcare staff attended and attempted to resuscitate the man. When paramedics arrived they took over his care and, as he had a weak pulse, they took him to outside hospital. The man was pronounced dead by a hospital doctor at 11.00am.
6. The clinical review carried out on behalf of Devon Primary Care Trust considered both the care provided for the man throughout his time in prison and the emergency response when he was found hanging. With regard to the emergency response, the clinical reviewer concludes that this was comparable to what he would have received in the community. However, he expresses concern that the mental health assessment carried out while the man was in police custody was not shared with prison healthcare staff. Overall, the investigation concludes that prison staff relied too much on the man's personal presentation when assessing his risk and ended monitoring too early. We make four recommendations, two about information sharing and access to relevant information and two about suicide and self-harm monitoring procedures.

THE INVESTIGATION PROCESS

7. This office was informed of the man's death in August 2011. The investigator issued notices to both staff and prisoners at HMP Exeter informing them of the investigation and asking anyone who had relevant information to contact him. Two prisoners asked to be seen. The investigator examined all the man's relevant prison records, including his medical records.
8. A clinical reviewer was commissioned by Devon Primary Care Trust to carry out a review into the clinical care provided for the man during his time in custody. The purpose of the review was to establish whether the care which he received in prison was comparable with that he would have been offered in the community and to identify any points of learning. The clinical review was not received until 15 February 2012. Unfortunately, the investigation was then further delayed due to work pressures in this office. We apologise for the consequent late issue of this draft report.
9. The investigator visited HMP Exeter on 8 August 2011, and spoke to the Deputy Governor as well as other staff involved in the man's care. He returned in September and October to conduct joint interviews with the clinical reviewer. They interviewed a health care assistant and two doctors. The investigator interviewed four prisoners who were located on the man's wing. He also interviewed three officers, two senior officers, a mental health coordinator and a registered mental health nurse. After completing the interviews, the investigator discussed the emerging issues with the Governor and later confirmed these in writing.
10. The investigator contacted Her Majesty's Coroner to inform her of the investigation and to request a copy of the post mortem report. This investigation report will be sent to the Coroner to assist her enquiries.
11. One of our family liaison officers contacted the man's mother to outline the purpose of the investigation and to invite her to raise any concerns or questions. Subsequently, the family liaison officer and the investigator met the man's mother. She raised a number of concerns, summarised as follows:
 - The man's mother was concerned that her son's mental health needs were not supported. She said that her son had been assessed by a psychiatrist while in police custody and that a community care plan had been recommended and that this was not acted upon once he was remanded to prison.
 - The man's mother said that, on several occasions, she had been concerned for her son's welfare and, following a visit, had submitted a letter to the prison raising these concerns. She said that her son had lost weight and she wanted to know if he had access to medical and mental health care.
 - She asked if prison resources were limited and, if so, whether this impacted on the suicide and self-harm monitoring of her son.

- The man's mother requested clarification about the sequence of events after her son's arrival at Exeter and information about the care he received while in prison custody.
12. The man's family spoke highly of the staff at the visitors' centre and the after-care they received from prison staff following his death. They hope that lessons can be learned from his death. We hope this report helps provide the man's family with a better understanding of his time in prison and the circumstances surrounding his death. The man's mother received a copy of the draft report and she raised further issues in light of the findings. She noted the recommendations made in relation to information sharing but felt staff at the prison would have taken different action in relation to suicide and self-harm monitoring if they had received all relevant information from both court and mental health services. The man's mother felt that the management of the self-harm and suicide monitoring procedures needed to be improved. She also confirmed that had she realised that her son's suicide and self-harm monitoring had stopped she would have made more active efforts to ensure adequate support was made available. The man's mother realised that her son may have attempted to kill himself at a later date if "he had not succeeded in prison". However, she stated that "serious errors of judgement were made which prevented his survival on this occasion". The man's family were also grateful for the compassion shown by some of the staff and prisoners interviewed during this investigation.

HMP EXETER

13. HMP & YOI Exeter can accommodate up to 533 prisoners. It serves the courts of Cornwall, Devon and West Somerset, and holds remanded and convicted adults and young adults. The prison has four residential wings, three of which (A, B and C wings) were originally built in the 1850s. A fourth wing (D wing) was added in the 1960s.
14. Healthcare services at Exeter are commissioned by Devon Primary Care Trust and provided by Devon Partnership Trust. There is an inpatient facility offering 24-hour healthcare, as well as outpatient services on the residential wings.

Suicide and self-harm monitoring

15. The Assessment, Care in Custody and Teamwork (ACCT) system monitors and supports prisoners who are assessed as at risk of suicide or self-harm. It is designed to be a flexible, prisoner-centred assessment and care planning system, which aims to identify individual needs and offer personalised care and support before, during and after crisis. Within 24 hours of an initial assessment there should be a first case review. At this review a care and management plan (caremap) must be completed. This is a plan that should reflect the individual prisoner's needs and address the issues identified in the ACCT assessment. Once placed on ACCT support, the prisoner is observed at intervals determined by their perceived level of risk. The arrangements should be reviewed regularly at multi-disciplinary meetings, including the prisoner.

HM Inspectorate of Prisons (HMIP)

16. The last inspection of HMP Exeter was a short follow-up inspection in July 2011 of a full inspection in October 2009. In 2009, the Inspectorate recommended that ACCT procedures should be improved, particularly in relation to multi-disciplinary reviews. The follow up inspection acknowledged the partial achievement of this recommendation but said that multi-disciplinary representation at reviews was still not consistent. The report acknowledged there had been significant improvements in general safety, which had been a major concern at the previous inspection. Inspectors commented that "violence reduction was well managed and prisoners at risk of self-harm were properly cared for".
17. In relation to mental health, the Inspectorate reported that a programme of mental health training had been organised and was available to all staff. Work was also in hand to introduce a 'mental health champions' programme for prisoners, to help their understanding of mental health issues. The Inspectorate also noted that the prison was in the process of developing day care facilities for prisoners with mental health problems who found it difficult to cope on the wings.
18. In 2009, the Inspectorate also found that little had been done to follow up Ombudsman's investigation reports and recommendations following previous

deaths in custody. In the follow up inspection, it was noted that actions plans based on recommendations from the Ombudsman were now in place.

Independent Monitoring Board (IMB)

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor day to day life in the prison to help ensure prisoners are treated fairly and humanely.
20. The last annual report published by the Exeter IMB covers the period from October 2010 to November 2011. The Board noted that:

“Mental healthcare has been reformed from a narrow and somewhat restrictive idea about mental health, to a very inclusive one. Referrals can be made to the Mental Health Team by anyone who has concerns about the behaviour or attitude of a prisoner. They will then be seen, assessed and, if needed, be referred by the team within a week; a process which was lengthy and cumbersome has now been streamlined enormously. Similarly the Consultant Psychiatrist has been successful in finding beds in Secure Units and the funding to facilitate the referral. Although [the consultant psychiatrist] is only contracted for one session per week, staff report that she makes time to come in whenever required.”

Previous deaths at HMP & YOI Exeter

21. The Ombudsman’s office has been responsible for investigating deaths in custody since April 2004. Before this man’s death, seven apparently self-inflicted deaths have been investigated at Exeter. Aside from the method used (hanging is the most common form of self-inflicted death in prison), there were no obvious similarities between the circumstances of this man’s death and those of other prisoners.

KEY EVENTS

22. The man was born in March 1987. He was 24 years old when he died in August 2011 at outside hospital.
23. On Monday 13 June 2011, the man attended his local Accident and Emergency (A&E) Department after taking an overdose of painkillers. During the early hours of Friday 17 June, he contacted the police to inform them that a man had been seen with a gun in a local park. Police attended the park and found the man with an imitation gun and he was arrested. After being taken to hospital for treatment to cuts on his wrists, the man was taken into custody at a police station. He was charged with possession of imitation firearm with intent to cause fear of violence. While in police custody, on 17 June, the man was seen by a psychiatrist who recommended a full psychiatric assessment.
24. On 18 June at a magistrates' court, the man was remanded into custody at HMP Exeter and was ordered to reappear at the court on Monday 20 June.
25. The man arrived at Exeter around 2.00pm on 18 June; this was his first time in prison. Information that the psychiatrist who had seen the man in police custody had recommended a full psychiatric assessment, was not passed to the prison. At his first reception health screen interview (which assesses any immediate mental or physical health needs), it was recorded that he had recently self-harmed and had previously been prescribed medication for depression (diazepam, mirtzapine and propranolol). As a result of his recent act of self-harm an Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support plan was opened. A registered mental health nurse noted that the man had overdosed and cut his wrists "which required stitching and glue". She also noted that he had brandished a gun in the hope police would shoot him and had openly stated that he wanted to die. The nurse noted that he appeared calm on the surface but detached. The man also informed staff that he had been previously treated for depression but had not seen his doctor for this recently, although he had an appointment to see his GP on 21 June. Routine tests showed that he was not taking any medication. Healthcare staff did not request a copy of the man's GP records.
26. After his health screen interview, the man was also seen by one of the prison doctors. She recorded that the man was suicidal but had "no supporting factors" and "no current plan". She recommended that the man be located in the healthcare centre and observed on intermittent observations of five times an hour until his ACCT assessment was completed. She was unaware that he had been seen by a psychiatrist while he was in police custody and that a full psychiatric assessment had been recommended.
27. As part of the ACCT process, an assessment was conducted by a registered mental health nurse on the following day, 19 June. She recorded that the man's relationship with his girlfriend had ended the previous week and he had found this very difficult to deal with. She noted that "his mood is quite low at the moment". She said that the man described the act of self-harm in the following terms: "Cut wrists with kitchen knife, overdose of paracetamol and

brandished a 'gun' in public hoping to be shot by police – although did not realise they would have tazers". During the assessment it was decided the level of observations was to be reduced from intermittent observations to three conversations during the day and three observations during the night and that he was to stay in the healthcare centre for further assessment. The nurse recorded that the man appeared to be "settled, lucid, orientated, calm and willing to engage with staff".

28. On 19 June, there was a case review which was attended by the man, a registered mental health nurse and an officer. In the record of the case review it was recorded that the man was willing to engage with the ACCT process. The following entry was made: "He is insightful and articulate, able to discuss his worries and precipitating factors to the incident of which he has been charged". He assured the staff that he did not have plans to engage in any acts of self-harm and had no thoughts or intention of suicide. The following entry was made: "States that he feels he would be willing and able to discuss any thoughts he may have with staff". Although the likelihood of further risky behaviour was recorded as "low" it was decided to keep the ACCT plan open.
29. A Caremap was drawn up and three goals, to improve his mood, to maintain his safety and promote positive thinking skills and for him to be able to discuss his issues constructively in a professional manner. The action points to meet these goals were:
 - Discuss with medical officer regarding anti-depressants (this was also recorded in the man's medical record) and encourage out of cell activities to promote mood.
 - Promote confidence by encouraging him to feel able to join in with his peers.
 - Refer to prison chaplaincy for counselling.
30. The following day, Monday 20 June, the man was taken to a magistrates' court. He was again remanded into custody at Exeter and ordered to re-appear at a Crown court on 4 July.
31. The man was seen by another prison doctor on 21 June. He told her that he had wanted to die when he cut his wrists but now realized his actions were "foolish" and no longer had plans to harm himself. The doctor recorded the following entry in the man's medical record: "Self volunteered that will seek out help if emotions change – in fact did this when cut last - informed mother and brother and posted it on Facebook. No mental health involvement before". She noted that the man had been prescribed anti-depressant medication in the past but she decided not to prescribe them again. When interviewed as part of this investigation, she said: "I felt there was no indication for starting an anti-depressant. He showed no signs and expressed no verbal indication that his mood was low or that he was depressed and having [to be] what I would call safety netted".

32. After her consultation, the doctor recommended that the man be discharged from the healthcare centre. She was also unaware of the recommendation made by the psychiatrist while the man was in police custody.
33. On the same day, 20 June, the man attended the second ACCT case review. A registered mental health nurse, the doctor and a further nurse were also present. The man said that he felt he would be able to cope if he was located in the main prison. The level of risk was reviewed and remained as “low” and the frequency of observations, conversations and recording requirements remained the same.
34. The following was written in the summary of the review:

“He is an articulate and insightful young man, aware of the incidents leading up to charge and the reason why he engaged in self-harm. He is aware of all support systems that can be accessed as necessary. No issues with self-harm currently.”

Later that same day, he was discharged from the healthcare centre and moved to a shared cell on B wing.

35. On 25 June, a health care assistant (HCA) saw the man as part of his secondary health screening. The secondary health screening is a general health assessment equivalent to a primary care assessment when registering with a doctor in the community. It provides an opportunity for gathering further health information, health education and promotion and, importantly, checking how a prisoner is settling in. The health care assistant made a referral to the Mental Health Team due to the man’s history of depression, anxiety, poor sleep and his history of self-harm before he arrived in custody. He recorded in his medical records that the man was still low in mood and was still having thoughts of harming himself. In his statement to the investigator, the health care assistant was unable to recall dealing with the man or any of the actions he took with regard to the referral to the Mental Health Team.
36. During the morning of 28 June a chaplaincy counsellor spoke to the man and recorded that he was very “open about his feelings and talking about his thoughts at present. Not feeling suicidal at present. Getting on well with his pad [cell] mate”. At the third ACCT case review, later that same day, it was again recorded that the man had no thoughts of self-harm. However, he explained that his offence was a suicide attempt stating that he wanted the police to shoot him. Two senior officers (who both worked as Residential Senior Officers on B wing), a nurse, an officer and the man attended the review. The review noted that the man said he was adjusting well to prison life and had no concerns on the wing. He was relaxed and articulate during the review. The possibility of closing the ACCT was discussed, but because the man was due in court on the Monday (4 July) for sentencing it was decided to keep the document open.

37. It was recorded in the man's medical record on 1 July that his case was discussed at the mental health multi-disciplinary team meeting held that day. The following entry was written in the medical record:

"Issues with girlfriend now resolved. Reviewed by GP 21st June no sustained low mood. Plan: Doesn't require mental health intervention currently to continue under ACCT process, please re-refer as appropriate".

38. In her statement to the investigator, the consultant psychiatrist for Devon Cluster Prisons confirmed that the man's referral had been discussed at the mental health multi-disciplinary team meeting and the review of his clinical information gave no cause for concern. The consultant psychiatrist stated that they were aware the man had been reviewed by a GP colleague at the prison, who had not thought it appropriate to refer him to the mental health team. She felt this indicated they were confident to continue to treat any mental health issue in primary care. The team felt there was no further specialist mental health intervention they could suggest and were satisfied that he would continue to be reviewed through the ACCT process. The consultant psychiatrist felt that "the safer custody team would make further referrals for review by the mental health team if appropriate". She was not aware of the request for a full psychiatric assessment that had taken place in police custody.
39. On 4 July, the man was taken to a Crown court and the case was adjourned pending the receipt of a psychiatric report. He was again remanded in custody and charged to re-appear on 26 September. The staff who escorted him recorded that he seemed okay and that he was "fairly chatty looking forward to early bus [prison transport] back to HMP Exeter".
40. On the following day, 5 July, the fourth ACCT case review was held and a senior officer, the man, an officer and a nurse attended. The level of risk was reviewed and continued to be regarded as low. The frequency of observations, conversations and recording requirements remained the same. It was recorded that the man was in a positive mood and that his case had been adjourned by the Crown court. The following was written in the summary of the review:

"He received a visit from his mother and brother and they remain very supportive. [The man] said he has no further thoughts of self-harm. He feels he has settled well on B wing. He gets on well with his cell mate and staff and would confidently approach staff if his mood changed or if he felt in need to talk."

Following the case review and confirmation that all actions of the Caremap had been completed, the ACCT plan was closed.

41. An ACCT post closure review took place on 12 July and was conducted with the man by two senior officers. One of the officers recorded that the man was managing well on the wing and that his court case had been adjourned for psychiatric reports. He noted that the man engaged well in the review and explained himself clearly. He had received a visit from his mother and brother

which had gone well. It was agreed by all present that the ACCT plan would remain closed.

42. When interviewed as part of this investigation, the senior officer said:

“I saw [the man] on the wing and he looked fine and there was absolutely nothing in his behaviour that raised any concerns. To be honest we wouldn’t hesitate to open another ACCT document on any prisoner that portrayed that they might be struggling on the wing.”
43. While he was at Exeter, the man started to attend a music workshop, ‘Changing Tunes’. In a memorandum to the Governor completed after his death, the tutor from ‘Changing Tunes’ confirmed the man had attended the Changing Tunes music workshop in the chapel on 25 July and 1 August.
44. The tutor wrote: “We discovered that [the man] was an excellent drummer and that he was very enthusiastic about joining the band that we were creating together with the other prisoners in the session”. Another prisoner, who was also on B-wing, mentioned to the tutor that after both sessions that the man was “buzzing” and was excited about the music that they were working on and that he was enjoying his time with the group. The tutor said that although his previous self-harming was quite evident (there were scars on his wrists although none of them appeared to be fresh) he showed no signs that he was contemplating any self-harm during the time they spent together.
45. Following her visit to her son on 26 July, his mother completed a Visit Safeguard Report (VSR), which allows visitors to report any concerns they have about a prisoner’s safety. His mother wrote, “Two suicide attempts prior to his being on remand. I think this is already known. Has the medical team seen him yet? He is not taking any fresh air again”. When interviewed as part of this investigation, the senior officer confirmed that he had received the VSR and that he passed it on to his colleague to action. She then asked a further colleague to speak to the man.
46. When interviewed as part of this investigation, the officer said that when he spoke to the man, on 26 July, there was nothing in his behaviour that raised any concerns. He also said: “It was nice to see that he had made a few friends and that he was interacting with others and sitting in a cell when he was unlocked and having a coffee in there”. The officer said that subsequently neither staff nor prisoners raised any concerns about the man.
47. In her statement to the investigator, the senior officer reported that she had also spoken to the man, on 26 July. She said that he told her that his mother always worried about him, but he was fine and that he got on well with his cell mate. She had no concerns for his safety at that time and said she continued to see the man around the wing, and he did not display any behaviour that concerned her.
48. On 1 August, the man spent both the morning and afternoon in the chapel. At lunchtime the man’s mother rang the chaplaincy because she was concerned

by a letter she had received from him that morning. The man's mother told a prison chaplain that her son was full of guilt because he felt he had abandoned his girlfriend who was a manic depressive. In his letter to his mother the man asked her to pray for his girlfriend because God would not hear his prayers. The man's mother asked the prison chaplain to speak to her son and to reassure him. The prison chaplain spoke to the man in the afternoon with another prison chaplain. In a memorandum to the Governor completed after the man's death, the prison chaplain said that the man had seemed happy that people were concerned about him but had not said much. He had been invited to attend the chapel on the following Tuesday to play the drums alongside the guitarist and said that he would be there.

49. The tutor from 'Changing Tunes' said that he also spoke to the man on 1 August, during a coffee break. They talked about his mother's faith and about the telephone conversation his mother had had with the prison chaplain about his prayers not being answered as he was a "bad person". The tutor wrote:

"Being a Christian, I told him that I believed God would hear his prayers and that he was not beyond God's love and reach. He listened and then carried on the session in the same way he had done before, interacting with the others and enjoying himself."

The tutor also said that the man gave no indication that he was contemplating taking his life during the time they spent together.

50. At around 8.00am on a day in August, the man's cell was unlocked and he and his cell mate went down together to collect their breakfast. They then returned to the cell with their food and were locked in again at around 8.15am. His cellmate was unlocked for work at around 9.10am and the man was left by himself in the cell. This was the last time he was seen before being discovered hanging.
51. At around 10.00am, an officer was carrying out routine daily fabric checks on B wing. The cells were unlocked at the time for prisoners to take a shower and clean their cells. He arrived at the man's cell at around 10.08am. The officer knew the man was the sole occupant of the cell at that time because his cell mate was at work. When he pushed the door open it met with resistance as the locker with the television on top of it was in front of it. This did not cause the officer much concern because the prisoners often watch television this way as it is difficult to see it from the bed.
52. The officer shouted into the cell for the man to move the locker. He got no reply and could see through the observation panel that the cell toilet door was closed. He called again assuming that the man was in the toilet but again received no reply. The officer then tried to reach around the door to move the locker but was unable to do so.
53. The officer sought help from two of his colleagues. The officer and one of his colleagues moved the locker and went into the cell with the remaining officer. When one of them reached the toilet door, he saw that the man was suspended

by a ligature around his neck made from jogging bottoms tied to the bar on the end of the top bunk. The officer lifted the man to relieve the pressure around his neck, and his colleague untied the knot in the ligature. They lowered him on the floor to check for a pulse and any signs of life. One of the officers then used his radio to call for a code blue response (a radio code which is used to indicate an emergency where someone was not breathing). His colleague immediately started cardiopulmonary resuscitation (CPR). Four nurses arrived at the cell within a couple of minutes. Two of the officers then left the cell while the remaining one assisted the healthcare care staff in their attempts to revive the man.

54. The healthcare staff used a defibrillator which first advised to continue with CPR. (A defibrillator measures electrical activity in the heart and issues audible instructions about treating the patient including, when appropriate, delivery of an electric shock.) On its second analysis, the defibrillator indicated for a shock to be administered. This was carried out and CPR continued. The healthcare staff were joined shortly afterwards by the prison doctor. At approximately 10.20am paramedics arrived, and took over the man's care. They found a weak pulse and he was taken to outside hospital. The ambulance left the prison at 10.40am. The man was pronounced dead by a hospital doctor at 11.00am.
55. The Governor contacted the man's mother at 10.50am that morning to inform her about her son's attempt on his life and his hospital admission. She told the man's mother that she would make arrangements for her to get a taxi to the hospital. When she then discovered that the man had died, she contacted his mother again. The man's mother asked whether her son had died, and the Governor confirmed that he had. The Governor and a prison chaplain later met the man's family at the hospital.
56. Prisoners were informed of the man's death during the afternoon of the day he died. They were asked whether they required any additional support or wanted to speak to a Listener (prisoners selected and trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress). All prisoners who were subject to self-harm and suicide monitoring were reviewed.
57. A 'hot debrief' was held later that day for staff who were involved in finding and attempting to resuscitate the man. The aim of such a debrief is to focus on reassurance, information sharing and mutual support. No specific areas of concern were identified and the staff who had been on duty were offered support from the prison's care team.
58. The Governor continued to liaise with the man's family and helped with funeral arrangements, including the cost. A memorial service took place at the prison on 4 August which was well attended by staff and prisoners. The man's funeral took place on 20 August 2011.
59. As is usual following a death in custody, the police visited Exeter and interviewed staff. There were no suspicious circumstances. The police found a

note in the man's cell addressed to his girlfriend, with messages for his brother and mother.

60. The post mortem examination recorded the man's death as being due to hanging.

ISSUES

Clinical care

61. A review of the man's clinical care while in the custody of Exeter was carried out by a clinical reviewer on behalf of Devon Primary Care Trust.
62. In his review, the clinical reviewer finds that although when the man arrived at Exeter the exact circumstances of his arrest were not known to prison doctors they were concerned about his mental health and acted accordingly. During his time at Exeter he had regular meetings with both officers and healthcare staff. He writes: "During these meetings [the man] had expressed a consistent view that he was not in need of further mental health help and had given assurances that if the need arose he knew how to access this support".
63. In his review, the clinical reviewer finds that the man had input from a community psychiatrist while he was in police custody before he arrived at Exeter. The community psychiatrist did "not feel that he [the man] would do well in hospital" and considered referring him for treatment at home "with a view to a referral to the psychology service in the future". He also wrote that if the man was remanded into custody a "forensic psychiatric report should be sought". However, these records did not follow the man into prison. As a result, staff at the prison did not receive the report from the psychiatrist who saw him while he was in police custody and were therefore not in possession of key information about his mental health needs. This affected the man's dealings with both healthcare professionals and the Mental Health Team at Exeter.
64. In addition, the prison did not request the man's community GP records, which would have given important background information on him and the support he might need.
65. The clinical reviewer makes a recommendation about the non receipt of the psychiatric records which we reframe and endorse. We make an additional recommendation that when a prisoner arrives in custody reception staff should request a copy of the GP's records. Both are issues which have been raised with other prisons.

The Governor and Head of Healthcare should discuss the man's case with senior leaders of local criminal justice and health agency partners to improve understanding of the need for important information concerning a prisoner's mental or physical health to be shared effectively.

The Head of Healthcare should ensure that General Practitioner records are requested routinely when a new prisoner arrives.

The emergency response

66. The man was discovered hanging by an officer during routine cell checks. Within a few minutes of this discovery the officer had radioed for and received

assistance, an ambulance had been called and the man had been released from his hanging position. Paramedics arrived ten minutes after the initial call for help and after they carried out an assessment they took him to hospital where he was pronounced dead soon after.

67. From both the written records and the investigator's interviews with staff it appears that all those involved acted quickly and professionally. We agree with the clinical reviewer's comment that:

"The prison and healthcare staff involved in the CPR attempt on [the man] should be commended for their prompt actions. Their efforts did result in them being able to re-establish a pulse and some cardiac output. Sadly this was not sufficient to save [the man's] life."

Suicide and self-harm monitoring

68. Suicide and self-harm monitoring arrangements were put in place soon after the man's arrival at HMP Exeter. He informed staff that he had recently taken an overdose, there was evidence that he had cut his wrists and he said he had tried to get shot by the police. His needs were assessed and the support he needed identified. However, he was assessed as "low risk". We find this assessment surprising as it clearly does not fit with the man's risk factors. His recent suicide attempts, a recent relationship break up and this being his first time in prison should have indicated at least a raised risk. He was monitored as required under the ACCT procedures with review meetings on 28 June and 5 July. On 28 June, he was again recorded as "low risk" and it was noted that he stated that he had "no thoughts of self-harm". However, only three days earlier he had told a health care assistant (HCA) that he had suicidal thoughts. The HCA recorded this in his medical notes, but not on his ACCT plan. This was also not raised by the healthcare staff present at the review meeting. It is important that ACCT review meetings are multi-disciplinary and that relevant staff are present, however it is equally important that such staff fully appraise themselves of relevant information before the meeting. It is also important that any interactions with a prisoner on an ACCT plan are recorded on the ongoing record.
69. On 5 July, just over two weeks after his arrival at the prison, the ACCT monitoring ended. It is reported that the man was engaging with staff and others, including taking part in a music workshop. Prison staff did not believe that there were any indications that he intended to harm himself. Both prison and healthcare staff felt that he had turned a corner and the crisis which had occurred before his arrival in custody had passed. They reported that they were shocked and surprised that he apparently took his own life.
70. In his review, the clinical reviewer draws attention to the differences in how the man presented to staff and his family. Although prison staff thought he was coping well and had no thoughts of self-harm to staff, his family were more concerned about his state of mind. The clinical reviewer writes: "Because this seems such a consistent picture from all the professionals involved in the care

of [the man] I can only conclude that this was a conscious decision on his part not to discuss his mental health problems with staff”.

71. Assessing the risk a prisoner poses to himself is not an exact science and involves balancing the prisoner’s demeanour and behaviour against known risk factors. It is regrettable that the man was not subject to self-harm monitoring at the time of his death. Prison Service Order (PSO) 2700, Suicide Prevention and Self-harm Management, was the guidance in place at the time of the man’s death. The PSO advised prison staff not to rely just on how the prisoner presents but also take account of other risk factors. Some of those identified in the PSO which indicate that prisoners are a greater risk of suicide and self-harm and which applied to the man include being in prison for the first time, a history of self-harm and attempted suicide, being on remand and possibly those with a mental disorder (in the absence of a psychiatric assessment the latter had not yet been determined). These factors do not appear to have been reflected in the level of risk assigned to him at his ACCT reviews when it was regarded as low. The judgement appeared to be based almost wholly on the man’s personal presentation rather than any consideration of the other risk factors.
72. We note that the post closure review held on 12 July recorded that the man’s court case had been adjourned for psychiatric reports, yet still the decision was that the ACCT should remain closed. We believe that this is another sign that the wider picture was not being taken into account.
73. The man’s mother had raised concerns about him following a visit on 26 July and was also sufficiently concerned about a letter she had received from him to telephone the chaplain on 1 August. The contents of the letter do not appear to be from someone who was in a stable mental condition, or that he had resolved issues with his girlfriend as had been suggested at a healthcare multi-disciplinary meeting on 1 July. Although chaplains spoke to him after his mother contacted them, there was again a reliance on the man’s personal presentation. It was the next morning that the man killed himself. The National Offender Management Service received a copy of the draft report and in their response stated: “This paragraph [73] does not state the actions taken by the Chaplain when he received the information [the man’s mother] had disclosed to him in relation to the letter”.
74. We are satisfied that the ACCT process was used within a multi-disciplinary setting and was well recorded and processes followed. However we are not satisfied that the level of risk the man posed to himself was appropriately assessed, taking into account all known risk factors. We therefore recommend:

The Governor should ensure that staff take fully into account all known indicators of risk when assessing the risk of self-harm at all stages of an ACCT plan, including before closure.

The Governor and Head of Healthcare should ensure that all members of staff update the ongoing ACCT record after interacting with prisoners.

CONCLUSION

75. On 17 June 2011, the man was arrested for possession of an imitation firearm with intent to cause fear of violence. This was following an attempt to allegedly get the police to shoot him while he brandished the imitation firearm. After his appearance in court on the following day he was remanded into the custody of HMP Exeter. On his arrival at Exeter, he was placed on self-harm and suicide observation. This was reviewed and closed just over two weeks later, on 5 July, when it appeared that he had settled and had no further thoughts of self-harm. However, information on all the risks the man presented to himself does not appear to have been fully considered when assessing his level of risk.
76. During the morning on a day in August 2011, the man was found hanging from the bed frame in his cell. Attempts to resuscitate him were started immediately, paramedics attended and he was taken by ambulance to outside hospital where he was pronounced dead by a hospital doctor.
77. When the man arrived in custody he informed staff that he had previously been treated for depression and had received medication for this although this had not been for some time. This information does not appear to have been verified nor the man's community GP records requested. In addition, key information from a psychiatric assessment carried out in police custody was not passed to the prison. This meant that those assessing the man on his arrival at the prison did not have important information about his mental health needs.
78. We are satisfied that the ACCT process was used within a multi-disciplinary setting, was well recorded and processes followed. However, we are not satisfied that his level of risk was appropriately assessed taking into account all known risk factors. We make four recommendations, two about information sharing and access to relevant information and two about the ACCT process.
79. Sadly, it is not possible to say whether the outcome would have been different had all the relevant information been available and acted upon.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendation. That response is included in italics below the recommendation.

1. The Governor and Head of Healthcare should discuss the man's case with senior leaders of local criminal justice/health agency partners to improve understanding of the need for important information concerning a prisoner's mental or physical health to be shared effectively.

Accepted - We have contacted [name of person] for minutes of the serious untoward incidents review and are awaiting feedback. We will then discuss this case with those agencies who were involved in the man's care and extract any learning for dissemination.

2. The Head of Healthcare should ensure that General Practitioner records are requested routinely when a new prisoner arrives.

Partially accepted - This will not be done as part of a blanket process for all newly received prisoners however, if a clinical need is determined during any healthcare assessments or appointments, medical records will be sought from the community GP.

3. The Governor should ensure that staff take fully into account all known indicators of risk when assessing the risk of self-harm at all stages of an ACCT plan, including before closure.

Accepted - This is included in the Safer Custody training package. Delivery to staff commenced in April 2012 by 4 new trainers. All staff have also been made aware by a General Notice to Staff (GNTS 110/2012)

4. The Governor and Head of Healthcare should ensure that all members of staff update the ongoing ACCT record after interacting with prisoners.

Accepted - This is included in the new safer custody training package effective from April 2012 and the Safer Custody induction which is delivered to all existing and new staff (existing staff on a rolling programme). It has been followed up by GNTS110/2012.