PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in February 2014 at HMP Exeter

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Exeter in February 2014. The man was 34 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care in prison. Exeter cooperated fully with the investigation.

The man arrived at Exeter on 16 December under constant observation by escort staff, after self-harming in police custody. Despite this and a history of mental health issues, the prison did not begin suicide and self-harm monitoring procedures. There were a number of other occasions in the following months when the man's apparent risk of suicide or self-harm did not result in monitoring procedures, nor did his frequently difficult behaviour lead to a formal mental health assessment. In the weeks leading up to his death, the man spoke regularly with his partner, with whom he had a child. Their relationship was difficult and a week before his death he took the decision to end contact with her.

In the early hours of 22 February, the man's cell mate raised the alarm when he found the man had hanged himself. Staff responded promptly, but efforts to resuscitate the man were sadly unsuccessful.

The man was a challenging prisoner, who admitted to a history of manipulative behaviour and this complicated his relationship with staff. Nevertheless, the clinical reviewer considers that the standard of healthcare the man received at Exeter was not equivalent to that he might have expected in the community. Medical record keeping was poor and, despite his difficult behaviour, his mental health was never formally assessed. Similarly, a number of significant opportunities were missed to put in place suicide and self-harm prevention measures which might have enabled staff to gain a better understanding of him and provide him with adequate support. While it would have been difficult for staff at Exeter to predict the man's tragic actions, the investigation raises concerns that his known risks were not taken as seriously as they should have been.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2014**

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SUMMARY

1. The man had previously served a number of custodial sentences, including one in Thailand. He had last been released from prison on 30 August and had been on prison suicide prevention procedures at the time of his release. On 16 December 2013, he self-harmed in police custody by head-butting the wall of his police cell. After threatening to self harm at court, staff opened a suicide and self-harm warning form to alert colleagues in the Prison Service and observed him constantly.

2. An officer interviewed the man at HMP Exeter and he was seen by two nurses, one of whom formally assessed him during the reception process. Despite displaying a number of risk factors, including a history of self-harm and mental health issues, none of the staff who saw him assessed him as at risk of suicide or self-harm.

3. On 9 January 2014, the man threatened staff and was taken to the segregation unit. That evening, he was found sitting naked in the corner of his cell and would not communicate with the prison doctor who was asked to assess him. Although the man was placed on half-hourly observations, staff did not think it necessary to place him on suicide prevention procedures and the prison doctor did not record her contact with him in his medical records.

4. On 14 January, the man told the prison chaplain about the break down of the relationship with his partner and his frustration at being in prison. He said that he wanted to end his life. The following day, the chaplain noted that the man was in a better mood and seemed more motivated. He did not consider that it was necessary to place the man on suicide prevention procedures.

5. During the evening of 24 January, the man told staff that he was hallucinating and hearing voices. He was seen by a healthcare assistant, but not by the qualified nurse on duty. The healthcare assistant made a referral for the man to be seen by the prison mental health team, but did so incorrectly so he was not added to their waiting list. The healthcare assistant did not place the man on suicide prevention procedures or note her contact with him in his segregation unit records.

6. The man left the segregation unit on 6 February and moved to C wing. Over the following weeks, he had daily contact with his partner, speaking with her several times each day on the telephone. The conversations were often argumentative and aggressive and centred on access to his daughter. On 15 February, the man spoke with his partner for the last time. He later told his cellmate that he wanted no further contact with her.

7. In the early hours of 22 February, the man was found hanging by his cellmate who immediately called for help. Officers responded and called an ambulance promptly. Healthcare staff and paramedics attempted resuscitation, but were unsuccessful.

8. This investigation into the man's death raises concerns about assessment of his risk on several occasions. The clinical reviewer also raises a number of concerns about the standard of care given to the man. We make five recommendations.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at Exeter informing them of the investigation and inviting anyone with information to contact him. No one responded.

10. The investigator obtained all relevant documents relating to the man's time in prison. During the course of the investigation, he interviewed a number of staff at Exeter and one prisoner. The investigator gave feedback to the Governor of Exeter about the emerging findings of the investigation.

11. NHS England (Devon, Cornwall and the Isles of Scilly) appointed a clinical reviewer to review the clinical care the man received at Exeter.

12. We informed HM Coroner for Exeter and Greater Devon district of the investigation and we have sent the Coroner a copy of this report.

13. One of the Ombudsman's family liaison officers, contacted the man's mother to inform her of the investigation and to invite her to identify any relevant issues that she wanted the investigation to consider. The man's mother raised a number of issues that have been addressed outside of the report and we hope that our report answers any other questions that she may have.

14. The man's mother received a copy of the draft report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

15. In addition, the man's mother pointed out that her son's name had been spelt incorrectly in a number of the interview transcripts annexed to this report. We apologise for this error.

HMP EXETER

16. HMP Exeter is a local prison serving the courts of Cornwall, Devon and West Somerset. It holds just over 500 un-convicted and convicted adults and young adults.

17. At the time of the man's death, Dorset Healthcare University NHS Foundation Trust provided healthcare services at the prison.

Her Majesty's Inspectorate of Prisons

18. HM Inspectorate of Prisons' (HMIP) most recent inspection of Exeter was an unannounced inspection in July and August 2013. Inspectors were struck by the positive culture they observed at the prison. Inspectors considered that reception arrangements were generally satisfactory. Staff paid attention to safety and vulnerability issues and initial identification of risk of self-harm and suicide was regarded as very good. However, there was little support for newly-arrived prisoners and night staff were unaware of their increased vulnerability. Inspectors also reported that suicide and self-harm case management procedures, known as ACCT (Assessment Care in Custody and Teamwork) had many shortfalls.

19. Inspectors reported that the integrated mental health team provided a good level of primary and secondary care with good access to a psychiatrist and that more prisoners than at comparator prisons were positive about the quality of care they received.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. The IMB reported in 2013 that the mental health team within the prison were working well and continued to deal with very demanding patients. The Board reported that ACCT processes needed to be improved by closer management of prisoners at risk.

Previous deaths

21. The man's death is the third of three self-inflicted deaths at Exeter since 2011. An investigation into the death of a prisoner, in January 2014, will raise similar concerns to those in this report about the assessment of the risk of self-harm when arriving at the prison

Assessment, care in custody and teamwork (ACCT)

22. Assessment, care in custody and teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be

carried out at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions in the caremap have been completed.

KEY EVENTS

23. The man had served a number of custodial sentences, including one in Thailand from which he was repatriated to HMP Wandsworth on 29 June 2011. He told the reception nurse at Wandsworth that he had schizophrenia and a personality disorder. (It does not appear that the man's medical records from Thailand arrived with him.) He said he had been prescribed flupentixol (depixol - an anti-psychotic medication usually given by depot injection every two or three weeks and is slowly released through the body) The man told the prison doctor he had not experienced any hallucinations for six years, but had played on his symptoms in Thailand to secure additional benefits. He was prescribed haloperidiol (an anti-psychotic drug) and sodium valproate and diazepam (for anxiety).

24. In September, the man made threats to self-harm and staff started ACCT procedures. In November, he transferred to HMP Dorchester. In January 2012, he was released from prison, but immediately re-arrested and remanded back in to custody for an earlier offence. In February, he told the prison's mental health team that he was hearing voices and experiencing flashbacks, panic attacks and nightmares about incidents in Thailand. He was prescribed anti-depressants. On 23 March, the man was released from prison.

25. On 28 May 2013, the man was remanded back to Dorchester but, due to missing prison records, little is known about his time at the prison. His medical records indicate that he told the prison GP he was not receiving his prescribed medication and had received depot injections in the past. He denied any thoughts of self-harm or of hearing voices and said he had previously "played up" to get medication. He was not prescribed any medication at that time.

26. On 12 June, the man requested medication from a nurse to calm him. He told the nurse it was "… either the meds or would you prefer I tie a rope round my neck or stab a pen through an officer's eye?". The nurse began ACCT procedures and referred him to the prison's mental health team.

27. On 15 June, the man was noted by the prison GP as being low and tearful, due to his daughter being in hospital and him splitting up with his partner. The GP prescribed a course of diazepam and zopiclone (antidepressants). The following day, in a sequence of self-harm incidents, the man tried to suffocate himself by placing a bag over his head; tied a ligature around his neck; swallowed plastic; and scalded the back of his hand. He was put on constant observation (the level of observation reserved for prisoners considered to be at the highest risk of suicide and self-harm).

28. On 18 June, as a result of the referral made on 12 June, the man was assessed by a psychiatric nurse. He said he was being harassed by his offender manager and had feigned symptoms of schizophrenia to manipulate doctors. The man categorically denied suffering from any serious mental illness. The following day, he told the psychiatric nurse that he felt depressed and stressed because of his current situation and was experiencing

flashbacks. The nurse concluded the man was not clinically depressed and exhibited no psychotic symptoms.

29. On 27 June, the man was taken to A & E after making two cuts to the side of his neck. It is not clear from his medical records how frequently he was being observed at this time. He returned to the prison after treatment. On 25 August, two days before the start of his trial, the man told staff that he would cut his throat. The following day, he said he was in prison due to a misunderstanding and that if his court case did not go well he would "let rip" at prison staff. After appearing at court on 30 August, the man was released from prison custody while on an open ACCT.

30. On 15 December, the man was arrested for assault and theft. In police custody, the man was observed shouting aggressively and hammering on his cell door. He banged his head against the cell door, sustaining an open wound. Medical assistance was provided and the man was observed hourly.

31. On 16 December, the man appeared at Weymouth Magistrates Court. The Person Escort Record (PER) noted he had self-harmed by head butting a cell door in frustration and was a "self diagnosed" schizophrenic.

32. Court custody officers wrote that the man was "very down and depressed" and had threatened to self-harm by head butting the cell wall if he was remanded in custody. Because of the man's behaviour, court custody officers completed a suicide and self-harm warning form and the man was observed constantly. Later that afternoon, the man was remanded in custody at Exeter.

HMP Exeter

33. The man arrived in reception at 7.30pm on 16 December 2013. The escort staff handed over all accompanying documentation, including the PER and suicide and self-harm warning form, to an unidentified reception officer. The man then transferred to the prison's first night centre, where he was interviewed by an officer. The officer noted in the electronic prisoner record (known as NOMIS) that the man had arrived at the prison on a suicide and self-harm warning form and had a history of self-harm. The man told the officer that his self-harming was a ploy to "get what he wanted" and that he had no current thoughts of self-harm and no immediate issues or concerns. The officer also completed a cell sharing risk assessment for the man and assessed him as being suitable to share a cell.

34. The officer told the investigator that the man then saw a nurse, for an initial healthcare assessment. The officer said that he gave the self-harm warning form to the nurse and discussed the man's risk of self-harm and whether to open an ACCT. The officer said he and the nurse agreed that it was not necessary and, at 7.50pm, the nurse signed the suicide self-harm warning form to indicate that the man had been assessed by healthcare staff and that it was not necessary to open an ACCT. The nurse told the investigator that she could not remember whether she accessed his previous medical records before she completed the paperwork.

35. A mental health nurse based on the first night centre, carried out a reception health screen shortly before 8.00pm. He noted that the man was not on any current medication and had not received medication for mental health issues previously. The man told him he had been admitted to hospital due to a personality disorder. The man told the nurse he had not self-harmed outside of prison and denied any current thoughts of doing so, but said he had a history of saying he did in order to obtain what he wanted. Although the mental health nurse noted a small laceration to the man's forehead, he assessed him as fit and well and did not consider it necessary to open an ACCT.

36. The next day, 17 December, the man transferred to A wing. A member of staff from the safer custody and equalities team, was updating the prison's ACCT database and noticed that the electronic prisoner record indicated that the man was on an open ACCT. (This related to the ACCT that had been opened when the man was at Dorchester and was still open when he was released.) The member of staff told the investigator that he contacted staff on A wing who told him that this was not the case and so he removed the ACCT flag on NOMIS.

37. Because of court restrictions from previous offences, the man was not allowed contact with two named individuals. Social services also requested that the man should not have contact with his ex-partner and baby daughter. Despite requests from the prison, Exeter social services were unable to provide any official clarification for why this was not permitted. As a result, the man was allowed contact with his ex-partner and supervised visits with his daughter. (Although the man was to speak regularly with his ex-partner on the telephone, he received no visits from her or their daughter.)

38. Over the following weeks, the man was occasionally angry and threatening when he did not get what he wanted. On 9 January, he threatened staff and told officers to get "the fuck out of my cell before you get hurt". The SO pushed the man away and warned him about his behaviour. The man repeated his threats and the SO, with the assistance of other officers, restrained him and took him to the prison's segregation unit for reasons of good order and discipline.

39. In the segregation unit, a nurse saw the man. The nurse treated a minor injury to his forehead and, on completion of an initial segregation health screen, concluded that there were no clinical reasons which prevented his segregation.

40. When the man was unlocked for his evening meal at 5.30pm, he was found lying naked in his cell. The prison GP attended with the duty governor. The man refused to communicate with the GP or with any of the other staff present. The GP said the duty governor told her about the man's volatility and, because of the man's lack of communication, a plan was put in place for him to be checked hourly by staff and to be told each time that a doctor or nurse was available if he wanted to speak to them. The man's checks were in

fact carried out twice an hour, but no ACCT procedures were opened and no mental health referral was made. The GP made an entry of her visit in the man's segregation history sheets, but did not record her interaction in his medical records.

41. Over the next two days, the man frequently refused to engage with staff, but took his meals and was compliant with requests. On 12 January, three days after initially being segregated, he told staff that he would be civil and compliant, but wanted to be left alone and did not want to return to the wing. He repeated this at a segregation review the next day, when he said that he would only return to the wing if staff apologised to him, provided him with five smoker's packs and returned him to the standard level of the prison's incentive and privileges scheme. These demands were refused.

42. Although healthcare staff saw him daily in the segregation unit, on five occasions no note of that contact was made, either in the segregation records or in the man's medical records.

43. On the afternoon of 14 January, the man told the prison chaplain that he had lost contact with his daughter due to the breakdown of his relationship with his partner and was frustrated, fed-up, had had enough of life and being in prison and wanted to end it all. The chaplain told the investigator that he became concerned when the man said he wanted to end his life and they talked about this and how his partner was feeling about him. The chaplain spent half an hour listening to and praying with the man, who said he felt better at the end of their meeting. The chaplain told the man they would continue their discussion the following day. The chaplain told the investigator that he informed officers of his concerns, but could not recall whom he told. He did not make an entry in the segregation unit observation book, but did make an entry in the man's prison record. Segregation unit staff told the investigator that they were not aware of the chaplain's concerns.

44. On 15 January, the man declined to take his breakfast. He refused to interact with the GP and refused to attend a GP appointment later that day. In the afternoon, the man told the chaplain that he had slept well, had written to his partner and had resumed writing his diary. The chaplain noted in the man's electronic prison record that he was in a better mood and seemed 'motivated to live his life to the betterment of his family and society'. The chaplain also noted that he did not think an ACCT needed to be opened, but would visit the following week. The chaplain told the investigator that he did not speak with staff about his interaction with the man.

45. Over the following days, staff recorded in the man's segregation history sheets that his behaviour was odd, manipulative and controlling. He again presented to staff a list of demands before he would consider a move back to his wing. On occasions, the man declined to take his meals and exercise and a segregation unit officer, described him as wanting to be the "top dog" and in charge of any situation. During this time, the man made many emotional and sometimes aggressive telephone calls to his partner, indicating their relationship was ending and that she was not to contact him, but that he

would stay in contact with his daughter.

46. On 24 January, duty governor noted the man as being "uncommunicative, and as possibly sulking from his previous challenged behaviour". The duty governor told the investigator that in his contact with him the man never struck him as being depressed. The GP saw the man later that day and noted in his segregation history sheets that he was sitting on the floor of his cell complaining of muscular pain in his shoulder. Again, no note of this interaction was made in the man's medical records.

47. At around 10.30pm, healthcare assistant was asked by an officer (she could not recall who) to see the man in the segregation unit. The healthcare assistant found the man sitting on the floor of his cell. She talked to the man through the cell door, but did not go in. The man told her that he had been hallucinating and hearing voices and had thoughts of self-harming, stating that he would do something to get what he wanted. The healthcare assistant told the investigator that the man said to her "I'll keep doing this till I get what I want." She described him as a "bit strange", but said that he did not specifically say he was going to harm himself.

48. The healthcare assistant told the investigator that the man had insisted that he wanted help that night. The healthcare assistant explained that there were no mental health nurses on duty to speak with him, but that she would refer him to the mental health team. The healthcare assistant said the man began to calm down and, having provided reassurance, she left.

49. The healthcare assistant briefly discussed her contact with the man with Custodial Manager (CM) the manager who was in charge of the prison. The healthcare assistant told the custodial manager that the man had been hearing voices and that she was going to refer him to the mental health team. The healthcare assistant said she also told a nurse, who was on duty that night, about the man and how he was presenting. The nurse did not follow up this information. Unfortunately, the nurse was not available for interview to establish why he did not do so. The healthcare assistant completed a mental health referral for the man. However, she did not process the referral correctly on the electronic medical records system (known as Systm One) and the mental health team were therefore not made aware of it.

50. On 25 January, another nurse saw the man during a routine segregation unit round. The nurse noted in the man's medical record that he was fit and well. The nurse said that, during her handover that morning, the man was not mentioned. (No record of the previous night's events was recorded in the healthcare night folder handover log.) Over the following days, the man's behaviour remained the same. On occasions, he refused to take his meals, was uncommunicative and asked that he be left alone. Segregation unit staff again described him as being manipulative and refusing to leave the unit.

51. On 3 February, the man was agitated at not being able to contact his partner. He later left two telephone messages for her. Over the following two days the man made eight telephone calls to his partner. He left several messages

mentioning his daughter. In some of the calls, the man expressed his anger and frustrations by shouting at his partner and blaming her for not fighting for him to see his daughter. In others, he was upset and apologetic and asked that they start afresh. During this time, the man also wrote several long letters to his partner.

52. On 5 February, the chaplain spent time with the man. They talked about him resolving issues with his partner and having contact with his daughter. The man also discussed this with staff in the segregation unit and an officer noted that the man's usual reaction in such circumstances was to 'act like a petulant child and that it would be interesting to see how he dealt with the situation this time'.

53. On 6 February, after a discussion with the Head of Safer Custody, it was agreed that the man would move to C wing. He left the segregation unit that afternoon. The officer noted that the man's agreement to move to C wing had been a surprise and that he had begun to look at his situation in a more mature way.

54. Between the man's return to C wing and his death, little is recorded in the prison records. However, the man made numerous daily telephone calls to his partner. In some of these calls, the man was aggressive and argumentative, in others he was more calm and considered.

55. On the afternoon of 6 February, the man made three telephone calls to his ex-partner. Unable to speak with her, he left several messages. In one message, he again blamed social services for him not having contact with his daughter. In another, he told his partner that everything was in her power and asked her to fight for him to see his daughter, adding that his leaving her messages was "driving him nuts". In a third message, the man told his partner he had "nothing left" and said goodbye. In a fourth, message he simply said "point made" before hanging up.

56. At around 11.25pm, an officer who was carrying out routine but random listening of prisoner telephone calls noted that in one call made by the man he had said he had nothing left and seemed very low (this is the only phone call made the man that staff listened to. The investigator became aware of the nature of the other calls when he listened to him during the investigation). An officer told a Custodial Manager (CM) of his concerns. On the instruction of the custodial manager, an officer went to the cell to check on the man, who was laughing and joking with his cellmate. The custodial manager asked the officer to observe the man hourly overnight with the possibility of opening an ACCT in the morning.

57. The next morning, 7 February, the man made several telephone calls to his partner, some of which were aggressive. He also wrote a long letter to her and his daughter telling them that he loved them.

58. The SO spoke with the man regarding concerns raised by staff the previous evening. The SO told the investigator that the man seemed emotional about

his relationship issues, but that he considered it was not necessary to open an ACCT.

59. On 8 February, the man made further telephone calls to his partner. During some of these he said that he and his ex-partner should separate and that there should be no ill feeling between them, in others he was aggressive and emotional.

60. On 15 February, the man made a number of highly charged and emotional telephone calls to his partner. He spoke with her for the last time at 4.11pm. The man said he had nothing left, he had tried but things had not worked, that he could not do this anymore and that there was nothing to chase, before the telephone call cut off.

61. The man made no other telephone calls as he had no credit left on his telephone account. He told his cell mate not to let him ask staff for more credit on his telephone account as he did not want to speak with his partner again. (The man did not ask for any further credit before his death, although he did have funds available in his prison account had he chosen to do so.).

62. On 17 February, the man sent two letters to his partner. One told her that their relationship was over and the other asked her to visit him in prison. The following day, he sent a further letter saying that their relationship was over.

63. The man's cellmate, who had shared a cell with the man for three weeks before his death, told police that the man came across as an agitated and restless person and appeared constantly to go from "one thought to another". The man's cellmate said the man talked about plans to build his relationship with his partner and of the problem he was having in seeing his children, saying it was a "struggle about control". The man's cellmate said it was hard to tell if what the man was saying was true or not and that he would often talk about God and his partner.

64. The man's cellmate told police that around four or five days before he died, the man had talked about killing himself by placing pens in his nose and forcing them into his head, saying it would be best if he was dead. The man's cellmate said he told the man "not to be stupid" and did think about telling a member of staff. However, he said he had told staff about a previous cell mate's threats to self-harm, but that staff then did nothing and didn't appear to care. The man's cellmate said that over the following days there were no further incidents, but that the man talked "strangely" and that he did think that he had mental health issues.

65. The man's cellmate said that, on the afternoon of 21 February, the man had hit him in the face because he had a headache and wanted the television turned down. Staff had come to the cell and the man was removed. The man later apologised to the man's cellmate and told officers that it would not happen again. The man's cellmate told prison staff that he was happy to go back in the same cell and this was approved by the duty governor. The man's cellmate said the man was very apologetic, telling him "I just can't do anything

good."

66. The man's cellmate said that evening the man did not leave the cell to collect his dinner. He said that this was unusual, but he did not ask the man why he did not want it. The man's cellmate said that, when he returned to the cell, the man had a postal order from his partner, but was not happy because it was not accompanied by any form of letter. The man told the man's cellmate that his partner was too scared to speak to him.

67. The man's cellmate said he slept on his bed for a couple of hours and when he woke the man was writing. The man's cellmate said they both had a cup of tea, and the man continued writing but seemed quiet. The man's cellmate said that at one point the man said: "you were right, the hardest person to live with is yourself." He also read out a religious quote from his calendar. The man's cellmate fell asleep and he believed that the man carried on writing.

22 February

68. At around 2.57am on 22 February, the man's cellmate got up to use the toilet and discovered the man hanging from the window bars of the cell with his hands tied to his ankles. The man's cellmate immediately pressed the cell bell and tried to release the man from the ligature while he waited for staff to arrive. He was unable to initially, but then managed to burn through the ligature with a lighter.

69. An officer was on the floor above the man's cell at the other end of the landing when he heard a cell bell accompanied by continual shouting and screaming for assistance. He told the investigator that he could tell that someone was in genuine distress and desperately needed help. It took the officer about a minute to reach the cell, arriving around 3.00am. Looking into the cell, the officer saw the man with a ligature around his neck and his wrists tied to his ankles to the front of his body, with the man's cellmate supporting his body. The officer called on his radio "immediate assistance required to C3 landing", but was asked to repeat the message as it was not clear. Before he was able to repeat the message, another Custodial Manager (CM) and an officer arrived.

70. The officer broke the seal on his emergency key and the officers entered the cell. The Custodial Manager called an emergency code blue and for an ambulance to be called immediately. On entering the cell, the man's ligature snapped, as the man's cellmate had burnt through it with a lighter, and the man fell to the floor despite the man's cellmate attempts to hold him up. The man's cellmate was taken from the cell by an officer Hunter. The Custodial Manager told the investigator that the man was cold to the touch and, in his opinion, clearly dead.

71. The Custodial Manager cut the ties from around the man's wrists and ankles and the officer removed the remaining ligature from around the man's neck. A nurse then arrived at the cell followed by her colleague, another nurse. The nurse checked for signs of life and found that there were none. She said that

the man had no pulse and was blue in colour, but she immediately commenced cardio pulmonary resuscitation (CPR) as it was her understanding that this should always be attempted. The nurse left the cell on two occasions to collect further equipment. A defibrillator was used during the attempted resuscitation. The healthcare staff were relieved by paramedics at 3.05am. They pronounced the man dead at 3.35am.

72. The man left notes in his cell addressed to his daughter and ex-partner.

Family Liaison

73. The Reverend was appointed family liaison officer. The family liaison officer and the deputy governor, broke the news of the man's death to his ex-partner early on the morning of 22 February. Contact was later made with the man's mother. The prison offered funeral expenses in line with national policy.

Support for staff and prisoners

74. A hot debrief was held for the staff involved in the emergency response. (A hot debrief is a meeting to give staff involved in a traumatic incident, the opportunity to share their feelings and for support to be offered.) Those involved said they found it helpful and that they had been well supported by the prison's care and welfare team.

75. Prisoners on open ACCTs were reviewed to see whether they had been affected by the man's death. The man's cellmate said he had felt well supported by prison staff after the incident.

Post-mortem report

76. A post-mortem examination concluded that the man's death was caused by hanging.

ISSUES

Medical record keeping

77. The clinical review notes that, on a numerous occasions, healthcare staff, including prison doctors and nurses, had contact with the man, but did not record this in his medical record. The clinical reviewer notes that, when entries were made, they were usually of a poor standard.

78. The clinical reviewer notes that accurate contemporaneous clinical records are good practice and not an optional extra. Interactions with patients should be recorded immediately, or as soon as possible afterwards, and should include the reasons for contact with the patient. The clinical reviewer concludes that the standard and quality of record keeping at Exeter was unacceptably poor.

79. We agree with the clinical reviewer's conclusions and make the following recommendation:

The Head of Healthcare should ensure that clinical data is recorded in according to GMC guidance and that an action plan for its introduction into the segregation unit be produced.

Mental health

80. The clinical reviewer notes that the man had a long history of apparent mental health problems prior to his arrival at Exeter. However, the man's diagnosis of schizophrenia was largely based on self-declaration and on several occasions he told staff that he used his diagnosis to obtain favourable treatment. The clinical reviewer also reports that the man frequently self-harmed and on at least two occasions told staff that he would harm himself to "get what he wanted". The clinical reviewer notes that all of this information was available in his medical records.

81. The man had a history of manipulative behaviour, but he also had a significant history of reported mental health issues. Despite this, on his reception at Exeter, he was not considered to be in need of mental health assessment. The nurse could not clearly remember her interactions with the man and did not know whether she read his medical history. It has not been possible to interview the mental health nurse, but it appears that he did not consider that the man was at risk or that he needed a psychiatric evaluation. The clinical reviewer concludes that, given the man's mental health history, it would have been appropriate for him to have been referred to the mental health team when he first arrived at the prison.

82. On 9 January, the man was found lying naked in his cell in the segregation unit. He refused to interact with staff. The GP saw the man that afternoon, but did not make a referral to the mental health team. The doctor said she did not consider a referral because, despite the man's unusual behaviour, a 'one-off situation' would not normally warrant this. The GP said that she believed

that the planned observations of the man while he was in the segregation unit would have been enough to build a picture of what was happening which could then be used to make a mental health referral if necessary. The GP did not make an entry into the man's medical records and did not communicate this to her colleagues Without any kind of care plan in place it is difficult to see how this would have happened in practice.

83. On 24 January, the man told staff that he was experiencing hallucinations. He was seen by a healthcare assistant, who told him that there was no mental health nurse available, but that she would make a referral for him to be seen by the prison's mental health team. Although the referral was completed, an administrative error meant that the man was not added to the mental health team's waiting list. (The referral template had now changed to ensure that all referrals are added to the waiting list.) The nurse on duty that night did not go to see the man that night, despite being aware of the symptoms he had reported. Despite daily contact with healthcare staff over the following days, no attempts were made to identify whether the man was still hallucinating.

84. The clinical reviewer concludes that the man's mental health issues were not taken as seriously as they should have been. Entries about him in prison records and information given to the investigator suggest that staff focused on his potentially manipulative behaviour and did not give adequate consideration to the symptoms he described. This appears to have led to his potential mental health needs being over-looked. We make the following recommendation:

The Head of Healthcare should ensure that all staff are aware of the circumstances in which a mental health referral is appropriate and are competent in how to make such a referral.

Assessment of risk of self-harm

85. Prison Service Instruction (PSI) 64/2011 – Management of prisoners at risk of harm to self, to others and from others (Safer Custody), and PSI 74/2011 – Early days in Custody both list a number of risk factors for suicide and self-harm. PSI 74/2011 states that all staff should be alert to the increased risk of suicide/self-harm posed by prisoners during their early days in custody and act appropriately to address any concerns.

86. When the man arrived at Exeter in December 2013, he had a number of suicide risk factors. He was on remand and had been released from prison only three months previously while on an open ACCT. He had a number of additional factors that were significant indicators of risk, including arriving at the prison on an open suicide and self-harm warning form and a history of deliberate self-harm, irrational behaviour, possible mental illness and depression. We are concerned that staff took insufficient account of all of the man's risk factors, which we consider were readily apparent in the information available about them.

87. When the man was found naked and uncommunicative in his cell in the segregation unit on 9 January, the GP said that he did not display any behaviour which would have resulted in an ACCT being opened. The officer said that although the man was placed on hourly observations following this incident, the man gave no indication that he was at risk of self-harm. The man also reported hallucinating in his cell on the night of 24 January and having thoughts of self-harm. This was another missed opportunity to put the ACCT process in place to support the man and understand his needs.

88. An ACCT was not opened on 14 January, when the man told the prison chaplain that he wanted to end his life. When asked why he didn't open an ACCT the chaplain said,

> "I suppose because at the end of our discussion he seemed quite positive and hopeful really about giving it a go. He didn't seem to be that down in himself as I previously experienced with him; there was a change in him."

The chaplain said that he mentioned the matter to staff, but could not recall to whom. None of the segregation staff interviewed during the course of this investigation could recall being told of the chaplain's concerns and he did not record the conversation in the segregation unit observation book.

89. We consider that more weight should have been given to the man's known risk factors. Although we accept that the man was clearly capable of being manipulative, we believe staff in reception and the segregation unit, as well as healthcare professionals were too willing to assume that his distress was not genuine. They did not adequately take into account the risk-related information that was available to them.

90. Clearly, the man's anxiety and upset about the breakdown of his relationship also played on his mind. Although he made numerous telephone calls, on a daily basis, during which he was often upset and emotional, staff were not fully aware until after his death. He also talked at length with the prison chaplain and his cell mate about his relationship issues. However, most of the staff who interacted with the man on a daily basis were not aware of this.

91. We accept that the man's actions on 22 February would have been difficult to predict, not least as staff did not know the extent of his relationship difficulties. However, with his known range of risk factors, we consider it would have been prudent to open an ACCT on a number of earlier occasions, although we cannot say that such support would have changed the outcome. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that all staff who work with prisoners:

- **Have a clear understanding of responsibilities and the need to share and communicate all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

Emergency response

92. The clinical reviewer comments in his clinical review that healthcare staff attended promptly and resuscitation was attempted. The officers who attended the man before the nurses arrived were of the opinion that he was already dead and so did not attempt CPR. This was not unreasonable in the circumstances and we make no criticism.

93. Although the correct equipment was available, there was a delay in fetching the defibrillator and airway equipment. The nurse had to leave the cell on three occasions to collect this equipment as it was kept in different locations and not together in one bag. Although it is unlikely that this had any impact on saving the man's life, quick access to emergency equipment could be crucial in other situations. We make the following recommendation:

The Head of Healthcare should ensure that adequate and appropriate equipment, including a defibrillator and airway, is kept with the emergency response bag and that it is regularly checked.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all staff are aware of the Head of Healthcare should ensure that clinical data is recorded in according to GMC guidance and that an action plan for its introduction into the segregation unit be produced.

2. circumstances in which a mental health referral is appropriate and are competent in how to make such a referral.

3. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that all staff who work with prisoners:

    - Have a clear understanding of responsibilities and the need to share and communicate all relevant information about risk.
    - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
    - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

4. The Head of Healthcare should ensure that adequate and appropriate equipment, including a defibrillator and airway, is kept with the emergency response bag and that it is regularly checked.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that clinical data is recorded according to GMC guidance and that an action plan for its introduction into the segregation unit be produced	Accepted	Due to the distance between the segregation unit and the NHS secure IT cable, the Head of Healthcare will request an assessment of the costings involved to see how feasible it is to have a PCT computer in the segregation area The recording of clinical data in accordance to GMC and NMC guidance is discussed regularly in team meetings and checked by the lead GP and the Healthcare Manager	Target time frame for completion: first quarter of 2015 DHUFT – IT Department Regional Manager Healthcare Manager Healthcare Manager and Lead GP	
2	The Head of Healthcare should ensure that all staff are aware of the circumstances in which a mental health referral is appropriate and are competent in how to make such a referral.	Accepted	Mental health referrals have been discussed in staff meetings, where the process itself explained in detail by mental health nurses to primary care staff. Guidance has been produced and displayed in the reception area and the nurse's station at the prison.	Completed Healthcare manager and Mental Health Nurses	
3	The Governor should produce clear local guidance about procedures for identifying prisoners at risk	Accepted	A comprehensive review of all Safeguarding procedures is currently being undertaken.	Target time frame for completion: end of November 20014	

	of self-harm and for managing and supporting them. In particular this should ensure that all staff who work with prisoners: • Have a clear understanding of responsibilities and the need to share and communicate all relevant information about risk. • Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and Prisoner Escort Records (PERs).		HMP Exeter's local Safeguarding Policy includes a comprehensive local ACCT guide, which will be reviewed to ensure full compliance with relevant instructions. Further to this, a risk and triggers form is in use at the First Night Centre which is used to record and assess known risks and triggers (as per PSI 64/ 2011) and reminds staff of requirements, including that case notes are completed accordingly. To assist this assessment, the documents below are also considered by First Night Centre staff are: • Self Harm notification alert / notification sheet which is completed by escort services. • Prisoner Escort Record, CNomis records. • SystmOne (medical information by Healthcare staff). • PNC records, and any other available reports which may include court reports and safeguarding reports. • There are also one to one interviews with all prisoners which allows interviewing staff to make an informed assessment regarding risk. The outcome of interviews and risk	Head of Residence and Safety.	

	Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.		analysis is recorded within the prisoner's case notes and risk and triggers form. • A Risk and Triggers briefing was given to all staff in the form of a new Governors Order in June 2014, reminding staff about risks and triggers identification. • A new ACCT review process started August 2014. This is subject to ongoing monitoring. • All new staff during induction will continue to receive Safer Custody Awareness training. Further ACCT Case Manager Courses, ACCT Assessor Initial and ACCT Assessor Refresher courses will be provided during the year. • The establishment is planning a further training event in September focusing on Risks and Triggers. This training package will be published and given to all members of staff not able to attend. • The Head of Residence and Safety will be holding monthly supervision with all Band 4 managers holding a		

			caseload of prisoners subject to ACCTs. This will begin on 10th September 2014. This supervision is structured and designed to improve ACCT processes, and improve risk and triggers identification and management. A Governors Order issued to all staff will support these arrangements.		
4	The Head of Healthcare should ensure that adequate and appropriate equipment, including a defibrillator and airway, is kept with the emergency response bag and that it is regularly checked	Accepted	There are 4 defibrillators located in strategic areas around the prison, and there are posters displayed in different areas of the prison indicating to staff where the defibrillators are to be found when needed in an emergency. There is now a central emergency response bag/kit that includes, in addition to the first response kit, a defibrillator and different sizes airways.	Completed Head of Healthcare	

For the Head of Healthcare					
No	**Recommendation**	**Accepted/Not accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Head of Healthcare should ensure that clinical data is recorded in according to GMC guidance and that an action plan for its introduction into the segregation unit be produced.	**Accepted.**	The Trust will develop a guideline on the standards and expectations for clinical documentation and recording of clinical notes within the prison setting. These will outline the standards expected to record accurate, comprehensive and contemporaneous clinical records and the timeframe expected to complete these records after assessment/intervention. These will highlight and reinforce the need to document clear rationale behind clinical decisions and will outline the need for clearly documented and easily accessible, specific and measurable care planning. The new guidelines and new referral and assessment process will restrict the use of “macros” or shortcuts without a narrative outlining the assessment, care plan and intervention used or being offered.	**01 November 2014.**	
2	The Head of Healthcare should ensure that all staff are aware of the circumstances in which a mental health referral is	**Accepted.**	The Trust is developing a new mental health referral and assessment process. This will include a referral process within SystmOne that will be completed by the general healthcare staff. To ensure that	**01 November 2014.**	

	appropriate and are competent in how to make such a referral.		referrals are not missed due to user error, the referral will automatically generate a task to the mental health team alerting them of the referral. The prison service can refer into the team via a referral form that is delivered or sent to the mental health team. These referrals are reviewed by a member of the mental health team, and offered appropriate assessment based on need and within the contracted time frame. The Prison Mental Health Operational Policies outline that if a prisoner has a history of serious mental illness, a previous diagnosis of serious mental illness, or a previous or current prescription of a psychotropic medication, then a referral should be made to the mental health team. The Trust will ensure that this is clearly communicated to all in healthcare and that the new referral and assessment process outlines the need for referral if this history is highlighted. The mental health team is developing a package of mental health awareness training for the prison and healthcare staff. This training will cover mental health conditions and treatments and when and how to refer to services.		

3	The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that all staff who work with prisoners: □ Have a clear understanding of responsibilities and the need to share and communicate all relevant information about risk. □ Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. □ Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.		HMP Exeter Responsibility		
4	The Head of Healthcare should ensure that adequate and appropriate	**Accepted**	There is now a large emergency bag containing in addition to the usual emergency kit a defibrillator and different	**Action completed**	

	equipment, including a defibrillator and airway, is kept with the emergency response bag and that it is regularly checked		sizes airways. This bag is located in a central location easily accessible by members of healthcare or prison. Healthcare also purchased another defibrillator that will be located on it's own in the "centre" just in case the emergency requires immediate intervention and the officers initiate the process before the nurse getting there with the bag. They are all checked weekly. There are also posters around the prison detailing clearly where the defibrillators are located.		