Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Devoy, a prisoner at HMP Guys Marsh, on 15 August 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michael Devoy was found hanged in his cell at HMP Guys Marsh on 15 August 2015. He was 22 years old. I offer my condolences to his family and friends.

Staff identified a number of factors which increased Mr Devoy's risk of suicide when he was first remanded to prison in May 2015 and had managed him under Prison Service suicide and self-harm prevention procedures for a month. At the time of his death, he was no longer being monitored as a risk and I consider that it would have been difficult for staff to have identified that he was at imminent or particularly high risk of suicide at that time.

The investigation also found that the officer who unlocked Mr Devoy's cell on the morning of 15 August did not check his wellbeing. This meant that a friend of Mr Devoy's found him hanged in the cell 20 minutes later, which is not acceptable.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2016**

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Summary

Events

1. On 19 May 2015, Mr Michael Devoy was remanded to HMP Bristol, charged with threatening and abusive behaviour towards his partner, possession of a weapon and criminal damage. During the incident, Mr Devoy had cut his neck with a knife and needed hospital treatment.

2. At an initial health screen, Mr Devoy said he had been high on drugs at the time. He was not sure if his partner had ended their relationship, or whether this would affect his contact with his young child. His father had been murdered a year earlier, he had lost an arm through meningitis (and wore a prosthesis) and said he was depressed. He said he had no current thoughts of suicide but staff identified him as a risk and began Prison Service suicide and self-harm prevention procedures (known as ACCT). Mr Devoy continued to be monitored until 15 June, when staff had no further concerns about him.

3. On 14 July, Mr Devoy transferred to Guys Marsh. Shortly after he arrived, he told a prison doctor that he was being bullied due to his disability and wanted a single cell. His friends at the prison were sure that he was not being bullied and he did not make any further complaints to staff. (On 11 August, he was given a single cell.)

4. On 27 July, Mr Devoy had a routine assessment with a mental health nurse. The nurse had no concerns about Mr Devoy.

5. Mr Devoy had an illicit mobile phone, which he used to contact his partner and friends. Mr Devoy believed his partner was seeing someone else and his friends in the prison said he was paranoid and upset about this. Prison staff did not know that Mr Devoy had a phone, or that he had relationship difficulties.

6. At 8.50am on 15 August, a friend of Mr Devoy's friend found him hanged in his cell. Despite signs that Mr Devoy was dead, staff tried to resuscitate him. When paramedics arrived, they examined Mr Devoy and recorded that he had died.

Findings

7. Mr Devoy had a number of factors which increased his risk of suicide. These had been appropriately identified at Bristol when he arrived and staff monitored him until they were satisfied that his risk had reduced. Staff at Guys Marsh did not know he was anxious about his relationship and contact with his child at the time of his death. We accept that they had no particular reason to consider that his risk of suicide had substantially increased and begin ACCT procedures again. We do not consider that they could have foreseen his actions or prevented his death.

8. Contrary to local and national instructions, the officer who unlocked Mr Devoy's cell in the morning did not check his wellbeing, which meant that

another prisoner subsequently found him hanged. Staff tried to resuscitate him, although the presence of rigor mortis should have indicated this would be futile.

Recommendations

- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

- The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Guys Marsh informing them of the investigation and asking anyone with relevant information to contact her. Three prisoners responded, although one later declined to be interviewed.

10. The investigator visited Guys Marsh on 18 August and obtained copies of relevant extracts from Mr Devoy's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Devoy's clinical care at the prison.

12. The investigator interviewed five members of staff and three prisoners at Guys Marsh on 16 and 17 September. She spoke to another prisoner and a probation officer over the telephone. The clinical reviewer joined her for interviews with clinical staff on 16 September.

13. We informed HM Coroner for Dorset of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Devoy's mother to explain the investigation. Mr Devoy's mother had no specific issues for the investigation to consider.

15. Mr Devoy's family received a copy of the initial report. They pointed out a factual inaccuracy. This report has been amended accordingly. Mr Devoy's family also made a number of comments that do not impact on the factual accuracy of this report.

16. The prison also received a copy of the report. They pointed out a factual inaccuracy, and the report has been amended accordingly. The prison provided an action plan for the recommendations.

Background Information

HMP Guys Marsh

17. HMP Guys Marsh holds up to 579 men who are usually nearing the end of their sentence. Dorset University Healthcare Foundation Trust provides primary and secondary general and mental healthcare, and commission another agency, EDP, for substance misuse services. Healthcare staff are on duty every day, but not evenings. A doctor is on duty most Saturday mornings.

HM Inspectorate of Prisons

18. The most recent inspection of Guys Marsh was in November 2014. Inspectors were very critical and described the prison as in crisis. Levels of violence were three times higher than at the last inspection and many prisoners told inspectors that they did not feel safe. Violence was driven by the supply of drugs, particularly subutex and synthetic cannabinoids (also known as new psychoactive substances). Prisoners said it was easy to get drugs and alcohol. A third of prisoners had no work and spent too long locked in their cells.

19. However, Inspectors reported that relationships between staff and prisoners were mostly good and there was a proper focus on providing care and support to prisoners at risk of suicide and self-harm.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2014, the IMB reported concerns about the availability of drugs and associated violence and debt, but said the prison was decent and humane.

Previous deaths at HMP Guys Marsh

21. Before Mr Devoy's death, there had been two deaths at Guys Marsh in the last two years. One was from natural causes, and the other a self-inflicted death in April 2015. There were no significant similarities with the circumstances of the other deaths.

Assessment, Care in Custody and Teamwork

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

23. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings

involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

24. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25. On 19 May 2015, Mr Michael Devoy was remanded to HMP Bristol, charged with using threatening and abusive behaviour towards his partner, possession of a bladed weapon and criminal damage. During the offences, which were committed in front of his young son, Mr Devoy stabbed himself in the neck with a knife and needed stitches. Afterwards, his partner said that she did not want any further contact with him. Mr Devoy had been in prison before.

26. Court custody staff completed a suicide and self-harm warning form and recorded that Mr Devoy had recently self-harmed and was very upset about being remanded to prison. They noted that he had tried to remove the stitches from his neck. When Mr Devoy arrived at the prison, a reception officer began ACCT suicide and self-harm prevention procedures and recorded that his partner ending their relationship was the main trigger that might increase his risk of suicide and self-harm. He noted that Mr Devoy said he had been under the influence of drugs when he had cut his neck.

27. A nurse saw Mr Devoy in reception and noted his recent self-harm, and that he was anxious and depressed. Mr Devoy said that he had self-harmed in the past, and still had thoughts of suicide and self-harm. He said that his father had been murdered in 2014, and that he had used drugs to cope with his emotions. She referred Mr Devoy to the mental health team. Mr Devoy had had meningitis a few years earlier and his right arm had been amputated as a result, so he wore a prosthetic limb. He had lost the prosthesis when he was arrested, so she referred him to the GP. (Mr Devoy's medical record does not record when his prosthesis was found and returned to him, although we know that this happened.)

28. On 20 May, a prison chaplain assessed Mr Devoy as part of the ACCT process. Mr Devoy said that he was feeling suicidal but would not want to kill himself if he got back together with his partner and could see his son. He said that his father's murder, his increased use of mephedrone (a synthetic amphetamine) and his partner leaving him had made him feel like it was 'the end'. He said he would be okay if he could speak to his partner or his mother.

29. A custodial manager chaired an ACCT case review later that day, and assessed Mr Devoy as a raised risk of suicide and self-harm. The custodial manager recorded two actions on the ACCT caremap for Mr Devoy to work with the prison drug services and to be referred to the mental health team as Mr Devoy was still grieving about his father's death. There was no action about contact with his partner and family.

30. The next day, the custodial manager chaired another case review, attended by a nurse from the mental health team. Mr Devoy said that he was worried about his relationship with his partner, struggled with the circumstances of his father's murder, and had used drugs to cope. He said that he still had thoughts of suicide and self-harm because he was depressed and had so much going on.

31. Later, the nurse assessed Mr Devoy's mental health and noted he had a long history of drug use, linked to coping with stress, but he did not have a mental illness. The nurse recorded that Mr Devoy did not need any further input from the mental health team and gave Mr Devoy advice about how to access bereavement counselling in the community.

32. The custodial manager chaired three further ACCT reviews in the next few weeks. Mr Devoy said that, although he still felt depressed at times and stressed about his court case, he did not want to kill himself.

33. On 15 June, the custodial manager chaired another ACCT case review with a nurse. He noted that Mr Devoy was more positive, and again said he had no thoughts of suicide or self-harm. Mr Devoy said that his partner was pregnant, and that coming to prison had made him realise what he had. The case review decided that his risk had reduced and ended ACCT monitoring.

34. Later on 15 June, a worker from the substance misuse team assessed Mr Devoy. She gave him some health education and cannabis awareness information but did not think that he needed any further support. She did not record anything about his use of mephedrone.

35. There is no record that Mr Devoy's partner visited him while he was in prison, or that he used the prison telephone system to speak to her. However, Mr Devoy's friends told the investigator that he had had a mobile phone throughout his time in prison and kept in contact with his partner.

36. On 18 June, Mr Devoy was sentenced to nine months in prison. A nurse assessed him when he got back from court. Mr Devoy said that he was frustrated and annoyed about the sentence, but was feeling mentally okay and had no thoughts of suicide or self-harm.

37. On 22 June, at an ACCT post-closure review, Mr Devoy told a custodial manager that he felt well supported and that he had no thoughts of harming himself because he was not using drugs anymore. Mr Devoy said he did not have any work in the prison and did not really have any hobbies. He said that he would like a single cell.

38. After his conviction, Mr Devoy's son was placed on the child protection register and until further assessments Mr Devoy was not allowed to contact his partner (who was 17 years old) or his son. On 29 June, Mr Devoy's offender manager (probation officer) explained the safeguarding measures to Mr Devoy and contacted the prison to ensure they were aware of the restrictions and that they should monitor his wellbeing.

39. On 2 July, an officer explained the restrictions to Mr Devoy, who signed to confirm he understood he could not contact his partner and son. Staff at Bristol did not consider Mr Devoy's risk of suicide and self-harm had increased.

HMP Guys Marsh

40. On 14 July, Mr Devoy was transferred to Guys Marsh to complete his sentence. He was housed on A Spur, Wessex Wing in a cell, which he shared with two friends he knew from previous sentences. A nurse saw Mr Devoy when he arrived and noted that he had previously cut his neck. He said it was a "one off". She did not consider Mr Devoy was at risk of suicide and self-harm and had no concerns about his mental health.

41. On 15 July, Mr Devoy told a GP that he was embarrassed about his prosthesis and particularly sharing a cell and showering. He said that other prisoners teased and bullied him. The GP sent a request to a prison manager for Mr Devoy to be given a single cell as soon as possible.

42. On 16 July, Mr Devoy referred himself to the integrated substance misuse services (ISMS) due to his addiction to mephedrone and cocaine. On 20 July, a drug recovery worker assessed him, devised a recovery plan and gave him work to complete in his cell. Mr Devoy did not say he was currently using drugs in the prison. Some of the prisoners we interviewed said that Mr Devoy had used drugs in prison, but most did not think that he had at Guys Marsh.

43. On 21 July, a member of education staff enrolled Mr Devoy on the victim awareness, violence reduction and family relationships courses. Mr Devoy had applied for work at the prison, but he had not yet been allocated a job.

44. On 27 July, a mental health nurse assessed Mr Devoy's mental health, which is routine for all new prisoners at Guys Marsh. The nurse assessed Mr Devoy as at low risk, but did not record how he had reached his conclusion. The nurse told the investigator that he would have asked Mr Devoy about thoughts of suicide and self-harm and, if he had had any concerns about Mr Devoy's mental health, he would done a more detailed assessment.

45. On 6 August, Mr Devoy asked an officer to arrange more work books for him to complete in his cell. A worker from the Thinking Skills course talked to Mr Devoy about this and sent him work books on anger, relapse prevention, harm minimisation, self-harm and depression. (Mr Devoy had completed the work books by 12 August.)

46. On 11 August, Mr Devoy moved to a single cell on B Spur, Wessex Wing. Mr Devoy's friends told the investigator that he was embarrassed about his prosthetic arm, but they were certain that he was not being bullied. They said Mr Devoy was preoccupied about his partner and son, and he believed that his partner was seeing someone else.

47. One of Mr Devoy's friends told the investigator that he knew Mr Devoy had a mobile phone. He said that he had pleaded with Mr Devoy to get rid of the phone because contacting his partner made him paranoid. He said that he had also tried to persuade Mr Devoy to stay in the shared cell. When Mr Devoy moved cells, his friends said that they often went to check he was

okay. Although they were concerned about him, and thought he was paranoid about his relationship, they did not think he was suicidal.

48. Staff on Wessex Wing did not recall anything unusual about Mr Devoy in the days before his death. At about 6.00pm on 14 August, officers on the wing locked prisoners in their cells. According to the police (who checked Mr Devoy's mobile phone after his death) Mr Devoy last used his mobile phone at 12.59am to text his partner.

Saturday 15 August

49. At about 6.00am on 15 August, the night patrol officer on Wessex Wing completed a routine security count to check that all prisoners were in their cells. He did not particularly recall seeing Mr Devoy during the check. At 7.40am, an officer did another check before the day shift started. Neither check required them to get a response from prisoners, but they should be alert for any safety concerns. She told prison managers that, when she looked into Mr Devoy's cell, she thought he was standing up. She did not make a full written statement and was absent from the prison on sick leave throughout the investigation, so we have been unable to speak to her.

50. At around 8.30am, an officer began to unlock the cells on B Spur and unlocked Mr Devoy's cell not long after. The officer was also absent from the prison on sick leave for the duration of the investigation. He did not make a statement for the police or prison managers and so we know nothing about his actions that day. We have to assume that he saw nothing of concern when he unlocked Mr Devoy's cell.

51. At 8.50am, one of Mr Devoy's former cellmates went to Mr Devoy's cell to check how he was. He told the investigator that he knew that Mr Devoy had been quite low and had relationship problems. He said that he went to see Mr Devoy every morning to talk to him and support him. He thought it was unusual that Mr Devoy had not opened his door and looked through the observation panel in the cell door. Initially, he thought Mr Devoy was standing up, but then saw that his feet were not on the ground. He shouted for help and staff responded immediately.

52. At 8.51am, an officer radioed a medical emergency code blue and the control room called for an ambulance straightaway. Mr Devoy had placed a wooden locker in front of his door, but the officers managed to move it and get into the cell. Mr Devoy was suspended from the light fitting with a sheet around his neck. An officer supported Mr Devoy's weight and a Supervising Officer (SO), who had also responded to the code blue, cut the sheet. The officers placed Mr Devoy on the bed and started cardiopulmonary resuscitation. An officer told the investigator that Mr Devoy was very cold and his legs were purple where blood had pooled.

53. A nurse responded to the emergency code and arrived shortly afterwards. She attached a defibrillator, which detected no shockable heart rhythm, so she and the officers continued resuscitation. At 9.01am, paramedics arrived, assessed Mr Devoy and noted the presence of rigor mortis. At 9.05am,

they recorded that he had died. A GP arrived at around 9.10am. She noted in the medical records that Mr Devoy had been dead for sometime.

Contact with Mr Devoy's family.

54. The prison appointed family liaison officers. They arrived at Mr Devoy's mother's house at 12.15pm to break the news of Mr Devoy's death, but another prisoner had already contacted her and told her.

55. Mr Devoy's family visited the prison on 26 August. A chaplain and the Governor went to Mr Devoy's funeral. In line with Prison Service guidance, Guys Marsh contributed towards the costs of the funeral.

Support for prisoners and staff

56. The duty governor individually debriefed the staff involved in the emergency response to offer them support and allow them to discuss any issues arising. The staff care team also offered support.

57. After Mr Devoy died, staff checked all prisoners assessed as at risk of suicide and self-harm every 30 minutes, until staff held full case reviews the next morning, in case they had been adversely affected by Mr Devoy's death.

Post-mortem report

58. The pathologist concluded Mr Devoy died from hanging. The toxicology tests found no drugs (including synthetic cannabinoids, also known as new psychoactive substances) or alcohol in his body.

Findings

Identification and management of risk of suicide and self-harm

59. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm, relationship instability, being charged with a violent offence against a close family member, a history of substance misuse, a history of mental health problems, and court appearances.

60. On 19 May 2015, staff at HMP Bristol began ACCT suicide and self-harm prevention procedures as Mr Devoy had self-harmed during the incident when he was arrested. Mr Devoy was charged with a domestic violence offence against his partner and staff noted that his relationship with her was a trigger for his self-harm. At an initial ACCT assessment, Mr Devoy said that he had suffered from depression since his father's murder and had self-harmed while under the influence of drugs.

61. Staff at Bristol managed Mr Devoy under ACCT procedures until 15 June, when they assessed that he was no longer at raised risk. A post closure review on 22 June identified no further concerns. Shortly afterwards Mr Devoy's probation officer told him that his partner and young son were subject to safeguarding measures, which might affect his future contact with them. Staff were aware of this but had no further concerns about Mr Devoy's risk. We are satisfied that staff at Bristol appropriately began ACCT procedures when Mr Devoy arrived and made a reasonable decision to end ACCT monitoring, once they were satisfied his risk of suicide had reduced.

62. After Mr Devoy transferred to Guys Marsh on 14 July, there was little indication that Mr Devoy was at raised risk of suicide and he gave no sign of his intentions. On 27 July, a mental health nurse assessed his mental health and had no concerns about his risk to himself. Mr Devoy saw a substance misuse worker and there were no indications that he was using drugs at Guys Marsh.

63. Mr Devoy had an illicit mobile phone, which he must have smuggled into the prison and which he used to contact his partner and friends. Mr Devoy's friends in prison said that he was paranoid about his relationship and thought his partner was seeing someone else. The text messages they shared suggested that their relationship was volatile. Although Mr Devoy's friends had some concerns about his wellbeing, they were shocked by his death and had not thought he was suicidal. Prison staff did not know that Mr Devoy had a mobile phone or that he was worried about his relationship. We do not consider that prison staff could reasonably have identified that Mr Devoy's risk of suicide had increased in the days leading to his death and we do not consider they could have prevented his death.

Clinical care

64. The clinical reviewer reviewed the clinical care that Mr Devoy received at Guys Marsh and concluded that his overall care was equivalent to that he

would have expected to receive in the community. He had some concerns that the quality of the clinical records fell below the standard expected, including the record of the mental health assessment by the mental health nurse. He has made a recommendation about this in his clinical review, which the Head of Healthcare will need to address.

Unlock procedures

65. At unlock, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

66. Prison Service Instruction 75/2011 Residential Services states that:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...
>
> "[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

67. On 15 August, when an officer unlocked Mr Devoy's cell, he should have checked his welfare and obtained a response from him. Although we were not able to interview the officer, the investigator concluded that it was accepted practice at Guys Marsh that staff did not obtain a response from prisoners when unlocking cells.

68. After the investigator's initial visit to the prison, a governor issued a Notice to Staff (133/2015) on 18 August, reiterating that officers must check prisoners' wellbeing when they unlock cells. While we welcome the governor's response, staff interviewed after 18 August told the investigator that they did not have enough time or motivation to read publications on the intranet and some had not seen the Notice to Staff. We therefore make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Resuscitation

69. The European Resuscitation Council Guidelines for Resuscitation 2010; Section 10: The ethics of resuscitation and end-of-life decisions states that

'*Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile*'. The guidelines define examples of futility as including the presence of rigor mortis and post mortem staining. In October 2014, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. Decisions should never be dictated by 'blanket' policies.

70. In 2012, Dorset University Healthcare Foundation Trust, which provides healthcare at Guys Marsh, issued a Cardiopulmonary Resuscitation (CPR) Policy. It notes that staff may withhold CPR where rigor mortis or hypostasis (pooling of blood post-death) are present. Both were evident when Mr Devoy was found. However the policy does not specifically cover prison settings.

71. Healthcare staff at Guys Marsh told the investigator that they believed they should continue CPR in all circumstances until a prison GP or paramedics pronounce death. We understand that the natural inclination of healthcare staff is to begin emergency first aid by giving life support but attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. As Guys Marsh does not have 24 hour nursing cover, all staff should be given clear guidance on when resuscitation is inappropriate. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

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