

**Independent investigation report by the
Prisons and Probation Ombudsman
Nigel Newcomen CBE
into the death of a man,
a prisoner at HMP Exeter,
in December 2014.**

Our Vision

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

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.

The man was found hanged in his cell at HMP Exeter in December 2014. He was 46 years old. I offer my condolences to his family and friends.

The investigation found that the man had a number of factors to indicate he was at risk of suicide, which prison staff did not identify. This information was readily available but no one fully assessed him and drew it all together. I am pleased that Exeter have reviewed and revised their reception procedures in light of his death. I also recognise that he was apparently determined to kill himself and, even if Prison Service suicide and self-harm prevention procedures had been put in place, we cannot know whether such support would have changed the outcome.

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

September 2015

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SUMMARY

Events

1. On 26 August 2013, the man was remanded to HMP Exeter charged with burglary and motoring offences. In April 2014, prison security information suggested he was involved in trafficking drugs in the prison. In May 2014, he was transferred to HMP Channings Wood.
2. At about that time, the man's daughter alleged that he had sexually abused her over a number of years. His daughter was taken into care and his wife stopped taking his telephone calls. On 7 June, officers found a mobile phone and SIM cards in his cell. On 9 June, he took an overdose of medication prescribed for a foot condition and was treated in hospital for burns to his oesophagus and stomach.
3. Officers began Prison Service suicide and self-harm prevention procedures, known as ACCT. The man said he had wanted to die because of his family situation. He said he no longer had suicidal thoughts and prison staff ended ACCT monitoring on 19 June. In September 2014, police charged him with 14 counts of sexual assault against his daughter. He had been due to be released on 10 October, but returned to Exeter as a remand prisoner on 30 October.
4. The man told a substance misuse team that at Channings Wood, he had been taking illicitly obtained subutex (buprenorphine an opiate substitute) to block out his emotions and completed a detoxification programme. On 3 November, he signed an agreement that he would not contact anyone under 18 years.
5. On 10 December, Avon and Somerset police informed the prison that the man had told his sister during a telephone call that he had no reason to go on. His wing manager spoke to him and decided that he was not suicidal. On 19 December, he refused to sign a form agreeing not to contact his wife, three children, mother-in-law and sister-in-law after the police discovered he had contacted his mother-in-law. A prisoner who knew him well said that he had seemed his normal self that day.
6. An officer checking prisoners in their cells found the man had hanged himself. Staff responded quickly and well to the emergency response but paramedics confirmed that he had died.

Findings

7. The man had a number of factors, which indicated he was at risk of suicide. We consider that there were missed opportunities at both Channings Wood and Exeter to coordinate and assess all the information about him, identify his risk and manage him under Prison Service suicide and self-harm prevention procedures. We cannot know whether ongoing support might have prevented his death.

8. While it did not affect the outcome for the man, we are concerned that a member of staff in the control room did not call an ambulance immediately, in response to the medical emergency.

Recommendations

- The Governor and Head of Healthcare at Channings Wood should ensure that all prisoners have a documented assessment of their risk of suicide and self-harm after events which could involve a change in status, including new charges and court appearances, including by video-link.
- The Governor and Head of Healthcare at Exeter should ensure that staff consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including information from all sources and that staff understand the circumstances when they should open an ACCT.
- The Governor of Exeter should ensure that control room staff call an ambulance as soon as a medical emergency code is called.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. On 8 January 2015, the investigator visited Exeter and obtained copies of relevant extracts from the man's prison and medical records. She watched CCTV of the emergency response and listened to the emergency radio messages from 20 December. She also interviewed one prisoner.
11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. In February, the clinical reviewer and investigator interviewed six members of staff together. The investigator spoke to two other members of staff by telephone.
12. We informed HM Coroner for Exeter and Greater Devon District of the investigation and have sent her a copy of this report.
13. One of the Ombudsman's family liaison officers contacted the man's wife and his sister to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked us to clarify whether staff at Exeter were aware of his suicide attempt at Channings Wood, whether the risk assessment at Exeter took into account all relevant information and, if they were aware of his risks, why he was not monitored more closely.
14. The man's wife and sister received a copy of the draft report. They made some comments that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

BACKGROUND INFORMATION

HMP Exeter

15. HMP Exeter is a local prison holding about 500 men. The prison primarily serves the courts of the South West. Dorset NHS University Foundation Trust provides health services.

Her Majesty's Inspectorate of Prisons

16. The most recent inspection of HMP Exeter was in July and August 2013. Inspectors reported a positive culture at the prison. They 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. A small group of staff was responsible for safer custody and was properly focused on risk factors. The safeguarding policy was clear and concise, but had not yet been fully implemented. Prisoners with substance misuse issues received excellent clinical care.

Independent Monitoring Board

17. 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 the most recent published annual report, for the year to December 2013, the IMB reported good relationships between staff and prisoners despite the overcrowding in the prison. The substance misuse service worked well with the primary care and mental health teams. A safer custody questionnaire had indicated that most prisoners said they had not experienced any antisocial behaviour in the prison.

Previous deaths at HMP Exeter

18. The man's was the fourth self-inflicted death at Exeter since November 2012. There have been two self-inflicted deaths since. In the reports into the two self-inflicted deaths immediately before his (in January and February 2014), we were concerned about how effective the assessment of the risk of suicide and self-harm was for new arrivals at the prison. During the investigation of the death in January 2014, the clinical review identified weaknesses in night welfare checks for prisoners on substance misuse programmes.

Assessment, Care in Custody and Teamwork - ACCT

19. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular 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. Staff should hold regular

multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Risk and triggers form

20. The Safer Custody team at Exeter have developed a risk and triggers form for staff in reception to use when assessing a prisoner's risk of suicide and self-harm. Staff began using the form in September 2014. The original form instructed staff to confirm they had considered a number of risk factors and to say why they had or had not started ACCT procedures.
21. The form was reviewed and changed after the man's death and again following a subsequent death. The current form instructs staff to check the escort record (PER), warrant, prison record (NOMIS including alerts), pre-convictions and suicide and self-harm warning forms and answer questions about previous self-harm, current thoughts of suicide or self-harm, the prisoner's status (remand or first time in custody) and nature of offence (especially if the victim is a family member). First night staff should record what factors they have considered and the reasons for their decisions. If they have any doubts about the prisoner's risk, they are instructed to open an ACCT. The nurse assessing initial health needs should indicate if the prisoner is undergoing detoxification or has mental health problems.

KEY EVENTS

22. The man had served many prison sentences. In 1996, he was found guilty of the rape and indecent assault of a girl under 13 years (a member of his extended family) and was put on the sex offender register for life.
23. On 26 August 2013, the man was remanded to HMP Exeter for burglary and motoring offences. At an initial health screen, he told a nurse that he was on a methadone maintenance programme (as a substitute for heroin), which a locum prison GP continued.
24. Because he was on the sex offender register, in prison the man was not allowed to contact any child and his mail and telephone calls were monitored. On 2 September, he asked an offender supervisor for permission to contact his 15 year old daughter. He said he lived with her and her mother, his wife. She told him he would have to apply for contact because of the restrictions in place. (He received permission, on 6 November, to have contact with his daughter.)
25. On 17 September, a prison GP specialising in substance misuse reduced the man's daily methadone dose by five millilitres. He attended a 'Recovery is Possible' group run by the substance misuse team. On 25 September, he told a substance misuse worker that his daughter had taken an overdose and he felt guilty because it was his fault.
26. On 10 October, a prison GP began the man on a four-week buprenorphine (subutex) detoxification programme in place of the methadone maintenance programme. On 29 October, he asked to remain on buprenorphine because he said it would help stop him taking heroin offered to him by other prisoners. On 8 November, a nurse told him the buprenorphine would not be continued.
27. On 11 November, the man was sentenced to two years and three months. Personal officer entries from his prison record describe him as a happy and hard working prisoner. He was given the job of wing painter on A Wing. On 23 November, he achieved the enhanced level of the Incentives and Earned Privileges (IEP) scheme.
28. On 25 November, the man told a recovery worker with the substance misuse team, that he was taking illicit buprenorphine to stop himself taking heroin. In January 2014, he said he no longer wanted to work with the substance misuse team.
29. On 14 February, the man moved to D Wing, a wing reserved for prisoners on the enhanced level of IEP. He successfully applied for a trusted job in the prison grounds and personal officer entries in his record described him as happy, reliable and hard working. He was in touch with his wife and children by telephone, letters and visits. He told his personal officer that he loved his contact with them because he was a family man.

30. During April, security intelligence, (gathered in part from routine monitoring of telephone calls), indicated that the man was involved in trafficking drugs on D Wing, which he received during visits from his family. The content of his telephone conversations led officers to suspect he had a mobile phone. On 2 May, he was transferred to HMP Channings Wood, because of increasing intelligence that he was involved in distributing drugs on his wing. At about the same time, his daughter alleged that he had sexually abused her for several years.
31. On 7 May, an officer submitted an intelligence report (IR) after routine monitoring of the man's prison telephone calls to his wife. According to the intelligence report, he was using a mobile phone to contact his daughter and threatening her about what he would do to her when he was released from prison. Officers searched his cell but did not find a phone.
32. On 31 May, Avon and Somerset police contacted Channings Wood to tell them about the allegations against the man. Prison staff monitored his telephone calls, which showed that he and his wife were in constant contact about their daughter. On 1 June, officers searched his cell again, but did not find a mobile phone.
33. On 7 June, officers found a mobile phone and SIM cards in his cell. The man was charged with a disciplinary offence and a Supervising Officer (SO) reviewed his IEP level. He became upset during the review and said he had used the mobile phone because he had been unable to get through to his wife on the prison telephone. He said he was deeply concerned about his daughter because she had been taken into care. The SO demoted him to the basic level of IEP because of the seriousness of being found with a mobile phone.
34. On 9 June, the man was found guilty at a prison disciplinary hearing of having the mobile phone. According to his security record, he ran out of the wing office after shouting that he had nothing left to live for. He went to his cell and swallowed 30 permi-tabs (potassium permanganate based foot medication). Soon afterwards, he was sick and complained of severe stomach pains. He told a nurse that he had swallowed the tablets because his daughter was in care and his wife had told him she was ending their relationship. He was taken to hospital by ambulance and found to have extensive damage to his oesophagus and stomach.
35. The Head of Safer Custody began Prison Service suicide and self-harm prevention procedures, known as ACCT. He wrote on the triggers page, "Partner and children not wanting contact". An officer noted that as the man was in hospital with two officers escorting him, he was effectively on constant supervision. A SO telephoned the man's wife to tell her he had been taken to hospital. She said she did not want him to contact her and that was why she had not answered his telephone calls.
36. An officer completed an ACCT assessment on 11 June in the hospital. The man said he was depressed because his wife was not taking his calls, his

daughter had been taken into care and his wife had turned his sons against him. He said the overdose was an attempt to kill himself and he still planned to end his life. He said he had lost everything and had no reason to live. He said he had never self-harmed or attempted suicide before and had no family history of suicide or self-harm.

37. After the assessment, a SO and an officer held an ACCT case review at the hospital with the man. The SO assessed his risk as raised, as he was unpredictable but noted that he was constantly in the presence of the two escorting officers. He entered two actions on the caremap – for the man to write to his wife, as she was not taking his calls and for him to have a mental health review.
38. On 12 June, the hospital discharged the man and he was taken back to Channings Wood. The SO held an ACCT case review the same day with another SO and a mental health nurse. The man said he had not intended to take his foot medication and had thought it was paracetamol. He said he had only three months left to serve in prison and had no reason to want to kill himself. He was dismissive of the physical damage the overdose had caused but agreed to take the medication the hospital had prescribed. He said his issues were about contact with his family and asked whether his wife would allow him to write to her. The review assessed his risk of suicide and self-harm as raised. The SO marked on the caremap that the mental health review had been completed, but there is no record of any mental health assessment, other than the mental health nurse's attendance at the ACCT review.
39. On 16 June, the man's wife told an officer that she still did not want him to telephone her, but she would accept a letter from him. On 17 June, he signed a form to say he understood that he should have only written contact with his family. The officer described him as happy with the decision and a little relieved.
40. On 19 June, a SO held another ACCT case review with a custodial manager and a mental health nurse. The man said he had written to his wife and was hoping for a reply, but the lack of contact with her was still an issue for him. He said he had intended to kill himself on 9 June, but now had no plans or thoughts of suicide. He reported some low mood, but the nurse noted that there was no evidence that he required secondary mental health services. The staff decided that he was no longer at risk of suicide and self-harm and closed the ACCT
41. On 24 June, the man's wife told an officer that she did not want any further contact with him at all. He signed a form agreeing not to contact his wife. On 26 June, a SO held an ACCT post closure review and spoke to him about his wife's change of mind. He told the SO that his problems were not resolved but he was able to talk about them and had started an education course, which was helping take his mind off things. He told the SO he had no current thoughts of suicide and was mentally stable. On 28 June, he regained the standard level of IEP.

42. On 9 July, the police told the prison that the man had contacted his wife indirectly by using other prisoners to send letters to her. Two officers warned him that any further attempt to contact his wife would result in police action against him.
43. On 1 September, the man asked an officer to seal a legal letter for him. The officer said she could feel photographs in the envelope, but he would not show her the contents because he said it was legal correspondence. She refused to seal it. She noted in his prison record that she suspected he was using legal mail as a means of contacting his wife. On 9 September, the prison received information from the police that he was texting his wife from a mobile phone.
44. On 22 September, the man was charged with 14 sexual offences against his daughter. On 8 October, he was formally remanded into custody on these charges and, on 30 October, he was sent back to HMP Exeter as a remand prisoner. (He had been due for automatic conditional release from his sentence for burglary on 10 October.) There is no record that officers or healthcare staff at Channings Wood or Exeter spoke to him about the new charges, or reviewed his risk of suicide or self-harm, after he was charged with these further offences.
45. At an initial health assessment when he arrived at Exeter, the man told a nurse that he had been taking illicit buprenorphine at Channings Wood. A urine test confirmed he had buprenorphine in his system. She referred him to a specialist substance misuse doctor and a GP saw him shortly afterwards. She diagnosed buprenorphine dependence syndrome but noted he seemed well and did not show signs of withdrawal. She referred him to the substance misuse team for review and possible detoxification.
46. An officer spoke to the man as part of the prison's reception and first night procedures. She noted in his prison record that he did not have thoughts of suicide or self-harm and was polite and cooperative and had no immediate concerns. She completed a form listing risks and triggers for suicide and self-harm and decided that it was not necessary to open an ACCT.
47. On 31 October, a substance misuse nurse assessed the man, who told her he had been using about 16mg of illicitly obtained buprenorphine a day at Channings Wood and had taken some on his first night in Exeter. His urine tested positive for buprenorphine. He said he had managed to stop taking illicit buprenorphine for five months after his last detoxification, but had started taking it again after his wife left him and his daughter was taken into care. He told her that he had taken an overdose of potassium permanganate at Channings Wood. He said he did not currently feel suicidal but had been taking the buprenorphine to block out his feelings. She booked him an appointment with the substance misuse team's nurse prescriber.
48. On 3 November, the man signed a new form agreeing not to contact anyone under the age of 18, which was required because of the new charges. An

offender supervisor told the investigator that he was dismissive of the charges against him.

49. Also on 3 November, a recovery worker in the prison's substance misuse team assessed the man. He said he did not feel suicidal and knew how to ask for mental health support if he needed it. They discussed his illicit buprenorphine use and he asked for a buprenorphine detoxification because he said that sugar-free methadone made him sick.
50. The recovery worker said he did not know anything particular about the man's personal circumstances. From what the man said at first, he was under the impression that his wife had died. He said this seemed to be weighing on him but he did not talk to him about it or raise any other issues or concerns. One day, he saw him on the wing and he was looking a bit down. He asked him what the matter was and he told him he and his wife were separating after a long time. He said he was coping with it. The recovery worker said it was not a long conversation, and it was not unusual for prisoners' long-term relationships to end when they were in prison.
51. On 4 November, the man completed his induction and moved to a cell on C Wing. A nurse prescriber saw him that day for the appointment booked by a nurse. He told him that his wife had left him at the end of May and he had taken an overdose of potassium permanganate. A nurse told the investigator that his assessment included questions about mental health. He said he would have asked follow up questions of him to try to understand why he took the overdose, but he had not noted this in his record. He could not remember the conversation but said he was confident that if he had thought he was at risk of suicide or self-harm he would have documented it and opened an ACCT.
52. The nurse said the man's presentation was not indicative of someone in withdrawal. He told the nurse that he had taken illicit buprenorphine the night before and a urine test confirmed this. He asked for a buprenorphine detoxification programme but the nurse wrote on his medical record that he should be considered for lofexidine detoxification.
53. The man was initially resistant to taking lofexidine but began a ten-day detoxification programme on 17 November. On 19 November, a substance misuse worker assessed him and he told her that the lofexidine was supporting his withdrawal symptoms. He completed his detoxification programme on 26 November. He did not have a follow-up assessment after this, as he should have done.
54. The substance misuse worker told the investigator that the lofexidine seemed to stabilise the man's mood. At about the same time he got a job as a wing painter. She said she saw him at the beginning of December and he seemed happy at the time. She did not think he was at risk of suicide and self-harm. She was aware he had been in a relationship before he went to Channings Wood and that this had finished by the time he returned to Exeter, but she thought his main concern was his opiate addiction and detoxification.

55. On 10 December, a Detective Constable (DC) from Avon and Somerset police told an officer, during a telephone call on 5 December, that the man had told his sister that he had no reason to go on. She had reported this to his wife and she in turn had told the police. The officer completed a Safeguard Report and asked a SO, the wing manager, to speak to him.
56. The man told the SO that his mother was very ill and he had told his sister that, if she died, he would have nothing left. He told the SO he was coping, had no wish to die and to tell the police to "fuck off". The SO told him that he could telephone his mother in the evenings. The SO told the investigator that he knew the man from several previous sentences in Exeter. However, he did not know anything about his current personal circumstances, the charges against him or his suicide attempt at Channings Wood and he did not tell him. He said the man was trusted prisoner and did not appear vulnerable in prison. When he spoke to him on 10 December, he appeared to be his normal self. He was angry with the police for misinterpreting what he said to his sister and making a fuss over nothing.
57. On 18 December, a DC told the SO that the man had written to his wife's mother and the police were concerned that he was trying to intimidate witnesses. The DC emailed him a new list of people the man should not be allowed to contact - his wife, daughter, two sons, mother-in-law and sister-in-law.
58. The prisoner (who has subsequently died of natural causes) who was in the cell next to the man at Exeter. He told the investigator that he knew him very well and they spoke every day. He said the man's mother was very ill and her illness and the charges relating to his daughter were both obviously playing on his mind. He said, apart from that, the man appeared to be his normal cheerful self. He said the man could handle himself in prison. He was a talented painter and enjoyed painting the wing or doing artwork in his cell.
59. On 19 December, the SO asked the man to sign a form agreeing not to contact his wife, two sons, daughter, mother-in-law and sister-in-law. He refused to sign and said that he had already signed the same paperwork. The SO told the investigator that the man was aggressive and said he would be taking legal advice. He did not appear vulnerable and the SO was not concerned that he was at risk of suicide or self-harm. The prisoner said the man had seemed his normal self that day. He had chatted to him and they shared a laugh about something.
60. An officer said he saw the man at about 5.30pm, after the evening meal. The man told him that he did not need to come out of his cell that evening because he had already called his mother. The officer said he saw him again at the 6.00pm roll check (a count of all prisoners when they are locked in their cells to ensure they are all present) and thought he appeared fine.

61. An officer completed an evening roll check at 8.00pm. He said the man was sitting at the table in his cell watching TV. He recalled that he had said, "All right" and he had replied, "All right".
62. Early the next morning, the officer looked through the man's observation panel during the morning roll count and saw that he had hanged himself from the window bars by a blue fabric band (later identified as coming from the gym). He shouted to a custodial manager, who was the night orderly officer in charge of the prison at the time, who was also on the landing. For security reasons officers do not carry cell keys at night on an open key ring, but have a key in a sealed pouch for use in an emergency. The officer broke the seal on his pouch and the manager radioed a code blue medical emergency (used in circumstances such as when someone is unconscious or not breathing). The officer opened the door and they went in. CCTV indicates this was at 5.24am. The timing on the recording of the emergency radio message is about one minute 20 seconds ahead of the time shown on CCTV. The radio message times the manager's code blue call at 5.26am. The control room officer asked if an ambulance was required and received confirmation at 5.27am.
63. The officer supported the man's weight while the manager cut through the ligature. They laid him on his back. The manager checked for signs of life and started cardiopulmonary resuscitation.
64. CCTV shows that a nurse and a healthcare assistant arrived with emergency equipment within a minute. They gave the man oxygen and the nurse attached a defibrillator. (A defibrillator is a life-saving device that gives the heart an electric shock in some cases of cardiac arrest.) He showed no signs of life and was blue. The nurses continued cardiopulmonary resuscitation at a rate of two breaths to 30 compressions. The defibrillator checked him at regular intervals but found no shockable heart rhythm.
65. The recorded radio message showed the ambulance service asked for more information at 5.30am. The control room officer replied that a man in his forties was not breathing. The radio message recorded that the ambulance arrived in the vehicle lock of the main gate at 5.32am and paramedics arrived at the cell two minutes later. They took over emergency treatment and gave the man adrenaline but he remained unresponsive. At 6.00am, paramedics confirmed that he had died.
66. Staff found a letter on the man's table. He apologised to whoever found him but said he could not live without his family. He left telephone numbers for his solicitor, mother and sister.

Contact with the man's family

67. At 7.15am, the Governor of Exeter and the chaplain drove to the address the man had given for his wife, but found she no longer lived there. They contacted the police who told them that his family had moved to a police safe house. The police therefore broke the news to his wife. Officers found letters from his mother in his cell with her address and the duty governor contacted

Cleveland police, asked them to inform her he had died, and gave them his contact details to pass on. The next day, his sister phoned the prison and spoke to him. On 24 December, his sons visited the prison. The prison contributed to the costs of the funeral in line with national guidance.

Support for prisoners and staff

68. At 8.20am, the duty governor debriefed the staff involved in the emergency response and offered them support. All prisoners being monitored under ACCT procedures were reviewed that day, in case they had been affected by the news of the man's death. The prison issued notices to staff and prisoners directing them to support services if they needed help. A prisoner told the investigator that staff had supported him well.

Post-mortem report

69. The post-mortem examination concluded that the man died as a result of compression of the neck due to hanging. No drugs were detected by toxicology tests.

FINDINGS

Assessing the risk of suicide and self-harm

70. Prison Service Instruction (PSI) 64/2011, about safer custody lists a number of risk factors and potential triggers for suicide and self-harm. Exeter's risk and triggers form lists some of these and reinforces PSI 74/2011 (in force at the time of the man's death and since replaced with PSI 7/2015), about early days in custody. The instruction included a mandatory requirement for reception staff to examine a prisoner's Person Escort Record (PER) and any other available documents, and interview the prisoner to assess the risk of suicide and self-harm.
71. The man had several factors that increased his risk - previous attempted suicide, opiate dependency, relationship problems, sexual offences against a family member and upcoming court appearances. He had signed a form agreeing not to contact his wife. Restrictions on contact with family can also be a trigger for suicide or self-harm. We consider that there were missed opportunities at Channings Wood and Exeter to capture this information.
72. Prison Service Order 3050 (PSO) about Continuity of Healthcare indicates that events such as attending court, sentencing at court and being questioned by the police are factors that might increase an individual's risk of suicide and self-harm and such prisoners should be screened afterwards. PSI 74/2011 states that assessments must also be made of prisoners who by-pass some reception processes and those whose status and demeanour might change after a court appearance via video link.
73. On 22 September, the man was charged with 14 serious sexual offences against his daughter but was returned to Channings Wood as he was already serving a prison sentence. On 8 October, he appeared at Magistrates Court by video link from Channings Wood and was remanded into custody for these alleged offences. Despite the nature of these charges, his court appearance and his change in status to a remand prisoner on 10 October, his risk was not reviewed at Channings Wood, as it should have been.
74. The prison has been unable to supply us with a copy of the man's escort record (PER) for his transfer to Exeter on 30 October. Although an officer signed a risk and triggers form when he arrived at Exeter, she did not remember what information she had taken into account and did not know about his new charges. She did not identify him as at risk of suicide and self-harm. However, his prison record contained alerts for suicide and self-harm, noted he was charged with sexual offences against a child and that he was not allowed to contact his wife.
75. Although the man's risk should have been identified at Channings Wood and at Exeter when he arrived on 30 October, further opportunities to identify his risk were missed. On 31 October, he told a nurse that he had attempted suicide after his wife left him and his daughter was taken into care. He said that he had been taking illicit buprenorphine to block out his emotions. On 4

November, he told a nurse about his suicide attempt but the nurse did not record any further exploration of this in medical record. Most of his risk factors, including his previous suicide attempt, the breakdown in his family relationships and the fact that he was opiate dependent were all recorded in his medical record.

76. The man did not have a full assessment after he completed his lofexidine detoxification programme, as he should have done. This was a further missed opportunity potentially to identify his risk of suicide and self-harm.
77. On 10 December, a SO completed a safeguarding interview with the man after the police said he had told his sister that he could not go on. He convinced the SO that his remark had been misinterpreted and he had no wish to die. The SO believed he knew him well because he had served several sentences in Exeter. He considered that the man was someone who coped well in prison but he knew little about his personal circumstances or the charges he was facing. The SO did not read his record before he went to speak to him, so his assessment relied entirely on what he told him and he was not aware of his new significant risk factors.
78. PSI 64/2011, specifically states as a mandatory action that, "Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form". We consider that once the prison received information from the police, via the man's family, suggesting that he might be at risk of suicide and self-harm, it would have been prudent to have opened an ACCT in line with the PSI. This would have allowed an assessment of all his risk factors in the round, rather than relying on what he told the SO.
79. Staff judgement is a crucial part of risk assessment. However, while a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in judging risk. Staff should make a considered and objective evaluation of all risk factors when assessing the risk of suicide and self-harm. The information about the man's risk factors was available in his records but nobody who assessed him drew it all together.
80. Exeter reviewed and re-wrote their risks and triggers form in the light of the man's death and then again following a subsequent death. The current form contains an expanded list of risk factors and instructs staff to begin suicide and self-harm prevention procedures if there is any doubt about their risk. There is now a section to be completed by healthcare staff. Had this form been in operation on 30 October, he would have had at least four and possibly five of the risk factors listed.
81. It appears that the man made a planned and determined effort to kill himself. He left legal papers for his solicitor and contact details for his next of kin. He appears to have obtained some material from the prison gym to use as a ligature. Ultimately, it is very difficult to prevent someone who makes a

determined decision to kill himself from carrying out that plan, but we are concerned that prison staff missed a number of opportunities to identify his risk and put in place procedures to protect him. We recommend:

The Governor and Head of Healthcare at Channings Wood should ensure that all prisoners have a documented assessment of their risk of suicide and self-harm after events which could involve a change in status, including new charges and court appearances, including by video-link.

The Governor and Head of Healthcare at Exeter should ensure that staff consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including information from all sources and that staff understand the circumstances when they should open an ACCT.

Emergency response

82. Exeter's medical emergency response code protocol reflects the requirements of Prison Service Instruction 03/2013 about medical emergency response codes. It states that the purpose of the emergency code system is to ensure timely, appropriate and effective response to medical emergencies. It advises staff of the emergency codes (code blue and code red) and the mandatory responses required. The protocol also says that the control room should call an ambulance automatically on receiving a code blue emergency call and await updates from staff at the scene. While there was only a delay of a minute or so, on 20 December, the control room officer asked for confirmation that an ambulance was required before calling one. PSI 03/2013 directs that when a medical emergency code is called the control room must call an ambulance immediately and should not wait for a decision from healthcare staff or a duty manager. This did not affect the outcome for the man, but in other emergencies, even a slight delay could be crucial. We recommend:

The Governor of Exeter should ensure that control room staff call an ambulance as soon as a medical emergency code is called.

