Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Charles Broom a prisoner at HMP Exeter on 21 June 2016

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 Charles Broom was found hanged in his cell on 21 June 2016 at HMP Exeter. He was 66 years old. I offer my condolences to Mr Broom's family and friends.

Mr Broom was charged with the alleged murder of his partner, but it is of considerable concern that his mental health was not assessed in the seven months he was at Exeter. I have previously made clear that I consider that the small but particularly at risk group of prisoners charged with domestic homicide should always be referred for a mental health assessment. This was previously a mandatory requirement and it is difficult to understand the justification for lessening this safeguard.

While I recognise that there was little to indicate that Mr Broom was at an increased risk of suicide in the days immediately before his death, the investigation found weaknesses in the suicide prevention procedures and the personal officer scheme at Exeter.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2017**

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Summary

Events

1. On 4 December 2015, Mr Charles Broom was remanded to HMP Exeter for the alleged murder of his partner. It was his first time in prison. He had a recent history of depression, but said he had no thoughts of self-harm or suicide. A reception officer started Prison Service suicide and self-harm prevention procedures (known as ACCT) and staff monitored him for five days. Despite the nature of his alleged offence and victim, no one referred Mr Broom for a mental health assessment.

2. On 11 December, Mr Broom was assessed by the prison GP, who prescribed him antidepressants to treat his depression. Mr Broom received no further mental health support and his mental health was never assessed.

3. Records show limited contact with officers during Mr Broom's seven months in prison.

4. On 31 May, Mr Broom pleaded guilty to manslaughter on grounds of diminished responsibility, but denied murder. He was remanded to await trial for murder, but his visiting rights were reduced after this court appearance, as if he had been convicted.

5. On 17 June, Mr Broom told a GP that he had trouble sleeping and remembering things. The prison GP increased his antidepressants.

6. On 21 June at 5.35am, officers found Mr Broom hanging in his cell. An ambulance was called immediately and prison staff started resuscitation, despite signs of rigor mortis. Ambulance staff continued emergency treatment, but Mr Broom was pronounced dead at approximately 6.00am.

Findings

7. As Mr Broom had been charged with domestic homicide, we consider that he should have been referred for a mental health assessment when he arrived in prison. We are concerned that Mr Broom's mental health was never assessed, despite the nature of his alleged offence and victim and his ongoing treatment for depression.

8. We do not consider that prison staff could have known that Mr Broom was at imminent risk of suicide at the time he died. However, we are not satisfied that when Mr Broom was monitored under ACCT procedures, the process operated effectively to protect him. We also found that the personal officer scheme at Exeter was ineffective and did not offer meaningful support.

9. Despite signs of rigor mortis, staff attempted to resuscitate Mr Broom before ambulance staff pronounced him dead.

Recommendations

- The Chief Executive of the National Offender Management Service should ensure that prisoners charged with domestic homicide are referred for a mental health assessment.

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

    - holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care;
    - ensuring ACCTs are not closed until all caremap actions have been completed; and
    - identifying and recording events associated with increased vulnerability, including court appearances.

- The Governor should ensure that the personal officer policy is effective in providing meaningful support to prisoners, particularly in relation to the identification, discussion and recording of significant events, and that contacts take place at a frequency in line with the policy.

- The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

The Investigation Process

10. 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.

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

12. The investigator visited Exeter on 24 June 2016. She obtained copies of relevant extracts from Mr Broom's prison and medical records.

13. The investigator interviewed three members of staff and one prisoner at Exeter in August. The clinical reviewer conducted further interviews with two members of healthcare staff.

14. We informed HM Coroner for Exeter of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Broom's son to explain the investigation. Mr Broom's family instructed a solicitor who raised a number of questions on their behalf. In summary, these included:-

    - the support given to Mr Broom in terms of his mental health, including medication, assessments and referrals;
    - Mr Broom's movements before his death and whether he was monitored by prison staff; and
    - if there were any similarities between Mr Broom's death and other deaths at HMP Exeter, and how the prison deals with suicide and self harm.

16. Mr Broom's family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Exeter

17. HMP Exeter is a local prison holding a maximum of 560 men either on remand, convicted or sentenced. The prison serves the courts of the South West. Dorset NHS University Foundation Trust provides health services, including mental health services. Healthcare staff are on duty 24 hours a day. The prison has a palliative care suite for terminally ill prisoners.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Exeter took place in August 2016, but the report is yet to be published. The previous inspection in August 2013 found that staff were committed to meeting prisoners' needs. Inspectors said that Exeter was a safe prison and that arrangements to receive and induct new prisoners were good. Most prisoners felt safe on their first night in Exeter and staff paid good attention to safety and vulnerability issues. The initial identification of the risk of suicide and self-harm was very good. Inspectors found that staff were properly focused on risk factors for suicide and self-harm. They were knowledgeable about those at risk, and were properly focused on their risk factors. Despite this, inspectors were concerned that there were shortfalls in ACCT case management procedures, including poor care planning and a lack of multidisciplinary reviews. Overall, the inspectors thought that Exeter was a competent and caring prison, doing their best in difficult circumstances.

Independent Monitoring Board

19. 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 December 2015, the IMB noted that there had been five expected deaths in the prison's 'end of life' suite in 2015 as well as other deaths from natural causes. However, it was concerned about the increase in self-inflicted deaths. It recognised that there were many factors contributing to this but felt, in particular, that low staff numbers prevented staff from engaging as they would like with prisoners in difficulty. The IMB concluded that Exeter is a well-run prison facing significant problems.

Previous deaths at HMP Exeter

20. Since 2014, we have investigated 23 deaths at Exeter. Of these, seven were apparently self-inflicted. There were no significant similarities with the circumstances of the other deaths. Since Mr Broom's death, there have been two further apparently self-inflicted deaths at Exeter.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of 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 be irregular to prevent the

prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map 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 of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22. On 4 December 2015, Mr Charles Broom was remanded in custody charged with the murder of his partner. This was his first time in prison. On his "Exceptional Risk" form (police risk assessment), police noted that he might have suicidal tendencies. The prison identified Mr Broom was at risk of suicide or self-harm, because it was his first time in prison and due to the seriousness of the offence. A reception officer started suicide and self-harm prevention procedures, known as ACCT. The officer noted that Mr Broom had depression and was to be assessed. No one recorded that the victim of Mr Broom's alleged offence was his partner and no one referred Mr Broom for a mental health assessment, despite the nature of his alleged offence and victim.

23. On 5 December, Supervising Officer (SO) A completed an ACCT assessment interview with Mr Broom. At this assessment, Mr Broom said he felt confused and bewildered, he felt that he had destroyed his children's lives and he could not see much hope. He said he had no thoughts of suicide or self-harm but he did not have any particular interests other than watching television. SO B chaired the first ACCT case review later that day. The review was also attended by SO A and Officer A, but no one from the healthcare team was there. Mr Broom said that he was having difficulty sleeping and was feeling depressed, but had good support from his cellmate. Mr Broom was assessed as at low risk of suicide or self-harm. SO B completed a caremap for Mr Broom, which included actions to start education or employment and to see the prison GP in relation to his depression and sleep disturbance. The next case review was scheduled for 10 December.

24. On 6 December, Officer A introduced himself to Mr Broom as his personal officer. He noted that Mr Broom was being supported by a good cellmate and had no problems.

25. On 8 December, Officer B recorded that he spoke to Mr Broom, because other prisoners had said he was talking about hanging himself. Mr Broom reassured the officer that he had no thoughts of suicide or self-harm.

26. On 9 December, Mr Broom's cellmate moved to a different wing and he was left in a cell on his own, which he said he did not mind.

27. At the next ACCT case review on 10 December, Mr Broom was assessed as being no longer at risk of suicide or self-harm. The review was chaired by SO C and attended by healthcare staff, Nurse A. The only action on the caremap was for Mr Broom to see a GP and his appointment was arranged for the following day. The ACCT was closed and a post-closure review scheduled for 16 December.

28. Also, on 10 December, Mr Broom met his offender supervisor. This was the first time that he spoke to anyone about his offence and victim. The offender supervisor wrote that Mr Broom was polite but shell-shocked and said that he did not need any additional support.

29. On 11 December, Dr A, prescribed Mr Broom citalopram (an antidepressant). The doctor described Mr Broom as bewildered and recorded that he could not express his emotions. During his consultation, Mr Broom spoke about the loss of his wife two years previously and the positive family relationships he had with his two sons. He said that he had started a new relationship with a family friend and was now charged with her murder. He appeared confused about the offence but said that he had no thoughts of suicide or self-harm. Mr Broom said that his legal team had asked for a psychiatric report.

30. The ACCT post-closure review took place on 16 December. SO C reported that Mr Broom was getting regular visits and support from his family and was also being supported by prison staff. No further review was scheduled.

31. Mr Broom's offender supervisor met him on 15 January 2016. They discussed his application to move to the enhanced prisoners' wing. Mr Broom told the offender supervisor that he had started taking antidepressants and was still trying to come to terms with his offence. He said he had settled into the regime and was grateful for the support he was receiving from his family.

32. Mr Broom moved to the enhanced prisoners' wing on 17 January. Officer C introduced himself to Mr Broom as his new personal officer, but recorded no other entries in his prison record.

33. On 13 February, Officer D introduced himself to Mr Broom as his new personal officer and recorded that he was settling in well and had no concerns about him. He saw him again two weeks later and noted that he was doing well on the enhanced prisoners' wing.

34. On 11 April, Officer E sent an email to the mental health team asking if Mr Broom had been referred for a psychiatric assessment as he had been expecting to have one. The mental health team responded to say that they had no record of a referral for Mr Broom.

35. On 26 May, Officer E recorded that he had spoken to Mr Broom, who said that all was well.

36. On 31 May, Mr Broom pleaded guilty to manslaughter on grounds of diminished responsibility. He denied murder. He was remanded back to prison and his trial for murder was due to start on 26 July.

37. When Mr Broom's son next rang to arrange to visit his father, he was told by prison staff that Mr Broom's visiting rights had reduced from two visits per week to three visits per month because of his guilty plea. (In fact, Mr Broom's visiting rights should not have changed, as he had not been convicted of an offence.) On 9 June, Mr Broom's son explained that he could not visit him as often, and he became quite anxious, although there is no record that he spoke to prison staff about it.

38. Around 14 June, a prisoner on the enhanced prisoners' wing, told Officer D that he was worried about Mr Broom. He said that Mr Broom was generally a quiet person, but he had noticed that he had become even more withdrawn. The prisoner told the investigator that he did not think that Mr Broom was at risk of suicide or self-harm.

39. On 17 June, Dr B assessed Mr Broom. The doctor recorded in his medical notes that he was "a little debilitated by depression" and that Mr Broom was worried he might have dementia because he was struggling to hold his thoughts long enough to have a conversation. The doctor conducted a memory test on Mr Broom, which he passed. He also increased Mr Broom's dose of antidepressants from 30mg to 40mg, the maximum dose. The doctor told the clinical reviewer that he asked Mr Broom if he had any thoughts of suicide or self-harm and Mr Broom said he did not. However, he did not record this exchange.

40. On 18 June, Officer D spoke to Mr Broom about the prisoner's concerns but he did not record his conversation. Officer D said that Mr Broom assured him that everything was fine and that he "would not do anything silly" as he was "not that way inclined". The officer offered him some extra cleaning work on another landing to keep him busy and Mr Broom accepted the work. He told the investigator that Mr Broom did not speak to him about his concerns about dementia or his restricted visiting rights.

41. On 19 June, Father's Day, Mr Broom's family visited him. The prisoner said that Mr Broom was in very good spirits after this visit and spoke a lot about his family. The prisoner said that he spent most of the evening with Mr Broom and he had no concerns about him.

42. On 20 June, the prisoner said that he helped Mr Broom with his extra cleaning work and he thought it was a good day. Mr Broom said that he was tired and he told him that he wanted to go back to his cell to watch football on television. The prisoner said that Mr Broom seemed happy.

43. CCTV footage shows Mr Broom left his cell at 11.00pm that night to go to the toilet. He left the toilet and returned to his cell at 11.22pm. There were no further movements to or from his cell during the night. Night officers did not check Mr Broom during the night as he had not been assessed as at risk of suicide or self-harm, or otherwise in need of monitoring.

44. At approximately 5.30am on 21 June, while carrying out the morning roll check, Officer F looked into Mr Broom's cell but something was blocking the observation panel. Mr Broom had barricaded the door with his mattress so it would not open. Officer F and Officer G, who was assisting with the roll check, shouted to Mr Broom and banged the door but there was no response. A prison manager went to get the anti-barricade kit and, at the same time, he radioed for healthcare staff to go to the cell. The prisoner joined the prison staff outside Mr Broom's cell door and tried to get a response from him.

45. The prison manager returned to the cell at approximately 5.40am with the anti-barricade kit. Nurse B and a healthcare assistant, arrived at the same time with oxygen and resuscitation equipment. The prison manager opened the door and the entrance was blocked with the mattress. When he pulled the mattress away, staff found Mr Broom hanging by a sheet attached to the air vent above the cell door. Officer F cut the ligature and Officer G lowered Mr Broom to the floor. The prison manager immediately radioed a code blue (the emergency code which indicates that a prisoner is unconscious, not breathing, or is having difficulty breathing). The incident log shows Mr F's call was received by the control room at 5.51am and the ambulance was called immediately.

46. Officer G started to resuscitate Mr Broom, even though there were signs that rigor mortis had set in, so Mr Broom had been dead for some time. Nurse B tried to insert an airway into Mr Broom's mouth, but she was unable to do this. The paramedics arrived at 5.55am and Mr Broom was pronounced dead at approximately 6.00am. Paramedics recorded that Mr Broom had died about four hours earlier, at around 2.00am.

Contact with Mr Broom's family

47. Mr Broom's son was listed as his next of kin. A deputy governor and the prison chaplain visited Mr Broom's son at his house on 21 June at approximately 8.30am to inform him of his father's death. The prison contributed to the cost of Mr Broom's funeral, in line with Prison Service instructions.

Support for prisoners and staff

48. After Mr Broom's death, the Head of Safer Custody, debriefed staff involved in the emergency response to offer support and ensure they had the opportunity to discuss any issues arising. The staff care team also offered support.

49. The Governor posted a notice for prisoners on the enhanced prisoners' wing informing them of Mr Broom's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Broom's death.

Post-mortem report

50. The Coroner found Mr Broom's preliminary cause of death was ligature suspension, although the post-mortem report was not available at the time of issuing the initial report. The toxicological report showed no evidence of illegal or unprescribed drugs in Mr Broom's blood when he died.

Findings

Mental health assessment and treatment

51. Mr Broom was charged with the murder of his partner. He had no offending history and it was his first time in prison at 66 years old. He had depression following his wife's death two years previously. In the circumstances, we are surprised that Mr Broom was not referred for an urgent mental health assessment when he arrived at Exeter, or throughout the seven months he spent at the prison. In the past, reception staff were required to refer prisoners charged with domestic homicide for an urgent mental health assessment, but this is no longer mandatory. We have previously expressed concern about this reduction in a standard protective intervention for a small but particularly high risk group of prisoners. We continue to consider that this is an appropriate and necessary safeguard for prisoners charged with killing a family member. We therefore repeat the following national recommendation:

    The Chief Executive of the National Offender Management Service should ensure that prisoners charged with domestic homicide are referred for a mental health assessment.

Management of risk of suicide or self-harm

52. When Mr Broom arrived at Exeter, he had been charged with the murder of his partner, it was his first time in prison, his wife had died two years previously, which had caused him to become depressed. All of these factors increased his risk of suicide. Prison staff assessed him as at risk of suicide and self-harm and appropriately monitored him under ACCT procedures. However, we have some concerns about how effectively the ACCT operated, particularly as it was only in place for five days.

53. Prison Service Instruction (PSI) 64/2011, which covers safer custody, says that ACCT caremaps should reflect the prisoner's needs, level of risk and the triggers for distress. There should be detailed time-bound actions aimed at reducing the risk posed by the prisoner and cover the issues identified in the ACCT assessment interview. They should say who is responsible for completing the action within a specified timeframe. Caremaps should be reviewed and updated at each case review with new actions added, if necessary. ACCT plans should not be closed until caremap actions are completed.

54. Mr Broom's caremap had an identified action for him to see a GP to assess his risk, but staff closed the ACCT before the appointment had taken place. Mr Broom hanged himself just before he was due to appear in court, charged with his first offence, his partner's murder, but there is no record that his trial was identified or recorded as a trigger. There is no record that anyone spoke to him about the nature of his alleged offence or victim as part of ACCT procedures. We consider that this was a missed opportunity for officers to identify Mr Broom's risk factors or triggers, his bereavement, his alleged offence and his mental health, and effectively address these risks. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care;**
- **ensuring ACCTs are not closed until all caremap actions have been completed; and**
- **identifying and recording events associated with increased vulnerability, including court appearances.**

Contact with staff

55. Mr Broom's personal officer changed three times within the space of two months and gaps between many of the recorded contacts were far too long. According to Exeter's personal officer policy, personal officers should speak to their allocated prisoners at least fortnightly and discussions, particularly in relation to significant issues, should be accurately recorded.

56. Mr Broom had attended court and pleaded guilty to manslaughter but a date was set for a murder trial. This was a significant event that was likely to have had an impact on Mr Broom's emotional wellbeing, especially as he erroneously understood that his visiting rights had changed. His personal officer should have spoken to Mr Broom at the time of his court appearance, which might have given him the opportunity to raise his concerns about the visiting rights.

57. Mr Broom had only five recorded personal officer contacts between 6 December 2015 and 26 May 2016. We found that personal officer support was insufficient, inconsistent and incompatible with the prison's own policy and we make the following recommendation:

The Governor should ensure that the personal officer policy is effective in providing meaningful support to prisoners, particularly in relation to the identification, discussion and recording of significant events, and that contacts take place at a frequency in line with the policy.

Resuscitation

58. When staff found Mr Broom hanging in his cell, it was apparent that he had been dead for some time, as rigor mortis was present. Despite this, staff attempted to resuscitate him before ambulance staff pronounced him dead. We consider that it was not necessary to attempt to resuscitate Mr Broom.

59. European Resuscitation Council Guidelines 2010 say that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" The guidelines give examples of futility as including the presence of rigor mortis. More recently, 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. Attempting resuscitation when

someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

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