

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Oliver Pascoe, a prisoner at HMP Dartmoor on 8 March 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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*



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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 Oliver Pascoe was found hanged in his cell at HMP Dartmoor on 8 March 2015. Mr Pascoe was 22 years old. I offer my condolences to Mr Pascoe's family and friends.

In 2014, during a previous sentence, Mr Pascoe's cellmate committed suicide by hanging himself in the cell they shared. This traumatised Mr Pascoe and he was prescribed antidepressants and referred to the mental health team. Exeter prison did not pass on this information when he transferred prisons during this sentence, nor was it picked up in prison records by staff at Dartmoor. Dartmoor also failed to consider a number of risks associated with Mr Pascoe. I am concerned that staff did not follow the correct emergency response procedures, and it took too long to call an ambulance, although I accept that it would not have made a difference in this case.

After Mr Pascoe died, a troubling picture of drug dealing and bullying emerged at Dartmoor which appears to have involved Mr Pascoe and even his family. This is the subject of an ongoing police investigation, but it is hard not to conclude that staff appear to have been woefully unaware of these challenges to safety and security at the prison. As we found no intelligence or information about Mr Pascoe before he died to suggest staff knew he was involved with drugs or being bullied, and nobody alerted the prison to these problems, it is difficult to conclude that Mr Pascoe's death was either foreseeable or preventable. However, robust action is evidently needed to ensure safety at the establishment.

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**

**November 2015**

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# Summary

## Events

1. Mr Pascoe found his cellmate hanging on 1 January 2014 on a previous sentence at HMP Exeter. This event traumatised Mr Pascoe. He was prescribed antidepressants and received mental health support.
2. On 19 December 2014, Mr Pascoe was sentenced to seven years for robbery. He initially served time at Exeter, where he was offered a mental health referral. Mr Pascoe refused, but continued to be prescribed antidepressants.
3. Mr Pascoe transferred to Dartmoor prison on 16 January 2015. Reception officers assessed that Mr Pascoe was not vulnerable or a victim of bullying.
4. On the morning of 8 March 2015, at approximately 5.20am, the night patrol officer carried out a routine roll check and saw Mr Pascoe hanging in his cell. She radioed for help, but did not go into the cell. A manager arrived with an officer at 5.26am. They went into Mr Pascoe's cell, cut him down and checked for any signs of life. They found none and noticed that rigor mortis had set in. The control room called an ambulance at 5.28am. The paramedics arrived at 5.50am and pronounced Mr Pascoe dead eight minutes later.
5. After Mr Pascoe's death, the prison received information that he had been involved in handling drugs and had got into debt. Prisoners had apparently bullied him. The police are investigating allegations that prisoners pressurised other prisoners' family members for money.

## Findings

6. We found that staff at Dartmoor did not adequately consider or assess Mr Pascoe's risks, associated particularly with his age and length of sentence. We are also concerned that Exeter prison did not complete the Person Escort Record (PER) more fully and include details of Mr Pascoe's post-traumatic stress disorder (PTSD).
7. We are concerned that Dartmoor had no information to suggest that Mr Pascoe was involved in drugs, was being bullied or at risk from other prisoners before he died.
8. We are concerned that staff did not follow the emergency response codes detailed in PSI 03/2013 and took too long to call an ambulance.

## Recommendations

- The Governor should ensure that officers are vigilant for signs of intimidation or drug misuse to protect prisoners' safety.
- The Governors at Exeter and Dartmoor should produce clear local guidelines about procedures for identifying prisoners at risk of self-harm and for managing

and supporting them. In particular, this should ensure that reception and healthcare staff:

- Have a clear understanding of responsibilities and the need to share all relevant information about risk.
  - Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm.
- 
- The Governor should ensure that all prison staff are aware of, and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator visited Dartmoor on 17 March 2015. She obtained copies of relevant extracts from Mr Pascoe's prison and medical records and interviewed three members of staff and a prisoner.
11. The investigator interviewed eight members of staff and a prisoner at Dartmoor on 30 April. She also spoke to a prisoner, who had been transferred from Dartmoor, on the telephone.
12. NHS England commissioned a clinical reviewer to review Mr Pascoe's clinical care at the prison. The investigator and clinical reviewer carried out three joint interviews.
13. We informed HM Coroner for the County of Devon of the investigation who sent the results of the post-mortem and toxicology examination. We have given the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Pascoe's mother to explain the investigation and to ask if she had any matters the family wanted the investigation to consider. Mr Pascoe's mother raised a number of questions;
  - Why was Mr Pascoe allocated to G Wing?
  - Was he treated for Post Traumatic Stress Disorder while at Exeter in 2014?
  - Was he able to exercise daily to help with his depression?
  - Was the prison aware that he was being intimidated and bullied?
  - Was the prison aware of Mr Pascoe's distress and physical deterioration?
  - Did he receive any support in prison?
  - What is Dartmoor doing about the drug and bullying problem?
15. Mr Pascoe's family received a copy of the initial report. They did not make any comments.

# Background Information

## HM Prison

16. HMP Dartmoor holds up to 659 adult male prisoners. The prison comprises six residential wings, a segregation unit, healthcare department, chapel, education facilities and a gym. Dorset Healthcare Unit Foundation Trust provides the prison's healthcare.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Dartmoor was in December 2013. Inspectors reported that reception procedures were thorough, efficient and welcoming. A first night safety interview focussed on risk and prisoners had support from Insiders (prisoners trained to introduce new prisoners to the prison). The experience was less positive for prisoners on G Wing, with dirty and poorly equipped cells.
18. Inspectors considered that the care for prisoners at risk of suicide or self-harm was reasonable. There was evidence of violent incidents and too many prisoners felt unsafe. The inspectors found there was significant under-reporting of incidents and there was little support for victims. Prisoner safety was compromised by the availability of prohibited drugs (which included synthetic cannabinoids such as spice, injectable drugs, tradable medication and illicitly brewed alcohol, known as hooch).
19. Inspectors reported a good drug-supply reduction strategy and wrote that proactive measures had been introduced.

## 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 their latest annual report, for the year to September 2014, the IMB reported that there was an unacceptable amount of illegal drugs and new psychoactive substances (NPS) in the prison. There had been an apparent increase in incidents of self-harm and violence among prisoners. Improvements had been made to reporting and recording safer custody issues. The Board noted that reception worked effectively.

## Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (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.

## New Psychoactive Substances

22. New Psychoactive substances (NPS) refer to drugs intended to imitate the effects of controlled drugs of three main types, cannabis, stimulants and

hallucinogens. There are a wide variety of NPS and they are known by various names, including legal highs, spice or black mamba.

#### **Previous deaths at HMP Dartmoor**

23. This was the first self-inflicted death at Dartmoor since 2004.

## Key Events

### Previous time in custody

24. On 1 January 2014, during a previous sentence at HMP Exeter, Mr Pascoe's cellmate hanged himself. Mr Pascoe discovered him and alerted staff. Mr Pascoe was traumatised and as a result, was prescribed medication to help him sleep and referred to the mental health team. Mr Pascoe told the Prisons and Probation Ombudsman's investigator for Mr Pascoe's cellmate's death that he felt well supported by staff and had no thoughts of harming himself.
25. Over the next few days, Mr Pascoe was assessed by a psychiatrist and received advice about coping strategies. Officers agreed to leave Mr Pascoe's cell unlocked during the day and he was prescribed sleeping tablets. A psychiatrist wrote to Mr Pascoe's GP to suggest counselling after his release. Mr Pascoe was released from prison on 10 February 2014.

### Return to custody

26. On 19 December 2014, Mr Pascoe was sentenced to seven years at Truro Crown Court for a serious offence of robbery with a knife and returned to Exeter prison. The accompanying Person Escort Record (PER) from court to the prison, recorded that Mr Pascoe suffered from Post Traumatic Stress Disorder (PTSD).
27. Mr Pascoe saw a nurse for his initial health screen. He told her that he had no thoughts of harming himself or of suicide, but said he was still affected by his former cellmate's death. Mr Pascoe said he had flashbacks. He asked to be referred to the mental health team. Mr Pascoe said he was prescribed mirtazapine (an antidepressant) but had not received any other treatment in the community. The nurse referred him to the prison's mental health team.
28. Mr Pascoe had arrived at Exeter with his prescribed antidepressants and he was issued the medication from that supply. (A repeat prescription for a 28 day supply was issued on 26 January. No further prescription was issued and, if Mr Pascoe was collecting his medication daily, he would have run out on 22 February, more than two weeks before he died.)
29. Mr Pascoe met a mental health nurse, three days later, on 22 December for a triage assessment. He told her that he was coping on the wing, felt fine and did not want to be involved with the mental health team. They discharged him from the team with a note in the medical record that he should be re-referred if staff became concerned and that they should monitor his flashbacks. It did not specify who should monitor the flashbacks or how. There is no record that this information was passed to officers.
30. On 23 December, Mr Pascoe was considered for transfer to a category C prison (a lower security prison). One of the criteria for suitability to transfer was whether Mr Pascoe was at risk of self-harm. This box was not ticked by staff considering his transfer, indicating that he was not believed to be at risk.

31. The mental health team discussed Mr Pascoe during a team meeting on 24 December. They noted he had declined a formal mental health assessment when he spoke to the nurse two days before and that he felt he did not need any mental health involvement, but that he knew he could speak to a member of staff if he changed his mind. They formally discharged him from the service.
32. Mr Pascoe spoke to a Violence Reduction representative as part of his induction on 23 December (a prisoner who has been trained to talk to prisoners and offer support and advice if they feel they are vulnerable or being bullied). He told the representative that it was not his first time in prison and he had no concerns.
33. The nurse saw Mr Pascoe on 15 January 2015 to assess whether he was suitable to be transferred to Dartmoor. She noted that he was taking mirtazapine but was fit enough to move prisons.

### Transfer to Dartmoor

34. Mr Pascoe was transferred to Dartmoor prison on 16 January 2015. The PER, completed at Exeter and which accompanied Mr Pascoe from Exeter to Dartmoor, did not mention that he had PTSD, was on antidepressants or had any mental health issues.
35. Mr Pascoe's transfer report from Exeter to Dartmoor included case notes from 19 December 2014 onwards. An entry made on 19 December noted that he said he had not self-harmed in the past and had no thoughts of doing so.
36. A registered general nurse, saw Mr Pascoe in reception. She checked his physical health and noted that he was on mirtazapine. Mr Pascoe told her he had no thoughts of suicide or self-harm. The nurse explained that when she examined prisoners she looked out for signs of risk, for example poor eye contact, dishevelled appearance of being confused. Mr Pascoe displayed none of these, so she considered he was not at risk of suicide or self-harm.
37. During her interview, the nurse agreed that nurses tended to use only SystemOne records for information about a prisoner. The nurse read on SystemOne that Mr Pascoe had seen the mental health team at Exeter previously but had not wanted to engage with them. She said she was not aware that he had PTSD, although it was recorded on SystemOne. She did not ask Mr Pascoe if he wanted to be referred to the mental health team. They spoke about Mr Pascoe's cellmate, but Mr Pascoe's only concern was that he did not want to share a cell, because he did not want it to happen to him again. The nurse saw that Mr Pascoe was taking antidepressants and made him a routine appointment to see a doctor.
38. Mr Pascoe lived on Granite (G) Wing in a single cell (all cells are single). G Wing is the main prison wing and new prisoners are initially allocated there. New prisoners start on the second landing, but move around the wing to accommodate other new prisoners.

39. An induction officer explained that all prisoners are asked if they have any concerns or worries. There is discussion of violence reduction and what to do if they are being bullied, and about safer custody and what to do if they feel vulnerable. There is also an explanation of how the prison works. The officer met Mr Pascoe on 16 January. Although Dartmoor cannot find Mr Pascoe's induction file, the officer made notes of his initial meeting with him. Mr Pascoe said he had no concerns, that it was his first time in Dartmoor but he was happy to be there.
40. An offender supervisor recorded talking to Mr Pascoe on 27 January. Mr Pascoe said he was on antidepressants but was trying to get them changed (although Mr Pascoe did not raise this with healthcare staff at any time) as he did not think they were helping him. Mr Pascoe seemed upbeat throughout their meeting.
41. During his time in custody at Dartmoor, Mr Pascoe rarely came to the attention of staff. He made no complaints, visited the healthcare department infrequently and did not tell staff that he felt vulnerable or was being bullied. There was no intelligence to suggest he had been involved in, or taken drugs.
42. At interview, a safer custody manager explained that if a prisoner felt they were being bullied they could telephone a hotline, speak to staff or Listeners (prisoners trained by the Samaritans to support other prisoners). The safer custody manager explained that prisoners are often bullied because they are involved with supplying or using drugs in prison. The safer custody manager said that he had no information about Mr Pascoe being bullied or at risk, until prisoners and his family made allegations after his death.
43. The investigator spoke to the Head of Security. The Head of Security explained that New Psychoactive Substances (NPS) were a national problem, as well as a problem at Dartmoor. The Head of Security said that prisoners were becoming involved in acquiring and dealing NPS and frequently getting into debt as a result. The Head of Security said that he had arranged two searches on G Wing for 19 and 27 December, because it was around the Christmas and New Year period and he suspected prisoners might have drugs or alcohol. Staff found approximately 200 litres of hooch (alcohol brewed by prisoners) on the wing, but no NPS or other drugs, and nothing in Mr Pascoe's cell.
44. Mr Pascoe made 80 telephone calls using the prison's pinphone system from 16 January to 6 March. These telephone calls were not routinely monitored, but were recovered after Mr Pascoe died. Aside from two calls to friends, the rest were to Mr Pascoe's mother and girlfriend. Mr Pascoe last called his girlfriend at 10.39 am and 12.21pm on 6 March.
45. During the first of these calls, Mr Pascoe and his girlfriend spoke briefly about booking a visit and Mr Pascoe said he would call back later. In the second conversation, they discussed his girlfriend's visit and Mr Pascoe said he needed £25 to 'get stoned' that weekend. It was also clear from the conversation that Mr Pascoe had access to a mobile telephone.

## 7 March 2015

46. A prisoner recalled that he had seen Mr Pascoe on 7 March. He said that Mr Pascoe appeared to be in a 'daydream'. He asked if he was all right and Mr Pascoe replied that he was in a world of his own. The prisoner last saw Mr Pascoe at approximately 5.30pm, when the wing was locked up for the night.
47. Another prisoner, lived in the cell next door to Mr Pascoe. That evening, Mr Pascoe asked the prisoner for some cigarette papers. They did not speak again and the prisoner did not hear any noises from Mr Pascoe's cell throughout the evening.
48. An emergency ambulance (for another prisoner) left Dartmoor that evening, so staff were reorganised to escort the prisoner and cover existing duties. An officer was moved from G Wing to the segregation unit, so an operational support grade (OSG) was asked to work on G Wing on her own. (There were usually two staff members on the wing every night.)
49. The OSG was responsible for carrying out roll checks to ensure all prisoners were accounted for, ACCT checks (although there were none on G Wing that night) and responding to any cell bells on the wing. Prisoners had not pressed their cell bells that night and she recalled that it had been very quiet apart from a prisoner playing some music.

## 8 March 2015

50. At 5.20am, the OSG began a roll check. When she arrived at Mr Pascoe's cell, about 5.25am, she opened the observation panel and saw him standing facing the door staring at her. She said 'all right boy?' but he did not reply. The OSG moved on to the next cell, but sensed something had not been right with Mr Pascoe, so went back. Again, she opened the observation panel and asked if he was all right, but got no response. She banged on the cell door with her torch. The OSG said the cell light and the television were both on.
51. The OSG looked more closely and saw that Mr Pascoe was standing at the back of the cell, against the wall. She could see his left leg was bent slightly and then saw Mr Pascoe was hanging from the bars of the window with a green bed sheet around his neck. The OSG immediately radioed to ask a manager to come to G Wing. The OSG said she had keys to open the cell door but did not feel safe and was shocked, so decided to wait for the night operational manager, the prison's night operational manager. The OSG did not call a code blue, which is the emergency call for a prisoner who is not breathing. She told the investigator that her mind went blank.
52. The officer in the control room, heard a radio call from the OSG at 5.26am, requesting that the night operational manager return to G Wing. The officer said he could hear urgency in her voice. The officer used his radio and repeated the request for the night operational manager to return to G Wing. The officer said the reception was poor in some areas of the prison and he wanted to ensure that the night operational manager heard the call. The night operational manager replied that he would go back immediately.

53. Within two minutes, the night operational manager arrived on G Wing with an officer. The night operational manager opened the cell immediately, and he and the officer went in. They used their anti-ligature knives to cut the bed sheet and noticed that Mr Pascoe's body seemed rigid. The officer told the investigator that he thought rigor mortis had set in. The night operational manager asked the officer to request an ambulance while he checked for signs of life, but he found none. As the night operational manager was clear that Mr Pascoe had died, he left and locked the cell.
54. The officer radioed at 5.28am for the control room to "straightaway call an ambulance". The control room radioed back requesting more details, so the officer went to the telephone in the wing office to call them. He explained what had happened and asked the control room to call an ambulance. They did so a minute later. The officer did not use a code blue emergency call.
55. At 5.50am, the ambulance arrived at the prison and an officer escorted paramedics to Mr Pascoe's cell. They pronounced him dead at 5.58am
56. Mr Pascoe left a note in his cell. Although the Coroner has disclosed the letter, she has not given us permission to discuss its contents in this report.

### Contact with Mr Pascoe's family

57. The police liaised with the prison and agreed they would break the news of Mr Pascoe's death. The police visited Mr Pascoe's family and let the prison know. The deputy governor then telephoned Mr Pascoe's mother. She mentioned that she had been putting money into various prisoners' bank accounts. Mr Pascoe had provided her with the account details. She also said that he had tried to take his life a few months earlier but she had not passed on this information to the prison.
58. In line with Prison Service guidance, the prison contributed to the costs of the funeral.

### Support for prisoners and staff

59. A debrief for the staff involved in the emergency response was held, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
60. The prison posted notices informing other prisoners of Mr Pascoe's death, and offering support. Samaritans visited the wing every night for a week and a memorial service was held on 9 March. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Pascoe's death.

### Post-mortem report

61. Mr Pascoe's post-mortem examination concluded that he died from hanging. His toxicology report said Mr Pascoe had traces of alcohol in his body, but no drugs.

They tested for NPS and did not find any. The report noted that there were so many different types of NPS that it had not been possible to test for them all.

### **Security intelligence received after Mr Pascoe's death**

62. The Head of Security told the investigator that the security department received information from prisoners about Mr Pascoe after he had died. He said that Mr Pascoe apparently asked his girlfriend to bring in an ounce of NPS on a visit. She booked the visit for Wednesday 4 March, but cancelled it. Prisoners said that Mr Pascoe was upset that his girlfriend had cancelled the visit.
63. Extensive evidence emerged from Mr Pascoe's family, other prisoners and the police to suggest that Mr Pascoe was pressured into obtaining drugs and had been assaulted by other prisoners when he failed to do so. Prisoners told staff and the police that other prisoners on the wing had threatened Mr Pascoe until he was locked up on the evening 7 March. This was because his girlfriend had not bought drugs in as agreed and had cancelled her visit.
64. Information also emerged that Mr Pascoe had access to a mobile telephone. A member of Mr Pascoe's family admitted to having regularly paid money into prisoners' accounts and the phone had been used to text bank account numbers.
65. The police found evidence of hooch in Mr Pascoe's cell after his death.
66. The prison received all of this information after Mr Pascoe died and it was passed to the police who are still investigating the allegations.

# Findings

## Bullying and drug intelligence

67. We are concerned that the prison had no security information about Mr Pascoe's apparently extensive involvement in taking or supplying drugs until after he died.
68. Mr Pascoe's family said that Mr Pascoe was under pressure from prisoners to bring drugs (NPS) into the prison. Prisoners said that, the night before he died, Mr Pascoe had been threatened and assaulted by prisoners because he either was in debt to them or owed them drugs. One of Mr Pascoe's family members also said she had transferred money into other prisoners' bank accounts, at his request. This has been the subject of an ongoing police investigation.
69. Safety at Dartmoor was also called into question in the December 2013 Inspectorate report which found that too many prisoners felt unsafe. Officers recorded violent incidents and intimidation in wing observation books, but these were not discussed at safer custody meetings and there was little evidence of any attempt to identify trends in order to take the appropriate action to make the prison safer. It is perplexing that there were no recorded violent incidents or reports of intimidation involving Mr Pascoe in wing observation books or security intelligence reports. Yet, after his death, it was alleged that he and his family were the victims of intimidation by other prisoners and that he was involved in taking or supplying drugs in prison.
70. Dartmoor took action once they received information about Mr Pascoe, resulting in a police investigation and prisoner arrests. Even though some of the information is still being tested by the police, it is of concern that so much intelligence only emerged after Mr Pascoe died. In the circumstances, we are not assured that staff were sufficiently vigilant while Mr Pascoe was alive regarding the use of drugs, bullying, and the intimidation of prisoners and family members.

**The Governor should ensure that officers are vigilant for signs of intimidation or drug misuse to protect prisoners' safety.**

## Mr Pascoe's risk of suicide and self-harm

71. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, young prisoners, being charged with a violent offence, substance misuse and a history of mental health problems. New prisoners must be assessed in reception so staff can assess their risk of suicide or self-harm. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and act appropriately to address any concerns, including opening an ACCT if necessary. The PSI clearly states that information received should be shared and acted upon appropriately.
72. Mr Pascoe had been in prison before, but he had received a long sentence on this occasion. He was also young, only 22 years old, and received mental health support at Exeter following the traumatic death of his cellmate.

73. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we identified that, too often, assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. The members of staff we interviewed at Dartmoor who spoke to Mr Pascoe after he arrived, all said they were not concerned about his presentation. The nurse who interviewed Mr Pascoe on the day he arrived at Dartmoor, told the investigator that she had not been concerned about Mr Pascoe and was not aware of the risks associated with a young man who had received a long sentence, had involvement with a mental health team, and was on antidepressants.
74. PSI 74/2011 about early days in custody, sets out mandatory reception procedures and requires reception staff to examine the Person Escort Record (PER) form that must accompany each new prisoner. It is concerning that when Mr Pascoe transferred from Exeter to Dartmoor, staff at Exeter had not recorded on the PER that Mr Pascoe had found his cellmate hanging in 2014, had PTSD as a result and received mental health support. This might have alerted Dartmoor staff that Mr Pascoe's risk was heightened.
75. When Mr Pascoe arrived at Dartmoor, he had several risk factors, which should have alerted staff that he was at risk of self-harm, or suicide, irrespective to the PER. It is a serious concern that processes designed to highlight risk for newly arrived prisoners were not followed and staff responsible for assessing prisoners were not aware of all of the documentation about Mr Pascoe's risk. Staff should have considered Mr Pascoe's risk factors and recorded their decision for not opening an ACCT. We make the following recommendation:

**The Governors at Exeter and Dartmoor should produce clear local guidelines about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception and healthcare staff:**

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm.**

### Opening a cell

76. Dartmoor's local instruction about opening a cell during the night says that entry must be kept to a minimum. However, if a member of staff finds a prisoner in a cell where the prisoner's life is in immediate danger they must *consider* entering the cell using a cell key kept in a sealed pack.
77. When she saw Mr Pascoe hanging, the OSG considered opening the door but said she did not feel it safe to do so while on the wing on her own. She radioed for a manager to return to the wing, rather than go in herself. Staff in this position must make a rapid assessment of the situation with a view to going into a cell to

help a prisoner. We accept that the OSG feared for her safety. We recognise that, sadly, entering the cell earlier would not have made a difference in Mr Pascoe's case,

### Emergency response

78. PSI 03/2013 requires governors to have a two-code medical emergency response system based on the instruction (code blue and code red are recommended). Dartmoor's medical emergency response protocol required staff to use codes, which should trigger the control room to call an ambulance immediately. However, the OSG who discovered Mr Pascoe did not use an emergency code, but asked a manager to return to G Wing. Neither did she request an ambulance.
79. When the night operational manager and the officer arrived at Mr Pascoe's cell, the night operational manager asked the officer to request an ambulance immediately. The officer radioed the control room and asked the officer to call for an ambulance straight away. The officer did not use an emergency code. The officer asked for more details before calling the ambulance. He said at interview that he thought he would need more details when requesting the ambulance. Dartmoor had recently re-issued PSI 03/2013, but the officer said he had not seen it.
80. The officer telephoned the officer in the control room to give him further details, which delayed the call for an ambulance further. Although the delay would have made no difference in this case, such a delay could be critical for other prisoners in life-threatening situations. We make the following recommendation:

**The Governor should ensure that all prison staff are aware of, and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance.**

### Clinical care

81. A clinical reviewer carried out the clinical review. He concluded that Mr Pascoe's death could not have been anticipated, nor prevented. He also concluded that the care Mr Pascoe received at both Exeter and Dartmoor was equivalent to that which he would have received in the community.
82. The clinical reviewer was concerned that there were poor recording systems to note when a prisoner fails to collect their medication. We agree with the clinical reviewer's recommendation regarding a review of the recording of both collected and non-collected prescribed medication which the Head of Healthcare will need to address.

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