

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Neil Sharman a prisoner at HMP Exeter on 18 November 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 Neil Sharman was found hanged in his cell at HMP Exeter on 18 November 2015. He was 43 years old. I offer my condolences to Mr Sharman's family and friends.

Mr Sharman had been at Exeter less than two days before his death. There were some deficiencies in the reception process, which meant that staff did not have all the available information about Mr Sharman when he arrived. However, even with the full background, I recognise that it is unlikely that prison staff would have identified that Mr Sharman was at risk of suicide.

Because of a lack of places in the prison's vulnerable prisoner unit, Mr Sharman was isolated in his cell for 36 hours before his death. Early days in prison are a time of particular vulnerability and I am concerned that Mr Sharman received minimal support from staff, did not leave his cell and had no opportunity to mix with other prisoners. I recognise that, in part, this isolation was due to operational difficulties, but the Governor needs to ensure there is appropriate support and monitoring for such prisoners, particularly during their first days at the prison.

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

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

**June 2016**

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# Summary

## Events

1. In April 2014, Mr Neil Sharman was released on licence from a four year prison sentence for a sexual offence. He had no history of suicide attempts and during his time in prison, he had never been assessed as at risk of suicide or self-harm. On 16 November 2015, he was remanded to HMP Exeter, charged with a further sexual offence. When he arrived reception staff did not identify that he had been in prison before, so did not consider information from his previous sentence and did not know that probation staff had begun recall procedures to revoke his licence.
2. Because of the nature of his charges, Mr Sharman was regarded as vulnerable to attack or threats from other prisoners and needed to be kept apart from the general prison population. However, the vulnerable prisoner unit was full and Mr Sharman was held in a cell on his own on a standard prison landing. As he was vulnerable, he could not be unlocked from his cell at the same time as other prisoners.
3. On 16 and 17 November, all the prisoners on Mr Sharman's wing were confined to their cells because of disturbances at the prison. Mr Sharman had no time out of his cell after he arrived at the prison. The only time he had any interaction with anyone was when staff brought meals to his cell.
4. At 5.29am on 18 November, the night patrol officer looked in Mr Sharman's cell for a routine count of prisoners and did not record any concerns. At 6.52am, a day officer checked Mr Sharman's cell and realised he had hanged himself. He immediately radioed for help and went into the cell. Nurses arrived, but found no signs of life. As it was apparent that Mr Sharman had been dead for some time, the nurses decided that it would not be possible to resuscitate him. Paramedics arrived and recorded Mr Sharman's death.

## Findings

5. Reception staff did not identify that Mr Sharman had been in prison before or that he had been charged with a further offence when on licence and was therefore subject to recall procedures. However, we consider that, even with this information, they would have been unlikely to have identified him as at raised risk of suicide. There was little in the records from his previous sentence to indicate he was at risk.
6. However, we are concerned that Mr Sharman, a newly arrived vulnerable prisoner located among the general population, was locked in his cell alone for about 36 hours before he died. Staff did not put in place any measures to compensate for his isolation and effectively, Mr Sharman was segregated under Prison Rule 45 without any of the usual safeguards.
7. When the night patrol officer checked Mr Sharman at 5.29am, it is apparent that he was already dead. Such checks are for security purposes, not welfare checks, and we accept that the officer must not have seen that Mr Sharman had hanged himself. The officer who subsequently found Mr Sharman hanged, radioed an

urgent and comprehensive message for help, but did not use the expected emergency code. Although this did not delay the emergency response on this occasion, we are concerned that we have found in a number of investigations at Exeter, that staff do not use emergency codes in line with local and national instructions.

## **Recommendations**

- The Governor should ensure that staff trained in reception procedures assess all new arrivals and check previous records.
- The Governor should ensure that there are supportive procedures for all new arrivals and that when there is no room in the vulnerable prisoner unit, prisoners kept apart from others because of their vulnerability, have an appropriate regime and are checked regularly by a nominated officer to ensure their wellbeing.
- The Governor should ensure that all prison staff understand the need to use emergency medical codes in line with PSI 03/2013 and the local protocol.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator visited Exeter on 27 November 2015. He obtained copies of relevant extracts from Mr Sharman's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Sharman's clinical care at the prison.
11. The investigator interviewed six members of staff at Exeter on 10 and 11 December. The clinical reviewer joined the investigator for an interview with the reception nurse. The investigator interviewed two other members of staff by video link and telephone.
12. We informed HM Coroner for Exeter of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Sharman's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not have any additional questions beyond the usual scope of our investigation.
14. Mr Sharman's family received a copy of the initial report. They did not make any comments.

## Background Information

### HMP Exeter

15. HMP Exeter is a local prison holding about 560 men. The prison primarily serves the courts of the South West. Dorset NHS University Foundation Trust provides health services. Healthcare staff are on duty 24 hours a day.

### HM 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. Inspectors noted that the dedicated first night unit was too small to hold all new receptions and its capacity was often further reduced as it was used as an overflow for the vulnerable prisoners unit. There was little support for newly arrived prisoners and night staff on all wings had no understanding of the increased vulnerability of new prisoners. Inspectors recommended that night staff should check new arrivals regularly through the night.

### 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 its latest published annual report for the year to December 2013, the IMB reported that most prisoners felt safe and said that there was a generally good relationship between prisoners and staff.

### Previous deaths at HMP Exeter

18. Since 2014, we have investigated 15 deaths at Exeter. Of these, five were apparently self-inflicted. We have previously made recommendations about the correct use of emergency response codes and this issue also arose in this investigation.

### Assessment, Care in Custody and Teamwork

19. 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 caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multi-disciplinary reviews and should not close the ACCT plan until all of the actions on the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

20. On 28 October 2011, Mr Neil Sharman was remanded to HMP Exeter, charged with a sexual offence and breaching a Sexual Offences Prevention Order. His probation officer warned the prison that Mr Sharman might be at risk of suicide. However, Mr Sharman told the reception nurse that he had been angry and had threatened to harm himself, but had no intention of doing so. He said he had spent time in a psychiatric hospital in 2003, and subsequently a consultant clinical psychologist had treated him for post-traumatic stress disorder. He said that his mental health was now stable.
21. Mr Sharman was regarded as a vulnerable prisoner because of the nature of his charges and located separately from the general prison population. He later received a four year prison sentence and was transferred to HMP Channings Wood. He was never assessed as at risk of suicide and self-harm or monitored under ACCT procedures.
22. Towards the end of his sentence, his offender supervisor had some concerns about his mental health and referred him for a mental health assessment. Mr Sharman told a mental health nurse that he had no concerns and did not need any mental health support. A consultant forensic psychiatrist reviewed Mr Sharman's case and asked the Cornwall forensic mental health team to consider working with Mr Sharman to reduce his risk of further sexual offending.
23. On 28 April 2014, Mr Sharman was released on licence. He initially lived in approved premises in Cornwall, and saw the local forensic mental health team. In December, he moved to a hostel in Exeter and had no further contact with community mental health services. In his most recent risk assessment, Mr Sharman's offender manager (probation officer) noted there had been concerns in the past about Mr Sharman's risk of suicide and self-harm but there were no current issues.
24. In October 2015, the police and probation services became concerned about Mr Sharman's behaviour after he was reported to have harassed a female employee in a department store. On 3 November, Mr Sharman's offender manager and a police officer met and challenged him about this and arranged for him to meet Circles of Support, a charity that works with sex offenders, on 16 November. The offender manager's next appointment with Mr Sharman was booked for 17 November. However, in the early hours of Sunday 15 November, Mr Sharman allegedly committed a further sexual offence while under the influence of alcohol.

### Monday 16 November 2015

25. At about 10.30am on 16 November, which coincidentally was his birthday, Mr Sharman appeared at Magistrates' Court, charged with a sexual offence and breaching a Sexual Offences Prevention Order. He was remanded to prison to appear at Crown Court on 17 December.
26. At 1.25pm, Mr Sharman arrived at HMP Exeter and an officer received him at the reception desk. The police had written on Mr Sharman's escort record that he was a registered sex offender, had post-traumatic stress disorder and had spent time in a psychiatric hospital. Mr Sharman also had a warrant from court

- detailing his new offences. He was still on licence but probation staff had not yet completed the process to revoke the licence and formally recall him to prison, so prison staff were unaware of this.
27. The officer told the investigator that he had never worked in the prison reception before but was covering for the reception staff, who were on their lunch breaks. He said that he followed the instructions left by the reception staff and could not remember anything specific about Mr Sharman.
  28. Mr Sharman had existing prison and medical records from his last sentence under his middle name, Edwin. The officer did not identify his previous prisoner number and allocated him a new one. This meant that his new prison and medical records were not linked to information from his previous sentence.
  29. Mr Sharman saw an Insider (a prisoner peer worker who supports new arrivals) to sign his induction papers. An officer then interviewed him in the First Night Centre. She assessed Mr Sharman as suitable to share a cell. For public protection reasons, she could not yet register him on the prison telephone system, but offered him a short telephone call to notify his family of his whereabouts. Mr Sharman declined and said that they knew where he was. Mr Sharman told her that he was slow with reading and writing and would need help with this
  30. Mr Sharman said he did not need a full induction programme because he had been to Exeter before. The officer advised Mr Sharman about sources of support, including the Samaritans and the Listeners (prisoners trained by the Samaritans to support other prisoners in distress). She told the investigator that Mr Sharman was polite and compliant and did not have any immediate issues. She said that Mr Sharman did not seem confused or distressed and she had no concerns about him.
  31. The officer completed a 'First Night Immediate Risk and Needs Assessment' form, which had a section about risk indicators. Mr Sharman said he had no history of attempted suicide or self-harm and had no current suicidal thoughts. She recorded that he was on remand, had been to prison before and was not a licence recall. (His recall had not yet been processed.) She wrote that Mr Sharman was very calm and collected and understood that he would be sentenced in a few weeks. He had raised no concerns, knew about prison life, and seemed content. She did not consider he was at risk of suicide or self-harm.
  32. Mr Sharman applied for vulnerable prisoner status under Prison Rule 45, because of his alleged offence. Prison Rule 45 allows prisoners to be held apart from others for their own protection. Mr Sharman told the officer that he had been a Rule 45 prisoner during his last sentence. A manager agreed this.
  33. At an initial health screen, a nurse created a new medical record for Mr Sharman using his new prison number and noted that he was a patient at a GP surgery in Exeter. He said that had not taken drugs in the last month and had drunk 20 units of alcohol in the previous week. He reported headaches. He was not taking any medication. She noted that Mr Sharman told her he had spent time in a psychiatric hospital and been treated by a consultant clinical psychologist. Mr

Sharman said that this had been a long time ago and he was no longer receiving treatment.

34. The nurse said that Mr Sharman seemed calm and had said that he had no current thoughts of suicide or self-harm. She noted that he had no history of self-harm in prison. She thought that Mr Sharman appeared to be fit and well and she did not refer him to the GP or the mental health team. She noted on the 'First Night Immediate Risk and Needs Assessment' form that there were mental health issues but she had not made a referral. She told the investigator that nothing about Mr Sharman concerned her. He did not seem anxious and had appeared straightforward and open about his previous mental health problems.
35. A worker from the Choices Consultancy Service (a not-for-profit organisation that assists prisoners and their families) also interviewed Mr Sharman. Mr Sharman said that his family knew he was in prison and he had no other concerns.
36. B Wing, the vulnerable prisoner unit which holds 88 men, was already full that night. When this was the case, the prison usually used C1 landing (the First Night Centre) or C2 landing to house 'overflow' vulnerable prisoners, but these were also full that day. An officer consulted another officer about where to locate Mr Sharman. Because she had not identified any risk of suicide or self-harm, he had been to prison before and had seemed fine during their interview, she located him on A Wing as a temporary measure. A Wing holds about 180 prisoners from the general population and any vulnerable prisoners located there must always be unlocked separately. The intention was that Mr Sharman would move to C2 or C1 as soon as a space was available, before moving to B Wing.
37. Mr Sharman was given a cell on his own on A4 landing. There was no other new vulnerable prisoner who was able to share with him. A Wing staff wrote in the wing observation book that Mr Sharman was a new rule 45 prisoner. There had been serious disturbances on A Wing and C2 landing that day and all prisoners were locked in their cells.

### **Tuesday 17 November**

38. Prison staff said that normally vulnerable prisoners on A Wing were unlocked separately at 8.00am each day and taken to the vulnerable prisoner unit on B Wing for phone calls, showers, exercise and social time and would stay there until returning to A Wing to collect their lunch and be locked up at 12.30pm. They would then spend the rest of the day locked in their cell, apart from being unlocked separately from the other prisoners to collect an evening meal.
39. The whole prison remained in full lockdown from the afternoon of Monday 16 November until mid-afternoon on Tuesday 17 November while eight prisoners were moved to other prisons. Some of these prisoners remained in their cells on A Wing as the segregation unit was full. Extra staff were deployed to Exeter to transfer the prisoners and encountered considerable resistance.
40. The prison cancelled all work, education and social time on 17 November but prisoners were able to have pre-booked visits. Officers delivered meals to prisoners in their cells and unlocked them one at a time for medication. The lockdown did not end until the afternoon. As Mr Sharman was not due to collect

any medication and had no visits scheduled, he did not leave his cell all day. His only interactions were with the staff who brought him meals.

### **Wednesday 18 November**

41. On A Wing, at 5.29am on Wednesday morning, the night patrol officer, as part of a routine security check, looked briefly into Mr Sharman's cell using a torch. He told the investigator that he could not remember any detail of the roll count but must not have noticed anything amiss as he had counted Mr Sharman as present and completed the roll count.
42. The night patrol officer handed over to an officer on A Wing at 6.45am. The officer then began a roll count. At 6.52am, he looked into Mr Sharman's cell through the observation panel. At first, he thought that Mr Sharman was getting up from the toilet, but hesitated and looked again. He then realised that Mr Sharman had hanged himself by a sheet tied to the window bars.
43. The officer immediately radioed the control room. He did not use a standard medical emergency code but said, 'Urgent message, staff assistance, prisoner with a ligature, ambulance required'. He gave the cell location. Within five seconds, he went into the cell, cut the sheet and lowered Mr Sharman to the floor. Control room staff called an ambulance at 6.53am.
44. Approximately a minute later, the night manager and two nurses reached the cell. The nurses brought emergency equipment and oxygen with them. Another nurse then joined them. Mr Sharman was lying on his back on the floor with the ligature loose around his neck. Two nurses assessed Mr Sharman and noted that his skin was ice cold, his limbs were stiff and there were no signs of life. At 6.55am, they agreed that Mr Sharman had died and decided it would not be appropriate to try to resuscitate him as it would not be possible. Paramedics reached the cell at 7.02am, noted the presence of rigor mortis, and at 7.05am, confirmed that Mr Sharman had died.

### **Contact with Mr Sharman's family**

45. Mr Sharman had left a note for his mother in his cell, in which he said that he could not hurt anyone any more and the offence had broken him. He asked his mother to put money in his bank account towards the cost of his funeral.
46. Mr Sharman had named his mother as his next of kin. As she lived a long way from Exeter, managers arranged for a family liaison officer and a manager from a prison near her home to visit her and Mr Sharman's stepfather and inform them that he had died.
47. On 19 November, the Governor of Exeter telephoned Mr Sharman's stepfather to offer condolences and discuss funeral arrangements. Exeter's family liaison officer telephoned Mr Sharman's mother and stepfather on Monday 23 November to offer further support.
48. Mr Sharman's funeral took place on 10 December. The prison contributed to the funeral costs, in line with Prison Service policy.

## **Support for prisoners and staff**

49. After Mr Sharman died, the police arrived to take statements from the staff involved in the emergency response, who were asked to remain on duty beyond the end of their shift. The Head of Safer Custody said that after the police had taken statements, managers did not want to further delay the night staff getting home. However, the prison said that the Head of Residence and Safety and a custodial manager and member of the prison's care team spoke to the officers involved in the incident individually to offer support.
50. The prison posted notices informing other prisoners about Mr Sharman'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 Sharman's death.

## **Post-mortem report**

51. The post-mortem examination found that Mr Sharman's death was caused by suspension by a ligature. Toxicology tests found no evidence that Mr Sharman had taken any drugs.

# Findings

## Reception

52. When Mr Sharman arrived at Exeter on 16 November, an officer, who had never worked in reception before and was following the instructions he had been given, did not establish that Mr Sharman had been in prison before, partly because Mr Sharman's previous records were in his middle name. This meant that Mr Sharman was allocated a new prison number, which restarted his records and no one looked at his previous records, even when it was later established that Mr Sharman had been in prison before.
53. In Mr Sharman's case, we are satisfied that there was nothing in his previous records that would have alerted staff to consider he was at risk of suicide or that he had any current mental health problems. However, in future, the same error could result in staff overlooking important risk information about a prisoner. We make the following recommendation:

**The Governor should ensure that staff trained in reception procedures assess all new arrivals and check previous records.**

## Clinical care

54. Mr Sharman had a history of mental health issues, had spent time in a psychiatric hospital twelve years earlier in 2003, and had subsequently received psychological treatment for post-traumatic stress disorder. In 2014, Mr Sharman had been referred to the local forensic mental health team but had had no contact with mental health services since he had moved to Exeter in December 2014. He had not attended his GP surgery for six months, was not on any medication, and did not have a diagnosed mental illness.
55. The clinical reviewer reviewed Mr Sharman's clinical care at Exeter. He was satisfied that the nurse asked all of the appropriate questions in reception and there was no reason to make a mental health referral. Although the nurse did not have access to Mr Sharman's previous medical record, the clinical reviewer did not consider this affected the outcome because Mr Sharman gave her his relevant medical history and he found no indication of depressive illness in any of the records. The clinical reviewer concluded that the level of care Mr Sharman received was at least equivalent to that available in the community.

## Early days in custody

56. Prison Service Instruction (PSI) 7/2015 (about early days in custody) emphasises the need to keep prisoners safe during their first few days in prison. It notes that the first few days are particularly stressful and overwhelming for prisoners, when family and community links are broken and the future is uncertain, and that many self-inflicted deaths and self-harm incidents occur within the first 24 hours or shortly afterwards. The PPO has recently issued a Learning Lessons Bulletin (February 2016) reinforcing the need for prison staff to be aware of the particular vulnerabilities of prisoners in the early days and weeks in custody.

57. At the last inspection of Exeter in August 2013, HM Inspectorate of Prisons recommended that night staff should make regular checks on newly arrived prisoners. In response, the prison said they had a system to record the names and locations of newly arrived prisoners and had implemented procedures to ensure that night staff checked them regularly. The prison's action plan of May 2014, said that first night policy and night operating procedures had been updated to reflect this.
58. However, we found that Exeter's operational order about 'C1 regime - first night and Rule 45 overflow', which was in place when Mr Sharman died and which sets out the roles and responsibilities of staff, does not require officers to make routine welfare checks on new arrivals, unless they are identified as withdrawing from substances or are considered to be at risk of suicide or self-harm. The night manager has to be advised of the location of all new arrivals, but there is no requirement for staff to check them while they are locked up. We found no evidence that staff checked Mr Sharman on either of the two nights he spent at the prison and there is no record of any meaningful interaction with him after he was locked in his cell on Monday 16 November.
59. The prison had accepted that Mr Sharman should be kept apart from the general population in his own interests, under Prison Rule 45. He should have been located in the vulnerable prisoner unit but the unit was full, as were the other areas normally used for 'overflow' vulnerable prisoners. He was therefore held alone in a cell on a standard prison wing to be unlocked separately. Mr Sharman never left his cell from the time he arrived at the prison on Monday afternoon. The only time staff interacted with him was when they brought meals to his cell. A system designed to protect prisoners at risk, in all likelihood exacerbated his risk of suicide and self-harm by isolating him.
60. We appreciate that Mr Sharman's arrival at Exeter coincided with a major operational difficulty for the prison. However, we are concerned that he was isolated in his cell for such a long time without the safeguards that would be in place in a segregation unit, such as daily healthcare assessment of fitness, daily time in the open air and frequent checks by officers, healthcare staff, and managers. No manager checked Mr Sharman's welfare during his time at Exeter and there were no additional arrangements to help promote his safety and compensate for his isolated conditions, which cannot have been conducive to good mental health. We make the following recommendation:

**The Governor should ensure that there are supportive procedures for all new arrivals and that when there is no room in the vulnerable prisoner unit, prisoners kept apart from others because of their vulnerability, have an appropriate regime and are checked regularly by a nominated officer to ensure their wellbeing.**

### Roll count

61. Exeter's local security strategy (section 2.06 about 'Routine roll counts – timing and reconciliation') says that 'Staff must physically see every prisoner' during a roll count.' Because rigor mortis was present when the nurses assessed Mr Sharman at 6.55am, it seems very likely that he had already hanged himself

when an officer checked the cell at 5.29am. We are satisfied from CCTV footage that the officer looked into the cell at the time.

62. The officer could not remember anything of the check, and said this indicated he had no concerns at the time. We accept that the primary purpose of such a check is for security reasons to establish that prisoners are present in their cells and it is not a welfare check. We would expect officers conducting such checks to identify any immediate safety issues, but we recognise that the officer might have considered that Mr Sharman was getting up from the toilet at the time, as another officer initially thought when he checked later. While it is regrettable that staff did not identify that Mr Sharman had hanged himself earlier, we cannot say that this was the result of a poorly conducted roll check.

### Emergency response

63. The prison issued a local notice to staff in September 2014 requiring them to use a medical emergency code blue in circumstances including when a prisoner is found hanged. This code should alert other staff to the nature of the emergency so that they bring appropriate equipment and control room staff to call an ambulance immediately. When the officer saw Mr Sharman hanging, he radioed a message for urgent assistance but did not say it was a code blue. The message was clear and comprehensive and we are satisfied that there was no delay in calling an ambulance or nurses attending the cell.
64. However, this was the third time in 2015 that our investigation into a death at Exeter has found that officers did not use the correct emergency code. Despite the local policy it is clear that use of the emergency code system is not embedded and managers need to do more than just issue instructions to ensure that staff understand their responsibilities in an emergency. We make the following recommendation:

**The Governor should ensure that all prison staff understand the need to use emergency medical codes in line with PSI 03/2013 and the local protocol.**

### Resuscitation

65. We are satisfied that the nurses made an appropriate decision not to try to resuscitate Mr Sharman. Attempting resuscitation when someone is clearly dead is distressing for staff, undignified for the deceased and should not be attempted when there is clear evidence, such as the presence of rigor mortis, that it will be futile. In his clinical review, the clinical reviewer noted that the nurses acted appropriately and any resuscitation attempt would have failed.

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