Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Toryino Williams a prisoner at HMP Exeter on 16 September 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.

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

Prison staff discovered Mr Toryino Williams hanging in his cell on 16 September 2016. Despite the best efforts of officers, nursing staff, and paramedics, Mr Williams was pronounced dead at 7.30am. He was 22 years old. I offer my condolences to Mr Williams' family and friends.

I recently made a recommendation following another investigation at Exeter that the small, but particularly at-risk, group of prisoners charged with domestic homicide should always be referred for a mental health assessment. I am pleased to see that such an assessment did take place in this case.

The investigation found that suicide and self-harm prevention procedures were managed appropriately. There was little to indicate that Mr Williams was at an increased risk of suicide in the days immediately before his death. Prison staff or healthcare staff could not have been expected to anticipate or prevent Mr Williams' death. Healthcare provided to Mr Williams at Exeter was of a standard equal to that expected in the community.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **April 2017**

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Summary

Events

1. On 25 June 2016, Mr Toryino Williams was remanded into custody, charged with the murder of his partner. It was his first time in custody. During his reception, a nurse completed a healthscreen with Mr Williams. No physical or mental health issues were identified but given it was his first time in custody, and the serious nature of his charge, Mr Williams was referred for a mental health assessment. Reception staff also began suicide and self-harm monitoring procedures (ACCT) for the same reasons, even though Mr Williams had not stated any intention or thoughts of self-harm and had no history of this.

2. A mental health assessment of Mr Williams was completed on 29 June. The assessment concluded that Mr Williams did present with some depressive symptoms, but these were related to his current situation, first time in custody and the nature of his charges. Mr Williams was referred to the prison GP for medication to be considered. At a mental health team (MHT) meeting on 7 July, Mr Williams's case was discussed and, based on this assessment, it was decided that he did not require formal mental health support and was discharged from the caseload.

3. Mr Williams continued to be supported under ACCT procedures until 12 August. Following a further mental health assessment, which had been requested to inform any decision concerning the ACCT process, it was decided to close the ACCT document. The mental health nurse who conducted the assessment spent about 25 minutes going through questions with Mr Williams and stated that he answered these satisfactorily. It was recorded that Mr Williams was composed, settled on the wing and able to express himself well. He gave no cause for concern about his mood or any intention to harm himself in any way.

4. Staff described Mr Williams thereafter as settled, engaging with the regime, and attending education and gymnasium on a regular basis.

5. On 16 September, at approximately 6.40am, an officer began a count of all prisoners on C wing. When, at 6.59am, they reached the cell occupied by Mr Williams, on looking through the observation panel they saw him hanging from the window bars. The officer immediately called a medical emergency code blue using his radio and attempted to open the cell door, which Mr Williams had barricaded.

6. Other prison staff and nurses attended and, on entering the cell, released the ligature from around Mr Williams' neck and placed him on the floor. Cardiopulmonary resuscitation (CPR) was then started. An ambulance was requested at 7.00am, and paramedics arrived at the prison at 7.04am. Efforts to resuscitate Mr Williams continued, but at 7.30am, paramedics pronounced him dead.

Findings

Assessment, care in custody and teamwork (ACCT) and Risk assessment

7. Reception staff at Exeter appropriately considered Mr Williams' risk and current situation and appropriately placed him on ACCT monitoring procedures. The initial healthscreen also identified the need for a mental health assessment due to his index offence.

8. The ACCT procedures were well-managed with multi-disciplinary case reviews and input sought from various persons who had knowledge of Mr Williams. The closure of the ACCT followed a full mental health assessment, requested to underpin the decision and to ensure that staff had missed no issues or risk triggers. We are satisfied that ACCT procedures at Exeter were well managed in accordance with PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody*).

9. Mr Williams was due to attend court for trial in November, and this was considered by staff to be a potential trigger. In view of this, Mr Williams was added to a database developed by Exeter which, among other things, flags up to staff when a prisoner is approaching a potential trigger date. This information is shared with all staff on a daily basis and enables them to monitor and support such prisoners that may otherwise go unchecked. We commend the system developed at Exeter and consider that this could be of benefit across the prison estate.

Actions of Officer Corner

10. At 6.00am on 16 September the officer on night duty signed to indicate that he had completed a full count of every prisoner on C wing. However, after Mr Williams was discovered hanging and following his subsequent death, the officer admitted to a prison manager that he had not checked any of the prisoners and had just signed the form. He was immediately informed that his actions would be subject to an internal investigation and he would be suspended from duty. He subsequently resigned from the Prison Service.

Clinical care

11. The investigation identified no concerns with Mr Williams' treatment while in custody. The clinical review also concluded that the healthcare provided was of an equal standard to that in the wider community. We do not consider that, at the time of Mr Williams' death, prison staff could have identified he was at imminent risk of suicide or done anything to prevent his death.

Recommendations

- Safer Custody & Public Protection Group (SCPPG) should review the system used at HMP Exeter and consider the benefits of its wider use across the prison estate.
- The Governor should remind all staff of the roll check procedures and expectations. There should also be a review of the current process to ensure that Officer Corner's actions were an isolated incident.

The Investigation Process

12. 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 responses were received.

13. HMP Exeter provided copies of relevant extracts from Mr Williams' prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Williams' clinical care at the prison.

15. The investigator interviewed three members of staff at Exeter on 16 November.

16. We informed HM Coroner for Exeter and Greater Devon of the investigation. The Coroner has confirmed the findings of the post mortem and results from toxicology tests. These indicate that the cause of death was compression of the neck, suspension by ligature. Toxicology indicated no prescribed or illicit drugs in Mr Williams' system.

17. On 3 November, one of our family liaison officers contacted Mr Williams' mother to explain the investigation. Mr Williams' mother raised the following concerns, which this report aims to provide clarity on:

    - How did Mr Williams take his own life?
    - Mr Williams was subject to suicide and self-harm monitoring, which had been closed. Was this process managed appropriately?
    - Was Mr Williams subject to any form of monitoring at the time of his death and had he been in receipt of medication?
    - Were there any delays in the emergency response and was the first aid provided appropriate?

18. Mr William's mother received a copy of the draft report, but has not provided any response to our findings.

Background

HMP Exeter

19. HMP Exeter is a local prison holding a maximum of 560 men 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. The prison has 24-hour healthcare cover.

HM Inspectorate of Prisons

20. 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 its best in difficult circumstances.

Independent Monitoring Board

21. 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

22. Since 2014, we have investigated 27 deaths at Exeter. Of these, ten were apparently self-inflicted. There were no significant similarities with the circumstances of the other deaths. Since Mr Williams' death, there have been three further deaths at Exeter apparently from natural causes.

Assessment, Care in Custody and Teamwork (ACCT)

23. 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

24. On 25 June 2016, the Magistrates Court remanded Mr Toryino Williams in custody at HMP Exeter. He was charged with the murder of his partner. This was the first time Mr Williams had been imprisoned.

25. An officer completed reception documentation with Mr Williams when he arrived at Exeter. He recorded that Mr Williams was quiet and had been remanded for a serious offence. He recorded that he had considered all the potential risk triggers for Mr Williams. These included the serious nature of his charges, his first time in custody and Mr Williams' presentation. As a result, he decided to place Mr Williams on suicide and self-harm monitoring procedures and opened an ACCT document. Staff would observe Mr Williams hourly until a full ACCT assessment had been completed.

26. A nurse completed Mr Williams' initial healthscreen on reception. During the screening Mr Williams expressed no concerns about his physical health, said that he had never self-harmed and had no thoughts of doing so. She recorded that an ACCT had been opened and, due to the nature of his charge, referred Mr Williams to the prison's MHT for an assessment.

27. Following reception procedures, staff moved Mr Williams to a shared cell on C wing. On 26 June, an officer completed the ACCT assessment with Mr Williams. He recorded that Mr Williams presented as though he were in a state of shock in relation to his situation. He was unable to express how he felt when asked by the officer, and stated that he had no family support. Mr Williams denied any previous self-harm. In relation to his mental state, the officer recorded that Mr Williams presented as distant, vacant, unable to engage, but genuine. Mr Williams said that his family in Grenada were a coping resource for him but that he was not in regular contact. He told the officer that he had been living in the UK for the past four years. In concluding his assessment, the officer recorded that although there were no signs or indications of self-harm, Mr Williams' situation had not yet sunk in, and his presentation was consistent with denial of his circumstances.

28. Following the assessment, a Supervising Officer (SO) chaired the first ACCT case review. Mr Williams, an officer Turnbull, a wing officer and a member of the chaplaincy team, attended the review. During the review, Mr Williams said that his family did not know that he was in custody, and he did not want them to know. He denied any thoughts or intentions to self-harm, but the ACCT was kept open. The SO recorded that Mr Williams presented as a low risk to himself and of self-harm. A further review was planned for 28 June. The SO completed the caremap actions, which included: access to Samaritans and Listeners as required, maintaining contact with his legal team, and contact with the chaplaincy as required. A referral was also made for an appointment with the healthcare team due to Mr Williams' low mood.

29. On 29 June, a nurse completed a mental health assessment with Mr Williams because of his referral at reception. The nurse completed a Patient Health Questionnaire 9 (PHQ9) with Mr Williams. The PHQ9 is used as a diagnostic tool for depression. Mr Williams scored 14 (indicating some depressive

symptoms) and had an anxiety score of seven. The nurse recorded that Mr Williams said that he had no family contact and did not wish for his mother to know where he was. The nurse recorded that the scores reflected Mr Williams' situation of being in custody for the first time. The nurse's contact with Mr Williams was discussed at an MHT meeting on 7 July. It was recorded that he had been referred to the GP to assess any need for medication and had been sent a self-help booklet for depression. However, the team concluded that Mr Williams did not meet the criteria for secondary mental health referral and he was discharged from the care of the MHT.

30. On 25 July, a prison GP assessed Mr Williams following the referral made by the MHT. Mr Williams told him that he felt things were going well, and he was keeping busy by attending art classes. Mr Williams said that he had been having "anger outbursts" which he said were worse in the mornings, but then settled down. The GP recorded that Mr Williams had good eye contact, although was rather withdrawn, and he diagnosed low mood. Mr Williams was not prescribed any medication.

31. Between 26 June and 12 August, there were nine case reviews. At each review, Mr Williams denied having any thoughts or intent to self-harm and continued to be considered as low risk. Actions recorded on the caremap were updated and actioned before the closure, and all case reviews were multidisciplinary.

32. The last ACCT case review, held on 12 August, was chaired by a Custodial Manager (CM) and attended by a member from the MHT. The CM told the investigator that he had first met Mr Williams on 22 July, when he had chaired an ACCT case review. He said that at that time he had found Mr Williams to be guarded in his responses. By way of example, he explained that when he asked a question, Mr Williams gave only 'yes' or 'no' responses and was limited in his interaction. The CM said that despite this Mr Williams presented as calm and relaxed and gave no cause for concern.

33. The CM said that in the weeks following his first contact with Mr Williams, he was aware that he had started to open up more. He said that he had asked the member from the MHT to attend and review as a further safeguard before closing the ACCT. The CM said that during the review on 12 August, Mr Williams presented as being well. He said that during the preceding month he had seen Mr Williams socialising on the wing with other prisoners, he knew that he regularly went to the gym and education, and was doing everything that any other prisoner would do. He said that he had also spoken to Mr Williams on the landing during this period and he always seemed fine. His mood remained consistent each time that he saw him.

34. The member from the MHT said that he had been invited to the ACCT review by the CM to make an assessment of Mr Williams because, after a lengthy period on the ACCT, the CM was considering closing it. He said that the CM sought his expertise to assist in evaluating how Mr Williams was, his thoughts about the future and whether there were any specific triggers in his thinking that might be of concern.

35. The member from the MHT said that he initially went and spoke with Mr Williams in his cell. He said that his cell was normal, there was nothing disorganised or

odd about it, and that Mr Williams said he was happy and agreed to attend the landing office for the review. He said that he used the PHQ 9 to look at Mr Williams' depressive scores and found that he was not presenting in a way that caused concern. He spent about 25 minutes going through the questions, which Mr Williams answered satisfactorily. There were no concerns at all. He said that Mr Williams presented with pleasant facial expressions, good eye contact, was warm, and he was reflecting on his time in education. He said that Mr Williams was quite composed, settled on the wing and was able to express himself. He said that Mr Williams gave him no cause for concern about his mood or any intention to harm himself in any way. As a result of Mr Williams' presentation, it was decided to close the ACCT. A post-closure review was scheduled to take place a few days later.

36. There were two post closure interviews carried out with Mr Williams. The first was held on 18 August and a further one on 29 August. The CM carried out the post closure interview on 29 August. He recorded that Mr Williams was settled, engaging with the regime, attending education and gymnasium and that he had been offered support. He recorded that future court dates could potentially be a trigger for Mr Williams, so he would be placed on a triggers warning list.

37. The warning list is part of a larger document developed by the safer custody team at Exeter. Sections include: a record of information on prisoners, self-harm triggers, cell-sharing risk information, and risks to staff. The entire document is updated and circulated daily to every member of staff. The CM explained that although Mr Williams was no longer subject to ACCT monitoring, the database would ensure that his court date would be flagged up as a potential trigger as it approached, allowing staff to monitor him.

38. On 1 September, Mr Williams attended a follow-up appointment with a prison GP in relation to his earlier low mood. However, during the appointment Mr Williams said that his mood was no longer low. He told her that he had just returned from an exam in education, and she recorded that he appeared relaxed, smiling and had good eye contact. When asked, Mr Williams denied any thoughts of hurting himself or others, and stated that he had never harmed himself. She recorded that there was no need for a further follow-up appointment but encouraged Mr Williams to return if he felt low or just wanted to talk.

39. Over the next two weeks there is little recorded about Mr Williams. He continued to attend education and no concerns were raised by him or about him by staff. He had originally been due to appear in court on 15 September but his hearing was postponed until 11 November, for psychiatric reports to be completed.

40. Officer A was on night duty over 15/16 September. He checked on Mr Williams during a roll check at the start of his shift, at 8.30pm, and noted no problems. Mr Williams was not subject to any additional monitoring and he had no reason to check on him during the night. There is an expectation that night staff will complete a further roll check at approximately 6.30am the following morning. On 16 September, at 6.00am, he signed the roll check form for C wing, indicating that he had checked the presence and well-being of every prisoner on the wing. He later informed the night manager, the CM, that despite signing to indicate he had completed the check, he had not done so.

41. On 16 September, at approximately 6.40am, Officer B was completing a count of all prisoners on C wing. When, at 6.59am, he reached cell C3-34 occupied by Mr Williams, he looked through the observation panel and immediately saw Mr Williams hanging from the window bars in his cell, having used a sheet as a ligature. He immediately called a medical emergency code blue using his radio and attempted to open the cell door, which Mr Williams had barricaded.

42. Officer A heard the radio call, responded immediately, and assisted Officer B in gaining entry to the cell. The CM, the manager on duty, also responded. As the CM made his way to the cell he was informed that an anti-barricade kit was required. (This is an Allen key used to loosen the cell door lock, allowing staff to open the door outwards.) The CM collected the anti-barricade kit from C wing office and returned to the cell, closely followed by a nurse and a healthcare assistant (HCA), who had responded with emergency medical equipment.

43. Staff loosened the door lock and entered the cell. They released the ligature from around Mr Williams' neck and placed him on the floor, CPR was then started. Staff requested an ambulance at 7.00am, and paramedics arrived at Exeter at 7.04am. The nurse and HCA inserted an airway to allow oxygen to be administered and attached a defibrillator. When paramedics arrived, they swapped this defibrillator for their own, which was able to provide a printed reading, and administered adrenalin while maintaining resuscitation attempts. The defibrillator continued to indicate that there was no shockable rhythm and, at 7.30am, paramedics pronounced Mr Williams dead. While in the cell, staff discovered a note left by Mr Williams in which he apologised to his family for his actions.

Contact with Mr Williams family

44. Following Mr Williams' death, Exeter identified that his mother, who was his nominated next of kin, lived in Grenada. The prison sought advice on the most appropriate way of contacting her and decided to request that an official in Grenada inform her. The Foreign and Commonwealth Office directed them to the High Commission of Grenada in London.

45. At 10.15am on 16 September, Deputy Governor at Exeter spoke with the Grenadian High Commissioner in London and passed on the contact details of Mr Williams' mother and the circumstances of his death. The Commissioner agreed to speak with local police in Grenada and ask them to inform Mr Williams' mother of her son's death.

46. The Deputy Governor remained in contact with the High Commissioner over the next ten days to confirm that Mr Williams mother had been notified. Copies of emails sent by the prison were made available to the investigator. On 26 September, the High Commission confirmed that Mr Williams' mother had been informed of his death.

47. The prison wrote to Mr Williams' mother, offering condolences and providing contact details of the family liaison officer at Exeter. The prison also arranged for Mr Williams' mother to fly to England for her son's funeral, in addition to meeting the full cost of funeral expenses.

Support for prisoners and staff

48. After Mr Williams' death, the Governor debriefed the staff involved in the emergency. He offered his support and that of the staff care team.

49. On 16 September, the prison posted notices informing other prisoners of Mr Williams' death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm prevention in case they had been adversely affected by Mr Williams' death.

Post-mortem report

50. The post mortem has confirmed that the cause of Mr Williams' death was compression of the neck, and suspension by a ligature. Toxicology tests record that no illicit drugs were found in Mr Williams' system at the time of his death.

Findings

Assessment, care in custody and teamwork (ACCT)

51. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. When he arrived at Exeter, Mr Williams was recorded as having no history of self-harm or any current thoughts. There was also no accompanying information that suggested that he was at increased risk to himself or others. However, due to the nature of the charges, Mr Williams that faced, and as it was his first time in custody, staff referred him for a mental health assessment, and ACCT monitoring was appropriately started.

52. Over the life of the ACCT document, there were ten ACCT reviews. All of these were multidisciplinary, and either attended by staff that had had contact with Mr Williams, or provided with written input from them. The caremap was completed at the initial case review and the actions set were appropriate to ensure that Mr Williams was supported during his initial period of custody. The caremap was updated at subsequent reviews as necessary.

53. When, on 12 August, the ACCT was closed, this decision followed a full assessment carried out by the MHT, to ensure that all outstanding issues had been addressed. There were then two post-closure interviews with Mr Williams over the next two weeks, during which no further issues were raised by Mr Williams or identified by staff.

54. Mr Williams was due to attend court for his trial in November, and staff considered this to be a potential trigger. In view of this, Mr Williams was added to a database developed by Exeter which, among other things, will flag up to staff when a prisoner is nearing a potential trigger date. This information is shared with all staff on a daily basis and enables them to monitor and support such prisoners that may otherwise go unchecked. We are satisfied that ACCT procedures at Exeter were well managed in accordance with PSI 64/2011 and make no recommendations in relation to these. Further, we commend the system developed at Exeter and, in the ongoing effort to learn from such tragic events, we consider that this could be of benefit across the prison estate, we therefore make the following recommendation:

    Safer Custody & Public Protection Group (SCPPG) should review the system used at HMP Exeter and consider the benefits of its wider use across the prison estate.

Actions of Officer Corner

55. Officer A was on night duty over 15/16 September and responsible for C wing. When he arrived for duty on 15 September, he began by completing a full count of all prisoners on the wing. During the remainder of his night shift, he patrolled the wing and checked on those prisoners who were subject to ACCT monitoring. Mr Williams was not one of those prisoners.

56. The forms used by prison staff to record the number of prisoners at each roll check indicate that a check should be completed at 6.30am. Officer A signed for

the roll on C wing at 6.00am, indicating that he had checked all prisoners on C wing at that time, and he reported no issues.

57. Officer B completed a further roll check when he came on duty at 6.40am. He discovered Mr Williams hanging at 6.59am and raised the alarm. When staff attended Mr Williams' cell, someone asked when he had last been seen, and Officer A replied that he had seen him at 8.30pm the previous evening. The CM then challenged Officer A and asked whether he meant 6.00am when he had completed the roll check. He replied "yes."

58. Staff said that a short while later, Officer A approached the CM and admitted that he had not checked any of the prisoners at 6.00am, but had just recorded the number of prisoners. The CM reported what the officer had told him to the Governor. The Governor immediately spoke with the officer and explained that in view of what he had been told there would be an internal investigation. During this process, the officer would be suspended from duty. The prison has informed the investigator that the officer has since resigned from the Prison Service. There is no evidence to suggest, and we are unable to say, that had Mr Williams been discovered during the roll check at 6.00am, the outcome would have been different. However, the officer's actions are concerning and we make the following recommendation:

The Governor should remind all staff of the roll check procedures and expectations. There should also be a review of the current process to ensure that Officer A's actions were an isolated incident.

Clinical care

59. The clinical reviewer completed the review into the medical care provided to Mr Williams while at Exeter. He has concluded that there are no significant concerns regarding the healthcare provided to Mr Williams. He says that based on the evidence provided, and the progress that Mr Williams had made, he considers that the closure of the ACCT was undertaken at the appropriate time. He also comments that the custodial staff acknowledged, and were able to demonstrate, that they had considered Mr Williams' further risks and took steps in order to highlight these triggers through the 'trigger warning list'.

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