

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Terence Crockett a prisoner at HMP Exeter on 17 July 2017

**A report by the Prisons and Probation Ombudsman**

PO Box 70769  
London, SE1P 4XY

Email: [mail@ppo.gsi.gov.uk](mailto:mail@ppo.gsi.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100  
F | 020 7633 4141

## 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*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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.

Mr Terence Crockett was found hanged in his cell at HMP Exeter on 16 July 2017 and died the next day in hospital. He was 53 years old. We offer our condolences to Mr Crockett's family and friends.

Mr Crockett had a history of alcohol misuse and was prescribed alcohol detoxification medication. We found no deficiencies in the operation of suicide and self-harm prevention procedures at Exeter or with the clinical care that Mr Crockett received. Prison and healthcare staff appropriately supported Mr Crockett who hid his true intentions from staff.

We do not consider that staff at Exeter could have predicted that Mr Crockett intended to take his own life when he did. While there was a delay in contacting Mr Crockett's next of kin, Exeter have since implemented measures to address this.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**March 2018**

## Contents

Summary .....	3
The Investigation Process .....	4
Background Information .....	5
Key Events .....	7
Findings.....	12

# Summary

## Events

1. On 15 July 2017, Mr Terence Crockett was remanded into custody at HMP Exeter, charged with sexual offences and assault against his partner. This was not Mr Crockett's first time in prison.
2. Staff monitored Mr Crockett under Prison Service suicide and self-harm prevention procedures (known as ACCT) throughout his short time at Exeter.
3. At around 11.55pm on 16 July, Mr Crockett's cellmate found him hanged in his cell, and alerted staff immediately. An officer called an emergency code promptly and began cardiopulmonary resuscitation (CPR). Officers and medical staff attended and continued CPR until paramedics arrived. The paramedics took over emergency treatment and found a pulse. Mr Crockett was taken to hospital but at 8.25am on 17 July, hospital staff confirmed that he had died. Staff found a suicide letter written by Mr Crockett in his cell.

## Findings

### Management of risk of suicide and self harm

4. ACCT procedures at Exeter were followed in line with mandatory national instructions and Mr Crockett received excellent support from staff during the very short time he was there. Healthcare staff correctly prescribed an alcohol detoxification programme and completed a mental health assessment immediately after Mr Crockett arrived at Exeter. The first ACCT case review was multidisciplinary, recognised Mr Crockett's risk of suicide and self-harm and set appropriate observations.
5. Although Mr Crockett had some risk factors for suicide and self-harm, there was little to indicate to prison and healthcare staff that he was at heightened or imminent risk in the period before his death. It would have been difficult for staff at Exeter to have anticipated his actions on the night of 16 July.

### Clinical care

6. The investigation identified no concerns with Mr Crockett's treatment at Exeter. The clinical review concluded that the care provided to Mr Crockett was equivalent to that which he could have expected to receive in the community.

### Family liaison

7. Staff delayed contacting Mr Crockett's partner after his death. Exeter has since put in place measures to prevent this happening again. We therefore make no recommendations.

## 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 came forward.
9. NHS England commissioned a clinical reviewer to review Mr Crockett's clinical care at the prison.
10. The investigator visited Exeter on 20 July 2017. He obtained copies of relevant extracts from Mr Crockett's prison and medical records. He interviewed eleven members of staff and one prisoner at Exeter.
11. We informed HM Coroner for Exeter and Greater Devon District of the investigation. She gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers, contacted Mr Crockett's partner to explain the investigation and to ask whether she had any questions or concerns she wanted us to consider. Mr Crockett's partner asked why Mr Crockett's ACCT observations were not conducted more frequently than hourly. She was disappointed that no one from Exeter contacted her within 24 hours of Mr Crockett's death.
13. Mr Crockett's partner received a copy of the initial report and chose not to comment or provide feedback.

# Background Information

## HMP Exeter

14. 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

15. The most recent inspection of HMP Exeter was in August 2016. Inspectors found that the levels of self-harm and the number of ACCT documents opened for prisoners at risk of suicide or self-harm were far higher than at other local prisons. Inspectors found that the healthcare team, including mental health, learning disability and general psychiatry practitioners provided a comprehensive approach to complex, serious and enduring illnesses and responded well to mild-to-moderate needs.

## Independent Monitoring Board

16. 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 annual report to December 2016, the IMB were again concerned about the accommodation for vulnerable prisoners. It highlighted that B Wing did not provide enough accommodation for all those assessed as vulnerable. They said that this had led to the unsatisfactory measure of housing some vulnerable prisoners on C Wing, a standard residential wing which included C1, the first night centre.

## Previous deaths at HMP Exeter

17. Mr Crockett's death was the thirteenth self-inflicted death at Exeter since 2014. There were no similarities between Mr Crockett's death and previous self-inflicted deaths at the prison. Previous cases investigated from 2016-2017 have shown that Exeter's suicide and self-harm prevention procedures were satisfactory and this was reflected in the quality of care of prisoners' self-harm and suicide monitoring.

## Assessment, Care in Custody and Teamwork (ACCT)

18. 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. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the

prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

## Key Events

19. Mr Terence Crockett had served a number of prison sentences since 1981. In February 2001, he was sentenced to life in prison. He was released from HMP Leyhill on 11 February 2009 after he became eligible for parole.

### 13 July 2017

20. On the afternoon of 13 July 2017, the police arrested Mr Crockett and charged him with the possession of offensive weapons. While in custody, the police charged him with sexual offences against his partner, allegedly committed on 28 May 2017. Because of his previous life sentence, the Ministry of Justice revoked Mr Crockett's licence.

### 15 July

21. On 15 July, Mr Crockett was recalled to prison and remanded to HMP Exeter. He arrived at Exeter at around 1.40pm. An officer booked him in at reception. Mr Crockett named his partner as his next of kin.
22. During his reception screening, a Supervising Officer (SO) recorded that Mr Crockett was detoxifying from alcohol, was on remand and his person escort record noted that he had said he would kill himself in custody. The SO started ACCT suicide and self-harm prevention procedures. He set hourly ACCT observations for Mr Crockett until his ACCT assessment. Due to his offence, staff offered to locate Mr Crockett on the vulnerable prisoner wing. The SO explained the support available to Mr Crockett and noted that he would be seen by the prison nurse and doctor.
23. A nurse saw Mr Crockett for an initial health screen. He noted that Mr Crockett was being supported by ACCT procedures. Mr Crockett had heart issues and had had two cardiac arrests in June 2016. He had a history of alcohol misuse and had alcohol-induced fits. He was receiving medication (including clopidogrel, atorvastatin, aspirin and lansoprazole) and had in the past (2009) been prescribed antidepressants and had seen a psychiatrist. While the nurse noted that in the 1990s, Mr Crockett had tried to take his life and had made cuts to his wrist, Mr Crockett said he had no current thoughts of suicide or self-harm. His mood was noted as low because of his situation. The nurse referred him to the mental health team and to the prison doctor for his alcohol misuse.
24. A prison GP, had assessed Mr Crockett in reception. Mr Crockett said that he drank up to two litres of whisky daily. He said that he had last had alcohol before he was arrested and the police had given him diazepam while in custody. The prison GP recorded that Mr Crockett had mild signs of alcohol withdrawal and diagnosed him with alcohol dependence syndrome. He prescribed librium detoxification medication and vitamins for ten days. It was agreed that a nurse from the substance misuse team would check Mr Crockett three times at night to see if he had any side effects while detoxifying.
25. A member of the chaplaincy team saw Mr Crockett in reception. He noted Mr Crockett was polite and respectful and raised no concerns.

26. A healthcare assistant completed a mental health screening for Mr Crockett. She noted his history of self-harm that dated back 15-20 years, that he was not known to the community mental health services and had no enduring mental health disorders. She recorded that the primary mental health and substance misuse teams would support Mr Crockett, as required.
27. An officer completed Mr Crockett's first night in custody assessment. She said that Mr Crockett was polite and compliant. She checked Mr Crockett's paperwork and noted that he was to start a detoxification programme. She assessed that he was suitable to share a cell with another prisoner. Because of his alleged offence against his partner, Exeter did not allow him to phone anyone until his telephone contact numbers had been checked. An officer gave Mr Crockett stationery to write letters. Mr Crockett arrived with £287.50 in cash and as he smoked, an officer gave him three e-cigarettes and a nicotine patch.
28. At 5.30pm, staff took Mr Crockett to C Wing and located him in a cell used for vulnerable prisoners. He shared the cell. The cell mate told the investigator that he talked to Mr Crockett who told him that prison had messed up his life.
29. At 8.00pm, an officer recorded in the ACCT record that Mr Crockett appeared to be in a good mood when he collected his medication from the treatment hatch. Staff checked Mr Crockett hourly overnight and recorded no concerns about him.

### 16 July 2017

30. At 5.36am, a healthcare assistant completed her overnight substance misuse checks on Mr Crockett and recorded that he was stable.
31. At 9.35am, a SO from the Offender Management Unit completed Mr Crockett's basic custody screening. She had first reviewed his prison paperwork and was familiar with his custodial history. She noted that Mr Crockett had been recalled to prison. Mr Crockett explained that he lived with his long-term partner but had an ongoing relationship with another woman, who was the victim of his current alleged offence.
32. The SO noted that Mr Crockett was emotional. She said that he was fully aware of the implications of being recalled and the prospect of spending a lengthy period in prison. Despite this, Mr Crockett said he was hopeful for his future as his long-term partner supported him. He had submitted her phone number to be added to his PIN phone account and hoped this would be sorted by the next day. The SO said that she did not think Mr Crockett presented an imminent risk to himself but felt that he might not be open and honest to staff about his intentions. She noted this and passed on her concerns to another SO, who was the ACCT case manager.
33. An Officer assessed Mr Crockett under ACCT procedures at 11.30am. Mr Crockett said that his offence was the main cause of his distress. He said that he felt guilty and angry. The officer noted that Mr Crockett became tearful when he talked about his two partners. Mr Crockett said he had last harmed himself over 20 years ago, had no current thoughts of suicide or self-harm and his long-term partner and friends were supporting him. The officer noted Mr Crockett engaged well despite his low mood. She explained the ACCT process to Mr Crockett and

summarised his main issues, including alcohol withdrawal, his offence against his partner and his status as a recall prisoner facing life in prison. Mr Crockett asked for another e-cigarette and after the meeting, she gave him two.

34. Shortly afterwards, a SO chaired Mr Crockett's first ACCT case review. Two officers attended. The SO told the investigator that before the review, he had spoken to two nurses who updated him about Mr Crockett's medical status.
35. The SO talked to Mr Crockett about his current situation and recall. He noted that Mr Crockett displayed withdrawal symptoms but he engaged well, was co-operative and polite. He described his mood as low and was aware that his current predicament did not look good. Mr Crockett said that he had made the comments noted in his person escort record in the heat of the moment. He assured the SO that he had no intention to hurt himself in any way, and said that he would have "done himself in" already if he had wanted to. The SO had spoken to another SO and was aware of her concerns about Mr Crockett's safety. He encouraged Mr Crockett to engage with prison support groups, including the substance misuse, mental health and healthcare teams, and Mr Crockett appeared to welcome this.
36. The review panel assessed Mr Crockett's risk of suicide and self-harm as raised and decided that staff should have three conversations a day with him (morning, afternoon and evening) and observe him five times at night between the hours of 10.00pm and 7.00am. The panel scheduled the next ACCT review for 20 July, and noted that a representative from the mental health and substance misuse teams should attend.
37. A SO completed Mr Crockett's ACCT caremap and noted three issues to address: Mr Crockett was withdrawing from alcohol and needed to complete the alcohol detoxification programme; his recall status (including his impending court trial); and concerns about his risk due to the nature of his offence. He recorded that Mr Crockett would be supported by the ACCT process and staff.
38. A healthcare assistant, and a nurse saw Mr Crockett at around 2.30pm as part of his substance misuse checks. Neither recorded any concerns about Mr Crockett. The nurse told the investigator that after he had given Mr Crockett his pabrinex injection (minerals and vitamins), Mr Crockett said, "see you tomorrow, boss".
39. At 3.30pm, staff unlocked prisoners on Mr Crockett's landing for tea, medication and food collection. A SO noted that Mr Crockett went straight to the kitchen servery, collected his evening meal and returned to his cell. Staff locked prisoners' cells on Mr Crockett's landing at 4.15pm for the rest of the evening.
40. Staff completed ACCT checks as required that evening. At 4.30pm, a SO noted that he saw Mr Crockett pacing up and down in his cell when he looked through his cell door observation panel. He recalled that he had seen Mr Crockett sorting out his legal paperwork that afternoon. He had no concerns and believed Mr Crockett was preparing for a court hearing.
41. When an officer checked Mr Crockett at 7.00pm, she noted that he was sitting at the table in his cell, writing a letter. An officer completed the roll check at 8.12pm and had no concerns.

42. An officer responded to Mr Crockett's emergency cell bell at 8.40pm. Mr Crockett told the officer that neither he nor his cellmate had had their evening medication. The officer told the investigator that after he confirmed this with the nurse on duty, he escorted both prisoners to the medication hatch to collect their medication. The officer had no concerns about Mr Crockett.
43. His cellmate said that he went to bed at around 9.00pm. CCTV footage showed that a healthcare assistant completed her substance misuse welfare check at 10.50pm. When she opened Mr Crockett's cell door observation panel, she saw him walking around in his cell. An officer completed his ACCT check at 11.00pm and noted that Mr Crockett was sitting on his chair, writing notes.
44. The cellmate woke up shortly before 11.55pm and started to make a cup of tea. Very soon afterwards, he realised that Mr Crockett was not in his bed. He then saw Mr Crockett hanging from a bed sheet tied to the window. Mr Crockett looked lifeless and his feet were off the floor. The cell mate said he immediately pressed the emergency cell bell to alert staff. The prison cell bell system recorded that the cell bell was pressed at 11.55pm.

### Emergency response

45. An officer arrived at the cell in less than a minute. He looked through the observation panel and saw Mr Crockett at the back of the cell and a strip of bed sheet attached to the window in the toilet area. The cell mate said that Mr Crockett was hanging. The officer did not have a clear view of Mr Crockett's legs and feet because a panel blocked the toilet. He called a medical emergency code blue (which indicates a life-threatening medical emergency such as when a person is found hanging, unconscious or not breathing). The control room operator recorded this as at 11.58pm, immediately alerted other staff and called an ambulance.
46. The officer unlocked and went into the cell. He cut the ligature from the window bar and Mr Crockett fell, limp, onto the toilet. He noticed that Mr Crockett had tied his hands together and his feet together. He was unresponsive and showed no signs of life. Another officer arrived at the cell within a minute of the radio transmission. He moved the cellmate out of the cell to create more space and then helped the officer move Mr Crockett to the centre of the cell floor.
47. A nurse and a healthcare assistant arrived at the cell with medical equipment within 30 seconds, at the same time as a custodial manager. The nurse checked Mr Crockett and found no pulse. He had cuts to both his wrists, which were tied together with ripped bed sheets. She asked an officer to untie Mr Crockett's wrists.
48. An officer noticed Mr Crockett's body was still warm and he had ligature marks on his neck and wrists. He started cardiopulmonary resuscitation by doing chest compressions the nurse administered oxygen through an ambu bag. The nurse attached the defibrillator but it did not find a shockable heart rhythm.
49. Resuscitation efforts continued until the paramedics arrived at 12.05am on 17 July. Paramedics continued emergency treatment, a pulse was found and Mr

Crockett was taken to hospital at 12.43am. He died in hospital later that morning at 8.25am.

### **Staff and prisoner support**

50. The duty governor had attended the prison at 12.52am. He debriefed the staff involved in the emergency response and offered his support and that of the staff care team. Staff checked on the cell mate and reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been affected by Mr Crockett's actions.

### **Family liaison**

51. Immediately after the duty governor had debriefed staff, he phoned Mr Crockett's partner and explained what had happened. He met her at the hospital at 3.43am on 17 July and offered support. Mr Crockett's partner was present when he died. He told Mr Crockett's partner that Exeter's family liaison officer would contact her soon.
52. Exeter had no family liaison officers on duty on 17 July. Two officers were appointed as family liaison officers on 18 July. They were told that Mr Crockett's partner had contacted the prison. An officer phoned Mr Crockett's partner at around 10.20am. They continued to offer support to Mr Crockett's partner and in line with Prison Service policy, Exeter contributed to the costs of Mr Crockett's funeral.

### **Post mortem report**

53. A post-mortem examination confirmed that the cause of Mr Crockett's death was hypoxic-ischaemic encephalopathy caused by suspension by a ligature.

### **Suicide note**

54. Staff found a note written by Mr Crockett in his cell which was addressed to his partner and indicated that he intended to take his life. He spoke of his love for his partner and praised the staff at Exeter.

# Findings

## Management of risk of suicide and self-harm

55. In line with Prison Service Instructions (PSI) 64/2011 on safer custody, staff appropriately started ACCT procedures for Mr Crockett when he arrived at Exeter on 16 July. The level of observations set was reasonable and reflected his circumstances.
56. Mr Crockett was at Exeter for a very short period, around a day and a half. During this time, he had significant contact with staff and his cellmate, and gave them no indication that he had any suicidal thoughts. He was fully aware that if he was found guilty of the charges against him, he faced a lengthy prison sentence. We do not consider that staff at Exeter could have predicted that Mr Crockett intended to take his own life imminently.

## Clinical care

57. The clinical reviewer, considered that the care that Mr Crockett received from healthcare staff at HMP Exeter was equivalent to the care he could have expected to receive in the community. He was satisfied that Mr Crockett was treated with appropriate alcohol detoxification treatment.

## Family liaison

58. Mr Crockett's partner told the investigator that she had expected a representative from Exeter to contact her within 24 hours after Mr Crockett died but no one did. When she called the prison, no one was available to speak to her.
59. Exeter told us that the reason for the delay in contacting Mr Crockett's partner was that there was no family liaison officer available at the time of Mr Crockett's death. This meant that a family liaison officer had not been appointed promptly enough to initiate immediate contact with Mr Crockett's next of kin.
60. Since Mr Crockett's death, the Governor has reviewed the operation of the family liaison function and implemented new procedures. There is now a duty rota in place so that a family liaison officer is always on duty and can contact a prisoner's next of kin promptly after a serious incident. Exeter has appointed additional family liaison officers to ensure cover can be provided at all times. We therefore make no recommendation.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations