

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lewis Francis a prisoner at HMP Exeter on 24 April 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: 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 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: 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 Lewis Francis was found hanged in his cell at HMP Exeter on 24 April 2017. He was 20 years old. We offer our condolences to Mr Francis' family and friends.

Mr Francis had a diagnosis of Asperger's syndrome, personality disorder and ankylosing spondylitis. He had a history of illicit drug use. Staff at Exeter appropriately referred Mr Francis for an assessment to establish whether he was suitable for transfer to a specialist mental health unit. The timing of this assessment was outside the prison's control and it had not taken place before Mr Francis' death.

The investigation found no deficiencies in the operation of suicide and self-harm prevention procedures at Exeter or with the clinical care given to Mr Francis. Mr Francis was appropriately supported as a complex needs prisoner by the mental health and safer custody teams. We consider that staff at Exeter could not have predicted that Mr Francis intended to take his own life on 24 April and, therefore, could not have prevented his actions.

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

January 2018

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	12

Summary

Events

1. Mr Lewis Francis had been diagnosed with Asperger's syndrome (a lifelong developmental disability that affects how people perceive the world and interact with others), personality disorder and ankylosing spondylitis (a long term chronic condition affecting the spine and other parts of the body). He also had a history of illicit drug use. On 17 February 2017, Mr Francis was remanded into custody at HMP Exeter, charged with attempted murder. He was next scheduled to appear in court on 17 July. This was Mr Francis' first time in custody.
2. On Mr Francis' arrival at Exeter, staff monitored him under Prison Service suicide and self-harm prevention procedures (known as ACCT) until 4 April. He continued to be monitored by staff as a complex needs prisoner throughout his time at Exeter.
3. On 9 March, Mr Francis was referred for assessment to establish whether he was suitable for transfer to a specialist mental health unit. The unit offered an appointment on 21 April but cancelled this shortly before Mr Francis' death and said a fresh date would be arranged.
4. On 24 April, at 7.28pm, an officer found Mr Francis hanged in his cell, requested an ambulance and began cardiopulmonary resuscitation (CPR). Both officers and medical staff attended and CPR continued until paramedics arrived. The paramedics took over emergency treatment but at 7.58pm pronounced Mr Francis dead.

Findings

Management of risk of suicide and self harm

5. We found that ACCT procedures at Exeter were correctly conducted in line with mandatory national instructions and Mr Francis received excellent support from staff. All case reviews were multidisciplinary and Mr Francis' father and grandmother were also involved in the ACCT procedures. After the ACCT was closed, Mr Francis continued to be monitored by officers and healthcare staff as a prisoner with complex needs.
6. Mr Francis was appropriately referred for assessment to establish whether he was suitable for transfer to a specialist mental health unit. The timing of this assessment was outside the prison's control and an appointment was outstanding at the time of Mr Francis' death.
7. Mr Francis had given no indication either verbally or in terms of how he presented to staff or other prisoners that he had thoughts of suicide. However, during a phone call to his father on the morning of his death, Mr Francis said that he did not want to live anymore but this was not reported to the prison. We do not consider that prison staff could have predicted or prevented his actions.

Clinical care

8. The investigation identified no concerns with Mr Francis' treatment while in custody. The clinical review also concluded that the care provided to Mr Francis was equivalent to that he could have expected to receive in the community.

The Investigation Process

9. 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. One prisoner responded.
10. The investigator visited Exeter on 4 May. He obtained copies of relevant extracts from Mr Francis' prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Francis' clinical care at the prison.
12. The investigator interviewed seven members of staff and three prisoners at Exeter in May. All the staff interviews were conducted jointly with the clinical reviewer.
13. 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.
14. One of the Ombudsman's family liaison officers contacted Mr Francis' parents, to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. Mr Francis' father wanted to know how his son's mental health and illicit drug withdrawal was assessed and managed, what medication was prescribed and the details of events on the day of his death. Mr Francis' mother wanted to know what consideration, if any, was given to sectioning her son under the Mental Health Act. Mr Francis' parents received a copy of the initial report. The solicitor representing Mr Francis' father wrote to us raising a number of questions that do not impact on this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Exeter

15. 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

16. The most recent inspection of HMP Exeter was conducted in August 2016. Inspectors found 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. Weekly multidisciplinary complex cases meetings were held with relevant safer custody and healthcare staff, including a psychiatrist, where cases were reviewed in detail which showed good individualised support. Inspectors found in cases where prisoners had been subject to constant watch, these had been properly authorised and were included in the complex cases meetings. Inspectors found that intelligence gathering was comprehensive, security information was analysed well and the drug supply reduction strategy and action plans were good. Inspectors found that healthcare, 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

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 annual report to December 2016, the IMB reported a significant concern about the number of seriously mentally ill prisoners whose needs could not be met in the prison environment, despite commendable efforts of safer custody and healthcare staff. The IMB was also concerned that there had been an increase in violence and believed that staffing pressures and the availability of illicit drugs were a factor in this. The IMB noted that the amount of workshop space available restricted the number of prisoners who could be offered work placements.

Previous deaths at HMP Exeter

18. Mr Francis' death was the twelfth self-inflicted death at Exeter since 2014. There were no similarities with the circumstances of the other deaths and that of Mr Francis.

Assessment, Care in Custody and Teamwork (ACCT)

19. 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. Regular multidisciplinary review meetings involving the prisoner should be held. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

20. On Friday 17 February 2017, Mr Lewis Francis was remanded into custody at HMP Exeter charged with the attempted murder of his mother. Mr Francis had not been in prison before. He had been diagnosed with Asperger's syndrome, personality disorder and ankylosing spondylitis. He also had a history of illicit drug abuse.
21. Immediately before the incident and his arrest, Mr Francis had taken an overdose of phenibut. (Phenibut was developed in Russia and used to treat stress, anxiety, depression and insomnia. However, in other parts of the world it is not approved for clinical use. Overdose withdrawal symptoms include psychosis, hallucinations, severe anxiety, agitation, insomnia, nausea and loss of appetite.) There is no intelligence to suggest that Mr Francis took any form of illicit drugs while he was in Exeter.
22. When Mr Francis arrived at Exeter at 2.00pm, an ACCT was immediately opened and he was placed under constant supervision as staff were concerned for his safety. The Head of Residence and Safety authorised the constant supervision. He recorded that Mr Francis had taken an overdose which gave serious concerns about his mental health, that he had been under constant supervision while in police custody and that he was at a high risk of self-harm. Mr Francis was allocated a cell in healthcare.
23. A prison doctor saw Mr Francis and recorded that he was agitated and distressed. During the consultation with him Mr Francis displayed evidence of thought disorder and his behaviour was severely disinhibited. The doctor recorded that he had serious concerns as to whether prison was an appropriate environment for Mr Francis to be housed. He commented that he had read the pre-custody psychiatric report. This echoed his concerns and did not give a clear reason why Mr Francis was processed through the criminal justice system. He also commented that a mental health assessment carried out on 16 February stated that Mr. Francis lacked the mental capacity to engage with the criminal justice system. He asked for an urgent mental health assessment to be carried out and prescribed diazepam (for anxiety disorders) for three days.
24. At 5.30pm, a mental health nurse visited Mr Francis in his cell, as requested by the prisoner doctor. She recorded that Mr Francis was on an ACCT, under constant supervision, had been asleep since 4.30pm, and was still sound asleep. She noted that Mr Francis had taken an overdose of phenibut before his arrest and had been overactive, aggressive and agitated. She recorded that Mr Francis would be assessed after the weekend.
25. Between 18 February and 26 February, there were seven enhanced ACCT case reviews. Each review was multidisciplinary and the assessment on each occasion assessed that Mr Francis remained at high risk of suicide and self-harm and that the constant supervision should remain in place. The prison doctor chaired the review on 24 February and arranged for Mr Francis' nominated next of kin, his father, and his grandmother, to be present, along with input from a consultant psychiatrist.

26. During the same period, Mr Francis had 29 face-to-face interventions with members of healthcare. These included an assessment on 20 February, by a mental health nurse and an assessment by the consultant psychiatrist on 24 February.
27. Mr Francis told the consultant psychiatrist that he had previously used cannabis, MDMA (commonly known as Ecstasy), phenylethylamine (a strong stimulant of the central nervous system). He said he had taken phenibut twice. Mr Francis said he believed that his current experiences had alien involvement, that he was being baked alive, and that he believed he was a ghost and the only way to escape this eternal torment was to kill his mother so that she no longer existed. The consultant psychiatrist recorded that Mr Francis had suffered a psychotic episode and that his level of insight into his beliefs fluctuated greatly. He prescribed risperidone (an antipsychotic).
28. On 27 February, a custodial manager chaired an ACCT case review with a mental health nurse, an officer and Mr Francis present. Mr Francis said he understood that the drugs he took in the community were very bad for him and the effects had started to wear off. He said he felt he was now able to communicate better. He said he had no thoughts of self-harm or suicide. The custodial manager recorded that Mr Francis' demeanour, health and wellbeing had all greatly improved since he first arrived at Exeter. He and the nurse assessed Mr Francis as being at a low risk of suicide and self-harm, and reduced the level of observations from constant to hourly over the course of the day, and to half-hourly over the course of the night. He completed the ACCT caremap which contained actions for Mr Francis to continue to engage with mental health, for him to be compliant in taking his medication and to move from healthcare to the main part of the prison.
29. The same day, the consultant psychiatrist and the learning disabilities nurse saw Mr Francis. Mr Francis said he felt he was burning up inside, suffered from disturbed sleep, heard voices and was distressed as he did not know how to deal with these experiences. He said he had stopped taking the risperidone because he felt it did not work. The psychiatrist prescribed olanzapine (an antipsychotic) to be administered at 8.00pm, as this would help Mr Francis sleep.
30. The consultant psychiatrist also recorded that he had contacted Mr Francis' mother by phone. Mr Francis' mother said she first had concerns about her son's mental health three weeks before he took the second large amount of phenibut. She said her son had been previously prescribed sertraline (an antidepressant) about two years earlier and was less anxious and stressed. He recorded that he informed Mr Francis' mother of her son's current presentation, medication, management of his care and emphasised the uncertainty of the diagnosis. He hoped Mr Francis' condition was drug-induced and would eventually resolve itself.
31. Between 28 February and 3 April, the custodial manager chaired seven ACCT reviews. Each review was multidisciplinary and included input from the consultant psychiatrist, and Mr Francis' father and grandmother. The assessment on each occasion was that Mr Francis was at low risk of self-harm and suicide, and the level of observations were gradually reduced to two

recorded conversations during the day and four observations during the night. The custodial manager updated the caremap, recording that Mr Francis moved from healthcare to a single cell on A wing on 7 March.

32. During the same period, Mr Francis had 21 face-to-face interventions with healthcare staff, including the consultant psychiatrist and two nurses. On 9 March, the psychiatrist referred Mr Francis for assessment by a hospital to establish his suitability for admission to their mental health unit, and an appointment was subsequently offered for 21 April. The psychiatrist also prescribed mirtazapine, in addition to olanzapine, to help Mr Francis sleep. Staff also held four multidisciplinary complex case reviews that considered Mr Francis' ongoing care and need for continued monitoring.
33. On 22 March, a nurse recorded that Mr Francis refused to take his olanzapine and attempted to divert his mirtazapine by not swallowing it and hiding it under his bottom lip. Mr Francis eventually swallowed it after persuasion from staff. A prison doctor stopped Mr Francis' prescription of mirtazapine. He recorded that Mr Francis would have to see a doctor if his mood deteriorated.
34. On 4 April, a custodial manager and a mental health nurse held an ACCT case review with Mr Francis. He recorded that Mr Francis mixed with prisoners on the wing and there were no signs of any concern. Mr Francis had regular contact and visits from his father and said he had no thoughts of self-harm or suicide but felt guilt for what he had done which upset him. He recorded that he and the nurse talked at length with Mr Francis to explain how he needed to take responsibility for himself and accept the situation in which he found himself. He and the nurse agreed that Mr Francis' risk of suicide and self-harm was low and agreed to close the ACCT. He updated the caremap as all the actions had been completed. They set a post-closure review for 11 April.
35. Following the review, the custodial manager contacted Mr Francis' father to explain that the ACCT had been closed, that Mr Francis' demeanour and condition had greatly improved, that he mixed with others on the wing and regularly used the gym. However, he said that while Mr Francis needed to take responsibility for himself, staff would still monitor him as a complex needs prisoner. Mr Francis' father agreed that his son had to take responsibility for his actions and his care.
36. On 5 April, a multidisciplinary complex case review was held to consider Mr Francis' ongoing care. It was recorded that the ACCT had been closed, the post closure interview was scheduled for 11 April, and the custodial would remain as Mr Francis' case manager. It was noted that Mr Francis mixed well with other prisoners, was on the waiting list for a place in the workshops and he had excellent family support. There was a concern that Mr Francis became aggressive when things did not go his way or when he did not get what he wanted. Mr Francis had been told he had to take responsibility for his actions. It was agreed that monitoring would continue.
37. On 11 April, the custodial manager conducted the ACCT post closure interview with Mr Francis. Mr Francis said that he got good support from staff and the other prisoners, was in regular contact with his father and enjoyed going to the gym.

38. The same day, a nurse recorded in Mr Francis' medical record that there had been a review concerning whether to restart his prescription of mirtazapine. As there had been no observations that Mr Francis' mood had deteriorated, it was agreed that that his mirtazapine would not be restarted.
39. On 13 April, a multidisciplinary complex case review was held to consider Mr Francis' ongoing care. It was noted that Mr Francis mixed well with prisoners and received good peer support. He had been allocated a place in the workshops but his attendance was inconsistent. He continued to receive support from his father. There was still a concern that Mr Francis became aggressive when things did not go his way or he did not get what he wanted. It was agreed that monitoring would continue.
40. On 19 April, a nurse saw Mr Francis for a mental health review. Mr Francis said that he doubted that his mother would ever forgive him for what he had done and their relationship was very strained. He said his father continued to give him support. He recorded that Mr Francis had no physical issues but he would continue to be monitored by the mental health team.
41. On 20 April, a multidisciplinary complex case review was held to consider Mr Francis' ongoing care. It was recorded that Mr Francis had settled down into life in prison. It was noted that the hospital had cancelled the psychiatric assessment scheduled for 21 April. A new date was to be arranged but this was a decision to be taken by the hospital and the prison was unable to do more in effecting Mr Francis' transfer to a secure unit. A letter had been received from Mr Francis' father about the review of his son's ankylosing spondylosis at another hospital. Healthcare would liaise with this hospital and facilitate any necessary appointments. It was noted that Mr Francis was due to appear in court on 17 July, and that this might affect his behaviour around this time. It was agreed that monitoring would continue.
42. The same day, the custodial manager saw Mr Francis and recorded that there was no need to re-open an ACCT as Mr Francis was doing well, mixed with other prisoners and enjoyed going to the gym. He also recorded in Mr Francis' prison computer record that he had contacted Mr Francis' father to provide him with an update on his son's progress, that monitoring would continue and that there was nothing to cause any concerns.
43. Mr Francis' prison phone records show that he called his father at 5.12pm, on 22 April. The investigator has listened to this call which lasted 14 minutes and 57 seconds. Mr Francis told his father he had pains in his stomach and complained that he did not get the medication he wanted. Mr Francis' father told his son this was because he had previously hidden his medication. Mr Francis said he wanted to know whether he was getting better. His father said that it would take time to recover, that Mr Francis should stop worrying and think positively. Mr Francis' father said he believed Mr Francis was in much better shape mentally, and he had spoken to the custodial manager who had told him that his son had made good progress. Prison records show that Mr Francis' father was scheduled to visit his son on 25 April and 29 April.

Events of 24 April

44. On 24 April, at 10.22am, Mr Francis called his father. This call lasted 11 minutes and 20 seconds. The investigator has listened to this call. Mr Francis complained that he had stomach pain, heartburn and loss of appetite. Mr Francis' father told him to get some medication from the doctor for heartburn. Mr Francis became very tearful and said, "I can't deal with the regret; I don't want to live anymore". Mr Francis' father kept reassuring his son that he could cope with his feelings and that his type of reaction was normal after people had taken an overdose of drugs. The call ended with Mr Francis' father telling his son that he could deal with his emotions, that he should get an appointment with the doctor and that he would see him the next day. Mr Francis replied, "See you tomorrow".
45. The custodial manager told the investigator that Mr Francis' father visited his son weekly and at these visits Mr Francis would exchange his clothing to be laundered. He said that there was no intelligence or evidence to suggest that Mr Francis was being bullied.
46. Two prisoners on A wing told the investigator that Mr Francis had seemed fine throughout the course of 24 April and gave no indication that he had thoughts of self-harm or suicide. Both prisoners said that Mr Francis was not being bullied.
47. Prisoner A said that Mr Francis enjoyed going to the gym and did so three to four times a week. Mr Francis would also exercise on the wing with him. Prisoner B said that when he spoke to Mr Francis at meal time that evening he noticed that Mr Francis had left damp clothes on his floor. Mr Francis said he was going to give these to his father when he visited the next day.
48. At 5.30pm, Officer A locked prisoners on A wing into their cells after the evening meal had been served. He told the investigator that when he got to Mr Francis' cell, Mr Francis was already there and sitting on the bed. He said Mr Francis was in a good mood and they shared a joke. He asked Mr Francis if he needed anything, and Mr Francis said he had everything he needed. He said he would see him in the morning and locked the cell door. He told the investigator that Mr Francis was fully dressed when he locked the cell door.
49. At 7.28pm, Officer B was conducting a prisoner roll check, when he saw Mr Francis hanging from the window bars in his cell by a ligature made from clothing. He was dressed only in his underwear. Mr Francis' cell was very close to the wing office and he shouted for staff assistance and immediately entered the cell.
50. Officers responded. A custodial manager immediately radioed an emergency code blue, which indicates a prisoner is unable to breathe or having difficulty breathing. The control room log shows the code blue was called over the radio at 7.28pm and an ambulance was called immediately. Officer B supported Mr Francis' body and an officer cut the ligature. They lowered Mr Francis to the floor and other officers began cardiopulmonary resuscitation (CPR).
51. Two nurses immediately responded to the code blue call. The nurses continued with the resuscitation and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is

found. The defibrillator found no shockable rhythm, so the nurses continued with CPR. Paramedics arrived at 7.32pm and took over Mr Francis' care. At 7.58pm, the paramedics pronounced Mr Francis dead.

Contact with Mr Francis' family

52. The Deputy Governor and a prison chaplain visited Mr Francis' father, his nominated next of kin, at his home in Somerset at 11.00pm. They broke the news of Mr Francis' death and offered their condolences and support. In the days that followed, Exeter maintained contact with Mr Francis' family and, in line with Prison Service guidance, the prison contributed to the costs of the funeral.

Support for prisoners and staff

53. The Deputy Governor held a debrief for staff involved in the emergency response, 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.
54. The prison posted notices informing staff and prisoners of Mr Francis' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Francis' death.

Post-mortem report

55. A post-mortem examination, conducted by a Home Office Forensic Pathologist, confirmed that the cause of Mr Francis' death was compression of the neck caused by suspension by a ligature. He noted that the toxicology results confirmed that Mr Francis was not under the influence of alcohol or any illicit drugs at the time of his death.

Findings

Management of risk of suicide and self harm

56. Staff correctly opened an ACCT on 17 February immediately on Mr Francis' arrival at Exeter. We consider that Exeter correctly authorised placing Mr Francis under constant supervision, and this decision was reviewed in accordance with the instructions contained in PSI 64/2011, which sets out the Prison Service's framework for delivering safer custody procedures.
57. We consider that the decision to end constant observation on 27 February was appropriate, and judge that Mr Francis received appropriate ongoing support from staff thereafter, in particular from the custodial manager. We judge that the decision to close the ACCT on 4 April was appropriate. We also consider it good practice that Mr Francis continued to receive support and monitoring as a complex needs prisoner.
58. Mr Francis gave no indication to staff or prisoners that he had any suicidal thoughts in the days immediately before 24 April. However, on the morning of his death, Mr Francis told his father, in a phone call, that he did not want to live anymore. This was not known to staff.
59. We do not consider that staff at Exeter could have predicted that Mr Francis intended to take his own life or therefore done anything to prevent his actions.

Clinical Care

60. The clinical reviewer considered that the care that Mr Francis received from healthcare staff at HMP Exeter was equivalent to the care he would have received in the community. He commented that Mr Francis had taken large doses of a drug known to cause psychosis, anxiety and aggression. He agreed with the consultant psychiatrist's conclusion that Mr Francis had a drug-induced psychosis, with underlying behavioural issues and Asperger's syndrome.
61. The clinical reviewer was satisfied that Mr Francis was treated with appropriate antipsychotic medication. His condition improved significantly and he displayed less anxiety, aggression and was less withdrawn. He noted that there was an outstanding assessment to consider whether Mr Francis was suitable to be transferred to a specialist mental health unit. He concluded that Mr Francis' death could not have been predicted or prevented.

**Prisons &
Probation**

Ombudsman
Independent Investigations