

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Phoenix Pritchard a prisoner at HMP Exeter on 7 December 2018

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

## 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 Phoenix Pritchard died in hospital on 7 December 2018, after being found hanged in his cell at HMP Exeter on 5 December. He was 18 years old. I offer my condolences to Mr Pritchard's family and friends.

Mr Pritchard had been in care since the age of 14. He had been diagnosed with a personality disorder, anxiety and depression. He had a history of illicit drug use.

He was managed under suicide and self-harm prevention procedures (known as ACCT) during the 12 days he spent at Exeter, and our investigation found that the management of these procedures was extremely poor.

We have expressed concerns about deficiencies in the management of suicide and self-harm procedures at Exeter in previous investigations. Following an inspection of Exeter in May 2018, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State setting out his significant concerns about the safety of prisoners at Exeter. The Secretary of State responded on 27 June 2018 with an action plan to deliver improvements and said, among other things, that the prison would put an updated safety strategy in place by the end of July 2018 which would take account of the findings from HMIP's inspection and the PPO's investigation reports.

I am, therefore, very concerned to find such poor practice again in November 2018. I am copying this report to Secretary of State to make him aware of my concerns.

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

**Sue McAllister, CB**  
**Prisons and Probation Ombudsman**

**August 2019**

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# Summary

## Events

1. On 24 November 2018, Mr Phoenix Pritchard was remanded into custody at HMP Exeter, charged with burglary. He was 18 years old. This was his second time in custody and he had been released from Exeter a few days earlier on 19 November.
2. Mr Pritchard had been in local authority care from the age of 14. He received support from Devon County Council Children's Services. He had been diagnosed with a personality disorder, anxiety and depression and was prescribed medication. He also had a history of illicit drug use.
3. On Mr Pritchard's arrival at Exeter, staff monitored him under Prison Service suicide and self-harm prevention procedures (known as ACCT). He was initially checked once an hour but on 25 November, his risk to himself was assessed as low and the checks were reduced to two during the day and five at night.
4. The ACCT review scheduled for 30 November did not take place.
5. On 1 December, Mr Pritchard received a cut lip during an argument with another prisoner. On 3 December, Mr Pritchard assaulted another prisoner. He was placed on a disciplinary charge and confined to his cell pending a disciplinary hearing. The ACCT review scheduled for 3 December did not take place.
6. On 4 December, a preliminary disciplinary hearing took place. Mr Pritchard said that the prisoner he had assaulted had stolen his trainers. The full hearing was adjourned until 14 December. Mr Pritchard had an ACCT review that afternoon. He said he had no thoughts of suicide or self-harm and his risk to himself was assessed as low.
7. On 5 December, at 4.49pm, a member of staff found Mr Pritchard hanged in his cell. He requested an ambulance and began cardiopulmonary resuscitation (CPR). Officers and medical staff attended and CPR continued until paramedics arrived.
8. The paramedics took Mr Pritchard to the intensive care unit at the hospital, where he was placed on life support. On 7 December, hospital doctors withdrew life support and at 2.35pm, Mr Pritchard was pronounced dead.

## Findings

### Management of risk of suicide and self-harm

9. Although Mr Pritchard it was appropriate that Mr Pritchard was monitored under ACCT procedures, we found that the management of these procedures was extremely poor.
10. We consider that Mr Pritchard's risk to himself was not adequately assessed. Staff did not give sufficient weight to Mr Pritchard's significant risk factors (including his young age, his mental health concerns and his history of suicide

and self-harm) and relied too much on his assertions that he had no intention of killing himself.

11. We found that ACCT procedures at Exeter were not conducted in line with mandatory national instructions. Staff did not carry out two scheduled case reviews, and Mr Pritchard had only two ACCT reviews, eight days apart, during the 12 days he spent at Exeter. The second case review was not multidisciplinary, staff did not maintain the ongoing record of interventions as required, and one officer knowingly made a false entry.
12. In addition, the ACCT document did not accompany Mr Pritchard as it should have done when he moved around the prison. As a result, the adjudicator who opened the disciplinary hearing on 4 December, did not know Mr Pritchard was on an ACCT.
13. Mr Pritchard's key worker only met him by chance 11 days after he entered the prison and did not know that he was on an ACCT.
14. In May 2018, HM Chief Inspector of Prisons invoked the Urgent Notification protocol because of his concerns about the safety of prisoners at Exeter. The Justice Secretary said in response that improvements would be made. We are, therefore, very concerned to have found such poor practice a few months later.

### **Clinical care**

15. The clinical reviewer concluded that the care provided to Mr Pritchard was equivalent to that which he could have expected to receive in the community. Mr Pritchard's physical health was appropriately assessed and reviewed and he received appropriate support from the mental health team.

### **Recommendations**

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - assessing a prisoner's level of risk on the basis of recognised risk factors and not just on the prisoner's presentation or what he says;
  - holding ACCT reviews as scheduled;
  - holding multi-disciplinary ACCT reviews as required;
  - accurately recording all conversations, contacts and observations with prisoners in the ACCT document; and
  - recording the reasons for decisions.
- The Governor should ensure that SO A and SO B receive further ACCT case manager training in conducting ACCT assessments and reviews before they perform those roles again.
- The Governor should ensure that key workers meet their assigned prisoners within a few days of their arrival.

- The Prison Group Director for Devon and North Dorset should provide the Ombudsman with an account of the actions she intends to take in response to the concerns about the management of ACCT procedures at Exeter set out in this report.

## The Investigation Process

16. 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.
17. The investigator visited Exeter on 13 December. He obtained copies of relevant extracts from Mr Pritchard's prison and medical records.
18. NHS England commissioned a clinical reviewer to review Mr Pritchard's clinical care at the prison.
19. The investigator interviewed 14 members of staff at Exeter in January 2019. Four of the interviews were conducted jointly with the clinical reviewer.
20. We informed HM Coroner for Exeter and Greater Devon District of the investigation. He gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.
21. The Ombudsman's family liaison officer contacted Mr Pritchard's mother to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Pritchard's mother wanted to know what support her son had received for self-harm and how this was managed. We have answered Mr Pritchard's mother's questions in this report. Mr Pritchard's mother received a copy of the initial report. She did not make any comments.

# Background Information

## HMP Exeter

22. HMP Exeter is a Victorian city-centre prison which covers the courts of Devon, Cornwall and Somerset. It holds up to 561 adult men and young offenders. Care UK provide primary healthcare and commission Devon Partnership NHS Trust to provide mental health care.

## HM Inspectorate of Prisons

23. HM Inspectorate of Prisons (HMIP) carried out an inspection of Exeter in May 2018. Inspectors found that, despite a significant increase in staffing since the last inspection in August 2016, there had been a sharp deterioration in outcomes for prisoners. They noted that many of their previous recommendations had been ignored. They were particularly concerned to find that the key area of prisoner safety attracted their lowest possible grading of 'poor'. Inspectors reported that two-thirds of prisoners did not feel safe, there had been a 40% increase in incidents of self-harm and six self-inflicted deaths since their last inspection, prisoner on prisoner assaults were at the highest levels seen in the previous three years, and illicit drugs continued to be readily available. The inspectors were also concerned about poor living conditions.
24. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State in May 2018 setting out his significant concerns about the treatment of prisoners at Exeter and the conditions in which they were held.
25. The Secretary of state responded on 27 June 2018 with an action plan to deliver improvements and said, among other things, that Exeter had been identified as a Prison of Concern for Safety and would receive bespoke support from the National and Group Safety Teams to help address the prison's safety issues. The prison would put an updated safety strategy in place by the end of July 2018 which would set out their priorities and supporting actions to address the drivers for violence and self-harm. This would take account of the findings from HMIP's inspection and the PPO's investigation reports.

## Independent Monitoring Board

26. 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, published in August 2018, the IMB commented on the large number of ACCTs that were opened, some containing only very brief comments and lacking detail. The IMB was concerned that the significant increase in the levels of violence and illicit substances remained the key driver behind this. The IMB commented that despite illicit substances being recovered through both random and intelligence-led cell searches, incidents of prisoners being found under the influence of illicit substances were frequent.

### Previous deaths at HMP Exeter

27. Mr Pritchard's was the second self-inflicted death at Exeter in 2018, and the eleventh since January 2016. In six of these earlier investigations, we identified concerns with the management of the ACCT process.
28. Over the same period, 15 prisoners died from natural causes.
29. Since Mr Pritchard's death, there have been three further deaths at Exeter, two from natural causes and one awaiting classification.

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

30. 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.
31. 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

32. On 24 November 2018, Mr Phoenix Pritchard was remanded into custody at HMP Exeter charged with burglary. This was his second time in custody and he had been released from Exeter a few days earlier on 19 November.
33. Mr Pritchard had been in local authority care since the age of 14. He had been diagnosed as having a personality disorder, anxiety and depression. He also had a history of illicit drug abuse.
34. When Mr Pritchard arrived at Exeter on 24 November, an ACCT was opened immediately as staff were concerned about Mr Pritchard's mental health and his ability to cope on returning to custody so soon after his release.
35. Supervising Officer (SO) A saw Mr Pritchard in reception and completed the immediate action plan. She assessed Mr Pritchard as being at raised risk and set his level of observations at hourly throughout the day and night until the first case review.
36. A nurse saw Mr Pritchard in reception. She recorded that an ACCT had been opened and that Mr Pritchard had returned to custody only a few days after release. He appeared calm and settled and said he had no thoughts of self-harm. She recorded that Mr Pritchard's prescribed medication was quetiapine (an antipsychotic), fluoxetine (an antidepressant) and melatonin (for insomnia). She referred Mr Pritchard to the doctor so that further medication could be prescribed.
37. A prison GP did not see Mr Pritchard but reviewed his medical record and prescribed quetiapine and fluoxetine but not melatonin. (She told the investigator that, because of the potential side effects, melatonin can only be prescribed for children and young people by a specialist, and GPs can only prescribe it for adults over the age of 55 for short periods.)
38. On the morning of 25 November, an officer assessed Mr Pritchard as part of the ACCT procedures. Mr Pritchard said that he had used illicit doses of Valium (prescribed for anxiety, muscle spasm and seizures) to help with his anxiety since the age of 14. He said he had self-harmed four months earlier by burning himself. Mr Pritchard said he only did this because his anxiety got the better of him. He also said that he had tried to hang himself at the beginning of 2018, but he knew he did not want to kill himself. However, Mr Pritchard said he had thoughts of self-harm most days and said the time over Christmas would be stressful for him.
39. At 10.20am, a SO chaired the first ACCT case review with a nurse from the mental health team and Mr Pritchard present. An officer provided verbal input to The SO before the case review about his assessment.
40. The SO recorded that Mr Pritchard had only been release from Exeter for a few days before being charged and remanded back into custody. Mr Pritchard said he felt frustrated about being back in custody but would feel better once he had been sentenced. Mr Pritchard said he had no thoughts of suicide or self-harm. He said he had been diagnosed with a personality disorder and depression and

was prescribed fluoxetine and quetiapine. He said he was not in contact with his family as he did not want to speak to them but that he did speak to his friends.

41. The SO and the nurse assessed Mr Pritchard as being at low risk of suicide and self-harm and reduced the level of observations to two during the day and five during the night, with one recorded conversation in the morning and afternoon.
42. The SO completed the ACCT caremap which contained one action for Mr Pritchard: to have an appointment with a doctor to review his medication. The next case review was set for 30 November.
43. The nurse recorded in Mr Pritchard's medical record that he was already known to staff from his last time in prison. She noted the medication that had been prescribed for Mr Pritchard. She assessed that Mr Pritchard would benefit from regular sessions with the mental health support practitioner. She recorded that Mr Pritchard said he felt anxious about being back in prison and wanted support from staff but said he had no thoughts of self-harm or suicide.
44. On 26 November, a nurse recorded in Mr Pritchard's medical record that he, and two other nurses, all members of the mental health team, had discussed Mr Pritchard's care. They agreed that he should be seen by the mental health support practitioner.
45. On 27 November, the mental health support practitioner saw Mr Pritchard for a mental health review. Mr Pritchard said he had misused prescription drugs, was back in prison charged with new offences and was due back in court in January. He said his mood fluctuated but he had no thoughts of self-harm or suicide. He said that before entering custody, he had worked with mental health staff in the community at Wonford House. (These are mental health services provided by Devon Partnership NHS Trust.) She suggested to Mr Pritchard that, in addition to her support, he might benefit from attending the 'anxiety group' run at Exeter. Mr Pritchard said he would like to do this and she put his name on the waiting list to join the group.
46. On 30 November, an ACCT review should have taken place. SO B recorded in Mr Pritchard's prison computer record that he saw Mr Pritchard because SO A was unable to see him. Mr Pritchard said he was absolutely fine and had no thoughts of harming himself. SO B recorded that he had no concerns and would schedule the next review for 3 December, when SO A would see Mr Pritchard. SO B did not make any entry in the ACCT document.
47. When interviewed, SO B told the investigator that he was fully aware that all ACCT reviews should be recorded in the ACCT document and could offer no explanation as to why he had not done so.
48. The same day, Mr Pritchard had an appointment for a medication review but he failed to attend. The reason is unknown.
49. On 1 December, Mr Pritchard was involved in an argument with another prisoner and sustained a minor injury. A nurse recorded that Mr Pritchard had a superficial split to his upper lip and he was advised to rinse his mouth regularly with water. No other treatment was required. Mr Pritchard told the nurse that he

had not been taking his medication as it made him feel “spaced out”. The nurse referred Mr Pritchard to be seen by the doctor to review his medication.

50. On 2 December, a pharmacy technician recorded in Mr Pritchard’s medical records that he had only missed one dose of medication. She explained to the investigator that part of her role was to review prisoners’ compliance in taking their medication. If they were not compliant, she would stop the medication and arrange a review with the doctor.
51. On 3 December, at 8.10am, an officer recorded in the ACCT document that Mr Pritchard had been in a fight with another prisoner over stolen items. Another officer recorded in Mr Pritchard’s prison computer record that Mr Pritchard had been placed on report for assaulting another prisoner.
52. At 3.40pm, SO A recorded in the ACCT document that it would be difficult to conduct the scheduled ACCT review because Mr Pritchard had been confined to his cell due to the earlier assault. She recorded that she had spoken to Mr Pritchard, who said he was fine and was happy for the review to take place after his adjudication the next day. She recorded there were no issues or concerns for Mr Pritchard’s wellbeing.

#### **4 December 2018**

53. On 4 December, at 11.30am, the Head of Residential and Services saw Mr Pritchard to open the adjudication (disciplinary hearing) in her capacity as adjudicating Governor. She recorded that Mr Pritchard pleaded not guilty to the charge of assaulting another prisoner, and the matter was adjourned until 14 December.
54. She explained that because of the serious nature of the charge she had the choice of dealing with the matter in-house, referring the matter to the police or referring it to an independent adjudicator (a judge) who had the power to add time to Mr Pritchard’s sentence if he was found guilty of the assault. She said because there were no injuries to the other prisoner, her recommendation was to refer to the matter to the independent adjudicator.
55. She told the investigator she spoke with Mr Pritchard and asked about his welfare. She tried to establish why the incident had occurred. She said he had been in custody before, but only for a short period. She asked him if he felt safe on the wing, and he said he did. She also asked Mr Pritchard whether he thought he would be at risk if he was sent back to his existing cell, and whether he thought there would be any further repercussions from his argument. He said not. Mr Pritchard said that the other prisoner was a friend of his and the argument had been over stolen trainers.
56. She confirmed with the prison’s Security Department that Mr Pritchard had reported to staff that his trainers had been stolen. She asked Mr Pritchard to provide a description of his trainers so staff could try to find them. Mr Pritchard declined and said that this would just antagonise the situation. She told the investigator that without an exact description of the trainers it was very difficult for staff to resolve the situation. She said staff gave Mr Pritchard a pair of prison shoes as an alternative, which he seemed quite happy with.

57. She told the investigator that she did not know Mr Pritchard was on an ACCT. She said that although being on an ACCT would not have affected the adjudication process, she should have had the ACCT document in order to make an entry in the ongoing record. She said when a prisoner is on an ACCT, the ACCT document should accompany him on every movement within the establishment.
58. At 3.30pm, the SO A chaired an ACCT case review with Mr Pritchard. No one else was present. SO A had obtained verbal input from healthcare staff. An administrative assistant to the mental health team, recorded that he had provided the SO with the detail of the intervention that took place between the mental health support practitioner and Mr Pritchard on 27 November.
59. At the review, Mr Pritchard said he had had a fight with a prisoner who had taken something from him. Mr Pritchard said the issue had been resolved and he would accept his punishment. He said he needed to have his medication reviewed and was on the waiting list to attend the anxiety group which he felt he would be beneficial. Mr Pritchard said he felt generally “pissed off” but had no intention of harming himself.
60. SO A recorded that she advised Mr Pritchard to take his medication and attend any appointments with healthcare staff. She assessed that Mr Pritchard’s risk of suicide and self-harm was low and left the level of observations unchanged until the next review. She updated the caremap and added that Mr Pritchard should obtain an appointment to have his medication reviewed. The next review was set for 12 December.

#### **5 December 2018**

61. On 5 December, at 2.30pm, an officer saw Mr Pritchard in his cell. The officer recorded in Mr Prichard’s prison computer record that he had met Mr Pritchard by chance and introduced himself as his ‘key worker’. The officer told the investigator that the role of the key worker is to provide support to a prisoner for issues that cannot be resolved by officers on the wing.
62. Mr Pritchard told the officer about the fight he had had with another prisoner. The officer referred Mr Pritchard to a behaviour change course, and Mr Pritchard was allocated a place on the course which was due to start on 10 January 2019. He told the investigator that Mr Pritchard showed no signs of distress during the time he was with him. He said he was unsure whether he was aware that Mr Pritchard was on an ACCT or not.
63. An officer recorded in the ACCT document that she spoke to Mr Pritchard through the observation panel in his cell door at 3.15pm and that he appeared in good spirits.
64. When interviewed, the officer told the investigator she had actually seen Mr Pritchard earlier that morning to obtain his next of kin details for the ACCT document. She said Mr Pritchard was sitting on his bed and appeared “very blasé” when she asked for the details. The officer said she had not recorded this contact in the ACCT document, as she should have done, but that she had

updated the next of kin details. She said that she did not see Mr Pritchard later, at 3.15pm, although she had recorded in the ACCT document that she had.

65. At 3.40pm, the pharmacy technician and a pharmacy assistant saw Mr Pritchard in his cell to discuss his compliance in taking his medication. The pharmacy technician recorded that she and her colleague spoke to Mr Pritchard at the cell door through the observation panel. She explained to Mr Pritchard that it was important for his health that he took his medication regularly and that they wished to check that he had no issues or concerns. Mr Pritchard said that he had taken his medication that day, said he was well and thanked them for coming to speak to him.
66. At 4.49pm, an officer arrived at Mr Pritchard's cell as part of the roll check of all prisoners on the wing. He found that Mr Pritchard had covered the observation panel in his cell door. The officer called another officer over from the other side of the landing and they opened the cell door. They found Mr Pritchard hanging from the window bars with a ligature made from bedding. The officer immediately called a code blue emergency code. This is a medical emergency code which indicates a prisoner is unable, or having difficulty, breathing. The officers entered the cell, cut the ligature and lowered Mr Pritchard to the floor and began cardiopulmonary resuscitation (CPR).
67. The control room log shows the code blue emergency was radioed at 4.49pm, and an emergency ambulance was called immediately. Four nurses responded within two minutes to the code blue and they continued with CPR until the paramedics arrived.
68. Paramedics arrived at 5.00pm and, after further treatment, they took Mr Pritchard to the intensive care unit at a hospital, where he was placed on life support.
69. The Governor contacted Mr Pritchard's mother to inform her that her son had been taken to hospital and was in intensive care. Later that evening, the Governor and a family liaison officer (FLO) at HMP Exeter, met Mr Pritchard's family at the hospital.
70. On 6 December, the Governor instructed Head of the Offender Management Unit, to contact Exeter Crown Court to make representations that Mr Pritchard should be granted bail. This was on the basis of his poor prognosis, and for the benefit of his family. If he was granted bail Mr Pritchard would no longer be held in custody and there would be no requirement to have prison staff present at the hospital. This request was granted by the court later that morning and escort staff left the hospital.
71. On 7 December, hospital doctors withdrew life support and at 2.35pm, Mr Pritchard was pronounced dead.

### **Post-mortem report**

72. A post-mortem examination found that the cause of Mr Pritchard's death was hypoxic ischaemic brain injury as a result of hanging. Toxicology results did not show that Mr Pritchard had taken any illicit drugs before his death.

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

73. In the days that followed Mr Pritchard's death, the FLO stayed in touch with Mr Pritchard's mother and in line with Prison Service instructions, the prison contributed to the costs of the funeral.

### **Support for prisoners and staff**

74. The Head of Reducing Reoffending held a debrief for staff, including healthcare staff, involved in the emergency response. This was to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
75. The prison posted notices informing staff and prisoners of Mr Pritchard's 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 Pritchard's death.

# Findings

## Management of risk of suicide and self-harm

76. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.
77. As we have noted many times in individual investigation reports, thematic reports and annual reports, too often staff make decisions about risk based on their perceptions of a prisoner's presentation and statements from the prisoner that they do not have any thoughts or intention of suicide or self-harm. Known risk factors which might increase the prisoner's risk, such as a history of suicidal behaviour, or the circumstances of their offence, can often be overlooked. The lesson we have identified repeatedly is that evidence of risk should be fully considered and balanced against the prisoner's demeanour.
78. Mr Pritchard had a significant number of risk factors. Prison staff appropriately started ACCT monitoring on 24 November, when Mr Pritchard arrived at Exeter, and we consider the immediate action plan of hourly observations was also appropriate.
79. The first ACCT case review held on 25 November, was multidisciplinary. However, we consider that the assessment of Mr Pritchard's risk as 'low' was inappropriate and the decision to reduce the level of observations was premature. Mr Pritchard had only been in prison for one day. He was very young and his risk factors, which included mental health concerns and previous self-harm, remained unchanged. We are concerned that staff based their assessment on Mr Pritchard's assertion that he had no thoughts of suicide or self-harm and did not give sufficient weight to his risk factors. Given Mr Pritchard's age and risk factors, we also consider that the gap of five days before the next scheduled ACCT review was too long.
80. The case review scheduled for 30 November did not take place. SO A asked SO B to see Mr Pritchard as she did not have time to conduct the review. We do not consider that this was acceptable.
81. SO B saw Mr Pritchard but did not conduct a review. He made an entry in Mr Pritchard's prison computer record but not in the ACCT document. SO B could offer no explanation as to why he did not do this. This was very poor practice.
82. We are also very concerned that SO A did not hold the scheduled ACCT review on 3 December. She recorded that this was because Mr Pritchard was confined to his cell, but we can see no reason why this should have prevented an ACCT

review taking place. Postponing a scheduled review would have been poor practice in any event, but was particularly so in this case as Mr Pritchard had not had an ACCT review since 25 November, eight days earlier, and in the last few days he had sustained a split lip in an argument with another prisoner, had his trainers stolen, been placed on a disciplinary charge for assault and was confined to his cell.

83. Further evidence that the ACCT process was being managed badly is the fact that the adjudicating governor was not aware that Mr Pritchard was on an ACCT when she opened the disciplinary hearing on 4 December. She did not therefore see the ACCT document, which should have accompanied Mr Pritchard, or make an entry in it.
84. Although we accept that the fact that Mr Pritchard was on an ACCT would not affect whether he was guilty of the charge or not, it might have affected the handling of the adjudication. In addition, the adjudicating governor should have had the ACCT document available to record her conversation with Mr Pritchard, in particular that he said, when asked, that he felt safe and was not at risk on the wing. If the adjudicating governor had known that Mr Pritchard was on an ACCT, she might also have been more concerned about his wellbeing and might have considered whether he should be protected and monitored under Exeter's anti-bullying procedures.
85. We are very concerned that when SO A finally held the ACCT case review on 4 December, she did so on her own. Given Mr Pritchard's mental health issues, this review should have been multi-disciplinary. We note that, although SO A recorded that she had obtained verbal input from healthcare staff, Mr Pritchard's medical records show that medical input to this ACCT review had actually been provided by an administrative member of healthcare staff, not by the mental health support worker (who had carried out the mental health assessment) or a medical professional.
86. In addition, SO A did not consider whether Mr Pritchard's recent problems with other prisoners, including having his trainers stolen, and being charged with a disciplinary offence and confined to his cell, might have affected his risk of suicide or self-harm. We do not consider that she properly considered the level of risk Mr Pritchard posed to himself and we are concerned that she did not schedule another ACCT review for seven days.
87. An officer was allocated as Mr Pritchard's key worker. He did not see Mr Pritchard for his first 11 days at Exeter and then only saw him by chance. As the key worker's role is to have meaningful conversations with a prisoner and help to identify any issues they may have, we think that it would be desirable for key workers to meet prisoners earlier than this, particularly if a prisoner is on an ACCT.
88. We are concerned that the officer said he was not sure whether he knew that Mr Pritchard was on an ACCT. We would have expected a key worker to check whether one of their assigned prisoners was on an ACCT.
89. On 5 December, Mr Pritchard's key worker recorded his first conversation with Mr Pritchard in Mr Pritchard's prison computer record. Although we consider that

the officer acted promptly in getting Mr Pritchard on the next available behaviour change course, this should have been recorded in the ACCT ongoing record.

90. An officer also failed to make an entry in the ACCT document when she saw Mr Pritchard to obtain his next of kin details on the morning of 5 December. She did, however, make a false entry in the ACCT ongoing record saying that she had seen Mr Pritchard at 3.15pm and that he was in good spirits. It is extremely worrying that an officer should falsify an ACCT record in this way and suggests that the officer did not have a proper understanding of what ACCT procedures are for.
91. The Governor instigated an internal investigation into the officer's actions. The outcome was that the officer received a formal written warning in accordance with HMPPS disciplinary procedures and was required to undertake further training. We do not, therefore, make a specific recommendation about the officer.
92. It will be clear from what we have said above that we are very concerned at the extremely poor management of the ACCT process in Mr Pritchard's case. We consider that SO A's case management was so poor that it amounted to poor performance.
93. We make the following recommendations:

**The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**

- **assessing a prisoner's level of risk on the basis of recognised risk factors and not just on the prisoner's presentation or what he says;**
- **conducting ACCT reviews as specified in the national instructions;**
- **recording conversations, contacts and observations with prisoners in the ACCT record; and**
- **recording the reasons for decisions.**

**The Governor should ensure that SO A and SO B receive further ACCT case manager training in conducting assessments and reviews before they perform those roles again.**

**The Governor should ensure that key workers meet their assigned prisoners within a few days of their arrival.**

94. Given the assurances given by the Secretary of State in response to HMIP's Urgent Notification in May 2018, we are very concerned to have found such extremely poor ACCT management in this case. We recommend:

**The Prison Group Director for Devon and North Dorset should provide the Ombudsman with an account of the actions she intends to take in response to the concerns about the management of ACCT procedures at Exeter set out in this report.**

## Clinical care

95. The clinical reviewer judged that the care that Mr Pritchard received from healthcare staff at HMP Exeter was equivalent to the care he would have received in the community.
96. The clinical reviewer was satisfied that Mr Pritchard's physical health was appropriately assessed and reviewed in line with the NICE Guidelines for the physical health of people in prison. He was also satisfied that the support and engagement of the mental health team with Mr Pritchard was appropriate, was at least equivalent to that available in the wider community in terms of access and quality, and the 'stepped' approach was appropriate and relevant to Mr Pritchard's needs.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations