

**Investigation into the circumstances surrounding the death
of a man who died at HM Prison Exeter
on 19 January 2005**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

November 2005

This is the report of an investigation into the death of a man who died at HM Prison Exeter, on 19 January 2005.

I wish to offer my sincere sympathy and condolences to the man's family for their loss.

This investigation was conducted by two of my Investigators.

I would like to extend my thanks to the Governor, his staff at Exeter for their help and co-operation during this investigation and the prisoners who agreed to take part in the investigation process. I would particularly like to thank the Principal Officer who was the appointed liaison officer and who greatly assisted my investigation team.

A Clinical Review undertaken by the Exeter Primary Care Trust into the medical care the man received was unfortunately not complete at the time of writing this report.

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Prison and Probation Ombudsman
For England & Wales

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Summary

1. The man who is the subject of this report had been remanded into custody at HMP Exeter on 29 July 2004, awaiting trial for a number of offences of assault both sexual and physical against a former partner.
2. It appeared that as early as August the man was planning to take his own life. My investigators found letters in his cell that he had written but not sent to his family dated from that time stating his intention.
3. On 10 January 2005 at Truro Crown Court, he pleaded guilty to some of the offences and was awaiting sentence. The expectation was that because of his previous offending history he would receive a life sentence.
4. During the evening of 18 January, the man spoke to a number of prisoners and his manner caused them to be concerned that he was intending to harm himself. One of the prisoners spoke to an Officer Support Grade (OSG) and subsequently an Officer had a conversation with the man. He reassured them that he had no intention of killing himself saying, 'I would not give them the satisfaction'.
5. The OSG looked into the man's cell about 3.15 am the following morning and saw him hanging from the window. When she and other officers tried to enter the cell they found it barricaded. This had been accomplished by moving the cabinet between the cell door and the bed that was bolted to the floor.
6. Officers eventually gained entry to the cell and cut the man down. Cardio Pulmonary Resuscitation (CPR) was begun by the initial officers and continued by the nurse and paramedics as they arrived on the scene. He did not recover and his death was confirmed at 3.55 am.

Investigation methodology

7. The investigation was opened at HMP Exeter on 31 January 2005. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices had been previously sent to the prison and were issued to staff and prisoners informing them of the investigation. Other notices were displayed around the prison.

8. My investigators spoke with members of the Prison Officers Association (POA) and the Chair of the Independent Monitoring Board (IMB) to elicit their views on the prison in general and the man's death in particular.

9. A meeting was arranged with the investigating officers from Exeter Police who were able to discuss their investigation and, by consent of the Coroner, allowed my investigators to read the witness statements.

10. Several members of staff and a number of prisoners were formally interviewed regarding the man's death.

11. One of my Family Liaison Officers contacted the man's family and offered them the opportunity to meet with that officer and an investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. The meeting took place on 9 February with his parents.

12. My investigator contacted Her Majesty's Coroner to inform her of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist her in her enquires into the death of the man.

The subject of this report

13. The man was born in Truro, Cornwall in 1976. He grew up with his parents and his three sisters.

14. The man had a problem in managing his temper and the family said he could be stormy and impetuous. The man himself had reported an unsettled childhood and said he stopped attending school from 13 years onwards. With time on his hands he began to mix with older teenagers who were involved with crime, drink and drugs. Later, aged 15, he committed his first offence of burglary. He said that over the years he had drunk to excess, as well as experimenting with various drugs, and much of his offending was connected to this.

15. The man had periods in custody at a number of prisons and was well known by staff and other prisoners at HMP Exeter. Both staff and prisoners there described him as a 'big' personality. Staff who knew him said that at first he could be over-whelming, but beneath a rough exterior he was a reasonable and likable person who responded well, particularly to staff he knew over time and felt he could trust.

16. Other prisoners who knew him both in prison and from Truro described him as a character who liked to be busy, kept himself engaged by going to the gym and visiting friends in their cells. They said he played with a Gameboy and spoke of buying one himself so he could become familiar with the games and would be able to discuss it with his son. They described the man as someone who was able to serve out his time without much concern.

17. The man had said that his parents had always supported him. They are the legal guardians to his son, who is nine years old. He is the only child of the man's relationship with a young woman who, because of her age at the time of his birth, felt unable to care for him. Consequently the man and his parents raised him.

18. He had worked with his father from time to time in his painting and decorating business. His father said that before this latest offence the man had started taking a more responsible attitude to the work, rather than messing around as he had done on previous occasions.

The man's family

19. The man's mother had a list of questions that she was intending to send to the governor. She said that they had been told that the man had been on a 15-minute watch and if so how he had been able to hang himself. My investigator told her that this was incorrect and he had not been on a suicide watch.

20. She raised the issue of two female members of staff who the man had complained about in his letters. My investigator told her that they had both been interviewed and there did not seem to be any evidence to suggest that they had been unpleasant or unprofessional to him. He said that other prisoners had not been critical of them.

21. The main concern of the family was that they could not accept that the man had intended to kill himself. They thought it was another of an apparently long series of cries for help. They said that he had frequently spoken of taking his own life and had self harmed in the past.

22. My investigator told the family that he had found letters in his cell that the man had written but never sent and that from reading these it seemed that as far back as August 2004 he was planning to kill himself. The man's sister responded to this by saying that this was how her brother had always behaved and she had spoken to him on the Friday before he killed himself and he had been his normal self.

23. The man's father said that he thought that the man could not bear the thought of doing a sentence for a crime he had not committed. The family seems to feel that although he was guilty of the assault he was not guilty of rape. The man's father also said that the man would not have wanted to put his parents through the trauma of all the publicity that a conviction for rape would bring.

24. His mother told my investigator that the man had tried to hang himself in the van taking him to his pre trial hearing in December and had had marks on his neck. She said he had used his shoelaces. These had then been removed from him at court. There is no record of that event and if it happened I believe that the authorities were unaware of it. The man's family did not bring the alleged incident to anyone's attention.

25. The man's mother said that he had always had a problem in controlling his temper and the family said he could be violent and impetuous. His family felt the system had let him down, as he was never offered psychiatric help. The man had apparently signed up for an anger management course on 17 January but obviously never attended.

HMP EXETER

26. The prison is located within the City of Exeter and was built around 1850. It currently has four accommodation units with a healthcare facility in support.

27. The Certified Normal Accommodation is 314 and the Operational Capacity 533. The prison holds both adult male remand and convicted prisoners committed to custody from Cornwall, Devon and Southwest Somerset. Additionally it holds young men between the ages of 18 and 21.

28. The Standards and Security Audit carried out in May 2003 assessed the prison as "Good".

Events prior to the man's death

29. The man arrived at HMP Exeter on 29 July 2004 having been remanded into custody on a number of sexual and physical assault charges. He was allocated a double cell, which he shared with another prisoner. He was well known to the staff at the prison having been there on previous occasions.

30. From letters that were found after his death I am aware that the man had decided almost immediately to take his own life. Part of his plan was to be allocated a single cell and to that end on 21 August he submitted a General Application Form. In it he stated that he was getting very angry, needing space to prepare for his trial and concerned that he would 'flip out' and hurt his cellmate. He was given a single cell.

31. From those same letters at some point in August or September the man claimed to have unsuccessfully tried to overdose on 200 milligrams of morphine. I have not been able to verify that.

32. During a domestic visit on 17 September, the man's sister raised her concern about his mental health with a member of staff. The man was spoken to and, although upset, said that he would deal with any problem himself. When asked how, he said that he may 'beat someone up'. Another cell sharing risk assessment was carried out and his high-risk, single cell status was confirmed.

33. The man pleaded guilty to two offences at Truro Crown Court on 10 January 2005. When he returned to Exeter he saw the doctor and at his request was given a mild sedative to help him sleep. The doctor said that she had a good relationship with the man and although he looked tired, she did not feel that he was at risk of self harm.

34. That evening the man was out on the landing during association. He had obtained some hot water in his flask to use during the night. After everyone was secured in their cells for the night, the man rang his cell bell and an officer responded. The man asked to be let out of his cell to get cold water. The officer told him that he had had the opportunity to get the water before 'lock up' and that he had a tap in his cell. Five minutes later he rang his bell again and when the officer again refused to let him out he became abusive and banged his cell door loudly. A Senior Officer responded to a third cell bell and eventually let the man out to get his cold water. The first officer heard the man ask the SO if he could have a Listener. A Listener is a prisoner who has volunteered to be trained by the Samaritans to provide a similar confidential service to fellow prisoners. Records show that the man spoke with a Listener between 8.15 pm and 9.25 pm that night.

35. The man returned to Truro Crown Court on 11 January where his sentencing was adjourned for medical reports to be prepared. He had been advised that he could expect a life sentence.

36. On 16 January a wing officer noted in the man's wing record that his behaviour and attitude had not been causing any further problems. She also noted that she had noticed that he was sleeping more than usual and rarely came out of his cell. The officer had spoken to the man who said that he was just tired and that the probability of getting life was on his mind.

Events surrounding the man's death

37. The 18 January was the man's 29th birthday and he received a number of cards. During the evening association time he briefly spoke to some prisoners that he knew. He said to one prisoner, 'See you in hell'. That man was concerned enough to talk to other prisoners and one of those decided to pass on their concerns to the night staff that the man might be thinking of taking his own life. That prisoner rang his cell bell after 'lock-up' and spoke to the night OSG. He told her that he thought that the man might be planning to commit suicide.

38. The OSG returned to the centre office and repeated the concern to the SO, the Night Orderly Officer. Another officer was also there and as he knew the man well, he offered to go and speak to him. The officer did speak to the man at 9.50 pm in his cell for about twenty minutes. It was put to him that there was a rumour that he was feeling suicidal. The man said that he wouldn't give anyone the satisfaction and that he was looking forward to the future. The man and the officer then spoke about a hospital nurse that they both knew. When the officer left he told the man to ring the cell bell if he had any problems.

39. According to staff and prisoners, the man often played his music loudly at night and that night was no exception. The OSG had heard someone shouting a couple of times on the wing during the night. She thought it was the man. When my investigators interviewed a prisoner on the same wing as the man, he said that he heard him shout, "get me a body bag" a couple of times. About 2.45 am on 19 January, she heard someone shout, 'They are going to take me out in a body bag'. It has not been confirmed if it was the man who shouted that.

40. At 3.05 am the OSG began her 'pegging round' (an officer on night duty has to patrol the wings at certain times and press certain electronic 'pegging points' to show they were there at that time) and was intending to tell the man to turn the music down and check on him at the same time. About 3.15 am she looked into his cell and saw him hanging from the cell window. She called over the landing to the centre office and the SO joined her at the cell door. He unlocked the door but they were unable to open the door due to an obstruction. Prison cell doors open inwards. They were joined by the officer who had earlier spoken to the man but were still unable to force entry. There was no response from the man. The OSG used her radio to request the assistance of an officer from D wing at 3.25 am (control room log). The Healthcare OSG who had radio call sign Hotel 2 heard the call and alerted the Nurse (Hotel 4) that some kind of incident was going on in C wing. Healthcare staff believed that Hotel 4 was the Healthcare response call sign at night.

41. The officer returned to the centre office to get the 'anti-barricade' kit. The kit consists of tools used to release the plate covering the door bolt, thereby allowing the door to be opened outwards. The officer could not find the kit in the centre office and rang the control room to ask if it was there. He was told where it was and went to get it. The control room officer had started a log at

3.25 am when he had the first call from the OSG, but he was still unaware of the exact nature of the incident. According to the log the officer told control, 'inmate had barricaded his door and may be attempting suicide by hanging. At 3.28 am the control room contacted Healthcare using the callsign Hotel 2. The control room believed that Hotel 2 was the correct call sign both during the day and at night.

42. When the officer Taylor he used the tools to open the door and the SO and OSG entered the cell. The movable low cupboard had been put between the door and the bed that was bolted to the floor thereby effectively preventing the door opening.

43. The officer left to get Prison Service Nurse, the Healthcare nurse. For security reasons there are only one full set of keys in the prison during the night. That meant that the officer, who had been given the keys by the SO, had to fetch both the anti-barricade kit and then bring the nurse on to the wing.

44. The OSG cut the shoelaces that the man had used as a ligature and she and the SO lowered him to the floor. Another officer joined them from D wing.

45. The SO felt for a pulse. At the time he thought he found one but now believes it might have been his own. He and the D wing officer commenced Cardio Pulmonary Resuscitation (CPR). The nurse arrived shortly after and assisted, although she noted that the man was not breathing and she could not find a pulse. She asked if an ambulance had been called and an officer used his radio to request one via the control room, at 3.31 am.

46. The ambulance arrived at 3.35 am and the paramedics continued to try to resuscitate the man. They were not successful and the ambulance left the prison at 3.50 am. The prison doctor arrived at the prison and officially pronounced death at 3.55 am.

47. The man had apparently finger written, 'One off' or 'One out' on the wall of his cell using ink from a ballpoint pen.

Events after the man's death

48. The control room officer continued to work through the prison contingency plan, contacting the Governor, Duty Governor, Area Manager, Care Team and the Police. The four officers directly involved in the incident spoke with members of the Care Team, the Police and a member of the Senior Management Team (SMT) later that morning, although there was not an official 'hot-debrief'. That is an opportunity for everyone involved in an incident to talk through their experience and feelings and to 'wind down' before going off duty.

49. Two letters were initially found in the man's cell after his death, one addressed to his parents dated 15 January and one to the Governor dated 16 January. In them the man makes it clear that he intended to be dead when they were read. He also singled out two female officers as treating him unfairly and making remarks about his offences, such as, 'Beat any women up lately?'

50. The Governor, and his deputy went to break the news of the man's death personally to his parents. A service was held in the prison chapel that afternoon to which staff and prisoners were invited.

51. When my investigators searched the man's cell as part of their investigation they found an envelope containing a number of letters, mainly addressed to his parents. None of those letters had been sent. The man had apparently written these over a period of time since August 2004. In them he made it clear that suicide had been on his mind since August and that making sure he was in a single cell was part of the plan.

52. My investigators interviewed various staff members and prisoners during the course of their investigation. Both of the female officers written about by the man denied any prejudice or unprofessional conduct towards him. None of the prisoners interviewed expressed any concerns about the two officers. Indeed, they were generally praised. One prisoner said that the man had told him that partner one of the female officers, also an officer at Exeter, had spoken to the man and told him to stop harassing his girlfriend. My investigators spoke with the officer and her partner, and they both denied the allegation. The officer said that she would have felt that her authority would have been undermined on the wing if this had happened. My investigators have been unable to establish the veracity of the remarks, but the man did not mention the incident in any of his letters.

Findings and conclusions

53. The man had a reputation for being a tough man, able to take care of himself and serve his sentence without a problem. He knew and was known by a lot of the older staff at Exeter, who said of him that he did not like to be told 'no' but that he was respectful. My investigators did not speak to anyone, staff or prisoner, who would have anticipated him committing suicide.

54. From reading the man's unsent letters it is clear that he was concerned about doing life and being labelled a 'woman beater' or worse. Until his death the other prisoners did not know the nature of the charges that he was facing.

55. When he returned from court on the 10 January 2005 he saw the doctor at his request. There are procedures in place for prisoners sentenced to life to be seen by the doctor upon their return to the prison from court. The purpose is to assess the person's mental health and/or counselling needs. However it does not take into account when the actual sentencing is adjourned but the prisoner knows what it will be.

56. On 18 January the night staff acted appropriately to the concern expressed by the prisoners about the man's mood. He convinced the officer, who spent about 20 minutes talking to him, that he was not thinking of self-harming. Again, his reputation and general manner alleviated any concerns the staff might have had if it had been another prisoner.

57. The man was able to effectively barricade his cell by the simple method of moving the low cupboard just a few inches forward of its normal position at the foot of the bed. In that position the cell door is blocked from opening more than a few inches by the cupboard and, as the bed is bolted to the floor, nothing can move.

58. The night staff believed that the anti-barricade kit was located in the wing centre office when in fact it had been moved to the control room. That meant that there was a delay while the officer went to fetch it. I do not believe that in this case the delay was significant.

59. As far as the control room were concerned, the radio call sign for the healthcare nurse at any time was Hotel 2. The healthcare staff believed that it was Hotel 2 during the day and Hotel 4 at night. That is why the healthcare OSG received the message on his radio, Hotel 2, and not the nurse, who had Hotel 4. The two members of staff were in close proximity and no delay was caused on this occasion.

60. There was a delay in calling for an ambulance. The man was discovered hanging in his cell about 3.15 am yet the ambulance was not called until 3.31 am. The control room officer was reliant on the staff at the scene to tell him what was happening and what was required. In fact the control room was not contacted at all until 3.25 am. The night staff on the wing focused their attention on getting into the cell and trying to save his life and it was not until the nurse arrived at the man's cell and asked if an ambulance had been called

that one was. Again on this occasion I do not believe the delay was significant.

Recommendations

61. The Governor should consider asking all staff to inform Healthcare if they become aware that a remand prisoner attending court is likely to receive a substantial sentence. The procedures for prisoners sentenced to long terms of imprisonment should then be applied.

The Governor should as a matter of urgency arrange for the movable low cupboards in the cells to be fixed securely or replaced.

Response from Area Manager 'Whilst you recommend the securing of the lockers to the wall this will not stop prisoners from barricading doors. It is conceivable that they will then use the chairs that we provide or the tables. It would necessitate major changes to the lockers, as it will require specific brackets making. Given that it is a prison Industry supplied item Prison Service Headquarters would need to be consulted on the modification. The recommendation to secure lockers is not necessarily likely to impact on prisoners' ability to erect effective barricades. Other, moveable items in cells, including chairs, can offer equally useable material to achieve this. We do normally secure beds, but, to go beyond that is likely to further de-humanise cells without a significant benefit to safety or security.'

62. The Governor should ensure that all staff are aware of the current location of essential equipment.

63. The Healthcare Manager should ensure that all staff are aware of the relevant call signs and consider introducing a coded system for alerts.

64. The Governor should review the incident. To consider further staff training, particularly in relation to correct radio procedure, notification of other staff and summoning of urgent medical assistance.