Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stewart Stanley, a prisoner at HMP Exeter, on 13 July 2020

A report by the Prisons and Probation Ombudsman

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Our vision

To carry out independent investigations to make custody and community supervision safer and fairer

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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 Stewart Stanley died from a brain injury in hospital on 13 July 2020, after being found hanging in his cell at HMP Exeter the previous day. He was 39 years old. I offer my condolences to his family and friends.

Mr Stanley was subject to constant supervision procedures at Exeter, following an attempt to take his own life on 9 July. The constant supervision was ended two days later at an unplanned case review that was not multidisciplinary, as national instructions require. This would be a concern by itself, but I am particularly concerned that there was insufficient evidence at that time to support a decision to stop the constant supervision.

I have expressed concerns to the Governor of HMP Exeter and to the Prison Group Director for Devon and North Dorset about deficiencies in ACCT procedures in previous investigations at Exeter and it is troubling that I have had to raise these issues again in this report.

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 **May 2021**

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Summary

Events

1. On 23 June 2020, Mr Stewart Stanley was remanded in custody to HMP Exeter. On arrival, he was referred to the mental health team and prescribed medication to treat the symptoms of alcohol withdrawal.

2. On 4 July, Mr Stanley presented with injuries consistent with having been assaulted, although he denied that this was the case. A supervising officer investigated and concluded that it was likely that an assault had occurred. He identified a potential perpetrator and arranged for that prisoner to move to a different wing. The next day, Mr Stanley was also moved to that wing.

3. On the night of 9 to 10 July, Mr Stanley's cellmate found him with a ligature around his neck, seemingly trying to hang himself. He alerted prison staff, who started Prison Service suicide and self-harm prevention procedures (known as ACCT). The staff placed Mr Stanley under constant supervision and moved him to a special cell that allowed an officer to observe him continuously. Mr Stanley told the staff that he was angry that he had not succeeded in taking his life and that he wanted to die as he thought that other prisoners were going to kill him.

4. On 10 July, an operational manager led the first ACCT case review. Mr Stanley repeated his statement that he was under threat and believed he would be killed in prison. The case review team agreed to continue constant supervision.

5. On 11 July, the Head of Security and Operations led a case review in the morning. Mr Stanley said that there were 300 people in the prison who wanted him to die and related this to an incident in the community. The case review team agreed to continue constant supervision and to hold another case review the next day.

6. The Head of Security and Operations asked a Custodial Manager (CM) to listen to Mr Stanley's recent telephone calls to try to understand more details of the threat he said he faced. Both told us that Mr Stanley spoke about trying to get a transfer to another prison and that they were concerned that his behaviour might be an attempt to influence a transfer.

7. At around 4.30pm, the Head of Security and Operations held another case review. Unlike the earlier case reviews, there was no one from the mental health team present. He concluded that constant supervision should end and directed that Mr Stanley should now be observed at least once every half an hour.

8. During the evening, Mr Stanley repeatedly asked staff to let him out of his cell and said that he feared he would be assaulted by other prisoners. At around 1.20am on 12 July, the night patrol officer found Mr Stanley hanging. She called for staff assistance and, when it arrived, they opened the cell, removed the ligature and began chest compressions. Paramedics arrived and took Mr Stanley to hospital, where he died on 13 July.

Findings

Managing the risk of suicide and self-harm

9. The decision to end the constant supervision was taken at an unplanned case review and without the input of the mental health team, in breach of national instructions. We are also concerned that the evidence used to reach this decision did not indicate that Mr Stanley's risk had reduced.

10. In the hours that followed, staff did not properly consider whether Mr Stanley's behaviour might indicate that he was at increased risk, and ACCT observations were not completed as required.

Alleged assault

11. Mr Stanley was moved to the same wing as the prisoner who allegedly assaulted him, without any thought given to providing additional support to him.

Emergency response

12. The night patrol delayed radioing a medical emergency when she found Mr Stanley hanging.

Recommendations

- The Prison Group Director for Devon and North Dorset should arrange a meeting with the Ombudsman to discuss what she is doing to improve the management of prisoners at risk of suicide and self-harm at HMP Exeter.
- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:
    - ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff.
    - Case reviews consider all relevant information that affects risk, address all issues through specific and meaningful caremap actions, and observations are only reduced when there has been a clear reduction in risk.
    - Observations are carried out as directed and documented in the ongoing record, and any behaviour observed that might indicate increased risk is shared with managers with consideration given to increasing the frequency of observations.
- The Governor should inform the Ombudsman of the findings of the internal investigations into the events of 11 to 12 July, and of any action taken as a result, by 31 March 2021.
- The Governor should ensure that all information about violence, bullying and intimidation is coordinated and investigated and that apparent victims are effectively supported and protected.

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.

The Investigation Process

13. 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.

14. The investigator obtained copies of relevant extracts from Mr Stanley's prison and medical records. He interviewed ten members of staff at Exeter in August and September. All the interviews were conducted by telephone because of the restrictions in place in response to the COVID-19 pandemic.

15. The investigator also contacted Mr Stanley's cellmate (who had been released).

16. NHS England commissioned a clinical reviewer to review Mr Stanley's clinical care at the prison. The clinical reviewer joined the investigator for interviews with clinical staff.

17. We informed HM Coroner for Exeter and Greater Devon of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Stanley's family to explain the investigation and to ask if they had any matters that they wanted us to consider. They asked the following questions:

    - was Mr Stanley's risk of suicide and self-harm properly assessed, particularly at the time the constant supervision was ended;
    - was Mr Stanley's mental ill health appropriately assessed and treated;
    - were concerns that Mr Stanley was being bullied or threatened in prison properly investigated?

19. We have addressed those questions in this report. Mr Stanley's family also asked several other questions that we have addressed through separate correspondence.

20. We shared the initial report with HM Prison and Probation Service (HMPPS). They identified one factual inaccuracy, which we have amended.

21. We also shared our initial report with Mr Stanley's family. Their solicitor wrote to us identifying a factual inaccuracy and an omission, which we have amended.

Background Information

HMP Exeter

22. HMP Exeter holds up to 561 adult men and young offenders, and serves the courts of Devon, Cornwall and Somerset. Care UK provides primary health services and Devon Partnership NHS Trust provide mental health care.

HM Inspectorate of Prisons

23. The most recent full inspection of HMP Exeter was in May 2018. Inspectors reported that there had been a deterioration in outcomes for prisoners since their previous inspection. They were particularly concerned about prisoner safety, which they described as poor (their lowest possible grading). Inspectors reported that two thirds of prisoners did not feel safe, and that there had been a 40 per cent increase in incidents of self-harm and six self-inflicted deaths since their last inspection in August 2016.

24. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State on 30 May 2018, setting out his significant concerns about the treatment of prisoners.

25. In April 2019, HMIP carried out an Independent Review of Progress which followed up 13 of the 47 recommendations they had made after their 2018 inspection. Inspectors found that there had been good progress on three recommendations, reasonable progress on three recommendations, insufficient progress on four recommendations and no meaningful progress on three recommendations. They reported that overall levels of violence had decreased since the 2018 inspection, but incidents between prisoners remained higher than in similar prisons. A number of actions had been taken to reduce violence and the strategy to reduce violence further in the future was promising.

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 latest annual report for 2019, the IMB reported that violence was a continuing problem at Exeter, often associated with bullying, debt or retaliatory actions, and mostly focused on A Wing and C Wing.

27. The IMB also reported that they were concerned by the management of prisoners subject to ACCT procedures, including that observations were not always completed on time.

Previous deaths at HMP Exeter

28. Mr Stanley was the fourteenth prisoner to die at Exeter since July 2018, and the fourth to take his own life in this time. Our investigation into the death of a prisoner in December 2018 found evidence of extremely poor ACCT case management and

in July 2019, we recommended that the Prison Group Director for Devon and North Dorset set out actions she intended to take to address our concerns.

Assessment, Care in Custody and Teamwork

29. 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

30. As part of the process, a caremap (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.

Reverse Cohort Units

31. During the COVID-19 pandemic, HM Prisons and Probation Service (HMPPS) took steps to help prisons to manage the threat of large numbers of prisoners and staff becoming infected and to reduce the likelihood of the infection spreading throughout the prison system. All prisons were required to establish designated areas for specific groups of prisoners. One of these areas, known as a Reverse Cohort Unit, provides for the temporary separation of newly arrived prisoners for up to 14 days, to allow the prison to check that the individual is not symptomatic.

32. During their 14 day 'reverse cohorting' period, prisoners have daily healthcare observations taken. They must receive a minimum of 30 minutes in the open air every day, have access to a telephone, and access to a shower at least once a week. At the end of the reverse cohorting period, prisoners who are not symptomatic are allowed to mix with the general population.

Key Events

33. Mr Stewart Stanley served two short prison sentences in 1998 and 2004. He was diagnosed with depression as a young adult and was prescribed short courses of antidepressant medication on occasions throughout his adult life.

34. On 9 June 2020, Mr Stanley was remanded in custody to HMP Winchester, charged with affray and criminal damage. On arrival, he told prison staff that he had attempted suicide ten years earlier and that his mental health was "up and down". The next day, Mr Stanley was released to a bail hostel.

35. On 22 June, Mr Stanley was arrested following an incident at the bail hostel. The next day, he appeared in court and was remanded in custody to HMP Exeter.

HMP Exeter

36. An officer interviewed Mr Stanley on his arrival at Exeter. He recorded that Mr Stanley presented as low in mood, had a history of taking antidepressant medication, and had self-harmed around seven years earlier. The officer also noted that Mr Stanley's relationship had recently broken down and he was separated from his children. He started ACCT procedures.

37. A nurse assessed Mr Stanley and recorded that he reported daily alcohol use and diagnoses of anxiety and depression. Mr Stanley said he had been 'sectioned' following a suicide attempt in 2008. (There is no record in his medical history of him spending any time in a psychiatric hospital.) Mr Stanley declined a referral to the substance misuse team but agreed to take medication to help relieve the symptoms of alcohol withdrawal. The nurse referred him to the mental health team.

38. On 24 June, a mental health nurse conducted a triage assessment. Mr Stanley reported a long history of low mood and said he had previously been prescribed an antidepressant. She recorded that the mental health team would discuss Mr Stanley's care at their team meeting and that the prison GP would consider prescribing an antidepressant.

39. A Supervising Officer (SO) then led an ACCT case review with the mental health nurse. Mr Stanley said he did not feel suicidal and spoke about protective factors, including his relationship with his daughter. The SO recorded that both he and the nurse agreed that they could end the ACCT procedures.

40. On 26 June, the healthcare multidisciplinary team discussed Mr Stanley. They recorded that the GP would be asked to prescribe an antidepressant and that no further action was required at the time.

41. On 1 July, an SO completed a post-closure ACCT assessment. He recorded that Mr Stanley said he was doing well and that he got on with his cellmate who provided good support.

42. On 4 July, an officer recorded that Mr Stanley had sustained some injuries which he said were caused by slipping in the shower. The officer recorded that he suspected

that Mr Stanley had been assaulted but that CCTV evidence was inconclusive. He referred the incident to the safer custody team to investigate.

43. Later that day, Mr Stanley told a healthcare assistant who treated him that he had been assaulted. He would not name the prisoner who had assaulted him.

44. On 6 July, an SO investigated the incident. He recorded that Mr Stanley denied that he had been assaulted. The SO identified a suspected perpetrator. He told us that CCTV showed that this prisoner was near the showers when the incident took place and that he was an "erratic" man who had a history of seemingly random assaults. The SO said that there was no evidence to support the accusation, other than the presence of this man in the area when the incident took place. He said that Mr Stanley appeared confident and that the incident did not appear to have affected him. The prisoner suspected of committing the assault was moved from C Wing to A Wing.

45. On 7 July, Mr Stanley's two-week period of 'reverse cohorting' ended. He moved to a cell on A Wing. No one recorded that they had identified that Mr Stanley had moved to the same wing as the prisoner who had allegedly assaulted him, or that they had spoken to him about this.

46. On 8 July, a prison GP prescribed a course of sertraline (antidepressant medication). She spoke to Mr Stanley by telephone before issuing the prescription. The GP told us that Mr Stanley was responsive to her questions and showed evidence of thinking about the future.

9 July

47. Mr Stanley made several telephone calls to his sister during the day. Prisoners' telephone calls are recorded, and we have listened to recordings of Mr Stanley's calls. In the calls, Mr Stanley spoke about fears that he was being watched by other prisoners and that he was scared that he would be stabbed. Mr Stanley also telephoned a friend. He was mostly jovial during the call but also spoke about a potential transfer and said he was paranoid after being assaulted.

48. In the last call to his sister at 8.34pm, Mr Stanley said that he had heard some prisoners shouting that they were going to "carve me up" and that this related to an incident in the community.

49. At around 11.45pm, Mr Stanley's cellmate found him with a ligature around his neck. He removed the ligature and alerted staff, who found Mr Stanley "dazed but breathing" and noted that he regained consciousness before healthcare staff arrived. A Custodial Manager (CM) recorded that Mr Stanley was in a very low mood. Mr Stanley told the CM that he was being blamed for the suicide of a man in the community and that other prisoners wanted to kill him because of this. He said that he had decided to kill himself instead and was angry that he had not succeeded. An officer recorded that Mr Stanley said that he had heard prisoners say that he was going to be "cut up".

50. The CM started ACCT procedures and received authority from the duty governor to place Mr Stanley on constant supervision. Mr Stanley moved to a different cell on A

Wing that had a photochromatic cell door (rather than the usual cell door) to allow staff to see clearly into the cell.

10 July

51. At 9.15am, an officer interviewed Mr Stanley as part of the ACCT procedures. He recorded that Mr Stanley appeared distressed and said he believed he was going to be "cut up". Mr Stanley "begged" not to be put back onto the main wing and said he would kill himself if that happened. The officer recorded that Mr Stanley said that his mind was made up and he "wants to die".

52. Later in the morning, the Head of Reducing Reoffending led the first ACCT case review. Others present included the CM, the prison GP, and a nurse from the mental health team. The CM recorded that Mr Stanley said that he had tried to take his life as he would rather do this than allow others on the wing to kill him. He said he was under threat from other prisoners and that it related to issues in the community. Mr Stanley said that he had been assaulted in the shower on 4 July, and that he had heard prisoners on his previous wing threatening to kill him. He said he had also heard prisoners threatening him while he was on constant supervision. The constant supervision officer present said he had not heard anything that may constitute a threat. The CM recorded that Mr Stanley was "highly upset" and said he would kill himself if moved back onto the wing.

53. One issue was recorded on the caremap: that Mr Stanley felt unsafe on the wing. The action required was for the duty governor to find a "safe and suitable" location for Mr Stanley.

54. The Head of Reducing Reoffending told us that Mr Stanley was not very communicative during the case review, became emotional and spent time with his head in his hands. He said that this made it difficult to ask probing questions about the threats Mr Stanley described. He said that he concluded that the constant supervision should continue until the staff could obtain more information about any threat to Mr Stanley.

55. The nurse recorded that Mr Stanley displayed symptoms of a highly agitated anxiety state. He told us that Mr Stanley was in a highly volatile mental state and was not in a position to process what was happening. He told us that he linked this to trauma from recent events which led him to conclude that Mr Stanley's symptoms were typical of post-traumatic stress disorder (PTSD).

56. The nurse told the case review panel that he would contact the prison's psychiatrist for advice. The nurse exchanged emails with the psychiatrist that afternoon, and they discussed possible diagnoses and medication. The nurse told us that they did not agree to a prescription, but he added Mr Stanley to his caseload.

57. At 4.30pm, the constant supervision officer recorded that Mr Stanley was "very agitated" and said that he could hear other prisoners talking about him. The officer recorded that he could not hear anything.

58. At 7.45pm, Mr Stanley telephoned his sister. He told her that he had tried to take his life the previous night. He said that he was going to be killed and that the people who were after him would be able to get to him wherever he was in the

prison. Mr Stanley was tearful and said that he did not think he would "get out of here". He also said he believed that the telephone was "bugged".

11 to 12 July

59. At 12.00am, the constant supervision officer recorded that Mr Stanley said he could "hear other prisoners shouting at him saying he's a dead man". The officer recorded that he could hear nothing and described Mr Stanley as "extremely paranoid".

60. At 8.30am, an officer recorded that Mr Stanley was "very distressed". Around an hour later, he recorded that Mr Stanley was "repeating a sentence that made no sense".

61. At around 11.15am, the Head of Security and Operations led an ACCT case review. Also present were a CM, a nurse and the constant supervision officer. The CM recorded that Mr Stanley said he felt much better and wanted to live. Mr Stanley described an incident in the community that led to a man taking his own life and said that he had wanted to take his life due to guilt over this, but that he now felt better. He said that there were around 300 people in the prison who "want him dead" but would not give any names. He asked to be moved to B Wing (the vulnerable prisoners' unit) and became agitated and frustrated when the CM explained that if there was such a widespread threat against him, it was unlikely to make any difference which wing he lived on. The CM explained that to help protect Mr Stanley better on a main wing, they would need to know more about the nature of the threat and who was making it. She told us that Mr Stanley was angry during the case review, was not open and could not answer questions about where the threat was coming from.

62. The Head of Security and Operations told us that it was a confusing and frustrating review as Mr Stanley repeatedly said he was under threat from 300 people but could not give specific details about why this was the case. He said that his perception at the time was that Mr Stanley was in debt.

63. The nurse told us that Mr Stanley appeared genuine and that she saw no evidence of paranoia or psychotic symptoms. She said that Mr Stanley alternated between being calm and appearing to be in distress.

64. The panel concluded that Mr Stanley was still at high risk of suicide and self-harm and should remain on constant supervision. They arranged for the next case review to take place the following day.

65. During the morning, members of Mr Stanley's family had telephoned the prison to raise concerns about his wellbeing. The Head of Security and Operations telephoned Mr Stanley's step-mother and sister (the sister with whom Mr Stanley had spoken on the telephone in the previous two days) after the case review. He told us that he wanted to obtain more information about any debt or threat that Mr Stanley was under.

66. The Head of Security and Operations told us that Mr Stanley's sister had sent him some money and that this was still in his account. He said that his family told him that they were not under any pressure to pay off prison debts. He said that they

also told him that Mr Stanley had discussed future plans, including moving closer to his family. He said that they told him that Mr Stanley had tried to take his life several years ago. Mr Stanley's sister told us that she gave the Head of Security and Operations the names of two men who were threatening her brother. He told us that following these conversations and from looking at Mr Stanley's prison accounts, he saw no evidence that Mr Stanley was in debt. He then asked the CM to listen to Mr Stanley's telephone calls to try to find more information.

67. At 1.57pm, Mr Stanley telephoned his father. He named two prisoners whom he said were going to "murder" him and repeatedly said that he was going to be killed. Mr Stanley said he had "half an hour to live … they're setting it up".

68. The CM then listened to Mr Stanley's telephone calls. She told us that she listened to the telephone call between Mr Stanley and his father, and that Mr Stanley was shouting at his father that people were coming to get him in his cell. She said she also listened to calls Mr Stanley made to his sister and to a friend (earlier in the week), none of which indicated to her that Mr Stanley was under the threat that he described. She also said that Mr Stanley presented very differently to his sister compared to the case review and that there was nothing to indicate that the threats he spoke about were genuine. She also said that Mr Stanley spoke about doing "whatever he's got to do" to get a transfer to another prison.

69. The Head of Security and Operations said that the CM told him that Mr Stanley was joking to a friend on the telephone about getting a transfer. He said that the CM also reported that Mr Stanley was trying to pressurise his family into asking for a transfer by saying that there were two people outside his cell waiting to get him.

70. At around 4.30pm, the Head of Security and Operations held an ACCT case review with another CM and the constant supervision officer. The previous CM was recorded as attending but told us that she did not. The CM recorded that the Head of Security and Operations challenged Mr Stanley about the content of his telephone calls, and that Mr Stanley said that he was in debt and he set up the ligature attempt as a means of keeping himself safe.

71. The Head of Security and Operations told us that Mr Stanley reacted angrily when he discussed the contents of the telephone calls with him. He said that he thought the content of the telephone calls indicated that Mr Stanley had come through his crisis period. He said that he suggested to Mr Stanley that he should share a cell with another prisoner who was due for release in a couple of days and that he should effectively self-isolate during this time.

72. The Head of Security and Operations told us that he concluded that Mr Stanley no longer needed to be observed constantly and that he would benefit from peer support. He said that he set observations at a minimum of one every half an hour, and that he did not want to set them any more frequently because Mr Stanley had described having difficulty sleeping. Mr Stanley therefore moved out of the constant supervision cell and into a shared cell with another prisoner.

73. Mr Stanley's cellmate told the police that, shortly after moving into the cell, Mr Stanley started saying that he would be "carved up" and that "everybody" wanted to do this. He said that Mr Stanley also spoke about drugs. Mr Stanley's cellmate also told the police that Mr Stanley took a shoelace from his shoe and twice

wrapped it round his neck and attached it to the window bars, with his feet suspended from the ground. He did not say anything about this to the prison staff.

74. An officer spoke to Mr Stanley twice in the evening. He told us that Mr Stanley appeared upset and repeatedly asked to be let out of his cell. He told us that he reported this to a CM (the CM who had attended the case review at around 4.30pm). The officer did not record these events in the ACCT document or elsewhere. The CM told us that he did not remember any officer speaking to him about this.

75. Officer A was the night patrol officer on A Wing. At around 8.10pm, she completed an ACCT observation. She recorded that Mr Stanley said that "he is going to be stabbed" and that she reassured him that nobody could enter his cell. She told us that Mr Stanley would not expand on this and appeared quite "erratic".

76. Officer A then completed observations around every half an hour. At around 9.30pm, she recorded that Mr Stanley was standing "at the window shouting about not bringing any powder with him".

77. At 11.55pm and again at 12.00am, Mr Stanley pressed his cell bell. In the ACCT document, Officer A recorded that Mr Stanley told her on the first visit that he had slept for half an hour and, on the second visit, that he had pressed the bell "to be annoying". In her police statement, Officer A said that Mr Stanley asked her to "get him out [of the cell]" on the first of these visits and spoke about being "stabbed". She told us that she did not remember this conversation.

78. Mr Stanley's cellmate said that Mr Stanley pressed the cell bell several times during the night. He said that Mr Stanley told the staff that he was worried that people would come and kill him. He said that Mr Stanley also told the staff that he was pressing the bell "to annoy them". Mr Stanley's cellmate said that he fell asleep after the last cell bell and did not wake up until the staff later went into the cell.

79. Officer A recorded that she made an ACCT observation at 12.30am, during which she noted that Mr Stanley was sitting on his bed, watching television. There is no evidence on CCTV footage that this observation took place.

80. At 12.42am, Officer A completed an ACCT observation. She recorded that Mr Stanley was sitting on his bunk.

81. At 1.22am, Officer A went to Mr Stanley's cell for an ACCT observation. She said that she saw Mr Stanley hanging from a ligature, attached to the window bars. In her police statement, Officer A said she believed Mr Stanley was fully suspended (with his feet off the floor). She told us that she could not see if this was the case from outside the cell. Officer A then radioed for staff and healthcare assistance. She told us that she did not open the cell at this stage because of Mr Stanley's earlier erratic behaviour.

82. At 1.23am, an SO arrived and entered the cell with Officer A, followed shortly afterwards by others. They cut the ligature and the SO began chest compressions. At 1.24am, Officer A radioed a medical emergency code blue. The control room operator telephoned for an ambulance.

83. At 1.25am, a nurse arrived and took over the resuscitation efforts. Paramedics arrived shortly afterwards. At 2.30am, they took Mr Stanley to Royal Devon and Exeter Hospital. He died at 10.06am on 13 July.

Contact with Mr Stanley's family

84. At 3.20am on 12 July, prison staff telephoned Mr Stanley's father and step-mother and told them that he was in hospital. Mr Stanley's family visited him later that morning and were with him when he died.

85. Exeter contributed to the costs of Mr Stanley's funeral in line with Prison Service instructions.

Support for prisoners and staff

86. After the emergency response, the Head of Security and Operations debriefed the staff involved to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

87. The prison posted notices informing other prisoners of Mr Stanley's death, and offering support.

Post-mortem report

88. The post-mortem examination found that the cause of death was a hypoxic ischaemic brain injury (lack of oxygen to the brain) caused by hanging.

Mr Stanley's cellmate

89. Mr Stanley's cellmate was released from custody on 13 July, the day of Mr Stanley's death. The investigator wrote to him at his release address on 15 July asking him to get in touch. He received a phone call in response on 6 August. The former cellmate was very incoherent, and the investigator could understand very little of what was said. The call cut out after about 10 minutes. The former cellmate also left a short voice message on the PPO office phone over the weekend of 5/6 December 2020. Again, it was incoherent, and the investigator could make little sense of what was said.

Findings

Management of risk of suicide and self-harm

90. Prison staff appropriately started ACCT procedures when Mr Stanley harmed himself on the night of 9 July. We agree that his risk was heightened to the extent that constant supervision was suitable. However, we are concerned that some of the ACCT procedures were poorly managed.

Caremap

91. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It states that a caremap must be completed at the first case review for all prisoners subject to ACCT monitoring. PSI 64/2011 says that the caremap should reflect the prisoner's needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview and at later case reviews. The caremap should set time-bounded actions and be aimed at reducing prisoners' risk to themselves.

92. There was one action on Mr Stanley's caremap: for the duty governor to find a suitable and safe location on the wing. This was clearly important given the fears Mr Stanley described. However, there was no action recorded to determine whether, when or how the threats he described would be investigated, or how Mr Stanley would be supported through this process. There was also no record in the caremap of the action proposed by the mental health team: contacting the prison's psychiatrist for advice.

Ending constant supervision

93. PSI 64/2011 contains the mandatory instruction that, in the first 72 hours of constant supervision, a multidisciplinary case management review must be held daily. It states that a member of the nursing staff (or senior clinical manager) must be in attendance, as well as other relevant staff. PSI 64/2011 also says that any ACCT case review (whatever the level of observations) must be multidisciplinary, where possible.

94. Mr Stanley's constant supervision was ended at an unplanned case review which was not attended by – nor had any input from – the mental health or primary care teams. The decision to remove Mr Stanley from constant supervision was based on the content of telephone calls he had made on 11 July and earlier. The Head of Security and Operations told us that the content of the calls indicated that Mr Stanley's crisis period was over. We have listened to all of the calls that Mr Stanley made from 9 July onwards, and we are concerned by this conclusion.

95. In a call to his father on 11 July – just two hours before the case review – Mr Stanley repeatedly said that he would very soon be murdered in prison and repeatedly asked his father for help. The investigator considered that Mr Stanley sounded as though he was in considerable and genuine fear and distress. In earlier calls to his sister, Mr Stanley frequently expressed fears that he would be seriously assaulted or killed at Exeter and was sometimes tearful when discussing this.

96. Mr Stanley spoke to his family about trying to get a transfer to avoid these threats. Prison staff interpreted this as meaning that his self-harm was a means of manipulating a transfer. Given the nature and content of the calls that we heard, we are concerned that they reached this conclusion, particularly as it led to constant supervision being ended at a case review held outside of the requirements of national instructions.

97. Following Mr Stanley's death, the Governor commissioned a local investigation into the events of 11 July. The investigation recommended that the Head of Security and Operations be subject to a formal disciplinary hearing. Following the hearing, he was dismissed from HM Prisons and Probation Service.

Evening of 11 July

98. We are concerned by reports of Mr Stanley's behaviour on the evening of 11 July. An officer told us that Mr Stanley appeared upset and repeatedly asked to be let out of his cell. He told us that he reported this to a CM, who said he did not remember anyone speaking to him about the matter.

99. Officer A said that Mr Stanley told her that he would be "stabbed" and that she later saw him shouting out of his window. In her police statement, she said that later in the night, he asked to be let out of his cell. She told us that she did not remember this conversation.

100. We do not know exactly what Mr Stanley said to staff that evening. However, we consider that they should have been more alert to signs that he was at increased risk, given that it was only two days since he had tried to take his own life and a matter of hours since constant supervision was ended.

101. We consider that the staff should have better recorded their observations and concerns about Mr Stanley, discussed these with duty managers, and recorded the outcome. In association with managers, they should have acknowledged that Mr Stanley's actions indicated a possible increased risk of suicide and self-harm. This might have led them to monitor Mr Stanley more closely during the night.

Conducting ACCT observations

102. PSI 64/2011 states that staff must follow the level of observations noted on the ACCT document and must record these immediately or as soon as is practical. It states that observations must be completed at unpredictable intervals, so that prisoners cannot predict when they will be checked and plan around this. Mr Stanley's observations were set at a minimum of one every half an hour.

103. CCTV footage of the night of 11 to 12 July shows that Officer A checked Mr Stanley around every 30 minutes for most of the night, and many of these checks were a little over 30 minutes apart. When she left Mr Stanley's cell shortly after midnight, CCTV shows that she made only one further observation in the next hour and 20 minutes, at 12.42am. She recorded two observations in the ACCT document in this time, one of which clearly did not take place.

104. The Governor has also commissioned a local investigation into Officer A's conduct on the night of 11 to 12 July. This investigation is ongoing.

105. We have previously expressed concerns about the management of ACCT procedures at Exeter. In July 2019, we made a recommendation to the Prison Group Director (PGD) for Devon and North Dorset asking her to set out the actions she intended to take in response to our concerns. The PGD responded by saying that additional ACCT case manager training had been delivered and that she had increased support and assurance visits to Exeter to ensure that ACCT procedures were a priority. Nevertheless, we are concerned that this investigation has again highlighted poor practice. We make the following recommendations:

The Prison Group Director for Devon and North Dorset should arrange a meeting with the Ombudsman to discuss what she is doing to improve the management of prisoners at risk of suicide and self-harm at HMP Exeter.

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:

- **ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff.**
- **Case reviews consider all relevant information that affects risk, address all issues through specific and meaningful caremap actions, and observations are only reduced when there has been a clear reduction in risk.**
- **Observations are carried out as directed and documented in the ongoing record, and any behaviour observed that might indicate increased risk is shared with managers with consideration given to increasing the frequency of observations.**

The Governor should inform the Ombudsman of the findings of the internal investigations into the events of 11 to 12 July, and of any action taken as a result, by 31 March 2021.

Mental health care

106. The clinical reviewer found that Reception staff appropriately referred Mr Stanley to the mental health team when he arrived at Exeter. He was promptly assessed and referred to the GP to prescribe medication.

107. After Mr Stanley attempted to hang himself on the night of 9 July, the mental health team was appropriately included in the first ACCT case review. The clinical reviewer concluded that the team members involved in Mr Stanley's care were suitably qualified. He found that they took appropriate steps to support Mr Stanley, including promptly consulting the psychiatrist by email before he could make a face-to-face assessment.

108. As we have identified, the mental health team were not included in the final ACCT case review as they should have been. Otherwise, the clinical reviewer concluded that the clinical care that Mr Stanley received in custody was at least equivalent to that which he might have expected to receive in the community.

Alleged assault

109. Exeter has a local procedure for investigating unexplained injuries. We are satisfied that the alleged assault on Mr Stanley on 4 July was properly referred and investigated in line with this procedure. While there was no conclusive evidence to confirm that an individual had assaulted Mr Stanley, the suspected perpetrator was moved to a different wing away from him.

110. On 7 July, Mr Stanley was also moved to this same wing. The SO's report stated that the suspected perpetrator was due to transfer out of Exeter that day, but in fact he remained at the prison. We appreciate that Mr Stanley completed his 'reverse cohort' on this day and therefore had to move to a different area within the prison. However, there is no evidence that thought was given to providing him with additional support with the now increased likelihood that he would have contact with his alleged assaulter. We make the following recommendation:

The Governor should ensure that all information about violence, bullying and intimidation is coordinated and investigated and that apparent victims are effectively supported and protected.

Emergency response

111. We have some concerns about the emergency response on 12 July. At night, officers have a key in a sealed pouch for use in an emergency. Prison Service Instruction 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

112. In her police statement, Officer A said that she could see from outside the cell that Mr Stanley was fully suspended. She told us that she could not see this from outside the cell and it was only when she went into the cell that she realised that Mr Stanley was fully suspended. She told us that she did not open the cell until other staff arrived due to Mr Stanley's erratic behaviour earlier in the evening.

113. We cannot be certain what Officer A could see from outside Mr Stanley's cell, but it is concerning that she gave different accounts to the police and us. We understand her concerns about opening the cell by herself, but this must also be balanced against her knowledge that Mr Stanley had tried to take his life just 48 hours earlier and had only very recently been removed from constant supervision.

114. We recognise that it can be difficult for staff in such situations to make instant decisions, but when there is a potentially life-threatening situation it is essential to act quickly and we would expect staff to enter a cell immediately if it is safe to do so. Nevertheless, we are satisfied that she made a dynamic risk assessment in line with national policy.

115. PSI 03/2013 on medical emergency response codes sets out the actions that staff should take in a medical emergency. It contains mandatory instructions for prisons to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called by radio, an ambulance must be called immediately.

116. Officer A did not radio a medical emergency code blue when she saw Mr Stanley hanging. Instead, she radioed for staff and healthcare assistance, and it was not until the cell was opened that she radioed a code blue. She acknowledged to us that she should have radioed a code blue in the first instance.

117. We cannot say whether any of these delays affected the outcome for Mr Stanley. Nevertheless, it is important that prison staff understand their roles in a medical emergency, as early intervention when someone is found hanging might save their life. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.

Inquest

118. The inquest into Mr Stanley's death concluded on 17 July 2023. The jury concluded that Mr Stanley deliberately chose to suspend himself, but the evidence available did not fully explain whether he intended to end his life.

119. In the record of inquest, the jury concluded that failure to follow processes meant that staff best qualified to appreciate Mr Stanley's risk to himself were excluded from the decision to end constant supervision.

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