Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Hellyer, a prisoner at HMP Exeter, on 26 July 2019

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Lee Hellyer died on 26 July 2019, after taking an overdose of his prescribed medication at HMP Exeter. He was 40 years old. I offer my condolences to Mr Hellyer's family and friends.

Mr Hellyer was sent to Exeter on 13 March 2019, after being charged with malicious wounding of his wife (later changed to attempted murder). It was his first time in prison. He had a history of depression and had tried to take his life at the time of his arrest. Staff started suicide and self-harm monitoring (known as ACCT) when he arrived at Exeter, but only monitored him for one day.

The day before he died, Mr Hellyer had been found guilty of wounding with intent and thought he faced a minimum of 12 years in prison.

I am concerned that staff stopped ACCT monitoring prematurely because they failed to adequately assess Mr Hellyer's risk of suicide and self-harm, and that his risk was not reassessed after he was convicted. I am also concerned that healthcare staff assessed him as suitable to have his medication in his possession, despite his obvious risk factors. Staff did not give sufficient weight to Mr Hellyer's risk factors and focused solely on what he said or how he 'seemed,' a problem that this office has highlighted repeatedly over many years.

I have expressed concerns about deficiencies in the ACCT procedures at Exeter in previous investigations and in July 2019, I made a recommendation to the Prison Group Director for Devon and North Dorset to set out the actions she intended to take to address my concerns. She said that staff had been trained and an Early Days Project had been commissioned focusing on risks and safety. I hope that these measures have resulted in an improvement in the management of ACCT procedures since Mr Hellyer's death.

The investigation also found failings in mental health support, healthcare record keeping and the emergency response when Mr Hellyer was found collapsed in his cell.

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 **February 2021**

Contents

Summary

1. Events Mr Lee Hellyer was remanded in custody on 18 March 2019, charged with the malicious wounding of his wife, and sent to HMP Exeter. This was his first time in prison.

2. Mr Hellyer had attempted suicide shortly before he was charged. Staff started suicide and self-harm prevention procedures (known as ACCT) on the day he arrived at Exeter and assessed his risk of harm as high. Staff also considered whether he should be monitored on a constant watch due to his high risk, but a prison GP decided this was not necessary.

3. On 19 March, staff stopped ACCT monitoring after Mr Hellyer said he felt 'okay' and would not harm himself. Mr Hellyer was placed on a waiting list for a depression and anxiety group but he did not attend.

4. On 26 March, Mr Hellyer attended court by videolink and was charged with the attempted murder of his wife. He had his ACCT post-closure interview on the same day but staff did not discuss how he felt about the new charge.

5. On 29 March, Mr Hellyer was moved to D Wing, the wing for enhanced prisoners. He remained there until he died.

6. Before arriving at Exeter, Mr Hellyer had been prescribed propranolol (for migraines) and sertraline (for depression and anxiety) in the community. This medication was continued at Exeter and prison GPs twice increased his dosage of propranolol because Mr Hellyer told them it helped with his anxiety. On 2 April, a nurse assessed Mr Hellyer as suitable to have his medication in his possession, which a doctor authorised.

7. On 25 July, Mr Hellyer attended court where he was found guilty of wounding with intent. When he was returned to Exeter, reception staff recognised that his custodial status had changed from a remand prisoner to a convicted prisoner and he was seen by a nurse. He told the nurse he was fine and said he had no thoughts of suicide or self-harm.

8. On 26 July at around 10.50am, an officer saw Mr Hellyer lying on the floor of his cell snoring. The officer called a colleague and they both went into the cell to assess Mr Hellyer. They realised that he was unresponsive and had a pool of blood near his mouth. One of the officers used his radio to call for healthcare assistance and, while they were waiting for healthcare staff to arrive, Mr Hellyer began fitting.

9. Healthcare staff arrived shortly afterwards and Mr Hellyer continued fitting so staff called for an ambulance and started cardiopulmonary resuscitation (CPR). Paramedics arrived at approximately 11.10am and took over CPR but they were unsuccessful in resuscitating Mr Hellyer and, at approximately 12.10pm, an air ambulance doctor pronounced he had died.

10. The post-mortem report found that Mr Hellyer had died from propranolol toxicity.

Findings

11. Staff stopped ACCT monitoring after only one day. We found that staff failed to adequately assess and manage Mr Hellyer's risk of suicide and self-harm because they focused on what he said and how he presented, without giving sufficient weight to his risk factors.

12. It was a mistake to allow Mr Hellyer to have his medication in his possession. We found that healthcare staff made this decision without considering all available information about Mr Hellyer's risk factors.

13. We are also concerned that prison GPs twice increased Mr Hellyer's dose of propranolol at his request.

14. We found no evidence that Mr Hellyer was invited to attend an anxiety and depression group or offered any further support for his mental health problems, other than medication.

15. Some of Mr Hellyer's healthcare assessments were not appropriately conducted or documented. His mental health assessment was carried out during the first ACCT review on 19 March. When he returned from court on 25 July after being found guilty, he was seen by a nurse in the corridor. Staff did not record why these important assessments were not carried out privately.

16. Staff did not call a medical emergency code when Mr Hellyer was found unresponsive in his cell, even when he began fitting. This resulted in a five-minute delay in an ambulance being called. We cannot say whether the delay affected the outcome for Mr Hellyer but we know that in a medical emergency, a delay of a few minutes may be critical.

17. Mr Hellyer was on D Wing (the enhanced regime wing) when he died. Prisoners subject to ACCT monitoring are unable to remain on D Wing and are moved to a standard wing if ACCT procedures are started. We are concerned that prisoners might be reluctant to tell staff that they are having thoughts of suicide or self-harm because that would mean they would probably be moved off the enhanced prisoners' wing.

Recommendations

- The Governor and Head of Healthcare should ensure that staff assess risk based on all known risk factors rather than on the prisoner's presentation, and ensure that triggers are appropriately recorded.

- The Head of Healthcare should ensure that staff fully consider a prisoner's risk of suicide and self-harm, reviewing all available evidence, before approving in-possession medication.

- The Head of Healthcare should ensure that, wherever possible, consultations and assessments with prisoners are carried out privately and, if this cannot happen, the reason is clearly documented.

- The Head of Healthcare should review the process for providing prisoners with mental health support, including providing them with further opportunities to engage if they fail to attend an appointment.
- The Head of Healthcare should ensure that:
    - there is a clear audit trail when prisoners are assessed for in-possession medication;
    - staff accurately record all relevant information from their interactions with prisoners, including whether or not a consultation was carried out privately;
    - details of appointment letters and times are clearly recorded on the prisoner's medical record.
- The Governor and Head of Healthcare should ensure staff promptly radio the appropriate code when they discover a medical emergency, so that healthcare staff attend with the relevant equipment and an ambulance is called immediately.
- The Governor should ensure that:
    - a family liaison officer is appointed as soon as possible after a death in custody; and
    - staff are reminded of the guidance in PSI 64/2011 when delivering news of a death to the appointed next of kin, in particular that they are familiar with the details of the death and the prisoner's history.
- The Governor should ensure that:
    - arrangements are in place for managing prisoners at risk of suicide and self-harm on D Wing; and
    - if a prisoner must be removed from D Wing for a period of ACCT monitoring, that they can be returned there once ACCT monitoring stops.
- The Governor should share this report with Officer A, Officer B and SO A and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Head of Healthcare should share this report with Nurse A, Nurse B and Nurse C and discuss the Ombudsman's findings with them.

The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

19. The investigator obtained copies of relevant extracts from Mr Hellyer's prison and medical records.

20. NHS England commissioned an independent clinical reviewer to review Mr Hellyer's clinical care at the prison.

21. The investigator and clinical reviewer jointly interviewed six members of staff at Exeter. The investigator also separately interviewed two members of staff by telephone. The interviews took place between October and November 2019.

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

23. We contacted Mr Hellyer's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Hellyer's father asked several questions which we have addressed in this report, including:

    - What risk assessments did Mr Hellyer have when he returned from court?
    - Was he being monitored as a vulnerable prisoner and, if so, how often was he checked?
    - Why did he have his medication in his possession and was an appropriate risk assessment carried out?
    - Why did the prison have little knowledge of Mr Hellyer when they broke the news of his death to his family?

24. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

25. We sent a copy of our initial report to Mr Hellyer's father. He identified no factual inaccuracies within the report.

Background Information

HMP Exeter

26. 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

27. The most recent full inspection of HMP Exeter was 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 the 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. The inspectors were also concerned about poor living conditions.

28. 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 and the conditions in which they were held.

29. 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.

Independent Monitoring Board

30. 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 the 2019 reporting year, the IMB noted that it had been another challenging year for Exeter. The Board noted that the reporting year covered both a time when staffing had improved, and a time when it deteriorated and subsequently became a concern. Retention of both new and experienced staff had become very difficult, and the prison had often had too few officers to maintain an adequate and effective regime.

31. The Board was pleased with the awareness of prison staff to the needs of newly arrived prisoners and noted that risks had been identified, with ACCTs opened and then closed the next day after further assessment. However, the management of prisoners on ACCTs still gave the Board cause for concern. ACCT documentation did not always accompany the prisoner and ACCT observations were sometimes overdue.

32. The Board was impressed at the quality of care offered by the mental health team.

Previous deaths at HMP Exeter

33. Mr Hellyer was the 15th prisoner to die at Exeter since July 2017. Of the previous deaths, six were self-inflicted, six were from natural causes and two are awaiting classification. Previous investigations have highlighted failures in management of suicide and self-harm prevention measures and assessing risk.

Assessment, Care in Custody and Teamwork (ACCT)

34. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

35. 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. 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.

36. 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.

In-possession medication

37. Ideally, prisoners should be responsible for managing their own medication and have the autonomy they would have in the community. There are a number of benefits to this approach, but prisons also have a duty of care to ensure security and the safety of prisoners. In addition to the risk of deliberate overdose, allowing prisoners to keep stocks of medication in their possession can lead to bullying and intimidation or trading in medication and other misuse. The risks and benefits therefore need to be carefully assessed.

Key Events

38. Mr Lee Hellyer was remanded in custody on 18 March 2019 and sent to HMP Exeter. He was charged with the malicious wounding of his wife. He had never been in prison before. Mr Hellyer arrived from court with a suicide and self-harm warning form as he had a history of depression and self-harm and had tried to kill himself at the time of his arrest. Reception staff started suicide and self-harm monitoring (known as ACCT).

39. An officer completed the Concern and Keep Safe Form at 6.30pm. The officer recorded that Mr Hellyer was low in mood and he said that he had tried to take his life seven weeks ago. Mr Hellyer said that he intended to kill himself in prison. He said he was due to return to court on 23 March and he was worried about this. Staff agreed to place Mr Hellyer in a shared cell and monitor him four times an hour.

40. During the evening, Mr Hellyer continued to tell staff that he would kill himself or get other prisoners to harm him, so staff asked a doctor to see him with a view to considering constant watch. A prison GP saw Mr Hellyer at approximately 8.30pm. He told her that his problems started around eight weeks ago and his relationship with his wife had broken down. He spoke about his three young children and how much he missed them. The prison GP recorded that Mr Hellyer said he wanted to clear his name and she felt that he was focused on the future. She did not consider that constant watch was necessary but expected he would be supported by ACCT monitoring with a high level of observations, as well as his regular medication. Mr Hellyer continued to be monitored by staff four times an hour throughout the night.

41. On the morning of 19 March, Officer A carried out an ACCT assessment interview with Mr Hellyer. Mr Hellyer told Officer A that he had thought of jumping off a bridge shortly before he was arrested. He said he had thought of killing himself in his cell during the night. Officer A recorded that Mr Hellyer's mood was low and depressed and that he said he missed his children and his parents. He told Officer A that he wanted to stay alive for his children. Officer A told the investigator that he was concerned for Mr Hellyer and felt that staff needed to keep a close eye on him.

42. Later that day, Mr Hellyer attended his first ACCT review. Supervising Officer (SO) A chaired the review, which was also attended by Nurse A, a mental health nurse. SO A wrote on the documentation that Officer A had provided verbal input to the review but did not record what his input was. Officer A could not recall exactly what he had said to SO A but he told the investigator and the clinical reviewer that he remained concerned for Mr Hellyer.

43. Mr Hellyer told SO A and Nurse A that he had prepared an overdose seven weeks ago but did not take it because of his children. He said that he did not feel like harming himself and he spoke positively about his hopes of getting bail to his brother's address. SO A recorded that Mr Hellyer engaged well with Nurse A on his mental health and that he was on medication for depression and anxiety. SO A and Nurse A assessed Mr Hellyer's risk of harm as low and decided to stop ACCT monitoring. They recorded on the caremap that an action of "family contact" had been completed.

44. On 25 March, Nurse A discussed Mr Hellyer at a multidisciplinary team meeting. The team referred Mr Hellyer to the GP to assess his mood and review his

medication. They also placed Mr Hellyer on a waiting list for the depression and anxiety group. Before arriving at Exeter, Mr Hellyer was prescribed propranolol (for migraines) and sertraline (for depression and anxiety) and this was re-prescribed in prison.

45. On 26 March, Mr Hellyer attended court by videolink. The charges against him were changed to attempted murder and wounding with intent. He was refused bail and remanded in custody awaiting trial.

46. Later that day, Mr Hellyer had his ACCT post-closure interview with a SO. Mr Hellyer said that he was trying to cope and he knew where to go for support if he needed it. He said he had no thoughts of suicide or self-harm and he was hoping to move to D Wing (the enhanced prisoners' wing) soon. The SO did not record anything about Mr Hellyer's court appearance that day or whether he had spoken to him about how he felt about it.

47. A prison GP saw Mr Hellyer on the afternoon of 26 March about his anxiety. He asked for an increase in his propranolol medication. The prison GP increased the dosage from 160mg to 200mg daily.

48. Mr Hellyer was moved to D Wing on 29 March.

49. On 2 April, Nurse B assessed Mr Hellyer for in-possession medication. Nurse B incorrectly recorded that Mr Hellyer had not self-harmed or attempted suicide in the past 12 months and she approved his request for in-possession medication. Nurse B told the investigator and the clinical reviewer that her assessment was based on what Mr Hellyer told her. She said she was not aware of the recent concerns about suicide and self-harm or that staff had stopped ACCT monitoring one week before. Nurse B said that the final decision on whether or not to give in-possession medication would be signed off by a duty doctor. A prison GP authorised Mr Hellyer's in-possession medication later that day.

50. On 3 April, a prison GP saw Mr Hellyer. The prison GP recorded that Mr Hellyer said he did not feel suicidal and that his children were a protective factor. She prescribed him in-possession medication for seven days.

51. On 31 May, a prison GP saw Mr Hellyer. Mr Hellyer said that he had been feeling more stressed and had not had sufficient sleep and, as a result, he had suffered three migraines over the past two weeks. He said that propranolol had helped his migraines in the past. The prison GP increased the dosage of propranolol from 200mg to 240mg daily and also prescribed metoclopramide (medication for reducing nausea associated with migraines).

52. On 26 June, a pharmacy technician held a medication review with Mr Hellyer. She wrote in his medical record that the review was carried out to see if the metoclopramide was helping with Mr Hellyer's migraines before reissuing it. Mr Hellyer said it was helping with his migraines so she arranged for it to be reissued and a prison GP prescribed it later that day.

53. On 2 July, a healthcare assistant wrote in Mr Hellyer's medical record that he did not attend an anxiety management group so he would be removed from the waiting list. We found no evidence in Mr Hellyer's medical record that he had been invited to the group. Mr Hellyer had no further contact with the mental health team although he continued to receive medication for anxiety and depression.

Events of 25-26 July

54. On 25 July, Mr Hellyer attended court and was found guilty of wounding with intent. On return to Exeter, reception staff identified that his custodial status had changed and informed the reception nurse and staff on D Wing. An officer wrote in Mr Hellyer's prison record and the wing observation book that Mr Hellyer could be facing up to 12 years in prison but that he said he was fine. Nurse C assessed Mr Hellyer in reception. Nurse C said that she tried to see Mr Hellyer in an office, but he did not want to go in and said he would talk to her in the corridor. Nurse C recorded that Mr Hellyer said he was fine, his mood appeared stable and he had no thoughts of suicide or self-harm. She assessed that he was suitable to continue to have his medication in his possession.

55. On the morning of 26 July, Officer A saw Mr Hellyer talking to other prisoners about his likely sentence before going to collect his medication at around 8.15am. Officer A said that he did not have any concerns about Mr Hellyer at the time but thought he would go to speak to him later to see how he was doing.

56. At approximately 10.45am, Officer B was carrying out accommodation fabric checks (checking cells to make sure everything is in order) when he saw Mr Hellyer lying on the floor of his cell. Officer B went into the cell and tried to rouse Mr Hellyer to let him know that he was carrying out a check. Officer B said that Mr Hellyer was snoring and he had earplugs in his ears so he decided not to disturb him. He closed the door and decided to come back later. However, he immediately felt that something was not quite right, so he went to get Officer A for a second opinion.

57. Both officers returned to Mr Hellyer's cell and tried to rouse him but he was unresponsive. Officer A saw a small pool of blood near Mr Hellyer's mouth so he used his radio to call for healthcare assistance. The incident log shows this call was made at 10.57am. While they were waiting for healthcare to arrive, Mr Hellyer started to have a fit. The officers tried to hold him still and to put him in the recovery position.

58. Healthcare staff arrived within two minutes of the radio call at approximately 10.59am. A nurse was the first responder but as there had been no medical emergency code over the radio, he had only brought a basic response bag and no oxygen or defibrillator. While assessing Mr Hellyer, he asked his colleagues to bring the necessary emergency equipment, which arrived promptly.

59. The nurse administered medication to try to control Mr Hellyer's seizure, but he remained unresponsive so healthcare staff started cardiopulmonary resuscitation (CPR) and requested an ambulance. Officer A used his radio to call for an ambulance at approximately 11.02am. The ambulance log shows they received a call from the prison at 11.04am and they arrived at Mr Hellyer's cell within six minutes. Paramedics took over Mr Hellyer's care and called for an air ambulance. However, when it arrived, the air ambulance doctor advised paramedics to stop CPR and, at 12.11pm, he declared that Mr Hellyer had died.

Contact with Mr Hellyer's family

60. Two prison managers visited Mr Hellyer's father's home at 2.30pm on 26 July to let him know that his son had died. Mr Hellyer's father contacted other family

members who arrived at the house and were told of Mr Hellyer's death. The prison contributed to the cost of Mr Hellyer's funeral in line with national guidance.

61. Mr Hellyer's father was concerned that prison staff who broke the news of his son's death did not have any knowledge of his son and did not know that he had been found guilty at court the previous day.

Support for prisoners and staff

62. The prison posted notices informing other prisoners of Mr Hellyer'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 Hellyer's death.

63. After Mr Hellyer's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

Post-mortem report

64. The post-mortem report concluded that Mr Hellyer died from propranolol toxicity. Mr Hellyer was prescribed propranolol as in-possession medication. Other prescribed medication was found in the toxicology samples but these were within normal therapeutic levels.

Findings

Identifying and managing Mr Hellyer's risk of suicide and self-harm

65. Prison Service Instruction 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out a list of triggers that may increase the risk of suicide and self-harm. These include offences against family members, family breakdown, previous suicide attempts, mental health issues, court appearances and changes in status, all of which were relevant for Mr Hellyer during his time at Exeter.

66. When Mr Hellyer arrived at Exeter on 18 March, there were clear indications that he was at risk of suicide and self-harm and staff rightly started ACCT monitoring. When he continued to say that he intended to harm himself, staff asked a doctor to consider whether constant watch was necessary in order to keep him safe.

67. Although it made sense to get a prison GP's view on Mr Hellyer's mental state, we consider that the GP's view should have been only one of the factors taken into account when reaching a decision about the need for constant supervision. It is not clear whether the GP had received training in the assessment of risk or whether she was aware of all Mr Hellyer's risk factors. We are also concerned that she advised that constant supervision was not necessary because Mr Hellyer was 'focused on the future'. The idea that a prisoner who talks about future events will not kill themselves is a common misapprehension that we see repeatedly in our investigations. It is not a reliable guide to risk and, while it may be taken into account, it should not replace consideration of the prisoner's risk factors when assessing risk.

68. When Mr Hellyer had his first ACCT case review on 19 March, the risk factors that were present on reception were still present. Despite this, SO A and Nurse A considered that his risk had reduced sufficiently to stop ACCT monitoring less than 18 hours after it was started. Additionally, a single caremap action of "family contact" was recorded as completed but SO A told the investigator that she could not be sure if Mr Hellyer had indeed had any contact with his family.

69. While ACCT monitoring stopped some four months before Mr Hellyer took his life, we are concerned that experienced staff (an ACCT assessor/trainer and a mental health nurse) failed to recognise Mr Hellyer's risk factors and to offer him ongoing support through the ACCT process at that time. Officer A completed Mr Hellyer's ACCT assessment interview and had concerns about his level of risk. He was surprised to learn at interview that the ACCT was closed so quickly. Additionally, a prison GP assessed Mr Hellyer for constant watch and recorded that she would expect him to be supported through the ACCT process with a high level of observations.

70. We consider that the ACCT was closed prematurely and that SO A and Nurse A based their assessment on Mr Hellyer's presentation and what he said to them rather than his obvious risk factors.

71. We consider that Nurse B's assessment on 2 April that Mr Hellyer was suitable for in-possession medication fell seriously short of the standard expected. This was only one week after Mr Hellyer's ACCT post-closure interview. Nurse B did not

read Mr Hellyer's history and relied on what he told her. As a result, she was not aware that he had previously been monitored under ACCT procedures or that he had a recent history of self-harming behaviour and suicidal thoughts. She said that she based her assessment on how he looked and what he said to her. This was not acceptable given that propranolol may be lethal if taken in excess.

72. Nurse B said that the final decision on whether Mr Hellyer could have his medication in possession would be made by a GP. However, this did not absolve Nurse B from the responsibility of checking that Mr Hellyer did not have a history of suicide attempts, and the GP was entitled to assume that this had been done.

73. We are also concerned that prison GPs twice increased Mr Hellyer's dose of propranolol at his request without considering his risk factors.

74. When Mr Hellyer returned from court on 25 July, having been found guilty of a serious offence and facing up to 12 years in prison, he told staff that he felt fine and had no thoughts of suicide or self-harm. Reception staff correctly identified that there had been a change in his custodial status. They made sure that he was seen by healthcare staff and that staff on D Wing were told.

75. Nurse C said that she offered to assess his risk in an office, but he did not want to go in and preferred to speak to her in the corridor. She did not document that he did not want to go into the office to speak to her privately or why this was. Nurse C reported that Mr Hellyer presented well and she had no concerns about him. We are concerned that she considered it was safe for him to continue with his in-possession medication without being aware of the length of sentence he was facing and that she based this assessment solely on how he presented.

76. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in 2014, we identified that too often risk assessments place too much weight on staff's perception of the prisoner's behaviour and demeanour and insufficient weight on known risk factors. We reinforced these lessons in another learning lessons bulletin, issued in February 2016, about early days and weeks in custody.

77. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff assess risk based on all known risk factors rather than on the prisoner's presentation, and ensure that triggers are appropriately recorded.

The Head of Healthcare should ensure that staff fully consider a prisoner's risk of suicide and self-harm, reviewing all available evidence, before approving in-possession medication.

78. We have previously expressed concerns about the assessment of risk and 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 risk and triggers training had been delivered to all reception and first night staff, and that the Group Safety Team had carried out staff briefings on ACCT and quality assurance. The PGD also commissioned an Early Days Project incorporating reception, first night and induction, focusing on risks and safety. The implementation of the agreed actions was being driven by a multidisciplinary working group which was chaired by the Governor.

79. These measures were being taken at the time of Mr Hellyer's death in July 2019. There have been two self-inflicted deaths since then which we are currently investigating and we will expect to see that the measures that were being taken have made a difference.

Mental health

80. Mr Hellyer had a history of depression and anxiety and had recently self-harmed. He was remanded for a serious assault against his partner and, at the time of the offence, he had contemplated jumping from a bridge. He had never been in prison before and arrived at Exeter with a suicide and self-harm warning form. Staff referred him for a mental health assessment.

81. Nurse A attended Mr Hellyer's first ACCT review and completed his mental health assessment during the review. She said at interview that she asked him whether he would prefer to have the assessment separately or in the review, but she did not record that she had given him this choice or whether he knew she was conducting an assessment. We do not consider that it is good practice for such a review to take place during an ACCT review. Prisoners are entitled to expect that a mental health assessment will be done separately and privately but, if for some exceptional reason this cannot happen, we would expect to see the reason clearly documented.

82. Nurse A told us that she referred Mr Hellyer for an anxiety and depression group and he was placed on a waiting list. We found no evidence in his medical record that he had been invited to attend this group. However, an entry made on 2 July states that he did not attend and was therefore removed from the group. No further attempts were made to engage Mr Hellyer in group work or provide him with any support for his mental health needs after he saw Nurse A on 19 March. We make the following recommendations:

The Head of Healthcare should ensure that, wherever possible, consultations and assessments with prisoners are carried out privately and, if this cannot happen, the reason is clearly documented.

The Head of Healthcare should review the process for providing prisoners with mental health support, including providing them with further opportunities to engage if they fail to attend an appointment.

Recording healthcare contacts

83. Nurse B completed the medication in-possession assessment with Mr Hellyer on 2 April. She said that this would normally be signed off by the duty doctor but we have been unable to establish from the healthcare records who approved her assessment.

84. There were two occasions where healthcare staff said that they carried out consultations with Mr Hellyer that were not done in private. One was Nurse A's mental health assessment during the ACCT review on 19 March, referred to above. In addition, Nurse C said that she tried to speak to Mr Hellyer in an office on his return from court on 25 July after being convicted, but he said he would only speak to her in the corridor. The reasons for not holding an assessment in private were not documented on either occasion.

85. Both the mental health assessment and the review when Mr Hellyer returned from court were opportunities for him to open up about how he was feeling and to seek support. It is possible that he would not have chosen to talk about his feelings whatever the circumstances. However, it was much less likely that he would do so in a public place while other things were going on around him. To be effective, reviews should have been carried out in private and time should have been allowed for a proper discussion. Nurse C should also have been aware that Mr Hellyer was facing a long sentence when he returned from court.

86. We also found no evidence that Mr Hellyer had been invited to attend the anxiety and depression workshop or when he was expected to attend. We make the following recommendation:

    The Head of Healthcare should ensure that:

    - **there is a clear audit trail when prisoners are assessed for in-possession medication;**
    - **staff accurately record all relevant information from their interactions with prisoners, including whether or not a consultation was carried out privately;**
    - **details of appointment letters and times are clearly recorded on the prisoner's medical record.**

Emergency response

87. When Officer A and B found Mr Hellyer unresponsive and snoring, they called for healthcare assistance. Being unresponsive and making a snoring sound are typical signs of a drug overdose which prison staff should be aware of. Given that Mr Hellyer was also lying on the floor and with blood near his mouth and Officer B had a feeling that something was not right, we consider that they should have called a medical emergency code at that point.

88. However, before healthcare staff could arrive, Mr Hellyer began to have a fit and we consider that they should definitely have called a code blue immediately. (A code blue should be used where a prisoner is unconscious, having chest pain or breathing difficulties, is choking, is fitting or concussed, is suffering a severe allergic

reaction or is having a stroke.) As a medical emergency code was not used, healthcare staff arrived without the correct equipment for a medical emergency. It also meant that the control room had not called an ambulance. We are concerned that, although Mr Hellyer was still having a fit when healthcare staff arrived, they still did not call for an ambulance.

89. We found there was a delay of around five minutes in calling an ambulance. While we do not know if this affected the eventual outcome for Mr Hellyer, we know that in an emergency situation, a delay of a few minutes may be critical. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure staff promptly radio the appropriate code when they discover a medical emergency, so that healthcare staff attend with the relevant equipment and an ambulance is called immediately.

Contact with Mr Hellyer's next of kin

90. PSI 64/2011 contains a section on informing the next of kin following a death in custody. The PSI sets out guidance on the information that should be gathered before contacting the next of kin, including that the member of staff should be familiar with the details of the death and the prisoner's history. The guidance goes on to say that the visit to the family should not be delayed while gathering this information as it is important that the family are informed before they find out through other means, such as in the media.

91. When two prison managers visited the family, a family liaison officer had not yet been appointed. One prison manager wrote a detailed note of his and the other prison manager's contact with the family. This reflected that they were familiar with the details of Mr Hellyer's death and passed this information onto the family appropriately. However, Mr Hellyer's father raised a concern that the staff did not know that his son had been found guilty at court the previous day. We agree that this is relevant prisoner history information that staff should have been aware of when speaking to the family. We consider this information should have been readily available, given that it was a recent event, so gathering this information would not have delayed the visit to the family.

92. We found no evidence in the written document from the prison managers or the subsequent family liaison log that the family had expressed any concerns about the way the news was broken to them or ongoing family liaison support. However, given their concerns about the lack of information staff seemed to have about Mr Hellyer before they visited, we make the following recommendation:

The Governor should ensure that:

- **a family liaison officer is appointed as soon as possible after a death in custody; and**
- **staff are reminded of the guidance in PSI 64/2011 when delivering news of a death to the appointed next of kin, in particular that they are familiar with the details of the death and the prisoner's history.**

Supporting vulnerable prisoners on D Wing

93. D Wing is a wing for enhanced status prisoners. Prisoners are given more freedom to leave their cells and associate with each other, with the corridors locked at either end of the wing. We heard that prisoners work hard for their enhanced status and to become trusted individuals so that they can earn a place on D Wing.

94. However, we were also told that, because of the layout of the wing, the flexibility of the regime, and the lower staffing levels, there are difficulties in managing prisoners subject to ACCT monitoring on D Wing. For this reason, prisoners are moved away from D Wing if there is a need to start ACCT monitoring so that they can be adequately supported. They do not automatically return to D Wing when ACCT monitoring stops and they will have to work to earn their place there again.

95. Mr Hellyer was on D Wing when he died and we previously investigated the self-inflicted death of a prisoner, in similar circumstances, on D Wing in June 2016. We consider it unfair that prisoners who have worked hard to earn their place on D Wing are removed if they require the additional support of ACCT monitoring. We are concerned that this might make prisoners reluctant to tell staff that they are having thoughts of suicide or self-harm. There is also a risk that staff are having to make a 'judgment call' on whether to open an ACCT, even when there may be indications that they should do so, so that prisoners do not lose their place on the wing.

96. While we recognise that there may be logistical challenges, we do not think that prisoners should have to choose between remaining on D Wing or being supported under ACCT. We therefore make the following recommendation:

The Governor should ensure that:

- **arrangements are in place for managing prisoners at risk of suicide and self-harm on D Wing; and**
- **if a prisoner must be removed from D Wing for a period of ACCT monitoring, that they can be returned there once ACCT monitoring stops.**

Learning lessons

97. We consider it essential that staff learn the lessons from our reports. We therefore recommend that:

The Governor should share this report with Officer A, Officer B and SO A and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Head of Healthcare should share this report with Nurse A, Nurse B and Nurse C and discuss the findings with them.

Inquest

98. The inquest was heard before a jury from 9 to 27 October 2023. The jury gave a narrative conclusion. They concluded that Mr Hellyer's death was by suicide and

that the lack of attention given to his risk factors, the prison's inadequate procedures to manage his risk and the inadequate medication in-possession risk assessment were contributing factors.

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