Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Samuel Jordan, a prisoner at HMP/YOI Exeter, on 27 March 2020

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 Samuel Jordan was found hanging in his cell at HMP Exeter on 26 March 2020. He was resuscitated but he died in hospital on 27 March. He was 25 years old. I offer my condolences to Mr Jordan's family and friends.

This was Mr Jordan's first time in prison, and he had only been at Exeter for two weeks when he hanged himself. At the time of his death, Mr Jordan was being managed under suicide and self-harm prevention procedures (known as ACCT). However, our investigation found deficiencies in the procedures, and I am also concerned that staff underestimated his level of risk and placed too much reliance on his denials of suicidal thoughts.

The investigation also found deficiencies in the way HMP Exeter dealt with several incidents of violence involving Mr Jordan.

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 2022**

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Summary

Events

1. On 12 March 2020, Mr Samuel Jordan was received into prison custody at HMP Exeter on an eight week sentence for assault.

2. On 20 March, Mr Jordan had a fight with his cellmate and suffered a cut to his head. Staff also saw that Mr Jordan had made cuts to his wrist and they started suicide and self-harm prevention procedures (known as ACCT). Mr Jordan and his cellmate remained in the same cell for the next 24 hours.

3. At an ACCT case review on 21 March, Mr Jordan gave little information, but staff assessed him as low risk for suicide or self-harm. At his next ACCT review on 24 March, he was again assessed as low risk. The ACCT manager telephoned healthcare for information, but no nurse attended the review. Mr Jordan should have had two ACCT conversations with officers that day, but he had none.

4. On 26 March, Mr Jordan had a fight with his new cellmate and was moved to a single cell. At 8.08pm that evening, an officer found Mr Jordan hanging from his cell bars. The officer called an emergency code, and the ligature was removed. Nurses responded promptly and began cardiopulmonary resuscitation. Paramedics arrived at 8.14pm and established a pulse. Mr Jordan was taken to hospital and placed in intensive care. He died in hospital on 27 March.

Findings

5. We are concerned about the management of Mr Jordan's ACCT. There was no continuity in staff attendance, an important caremap action was omitted and some ACCT interactions were missed. We also consider that staff might have set ACCT observations and interactions at too low a level given Mr Jordan's odd behaviour and equivocal responses when asked about his intentions to self-harm, and no adjustment was made to his level of observations when he was moved to a single cell.

6. We are concerned at the apparent failure to investigate several incidents of violence between Mr Jordan and other prisoners and about cell sharing arrangements following these incidents.

7. Staff involved in the emergency response did not complete incident statements.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:
    - staff hold multidisciplinary ACCT reviews with the same case manager;
    - case managers complete caremaps setting specific and meaningful caremap actions;
    - staff set a level of conversations and observations appropriate to the prisoner's level of risk;

    - staff review the level of conversations and observations if the prisoner's circumstances change, for instance if they move from a shared to a single cell; and
    - officers conduct ACCT conversations as indicated in ACCT plans.
- The Governor should ensure that incidents of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies.
- The Governor should ensure that:
    - cell sharing risk assessments are reviewed when there is information that a prisoner might be at increased risk of violence towards a cellmate; and
    - changes that suggest increased risk of harm between cellmates are reported to a manager and recorded in NOMIS.
- The Governor should ensure that staff directly involved in a death in custody complete incident statements as soon as practicable following the death.

The Investigation Process

8. 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.

9. The investigator obtained copies of relevant extracts from Mr Jordan's prison and medical records. She interviewed seven members of staff at Exeter in August 2020. All of the interviews were conducted by telephone due to revised working practices during the COVID-19 pandemic. The investigation was subsequently reallocated to another investigator who interviewed two further members of staff by telephone and had a follow-up discussion with one of the original interviewees.

10. NHS England commissioned a clinical reviewer to review Mr Jordan's clinical care at the prison. The investigator and clinical reviewer jointly interviewed the clinical staff.

11. We informed HM Coroner for Exeter and Greater Devon of the investigation. The Coroner gave us Mr Jordan's cause of death. We have given the Coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Jordan's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She responded via her solicitor. She said that before his arrest, her son was showing significant signs of mental ill health and she asked the following questions:

    - did Mr Jordan receive appropriate medical treatment at Exeter;
    - were prison officers aware of her son's risk of suicide and self-harm;
    - did the prison follow procedures on managing prisoners assessed as being at risk of suicide and self-harm; and
    - were emergency protocols followed when her son was found hanging?

13. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.

14. We also shared the initial report with the solicitors representing Mr Jordan's family. The solicitors raised several queries. We have addressed these in separate correspondence but have also identified and spoken to some of the staff who were captured on CCTV visiting Mr Jordan's cell on the afternoon and early evening of 26 March. Paragraphs 56 to 60 summarise these visits.

Background Information

HMP Exeter

15. HMP Exeter is a local prison that covers the courts of Devon, Cornwall, Dorset 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 (HMIP)

16. 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. Inspectors were particularly concerned to find that the key area of prisoner safety attracted the lowest possible grading of poor. Inspectors reported that two-thirds of prisoners did not feel safe and that there had been a 40% increase in incidents of self-harm with six self-inflicted deaths since their last inspection.

17. 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.

18. In April 2019, HMIP conducted an Independent Review of Progress to look at the progress made in implementing the key recommendations from the 2018 inspection. They reported that there had not been a sufficient sense of urgency in the prison's response to a number of key recommendations. Nevertheless, there had been a proactive response to some recommendations in critical areas and there were credible plans in place to make further improvements in the future. Inspectors found that overall levels of violence had decreased since the 2018 inspection but incidents between prisoners, some of which were serious, 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

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report for the year to December 2020, the IMB wrote that it was impressed by the prison's response to the significant challenges posed by the COVID-19 pandemic and noted how settled the prison had been, given the severe restrictions.

20. The IMB noted that it understood the need for prisoners to be locked in their cells for many hours each day but identified that the restricted daily regime came at a cost with reduced opportunities for out of cell activities. The IMB pointed out that the impact at Exeter would have been particularly severe as most cells were shared by two people, making them cramped and lacking in privacy.

21. The IMB also noted that their reporting year continued to cover a period where the prison was taking forward an action plan arising from the 2018 HMIP inspection and which included monthly review meetings by senior management and functional heads.

Previous deaths at HMP Exeter

22. Mr Jordan was the 11th prisoner to die at Exeter since January 2018. Of the previous deaths, three were self-inflicted and six were from natural causes. The other death was from sudden cessation of alcohol consumption.

23. There have been eight deaths at Exeter since Mr Jordan's: four were self-inflicted and four were from natural causes.

24. In our previous investigations into the death of two prisoners at Exeter we found that staff had underestimated the risk of suicide and self-harm. We recommended that the Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines.

25. In June 2019, we asked the Prison Group Director (PGD) for Devon and North Dorset to provide the Ombudsman with an account of the actions she intended to take in response to our concerns about the management of ACCT procedures at Exeter. The PGD said that they had put in place risk and triggers training and Cell Sharing Risk Assessment (CSRA) training which had been delivered to all Reception and First Night Staff. Supervision for ACCT had been delivered to ACCT Case Managers via floor walking by the national and group Safety Teams to support and develop Case Managers as they conduct their ACCT case management work and the group Safety Team completed staff briefings and bite size learning on ACCT, provided regular support visits, and quality assured the ACCT process as part of those visits. The PGD also commissioned an early days project and introduced a safety assurance framework to monitor the delivery of HMPPS Policy and PPO action plan commitments.

26. In another investigation, officers did not complete incident statements following a death. We recommended that the Governor should ensure that all evidence including electronic evidence relevant to a death in custody was retained and made available to the PPO, in line with PSI 58/2010. The prison accepted our recommendation and said that a new death in custody policy and procedures strategy document had been developed to complement the death in custody contingency plan to ensure that all relevant documentation is retained immediately following an incident.

Assessment, Care in Custody and Teamwork

27. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

28. On 12 March 2020, Mr Samuel Jordan was convicted of possession of a class B drug (cannabis) and was sentenced to five days in prison. His conviction activated a previous eight week suspended sentence for assaulting emergency workers (police officers). Mr Jordan was sent to HMP Exeter. This was his first time in prison custody.

29. Mr Jordan arrived at Exeter with suicide and self-harm warnings recorded on his Person Escort Record (PER) and on a suicide/self-harm (SASH) warning form. The PER said that Mr Jordan had anxiety and depression and had a history of "slashing" and threats of suicide and self-harm. The SASH warning form said that when court transport staff asked Mr Jordan if he intended to harm himself, he answered that he might or might not.

30. An officer saw Mr Jordan in reception. She told the investigator that she remembered Mr Jordan because he stuck his tongue out when reception staff were trying to photograph him. She saw both the PER and SASH forms, but she said that after she spoke to him, she was content that he did not have any current thoughts of suicide or self-harm. She told the investigator that there was no reason to start ACCT procedures for Mr Jordan but acknowledged that she made an erroneous entry in his records to suggest that he did need support.

31. A reception nurse tried to interview Mr Jordan but noted that she could not complete her assessment due to Mr Jordan's challenging behaviour. She noted that another attempt would be made to assess him the next day.

32. On 13 March, Mr Jordan was assessed by a different nurse. She noted that Mr Jordan had behaved oddly which included him trying to show that he understood more than her about the questions she was asking. Mr Jordan told her that he had no current thoughts of self-harm but said that he had a history of attempted suicide. He said he had tried to hang himself when he was ten and had taken several overdoses. He also said that he had a history of mental health problems but had never sought help. The nurse referred Mr Jordan to the mental health team and to a prison GP.

33. Mr Jordan was seen on the afternoon of 15 March, by a mental health nurse. He noted that it was difficult to obtain information from Mr Jordan as he seemed to resent having to talk with him. The nurse noted that Mr Jordan denied having any present thoughts of suicide or self-harm and declined any additional support from the mental health team. (The nurse noted that he saw Mr Jordan talking to other prisoners later that afternoon and he did not appear tense or anxious.)

34. At around 4.00pm on 15 March, Mr Jordan was punched in the back of his head by another prisoner. He was examined and had no injuries. Neither Mr Jordan nor the other prisoner would explain the reason for the incident.

35. On 16 March, a prison GP established that Mr Jordan was not in receipt of any community prescribed medication.

36. On the same day, Mr Jordan was discussed at a mental health multi-disciplinary team meeting which concluded that there were no indications for further input from the mental health team.

37. At around 9.00am on 20 March, an officer saw Mr Jordan on the wing landing with a bloodied head. He said that his cellmate had hit him with a kettle.

38. The officer took Mr Jordan to the healthcare unit where a nurse noted that Mr Jordan had a small wound to his head that had stopped bleeding. The nurse also noted on a self-harm examination form that Mr Jordan had used a razor to make superficial cuts to his wrist, but the injuries required no treatment. The nurse did not make an entry in Mr Jordan's SystmOne record about the self-inflicted injuries to Mr Jordan's wrist.

39. Mr Jordan told the officer that he had made the cuts the night before, but he gave no explanation for doing so. The officer started suicide and self-harm prevention procedures (known as ACCT).

40. The officer spoke to the cellmate, who said that Mr Jordan had started the fight and had hit himself with the kettle during the scuffle. There is no evidence that Exeter investigated the fight any further and we note that Mr Jordan and his cellmate remained in the cell together that night. The cellmate moved to a new cell the following day. No review was made of Mr Jordan's suitability to share a cell (his cell sharing risk assessment), and he remained standard risk.

41. On the morning of 21 March, an officer saw Mr Jordan for an ACCT assessment interview. The officer told the investigator that it was difficult to get much information out of Mr Jordan, but in answer to a question about current suicidal intentions, Mr Jordan said that he had no suicidal thoughts, but might self-harm as he was "pissed off".

42. A Supervising Officer (SO) chaired the case review following the assessment interview. The SO noted that Mr Jordan believed he should not be in prison as he had only received a five day sentence. He noted that he tried to explain about the activation of the eight week suspended sentence, but Mr Jordan said that he was being held in prison against his will and should be released. The SO also noted that Mr Jordan was annoyed at the restricted regime which had just been introduced due to COVID-19. He assessed Mr Jordan's level of risk as low and arranged for him to have two conversations with staff during the day, with hourly observations day and night. He completed a caremap with two actions: for Mr Jordan to see a learning disability nurse and for him to be provided with a distraction pack (a book of puzzles and other activities).

43. A mental health nurse also attended the case review. She wrote in Mr Jordan's medical record that he denied suicidal thoughts but said he would harm himself if he was antagonised. He said that he was angry that officers were checking him every hour (which they had been doing pending the ACCT review) and he thought they were deliberately stopping him from sleeping. She noted that Mr Jordan had not engaged well and that by the end of the review he had stopped answering questions. She also noted that he smiled inappropriately at times and had stared at panel members in an intimidating way.

44. As they left the office, Mr Jordan resisted returning to his cell and at one point took hold of the banister rail. The SO and an officer took hold of Mr Jordan's arms and walked him back to his cell. The SO placed Mr Jordan on report for disobeying a lawful order for refusing to return to his cell.

45. On the afternoon of 22 March, an officer made an entry in Mr Jordan's ACCT plan that he had tried to engage with him, but all Mr Jordan had done was to complain about being placed on report. The officer told the investigator that he tried to explain the process to Mr Jordan, but he would not listen and said that staff were ganging up on him. He said that at other times, Mr Jordan would ask strange questions such as asking to go out for exercise during the prison night state.

46. On the morning of 23 March, Mr Jordan attended a disciplinary hearing (adjudication) on the charge of disobeying a lawful order on 21 March. Mr Jordan was found guilty, and he received a suspended punishment.

47. An officer spoke to Mr Jordan at 11.30am on 23 March. He noted that Mr Jordan was complaining about the adjudication outcome but said he did not have any thoughts of suicide or self-harm. The officer had a further conversation with Mr Jordan in the afternoon and noted that he seemed in a better mood.

48. In the late afternoon, Mr Jordan gained a new cellmate.

49. Mr Jordan's next ACCT case review was on 24 March. An SO chaired the review and an officer and another SO also attended. The SO telephoned the healthcare unit before the review and was advised that Mr Jordan had been discharged from the mental health team caseload but was due to be seen by the learning difficulties nurse. The SO noted that Mr Jordan appeared to engage better than he had at his previous review. Even so, he wrote: *"it was clear to us that Sam does have issues but was either reluctant to share these … or is in denial … that there are … issues …".* He kept the ACCT plan open but noted that Mr Jordan's level of risk was low. He was to continue having two conversations with staff during the day, but his observations were reduced to three observations during the night, with no observations during the day. His next review was set for 1 April.

50. On 24 March staff did not record that they had had any conversations with Mr Jordan.

51. An officer spoke to Mr Jordan in the late morning of 25 March. Mr Jordan said that he was feeling "pretty miserable" due to the amount of time locked in his cell. The officer asked Mr Jordan if he had any thoughts of suicide or self-harm and Mr Jordan answered, "Not at the moment".

52. Another officer spoke to Mr Jordan at 12.30pm on 25 March. Mr Jordan said that he was 'okay', but she thought he was a little quiet. She asked him if he wanted her to come back later on when the wing was a little less busy, and he answered 'yes'. She told the investigator that it was her general practice to offer prisoners the chance to speak again later, and there had been nothing about Mr Jordan's demeanour to indicate he was desperate to speak. She could not recall why she did not return to speak again with Mr Jordan but assumed that other duties had intervened.

26 March

53. At 10.15am on 26 March, an officer spoke to Mr Jordan while his cellmate was out of the cell. She told the investigator that Mr Jordan said that he was struggling with being in prison and told her that all his friends were female and that he did not get on with men.

54. At around 3.45pm, the officer responded to a cell bell from Mr Jordan's cell. The cellmate told her that Mr Jordan had kicked him in the face and had grabbed him around the throat. He said that he then pushed him off him. She noted that Mr Jordan did not deny the allegation and just smiled. She noticed that Mr Jordan had a cut to his eyebrow, so she took him to the healthcare unit for treatment.

55. Mr Jordan was moved to a single cell, cell A2-20. He was charged with the offence of fighting and was told that he would have a disciplinary hearing the following day.

56. At 4.42pm, a nurse went to check Mr Jordan for any injuries he might have sustained in his fight with his cellmate. The nurse noted that Mr Jordan had no swelling on his forehead and had no symptoms of dizziness. Mr Jordan said that he was happy to be in a single cell.

57. At 4.48pm, another nurse, accompanied by an officer, also went to check Mr Jordan for injuries unaware that a nurse had already checked him.

58. Mr Jordan rang his cell bell at around 5.25pm and an SO responded at 5.28pm. The SO remained at Mr Jordan's door for only a few seconds and, when spoken to by the investigator, said it was possible that Mr Jordan had pressed his call button by mistake or had said that he no longer had an issue.

59. While conducting a roll check at 5.54pm, an officer spoke to Mr Jordan for around 10 seconds. The investigator spoke to the officer about the conversation, but she could not recall what they had spoken about.

60. At 7.14pm, an officer went to Mr Jordan's cell and spoke to him for around 45 seconds. The investigator was unable to speak to the officer about this discussion as she had left the Prison Service.

61. At 8.08pm, an officer was conducting the roll check. When she looked into Mr Jordan's cell, she saw him hanging from a ligature tied to the window bars. She noted that his feet were off the floor. She radioed a medical emergency code blue (indicating that a prisoner is unconscious or having breathing difficulties), which the control room asked her to repeat. The control room called an emergency ambulance immediately.

62. The officer unlocked Mr Jordan's door and went in and was joined by other staff. An officer lifted Mr Jordan, but the ligature, which was made from a blanket, was too thick to be cut with an anti-ligature knife, so another officer and an SO untied it. As Mr Jordan was lowered to the floor, a healthcare assistant (HCA) arrived and started cardiopulmonary resuscitation (CPR). A nurse arrived and inserted an airway to help deliver oxygen. A prison GP arrived and noted that although Mr Jordan had no pulse, his body was warm. Staff alternated in giving CPR. Mr Jordan was checked with a defibrillator, which instructed that a shock could not be given, and that CPR should continue.

63. Ambulance paramedics arrived at around 8.14pm and they took charge of the efforts to resuscitate Mr Jordan. At around 8.29pm, the paramedics established a pulse and Mr Jordan was taken, unrestrained, to the Royal Devon Infirmary. He arrived there at 9.20pm and was placed in intensive care. Mr Jordon remained in

64. intensive care until he died at 7.27pm on 27 March.

Contact with Mr Jordan's family

65. The Governor telephoned Mr Jordan's mother at around 10.00pm on 26 March to tell her that her son was seriously ill in hospital. Mr Jordan's mother and step-father went to the hospital, where they met the Governor and saw Mr Jordan and the doctors who were treating him.

66. Exeter contributed to the cost of Mr Jordan's funeral in line with national instructions.

Support for prisoners and staff

67. Following Mr Jordan's death, one of Exeter's functional Heads debriefed the staff who responded when Mr Jordan was found hanging and the staff who were with him when he died. The staff care team also offered support.

68. The prison posted notices informing other prisoners of Mr Jordan'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 Jordan's death.

Post-mortem report

69. The pathologist gave Mr Jordan's cause of death as complications of prolonged cardiorespiratory arrest following compression of the neck caused by suspension by ligature.

70. No illicit substances were found in Mr Jordon's body. The only substances identified in toxicology tests were medicines used during Mr Jordan's emergency medical treatment.

Findings

Assessment of Mr Jordan's risk of suicide and self-harm

71. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, states that ACCT case review teams must be multi-disciplinary where possible. It advises that the ACCT process will operate more effectively if there is continuity in the attendance of staff from relevant departments and services so every effort should be made to ensure the same members of staff attend the reviews, including input from healthcare staff.

72. ACCT procedures were started for Mr Jordan on 20 March when he was seen with cuts to his wrists. A nurse examined the injuries and noted in a self-harm examination form that they did not require treatment.

73. Mr Jordan had an ACCT assessment interview and multidisciplinary case review on 21 March. Mr Jordan did not engage with staff properly but said that he had no suicidal thoughts. He also said that he should not be in prison as he had only received a five day sentence. An SO tried to explain the activation of Mr Jordan's previous eight week suspended sentence, but it seems Mr Jordan was unconvinced by the explanation. The SO made no caremap action for an appropriate person to meet with Mr Jordan to further explain his sentence.

74. Mr Jordan seems to have engaged a little more at his next ACCT review on 24 March, but it is clear that he remained very guarded in disclosing information. We note that the review was chaired by a different SO and that there was no healthcare attendee at the review. The review team decided that Mr Jordan's observations should be reduced to three during the night with no observations during the day. Mr Jordan was to continue having two recorded conversations a day, although none were recorded for him for that day.

75. Deciding on the level of risk and the appropriate level of conversations and observations is a matter of judgment for the staff involved. In Mr Jordan's case, we are concerned that staff gave too much weight to his denial of suicidal thoughts and did not give enough weight to his risk factors: it was his first time in prison, he had a history of suicide attempts, he had recently self-harmed (albeit not seriously), he had been assaulted twice by other prisoners, and he had disclosed a history of untreated mental health problems.

76. In addition, he was very guarded in revealing any information, he gave conditional answers to questions on his intent to self-harm, and he sometimes behaved strangely (for example, smiling inappropriately, asking to go out for exercise at night, and had two unexplained fights with two different cellmates). Staff did not yet know him, as an SO recognised on 24 March (two days before Mr Jordan hanged himself), when he recorded that it was clear that Mr Jordan had issues but was either reluctant to share them or was in denial about them. Given these risk factors, we consider that staff underestimated Mr Jordan's level of risk and set his level of conversations and observations at too low a level.

77. We are also concerned that when Mr Jordan was moved to a single cell on 26 March, there was no consideration of whether this might affect his risk and no adjustment was made to his level of observations (meaning he was still not subject to observations during the daytime, apart from standard times when all prisoners would be observed).

78. We make the following recommendation:

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

- **staff hold multidisciplinary ACCT reviews with the same case manager;**
- **case managers complete caremaps setting specific and meaningful caremap actions;**
- **staff set a level of conversations and observations appropriate to the prisoner's level of risk;**
- **staff review the level of conversations and observations if the prisoner's circumstances change, for instance if they move from a shared to a single cell; and**
- **officers conduct ACCT conversations as indicated in ACCT plans.**

Cell Sharing Risk Assessment and violence reduction

79. Prison Service Instruction (PSI) 20/2015 governs cell sharing risk assessment (CSRA). There are two risk categories: high risk prisoners are those for whom there is evidence that they may be severely violent to a cell mate, or that a cellmate may be severely violent to them; standard risk prisoners are those for whom there is no evidence of immediate risk of severe violence. The PSI says that a CSRA must be completed as part of the reception process when prisoners are first received into custody, and before they are allocated to a shared cell. The PSI goes on to say that as standard risk prisoners will normally share a cell, changes in their behaviour indicating increased risk, must be considered. The PSI also instructs that changes relevant to increased risk of harm between cellmates must be reported to the duty governor or manager and must be recorded on NOMIS (a prisoner's electronic prison record). Exeter's local policy reflects much of the guidance given in the PSI.

80. Exeter has a Challenge Support and Intervention Plan to inform strategies to reduce prison violence. The plan includes the need to investigate incidents of violence.

81. Mr Jordan was involved in three incidents of violence in his brief time at Exeter, two of which were fights with cellmates. While we appreciate that little time elapsed between Mr Jordan's final fight and his act of significant self-harm later that evening, there appears to have been little or no investigation into any of the incidents. We note with particular concern that Mr Jordan and his first cellmate shared a cell for a further night following their fight on 20 March.

82. When Mr Jordan arrived at Exeter, he was assessed on his CRSA as standard risk. No adjustment was made to this following his fight with his cellmate and, on 23 March, he gained a new cellmate. Mr Jordan and his second cellmate had a fight on 26 March and although Mr Jordan was then moved to a single cell, no note of the fight was made in his NOMIS record.

83. The safety of prisoners at Exeter was the major cause of concern for HM Inspectorate of Prisons following their inspection in May 2018. We make the following recommendations:

The Governor should ensure that incidents of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies.

The Governor should ensure that:

- **cell sharing risk assessments are reviewed when there is information that a prisoner might be at increased risk of violence towards a cellmate; and**
- **changes that suggest increased risk of harm between cellmates is reported to a manager and recorded in NOMIS.**

Incident report forms

84. PSI 64/2011 governs procedures on the management of prisoners at risk of harm. It says that staff directly involved in a death in custody, particularly those who were first on scene, must complete incident statements as soon as practicable. In Mr Jordan's case, staff did not complete incident statements. This might be because the prison did not initially treat this as a death in custody. However, while staff and paramedics managed to resuscitate Mr Jordan, his prognosis was poor, and he died within 24 hours of going to hospital. When his death was confirmed, a hot debrief with staff was arranged and relevant staff should have been told to complete response statements. We make the following recommendation:

The Governor should ensure that staff directly involved in a death in custody complete incident statements as soon as practicable following the death.

Clinical care

85. The clinical reviewer found that the care Mr Jordon received at Exeter was of a reasonable standard and equivalent to that which he could have expected to receive in the wider community.

86. She noted, however, that it had not been possible for her to comment on every episode of healthcare because some episodes were not documented in his SystmOne healthcare record. The most notable of these was the incident of self-harm that occurred on 20 March, or the evening before, when a nurse found that Mr Jordan needed no treatment for cuts to his wrist but made no entry about the injuries in the SystmOne record.

87. The clinical reviewer also noted concern that several reports of alleged assault by other prisoners, did not result in any safeguarding concerns being raised. The clinical reviewer has made five recommendations, which we do not repeat here but which the Head of Healthcare will need to address.

Inquest

88. An inquest into Mr Jordan's that the cause of his death was suicide.

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Independent Investigations

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