

**Investigation into the circumstances surrounding the
death of a man who died at
HMP Exeter in September 2007**

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

February 2008

The man aged 27 years, was found hanging in his cell at HMP Exeter in September 2007. He had been in custody for less than three weeks. He had used his bed sheet as a ligature attached to his cell window frame. Staff upon discovering him responded immediately to cut the man down, laid him on the floor and attempted resuscitation. Sadly, he had died and was pronounced dead in his cell.

I would like to add my sincere condolences to those already expressed by staff and prisoners at Exeter to the man's family and friends for their loss.

The man was a convicted prisoner who had been released on a Probation Licence in December 2006. He breached the conditions of his licence and absconded in February 2007. He was subsequently arrested on suspicion of murder and was recalled on 23 August to HMP Exeter for breach of his licence. He did not give staff or other prisoners any cause for concern. His death was a shock to all who knew him.

One of my investigators conducted the investigation. The local Primary Care Trust conducted a clinical review into the man's care and treatment whilst at Exeter. I would like to thank the Governor of Exeter and his staff for their help and active co-operation during this investigation. I am also grateful to the police for their assistance.

The man's father has been in contact and visited Exeter. He has also been in contact with one of my Family Liaison Officers from an early stage. A key part of the investigation was to ensure the man's father had the opportunity to raise his concerns.

The death of the man was the fourth apparent self inflicted death at Exeter since I became responsible for investigating all deaths in prisons in April 2004. I am satisfied that he did not share with staff, prisoners, friends or family outside prison any indication that he intended to take his own life.

**Stephen Shaw CBE
Prisons and Probation Ombudsman
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SUMMARY

On 14 December 2006, the man was released on a nine month Probation Licence from HMP Lowdham Grange, which was due to expire on 29 September 2007. He had spent six and a half years in prison. A condition of his licence was to reside in a designated hostel in London and comply with the hostel rules. He breached the hostel rules by failing to adhere to an 11.00pm curfew on 22 January 2007.

The man telephoned the hostel the following day and was informed that his licence had been breached. He said that he would probably hand himself in but he would need to sort things out first. He was arrested nearly seven months later in August, in Exeter, on suspicion of a murder that had occurred in the city days previously. He was released on police bail pending further enquiries, and taken to Exeter prison on 23 August 2007, for breaching his probation licence.

The man went through the prison's reception process and during the completion of his cell sharing risk assessment he presented as high risk of assaulting another prisoner. The first night centre prisoner profile form was completed. The man expected to be in prison, he said that he had previously served four periods of custody and had never committed an act of self harm or felt at risk of self harm. He denied misusing drugs or alcohol, but said he used cannabis recreationally.

The man was located at his request alone in a single cell C4:20. He received visitors and made telephone calls and was able to communicate with a girlfriend by shouting to her as she stood on the road outside the prison wall directly below his cell. During the morning roll check at 6.00am on 10 September, the man was found hanging from a ligature made from a bed sheet attached to his neck and tied around the window bars. Staff acted quickly to cut him down and commence resuscitation. Sadly he was pronounced dead in his cell.

A post mortem examination concluded the man had died as a result of hanging. There was no evidence to suggest third party involvement. He had given no outward indication to staff or fellow prisoners that he intended to take his life.

Found in the man's cell at the time of his death was a local newspaper covering the murder investigation for which he was on bail. Next to it was a hand written document listing the offences he had been convicted of, and the resulting sentences, and his age at the time of his release.

THE INVESTIGATION PROCESS

1. The investigation was formally opened at HMP Exeter on 14 September 2007 by my investigator. The Governor and his staff produced the man's core record and a number of other documents for examination. My investigator met with members of the Chaplaincy, Prison Officers' Association (POA) and Independent Monitoring Board (IMB).
2. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to make themselves known to the investigator. My investigator was given unrestricted access to the prison, staff, prisoners, and documentation relating to the man. He was also able to speak with the local police in relation to issues of common interest.
3. Prison officers, members of health care staff and prisoners were formally interviewed and those interviews were tape recorded. The interviews have been transcribed and interviewees invited to sign and return them. Although not all transcripts have been returned signed, they are attached as annexes to this report. My investigator wrote to the man's criminal solicitor and three people that visited the man whilst at Exeter, inviting them to get in touch if they have information that may assist the investigation. To date only one of the man's friends has contacted my investigator.
4. The local Primary Care Trust conducted a clinical review of the man's care and treatment by reviewing his Inmate Medical Record and a report by his general practitioner. Reference was also made to the prisoner's core record. A panel review of his medical care was conducted on 4 December 2007.
5. CCTV footage of C wing was obtained but sadly the camera equipment was not functioning properly and images of C4 wing could not be properly captured.
6. A Family Liaison Officer from my office contacted and visited the man's father with my investigator. The man's father said he had visited the prison after his son's death, the staff were extremely friendly and helpful towards him. He was able to speak to other prisoners and they told him that his son was happy on the night he died.
7. The man's father did not believe his son could end his own life. He said his son was not under stress as he was due to transfer prisons. He had proposed to his girlfriend and she had accepted. On the night he died he had been speaking to her out of the window of his cell. The man had asked her to thank his father, for sending a postal order. He said his son hated prison. He believes he must have been innocent of the alleged murder charge because if he

were guilty he would have fled to Cyprus where he would have been safe from arrest.

8. The man's father knew that his son wrote him a letter which was not actually posted before he died. The police have the letter and he did not see it, until my investigator arranged for him to receive a copy. The content did not give him cause for concern.
9. My investigator told the man's father that he visited the prison within three days of his son's death. He saw the cell where his son had died and interviewed three prisoners who knew him.
10. The man's father pointed out that his son was tall yet he was found hanging from a low window approximately 1m high. He had doubts that this was possible. He also told us that his son hated pain so would not inflict any on himself. He understood that he would possibly never know what really happened that night, and was concerned that his son was not checked between 10.00pm and 6.00am.
11. The man's father suggested that had the prison staff read his son's outgoing correspondence they might have noticed he was upset or worried. It was explained that prisons randomly read some mail, unless they have concerns about a particular prisoner. On arrival at Exeter his son had told the staff he was not depressed and they had no reason to be concerned about him. In the man's letters he wrote about his relationship with a girl who had not written back to him.
12. The man's father told the investigators that his son had access to a mobile phone when he was in custody previously. He alleged that the phone was given to him by a prison officer for a charge. He said if the staff were prepared to do this, they may have been responsible for his son's death.
13. My investigator wrote to HM Coroner to inform her of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist her enquiries into the man's death.

BACKGROUND

HMP Exeter

14. The prison is located within the City of Exeter and was built around 1850. It currently has four accommodation units with a healthcare facility in support. The Certified Normal Accommodation is 314 and the Operational Capacity 533. The prison holds both adult male remand and convicted prisoners committed to custody from Cornwall, Devon and Southwest Somerset.

Suicide and self harm monitoring

15. As in all prisons, Assessment, Care in Custody and Teamwork (ACCT) has been introduced at Exeter to monitor and support prisoners assessed to be at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk.

16. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people who know the person at risk or are involved in their care. The key questions for each review are listed as:

- have the problems that caused the ACCT plan to be opened now been resolved?
- if not, what needs to be done to resolve them?
- have any further problems arisen that are now causing distress and more risk?
- if so, what action can be taken to address these?
- is the person at risk now in contact with friends, family or other support?
- does the person at risk now have something in their lives that they feel good about?
- if not, how can this be improved?

17. Over time, the reviews should also consider other factors such as:

- distress – has anything changed to make the person at risk more or less desperate?
- resources – has anything changed that makes the person at risk now feel more or less alone?
- previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?

- suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
- pattern of self harm – is self harm becoming more or less frequent?

18. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment and it is for the Case Review team to decide the most appropriate place to locate an individual prisoner. The man was not identified as a prisoner at risk of self harm and was therefore not subject to self harm monitoring. There was no requirement for staff to check on him after the last roll check of the day just before 10.00pm until the morning roll check at 6.00am.

Listeners/Samaritans

19. As part of the community approach to suicide prevention, Exeter offers a Listeners service. Listeners are prisoners who are trained by the Samaritans to listen to and befriend prisoners who are in crisis. The service offered by the Listeners is completely confidential. All prisoners are advised of the existence and availability of the Listeners and Samaritans.

20. Prisoners at Exeter also have the opportunity to contact the Samaritans through letters, visits and telephone calls. Details of how to contact the Samaritans are displayed alongside all prisoner telephones. There is no evidence that the man made contact with the Samaritans or Listeners.

Previous deaths in custody in Exeter

21. There have been three previous apparently self inflicted deaths and one of natural causes since I became responsible for investigating all deaths in prisons in April 2004.

HM Chief Inspector of Prisons' Inspection

22. The HM Chief Inspector of Prisons conducted an inspection of Exeter in December 2004. She found Exeter to be a largely safe prison and she had few concerns about bullying or intimidation, even though it held young adults alongside adult prisoners.

23. The HM Chief Inspector of Prisons found almost all newly received prisoners, including those recalled because they had breached their licence, spent their first three days in the first night centre (FNC). Their immediate and longer-term needs were assessed by specially trained prison staff and voluntary sector workers as part of a two-day induction programme, which also provided information about the prison routine and facilities.

24. The prisons' policy of protecting people from being bullied and challenging bullies, was widely advertised and supported by a clear, published strategy. A senior officer coordinated anti bullying issues. Prisoners including young adults told the inspectors that there was little bullying and only four prisoners were registered as bullies at the time of their visit. They faced appropriate levels of observation and sanction and, in the case of persistent bullies, education.
25. The inspectors found that there were comprehensive arrangements to minimise the risk of self-harm or suicide. Assistance for distressed prisoners was extensively advertised, the clear strategy document was widely understood and adhered to. There was a full time co-ordinator who was a member of the safety custody committee and there was assistance from the Samaritans and trained listeners. The safer custody committee met monthly and was well attended by senior managers and a range of people from within the prison and the wider community. Monitoring of distressed prisoners was of a good standard, except at night when they found examples of cursory recording.

Approved Premises

26. Approved Premises provide supervised accommodation for offenders under the supervision of the Probation Service. They provide a greater degree of supervision for offenders than is possible in other forms of housing.
27. Approved Premises were formerly known as bail hostels. Most approved premises are owned and managed by the National Probation Service for England and Wales. A small number are run by voluntary sector providers but all are required to work to the same operating standards. Residents follow a structured regime, which includes overnight curfew. There is 24 hour supervision at the Approved premises by trained staff.
28. Approved Premises accommodate offenders who have committed a very wide range of crimes. Approved Premises hold a range of offenders on bail and on licence.¹

¹ Licence is the term to describe the agreed conditions and restrictions with which a released prisoner must comply when they are first returning to the community at the end of the custodial element of their sentence.

KEY FINDINGS

29. In 2000, the man was sentenced to 96 months imprisonment for serious offences. On 14 December 2006, he was released from custody on a Probation Licence. The licence expiry date was 29 September 2007. A condition of his release was that he must permanently reside at Probation Approved Premises and abide by an 11.00pm curfew.
30. The man initially presented well whilst at the Approved Premises. He was proactive in finding himself employment and worked for four weeks until 20 February 2007. He told his supervising probation officer that he lost his employment when he disclosed he had a criminal record. His supervising probation officer said that the man was always polite and co-operative and reacted positively even when he was denied an overnight pass. On 21 February, he failed to return to the approved premises.
31. Two days later on 23 February, the man telephoned the Approved Premises and was informed his Probation Licence had been revoked. He said that he would probably hand himself in but would need to sort a few things out. His details were circulated on the Police National Computer because he had breached his licence.
32. The man remained at large until August when he was arrested and interviewed regarding a murder in Exeter earlier in the month. After arrest and interview, he was bailed by the police pending further enquiries and taken under prison escort to Exeter prison at 2.25pm on 23 August, for breach of his licence. He was bailed to return to Exeter Police Station on 3 October.
33. Upon his arrival the man went through the reception process. He was interviewed by a member of the healthcare staff who completed the First Reception Health Screen. It was noted that he had been in custody before having been recalled from licence. The man said he had seen a doctor recently for a chest infection. He was concerned regarding a green discharge from his nose. He said that he was a social drinker and had not abused drugs recently.
34. In relation to his mental health the man said that he had not received treatment from a psychiatrist outside prison. He had never been to a psychiatric hospital, or been allocated a psychiatric nurse. He said he had received antidepressants in 1996, but had never tried to harm himself and had no current thoughts of self harm. His previous prison medical records were not requested until after his death.
35. The man was deemed fit for all prison work, physical education and gym work. A Cell Sharing Risk Assessment (CSRA) was completed and he said he had a history of assaulting previous cell

mates and would harm cell mates. A first night centre prisoner profile form was completed, in which the man said he did not feel at risk of self harm but had been treated for depression in the past. He was allowed a television set and given access to telephones.

36. The Anglican and co-ordinating Chaplain at Exeter told my investigator that the man was seen by the duty Chaplain upon his arrival at Exeter on 24 August. The duty Chaplain noted that the man was on licence recall and had registered his religion as Church of England. The man had no further recorded contact with the chaplaincy department.
37. The man spent his first night in Exeter on the first night centre in cell B3-5. The following day he was moved to cell C4:20 which is situated at the end of the top floor of C wing overlooking St David's railway station Exeter. It is not unusual for prisoners on C wing overlooking the station to communicate with people outside the prison by shouting through their windows. It is known that the man used to shout to a girlfriend from his cell whilst she stood on the road outside, and that he received visits from his friends and made telephone calls.
38. Another prisoner returned to the prison from court on 24 August. Up until that time he had been in cell C4.20. On returning to his cell he discovered it had been occupied by the man. Officers opened the cell door to allow the prisoner to collect his belongings. The prisoner said that the man was pleasant to him and he collected his belongings and left. Subsequently they spoke and discussed the view from cell C4.20. The prisoner worked on the food servery and saw the man regularly as he collected his meals.
39. A physical education instructor at Exeter recalled meeting the man twice. The first time was when the man went through an induction process to join the gym. The instructor recalled that they talked at that meeting about Cyprus. He said that the man seemed quite affable. A couple of days later on 10 September, the man played football in the gym. The instructor saw nothing in the man's demeanour that gave him cause for concern.
40. An officer recalled that on the morning of Tuesday 10 September, the man was unlocked for breakfast. During the morning he went to exercise classes for an hour before returning to his cell. The officer spoke to him regarding an inter-prison phone call with a female prisoner at Eastwood Park. The officer said he would speak with his senior officer who would let the man know if the phone call could take place. The officer was aware that the man was being transferred to HMP Channings Wood on Thursday so was trying to organise the call for Tuesday evening's association. That afternoon the man attended the gym and after his return went out of his cell to wash. The officer recalled locking prisoners into their cells at

6.00pm. As he approached the man's cell he came out and asked if he could get something. The officer allowed him to do this and he returned to his cell. The officer locked him in the cell and the man gave him thumbs up sign and said 'cheers'.

41. An Operational Support Grade (OSG) was working nights on the evening of 10 September, when at 10.00pm he physically checked all the prisoners on C wing by looking through the door observation panel. The OSG recalled that the man was alive and on his bed in cell C4.20. They did not speak to one another.
42. At 5.55am, a second OSG answered a cell bell on C4 wing. He then started his morning roll check. He opened the cell flap of cell C4.20 and put the cell light on. He could clearly see the man hanging from the cell bars of his window with a ligature made from his bed sheet attached to his neck. The man was in a seated position on the floor. Using his prison radio the second OSG called for assistance and gave his location. He attempted to open his sealed pouch containing a cell key to be used in emergencies, but could not break the seal. A third OSG and another officer arrived next and opened the cell door. The officer released the man by cutting the ligature with his anti ligature knife, and placed him face up on the floor. He believed that the man had died as his body was very cold and stiff. The third OSG also said that the man had his eyes open and was very stiff. As the nurse had arrived the third OSG waited outside the cell for the ambulance crew to arrive. The Night Orderly Officer arrived with a nurse. En route he confirmed with prison control, using his radio that an ambulance had been called. Once he was satisfied that the situation was under control, he resumed his normal duties.
43. The OSG heard a call over his prison service radio for urgent assistance and medical assistance to C4 landing. He went to C4 landing and to cell C4.20 where he saw the man lying on the floor on his back with the officer, and two OSG's in attendance. The man appeared to the OSG to be stiff. The nurse attended and the OSG continued with his duties.
44. The nurse was on night duty during the night, providing healthcare cover for the prison and using radio call sign hotel one. He received a radio call at 5.55am asking him to urgently attend C-4 landing. He collected the emergency medical bag and arrived at cell 4.20 at 6.00am. He saw the man lying on the floor of the cell, face up. He saw a ligature mark on his neck and checked for a pulse and signs of breathing but found neither. The nurse called for a defibrillator and immediately started the resuscitation procedure continuing for at least two minutes until the ambulance crew arrived and took over. The nurse noticed the man's limbs were stiff and his face was pale. The ambulance staff examined him and could find no signs of life, and noted he had rigor mortis. The man's life was

pronounced extinct at 6.12am. His cell was sealed pending the arrival of the police, who seized exhibits and photographed the cell.

45. Found in the man's cell at the time of his death was a local newspaper concerning the murder investigation for which he was on bail. Next to it was a hand written document listing the offences he had been convicted of, the resulting sentences and estimated age at the time of his eventual release.
46. After the man's death, the Chaplain offered care and support to prisoners in nearby cells. The prisoners she spoke to were completely surprised that the man had died. He gave them no indication that he intended to harm himself, and they described him as a pleasant individual who kept himself to himself. The prisoner who had previously occupied the man's cell was also shocked to hear of his death.
47. The Chaplain held a memorial service for the man the following day which was attended by prisoners and staff. She subsequently met with the man's friend, his father and family friends at the prison.
48. The man's friend said she was a girlfriend of his and had visited him in prison the week before he died when he had proposed to her. He knew he was being transferred to Channing's Wood and was looking forward to the move. The man's friend and her sister had spoken to the man by shouting up to his cell from the road outside the prison the evening before he died. She said the man had seemed in good spirits and did not seem unhappy. She was aware that he was on bail for a serious offence and had seen his lawyer. She too was shocked to learn of the man's death.

Post Mortem

49. A post mortem examination on the man was conducted by a Home Office Pathologist on 11 September 2007, at hospital. The post mortem found no evidence of significant injuries beyond those consistent with hanging. There was nothing to indicate that he had been forcibly restrained or involved in a struggle. It was the pathologists opinion that the cause of death was asphyxia caused by hanging.

Contact with family

50. The man's friend had been nominated as his next of kin. She was notified of his death as soon as practicable by the Governor. The man's father was subsequently notified. The man's father praised the contact he had from the prison after his son had died and the support he received from the prison family liaison officer. He visited the prison with other family members and spoke to the Governor, a member of the chaplaincy and prisoners who knew his son.

ISSUES

The discovery of the man hanging

51. Staff acted promptly when they found the man hanging. The nurse arrived promptly and commenced resuscitation, continuing until the arrival of the ambulance staff who pronounced his death. The prison contingency plans worked well allowing for the speedy entry to the prison by the ambulance crew.

Clinical care

52. The Primary Care Trust clinical review of the man's treatment was aware that he had spent a period of previous custody until 14 December 2006 at HMP Lowdham Grange, Nottinghamshire. His previous Inmate Medical Record was not available at the time of reception, nor had it been requested until after his death. I do not believe this to be a contributing fact in his death. However, healthcare staff should be reminded that previous medical records should be sought to ensure continuity of care.

The Head of Healthcare should ensure that previous medical records are sought to ensure continuity of care.

53. The man's reception screening reported little of any significance to contribute to his eventual death. He did not report any alcohol or substance misuse. He had only seen a doctor in recent months because of a chest infection. He had previously been prescribed anti-depressants in 1996.

54. The man had not presented to healthcare staff since his routine reception screening consultation. There were no other causes for concern. He did not display any noticeable risk factor warranting intervention to healthcare or discipline staff. All the relevant policies and procedures for healthcare screening were complied with.

Family concerns

55. The man's father suggested to my family liaison officer and investigator that staff might have been responsible for his son's death. The post mortem examination showed only injuries consistent with hanging. The police and my investigator are satisfied that no third party was involved.

The man's cell

56. On my investigators initial visit to Exeter he visited the cell that the man had occupied (C4:20). He found that it was reasonably spacious and was situated on the top floor of the wing at an end of the landing. It contained a bed, toilet, a television and reading and

writing materials. A copy of the local newspaper was in the cell with details of the murder that the man was suspected of, together with a hand written tariff of likely earliest dates of release.

57. There was broken Perspex covering the cell window which is designed to keep the cell warmer. Apparently prisoners break the Perspex to allow them to communicate with persons outside the prison walls. It is known that the Perspex covering was broken prior to the man occupying the cell. Although the man used the window frame as a ligature point the cell contained many potential other ligature points.

Bullying

58. My investigator has interviewed members of staff, prisoners a member of healthcare and a chaplain. He has found no evidence to suggest that the man was either being bullied or a bully.

CCTV

59. My investigator was supplied with a CD Rom which was supposed to provide CCTV coverage of C wing on 10/11 September 2007. However, on viewing the CD, there are no images of C4 landing. Staff and paramedics can be seen entering C2 wing which lead them to C4 wing at around 6.00am. The security staff at Exeter have been aware that the CCTV system has not been operating as well as it should. I am informed that Exeter did not have a maintenance contract for the CCTV equipment suppliers and there was no system for monitoring its effectiveness.

The Governor should ensure that the CCTV system is regularly maintained and working effectively.

Care and welfare for staff and prisoners

60. Staff and prisoners felt generally well supported and staff involved in the finding of the man completed incident statements prior to going off duty. However, staff said they had not been involved in a 'hot 'debrief' to learn immediate lessons from the death.

The Governor should ensure that where staff are involved in critical incidents attend a 'hot debrief' as soon as practicable.

CONCLUSION

61. The man was described as a decent, well-behaved prisoner who, although was only at Exeter for a short time, was known by staff. He had been arrested on suspicion of murder and bailed. However, as he had breached his release on licence conditions, he was returned to custody, and expected a further term of imprisonment. That said, it is clear that his death came as a complete surprise to those who had dealings with him. Outwardly, he gave those who knew him including his father, girlfriend, fellow prisoners and staff no indication of the distress that he must have been suffering.
62. When the man was discovered hanging, staff commenced resuscitation promptly and ensured the unhindered entry and access to the prison by the ambulance staff. I do not believe that through the man's general demeanour his final actions could have been predicted by staff at Exeter.

RECOMMENDATIONS

The Head of Healthcare should ensure that previous medical records are sought to ensure continuity of care.

The Governor should ensure that the CCTV system is regularly maintained and working effectively.

The Governor should ensure that where staff are involved in critical incidents attend a 'hot debrief' as soon as practicable.

GOOD PRACTICE

I have been most impressed by the prison's response to finding the man hanging and then to his death. The prisoner and staff who first found him responded quickly and efficiently to the emergency. The family liaison was sensitively handled.