

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adrian Skrivanos, a prisoner at HMP Exeter on 15 April 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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.

This is the investigation report into the death of Mr Adrian Skrivanos, who was found hanged in his cell at HMP Exeter on 15 April 2015. Mr Skrivanos was 45 years old. I offer my condolences to Mr Skrivanos' family and friends.

Staff at HMP Exeter assessed Mr Skrivanos' risk of suicide and self-harm when he arrived at the prison. They took into account all his risk factors for suicide and concluded that he was not at risk. While I consider that the staff relied too much on Mr Skrivanos' assurances that he would not act on suicidal thoughts, I recognise that this was a carefully considered and finely balanced assessment. I therefore do not criticise the decision not begin suicide and self-harm prevention procedures. However, the investigation did identify the need for improved emergency response procedures and more inclusive family liaison.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2015

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Summary

Events

1. On 25 March 2015, Mr Adrian Skrivanos was released from HMP Exeter on home detention curfew after serving six weeks of a sixteen-week sentence. On 6 April 2015, he returned to Exeter, after being charged with assaulting his then partner. A safer custody manager, a nurse and an offender supervisor assessed him and considered his risk factors. They decided he did not need to be managed under Prison Service suicide and self-harm prevention procedures, known as ACCT.
2. The nurse referred Mr Skrivanos for a mental health assessment, which took place the following day. Mr Skrivanos said he did not want to start taking painkillers or antidepressants again. His cellmate told the investigator that Mr Skrivanos was in considerable pain because of a hip injury but he did not report this to staff.
3. On 13 April, Mr Skrivanos received a letter from his ex-partner which upset him. He was concerned about how long he would be in prison and what he had done to her. Staff spoke to him about the letter but he does not appear to have revealed the extent of his distress.
4. On the morning of 15 April, Mr Skrivanos' cellmate went to an education class. Mr Skrivanos rang his cell bell at 9.15am, but an officer did not answer it for 14 minutes. The officer could not remember what Mr Skrivanos had wanted. At 10.41am, a substance misuse worker went to see Mr Skrivanos. He had obscured the observation panel on the cell door but she thought she could see his feet off the floor. She alerted an officer, who opened the cell and found Mr Skrivanos had hanged himself. He immediately radioed for healthcare staff to attend, but did not use a medical emergency code. The staff tried to resuscitate Mr Skrivanos and paramedics took over emergency treatment when they arrived. At 11.15am, paramedics pronounced Mr Skrivanos dead.

Findings

5. Mr Skrivanos had a number of risk factors for suicide. He had a history of suicide attempts after relationship breakdowns, he had made a statement about suicide in police custody, he was charged with assaulting his ex-partner, his relationship had broken down, he was diagnosed with depression but had not been taking his prescribed antidepressants and he misused alcohol. However, staff fully discussed these risk factors with him and assessed that he did not need the support of ACCT procedures. With hindsight, we consider that the weight of his risk factors could have led the staff to act with more caution, but accept that they made an informed decision based on the evidence before them.

6. The officer who found Mr Skrivanos had hanged himself did not use a medical emergency code. This led to a delay of two minutes in calling an ambulance and meant that nurses were unaware of the nature of the emergency and did not bring all the required emergency equipment. This was unlikely to have changed the outcome for Mr Skrivanos, but in other circumstances, even a short delay could be critical. We are also concerned that it had taken an officer fourteen minutes to answer Mr Skrivanos' cell bell that morning.
7. When Mr Skrivanos' ex-partner contacted the prison, they refused to give her any information about the circumstances of his death and did not offer her any support. We consider that she should have been recognised as a family member, in line with Prison Service instructions.

Recommendations

- The Governor should ensure that all cell bells are answered within five minutes and, where possible, establish and resolve the issue that led to the bell being rung.
- The Governor should ensure that all prison staff understand the need to use emergency medical codes in line with the national instruction and the local protocol and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further confirmation.
- The Governor should ensure that, after the death of a prisoner, family liaison officers include all appropriate family members in information and support.

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. NHS England commissioned a clinical reviewer to review Mr Skrivanos' clinical care at the prison.
10. The investigator visited Exeter on 23 April 2015. She obtained copies of relevant extracts from Mr Skrivanos' prison and medical records.
11. The investigator interviewed 11 members of staff and six prisoners at Exeter or on the telephone. The clinical reviewer joined the investigator for some of the interviews with staff.
12. We informed HM Coroner for Devon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Skrivanos' daughter, who he had named as his next of kin, to explain the investigation. She wanted the investigation to consider why Mr Skrivanos had been allowed to receive a letter from his ex-partner, as she had understood that contact was restricted. She also asked how Mr Skrivanos' risk of suicide and self-harm had been assessed when he arrived at Exeter and whether staff had taken into account his previous suicide attempt. Mr Skrivanos' daughter was informed that the initial report was available but did not reply to indicate she wished to receive a copy.
14. The family liaison officer also wrote to Mr Skrivanos' ex-partner but did not receive a reply.

Background Information

HMP Exeter

15. HMP Exeter is a local prison holding about 500 men. The prison primarily serves the courts of the South West. Dorset NHS University Foundation Trust provides health services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Exeter was in July and August 2013. Inspectors reported a positive culture at the prison. They considered that reception arrangements were generally satisfactory. Staff paid attention to safety and vulnerability issues and initial identification of risk of self-harm and suicide was regarded as very good. A small group of staff was responsible for safer custody and was focused on risk factors. The safeguarding policy was clear and concise, but had not yet been fully implemented.

Independent Monitoring Board

17. 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 the most recent published annual report, for the year to December 2013, the IMB reported good relationships between staff and prisoners despite the overcrowding in the prison. A safer custody questionnaire had indicated that most prisoners said they had not experienced any antisocial behaviour in the prison.

Previous deaths at HMP Exeter

18. Mr Skrivanos' was the sixth self-inflicted death at Exeter since April 2010. There has been one self-inflicted death since. In a report into a death in 2010, we were concerned that the prison did not involve different branches of a family after the prisoner had died. During the investigations of the deaths in January and November 2014, we identified that the medical emergency code system was not used effectively.

Assessment, Care in Custody and Teamwork

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

Key Events

20. On 12 February 2015, Mr Skrivanos was sentenced to sixteen weeks in prison for driving offences and was taken to HMP Exeter. Mr Skrivanos said he had depression, misused alcohol and needed a hip replacement. A prison GP prescribed tramadol (a painkiller) and sertraline (an antidepressant) in line with what he had been prescribed in the community.
21. Mr Skrivanos spent six weeks in prison. His offender supervisor and the prison chaplain told the investigator that Mr Skrivanos was a quiet man and had been concerned about his son, who had been born prematurely while he was in prison. Mr Skrivanos' cellmate and another friend said that, during this sentence, Mr Skrivanos was cheerful and looking forward to the future with his baby and partner. On 25 March, Mr Skrivanos was released on Home Detention Curfew (HDC) to temporary accommodation. This meant Mr Skrivanos had an electronic tag fitted and had to abide by a curfew every night.
22. On 4 April, police arrested Mr Skrivanos for assaulting his partner. (It seems that their relationship had ended around this time.) He appeared at a Magistrates' court on 6 April. A police officer noted in the Person Escort Record (PER – which accompanies all prisoners when they move between police stations, courts and prisons) that Mr Skrivanos had attempted to jump off a bridge in 2012 and he “stated if released will kill himself 2015”. The police also noted that Mr Skrivanos was depressed, misused alcohol and had pain in his hip.
23. The court committed Mr Skrivanos' case to Crown Court and remanded him to prison until 24 April 2015. Mr Skrivanos arrived at Exeter at 1.25pm. The safer custody manager interviewed Mr Skrivanos. He had read the PER and had access to prison records, which noted that Mr Skrivanos had taken an overdose in prison in 2008.
24. The safer custody manager assessed Mr Skrivanos' risk of suicide and self-harm. He told the investigator that Mr Skrivanos had seemed quite relaxed, open, and honest and he had no concerns about his demeanour. He asked about previous incidents of self-harm and attempted suicide. Mr Skrivanos told him that the overdose in 2008, was when he had just split up from his wife and it had been his first time in prison. He said he had tried to jump off a bridge in 2012 when he was drunk and had just split up with a partner. He told the safer custody manager that when he was in the police cells, he had said he intended to kill himself out of frustration but he did not intend to do so. Mr Skrivanos told him that he had no thoughts of suicide or self-harm as he had children and said, “that would be the last thing I would do.”
25. The safer custody manager knew that Mr Skrivanos was charged with assaulting his ex-partner and they discussed this relationship breakdown, because of its relevance to his previous suicide attempts. The safer custody manager said Mr Skrivanos did not seem upset about it. Mr Skrivanos had recently stopped taking antidepressants but said he felt no different. The safer custody officer told the investigator he had no concerns that Mr Skrivanos was at risk of suicide or self-harm and recorded this in Mr Skrivanos' prison record.

26. Because of the charge against him, the safer custody manager told Mr Skrivanos that he could not contact anyone in the community until the Public Protection Unit (PPU) had completed a risk assessment.
27. At 4.15pm, a nurse assessed Mr Skrivanos. She had access to his previous prison medical record but said she did not read all his notes or his PER. She also had a cell sharing risk assessment (CSRA) which is designed to assess the risk of violence towards a cellmate in a locked cell. The safer custody manager had included the information from the PER on the CSRA about Mr Skrivanos' suicide attempts in 2008 and 2012 and the statement he had made in police custody about suicide. As Mr Skrivanos had been released from prison twelve days earlier, the nurse did not do a full medical assessment. Mr Skrivanos said he did not misuse alcohol or drugs. He said he had been prescribed tramadol and sertraline in prison but had not taken any medication since 25 March, as he had been released without medication and had not seen his GP in the community.
28. The nurse spoke to a doctor, who said he wanted confirmation from Mr Skrivanos' community GP before prescribing any medication. Healthcare staff requested these records the next day. Mr Skrivanos told the nurse he did not want to take sertraline or tramadol as he had not felt any different since he had stopped taking it. She told him that if he changed his mind he should make an appointment with a GP. She told the investigator that Mr Skrivanos seemed to be moving freely and was not in any obvious pain.
29. Mr Skrivanos said he had been frustrated in police custody, which was why he had said he would kill himself if he was released. He said that he did not intend to do so. The nurse noted that Mr Skrivanos had tried to jump off a bridge in 2012. Mr Skrivanos said he now had a young baby and would not harm himself. The nurse was satisfied that he was not at risk of suicide and self-harm. She referred Mr Skrivanos to the mental health team because he was not taking his antidepressants, appeared slightly low in mood, was not engaging well, had a child in intensive care and had relationship problems.
30. On 7 April, his offender supervisor discussed with Mr Skrivanos the reasons why he was back in prison. She telephoned Mr Skrivanos' baby's social worker, who told her that Mr Skrivanos' baby was due to be discharged from hospital that day to foster care. Mr Skrivanos said that he was hoping his adult daughter would be able to foster his baby. The offender supervisor told the investigator that Mr Skrivanos seemed fed up, sad about what had happened with his ex-partner and upset at being back in prison, but she did not think he was a risk to himself.
31. Also that morning, the chaplain went to see Mr Skrivanos, who asked him to telephone the hospital about his baby, which he did. The chaplain did not notice any change in Mr Skrivanos from when he was last in Exeter and Mr Skrivanos told him that he would be able to cope.
32. The prisoner wing equality representative saw Mr Skrivanos that morning to explain prison processes to him, such as how to make an application to healthcare. He said Mr Skrivanos seemed low in mood but not unusually so, for someone's second day in prison.

33. Mr Skrivanos was able to phone his daughter that afternoon. They discussed who would get custody of his baby and the likelihood that he would be fostered. They also discussed Mr Skrivanos' alleged offence and the impact this would have on where he would be allowed to live. Mr Skrivanos said he needed to provide the court with an address at his next appearance so that he could apply for bail. He said he had no money in prison.
34. A mental health nurse assessed Mr Skrivanos that afternoon. He told her that he did not want to start taking sertraline again as he felt he was managing without it. The nurse noted that he engaged well. They discussed his previous suicide attempts and Mr Skrivanos told her that he had no current thoughts of suicide or self-harm. He assessed his mood as five out of ten, which the nurse interpreted to mean he was not low in mood.
35. Mr Skrivanos said that he was having difficulty sleeping and slept only for about two hours each night. He said he had not been eating properly and had lost two stones. His weight was the same as it had been when he was in prison in 2012 and the nurse considered that he did not seem obviously underweight. He said he drank four cans of lager each day.
36. Mr Skrivanos told her that he was worried that his son would be taken into foster care. He said he was keen to attend activities and would go to education or the gym. The nurse recorded that she would discuss Mr Skrivanos in the mental health triage meeting and refer him to the substance misuse service about his alcohol consumption.
37. The nurse discussed Mr Skrivanos in the triage meeting later that day with the mental health team manager. They decided to discharge Mr Skrivanos from the mental health team back to primary healthcare because he said he was not depressed, had no thoughts of suicide or self-harm and there was no evidence of a severe and enduring mental illness. The nurse did not know that when Mr Skrivanos was in police custody he had said he would kill himself, but she said this would not have changed her assessment.
38. At 3.00pm, a substance misuse worker assessed Mr Skrivanos. He said that he felt physically healthy and would ask for help if he needed it. He agreed to attend the inside out group, a week-long course aimed at addressing substance misuse issues.
39. On 8 April, Mr Skrivanos' community GP sent his medical records to the prison. These showed that his community GP had last prescribed tramadol and sertraline on 10 and 11 February, before his previous sentence. A doctor reviewed his records and as she was aware Mr Skrivanos had said he no longer wanted to take medication, she left it to him to make a GP appointment, if he changed his mind.
40. The same day, a supervising officer (SO) went to Mr Skrivanos' cell and explained that he could not contact his ex-partner and that all of his telephone calls and mail would be monitored. This meant staff on night duty would listen to all of his telephone calls the day that they were made and staff would read all the letters he received or sent. The supervising officer said that Mr Skrivanos was reluctant to sign the monitoring papers but did so.

41. On 9 April, a healthcare assistant saw Mr Skrivanos for a secondary health screen. She noted that he suffered from depression and took his physical observations, including his height, weight and blood pressure.
42. On 10 April, Mr Skrivanos told a nurse that he was in pain and paracetamol and ibuprofen were not working. (Mr Skrivanos was never given any paracetamol or ibuprofen by healthcare staff at Exeter but prisoners at Exeter can buy paracetamol from the prison shop.) Mr Skrivanos told the nurse that the last time he was in prison doctors had prescribed tramadol. The nurse reviewed Mr Skrivanos' medical record. She did not consider that Mr Skrivanos needed an urgent appointment and put him on the waiting list to see a GP, which she said would normally take around ten days.
43. Mr Skrivanos' cellmate and also a friend of his, told the investigator that Mr Skrivanos said healthcare staff would not give him the medication he had been prescribed before he was released. He said he had asked for it several times and was waiting to see a doctor. His cellmate said that Mr Skrivanos was in a lot of pain, which was worst in the mornings.
44. At around 5.00pm on 10 April, Mr Skrivanos telephoned his daughter. He said he was a bit down but that this was understandable in the circumstances. The same day, the prison received a letter for Mr Skrivanos from his ex-partner. A supervising officer read the letter and noted in the monitoring document that Mr Skrivanos' ex-partner said she had been in hospital for two days after Mr Skrivanos had assaulted her. His ex-partner also wrote that she missed him and wanted him to be around for their baby.
45. The officer gave this letter to Mr Skrivanos' offender supervisor for her information in case she needed to contact social services. Both the supervising officer and offender supervisor were responsible for assessing whether the letter was likely to increase Mr Skrivanos' risk of suicide and self-harm.
46. On 11 April, Mr Skrivanos rang his daughter twice and said he felt isolated and thought his ex-partner had been in a relationship with someone else for three weeks. Mr Skrivanos said he was "not going to do anything stupid" but that sometimes he felt a bit low. He rang his daughter twice again the next day. He said he had good days and bad days but when he was locked up he could not stop thinking about things and his head was all over the place. An officer listened to this telephone call that evening and noted in the monitoring document that Mr Skrivanos said he felt a bit down.
47. On 13 April, Mr Skrivanos' offender supervisor passed the letter from his ex-partner to wing staff so that they could give it to Mr Skrivanos. (The offender supervisor told the investigator that incoming mail was always given to prisoners, unless it was very abusive or staff were concerned about the prisoner's welfare.) Mr Skrivanos rang his daughter three times that day. The first two times, he asked if there was any news from the social worker about his baby.
48. The third time, at 4.45pm, he told his daughter that he had received a letter from his ex-partner in which she had detailed her injuries. Mr Skrivanos said he was worried that the charges might be more serious than he had realised and believed that if he were found guilty he would be sentenced to about five years.

Mr Skrivanos said that his ex-partner had written that he should not give up on their baby and that she still loved him. He told his daughter he had no more money and would not be able to ring again until 15 April. He asked his daughter to send his ex-partner a letter. His credit then ran out and the telephone cut off. This was the last time he spoke to his daughter.

49. The offender supervisor spoke to Mr Skrivanos about the letter. He told her that he was worried about the charge against him. The offender supervisor told him to wait until his court appearance to see what happened. She said he seemed a bit down after receiving the letter but not worryingly so. She said he seemed focussed on getting custody of his baby son and was resigned that his relationship with his ex-partner was now completely finished. She was aware of his previous suicide attempts and that these were connected to relationship breakdowns but was not concerned that Mr Skrivanos was at risk of suicide or self-harm.
50. Mr Skrivanos' cellmate and a friend of his, said that when Mr Skrivanos came back to Exeter in April, he had appeared significantly different from his first period in prison. His cellmate said that he was very anxious, low and depressed. He could not sit still and often rang his cell bell to ask for phone credit to call his daughter. They said Mr Skrivanos was devastated by the letter he received from his ex-partner. He said he could not remember what he had done as he had been drinking and was concerned about whether he would get custody of his baby. They said he became more withdrawn after this letter and did not sleep at night. Neither thought Mr Skrivanos was at risk of suicide.
51. An officer said he did not notice any change in Mr Skrivanos' mood or demeanour from his previous time at Exeter. Mr Skrivanos' friend said that the officer had told Mr Skrivanos that he could get a sentence of five or six years in prison if he was found guilty of the charges against him. The officer told the investigator that he did not have any conversation with Mr Skrivanos about his likely sentence.
52. At around 7.45am on 15 April, staff unlocked prisoners. An officer remembered seeing Mr Skrivanos that morning, but he could not recall exactly when.
53. That morning, Mr Skrivanos had a routine appointment, which all new prisoners have, to discuss blood borne viruses and have their blood tested if necessary. He went to the B2 treatment area waiting room, which was close by. A healthcare assistant told the investigator she explained the reason for the appointment, but Mr Skrivanos said he did not want to discuss anything and asked to leave the room. She wrote this in his medical record at 9.47am, but the safer custody manager told the investigator that the appointment was likely to have been between 7.45am and 8.20am.
54. At 8.15am, Mr Skrivanos' friend spoke to him at his cell door. He said that Mr Skrivanos told him he was having problems with medication. His friend said that his head was twitching, he was stuttering and very tearful. He said that Mr Skrivanos did not want to talk about what was upsetting him.

55. Around 8.20am, staff locked prisoners in their cells and at 8.45am, unlocked them for an exercise period in the open air. His cellmate went out but Mr Skrivanos stayed in the cell. His cellmate said this was unusual. His cellmate went straight to an education class after the exercise period and did not go back to his cell. He said Mr Skrivanos had seemed no different that morning; otherwise, he would have stayed with him. By 8.50am, staff had locked the cells of all the prisoners who had not gone outside for the exercise period.
56. At 9.15am, Mr Skrivanos rang his cell bell. (The cell bell records indicate this happened at 9.20am, but the cell bell system times were five minutes ahead of the CCTV). At 9.16am, CCTV shows another prisoner standing outside Mr Skrivanos' cell door for two minutes apparently talking to him through the observation panel. The prisoner was a healthcare orderly. He did not remember Mr Skrivanos personally, but said he recalled going to the cell to remind the occupant of a healthcare appointment.
57. At 9.29am, an officer looked into Mr Skrivanos' cell through the observation panel, switched off and reset the bell and walked away after a few seconds. (Officers can only reset the bell when they have gone to the cell). The officer told the investigator that he could not remember answering the bell or what he saw when he looked into Mr Skrivanos' cell.
58. At 10.41am, a substance misuse worker went to Mr Skrivanos' cell to give him more information about the inside out group. She got no reply when she knocked on his cell door. Toilet paper covered most of the glass of the observation panel but through a small gap, she saw that Mr Skrivanos' feet were not touching the floor. She said the cell was very dark and although she thought something did not look quite right, she had not been concerned about Mr Skrivanos' welfare. Later, she reflected that she might have stopped processing what she saw, because of shock.
59. The substance misuse worker went to the wing office and asked an officer to come with her to Mr Skrivanos' cell, as she thought something was not right, but did not think there was an emergency.
60. The officer went to Mr Skrivanos' cell and looked under the gap in the paper. He told the investigator he saw that Mr Skrivanos had hanged himself from the window bars. The officer called to his colleague who was a short distance away, to radio for the emergency response nurse. She did not have a radio, so he himself radioed for immediate medical assistance. He unlocked the cell and both officers went in. One officer supported Mr Skrivanos' weight, while the other used an anti-ligature knife to cut the sheet from the window.
61. The officer who had first been alerted to the incident told the investigator that Mr Skrivanos felt cold and slightly stiff. The second officer to respond to the incident did not think he was stiff. They laid Mr Skrivanos on the floor. The second officer cut the sheet from around his neck and began chest compressions. The first officer radioed again for medical assistance, as staff had not received the first one clearly. He did not use a medical emergency code blue to indicate a life-threatening emergency, such as when a prisoner is unresponsive or unconscious.

62. An officer in the control room completed an incident log and noted that the officer had requested urgent medical assistance at 10.44am. Timings in the log were around a minute slower than CCTV.
63. The emergency response nurse for that day went straight to Mr Skrivanos' cell, taking a basic emergency bag. She did not take additional emergency equipment as no one had called a code blue. CCTV showed that she arrived at Mr Skrivanos' cell around 10.44am.
64. Two nurses and one officer got to Mr Skrivanos' cell a few seconds later. The emergency response nurse asked the officer to request an ambulance for a code blue situation. The officer immediately contacted the control room who then telephoned for an ambulance. A further nurse arrived at the cell around 10.45am and the emergency response nurse asked him to bring a defibrillator.
65. As one of the officers continued chest compressions, a nurse inserted an airway and administered oxygen. A further nurse then took over chest compressions. The emergency response nurse attached the defibrillator to Mr Skrivanos, which found no shockable heart rhythm. The staff continued to attempt resuscitation.
66. The ambulance arrived at the prison at 10.50am. The paramedics took over emergency treatment but, at 11.15am, pronounced Mr Skrivanos dead. At the request of the paramedics, a prison doctor also confirmed his death.
67. Mr Skrivanos had left two letters in his cell, one addressed to his ex-partner and the other to his children. He said that he could not cope with being in prison, could not eat or sleep and that he had had his life now. On a third piece of paper he had written, "Don't try to bring me back."

Contact with the family.

68. Mr Skrivanos had named his daughter as his next of kin, who lived a long way from Exeter. Staff contacted the nearest prison, HMP Risley, and, at around 1.00pm, the duty governor informed Mr Skrivanos' daughter of his death. The Exeter family liaison officer telephoned Mr Skrivanos' daughter that afternoon and kept in contact with her over the following weeks. In line with Prison Service instructions, the prison contributed to the costs of the funeral.
69. A few days after Mr Skrivanos' death, his ex-partner telephoned Exeter and spoke to the head of safer custody. She wanted further details about Mr Skrivanos' death. The head of safer custody told her that, as she was not Mr Skrivanos' listed next of kin, he could not disclose any details. The prison's family liaison officer spoke to Mr Skrivanos' daughter who did not want her father's ex-partner involved. The prison had no further contact with her.

Support for prisoners and staff

70. After Mr Skrivanos' death, the head of safer custody debriefed the staff involved in the emergency response to discuss any issues arising and to offer support. The staff care team also offered support.
71. The prison posted notices informing prisoners of Mr Skrivanos' death, and offering support. They checked prisoners being monitored as they had been

assessed as at risk of suicide and self-harm in case they had been affected by Mr Skrivanos' death.

Post-mortem report

72. The post-mortem report concluded that the cause of death was hanging.

Findings

Identification of risk of suicide and self-harm

73. There are recognised risk factors that raise the risk of suicide and self-harm which are set out in Prison Service Instruction (PSI) 64/2011, Safer Custody. Those relevant to Mr Skrivanos were the charges he was facing, his relationship breakdown, the statement he had made in police custody about suicidal intent, his recent decision not to take antidepressants and previous suicide attempts, which were linked to relationship breakdowns.
74. In 2014, we published a thematic report on risk factors in self-inflicted deaths in prisons. We identified several key lessons that prisons should use to help them manage prisoners at risk of suicide and self-harm. These included considering evidence of risk of suicide and self-harm and balancing this against a prisoner's presentation, that the first month of custody is especially risky, prisoners with restrictions on contacting their family are at an increased risk of suicide and understanding that a prisoner's level of risk is not fixed and can move depending on other events. A number of these applied to Mr Skrivanos.
75. The safer custody manager completed a safer custody risk of harm and triggers assessment when Mr Skrivanos arrived at Exeter. He recognised the risk factors, which could increase Mr Skrivanos' risk of suicide and self-harm, and discussed these fully with him. Mr Skrivanos told the safer custody manager he did not feel suicidal. The safer custody manager's judgement was that Mr Skrivanos did not present a risk of suicide and self-harm and therefore he did not begin ACCT suicide and self-harm prevention procedures.
76. A nurse was also aware of his risk factors but did not assess him as at risk of suicide or self-harm. She made an appropriate mental health referral. A mental health nurse completed this mental health assessment the next day and did not consider that Mr Skrivanos presented a risk of suicide or self-harm. Mr Skrivanos' offender supervisor also did not identify that he was at risk.
77. Mr Skrivanos later received a letter from his ex-partner. Two prisoners the investigator spoke to said that he became preoccupied with this letter and increasingly withdrawn, but they did not consider he was suicidal. He spoke to his offender supervisor about the letter and, although he was concerned about the length of sentence he might be facing, he seemed to be planning for the future and spoke to his daughter and to his offender supervisor about getting custody of his baby son.
78. We have previously made recommendations to Exeter about the need to record and take into account prisoners' known risk factors rather than relying on their presentation when assessing risk of suicide. We are satisfied that this was done in this case and the safer custody manager, in particular, fully discussed Mr Skrivanos' risk factors with him when he arrived at the prison in a long assessment, which took about 40 minutes.
79. Staff judgement is fundamental to the suicide and self-harm prevention and relies on them using their experience and skills, as well as local and national

assessment tools, to determine risk. We consider that the weight of Mr Skrivanos' risk factors was such that this should probably have outweighed any assurances that he would not harm himself. With such risk factors, we would caution against a reliance on what the prisoner says, but we recognise that risk assessment is not an exact science. The safer custody manager and the other staff made their decision based on the evidence available and detailed discussions with him at the time. They were fully aware of his risk factors and took them into account. Sadly, the decision appears to have been misjudged, but we do not conclude that it was unreasonable and we do not know that beginning ACCT procedures would have prevented Mr Skrivanos from killing himself.

Clinical care

80. The clinical reviewer concluded that Mr Skrivanos received medical care equivalent to that he would have received in the community. Other prisoners said that Mr Skrivanos suffered pain, but Mr Skrivanos had said he did not want to take tramadol when he returned to prison, as he had not been taking it in the community. Healthcare staff did not consider he appeared to be in pain. On 8 April, a doctor decided that as Mr Skrivanos had said he no longer wanted to be prescribed medication, he would need to make a GP appointment if he changed his mind. The clinical reviewer said that this was a reasonable decision.
81. On 10 April, Mr Skrivanos told a nurse he was in pain. The nurse did not assess this as urgent and added him to the list to see a doctor. We are satisfied that this was reasonable and that Mr Skrivanos received an appropriate standard of healthcare at Exeter.

Response to cell bells

82. At 9.15am on 15 April, Mr Skrivanos rang his cell bell. An officer responded, went to his cell, switched off the bell and reset it at 9.29am. He told the investigator that he could not remember doing this, and was unable to say what Mr Skrivanos had wanted at the time, whether he had spoken to him, or what he saw when he looked through the observation panel into the cell. He walked away from the cell just a few seconds after responding to the bell. This was the last time a member of staff looked into the cell before Mr Skrivanos was found hanged, just over an hour later. As the officer was the officer who responded to the emergency, after being alerted by the substance misuse worker, we find it difficult to understand that he could not recall anything about what had happened when he had gone to the cell not long before. However, the officer said that there was nothing unusual that made it stand out.
83. Cell bells are intended for emergency use only. HM Inspectorate of Prisons has an expectation that cell bells should be answered within five minutes. Inspectors at Exeter noted that when they were there, they saw staff responding to cell bells quickly but, in their survey of prisoners, fewer prisoners than at other prisons said that their cell bells were answered within five minutes.
84. The officer said he was the only officer on the landing that morning and this was probably why it took him so long to answer Mr Skrivanos' cell bell. The safer custody manager said that there were difficulties in responding to cell bells within

the timeframe but acknowledged the cell bell should have been answered within five minutes. We are concerned at the length of time it took to answer the bell and at the very short time the officer spent at the cell when he did respond. This does not provide reassurance that he dealt with the issue that had led to Mr Skrivanos ringing the bell. We make the following recommendation:

The Governor should ensure that staff answer cell bells within five minutes and, where possible, establish and resolve the issue that led to the bell being rung.

Emergency response

85. When the substance misuse worker looked into Mr Skrivanos' cell, she saw that his feet were off the floor. However, she did not realise that it was an emergency. The clinical reviewer noted that it is recognised that people who have no experience of emergencies do not always recognise the seriousness of the situation. We understand this and consider she acted appropriately in alerting an officer.
86. PSI 03/2013, Medical Response Codes, requires governors to have a medical emergency response code protocol and states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The instruction states that, when a medical emergency is called, the control room should call an ambulance immediately and there should be no requirement to wait for a member of healthcare staff or a manager at the scene to confirm that an ambulance is needed. Exeter has a protocol with the local ambulance service, in line with the national instruction, which makes it clear that staff should call an ambulance immediately and should not wait for additional information before doing so.
87. When the officer realised there was an emergency, he radioed for immediate medical assistance. He said he was aware of the emergency medical code system but forgot to use it. Officers and nurses responded quickly and competently when they discovered Mr Skrivanos unresponsive. However, because the officer did not use a code blue, there was a delay of around two minutes before an ambulance was called. The officers who were first to arrive at the scene both told us that they thought that healthcare staff would call an ambulance. Because nurses did not know the type of emergency they were attending, they did not bring all required emergency equipment with them and another nurse had to leave to bring one, which took another two minutes.
88. After Mr Skrivanos' death, Exeter reissued the guidance on medical emergency codes. However, we are concerned that some officers were confused about who should request an ambulance. The emergency response nurse also told us that officers sometimes used emergency codes inappropriately and because of this, nurses did not take the full resuscitation equipment to every code blue call. It does not appear that the slight delay in this case affected the outcome for Mr Skrivanos but it is important that all staff understand and use the emergency code system appropriately. We therefore make the following recommendation:

The Governor should ensure that that all prison staff understand the need to use emergency medical codes in line with the national instruction and

the local protocol and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further confirmation.

Family Liaison

89. In line with national instructions, Mr Skrivanos' daughter, who he had named as his next of kin, was informed about his death. When his ex-partner, who he had been in a relationship with until very shortly before his death, and was the mother of his young baby, telephoned the prison, they told her that they could not give her any information as Mr Skrivanos had not named her as his next of kin. Mr Skrivanos' daughter said she did not want his ex-partner to be given any information and the prison did not contact her again.
90. PSI 64/2011 states that,
- “All families are different; they can include “chosen” as well as biological members and will have their own dynamics. Any approach to the family should be done in accordance with individual needs and may include providing different members of the same family with information.”
91. We consider that, in line with this instruction, Exeter should have discussed his death with Mr Skrivanos' ex-partner, especially as he had left a letter for her. This could have involved appointing a second family liaison officer if necessary.

The Governor should ensure that, after the death of a prisoner, family liaison officers include all appropriate family members in information and support.

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