

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Stephen Queen a prisoner at HMP Exeter on 2 August 2016

**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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Stephen Queen was found hanged in his cell at HMP Exeter on 2 August 2016. He was 44 years old. I offer my condolences to Mr Queen's family and friends.

Exeter's suicide and self-harm prevention procedures were satisfactory and this was reflected in the quality of Mr Queen's self-harm and suicide monitoring. However, I am concerned that staff did not monitor Mr Queen at a frequency which appropriately reflected his risk.

While Mr Queen received appropriate treatment for drug and alcohol detoxification, he should have had access to adequate nicotine replacement therapies when he arrived at Exeter. I am concerned about the delay in ensuring Mr Queen had the antidepressants he needed and that the emergency response was not effective.

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

**Richard Pickering**  
**Deputy Prisons and Probation Ombudsman**

**April 2017**

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# Summary

## Events

1. On 27 July, Mr Queen was remanded in custody to HMP Exeter. It was not his first time in prison. He was recently released from HMP Northumberland with a prescription of antidepressants, which staff at Exeter did not identify. Mr Queen had a history of self-harm. Staff considered his risk factors and concluded that he was not at risk of suicide or self-harm. Yet, that evening, Mr Queen was found trying to hang himself in his cell. He told staff he planned to end his life and was unhappy that he could not smoke at Exeter, a non-smoking prison.
2. Mr Queen was moved to the prison's social care unit, which offered a supportive environment with increased levels of officer and healthcare contact. He was assessed as at high risk and placed under constant supervision under Prison Service suicide and self-harm procedures (known as ACCT). On 29 July, a senior manager agreed that Mr Queen's risk had lowered, so reduced the frequency of his observations to at least once an hour.
3. During his short time at Exeter, Mr Queen complained about not being able to smoke and said he would self-harm if he was not given e-cigarettes, which staff did on several occasions. At an ACCT review on 1 August, officers suggested that Mr Queen should start work and move back to one of the prison's standard wings.
4. Shortly before 8.00pm on 2 August, an officer found Mr Queen hanged in his cell. Staff and paramedics tried to resuscitate him, but sadly, he did not respond. He was taken to hospital and was pronounced dead at 10.08pm. Lancashire Police informed his mother of his death the next day.

## Findings

5. We are satisfied that staff appropriately considered Mr Queen's risk to himself when he arrived at Exeter. Despite this, we are concerned that staff placed too much emphasis on Mr Queen's location, rather than his level of risk when deciding to reduce his observations only two days after he tried to kill himself.
6. While we are satisfied that Mr Queen received appropriate drug and alcohol detoxification, there was a delay in Mr Queen accessing previously prescribed antidepressants.
7. Mr Queen struggled to cope in a smoke-free prison and linked his self-harm to not being able to have an e-cigarette. In the absence of a national and detailed local policy, Mr Queen did not receive smoking cessation support and staff did not arrange to manage Mr Queen's addiction to cigarettes from reception onwards as HM Prison and Probation Service and we would have expected them to.
8. The emergency response was poor. An internal inquiry concluded that the emergency response nurse needed additional training and supervision and therefore we make no recommendation.

## Recommendations

- **The Governor and Head of Healthcare should ensure that:**
  - **Staff manage prisoners at risk of suicide and self-harm in line with national guidelines and set observations at a frequency which reflect the risk.**
  - **Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors.**
- **The Head of Healthcare should ensure that prisoners receive prescribed medication without delay and there are no unnecessary breaks in treatment.**
- **The Governor and Head of Healthcare should satisfy themselves that adequate nicotine replacement therapies are available to all prisoners when they arrive.**

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. An assistant ombudsman visited Exeter on 11 August 2016. She obtained copies of relevant extracts from Mr Queen's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Queen's clinical care at the prison.
12. The investigator interviewed 14 members of staff at Exeter in September and October 2016. The clinical reviewer joined him for some staff interviews.
13. We informed HM Coroner Exeter and Greater Devon District of the investigation. We have sent the Coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Queen's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Queen's mother was concerned about how her son's risk of suicide and self-harm was managed and whether it was appropriate that he was in a single cell.

## Background Information

### HMP Exeter

15. HMP Exeter is a local prison holding about 560 men. The prison primarily serves the courts of the South West. Dorset Healthcare University Foundation Trust provides health services. Healthcare staff are on duty 24 hours a day. Exeter has been a smoke-free prison since early 2016.
16. The prison has a social care unit (F Wing) which cares for elderly and chronically ill and disabled prisoners. There is a small workshop on the wing, a day room and a garden for prisoners. The wing also houses prisoners who are being monitored constantly under suicide and self-harm procedures.

### HM Inspectorate of Prisons

17. The most recent inspection of HMP Exeter was in September 2016. The findings have not been published at the time of issuing this initial report. Inspectors reported that the allocation of first night cells appeared disorganised and that many of the cells lacked basic facilities, were dirty and that prisoners were locked in their cells at night without anything to occupy them. Despite this, inspectors noted that staff were sensitive and professional when conducting first night interviews and used a well-designed risk assessment to identify those at risk of suicide or self-harm. Inspectors reported that the quality of ACCT documentation was variable, but that the majority were satisfactory. In general, ACCT reviews were multi-disciplinary, involved specialist staff, and caremaps were adequate.

### Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2015, the IMB reported that Exeter was a well run and generally safe prison, but were concerned that low staff numbers prevented staff from engaging (as they would like) with prisoners in difficulty.
19. The IMB reported that Exeter had had very little time to prepare for the introduction of the national non-smoking policy, but despite this, had made good efforts to prepare with staff training, focus groups for prisoners and discussions with the healthcare team.
20. The IMB reported that inadequate staffing levels at Exeter were leading to regimes being restricted. They said that the low level of staff and lack of mental health cover out of working hours, meant it was difficult to provide appropriate support to a distressed prisoner, especially at night.

### Previous deaths at HMP Exeter

21. Mr Queen was the ninth prisoner to take his life at Exeter since 2011. Since Mr Queen died, another two prisoners have taken their life. In our investigation into the death of a man at Exeter in January 2014, we identified the need for adequate training for healthcare staff in resuscitation, an issue we repeat in this report.

## **Assessment, Care in Custody and Teamwork**

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
23. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
24. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## **Enhanced ACCT case management**

25. PSI 64/2011 sets out how staff should manage prisoners whose behaviour is so challenging and disruptive that they need additional case management to manage their risk of harm to themselves, to and/or from others. A manager oversees the enhanced ACCT case management process and ensures a higher level of co-ordination between the different teams involved in the prisoner's care.

# Key Events

## Background

26. In May 2015, Mr Stephen Queen was sentenced to three years in prison for burglary. It was not his first time in prison. On 8 July 2016, he was released on licence from HMP Northumberland, with a seven-day supply of antidepressants. His licence was revoked three days later for failing to keep in contact with his supervising officer. On 25 July, he was arrested again for burglary and possession of a controlled drug. He was remanded into police custody.

## HMP Exeter

27. On 27 July, Mr Queen was taken to HMP Exeter. An officer completed a first night interview and assessment of Mr Queen's risks. The officer noted that Mr Queen was a licence recall prisoner, that it was not his first time in prison and that he was calm, polite and relaxed. The officer also noted that although Mr Queen had a history of self-harm in the community and had been monitored under ACCT procedures in 2013, he had no current thoughts of suicide or self-harm. The officer considered Mr Queen's risk factors and his presentation, and concluded that he was not at risk of suicide or self-harm. Exeter has a no smoking policy, so Mr Queen was given an e-cigarette.
28. During an initial health screen, a nurse noted that Mr Queen had a history of drug and alcohol abuse and tested positive for opiates and benzodiazepines. She recorded that he had drug withdrawal symptoms. Mr Queen told the nurse he had depression and anxiety, and had tried to kill himself through excessive alcohol and drug use in the community. Mr Queen said he had no thoughts of suicide or self-harm and she assessed that he was not at risk. The nurse noted that he had previously been prescribed antidepressants and referred him to the prison's mental health team, but did not refer to his previous prison medical record or request his community medical records.
29. A prison GP prescribed a detoxification regime for alcohol and opiates, but did not record anything about Mr Queen's antidepressants or continue his prescription.
30. At 8.30pm, an officer found Mr Queen trying to hang himself in his cell. Mr Queen said he wanted to end his life, did not want to spend more time in prison and he had reached "rock bottom". Mr Queen said his cell was dirty, that he had no television or radio and he was unhappy that he could not smoke. A nurse took observations and noted that Mr Queen had a red mark around his neck, but was otherwise okay.

## Monitoring Mr Queen's risk of suicide and self-harm

31. An officer started ACCT suicide and self-harm prevention procedures. Mr Queen was moved to the prison's social care unit and staff supervised him constantly. During the night, an officer gave Mr Queen a replacement e-cigarette, as he had said the first one he had been given was faulty. The officer noted that Mr Queen asked for antidepressants. The officer told him that he first needed to be assessed by a nurse.

32. On 28 July, at 10.30am, a nurse assessed Mr Queen. He told the nurse he had depression and had self-harmed because he had been put in a dirty cell and was not allowed his possessions. The nurse noted that Mr Queen was irritable and anxious, and that staff should monitor his mild alcohol and drug withdrawal symptoms.
33. At 10.50am, an officer carried out an ACCT assessment interview. Mr Queen told the officer he had had enough of life, had lost his brother from an overdose in 2012, had no support from his family and would be better off dead. Mr Queen told him that he could not wait to get out of prison so he could kill himself.
34. A safer custody manager carried out an ACCT review which was attended by the Head of Residence, a mental health nurse, officers who knew Mr Queen and a member of the substance misuse team. Mr Queen's caremap was reviewed and updated. Goals included trying to make contact with his family and starting work on the wing. Although Mr Queen said he had no thoughts of suicide or self-harm, it was agreed that he should remain under constant supervision. (The safer custody manager later spoke to a family member but was told that his family wanted nothing further to do with him.)
35. A nurse from the mental health team initially assessed Mr Queen. She noted his impulsiveness, poor coping skills, described him as unkempt, tearful and lacking motivation. Mr Queen talked about his difficulty in accepting his brother's death and the relationship break down with his ex-partner. She concluded that Mr Queen exhibited no psychotic symptoms or delusional thinking, but referred him for a full mental health assessment. She did not record anything about his prescription for antidepressants.
36. Mr Queen told an officer that he wanted to give Exeter a chance, despite struggling with it being a non-smoking prison. The same day, Mr Queen complained to another officer that he had not been given medication for his depression and was finding it difficult to sleep.
37. Early in the morning of Friday 29 July, Mr Queen was abusive to an officer and threatened to kill himself if he could not see a nurse. At 4.07am, a nurse spoke to him through his cell door. Mr Queen told the nurse that he had been on antidepressants and could not sleep without them. She noted that Mr Queen had last been prescribed antidepressants on 1 July. She made an urgent referral for the prison GP to re-prescribe them.
38. At 10.00am, the Head of Safety chaired an enhanced ACCT case review which a psychiatric nurse and the safer custody manager attended. Mr Queen said he would not be safe on a standard wing and wanted to remain in the social care unit. The Head of Safety noted that Mr Queen was demanding, but explained to him that he would not move to a standard wing until his medication had been sorted out and he had started work. Mr Queen said he felt better and had no thoughts or self-harm or suicide. The Head of Safety agreed that his level of risk has reduced from 'high' to 'raised'. He explained to the investigator that he thought Mr Queen was no longer in crisis, had been positive during the review, and received additional support on the social care unit. The review agreed to reduce the frequency of Mr Queen's observations to one an hour. He scheduled the next review for Monday 1 August.

39. The psychiatric nurse said that he assessed Mr Queen's mental health during the ACCT review. The nurse noted that Mr Queen's symptoms seemed genuine, but considered that some of his behaviour was manipulative. The nurse noted that Mr Queen claimed he had nothing to live for in his personal life. Although the nurse found no symptoms of serious mental illness, he noted that a GP needed to continue his prescription of mirtazapine (antidepressants).
40. A drug support worker assessed that Mr Queen had some symptoms of drug withdrawal, but had no concerns about his detoxification regime. Mr Queen told him that he felt supported by the ACCT process.
41. Officer A noted that Mr Queen spent the day in the unit's garden and appeared more settled than he had been. The officer noted that Mr Queen was finding it difficult not being able to smoke. Mr Queen cleaned his cell and another officer gave him two e-cigarettes.
42. A prison GP prescribed Mr Queen's antidepressant and approved a small increase in his methadone to address the withdrawal symptoms which had been identified.
43. At 8.35am on 30 July, Mr Queen asked Officer A for another e-cigarette, as he had no funds to buy any from the prison shop. The officer told him that he could not have more. The officer spoke with a healthcare assistant with responsibility for the smoking cessation clinics to ask if Mr Queen could be given some nicotine patches or pastels. He was told that Mr Queen had been put on the smoking cessation clinic's waiting list, but had to be assessed before he could be prescribed nicotine replacement therapy. Officers noted that Mr Queen mixed with other prisoners that day and moved from the constant supervision cell to a standard cell on the same unit.
44. On 31 July, Mr Queen became agitated and threatened to self-harm because he could not smoke and had no access to nicotine replacement therapy. Officer A noted that he had already asked for help with Mr Queen's smoking cessation. In the afternoon, Mr Queen was seen writing a letter, reading, watching television and chatting to other prisoners in the garden. Mr Queen said he was happy because he had now got some nicotine patches and lozenges. (The investigator was unable to establish who gave Mr Queen the nicotine patches and lozenges.)
45. Officer A noted another prisoner on the unit had ordered three e-cigarettes. Knowing that the prisoner did not smoke, and was vulnerable to bullying, the officer asked if the e-cigarettes were for his own use. The prisoner said they were for Mr Queen. He recorded that Mr Queen was no longer suitable for the social care unit.
46. On 1 August, the safer custody manager chaired Mr Queen's ACCT review. An officer and a drug support worker attended. A nurse provided a verbal report. The manager explained to Mr Queen that he would be moved to a standard wing as soon as they could agree a plan to support him. He told Mr Queen that he could remain and work on the unit, but he needed to be respectful of other prisoners. He agreed that Mr Queen's level of risk had not changed and kept his observations at once an hour.

47. After the ACCT review, Mr Queen told the drug support worker that he felt stable on his current dose of methadone, but felt he was being forced from the unit. Mr Queen talked about his recent suicide attempt, his brother's death and the shame of being back in prison. He discussed coping strategies, suggested Mr Queen focused on small goals and talk through his anxieties with staff. He noted that Mr Queen appeared reassured and they agreed to meet again more formally to open a care plan.
48. Later that afternoon, Mr Queen spoke at some length with an officer about not being able to smoke. He wanted to give his television back so he would have more money for e-cigarettes, but he still owed money from a previous advance to buy e-cigarettes. She noted that he was due to start work the next day, so would earn money.
49. At 7.30pm, Mr Queen rang his cell bell and asked an officer for an e-cigarette. The officer told Mr Queen that he could not give him more e-cigarettes.

## 2 August

50. On 2 August, at 10.15am, a mental health nurse from the substance misuse team noted that Mr Queen was stable on his current level of methadone. Mr Queen told the nurse that he might kill himself if he was moved to a standard wing. He said he would prefer to be segregated. The nurse discussed the conversation with the safer custody manager and noted that Mr Queen had already been assessed by the mental health team. At 10.30am, an officer noted that Mr Queen was writing a letter.
51. At 11.15am, an officer explained to Mr Queen that he could not go to work as planned as no officer was available to supervise the unit's workshop. Mr Queen told the officer that he wanted to go to the segregation unit. He said he was being treated unfairly by not having access to his clothes and other personal items, but the officer explained that only enhanced prisoners had access to such items. The officer noted that Mr Queen remained upset at not being able to smoke.
52. At lunchtime, the healthcare assistant assessed Mr Queen at a smoking cessation clinic. She gave Mr Queen nicotine patches and lozenges. She noted that he was a heavy smoker but was ready to stop smoking. At 12.30pm, an officer noted that Mr Queen was sitting in his cell, with his bags packed. The officer told him that he could not go to the segregation unit as it was full and that the safer custody manager would speak to him later.
53. At 3.15pm, the safer custody manager chaired an ACCT review, with a worker from a housing charity. Several officers spoke to the manager before the review. He recorded that Mr Queen was emotional, demanding and threatening. He told Mr Queen that he was no longer suitable to remain on the social care unit. In order to prepare for his transition from the unit, he said officers would start to unlock Mr Queen's cell at the same time as the rest of the prison and planned to move him to the prison's first night centre first. After the review, he gave Mr Queen two e-cigarettes. He said that Mr Queen shook his hand and thanked him for all his work. He noted that Mr Queen had agreed to the move, but his risk remained raised because his behaviour was unpredictable.

54. At a mental health triage meeting that afternoon, the team noted that Mr Queen was engaging with the substance misuse team and that a consultant psychiatrist would see him the next day. The psychiatric nurse told the investigator that he wanted the psychiatrist to review Mr Queen because of his depression.
55. At 4.03pm, a nurse noted that Mr Queen was in his cell and asked for e-cigarettes. At 5.10pm, Officer A gave Mr Queen his dinner. About an hour later, another officer noted that Mr Queen complained that the e-cigarettes he had been given did not work. A custodial manager told Mr Queen that he had been issued with more e-cigarettes than other prisoners and he could not have any more. This was Mr Queen's last conversation with a member of staff.

### **Emergency response**

56. At 7.57pm, Officer B looked through the observation panel on Mr Queen's cell door and saw him hanging with a bed sheet around his neck attached to the light fitting. He unlocked the cell door and went in. He did not have a radio, so shouted for assistance. Officer C was nearby helping a nurse, the prison's emergency response nurse, check medication. Officer C pressed her personal alarm and followed Officer B into the cell. Officer B supported Mr Queen while Officer C cut the ligature.
57. Officer C did not radio a code blue (an emergency code blue that indicates a prisoner is unconscious, not breathing or is having breathing difficulties). Although the officer did not call a code blue, the control room immediately radioed for emergency assistance on the social care unit and an ambulance was called a minute later.
58. Officer C left the cell to get the nurse who was on the unit but had still not yet responded. A healthcare assistant responded and said the nurse arrived after about three minutes with the emergency bag, and asked her to fetch the oxygen. Officer B described the nurse as panicked.
59. A SO responded to the alarm and arrived about two minutes later. He said Mr Queen was lying on the bed in the recovery position and that the nurse and Officer B were looking at him. He said he checked for signs of life, but found none. He said he turned Mr Queen on his back and started to try and resuscitate him, with Officer B's help.
60. Officer B attached the defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest), but it found no shockable heart rhythm. The officers continued trying to resuscitate Mr Queen.
61. The paramedics arrived at 8.07pm and Mr Queen was taken to hospital, where he was pronounced dead at 10.08pm.
62. Mr Queen left a suicide note in his cell addressed to his mother and another to his children. The note to his mother described how he could no longer cope.

### **Contact with Mr Queen's family**

63. Mr Queen had named his mother as his next of kin, but the prison could not make contact with her. Police eventually told Mr Queen's mother of his death on

3 August and the prison's family liaison officer contacted her. The prison offered to contribute to the cost of Mr Queen's funeral, in line with national instruction.

### **Support for prisoners and staff**

64. An operational manager and a custodial manager debriefed the staff involved in the emergency response and offered support. The prison notified other prisoners of Mr Queen's death and offered support. Officers checked on prisoners assessed as at risk of suicide and self-harm, in case they had been affected by the news of Mr Queen's death.

### **Post-mortem report**

65. The results of the post-mortem examination said that Mr Queen's cause of death was suspension by ligature around the neck. Toxicology tests detected levels of Mr Queen's prescription drugs which were consistent with therapeutic use.

# Findings

## Assessment of risk and level of observations

66. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 74/2011 on early days in custody list a number of risk factors and potential triggers for suicide and self-harm. Mr Queen had a number of these risks. He had a history of mental health issues, had previously tried to kill himself through substance misuse, had been recalled to prison and expressed feelings of hopelessness since the death of his brother. His risk increased because he was not allowed to smoke at Exeter.
67. We believe that staff at Exeter assessed and, largely monitored Mr Queen appropriately under suicide and self-harm monitoring procedures. Staff carried out regular reviews, including enhanced case reviews. The reviews, which were of an above average standard, were well documented and his caremap was regularly updated.
68. Despite this, we are concerned that managers did not fully consider Mr Queen's risk to himself when they reduced his observations from constant supervision to one observation an hour. Decisions about the required frequency of checks should be based on the available evidence, including an assessment of the prisoner's risk at the time and not based on the location of the prisoner. A governor lowered the frequency of Mr Queen's observations, even though there had been no obvious change in his risk. He explained that because of the increased support on the social care unit, staff concluded that it was appropriate to reduce Mr Queen's observations to at least one an hour. This decision did not adequately consider that Mr Queen had tried to kill himself at night just two days before, that the increased support available on the unit was not available at night, and that his risk factors had not significantly changed. We make the following recommendation.

### **The Governor and Head of Healthcare should ensure that:**

- **Staff manage prisoners at risk of suicide and self-harm in line with national guidelines and set observations at a frequency which reflect the risk.**
- **Case reviews assess the risk of suicide or self-harm based on all available information and known risk factors.**

## Medical Issues

69. The clinical reviewer concluded that Mr Queen was offered appropriate detoxification and support for his opiate and alcohol misuse.

### *Mental health*

70. The clinical reviewer reported that there was no evidence that anyone checked Mr Queen's previous prison medical record or community records. When Mr Queen arrived at Exeter, no one identified that he had depression and it took staff two days before they prescribed him his antidepressants. The clinical

reviewer said that if Mr Queen had told the GP he was taking antidepressants and needed more, the GP would have either issued a prescription or checked by contacting a previous prescriber to ensure continuity of care. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners receive prescribed medication without delay and there are no unnecessary breaks in treatment.**

### *Smoking cessation*

71. In his clinical review, the clinical reviewer highlighted that there is a well-established protocol to deliver detoxification from opiate and alcohol dependence to prisoners as soon as they arrive in prison, but no such arrangements for nicotine replacement therapy. At Exeter, a prisoner should attend a smoking cessation clinic within 72 hours of arriving to assess their needs and provide relevant support (such as nicotine replacement therapy in the form of patches or lozenges). At the time of Mr Queen's death, there were delays at Exeter in assessing prisoners about their smoking status and wish to stop smoking. Prisoners had to wait for up to a week to see the healthcare team about smoking cessation, and there were no arrangements in place for staff to manage prisoners' addiction to cigarettes as they transitioned to the smoke-free environment.
72. Mr Queen repeatedly told staff that he was frustrated by the no smoking policy at Exeter, and frequently linked not being able to smoke with feelings of self-harm. Although Mr Queen was given some e-cigarettes when he arrived, he had insufficient funds to buy more. Officers often gave Mr Queen e-cigarettes when he asked and he had obtained some lozenges and patches from an unknown source. He was only seen by a smoking cessation advisor on the day that he died. We are concerned that there was no formal clinical support available when Mr Queen arrived at Exeter to help him in his transition to a smoke-free environment from reception until he was seen by the smoking cessation advisor on the day of his death. We make the following national recommendation:

**The Governor and Head of Healthcare should satisfy themselves that adequate nicotine replacement therapies are available to all prisoners when they arrive.**

### **Emergency response**

73. The nurse did not go straight to the emergency when she heard the alarm on 2 August. She could not provide an adequate explanation for her delay. Staff raised concerns about her failure to take charge of the incident and the prison's healthcare provider conducted an internal inquiry, which concluded:
- She failed to use the oxygen and face mask properly
  - She attempted to artificially ventilate Mr Queen without opening his airway
  - She appeared not to know how to use the automated defibrillator correctly.
74. The internal inquiry concluded that the nurse required additional training and supervision and therefore we make no recommendation.

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