

**Prisons &  
Probation**

**Ombudsman**

Independent Investigations

# Independent investigation into the death of Mr Dwayne Stoneman a prisoner at HMP Exeter on 22 November 2017

**A report by the Prisons and Probation Ombudsman**

## 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.

Mr Dwayne Stoneman was found hanged in his shared cell at HMP Exeter on 22 November 2017. He was 31 years old. I offer my condolences to Mr Stoneman's family and friends.

Mr Stoneman was at heightened risk of suicide but there were a number of weaknesses in the way this risk was managed at Exeter. Although the prison had received information that Mr Stoneman was actively planning how he might die, their communication systems did not operate effectively and the opportunity to take more effective actions to address his risk was lost. I am also concerned that no caremap was drawn up to identify and address Mr Stoneman's key concerns.

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

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**June 2019**

## **Contents**

Summary .....	1
The Investigation Process .....	3
Background Information .....	4
Key Events .....	6
Findings.....	11

# Summary

## Events

1. Mr Dwayne Stoneman was convicted of assaulting his former partner. On 30 May 2017, he was sentenced to 13 months imprisonment and was sent to HMP Exeter. Mr Stoneman had a comprehensive mental health assessment and was diagnosed with moderately severe depression and anxiety. He denied having thoughts of self-harm and prison service suicide and self-harm prevention measures (known as ACCT) were not started. A care plan was put in place and after regular support from the mental health and substance misuse teams, he improved. Mr Stoneman was moved to a lower security prison, HMP Channings Wood, in July 2017 and was released on licence on 13 October.
2. On 22 October, Mr Stoneman was arrested for breaching the conditions of his licence. He had deliberately scalded his hand with hot water before being taken into custody. At the police station, he was interviewed by a nurse from the Devon Liaison and Diversion Team as he was banging his head against his cell wall. He said he had constant thoughts of dying since his release from prison and had started to plan how he might take his life. The nurse assessed that he would be at a higher risk of suicide if remanded to custody and emailed her concerns to Exeter's mental health team administrator. It was not acted on as the administrator was on leave.
3. Mr Stoneman arrived at Exeter with an exceptional risk form completed by court escort staff, highlighting his suicide risk. Staff began ACCT procedures. A nurse saw him for an initial health check but she was unaware of the liaison and diversion team assessment of his risk. Mr Stoneman saw a mental health nurse the next day who noted his low mood but found him willing to discuss his future. She discharged him from the mental health team caseload. His frequency of observations on ACCT were reduced until the ACCT was closed on 31 October.
4. On 30 October, the Liaison and Diversion assessment was added to Mr Stoneman's clinical records by the administrator when she returned to work. A psychiatrist reviewed Mr Stoneman's case at a healthcare meeting on 6 November. She considered that he was adjusting to his circumstances but that he could be referred to the mental health team again if necessary. While at Exeter, Mr Stoneman did not harm himself or express thoughts of self-harm to staff or other prisoners.
5. At about 4.15am on 22 November, Mr Stoneman's cellmate woke up and found Mr Stoneman hanging from the window by a bed sheet. He pressed his emergency cell bell, cut the ligature and shouted for assistance. Staff and paramedics tried to resuscitate Mr Stoneman but they were unable to do so. At 4.51am Mr Stoneman was pronounced dead.

## Findings

### Management of risk of suicide and self-harm

6. When Mr Stoneman arrived at Exeter, staff appropriately assessed him as at risk of suicide and self-harm and monitored him under ACCT procedures. However, there were a number of failings in the management of information about Mr Stoneman's risk. The assessment from the court liaison and diversion service and risk information from Mr Stoneman's licence recall documentation were not fed into the ACCT process and the decision to close the ACCT document after only a week was taken without knowledge of them. The first ACCT case review was not multidisciplinary and the staff at the case reviews had insufficient information about his known risk factors to gauge his true level of risk. Using the limited information at their disposal, they incorrectly assessed his risk as low. The ACCT caremap, where effective measures to support and monitor Mr Stoneman could have been put in place at an early stage, was not completed.

### Clinical care

7. The clinical reviewer concluded that the care Mr Stoneman received was equivalent to that which he could have expected to receive in the community. He found that all but one of the assessments made by clinical and mental health staff were comprehensive but noted that Mr Stoneman should have had a clinical assessment when he returned from court on 13 November, after charges had been dropped against him but he remained in custody. The clinical reviewer did not, though, feel that the delay in receiving mental health risk information impacted adversely on Mr Stoneman's care.

## 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, including in particular that they:
  - Ensure ACCT reviews are multidisciplinary and that mental health staff attend or contribute.
  - Assess the level of risk based on all available information and known risk factors and not on a prisoner's presentation, and record the reasons for the decision.
  - Ensure that a caremap is drawn up and that the ACCT is not closed until the caremap actions have been completed.
  - Assess prisoners on their return from court if there has been a change in custodial status.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at Exeter informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited Exeter on 28 November 2017. She obtained copies of relevant extracts from prison and medical records and interviewed one prisoner.
10. NHS England commissioned a clinical reviewer to review Mr Stoneman's clinical care at Exeter.
11. The investigator interviewed nine members of staff, some jointly with the clinical reviewer, in January 2018.
12. We informed HM Coroner for Devon, Exeter and Greater 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 Stoneman's step-father, to explain the investigation and to ask if he had any matters the family wanted the investigation to consider. He wanted to know whether Mr Stoneman's health needs were assessed, whether he received appropriate medication, whether his parents' telephone number had been approved and why, if his depression was known, was he not observed more closely.
14. Mr Stoneman's family received a copy of the initial report. They did not raise any further issues or comment on the factual accuracy of the report. HM Prison and Probation Service (HMPPS) pointed out three factual inaccuracies in the initial report which have been corrected. HMPPS accepted the Ombudsman's recommendation and implemented an action plan which has been annexed to this report.

# Background Information

## HMP Exeter

15. HMP Exeter is a Victorian city-centre prison which covers the courts of Devon, Cornwall and Somerset. It holds up to 561 adult men and young offenders. Care UK provide primary healthcare and commission Devon Partnership NHS Trust to provide mental healthcare.

## HM Inspectorate of Prisons

16. The most recent inspection of HMP Exeter was in August 2016. Inspectors reported that its outcomes had declined since the previous inspection in 2013 and there were high levels of self-harm. Inspectors found the quality of ACCT documents was variable with many opened as a precautionary measure and some were closed before all the risks had been addressed. Inspectors found that the healthcare team responded well to mild-to-moderate needs.

## 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 its latest annual report, for the year to December 2016, the IMB reported that Exeter was well-run and, although low staff numbers were putting pressure on its ability to run a varied regime, staff made an effort to treat prisoners with dignity and respect.

## Previous deaths at HMP Exeter

18. Mr Stoneman's death was the fifth apparently self-inflicted death at Exeter in 2017. HM Inspectorate of Prisons reported that an action plan to address PPO recommendations on previous deaths had generally been implemented effectively.

## Assessment, Care in Custody and Teamwork

19. Assessment, Care in Custody and Teamwork (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.
20. 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.
21. 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 Prisons Service Instruction (PSI) 64/2011.

## Home Detention Curfew

22. Home Detention Curfew (HDC) is a scheme which allows eligible prisoners serving short sentences to be released from custody before their normal release date. It provides a structured transition from prison to community by requiring them to meet specified licence conditions such as drugs or alcohol testing or residence in an AP to manage their risk and help them adapt to life in the community. One of the requirements is a curfew which is enforced by the offender wearing an electronic tag. Offenders can be returned to custody if they breach the conditions of their licence.

## Key Events

23. On 30 May 2017, Mr Dwayne Stoneman was sentenced to 13 months imprisonment for assault and criminal damage against his partner. It was his first time in custody for eight years. Mr Stoneman was sent to HMP Exeter.
24. On arrival at Exeter, a reception officer wrote in Mr Stoneman's records that he had a history of self-harm but no current thoughts of suicide or self-harm. An ACCT document was not opened. Mr Stoneman saw a member of the mental health team the next day and was assessed as having moderately severe depression and anxiety, which was managed using antidepressants and support from the mental health team.
25. On 31 July, Mr Stoneman was transferred to HMP Channings Wood, a lower security prison. He decided to engage with the alcohol awareness group to address his offending behaviour issues.
26. On 13 October, Mr Stoneman was released from custody on Home Detention Curfew. Among the conditions of his release, he was not allowed to approach or communicate with his partner or their son and he was not allowed to enter a specified exclusion zone.
27. On 16 October, Mr Stoneman was warned by his offender supervisor not to contact his partner after reports were made that he had sent her messages and turned up at her home. He was issued with a written warning. However, on 21 October he sent his partner another message. Mr Stoneman was arrested and charged with harassment. When he arrived at the police station, he told an officer that he had poured a kettle of hot water over his hand the previous week to burn it. On 22 October, the police referred Mr Stoneman to the Devon Liaison and Diversion Team (DLDT) for a review of his mental health as he had banged his head on his cell wall, causing a large bump on his forehead. (A criminal justice and diversion team provides services for people in police stations, the courts, prisons and probation service who have mental health problems and other vulnerabilities.)
28. A community DLDLDT nurse saw Mr Stoneman. She recorded that he presented as depressed in mood. He said that he could not see a future as his world had fallen apart and everything seemed bleak. He said he had constant thoughts of dying and, since his release from prison, he had started to plan his own death. The nurse listed his current risks as further self-harm, suicide by hanging or head banging and the risk of harm to others through domestic violence.
29. The nurse decided that if Mr Stoneman was remanded to prison, she would refer him to HMP Exeter's mental health team (MHT) for consideration of antidepressant treatment and for them to monitor his mood and risks. She emailed her assessment to Exeter's mental health team administrator with a request that she should highlight Mr Stoneman to reception staff if he was taken into custody. The nurse explained that she would be away on leave for a week.
30. On 23 October, Mr Stoneman was remanded in to custody and was sent to HMP Exeter. He arrived with a Person Escort Record (PER, which accompanies persons in custody on all journeys between police stations, courts and prisons)

and an exceptional risk form, completed by the court escort staff, which said he was still suicidal. The PER noted that Mr Stoneman had been charged under the Protection from Harassment Act, was at exceptional risk of self-harm, violent and on licence from a previous sentence. It described his current medical and mental risks as depression, self-inflicted burn to the hand and that he had banged his head on the wall in custody. The DLDT assessment was not available to reception staff.

31. An officer started prison service suicide and self-harm support procedures known as ACCT. A Supervising Officer (SO) drew up an immediate action plan that Mr Stoneman would be observed hourly and placed in a shared cell. They completed a first night immediate risk and needs assessment. Mr Stoneman said there were restrictions on his contact with his family and that he did not have a telephone PIN access. The restrictions applied only to contact with his former partner.
32. A nurse saw Mr Stoneman for an initial health check, which is a standard procedure for all newly received prisoners. She wrote in his clinical record that he had a history of deliberate self-harm and he had hit his head on the walls in police custody. She referred him for a mental health assessment and noted that he was depressed, was taking fluoxetine, an antidepressant, and had arrived with a suicide and self-harm warning form completed by court escort staff. A prison GP prescribed fluoxetine and planned that Mr Stoneman should see a GP in two weeks' time to review his depression. She did not see him in person.
33. A mental health nurse saw Mr Stoneman because he was a newly received prisoner. She noted that he had a history of mental health problems, was on an open ACCT document, feeling low, and he had headbutted the cell wall in the police station, but he assured her he had no intention of taking his life and had no thoughts of suicide or self-harm. The nurse noted that Mr Stoneman was waiting for an appointment with a GP to discuss his antidepressant medication, which he had been taking for seven months but found ineffective and gave him heartburn. They discussed his restraining order and that he missed his son. The nurse found him willing to talk about his future and establishing contact with his son through social services when released. He said that his mother provided him with support. The nurse decided that he did not need further mental health team contact.
34. On 24 October, an officer assessed Mr Stoneman as part of ACCT procedures. Mr Stoneman told him that he had burned his hand as he could not deal with what was happening to him. He disclosed that he had also cut his wrists several months previously. Mr Stoneman said he did not feel suicidal but was very miserable as he missed his partner and young son. The officer recorded in the ACCT document in the section titled summary of key issues that Mr Stoneman would like a flask.
35. A SO conducted a case review with Mr Stoneman about an hour after the assessment interview. The case review was not multidisciplinary – no one from healthcare attended or provided information because it was an exceptionally busy day. Mr Stoneman said that he had been taking antidepressants in the community and hoped he would be able to continue with them in Exeter. The SO

recorded on a separate piece of paper in the ACCT that Mr Stoneman was charged with harassment, was upset at being in prison and had issues with contacting his child, but did not have thoughts of self-harm or suicide. Mr Stoneman was talkative and said he hoped he would be released when he next went to court. The SO assessed Mr Stoneman's risk of self-harm as low and reduced his frequency of observations from hourly to a recorded conversation with staff in the morning and evening and hourly observations at night. He did not complete the ACCT caremap. He told the investigator he could not say why he had not done so but he might have been distracted.

36. Mr Stoneman's offender supervisor emailed a licence recall report to officials of the Ministry of Justice on 23 October. He wrote that Mr Stoneman had repeatedly breached the conditions of his licence and his offending behaviour had escalated because he entered the exclusion zone around his former partner's home when he had been warned not to. He recommended that he should serve the rest of his sentence in custody until 29 May 2018. In section 13 of the report detailing any issues of vulnerability in police or prison custody, he wrote that on both occasions he met Mr Stoneman, he appeared to be in a very low mood and that he might pose a risk of self-harm as he had cut his wrists after committing his original offence. Mr Stoneman's licence was revoked on 24 October.
37. On 25 October, a member of staff saw Mr Stoneman for a smoking cessation appointment. She recorded that he was a heavy smoker but was thinking about stopping smoking with the help of lozenges and patches. She noted that the burn on his hand appeared to be healing.
38. The mental health team administrator returned to work on 30 October and uploaded the DLDT assessment of Mr Stoneman's risk into his clinical notes. The clinical record does not show whether she brought its contents to the attention of any healthcare member of staff. The investigator was unable to interview her as she no longer works at Exeter.
39. On 31 October, a SO chaired an ACCT case review with Mr Stoneman and a landing officer. A nurse was unable to attend in person but gave telephone feedback. The SO found Mr Stoneman very positive with no thoughts of self-harm. He said he was settled, had a good cellmate and accepted he needed to consider 'drawing a line' under his current relationship. He told the SO that he knew where to get support and would ask if he needed it. The ACCT document was closed and a post-closure interview arranged for 7 November.
40. On 6 November, a consultant psychiatrist reviewed Mr Stoneman's referral at a mental health team meeting but did not meet him in person. She reviewed the DLDT assessment but felt Mr Stoneman had been more settled with ACCT support at Exeter and was adjusting to his circumstances.
41. On 7 November, a locum GP met Mr Stoneman who presented as cheerful and communicative. Mr Stoneman told him that fluoxetine, an antidepressant, was not effective and gave him heartburn. The GP prescribed citalopram, a different antidepressant and some cream for the burn on his hand, which had become infected. Mr Stoneman told the nurse who dressed his wrist later that afternoon that he was frustrated with 'everything'.

42. On 13 November, Mr Stoneman appeared at court. Magistrates imposed a restraining order until 12 November 2019, prohibiting him from contacting his former partner except through specified agencies for the purposes of child contact.
43. Mr Stoneman was returned to Exeter because he was still serving an existing custodial sentence. A nurse, who was on duty in the reception area, asked Mr Stoneman how he was. Mr Stoneman told him that he had returned from court and the charges against him had been dropped. It is unclear whether he understood that a restraining order had been put in place as he did not mention it to the nurse. The nurse did not ask Mr Stoneman any further questions about how he felt about remaining in custody. It was the last contact any member of healthcare staff had with him.
44. On 16 November, Mr Stoneman completed a form asking for his parents' telephone number to be placed in his list of approved numbers. It is unclear why he did not do so before as there were no restrictions on contact with his parents.
45. On 17 November, Mr Stoneman's ACCT post-closure interview took place with a SO. He said he was happy with his cellmate and did not have any further issues. The PIN clerk telephoned his parents' number on 21 November to check its authenticity but reached its voicemail. Exeter's communication policy is that if there is no reply, a member of staff will test a number submitted three times in a week at different times of day. If it remains unanswered, the prisoner will receive a letter explaining the situation.
46. Mr Stoneman's cellmate told the investigator that they watched television and talked during the evening of 21 November. His cellmate went to sleep at about 11.30pm while Mr Stoneman carried on watching television. His cellmate said that he woke up in the early morning to use the toilet and saw Mr Stoneman who appeared to be standing by the window. While he was washing his hands, he asked Mr Stoneman what he was doing and when he did not reply, he looked at him again and saw he was on his tiptoes hanging from a ligature made from a bed sheet. Mr Stoneman's cellmate grabbed a razor blade and tried to cut through the bed sheet, the blade snapped and Mr Stoneman fell to the floor.
47. Mr Stoneman's cellmate said he pressed the emergency cell bell, banged on his cell door and shouted. He thought about 10 minutes passed before two officers and a nurse arrived. Cell bell records indicate that the cell bell was pressed at 4.17am and answered at 4.19 am. CCTV footage showed a cell bell light flashing outside cell A4-33, followed a minute later by four officers and a nurse with torches running along the landings until they reach the cell.
48. An officer was in an office on A Wing and heard someone shout 'help me, help me' and banging on a cell door but she could not tell where the noise was coming from and it was dark. She ran upstairs, followed by a nurse who left the healthcare office to investigate. The officer saw that the cell bell light was on but no audible alarm could be heard. Mr Stoneman's cellmate's face appeared in the door observation panel and he was shouting 'he's dead'. The nurse asked him to step aside and looked into the cell. She saw a ligature attached to the window frame and Mr Stoneman's cellmate pointed to Mr Stoneman lying on the floor.

49. The officer radioed a Code Blue (the emergency medical code used to indicate when a prisoner is unconscious or having difficulty breathing). Staff in the control room called an ambulance at 4.20am. A Custodial Manager and two officers responded. The nurse checked Mr Stoneman and found no pulse. He was pale and cold to the touch. The CM removed the ligature and brought an emergency bag. The nurse started cardiopulmonary resuscitation by doing chest compressions and administered oxygen through an ambu bag. Paramedics arrived at 4.27am and continued emergency treatment until they declared Mr Stoneman dead at 4.51am.
50. A Detective Sergeant of Devon and Cornwall police examined Mr Stoneman's cell and removed several items including two unfinished letters to his parents, a letter from his solicitor which he had received on 21 November, and a copy of the restraining order.

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

51. At 11.00am on 23 November, the Governor of Exeter broke the news of Mr Stoneman's death to his parents at their home. The prison family liaison officer spoke with Mr Stoneman's step-father and answered some of his questions and offered support.
52. The prison contributed to the cost of Mr Stoneman's funeral, in line with national instructions.

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

53. After Mr Stoneman's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
54. The prison posted notices informing other prisoners of Mr Stoneman's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Stoneman's death.

### **Post-mortem report**

55. The post-mortem report concluded that the cause of Mr Stoneman's death was hanging.

# Findings

## Management of the risk of suicide and self-harm

### ACCT caremap

56. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm and suicidal ideation, being charged with a violent offence particularly against a family member, relationship breakdown, a history of mental health problems and recall to prison. All these factors applied to Mr Stoneman.
57. Staff correctly began ACCT suicide and self-harm prevention procedures as soon as Mr Stoneman arrived at Exeter but he was monitored under ACCT procedures for only the first week of his time there. We have some concerns about the management of his risk. Even in the absence of the court liaison and diversion team information, it is hard to see why the initial assessment of risk at the first ACCT case review was low, given that many of the known risk factors of suicide were clearly present in the information the prison had about Mr Stoneman.
58. Despite making a note of the issues, the SO who carried out the first ACCT review did not identify the risks or draw up a caremap at the review or in the following days. The SO who chaired the second case review did not draw up a caremap either and, thinking that Mr Stoneman was at low risk, chose to close the ACCT. This meant that there was no structured means of checking whether the relevant issues had been highlighted and satisfactorily resolved and that Mr Stoneman had good sources of support.
59. While the post-closure interview took place on a later date than scheduled, the delay gave staff an added opportunity to explore the significant outstanding matters of Mr Stoneman's court appearance, its outcome, the length of his recall to custody and how he was coping, given that change in custodial status is a known trigger of self-harm. Unfortunately, these topics were not addressed. 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, including in particular that they:**

- **Ensure ACCT reviews are multidisciplinary and that mental health staff attend or contribute.**
- **Assess the level of risk based on all available information and known risk factors and not on a prisoner's presentation, and record the reasons for the decision.**
- **Ensure that a caremap is drawn up and that the ACCT is not closed until the caremap actions have been completed.**
- **Assess prisoners on their return from court if there has been a change in custodial status.**

## Clinical care

60. The assessment from the DLDT set out to a very significant degree the level of risk Mr Stoneman posed to himself. He was candid during the assessment about his intentions and the risk factor that caused him the most distress, a court order preventing contact with his son, was ever present. It was most unfortunate that the assessment was not communicated quickly to the mental health team at Exeter and its absence was a missed opportunity. If it had been, the triage mental health team nurse who saw Mr Stoneman the day after his arrival at Exeter could have pin-pointed and challenged his claims that he did not have thoughts or plans of suicide and self-harm in prison. In addition, the first ACCT case review would have had more robust information to base its assessment of risk on, and staff would have had the opportunity to rely less on Mr Stoneman's external presentation, affable manner and insistence that he had no thoughts of self-harm, and more on his known risk factors.
61. Prison Service Order 3050 on continuity of healthcare describes court appearances as one of the significant events that can have a major impact on the health and risk of a prisoner. It recognises that the prison reception is a key area where the vulnerable can be reached. Mr Stoneman told a nurse on his return from court on 13 November that the charges against him had been discontinued. The nurse did not probe him further and Mr Stoneman noticeably did not mention the court order made against him. This was a missed opportunity to gauge the impact on him of remaining in custody.
62. As a result of Mr Stoneman's death, a number of changes have been made to the operation of the mental health team at Exeter. A generic email inbox has been established so that information from the courts can be accessed daily by a number of duty workers rather than one specific member of staff. Mental health referrals are categorised as urgent (must be seen within 48 hours) or routine priority (within five working days). The mental health team only sees newly received prisoners who have been referred or self-referred rather than all new receptions. This allows it to focus on prisoners who are the most vulnerable. In light of these changes, we make no recommendation.

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