Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Bassett, a prisoner at HMP Swansea, on 1 December 2019

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr David Bassett died on 1 December 2019, after he was found hanging in his cell at HMP Swansea. He was 52 years old. I offer my condolences to Mr Bassett's family and friends.

Mr Bassett had been at Swansea for only 36 hours when he was found hanging. He arrived with warnings that he was at risk of suicide and self-harm and yet staff failed to start suicide and self-harm prevention procedures.

I am concerned that reception staff appeared to place too much weight on Mr Bassett's presentation, rather than looking objectively at his risk factors for suicide and self-harm. This was a missed opportunity to put support in place.

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

Sue McAllister CB
Prisons and Probation Ombudsman **September 2020**

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Summary

Events

1. On 29 November 2019, Mr David Bassett was remanded in prison custody, charged with arson of his own home, and sent to HMP Swansea. This was his first time in prison for ten years.

2. Mr Bassett arrived at Swansea with suicide and self-harm warnings, which were recorded on his Person Escort Record (PER) and on a suicide/self-harm (SASH) warning form. The PER said that Mr Bassett was at risk of suicide and self-harm because he had tried to burn himself on 27 November. The SASH warning form said that Mr Bassett had tried to burn himself, was very depressed, that he had attempted hanging or self-strangulation in the last six months and that he was being checked six times an hour.

3. Neither the reception nurse nor the reception officer considered that suicide and self-harm prevention procedures (known as ACCT) were needed. Nor did the Duty Governor who also saw Mr Bassett. Mr Bassett was placed in a shared cell, in line with local procedures for prisoners' first night in custody.

4. On 30 November, Mr Bassett's cellmate was moved to a different cell and Mr Bassett remained in the cell on his own.

5. Mr Bassett was checked several times during the night during for his first few days, in line with standard practice at Swansea. When a nurse checked on Mr Bassett at 5.43am on 1 December, she saw him hanging from a ligature tied to the bed frame. The nurse radioed a medical emergency code and then went to collect an emergency medical bag. Three officers responded to the emergency code and went into the cell and cut the ligature from Mr Bassett's neck. As they laid Mr Bassett on his back, the nurse returned and ordered the officers to start cardiopulmonary resuscitation (CPR).

6. Paramedics arrived at 5.57am and assisted with resuscitation. Their efforts were unsuccessful and at 6.20am, the paramedics pronounced that Mr Bassett had died.

Findings

7. The reception nurse did not see the SASH warning form, only the PER. We were told that she took only one of his files before she carried out her assessment, and the SASH form was on the other file. The reception officer saw both documents but considered that there was no indication that Mr Bassett was at risk of suicide and self-harm. She said that Mr Bassett was relaxed, engaged well and was laughing and joking with other prisoners.

8. We consider that staff should have started ACCT procedures when Mr Bassett first arrived, given his clear risk factors for suicide and self-harm. Staff placed too much weight on Mr Bassett's appearance and what he told them, rather than considering his documented risk factors. The failure to start ACCT procedures was a missed opportunity to put support in place for Mr Bassett.

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, in particular that reception staff should:
    - have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm;
    - examine all relevant information that arrives with the prisoner, in particular the PER and SASH form;
    - identify risk factors and assess a prisoner's risk based on their risk factors and not just personal presentation; and
    - document the risk information considered and the reasons for not starting ACCT procedures.
- The Head of Healthcare should share a copy of this report with the reception nurse and discuss the Ombudsman's findings with her.
- The Governor should share a copy of this report with Duty Governor and discuss the Ombudsman's findings with him.
- The Governor should share a copy of this report with the reception officer and arrange for a senior manager to discuss the Ombudsman's findings with her.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Swansea informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

10. The investigator obtained copies of Mr Bassett's prison and medical records. He interviewed ten members of staff and one prisoner at Swansea from 27 to 29 January 2020.

11. Health Inspectorate Wales commissioned an independent clinical reviewer to review Mr Bassett's clinical care at the prison. They jointly interviewed staff.

12. We informed HM Coroner for Swansea, Neath and Port Talbot of the investigation. The Coroner gave us Mr Bassett's cause of death. We have given the Coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Bassett's next of kin to ask if the family had any matters they wanted the investigation to consider. The family wanted to know why he was in a cell on his own and why he was not watched carefully by staff. We have addressed these points in this report.

Background Information

HMP Swansea

14. HMP Swansea is a local prison that holds around 500 men and young adult men. Healthcare is provided by Abertawe Bro Morgannwyg University Health Board.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Swansea was in August 2017. Inspectors noted that in their survey, a third of prisoners said that they felt depressed or suicidal or had mental health problems on arrival. Inspectors noted that there had been four self-inflicted deaths since their previous inspection in October 2014, all within a week of arrival. Inspectors observed friendly interaction between reception staff and prisoners, but found that reception risk assessments were not sufficiently rigorous and first night procedures were inconsistent.

Independent Monitoring Board

16. 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 31 May 2017, the IMB noted that there had been two deaths in custody in the reporting period. The Board said that PPO recommendations were discussed in Safer Custody meetings but were not always implemented in a timely manner.

Previous deaths at HMP Swansea

17. Mr Bassett was the second prisoner to die at Swansea since December 2017. The previous death was also a self-inflicted death during the prisoner's first days in custody. There were no other similarities in the circumstances of that death and those of Mr Bassett's death. There has been a death from natural causes since Mr Bassett's death.

Assessment, Care in Custody and Teamwork

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

Key Events

19. On 27 November 2019, Mr David Bassett was arrested and taken into police custody charged with arson of his own home and of using dishonestly a quantity of electricity.

29 November

20. On 29 November, Mr Bassett was taken to Cardiff Magistrates' Court where he was remanded in prison custody. As HMP Cardiff was full, Mr Bassett was taken instead to HMP Swansea where he arrived at 5.15pm. This was his first time in prison custody for ten years.

21. The paperwork that accompanied Mr Bassett to Swansea included a Person Escort Record (PER - a document that accompanies prisoners between police custody, courts and prisons, which sets out the risks they pose), a suicide/self-harm (SASH) warning form, and a record of the medical treatment he received while he was in police custody. The PER said that Mr Bassett was at risk of suicide and self-harm as he had tried to burn himself on 27 November. The SASH form said that Mr Bassett was very depressed at present, that he had tried to burn himself on 27 November and was being checked six times an hour. It also said that he had attempted hanging or self-strangulation within the last six months.

22. When he arrived at Swansea, Mr Bassett was seen for a reception health assessment by a registered mental health nurse. She noted that Mr Bassett appeared fit and well and that he had no concerns about his physical health. Mr Bassett reported that he had a history of depression and was receiving fluoxetine (antidepressant). As Mr Bassett had some fluoxetine tablets with him, the reception nurse, who was a nurse prescriber, prescribed a short course of fluoxetine pending contact with Mr Bassett's community GP. She noted that Mr Bassett was pleasant and polite and that he had no thoughts of suicide or self-harm.

23. She said that she saw Mr Bassett's PER but she did not see the SASH form and did not know why the SASH form was not given to her. The investigator asked the reception nurse whether she should have started ACCT procedures based upon the comment in the PER form that Mr Bassett had tried to burn himself. She said that she could not specifically recall reading the comment that Mr Bassett had tried to burn himself, but if she had seen it she would have questioned him further and might have started ACCT procedures depending on their further discussion.

24. An officer saw Mr Bassett for a reception interview after he had seen the reception nurse. The reception officer told the investigator that she was still sorting out the papers for all the newly arrived prisoners when the reception nurse took one of Mr Bassett's two files. She told the reception nurse to wait, but she paid no attention. The reception officer told the investigator that Mr Bassett's SASH document was on his other file. She said that Mr Bassett was the last prisoner she saw and that she spent around 25 to 30 minutes with him. She said that she was an ACCT assessor and was aware that arson was a risk factor for suicide. She asked Mr Bassett about the offence and he told her that he had threatened to set fire to his home following a dispute with his local council about council tax arrears, but he said that it

had only been a threat and he had not acted upon it. She asked him if he had any current thoughts of suicide or self-harm and he said that he did not.

25. The investigator asked the reception officer whether the safe option would have been to start ACCT procedures, but she was adamant that there were no grounds to do so. She said that Mr Bassett was relaxed, he engaged well, he was laughing and joking with other prisoners and he denied that he had committed arson. She did not consider that he was at risk and nor did her colleagues.

26. As arson was recorded as Mr Bassett's index offence, the reception officer radioed the Duty Governor to assess whether Mr Bassett would be able to share a cell with another prisoner (there are various reasons why a prisoner might not be deemed suitable to share a cell including certain cases of arson).

27. The Duty Governor told the investigator that he was given all Mr Bassett's reception documents including the first part of the cell sharing risk assessment (CSRA) form that had been completed by the reception nurse. The Duty Governor said that he spoke to Mr Bassett about the incident and he said that he had lit a very small fire in his house which was prompted by a dispute that he had with his local council. He said that he extinguished the fire himself before emergency services arrived. The Duty Governor considered that Mr Bassett would be safe to share a cell.

28. The investigator asked the Duty Governor about the warnings contained in the PER and SASH form. He said that his role when he spoke with Mr Bassett was not specifically to assess whether ACCT procedures should be started, and he said that Mr Bassett had been calm in their interview and also seemed forward thinking as he asked if the Duty Governor could recommend solicitors to help him in his council dispute. The Duty Governor acknowledged that in hindsight, it might have been prudent to start ACCT procedures.

29. An induction unit officer saw Mr Bassett after he had finished in reception. The induction officer said that he took Mr Bassett to an interview room and worked through the induction booklet to explain various prison processes and about support services available to prisoners. The induction officer said that their discussion lasted around 10 to 15 minutes and Mr Bassett was polite and well mannered, and he made several witty remarks. The induction officer told Mr Bassett that he was entitled to make a telephone call but Mr Bassett said that he could not remember any telephone numbers and he planned to write to friends and family to get their numbers.

30. The induction officer said that he asked Mr Bassett whether he had any thoughts of suicide or self-harm and he said that he did not. He said that he saw Mr Bassett's PER, but he did not see the SASH form. The investigator asked the induction officer about the warning contained in the PER. The induction officer said that because the reception area was quite crowded, prisoners might not be open about their feelings but when they come to the first night centre they might then reveal that they are struggling and he would then start ACCT procedures. He said that Mr Bassett did not give him cause for concern.

31. The induction officer said that prisoner Insiders had then spoken to Mr Bassett. (Insiders are experienced and trusted prisoners who speak to new arrivals about prison processes and the support that is available.) The induction officer said that

the Insiders will speak to officers if they consider that a new prisoner needs additional support. They did not report any concerns about Mr Bassett.

32. At Swansea, the practice is to try to ensure that new arrivals share a cell for at least their first night in custody. Once Mr Bassett had completed his initial induction, he was moved to a shared cell.

33. The cellmate refused to speak to the investigator but gave no reason.

30 November

34. A second induction officer met Mr Bassett on 30 November. He unlocked the cells in the morning for prisoners to come out for the 'domestic' period when they can collect breakfast, make telephone calls and have a shower. He said that he recalled Mr Bassett collecting breakfast but he did not have a conversation with him. He said that Mr Bassett did not seem uncomfortable with being in prison and he saw that he was chatting with his cellmate.

35. A Supervising Officer (SO), an offender manager working in the Offender Management Unit, saw Mr Bassett early on the morning of 30 November for a basic custody screening interview. The SO told the investigator that before speaking to Mr Bassett, he reviewed his electronic prison record (the NOMIS record). This was the only record he checked. The SO said that the issues he covered during his interview with Mr Bassett included questions about possible issues with drugs or alcohol and questions about accommodation. The SO said that Mr Bassett was cooperative and "quite chatty'. The SO asked Mr Bassett if he had any thoughts of self-harm or suicide and Mr Bassett said that he did not.

36. A 10.50am, a second nurse saw Mr Bassett for a second reception screening interview. She told the investigator that the purpose of the second reception interview is to identify any issues that might not have been identified in the first interview. She noted that Mr Bassett engaged well with her and was polite and calm throughout the interview. She said that Mr Bassett told her that he was receiving fluoxetine and she told him that Swansea would contact his community GP. She said that she asked Mr Bassett if he had any thoughts of self-harm or suicide and he said no, and he laughed. She said that his laughter was in the context of questioning her why she needed to ask such a question. She said that she did not have access to Mr Bassett's paper records, only his electronic medical records.

37. Later that day, Mr Bassett's cellmate was moved to a new cell after he was found in possession of an unauthorised item. Mr Bassett remained in the cell on his own.

38. Another prisoner at Swansea, wrote to the investigator making an allegation against an officer. He said he had told the officer that Mr Bassett might harm himself. In a telephone interview, he told the investigator that he had known Mr Bassett for around 20 years. He said that they met when Mr Bassett bought a car from a friend and although they had not met again since then, they had spoken from time to time over the telephone. The prisoner said that at about 3.30pm on 30 November, he had gone to the OMU office which was in a portacabin opposite Mr Bassett's cell. He said that as he was walking away from the OMU office, Mr Bassett had called out to him saying "[*name redacted*], it's Bassett", and he then said that he was going to harm himself. The prisoner said he shouted back not to do it. He said that

when he returned to his wing he told an officer what Mr Bassett had said and that she needed to go to see him. He said that he challenged the officer after Mr Bassett's death and she said that she had forgotten to speak to him.

39. The investigator spoke to the officer about the prisoner's allegation. She denied categorically that the prisoner had spoken to her about Mr Bassett. She said that she and the prisoner did not have a good relationship.

40. Another induction officer said that he went off duty at 5.00pm that afternoon. Just before that time, Mr Bassett had collected his evening meal and had been locked back into his cell.

41. An officer, who worked a shift that evening, told the investigator that during their initial nights in custody, all prisoners on the induction unit are checked by officers on an hourly basis up to midnight and after midnight, the duty nurse makes three checks during the night. The records show that the night officer checked Mr Bassett three times between 8.00pm and 11.00pm and another night officer made the last check before midnight. The night officer said that each time she checked Mr Bassett, he was in bed and appeared to be asleep.

1 December

42. The investigator checked the CCTV recording taken for the night of 1 December. He saw that a nurse checked Mr Bassett at around midnight and at around 2.00am (the precise times are difficult to determine as the timings shown on the CCTV recording would appear to be around 45 minutes behind real time).

43. The first officer told the investigator that she made another check on Mr Bassett at around 4.00am. She said that there had been a disturbance with another prisoner on the upper landing of the induction unit, so she wanted to ensure that other prisoners had not been disturbed. She said that when she checked Mr Bassett, he again appeared to be asleep.

44. The nurse next checked Mr Bassett at around 5.43am. The nurse told the investigator that when she opened Mr Bassett's cell door observation panel, she saw him on his knees hanging from a ligature tied to the upper rail of the bunk bed. She radioed a medical emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties) and went to the treatment room to collect emergency equipment. (The nurse does not carry a cell key.)

45. The first night officer told the investigator that when she heard the code blue alarm, she was in the wing office, around 30 metres from Mr Bassett's cell, with two other officers. She said that when she reached Mr Bassett's cell, she and an officer looked through the observation panel and saw Mr Bassett hanging. She broke open her sealed key pouch and unlocked the door. She said that although Mr Bassett appeared to be on his knees, the ligature was taking most of his bodyweight. She said that she and the second night officer lifted Mr Bassett a little and used an anti-ligature knife to cut the ligature.

46. The second night officer told the investigator that Mr Bassett had made the ligature from a bedsheet and as it was twisted and thick it took him several attempts to cut through it. Once he cut it, the remainder of the ligature came away from Mr Bassett's neck.

47. Once the ligature was cut away, the officers laid Mr Bassett on the floor and at that point the nurse returned and ordered them to start chest compressions.

48. The nurse told the investigator that even without making checks on Mr Bassett she could see there were no signs of life so she did not want to waste any time in checking for a pulse or any signs of breathing. She said that while the officers began giving chest compressions, she inserted an airway tube to give Mr Bassett oxygen and also checked him with a defibrillator.

49. Ambulance paramedics were called when the code blue call was made and their records show that they arrived at the cell at 5.57am. The paramedics assisted with efforts to resuscitate Mr Bassett. Efforts continued until 6.20am, when the paramedics declared that further efforts should cease as Mr Bassett was dead.

Contact with Mr Bassett's family

50. The prison appointed a prisoner counsellor as family liaison officer (FLO). At just before 8.00am, the FLO and a colleague left Swansea to drive to Mr Bassett's next of kin's home, where they arrived at 8.50am. They tried several times to get a response from the house and they also tried adjoining properties, all without success. The FLO continued with his efforts and also sought guidance from the Duty Governor. At 10.45am, the FLO tried again to get an answer from the home and this time Mr Bassett's next of kin responded (she had not heard the previous attempts). The FLO broke the news and he and his colleague then took her to her next of kin's home where they also informed her of the news.

51. Swansea contributed to the cost of Mr Bassett's funeral in line with national instructions.

Support for prisoners and staff

52. A CM debriefed the staff who were involved in the response when Mr Bassett was found. The staff care team also offered support.

53. The prison posted notices informing other prisoners of Mr Bassett's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Bassett's death.

Post-mortem report

54. Toxicology tests showed the presence of amphetamine in Mr Bassett's blood. The toxicologist noted that it was unlikely that the drug would have caused Mr Bassett's death or would have had a significant effect on his cognition or motor skills. Mr Bassett's cause of death was hanging.

Findings

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

55. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* sets out the procedures for identifying and supporting prisoners at risk of suicide and self-harm. PSI 64/2011 sets out a list of risks and triggers that can increase the risk of suicide and self-harm. It also sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as at risk.

56. Mr Bassett's PER and SASH form both noted that he had tried to burn himself. In addition, Mr Bassett's SASH form noted that he was very depressed, that he had attempted hanging or self-strangulation in the past six months and that he was being checked six times an hour. PSI 64/2011 lists deliberate self-harm as a risk factor, along with a mental illness diagnosis (including depression). It also lists the offence of arson as a risk factor. Therefore, Mr Bassett had clear risk factors for suicide and self-harm.

57. The reception nurse did not see the SASH form because it was not included in the folder of documents she had when she assessed Mr Bassett. We are concerned that she carried out her assessment without sight of a key document that highlighted Mr Bassett's risk of suicide and self-harm.

58. The reception officer saw both the PER and the SASH form. When interviewed, she said she considered there were no grounds to start ACCT procedures. She said Mr Bassett was relaxed, engaged well and was laughing and joking with other prisoners. She acknowledged that arson was a risk factor but said that Mr Bassett told her he had only threatened to burn his house and had not carried out his threat.

59. In February 2016, we published a Learning Lessons Bulletin which examined self-inflicted deaths of prisoners within the first month of custody. We found that in many instances staff based their assessments on the prisoner's presentation and their statements that they had no thoughts of suicide or self-harm. We noted that known risk factors, such as a history of suicidal behaviour, were often overlooked.

60. We consider that the warnings on the PER and SASH form were sufficient for staff to start ACCT procedures. We consider that staff placed too much weight on Mr Bassett's presentation and his own statements that he had no thoughts of suicide or self-harm, and insufficient weight on the warnings that arrived with him and his risk factors. The failure to start ACCT procedures was a missed opportunity to put support in place for Mr Bassett. 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, in particular reception staff should:

- **have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm;**
- **examine all relevant information that arrives with the prisoner, in particular the PER and SASH form;**

- **identify risk factors and assess a prisoner's risk based on their risk factors and not just personal presentation; and**

- **document the risk information considered and the reasons for not starting ACCT procedures.**

The Head of Healthcare should share a copy of this report with the reception nurse and discuss the Ombudsman's findings with her.

The Governor should share a copy of this report with the Duty Governor and discuss the Ombudsman's findings with him.

The Governor should share a copy of this report with the reception officer and arrange for a senior manager to discuss the Ombudsman's findings with them.

Mr Bassett's cellmate

61. When Mr Bassett's cellmate was moved, he was then left as the sole occupant of his cell. A Custodial Manager (CM) told the investigator that she managed the induction unit. The CM told the investigator that the aim in Swansea is to try to ensure that prisoners share a cell for at least their first night in custody. She said that if a prisoner is subject to ACCT procedures, or has otherwise been identified as vulnerable, Swansea will try to keep them with a cellmate for a longer period. She said that with Mr Bassett, there was no apparent reason why he needed to be found a new cellmate.

62. The Prison Service acknowledges that having a cell-mate is a source of support for prisoners who might be at risk of suicide and self-harm. We have already explained why we consider that staff should have started ACCT procedures. Had this been the case, Swansea would have made efforts to find a new cellmate for Mr Bassett. However, as ACCT procedures had not been started, staff in the induction unit had no reason to believe that they needed to find him a new cellmate.

A prisoner's allegation against an officer

63. A prisoner wrote to the investigator and said that he was returning from the exercise yard when Mr Bassett called out to him that he was thinking of harming himself. Before speaking to him, the investigator re-visited Mr Bassett's cell. He noted that Mr Bassett's cell did not overlook the exercise yard, in addition, he noted that it would be difficult for Mr Bassett to have seen anyone below his cell as the cell window only opened a few centimetres and had an external grill. When the investigator challenged the prisoner about this, the prisoner said that when Mr Bassett called out to him he was not on the exercise yard, he said instead that he had gone to the OMU office, which was opposite Mr Bassett's cell, and he was returning to his wing via the exercise yard when Mr Bassett called out to him. He said that this was at about 3.30pm on 30 November, a Saturday.

64. The investigator asked an OMU SO about the opening hours of the OMU office. He said that OMU staff usually work Monday to Friday but he and a colleague had gone into Swansea on the morning of Saturday 30 November to catch up on a backlog of work. He said that OMU staff always visit prisoners on the prison wings,

that the OMU office is used to hold secure files and that prisoners do not attend the OMU office. We do not consider the prisoner's account to be credible.

Clinical care

65. The clinical reviewer found that Mr Bassett's care at Swansea was equivalent to that which he could have expected to receive in the community. In particular, he received comprehensive first and second health screens that covered both his physical and mental health and there was no delay in him receiving medication.

Inquest

66. An inquest into Mr Bassett's death held from 21 to 29 July 2025 found that his cause of death was suicide by hanging. The jury found that failures to respond to an obvious risk of self-harm contributed to Mr Bassett's death.

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