Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Davina Canning, a prisoner at HMP Hewell, on 29 July 2023

A report by the Prisons and Probation Ombudsman

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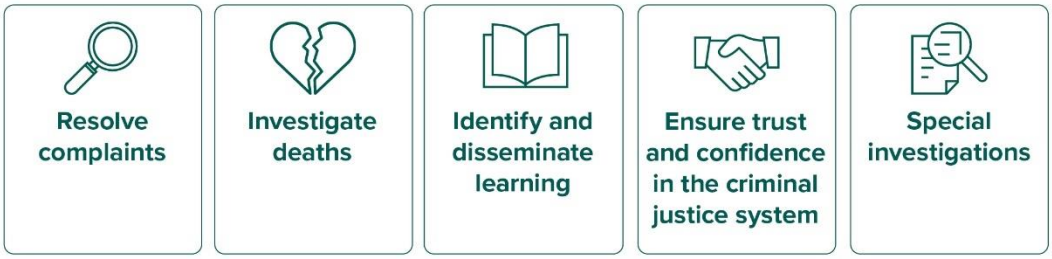
OUR VISION

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Ms Davina Canning, a transgender prisoner, was found hanged in her cell at HMP Hewell on 29 July 2023. She was 59 years old. I offer my condolences to Ms Canning's family and friends.

Ms Canning was a very challenging prisoner to manage. Throughout her two weeks at Hewell she engaged in persistent anti-social and self-harming behaviour. While staff monitored Ms Canning using suicide and self-harm prevention procedures (known as ACCT) throughout, the procedures did not provide the framework for managing Ms Canning's needs, risks and vulnerabilities that they should have.

On the night that she died, Ms Canning repeatedly pressed her emergency cell bell, exposed herself to two female staff, tied clothing around her neck and attempted to electrocute herself. Even considering her behaviour in the previous two weeks, this demonstrated an escalation in risk. The staff on her houseblock managed Ms Canning with patience and professionalism, but there should have been more input from the night manager with proper consideration given to the risk she posed.

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

Adrian Usher
Prisons and Probation Ombudsman **March 2025**

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Summary

Events

1. On 15 July 2023, Ms Davina Canning, a transgender prisoner, was remanded to HMP Hewell charged with a domestic violence offence and assault of a police officer. In court, Ms Canning told staff that she would take her life were she sent to prison. Prison staff started suicide and self-harm prevention procedures (known as ACCT) when she arrived at Hewell.

2. During her time at Hewell, Ms Canning displayed difficult and challenging behaviour. She tied ligatures with her clothing or tied fabric around her limbs to try to stop blood flow. Ms Canning sometimes scratched herself. She pressed her emergency cell bell dozens of times a day, including for much of the night, and was unpopular with other prisoners as a result.

3. On the night of 28-29 July, Ms Canning continuously pressed her emergency cell bell and engaged in other antisocial behaviour. She poured water into the electric sockets and placed her wet fingers in the socket. She tied clothing around her neck. At around 4.35am, the night staff found Ms Canning on the floor of her cell, unresponsive, with a ligature tied around her neck. Resuscitation attempts were unsuccessful, and, at 5.33am, paramedics confirmed that Ms Canning had died.

Findings

4. While prison staff appropriately started ACCT procedures when Ms Canning arrived at Hewell, there was insufficient strategic consideration given to managing her risks effectively. Her level of risk was underestimated, and observations set too infrequently as a result. More could have been done to identify and review support actions, that might have helped to address Ms Canning's ongoing issues.

5. Ms Canning's behaviour on the night that she died was particularly disruptive and difficult to manage. The night staff on her houseblock dealt with her behaviour professionally throughout. However, there was apparently only one conversation between the night manager and the junior staff on the houseblock about Ms Canning at the beginning of the night shift.

6. Despite her persistent and challenging behaviour, and history of mental ill-health, Ms Canning was not prioritised for a mental health assessment.

Recommendations

- The Governor should review the quality and compliance with policy of ACCT management in the previous 12 months, identify any improvements required, and devise a plan to deliver those improvements.

- The Head of Healthcare should ensure that prisoners who present with persistent and challenging behaviours are assessed according to their level of risk and need, with consideration given to their most suitable location.

- The Head of Healthcare should ensure that all emergency response staff attend medical emergency codes immediately.

The Investigation Process

7. The Prisons and Probation Ombudsman (PPO) was notified of Ms Canning's death on 29 July 2023.

8. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded, who was interviewed.

9. The investigator obtained copies of relevant extracts from Ms Canning's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Ms Canning's clinical care at the prison. In October, the investigator and clinical reviewer jointly interviewed four prison and healthcare staff and one prisoner. The investigator also interviewed three prison staff.

11. Between April and June 2024, another investigator interviewed a custodial manager and four healthcare staff with the investigator and obtained further information from a senior manager. She also completed a follow up interview with a member of staff who had previously been interviewed.

12. We informed HM Coroner for Worcestershire of the investigation. He provided us with a copy of the post-mortem and toxicology reports. We have sent the Coroner a copy of this report.

13. The Ombudsman's office contacted Ms Canning's husband to explain the investigation and to ask if he had any matters he wanted us to consider. Ms Canning's husband asked one question that we have addressed in separate correspondence.

14. Ms Canning's husband received a copy of the initial report. They did not identify any factual inaccuracies.

15. The prison also received a copy of the report. They did not identify any factual inaccuracies.

Background Information

HMP Hewell

16. HMP Hewell is a large category B local prison in Worcestershire, holding adult male prisoners. Hewell has six residential houseblocks.

17. Healthcare services are provided by Practice Plus Group (PPG) and mental health and substance misuse services are sub-commissioned to Midlands Partnership NHS Foundation Trust (MPFT). MPFT provide an integrated mental health and substance misuse service known as 'Inclusion' and are commissioned to be on site at Hewell between 9.00am and 5.00pm Monday to Friday, with regional on-call cover available at the weekends. MPFT also provide a Targeted Care Pathway (TCP) at Hewell which is covered by two mental health nurses, seven days a week. The TCP is for people who have been deemed to require increased mental health support due to their needs and are seen for daily reviews.

HM Inspectorate of Prisons

18. HMIP carried out a full inspection of Hewell in November/December 2022. Inspectors reported that the prison had made excellent progress since their last inspection and was now cleaner, more decent and safer. Assaults on staff and prisoners had significantly reduced and the prison felt safe and calm.

19. Inspectors remained concerned that not enough progress had been made to address previous concerns raised about support for those prisoners who are at most risk of suicide or self-harm. They found some of the processes to protect the most vulnerable were weak. Inspectors noted the minutes of the weekly safety intervention meeting showed good examples of support and individualised care. There were fewer prisoners receiving support when at risk of suicide or self-harm than at the time of the previous inspection, and staff awareness of prisoners in crisis was generally good. However, inspectors found the quality of ACCT documentation was variable and prisoners on the main units felt that staff did not have enough time to support them.

20. Transgender prisoners told inspectors that they felt well supported even though they were frustrated by some delays in the delivery of some gender-specific purchases.

21. Inspectors found mental health services were stretched because of staffing pressures and high health needs. An early days in custody pathway, which assessed prisoners arriving at the prison, had ceased and staff were prioritised to manage those with high-level mental health needs and those in crisis. The number of referrals was high, at around five a day, and waiting times for an initial assessment often took four weeks, which was too long. Staff had reduced capacity to undertake meaningful one-to-one interventions as most time was spent assessing new patients or supporting those being managed by suicide and self-harm measures. Psychiatry provision was good.

22. Inspectors returned to Hewell in November 2023, to undertake an independent review of progress. They identified there had been insufficient progress in key areas, including that too little had been done to reduce levels of self-harm. There was no

specific strategy to reduce self-harm and the recorded rate of incidents was on an upward trend. The quality of ACCT assessment and management remained variable. Inspectors noted the challenges of staff resources, the impact of the rising prison population and that Hewell had a 40% increase in new arrivals. Inspectors found that healthcare delivery had improved.

Independent Monitoring Board

23. 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 annual report for the year to 30 September 2023, the IMB reported that the Governor and staff at Hewell had striven to deliver a safe, fair, and humane regime.

24. The IMB reported that self-harm incidents had risen by 28.4% compared to the previous reporting year. Although they noted that an increase was expected due to the rise in the prisoner population, this was still high compared to similar prisons. There had been an increase in the use of suicide and self-harm procedures following additional training for all staff and a push to make reviews more multi-disciplinary. The IMB observed that while these were dutifully completed, they often lacked depth and analysis. Almost without exception, the opportunity for prisoners to contribute was not taken and the page for their views was blank.

Previous deaths at HMP Hewell

25. Ms Canning was the eleventh prisoner to die at Hewell since July 2020. Of the previous deaths, five were self-inflicted and five were from natural causes. There are no significant similarities between our findings in these deaths and Ms Canning's.

Assessment, Care in Custody and Teamwork

26. 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 prisoners. As part of the process, a support plan which includes support and intervention, should be in place. The ACCT plan should not be closed until all the actions of the support plan have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Incentives and Earned Privileges Scheme (IEP)

27. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

Background

28. Ms Davina Canning had served previous custodial sentences and was last released from prison on 17 June 2022. During a previous sentence in 2016, Ms Canning self-strangulated and was supported under suicide and self-harm prevention procedures, known as ACCT. During her previous prison sentences, Ms Canning identified as male and was known as Arthur or David Canning.

29. Following her release in June 2022, Ms Canning began to identify as female. She had not had gender reassignment surgery or hormone therapy and did not have a gender recognition certificate (which is necessary to obtain a new birth certificate recognising the acquired gender).

30. On 12 July 2023, Ms Canning was admitted to hospital after she was found unconscious. It was later established that she had drunk alcohol with diazepam, which she had recently been prescribed (for anxiety). Ms Canning told her community GP that she had not taken an overdose. However, the GP noted that Ms Canning said she felt suicidal because of life events, which included issues relating to her mental health. (Ms Canning was diagnosed with anxiety and depression, behavioural disorder, psychosis and attention deficit hyperactivity disorder.)

31. On 13 July, Ms Canning was arrested following an alleged incident of domestic violence. During her arrest she assaulted a police officer.

HMP Hewell

32. On 15 July, Ms Canning appeared in court, where she told staff that if she was sent to prison she would kill herself. Ms Canning was monitored five times an hour while held in court cells.

33. Ms Canning pleaded guilty to the assault of a police officer, and she was remanded in custody to await sentencing, and taken to HMP Hewell. Ms Canning was next due to appear in court on 4 August.

34. The person escort record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose) noted Ms Canning's previous history of self-harm, which included banging her head in a police van, punching herself and that she had attempted to self-strangulate with clothing while in prison. It was also noted that Ms Canning had taken an overdose the night before her arrest and had a history of depression, anxiety, and paranoia.

35. When Ms Canning arrived at Hewell, the escort officer told a Supervising Officer (SO) that Ms Canning was at a hight risk of suicide or self-harm and had been checked five times an hour by court staff. Ms Canning told the SO that she enjoyed being monitored and had told court staff that she had felt suicidal for attention. Ms Canning said that the thought of sharing a cell caused her anxiety. The SO told Ms Canning that she would be given a single cell (because she was transgender), which he noted alleviated a lot of her concerns.

36. During the first night interview, an officer noted that warnings had been raised in court about Ms Canning's risk of suicide and self-harm. Ms Canning told the officer that she had felt 'low' while in police custody and had 'wanted to end it', but that this was because she had smoked cannabis the previous Monday. He noted that it was not Ms Canning's first time in prison, that she said she had no dependants or family and was in rent arrears which caused her stress. He concluded that Ms Canning should be assessed by the mental health team. (He did not make a referral to the mental health team, although the reception nurse made one that same evening.)

37. A nurse started ACCT procedures and noted that Ms Canning had been kicking the cell wall and hitting herself in the head. He recorded that Ms Canning had a history of psychotic depression, anxiety and stress and used self-harm as a means to control this. A Custodial Manager (CM) completed an immediate action plan and set observations at once every two hours with two significant conversations a day. Ms Canning said that she was awaiting confirmation of the numbers that could be added to her prison phone account (because her husband was the victim of the alleged offence he was not automatically added). The CM noted that she had no current thoughts of self-harm. He recorded on the immediate action plan that the mental health team should attend the first ACCT case review.

38. A nurse completed Ms Canning's initial health screen. He noted that Ms Canning had a history of psychosis, depression, anxiety and insomnia and was being treated for several physical health conditions. He recorded that Ms Canning had arrived with her medication including zopiclone (to aid sleep), fluoxetine (an antidepressant), olanzapine (an antipsychotic) and diazepam (used to treat anxiety and help with alcohol withdrawal). He noted that she had a history of alcohol abuse. He assessed that Ms Canning was unsuitable to hold her medication in possession (meaning she would have to collect it each day and take it in front of a nurse). He referred Ms Canning to the prison's substance misuse service, mental health team and prison GP, who prescribed continuing medications.

39. An officer completed a cell sharing risk assessment (CSRA) and noted that Ms Canning was significantly vulnerable to assault as a transgender prisoner and that she was granted vulnerable prisoner status. He also noted that she wanted to be referred to as Davina and to use female pronouns.

40. Ms Canning was allocated a cell on Houseblock 2, the induction unit. (Typically, those with vulnerable prisoner status are held separately to other prisoners. Hewell has a mixed induction wing, because of limited availability on the vulnerable prisoner unit (VPU), where prisoners are unlocked at different times to access the regime. They remain there until they have completed the induction and are then moved to the VPU when a space becomes available.)

41. At around 9.50pm, Ms Canning told a CM that she might cut herself with a plastic knife (which had been given to her to eat meals) if it was left in her cell. Ms Canning handed over the knife as well as shoes and some clothing 'just in case', as she said she did not know how she would feel later in the night. An officer spoke at length with Ms Canning and reminded her of the support available, should she feel upset or anxious. Ms Canning said that she would call the Samaritans if she needed to talk.

Sunday 16 July

42. On 16 July, a nurse completed a secondary health screen. He recorded that Ms Canning was being monitored under ACCT procedures and had some bruising to her leg from kicking the cell door in court, but that she denied any current thoughts of self-harm or suicide. He noted that Ms Canning was to be prescribed diazepam to manage alcohol withdrawal and that the substance misuse service would monitor her daily. (Daily monitoring for alcohol withdrawal did not happen.) He also warned Ms Canning about taking illicit substances while in prison. He referred Ms Canning to the prison's mental health team.

43. A SO completed Ms Canning's ACCT assessment. Ms Canning said she was disappointed at being returned to prison and said that she believed the relationship with her husband was now over. Ms Canning told the SO that she had been diagnosed with anxiety, depression, paranoia, and gender dysphoria and that she self-harmed to control feelings of anxiety.

44. Ms Canning said that the previous night she had made a scratch to her leg and tied fabric around her neck as a cry for help. (These events were not recorded in Ms Canning's ACCT ongoing record, and we do not know if night staff were aware.) She denied any suicidal ideation. Ms Canning told the SO that her usual method of self-harm was to punch herself in the body and face, which was triggered by issues at home, alcohol use and mental health issues. She said she had no external support, other than her husband, who she was not allowed to contact due to her offence. The SO noted that Ms Canning was forward thinking, was planning ahead of her sentencing and how on release she hoped to get her own property and live a normal, healthy life.

45. The SO noted that a transgender board would be arranged. (This is to consider any offence related risks, risks to the safety of the individual, risks to other prisoners/staff and agree what support is required to support the wellbeing and safety of a transgender prisoner.) He recorded that Ms Canning's triggers for self-harm included her return to custody, mental health issues, and her next court appearance on 4 August. He noted that specific consideration should be given to Ms Canning's transgender status and poor literacy and that she had been referred to the prison's mental health team.

46. Another SO then chaired the first ACCT case review, attended by the previous SO, a learning disability nurse from the mental health team, and Ms Canning. She noted much the same information that the previous SO had recorded during the ACCT assessment and that had been gathered and recorded over the previous day.

47. Ms Canning told the review that she felt vulnerable and wanted to move to the vulnerable prisoners' unit. The SO noted that she would make the necessary arrangements, and Ms Canning would move when a space became available and when she had completed her induction. She noted that although Ms Canning had access to women's underwear, her outer clothing was awaiting approval by the transgender board. Ms Canning said that wearing her own clothes outside of her cell would make her happy. She planned for Ms Canning to be able to shower on her own.

48. Ms Canning told the review that she had no intention of taking her own life but might harm herself. She said she would tell staff if she felt her mental health was deteriorating. The SO added three support actions; for Ms Canning to move to the vulnerable prisoners' unit, referral to the substance misuse team (which had already been submitted), and for Ms Canning to attend a transgender board.

49. The review panel agreed to keep Ms Canning's observations at every two hours and for staff to record two quality conversations with her a day. The SO noted that it would be helpful for a member of the transgender board to offer support at the next review, which was set for 20 July, and that a keyworker would be allocated from the vulnerable prisoners' unit to support Ms Canning's transition to the unit when it happened.

50. In the afternoon, a nurse met Ms Canning as part of the process to identify prisoners who might require treatment or support from the mental health team.

51. The nurse recorded Ms Canning's history of alcohol misuse, which contributed to her risk of self-harm, and of psychosis and depression. Ms Canning disclosed she had previously been under the care of mental health services during her last period of prison custody and had spent time in a psychiatric hospital. The nurse recorded Ms Canning's current presentation was stable and that there was no evidence of thought disorder.

52. The nurse explained to Ms Canning that she would continue to be under the care of the prison GP, as she would have in the community, for all her healthcare needs. A care-coordinator from Inclusion (the integrated substance misuse and mental health service) would gather further information through assessment and observation, and she would be offered ongoing support. The nurse made a clinical plan for Ms Canning to be seen by Inclusion and that she would be added to the Multi-Professional Complex Case Clinic (MPCCC) for discussion. (There is no evidence in her medical record that Ms Canning was discussed at MPCCC.) The nurse told Ms Canning that if she had any future concerns she could self-refer to the mental health team. She encouraged Ms Canning to take part in activities as this would be beneficial for her mental health and wellbeing. Ms Canning was not added to the mental health team's caseload.

53. Later, a nurse sent a task to the GP at Hewell to review Ms Canning's prescribed medication. (There is no evidence that Ms Canning's prescription was ever reviewed, and it therefore remained at the dose she had been prescribed before prison.)

54. Staff noted in Ms Canning's ACCT record that she continuously pressed her cell bell (which is intended for emergencies) during the night. Listeners saw her at 11.00pm.

Wednesday 19 July

55. During the morning, Ms Canning asked an officer when she would be moved to the vulnerable prisoners' unit. He replied that they were waiting for a space. During the afternoon, an officer noted that Ms Canning had spent time with a friend, had taken part in the regime and appeared in high spirits.

56. During the night, staff gave Ms Canning three negative behaviour warnings for misusing her emergency cell bell and swearing at staff.

Thursday 20 July

57. At around 8.00am, Ms Canning pressed her cell bell and staff found her with her jumper knotted around her neck. Ms Canning said it was too tight, asked for help to remove it and said that she had attempted to strangle herself because she had had enough. Ms Canning then showed staff her underwear to confirm her desire to transition and said that she wanted to move to Houseblock 5 (the vulnerable prisoner unit) as she felt vulnerable.

58. A CM chaired an interim ACCT review, following Ms Canning's attempt to self-strangulate, with two officers also present. The CM noted that Ms Canning had pressed her cell bell 'relentlessly' during the night. She recorded that Ms Canning was in good humour and did not appear distressed. Ms Canning showed the CM her underwear and told her that she wanted to come out onto the landing wearing it. The CM told her that this would not be appropriate, might anger other prisoners, and that she should only come out onto the landing fully clothed. The CM noted that she had no concerns about the incident of self-harm and that Ms Canning just wanted to come out of her cell to talk to staff that she liked about her transitioning. She did not increase Ms Canning's observations and informed her that the ACCT would be reviewed again later in the day.

59. A nurse from the mental health team saw Ms Canning as an officer had taken her to the healthcare centre. She recorded that when Ms Canning arrived, she was laughing with the officer. She noted that Ms Canning had also made very small scratches to her thighs.

60. During the morning, an officer noted that Ms Canning had to be removed from other prisoners' doors for shouting abuse. During the afternoon, Ms Canning repeatedly misused her cell bell and spoke to wing staff about her wish to move to Houseblock 5.

61. In the afternoon, a SO chaired an ACCT case review. An occupational therapist from Inclusion also attended. The SO recorded that Ms Canning appeared to be in good spirits. Ms Canning said that her actions in the morning had been a cry for help and that she wanted to move off the induction unit. Ms Canning said she did not feel safe and had received abuse from other prisoners during association periods. Ms Canning said that other prisoners had been spitting through the side of her cell door. The SO noted that this was an ongoing problem with vulnerable prisoners on the induction unit, which she raised with other managers.

62. During the review, Ms Canning had a shoelace tied tightly around her arm, which she said she used to cut off the circulation to her hand. Ms Canning allowed staff to remove the shoelace and staff removed another shoelace from her cell at her request. The occupational therapist reassured Ms Canning that she had been referred to Inclusion and that someone would come to see her soon (an appointment had been made for 25 July). The SO told Ms Canning that an officer, who had worked with other transgender prisoners, had been allocated as her keyworker.

63. The SO noted that having conversations with staff made Ms Canning feel better and that she spent the duration of the ACCT review laughing and joking. She noted that Ms Canning's location on Houseblock 2 was limiting her ability to associate with others and feel safe. She also recorded Ms Canning had spoken to Listeners since the last review, and that she had been taken to Houseblock 5 to speak to another transgender prisoner, which Ms Canning had said she found helpful. The SO noted that it was a priority to move Ms Canning to Houseblock 5 as soon as possible.

64. Ms Canning said that she was only sleeping for a couple of hours a night, because she was given her diazepam at 4.00pm which kept her awake. The SO noted that Ms Canning enjoyed reading but did not have her glasses and had asked the chaplaincy if they had any spare glasses. She made applications for Ms Canning to see the optician and dentist.

65. Ms Canning showed the SO her foot and ankle, which were swollen after she had kicked her prison cell door in frustration. The SO contacted healthcare for them to examine Ms Canning's foot. She noted that Ms Canning benefited more from meaningful conversations rather than observations and told us that this was because she liked to talk and appreciated the attention from staff. Ms Canning denied having any current thoughts of suicide or self-harm and the panel set conversations at one in the morning and afternoon and observations every two hours during patrol state (when prisoners are locked in their cells). The SO updated the support actions and noted referrals to the optician and dentist, a request for reading glasses and a referral to healthcare for Ms Canning's foot to be assessed. The next ACCT review was scheduled for 27 July.

Friday 21 July

66. An officer noted that Ms Canning had asked for painkillers during the night, but she was told she would have to wait until the morning. Ms Canning slept from midnight until morning and raised no issues.

67. In the morning, a Healthcare Assistant (HCA) examined Ms Canning's foot. Ms Canning said she had placed a ligature around her neck and all four limbs and that officers had used their anti-ligature knives to release her. (There is no evidence of this event in either the prison or healthcare record.) Ms Canning said she had some pain in her neck and told the nurse that she had tied the ligature because she was not receiving sleeping medication. The HCA recorded that Ms Canning had told her that she wanted to move to Houseblock 5 so that she would feel safer, as other prisoners were calling her names and spitting through her cell door. Ms Canning denied any current thoughts of self-harm and the HCA said that she would escalate concerns to the emergency response nurse. (There is no evidence this was done.)

68. During the morning, an officer noted that Ms Canning had spoken to him and another officer 'many times' and that Ms Canning had used her cell bell constantly. In the afternoon, he noted that Ms Canning had collected her dinner and medications and was happy because she had vapes. Nothing was noted in the ACCT in relation to the evening observations and conversations.

69. An officer noted that Ms Canning saw Listeners during the night. Ms Canning asked him about moving to Houseblock 5. He recorded that, during the night, Ms Canning rang her cell bell for 'random things' and that it seemed she wanted attention.

Saturday 22 July

70. During the morning, Ms Canning asked if she could see a nurse because of pain in her leg and symptoms of diarrhoea but raised no other issues. An officer recorded that Ms Canning 'showed a displeasing attitude'. During the afternoon, Ms Canning apologised for her earlier behaviour.

71. An officer noted that, during the evening, Ms Canning had constantly rung her cell bell, and that she had tied clothing around her legs as she believed this would stop her circulation and that she would die. He noted that Ms Canning spoke to the Samaritans on the telephone. (During her time at Hewell, Ms Canning did not make any calls other than to the Samaritans.) She also flooded her cell.

72. During the night, the night manager recorded that he spoke to Ms Canning for around 15 minutes. She told him that talking made her feel better and that she would loosen the sock she had tied around her leg and go to sleep.

Sunday 23 July

73. At 4.11am, the communication room contacted Officer A. They asked for a welfare check on Ms Canning as they had received a call from Samaritans saying that she was going to kill herself. Officer B went to Ms Canning's cell. He observed a small amount of water on the floor and that Ms Canning was talking on the phone to Samaritans. She had socks tied loosely around her leg and arm. Ms Canning told him that Samaritans said he had to open her cell door and that she needed an ambulance. He explained that he was not able to open her cell. He informed a CM of the contact and agreed to continue monitoring Ms Canning as part of the ACCT process. There was nothing recorded in the ACCT regarding the contact from Samaritans or if any consideration was given to reviewing the ACCT or increasing the number of observations.

74. At 4.44am, the CM went to Ms Canning's cell. He recorded that she wanted him to enter her cell and remove the sock tied on her arm. He described the sock as being loose. He told her that he would not open the cell door for security reasons. Ms Canning told him that if he did not enter the cell, she would tie a ligature around her neck and jump off the top bunk of her bed to hurt herself. Ms Canning requested to see a Listener, but he noted that due to her unpredictable and non-compliant behaviour he would not authorise this to protect the Listener. He advised Ms Canning to contact Samaritans if she needed to talk. He submitted a referral to the mental health team and offered to provide Ms Canning with a distraction pack, which she declined.

75. At around 6.00am, Officer A responded to an emergency cell bell and found Ms Canning throwing bowls of water under the cell door. This behaviour continued while she was on the phone to Samaritans. The CM recorded that other prisoners were shouting at Ms Canning as they had not been able to sleep.

76. The CM submitted an intelligence report detailing that Ms Canning had continuously misused her cell bell and during the night had tried to manipulate staff into opening her door for non-emergency purposes. He noted that Ms Canning might be under threat from other prisoners on the wing, as she had kept them awake with her disruptive behaviour.

77. During the morning, an officer recorded that he spoke to Ms Canning about her poor behaviour since coming to Hewell. She told him that she wanted to move to Houseblock 5. He explained to Ms Canning that she was being placed on the basic IEP regime (the lowest level of the three-tier system designed to reward and encourage good behaviour in prisons which reduces access to things like in cell television, the prison shop and visits).

78. Another officer noted that Ms Canning had rung her cell bell most of the morning, that it was 'a nuisance' and that every time he spoke with her she verbally abused him. He noted that Ms Canning was too scared to leave her cell, because other prisoners were angry as she had kept them awake. She did not therefore collect her medication or any food.

79. Ms Canning continued to press her cell bell over the lunchtime period, and when officers answered the bell she accused them of harassing her.

80. In the afternoon, Ms Canning moved to Houseblock 5 (the vulnerable prisoners' unit). An officer and a CM escorted Ms Canning to her new (single) cell. At around 2.00pm, Ms Canning rang her cell bell. An officer responded, and she told him that she respected women but not men. He asked another officer and a CM to go with him to speak to Ms Canning to explain the use of the emergency cell bell. When the officer spoke to Ms Canning about the misuse of the cell bell, she became aggressive and spat in his face. He used force to restrain Ms Canning and applied handcuffs. Ms Canning quickly calmed down and, on the arrival of the CM, the cuffs were removed. Ms Canning was charged with a prison disciplinary offence.

81. Ms Canning later apologised to the officer for her behaviour and said she understood why she had been restrained, but that staff had been too rough with her. A prison paramedic assessed Ms Canning, noting mild bruising to her nose and wrists, but that no further medical attention was required.

82. During the afternoon Ms Canning left her cell to collect her medication and dinner. An officer noted that Ms Canning had agreed to a fresh start the following day. Nothing was noted in the ACCT in relation to the evening observations and conversations.

Monday 24 July

83. During the night, an officer recorded that Ms Canning saw a Listener and that she warned her on multiple occasions about misusing her cell bell. The officer also noted that, because of her behaviour, Ms Canning had received threats from other prisoners.

84. At around 6.30am, Ms Canning asked an officer if she could see a paramedic as she said she had passed out on the floor of the cell. There is no evidence that anyone from healthcare was informed.

85. During the day, staff noted that Ms Canning appeared to be in a good mood, raised no concerns and collected her medication and lunch.

Tuesday 25 July

86. During the night, an Operational Support Grade (OSG) noted that Ms Canning had not slept, had constantly rung her cell bell and had seen a Listener for around an hour. She said she told Ms Canning that pressing her cell bell constantly during the night and disrupting the wing would not help her to move off the basic IEP regime. Ms Canning said that she did not care.

87. In the morning, a worker from Inclusion attempted to meet Ms Canning for a mental health assessment. Ms Canning was attending her adjudication hearing for spitting at an officer, so the appointment did not go ahead. It was rebooked for 8 August.

88. During the adjudication hearing, Ms Canning apologised for spitting and did not dispute the evidence put to her. The adjudication was proven, but the case was adjourned for (unrecorded) further information. (Ms Canning died before the hearing was concluded.)

89. In the afternoon, an officer noted that Ms Canning had asked to see someone from the mental health team. She also asked about being on the basic regime and not having access to a television. Later, he noted that Ms Canning had been distressed due to a wing lockdown (for an unrelated matter), and again asked to speak with someone from mental health. He informed Ms Canning that she had an appointment booked for 8 August.

90. In the evening, an officer noted that Ms Canning had been settled. During the night, the OSG recorded that Ms Canning rang her cell bell for non-emergency reasons. She told the OSG she was ringing the bell for attention as she was a poor coper and did not like being locked in her cell. Ms Canning met Listeners at around 2.45am. The OSG had several conversations with Ms Canning and encouraged her not to misuse her cell bell as other prisoners would get frustrated. Ms Canning said she did not care and continued to misuse her cell bell throughout the night.

Wednesday 26 July

91. An officer noted that Ms Canning had rung her cell bell for most of the night, which had woken other prisoners. He also recorded that she had tied part of a jumper around her wrist out of frustration.

92. Another officer noted that Ms Canning had had a settled morning and had interacted well, collected her food, and raised no issues. Staff spoke to her again about misusing her emergency cell bell.

93. Later in the morning, Ms Canning complained of rib pain and attended healthcare. A nurse assessed her. Ms Canning told the nurse that she had been restrained several days earlier. The nurse noted no bruising and told Ms Canning to ask for pain killers, if required, from the medication hatch.

94. Ms Canning attended a transgender review board, which was chaired by the Head of Security. The Equalities Manager, the Safety Hub Manager and the keyworker also attended. It was noted that Ms Canning did not have a gender recognition certificate, but that she identified as a woman. Ms Canning said she might like to transition in the future but had no firm plans. The board recorded that Ms Canning did not have a

formal diagnosis of gender dysphoria. Ms Canning said she had little support outside of prison.

95. Ms Canning told the board that she had undiagnosed attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD) and depression. The board noted that they were 'not sure' of these diagnoses and that Ms Canning was to be seen by the mental health team on 8 August.

96. The Head of Security asked Ms Canning about her recent behaviour and that she was disrupting other prisoners by disturbing their sleep. Ms Canning said she felt safe and supported on Houseblock 5 and agreed that she would have a better relationship with other prisoners if she did not disturb them. Ms Canning acknowledged that she needed to be more considerate. The board noted that Ms Canning was on the basic regime and so did not have a television. They agreed that Ms Calloway would arrange for distraction packs, such as painting by numbers, to be provided to Ms Canning and she was told that she could apply for prison work. Arrangements were also made for Ms Canning to have access to a list of products available to female prisoners and that this would be arranged in time for her next order from the prison shop.

97. The keyworker later recorded that Ms Canning had had a 'really good afternoon', that she had been provided with fresh clothes, mopped her cell, been provided with a new in-cell phone (she had smashed hers during the night) and that a member of staff had supervised her while she shaved. Ms Canning also attended the library. She told the keyworker that she felt much better, appreciated what staff had done to support her and would try harder not to misuse her cell bell. Nothing was noted in the ACCT in relation to the evening observations and conversations.

98. Cell bell records show that Ms Canning did not use her cell bell between 10.00pm, when she asked for a toilet roll, and 7.12am on 27 July. An OSG noted that Ms Canning raised no concerns overnight.

Thursday 27 July

99. During the morning, an officer noted that Ms Canning was in good spirits, had spoken to the Probation Service via videolink, and returned in a good mood. She told him the meeting had gone well.

100. During the afternoon the officer noted that Ms Canning had been 'good' all afternoon and they discussed what behaviour had led to her being placed on the basic regime.

101. At 2.45pm, the acting SO chaired Ms Canning's ACCT review. A nurse also attended with Ms Canning. The SO noted that at first Ms Canning presented negatively. She said that earlier she had had a bad call with her solicitor who had told her that she might receive a custodial sentence, which Ms Canning said she was not expecting. The SO noted that Ms Canning was next due to appear in court on 4 August and he would schedule an ACCT review on 3 August, to assess Ms Canning's mood.

102. Ms Canning told the SO that she had thoughts of self-harm but did not intend to take her own life, as she did not want to hurt herself. The SO recorded that Ms Canning made use of the Samaritans for support, talked to officers and was being supported

by the substance misuse team and transgender board. The SO told Ms Canning that staff would look to return her television on Monday 31 July, dependant on her behaviour over the weekend.

103. The nurse recorded that Ms Canning asked for support for her alcohol use and was told that someone had been allocated to see her but had been unable to meet with her as she was attending her adjudication at the time. She noted that Ms Canning had said she had thoughts of self-harm, but when this was explored further, she reported that she no longer had these thoughts as talking about it had helped her. She noted that the review agreed that Ms Canning would find meaningful conversations more beneficial than observations. Observations remained at one every two hours during patrol state and meaningful conversations in the morning and afternoon.

104. In the evening, the keyworker noted that Ms Canning had been settled and had only rung her cell bell once.

105. At 8.30pm, an OSG recorded that Ms Canning had flooded her cell and was trying to put water in the cell electrics using her kettle. Staff temporarily switched off the electricity to the cell.

106. At 9.20pm, Ms Canning masturbated in front of staff and the OSG charged her with a prison disciplinary offence (the adjudication hearing was scheduled for 31 July). Ms Canning refused to put her clothes on. During the rest of the night, staff noted that Ms Canning constantly misused her cell bell and was threatening and abusive to staff. She said that she was doing it because she felt frustrated and was having nightmares. Staff also recorded that Ms Canning was loosely tying clothing around her neck and legs. The OSG observed that Ms Canning was breathing, talking, and moving as normal and there was no restriction to her airway. There is no evidence that the level of ACCT observations was reviewed.

107. Other prisoners on the wing shouted at Ms Canning to stop pressing the bell as they wanted to sleep.

Friday 28 July

108. During the morning, an officer recorded in Ms Canning's prison record that she had tried to speak with her, but that Ms Canning did not want to engage. She issued her with a negative entry as she had misused her emergency cell bell overnight.

109. At around 1.40pm the officer went to Ms Canning's cell and discovered her with two cleaning cloths tied around her legs, which she said would stop her circulation. Staff removed the cloths, and Ms Canning spoke to Samaritans.

110. Ms Canning was discussed as a complex case during the Safety Intervention Meeting. (SIM – a meeting to discuss managing risks to prisoners and the prison. It should be attended by heads of function, including safer custody, representatives from the offender management unit (OMU), and healthcare managers.) The Head of Safety and Equalities chaired the meeting, which was attended by two safety representatives, the Head of OMU, a member from OMU and a CM. There was no representative from healthcare present.

111. The Head of OMU told the SIM that she had previously managed Ms Canning in the community and that her behaviour in prison was similar. The safety hub manager noted that Ms Canning was impulsive and due to a shortage of Listeners on Houseblock 5, she was reliant on talking to Samaritans. Ms Canning had recently requested distraction materials, and she had been given some painting by numbers, which she enjoyed, but was on basic level of IEP. The CM told the SIM that Ms Canning continued to use her cell bell to get staff's attention and because she said she enjoyed talking.

112. Ms Canning had said that she hoped to be released from court. The Head of Safety & Equalities asked for staff to note Ms Canning's court date and to complete an immediate ACCT review should she not be released. During the meeting it was also noted that Ms Canning might benefit from being seen by the neuro-diversity manager.

113. Staff completed eleven ACCT observations between 2.50pm, and 11.00pm. (Although Ms Canning was not required to be observed this frequently, staff appeared to record ACCT observations at around the same time that they answered cell bells.)

114. At around 7.30pm, an officer noted in Ms Canning's ACCT that her behaviour was poor and that there was water on the floor of her cell.

115. At around 8.15pm, two OSGs started their night shift. They were responsible for Houseblocks 5 and 6. (OSG A was working her first set of nights. OSG B was more experienced having previously been a prison officer.) They were told by their colleagues that Ms Canning was not wearing trousers, had her penis out, and had threatened to make their night difficult.

116. Ms Canning repeatedly misused her emergency cell bell. Between 8.26pm and 11.09pm, she used it 26 times. The night staff answered most within a minute or two, and the longest to answer took five minutes. (Either OSGs sometimes answered the cell bells individually, and sometimes they went together.) Each time Ms Canning swore at them, and other prisoners began to get frustrated as their sleep was being disturbed. At 9.30pm, when OSG B answered the cell bell, she noted that Ms Canning was standing at her window with her legs open holding her penis. The OSG reminded her that her behaviour was inappropriate. Ms Canning said she was fed up and wanted sleeping tablets as she was worried about her sentencing hearing.

117. At around 10.30pm, OSG B said that Ms Canning continued to be verbally abusive to staff and continued to make sexually inappropriate comments. Around the same time, there was an unrelated medical emergency on Houseblock 5 which the operational manager for the night duty responded to. While he was on the houseblock he heard banging from Ms Canning's cell. The OSG told the manager that Ms Canning had been disruptive since the start of her shift and was constantly misusing her cell bell. He spoke to Ms Canning through the cell door. She did not engage in conversation and swore at him to go away. He told the OSG to record all poor behaviour in the observation book and charge Ms Canning with a disciplinary offence for exposing herself. He sent an email to The Head of Safety & Equalities, describing Ms Canning's behaviour as disruptive and asked whether a move to the Oak Unit should be considered. (Oak Unit is a small unit for prisoners who have severe mental health issues or complex social, emotional, and psychological needs.)

Saturday 29 July

118. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 29 July. She also obtained information from West Midlands Ambulance Service. Neither of the OSGs were wearing a BWVC, which meant Ms Canning's behaviour during the night was not captured. The following account has been taken from all sources.

119. Between 12.30am and 3.39am, Ms Canning pressed her emergency cell bell 34 times. The night staff answered most within a minute or two, and the longest to answer took five minutes. OSG B completed ACCT observations at 12.00am, 1.10am, 2.10am and 3.40am.

120. OSG B said that Ms Canning would often ring the cell bell as she and OSG A walked away and would then try and hide in the cell by lying flat on the top bunk of her bed, crouching in the corner, sitting behind the door, or down the side of the toilet. Ms Canning pretended to be hurt and asked for an ambulance or said she could not cope with the door being closed. OSG A said they knew these claims of being hurt were not genuine, as they stood outside the door for long periods listening and observing her behaviour. They explained to her that they were not able to open the cell door as the prison was in night state. CCTV footage confirms that they both attended the cell frequently and can be seen waiting outside the cell for periods of time.

121. At around 2.10am, Ms Canning used her kettle to pour water into the electrical sockets in the cell and the night staff saw her place her wet fingers on the socket. OSG B switched off the electricity to Ms Canning's cell for her safety, but she did not inform the night operational manager. Ms Canning then started to push water under the cell door onto the landing. Other prisoners who could hear what was happening continued to shout at her as they could not sleep. Ms Canning became angry and smashed her phone onto the floor and swore at staff to go away. OSG B said she continued trying to calm her.

122. Later, OSG B found Ms Canning with clothing loosely tied around her neck and a green cloth wrapped around her leg. (The time of this and some of the later events is not recorded and given the number of times that the night staff went to Ms Canning's cell it is not apparent from CCTV footage when exactly these particular events occurred.) She said there was no restriction to Ms Canning's breathing. They talked about her past, including Ms Canning's difficult childhood. Ms Canning refused to remove the clothing from around her neck, telling the OSG she liked the attention.

123. When OSG B answered the next cell bell, Ms Canning was sat on her side with the telephone cable around her neck and leg. The OSG asked her to remove it, but she refused. The OSG said that she could see the cable was tied loosely and there was no restriction to Ms Canning's airway. Ms Canning asked again for her door to be opened, but the OSG said that this was not possible.

124. OSG B said that when Ms Canning pressed her cell bell again she had removed the cable from around her neck, but still had it tied around her leg. She said she wanted to cut off the circulation in her leg. When she encouraged her to remove the cable, Ms Canning swore at her and told her to go away.

125. At around 4.00am, OSG B answered Ms Canning's cell bell. Ms Canning swore at her and told her to go away. She said she stood outside for around ten minutes and could hear Ms Canning moving around and could hear that there was water on the floor. She said she then left Ms Canning's cell to complete ACCT observations on other prisoners.

126. At around 4.28am, both OSGs went to check on Ms Canning, as she had been quiet for around 15 minutes. CCTV shows that OSG B used her torch to look in the cell. She saw Ms Canning lying on the floor by the side of the toilet. She knocked on the door but got no response. She said that she believed that Ms Canning was pretending to be injured as she had done earlier in the night. She radioed the night operational manager and asked him to attend. (She did not say that they could see anything tied around Ms Canning's neck.)

127. A 4.35am, the operational manager arrived on the houseblock and switched the electricity back on. He looked into Ms Canning's cell and, when he received no response, he opened the door. He discovered Ms Canning was not breathing with the telephone cable and a jumper wrapped around her neck. He radioed a code blue medical emergency (used when a prisoner is unconscious or has breathing difficulties) and the control room operator called an ambulance immediately. He cut the cable around Ms Canning's neck and started cardiopulmonary resuscitation (CPR). He said that both the cable and a jumper were loosely tied around Ms Canning's neck.

128. At 4.37am, the officers applied a defibrillator, which advised there was no shockable rhythm and to continue chest compressions.

129. At around 4.44am, the emergency response nurse and an HCA arrived. The nurse struggled to find the correct attachments for the oxygen cylinder, but resuscitation efforts continued. At 4.53am, an oxygen mask was placed on Ms Canning. At 5.15am, paramedics arrived and took over. At 5.33am, they confirmed that Ms Canning had died.

Contact with Ms Canning's family

130. Hewell appointed a family liaison officer and a deputy. On the morning of 29 July, they travelled to Ms Canning's husband's home to break the news of her death. They offered their condolences and ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Ms Canning's funeral, which was held on 29 August.

Support for prisoners and staff

131. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

132. Postvention procedures were not fully implemented. After Ms Canning's death, the duty governor held a debrief for prison staff involved in the emergency response. The staff care team and trauma risk management (TRiM) were also made available to them. Healthcare staff did not attend a debrief and described that they did not feel supported.

133. The prison posted notices informing prisoners of Ms Canning'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 Ms Canning's death.

Post-mortem report

134. The post-mortem report concluded that Ms Canning's death was due to hanging. Toxicology results showed only prescribed medication at levels consistent with the prescribed dosage.

Findings

Assessment of risk of suicide and self-harm

135. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), contains requirements for staff using ACCT procedures. Staff are required to use ACCT when they identify that a prisoner is at risk of suicide and self-harm, based on identified risk factors and triggers. The PSI says that ACCT case reviews should be multidisciplinary where possible, that a support plan should be completed at the first review, and that it must reflect the prisoner's needs, level of risk and the triggers of their distress. Support actions must be tailored to meet the individual needs of the prisoner, be aimed at reducing the prisoner's risk to themselves and be time-bound.

136. Ms Canning was monitored using ACCT procedures from 15 July, when she arrived at Hewell, until her death on 29 July.

137. It is clear that Ms Canning presented considerable management challenges in her fortnight at Hewell. She had a history of mental ill health and substance misuse. She was transgender. She had a history of self-harm in the community and in previous prison sentences, including by methods with a high chance of lethality, such as self-strangulation. She had said that she would kill herself if she was remanded to prison in relation to her most recent charges.

138. Additionally, she repeatedly and inappropriately used her cell bell, damaged items in her cell, was rude and inappropriate with staff and disturbed prisoners around her to the extent that she made herself more vulnerable to assault. Undoubtedly, a great deal of limited staff resource went into the day to day management of her behaviour. Staff noted that Ms Canning responded well to staff attention and benefited from discussing her concerns with staff.

139. In the context of her challenging and resource-intensive presentation, we found that the ACCT procedures did not provide the overarching strategy, clear for all staff to follow, to support Ms Canning's various needs, challenges and vulnerabilities.

Support actions

140. PSI 64/2011 states that during case reviews, the case review team must set and review support actions to mitigate risk. Support actions were agreed during the first two case reviews but were not updated at subsequent reviews. There was no support action specifically relating to Ms Canning's mental health, despite a history of stress and anxiety being identified during the ACCT assessment. Support actions could also have been set to address Ms Canning's frequent use of cell bells and concerns she raised about her medication and its impact on her sleep, and her impending court appearance.

141. We note that, over the two weeks, different staff from different disciplines proposed other support actions that did or might have helped Ms Canning. This included the suggestion that she might be suitable for Oak Unit, the provision of distraction activities to compensate for her not having a television in her cell and the suggestion that she might benefit from referral to the neurodiversity nurse. These were the

holistic and creative suggestions that an effective and well-managed multi-disciplinary ACCT process should have come up with.

Assessing risk and setting ACCT observations

142. Case review teams are required to set appropriate levels of observations and conversations. PSI 64/2011 also says that an urgent case review should take place as soon as possible if risk is likely to have increased, including when there is a change in behaviour that causes concern.

143. When ACCT procedures were begun in reception on 15 July, the CM set observation levels at once every two hours. At each following case review, the frequency of observations was never more frequent than that despite fluctuations in her mood, statements and behaviours (although we note that, at times, staff were essentially checking on Ms Canning more frequently than required, for example when responding to her persistent use of the cell bell). We did not find sufficient evidence that observations were set at appropriate levels or demonstrated a considered assessment of Ms Canning's risk. While staff felt that Ms Canning would benefit more from conversations (which, as we note later, did not always take place) these should be conducted alongside, rather than instead of, observations.

144. We found little evidence in the ACCT documentation that staff reviewed Ms Canning's risk factors or considered signs that her risk might be escalating or changing (such as anxiety about her impending court appearance). Other than on 20 July, there was no urgent case review when Ms Canning engaged in self-harming behaviour or other behaviour that might indicate increased risk.

Completing observations and conversations

145. PSI 64/2011 instructs that ACCT observations and conversations must be carried out in line with levels set by case review teams. It states that conversations, and written summaries of these, must be meaningful.

146. While we saw evidence that various staff had spent time trying to respond to Ms Canning's needs, address her challenging behaviour and provide reassurance, her ACCT record contained little evidence that meaningful conversations were carried out in line with the level set. On some days the only entries were brief comments on her behaviour or engagement with the regime. Meaningful conversations are important for all prisoners monitored under ACCT procedures, but were particularly so for Ms Canning, who had indicated that talking to staff helped to reduce her risk.

147. Observations were often at routine and at predictable times or not recorded at all. Supervisor checks, which should quality assure the ACCT document and verify that expected observations and conversations have been carried out, were not always completed.

Conclusion

148. Ms Canning was difficult to manage. There was a clear need for robust and supportive leadership from senior managers to junior staff on how best to safely manage Ms Canning's risk to herself and to others. There was no consistent strategy for staff to follow which meant that the staff response to her challenging behaviour

was inconsistent, and sometimes punitive, which left them and Ms Canning vulnerable.

149. We found that the overall ACCT management was not sufficiently robust. HMIP and the IMB, in their most recent reports, also identified areas for improvement in ACCT procedures. We make the following recommendation:

The Governor should review the quality and compliance with policy of ACCT management in the previous 12 months, identify any improvements required, and devise a plan to deliver those improvements.

Healthcare input into risk management

150. The clinical reviewer found that there was a missed opportunity to engage Ms Canning in conversation about her future risk of suicide and self-harm when she met a support worker on 20 July, after a ligature attempt that morning. There was no evidence that Ms Canning was asked about having any current thoughts of harming herself. There was another missed opportunity on 21 July, when Ms Canning met with HCA Poolman and said that staff had cut a ligature from her that morning. While there is no other evidence that these events occurred as Ms Canning described, the HCA indicated that this would be escalated to the duty response nurse, but there is no evidence in her medical record that Ms Canning was discussed or if there was a plan about her care and support seeking behaviours.

Management of Ms Canning on 28/29 July

151. Both OSGs acted with compassion and professionalism towards Ms Canning on the night that she died, in difficult circumstances. They were subject to verbal abuse from her for much of the night, and other provocative behaviour, some of which was sexually explicit. They continued to respond quickly to her many cell bells. When Ms Canning became quiet, they might easily have assumed that she had now settled for the night. Instead, they checked her and identified the emergency earlier than might otherwise have been the case.

152. Management of challenging behaviour during the night is particularly difficult given the strictures on opening cells and the fewer staff on duty. The night operational manager said that staffing levels had been impacted by other significant events that night (a prisoner was taken out to hospital and another prisoner was monitored on constant supervision requiring staff to be positioned outside his cell at all times). He said that he did not assess that Ms Canning's behaviour was problematic enough to justify sending over the only spare officer to support the OSGs or consider moving Ms Canning to a different location. He did not consider increasing ACCT observations because he said he knew staff were checking on Ms Canning frequently in response to the emergency cell bells. He did not consider that Ms Canning's risk of suicide or self-harm had increased because she continued to use her cell bell.

153. However, other than his conversation with the OSGs (one of whom was experienced, the other of whom was on her first set of night duties) at the beginning of the evening, the night operational manager did not visit the houseblock again until Ms Canning was found unresponsive. We consider that he could have provided the OSGs with any better support and guidance on how best to manage Ms Canning

overnight. We make no recommendation, but the Governor may wish to consider whether there is any learning.

Clinical care

154. The clinical reviewer found that the care Ms Canning received was not equivalent to that she would expect to receive in the community. The clinical reviewer made a number of recommendations that are not directly relevant to Ms Canning's death but should be actioned by the Head of Healthcare.

Mental health

155. When Ms Canning arrived at Hewell she was already experiencing poor mental health. She told staff that she was concerned that she may receive a custodial sentence, and that she believed her relationship had broken down, which further impacted on her anxiety and increased her risk of suicide and self-harm. Ms Canning was referred on reception for a mental health assessment and was triaged the next day. This identified that Ms Canning should be assessed by the mental health and substance misuse team (Inclusion) because of her complex needs. We note that a representative from Inclusion attended ACCT reviews, but no formal mental health assessment was carried out.

156. Inclusion tried to see Ms Canning on 25 July (one day over the seven-day target for referrals), but she was at an adjudication hearing. The appointment was rebooked, but the new appointment was not for two weeks.

157. The clinical reviewer found that there should have been a more proactive response to providing Ms Canning with mental health support. She concluded that this lack of recognition and consideration of Ms Canning's risks at the point of arranging a new appointment fell below the standard reasonably expected. The clinical reviewer also found that it would have been appropriate to consider a referral to Oak Unit sooner.

158. We also found no evidence that Ms Canning was considered for the Targeted Care Pathway (TCP) at Hewell, which has two mental health nurses available, seven days a week. The TCP is for people who have been deemed to require increased mental health support due to their needs and are seen for daily reviews. The mental health team manager explained that prisoners referred to the TCP required an increased level of mental health input that the core mental health services are unable to provide. The clinical reviewer concluded that it was difficult to say whether Ms Canning should have been under the care of the TCP, because while core mental health services may have supported her sufficiently, she was not assessed by Inclusion as she should have been.

159. We make the following recommendation:

The Head of Healthcare should ensure that prisoners who present with persistent and challenging behaviours are assessed according to their level of risk and need, with consideration given to their most suitable location.

Emergency Response

160. PSI 03/2013, Medical Emergency Response Codes, sets out the actions that staff should take in a medical emergency. It contains mandatory instructions for Governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately.

161. PSI 24/2011, Management and Security at Nights, contains instructions for staff on entering cells at night. When the OSGs discovered Ms Canning unresponsive on the floor of her cell, they did not immediately enter because of her behaviour earlier that night. They did not see the ligature until the door was opened. We found the decision not to enter the cell immediately to be reasonable.

162. Staff called a medical emergency code at 4.35am. Although Houseblock 5 is only around 400 meters away from the healthcare centre, it took the response nurses around nine minutes to arrive. The night operational manager said that he sent another message over the radio to advise healthcare staff that CPR was in progress as he thought they were taking too long to respond. A healthcare manager told us that she asked the response nurse and HCA why it took that length of time to reach Ms Canning's cell, but neither could account for this.

163. Ms Canning had flooded her cell, but staff did not consider moving her to the landing, which was dry, before attaching the defibrillator. This would also have given them more space to perform CPR.

164. When healthcare staff arrived, it took around nine minutes before oxygen was given to Ms Canning, a total of 18 minutes after the emergency was first radioed. BWVC footage shows that the communication between prison and healthcare staff was limited and there were delays finding the correct breathing mask. (The HCA told us that she was unsure what she was looking for.) The clinical reviewer was not able to conclude if these delays would have impacted Ms Canning's chances of survival, but that prioritising good quality chest compressions and use of a defibrillator were essential to the chances of survival. We make the following recommendation:

    The Head of Healthcare should ensure that all emergency response staff attend medical emergency codes immediately.

165. The HCA confirmed that she was Immediate Life Support (ILS) trained yet did not take an active role in the resuscitation efforts. The clinical reviewer found that prison staff provided good CPR, but the overall quality of the CPR by healthcare staff was poor.

166. We escalated the concerns regarding the quality of the CPR to a healthcare manager. We asked her to review the footage and respond. We were informed that PPG, Hewell's healthcare provider, were also going to review the emergency response and gave assurances that they will provide the appropriate additional support identified to healthcare staff involved and to all staff who are required to respond to an emergency. Given the response, we do not make a recommendation.

Body Worn Video Cameras

167. PSI 04/2017, Body Worn Video Cameras (BWVC), requires prison staff to use BWVCs during any reportable incident, including medical emergencies. It requires staff to start recording at the earliest opportunity, to maximise the material captured by the camera. BWVC's are an important source of evidence for PPO investigations, and wider learning for prisons following an incident.

168. Body worn video cameras were not worn by all staff, including the OSGs working on Houseblock 5 where Ms Canning lived. Therefore, events during the evening where she was being verbally abusive to staff, or acting inappropriately, were not captured, nor was the staff response. The HMPPS Early Learning Review after Ms Canning's death identified that that night staff should wear BWVC and record reportable incidents. In light of this, we do not make a recommendation, but the Governor will want to take appropriate action.

Governor to Note

Induction Unit

169. Hewell has a mixed induction unit, housing both standard prisoners and those deemed to be vulnerable, whether that is due to the nature of their offence or because they are deemed at risk for other reasons in the general population. We have identified in previous investigations that vulnerable prisoners have been subject to abuse when located with non-vulnerable prisoners but are not able to move to the vulnerable prisoner unit due to the lack of space. The Governor will wish to consider the learning from this case.

Head of Healthcare to Note

Alcohol detoxification management

170. When Ms Canning arrived at Hewell, she was prescribed an alcohol detoxification regime. Despite being on an alcohol withdrawal regime, Ms Canning was not assessed by a member of the substance misuse team on her arrival. While withdrawal observations were conducted on the day she arrived, no further clinical observations were completed. The clinical reviewer made a recommendation about this that the Head of Healthcare will wish to consider.

Suicide and self-harm awareness (ACCT) training

171. During the investigation we found that not all healthcare staff had received suicide and self-harm awareness (ACCT) training. This is mandatory training for all staff in contact with prisoners.

Prescribed medication

172. Ms Canning was prescribed diazepam, which was dispensed between 4.00pm and 5.00pm. She said that she would fall asleep quickly after taking the medication, but then be awake during the night. In the community, Ms Canning took her medication at around 10.00pm. The typical regime at Hewell is for medication to be dispensed at around 6.00pm (5.15pm at weekends). It was not clear why Ms Canning was given

her medication earlier, but it may have been because staff had to sequence when prisoners were unlocked for medication, taking into account her vulnerable status. The Head of Healthcare will wish to consider how medications that affect sleep are dispensed to prisoners.

Healthcare attendance at the Safety Intervention meeting

173. Ms Canning was identified as a complex case and discussed at the SIM on 28 July. However, there was no representative from healthcare at the meeting. We were told that the Interim Head of Healthcare and Team Leaders would attend the SIM, if resource allowed them to go. If healthcare staff had attended the SIM, it would have been an opportunity to identify that Ms Canning required timely mental health support.

174. On 11 September 2023, a Mental Health Team Leader was appointed, who attends the weekly SIM.

Postvention support

175. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

176. We found that the postvention approach was not followed. Prison staff said they felt well supported. However, healthcare staff who attended the medical emergency said that they did not attend a debrief and were not supported afterwards. It is unclear why they were unable to attend a debrief, but this is an important step in ensuring that staff are signposted to relevant support services. The Head of Healthcare will want to consider this.

PPO investigation

177. The HCA is a member of agency staff who does not work permanently at Hewell. We contacted her during the investigation, but she did not respond to emails inviting her to be interviewed and the Head of Healthcare could not provide any further contact details. We encourage the Head of Healthcare to ensure that they have full contact details for all staff, including agency staff, who had significant contact with a prisoner that has died, to assist with any investigations.

Inquest

178. The inquest into Ms Canning's death concluded in April 2025. The inquest found that Ms Canning's death was misadventure - asphyxiation and use of ligature.

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