Investigation into the circumstances surrounding the death of a prisoner at HMP Channings Wood, at Torbay Hospital on 13 April 2006

Report by the Prisons and Probation Ombudsman for England and Wales

January 2007

This is the report of an investigation into the death of a man who died whilst a prisoner at HMP Channings Wood. On the morning of 12 April 2006, the man was found hanging in his cell at Channings Wood. Staff resuscitated him and he was transferred to Torbay Hospital. Sadly, he never regained consciousness and the following day he died whilst his family were with him. The man was 30 years old.

I offer my sincere sympathy and condolences to the man's family and friends for their loss.

The investigation was carried out by two of my investigators. One of my Family Liaison Officers kept in touch with family members. I am grateful to the Governor of Channings Wood and to the principal officer who acted as liaison officer for their assistance during the investigation.

The man had spent many years addicted to a variety of drugs and had been in prison several times. By all accounts, he was a sensitive and thoughtful person who had tried to break free of the cycle of drugs and imprisonment. He had successfully applied for a place on Channings Wood's drugs therapeutic community, but could not meet its rigorous standards. He completed the first phase of the programme, but left after spending only two weeks in the second stage. He made several alternative plans for his future. He died just over a month after coming off the programme.

I make five recommendations in this report. These concern the cell furniture, the response to the emergency and informing the family about the possibility of media interest. I am pleased to highlight three examples of good practice as well. These relate to the prison's reports about the man, and their contact with his family.

Most of the apparently self-inflicted deaths in prison upon which I report occur in overcrowded local prisons. The death of this man demonstrates the importance of the safer custody agenda across the prison estate.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2007**

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SUMMARY

The man died on 13 April 2006 in Torbay Hospital.

The man had been a drug user for most of his teenage years and all his adult life, in spite of repeated efforts to break his addictions. He served a number of terms of imprisonment for offences committed to fund his drug habit.

In October 2005, the man recognised that his drug use was out of control, and that he had resumed offending. He surrendered himself to the police and was remanded in custody to HMP Dorchester. He was convicted on 27 October and transferred to HMP Exeter to await sentencing. On 30 November, he was sentenced to five years imprisonment. He was transferred to Channings Wood on 16 December, and immediately asked to be moved to HMP Guys Marsh in order to do a drugs course.

However, as part of his induction at Channings Wood, the man attended a presentation about the drugs therapeutic community located in the prison. He visited the community and learnt that the course was intensive and demanding, and lasted a minimum of 12 months. He applied for a place and was accepted. He began the programme on 28 December, and his aim was to end the pattern of drugs and prison that had filled his adult years. He completed the Induction phase on 22 February 2006 and moved into Orientation, but struggled to meet the standards, particularly being punctual and told what to do by other prisoners. After two weeks, the man decided to leave the community, saying that the pressures were too great. For the first 48 hours, staff and residents tried to persuade him to remain in the programme, but he was adamant that he was leaving.

Two weeks later, the man moved to another part of the prison, and then to a single cell where he appeared to settle in well. He met his drugs worker and was keen to focus on education as a means of turning his life around. He also felt that he needed some direction in his life, and the drugs worker suggested he speak to a chaplain. Three days later, the man told the doctor that he was sleeping poorly and was depressed, for which anti-depressants were prescribed. He attended a church service and spoke to the chaplain who told him about an Alpha course that was about to start.

On Wednesday 12 April, the man was unlocked as usual at 8:00am, collected his breakfast and took it back to his cell. He then returned to the ground floor to telephone his girlfriend. Although he spent 15 minutes on the telephone, he was unable to speak to her and returned to his cell. Half an hour later an officer gave him a slip to attend the gym that morning, which he took without speaking. At 9:00am, the same officer returned to the cell and saw him hanging from the leg of his upturned bed. She radioed for assistance and lifted his body to take the pressure off the ligature. Other staff responded quickly to the alarm, and held him until ligature scissors were located and used to cut him down.

Healthcare staff, aided by officers with first aid training began to administer cardio pulmonary resuscitation (CPR). After ten minutes, they detected a faint pulse which grew a little stronger. They continued until the paramedics arrived, by which time the man was breathing, although he was unconscious. He was taken to Torbay Hospital

where he was given an x-ray and a CT scan. He remained unconscious and was put on a ventilator to assist his breathing. His parents and girlfriend arrived, and the following day the consultant spoke to them. They decided to turn off the ventilator that afternoon, after which they remained with him until he died at 2.25pm.

THE INVESTIGATION PROCESS

1. The man died on 13 April but, because of the Easter break, my office did not appoint investigators until five days later. The investigation was formally opened on 21 April when my investigators visited Channings Wood. They met the Governing Governor, a member of the Independent Monitoring Board and a committee member of the Prison Officers' Association. They saw the man's cell on Living Block (LB) 3 and were given copies of his records. During the investigation, my investigators received full co-operation from all staff and prisoners.

2. My investigators returned to Channings Wood from 23 and 26 May to interview staff and prisoners. They also had a brief tour of the therapeutic community, which is the drug treatment programme where the man spent three months. At the end of the week, they met with the Governor to report their findings. They returned on 21 and 22 June to spend a day in the therapeutic community, interviewing staff and residents there and in the main prison.

3. One of my Family Liaison Officers contacted the man's parents and arranged to visit them with the investigator. His parents asked for information about the telephone call the man made shortly before he hanged himself, and for details of the therapeutic community. The man had referred to it as a course, and told his father that it was more intense than anything he had done before. I hope that my description of the community helps to explain his statement.

4. My investigators contacted the chief executive of the Teignbridge Primary Care Trust (PCT) to request that they undertake a clinical review of the treatment the man received in prison. The review was completed very promptly by the Director of Professional Practice, and I am most grateful for her assistance.

5. **The man**

5. The man was born in January 1976. He grew up in Dorset with his adoptive parents, and a younger adopted sister. In his teens, he was diagnosed as having bi-polar disorder, but later the diagnosis was changed to a personality disorder. When he was 14 years old, he began to use cannabis. By 16, he was taking LSD and amphetamines. One report states that at 16 he suffered an episode of drug induced psychosis. He left school with some qualifications and wanted to join the army, but by 18 was using heroin and committing offences to fund his addiction. When he was 18, his sister died from natural causes. This had a profound and lasting effect on him. He later claimed that he did not receive bereavement counselling, and felt isolated from his parents. However, his parents told my investigator that he was offered counselling but refused it. In response to his sister's death, he took as many drugs as he could, and consequently experienced further episodes of psychosis. According to his parents, his behaviour was bizarre, and he was difficult to manage and prone to spontaneous mood swings. The man told the Probation Service that his parents found it difficult to understand and cope with his drug addiction.

6. Eventually the man left home. However, at the time of his death his parents visited whenever they could and frequently exchanged letters with him. He was also supported by his girlfriend. According to his probation report it was his hope that they could eventually settle down together.

7. In August 2002, the man was given a three year custodial sentence for his failure to comply with a drug treatment programme. When he was released, he began to abuse drugs again, spending approximately £40-£50 per day on heroin and amphetamines, and selling personal items to fund his habit. The probation records state that he felt that his habit was spiralling out of control, and he was getting into more trouble. The man completed some drug courses whilst in prison, notably the Short Duration Drug Programme and the longer Prison Addressing Substance Related Offending.

8. The man handed himself into the police in February 2005, in order to receive support in addressing his drug misuse. Three months later, he appeared at Dorchester Crown Court and was sentenced to a Community Rehabilitation Order of 18 months, and an Addressing Substance Related Behaviour Order, with a six months Drug Treatment and Testing Order. However, shortly afterwards, he breached the conditions of the Orders, and a Crown Court warrant was issued for his arrest. In August, he appeared in court again, and was fined for theft and trespass. His probation officer reminded him of the outstanding warrants, and advised him to surrender to police but he failed to do so at that time.

9. In an interview with the Probation Service, the man described himself as a social misfit. To residents in the therapeutic community, he referred to himself as a hippy. He was variously described to my investigators as a deep thinker, an intellectual and a person with a lot of thoughts in his head. He wrote poetry, some of which was published in an anthology, and was a keen and talented artist.

HMP CHANNINGS WOOD

10. Channings Wood is a Category C training prison, built on the site of a former Ministry of Defence base, and officially opened in July 1974. A building programme took place in the 1980s and early 1990s, adding further accommodation. The operational capacity is 667 men, serving a wide range of sentences. The prison contains a specialist therapeutic community for tackling drug abuse.

The drugs therapeutic community

11. The therapeutic community opened in November 1997. It is a partnership between the Prison Service and Phoenix House, a national charity providing specialist treatment services for drug and alcohol users. The community offers an intensive, structured programme for prisoners who abuse drugs. It is housed in one of the prison's living blocks, and currently has space for 65 men, although when the man was there the capacity was 90. It is staffed by prison officers and drugs workers, all of whom have had specialist training.

12. The approach of the community is that, rather than drug dependency being seen as a medical, psychological or social problem, it is viewed as symptomatic of deep rooted problems within the person. Treatment is holistic and not limited to the drug dependency, with the focus on helping men develop an insight into their behaviour and emotions, and how it relates to their offending. The aim of the programme is to understand their thinking and behaviour, so they take positive steps to resolve problems rather than take drugs to mask them.

13. The community's information booklet sums up the process as:

> "Learning to be flexible and in control of feelings and behaviour. The resident gradually becomes aware of their behaviour and learns to control it through a wide range of situations, which mirror everyday experience. As self-control is demonstrated, more responsibility and status is given, and new skills (for most residents) of authority and responsibility for others are learned."

14. The programme differs from other drug treatment courses the man had undertaken in its length and intensity. Other courses consist of several sessions a week for a period of up to six weeks, during which the prisoner lives on a normal wing and participates in the standard prison regime. Here, the residents live in the community 24 hours a day, 365 days a year and the programme lasts a minimum of 12 months. It is designed to provide a safe environment with a highly structured daily routine, and demands a very high standard of behaviour from the residents in every activity all the time.

15. Prisoners who wish to take part in the programme have to complete a set of application forms, giving a great deal of personal information, including their drug use, personal history, reasons for wanting to join the community and possible obstacles to their successfully completing the programme. Other relevant information is provided by Counselling Assessment Referral Advice Throughcare (CARAT) drug workers, the healthcare and security departments.

16. There are three phases to the programme, Induction/Orientation lasting three to four months, Primary which lasts for six to nine months and Pre-entry for three months. Residents move at their own pace and must achieve individually set goals before moving to the next stage.

17. The community has a hierarchical structure and there is a social contract that prescribes very high standards of behaviour in every aspect of life. There is a formal process whereby residents receive positive feedback from other residents and staff. This is delivered publicly at each morning's meeting. If behaviour falls below the standard, other residents are expected to challenge him, first informally and then more formally if the behaviour persists. Challenges come in three forms:
    - Negative Pull-ups when a resident is challenged about his behaviour, the reason for the challenge is explained, accepted and action is taken;
    - Sanction, which is more formal and may involve the resident writing an essay to explain why his behaviour was not acceptable; and
    - Encounter when the resident is confronted by his peers in a group setting, the reasons are explored and support and advice is offered to the resident who is encouraged to commit to change.

18. The community offers a varied and high level of support for residents. Each resident has regular meetings with a personal officer to assist with prison related issues, and a key worker to focus on treatment related matters. The key worker sets a care plan and jointly reviews progress. Each resident also chooses two or three other residents to form his Peer Support Group (PSG), which meets once a week. During the Induction stage, new members are allocated a resident to be their Buddy, and they meet three times a week to discuss any problems.

19. The residents' day is tightly scheduled and includes two meetings and a seminar daily, and an encounter group three times a week. Residents in the Induction/Orientation phase spend the rest of the time in education and group work, learning about the concepts that underpin the programme. Residents in the Primary stage work in the community, and Pre-entry residents have community responsibilities and also work outside the wing.

20. As residents progress through the programme, they are given positions of increasing responsibility within the community. An important role is to be responsible for a group of residents at an earlier stage of the programme. Each phase has a resident nominated as the Department Head, with several team leaders. The whole programme has a resident Chief Co-ordinator, responsible for the day to day running of the Community. The posts holders are selected by interviews with staff and senior residents.

21. Residents leave the community before completing the programme if they break the rules of no violence, threats of violence, drugs or alcohol and sexual or racial harassment of staff. Also a resident may ask to come off the programme, which is known as taking off their badge, and is given 48 hours to consider their decision. During this time, a member of staff will offer support as will other residents. Residents may remain on the same wing, elect to return to the main

wings, or are moved as a result of operational requirements. Prisoners who subsequently wish to rejoin the community, may apply again.

KEY FINDINGS

HMP Dorchester and Exeter

22. On 12 October, the man surrendered himself to the police, as he had done in the past. He was charged with breach of his Drug Treatment and Testing Order, two counts of burglary and two of theft. On 13 October, he was remanded into custody at HMP Dorchester. As part of the reception process, a nurse completed a First Reception Health Screen form. A note was made that he needed metal work removing from the lower area of his spine. He told the nurse that he used heroin and amphetamines weekly, and took some drugs intravenously. The man also disclosed that he had seen a psychiatrist in 2000 for drug-induced psychosis (a psychiatric disorder with impaired functioning which grossly interferes with the capacity to cope with everyday life). He had been prescribed Flupenthixol Decanoate medication to treat psychoses and related disorders.

23. When the man was asked whether he had ever tried to harm himself, he confirmed that he had done so, both in prison and whilst out, most recently in the 1990s when he had cut his arms. However, he said that he did not currently feel like harming himself, and he was coherent and made good eye contact with the nurse. He told another member of staff that he did not have a fixed address, and it was noted that this would be referred to the Resettlement Department.

24. On 27 October, the man was convicted at Taunton Crown Court and was remanded to HMP Exeter. During the reception health check it was again noted that he needed metal work removing from his back, as should have happened in 2003. An appointment with the prison doctor was requested. The following day, he had a Resettlement interview during which he said that he was expecting a sentence of a couple of years. He was also seen by a drugs worker and they discussed different strategies to address his drug use, depending on his sentence. The man told the drug worker that he was not using drugs, but that it was a struggle.

25. Four days later, on 1 November, the man went to the healthcare centre complaining of a rash under his arms and in his groin. He said that he had suffered from the rash for about 18 months and that, while steroid cream made it worse, E45 cream helped. Previous doctors had prescribed steroid and anti-fungal creams and antibiotics. The prison doctor decided to refer the man to a dermatologist, and three days later she also contacted the surgeon who had operated on his back. He confirmed that the man needed the metal work removed and said that the waiting list was currently six months.

26. On 10 November, an officer noted that the man spent all his time in his cell and seemed to have no interest in working. He described him as having a bad attitude to staff and other prisoners. At the end of November, the man was sentenced to five years imprisonment at Taunton Crown Court for burglary. The Prison Escort Risk (PER) form from the court recorded that he had harmed himself while in prison previously, and also tried to hang himself whilst in police custody. The PER form was accompanied by a Prisoner Warning Notice: Possible Risk of Self-Harm or Suicide, completed after he was sentenced. This

noted that the man's mental health might need monitoring if he received a long custodial sentence.

27. The man returned to Exeter where a Further Reception Health Checks form was completed. His sentence was noted, and the man was recorded as saying that it was okay and he could deal with it. There is no record of any further action being taken about the warning notice. It was filed in his core record, which was held in the Discipline Office and not on the wing. The man started to attend Education, and an officer noted that his attitude had improved and he had no problems. However on 3 December, it was suspected that he was involved with drugs in the prison. No specific action was taken against him, as staff were on heightened alert in the run-up to Christmas.

The first week at Channings Wood

28. On 16 December, the man transferred to Channings Wood. The PER form said that he was at risk because of alcohol and drug issues. It did not mention any concerns about self harm and did not refer to the Prisoner Warning Notice from the Crown Court. When the man transferred to Channings Wood the PER form from Taunton Crown Court was still in his core file which went with him. However, because it was filed away, wing staff were not aware of the warning. It would be helpful if staff in the Discipline Office could check the files of newly arrived prisoners for warnings such as that on the man's PER form. However, after his return to prison from the Crown Court, the man did and said nothing to lead staff to believe he was contemplating harming himself.

29. The man told staff at Channings Wood that he was happy to be there, but he also said that he would like to be transferred to HMP Guys Marsh for a drugs course. (During a previous prison sentence, he had completed a Prison Addressing Substance Relating Offending programme (PASRO) at HMP Dartmoor. Using the lessons he had learned on the course, on release, he had remained drug-free for many months.) He was told to make a transfer application. The health screen noted that he still needed hospital appointments for both the rash and the metal work in his back.

30. The man was allocated to Living Block 4 in order to go through the induction process, which included a presentation about the therapeutic community which he expressed an interest in visiting. On 21 December, a principal officer interviewed the man, and described him as confused and not knowing what he wanted. He went to the community and was able to talk to some of the residents. He was impressed by what he saw, especially the artwork displayed on the walls. On 27 December, whilst applying for a place in the community, he moved to Living Block 1 where it is located. It was noted that he was happy to be there and anxious to address his drug problem. Two days later, he was told that the hospital appointments for his skin and back had been asked for.

The Induction phase of the therapeutic community

31. The man completed the application forms on 28 December and signed the resident's compact the same day. One sheet enquired about drug use, listed 12

different types and asked which ones he used and how frequently. The man said that he used all of them, except prescribed methadone, and he occasionally used magic mushrooms. He said that he had not used drugs during the previous four weeks in prison, which was confirmed by a voluntary drug test. He said that he first experimented with drugs at 14 when he used cannabis. By the time of his arrest, he used £100 worth of drugs per day. When asked to describe himself, the man wrote that he was just another prisoner. He said that he was ready to address his substance use and offending behaviour as he felt ready to accept change and find a better way of life that did not hurt anybody including himself. He gave a somewhat muted answer when asked what he hoped to achieve in the therapeutic community. He said that he was uncertain, but would like to be ready to live a full, drug-free life. He hoped that nothing could prevent him from achieving his goal and finished the forms by saying that he was desperate to change the pattern of drugs and prison that he had been caught up in.

32. The therapeutic community programme generates a number of reports on residents, many of which were completed by residents in positions of responsibility. Their informative, helpful and supportive entries are impressive and were most useful in the drafting of this report.

The Governor and Treatment Manager should commend the residents for the high standard of their reports.

33. The reports show how the man struggled to adjust to the demanding programme in the community. As early as week two, the landing representative noted that he found it hard to deal with other residents pointing out his failure to keep the rules. His buddy wrote that it was a tense week as the man had begun to identify issues which he needed to deal with.

34. On 19 January, the man and his key worker drew up his Individual Treatment Plan and identified six issues, including relationships and problem solving, with a number of aims and objectives to achieve them. The man signed the plan two weeks later, as required in the Induction phase.

35. By the end of the month, the man's personal officer wrote that he appeared to have settled into the community. Residents agreed that he fitted in and was well liked. However, time keeping was an increasing problem, as punctuality was not important to him. For example, on one occasion he was still in bed at 8.45am although he should have been at the morning meeting. Consequently, a Residents Review meeting took place on 1 February and the man discussed the problem with his key worker, the resident who was his landing representative, and two other residents. They decided that the man had a defeatist attitude and lacked motivation. It was recommended that his time-keeping should be monitored and he should buy an alarm clock. The programme manager accepted the recommendation and noted that the man needed to work on his laid back attitude. The man signed to say that he was satisfied with the review, which galvanised him for a while and his time-keeping improved.

36. The same day, the man attended an emergency Peer Support Group meeting because there was an altercation between him and another resident. This was a

residents only forum, composed of prisoners with no staff present. The other resident had gone into the man's cell, shut the door and asked for coffee. The man swore at him and told him to go away. Their behaviour was discussed and both were criticised. They agreed that things had got out of hand and apologised to each other.

37. Over the next two weeks, the man began to find his feet and the reports talk about him getting ready to move into the Orientation stage. Several residents warned him that he would then have to meet even more stringent requirements and standards of behaviour. However, they noted that, in their opinion, he would be an asset to the group. At the end of Induction, the man wrote his 'Life Story', which all residents must do and include as much detail about their lives as they feel able to share. He admitted to his buddy that he was nervous about the presentation, but asked several friends already in the Orientation group to come and support him.

38. On 19 February, the man and the Induction department head completed his Induction assessment. Again, he listed the issues to address and his goals whilst on the therapeutic community. The department head noted that the man would struggle in Orientation unless his attitude improved. He observed that the man's motivation was spasmodic, and his attitude to the programme was variable, but that he was ready for induction. He added that the man needed to take pride in his efforts and to find what motivated him. This second comment chimed with the opinion of several members of staff, who also identified a lack of clear motivation.

39. Three days later, a case conference decided that the man should move on to the Orientation phase of the programme. The man demonstrated to his key worker and two residents that he understood the concepts underpinning the community. They felt that he was more than ready to move to the next stage in the programme, but they too noted that he was somewhat unsure as to his direction. This was something that could be addressed in Orientation phase, where the man duly moved the same day.

Orientation phase and the man's withdrawal from the therapeutic community

40. The man's first report in Orientation was written by the landing representative. He noted that the man was very unsure, but was looking forward to a visit from his girlfriend which would help resolve his doubts. The following day, 26 February, the department head said that the man appeared to be fitting in well, but that it was too soon to say anything further.

41. The following week, the man was again challenged to meet the required standard of punctuality. He was given the post of Attendance Co-ordinator to try to encourage him to be at meetings before they began. The department head's report included, for the first time, the number of confrontations the man received during the previous week. He was given ten positive pull-ups when people commended him for a particular action, and eight negative pull-ups, meaning that his behaviour was challenged as not conforming to the required standard. The landing representative's report said that the man was still getting used to the new routine. The man's personal officer reported that he had gained a lot from the

Induction phase and his communication skills were improving. The report quoted a very telling phrase from the man who said that he felt “he had a big, fat addict inside himself he has to fight.” The officer concluded by saying that the man would need a lot of support to attain his goals.

42. In spite of the observation about improved communication skills, the man struggled during the visits he had from his family. His parents described him as under great strain and very tense. He had begun to look at his past life whilst writing his life story, and had to deal with the issues involved. One of the residents recalled the man telling him of a visit when he said some horrible things to his girlfriend who had left early in tears. The man told the resident that he felt very guilty and was writing to apologise.

43. By the end of the second week of the Orientation phase, the man had decided to leave the programme. He told staff that the course placed too much pressure on him, and he had to come to terms with aspects of his past. As with all residents, he was allowed 48 hours to consider his decision when he spent a lot of this time in his cell. Staff and residents tried to persuade him to stay, but he was adamant that he wanted to leave. One of the residents spoke about how strongly the residents try to persuade leavers to change their mind and remain in the programme. He described it as, “we put him on a guilt trip” and how they emphasise that the programme is what they need to get their life back on track. But the man did not change his mind.

44. The course de-selection summary reiterated the man’s problems during the programme, particularly his struggle with motivation. The objectives identified for the man to take forward were:
    - to see his drug worker
    - to see a probation officer about his resettlement needs
    - to investigate possible education courses.

45. Two weeks later, on 27 March, the man moved to Living Block 4. A week after that, he transferred to Living Block 3 where his cell was on an upper landing named Exe after the river. On 4 April, he again met his drug worker from Exeter, who was now working at the prison, and they discussed what he should do next. He expressed the need to have some direction in his life, and it was suggested that the chaplain might know of suitable courses.

46. Three days later, he had an appointment with the doctor as he was sleeping poorly and feeling depressed. The doctor prescribed a low dose of an anti-depressant, and said that he would see him two weeks later. The man neither did nor said anything to indicate that he was considering harming himself and gave the doctor no cause for anxiety. The medication was issued to the man to keep in his possession. There is no way of knowing whether he took it as prescribed.

47. On Sunday 9 June, the man went to a church service and stayed afterwards for a cup of coffee. He spoke to the chaplain and told him that he felt that he needed spiritual direction. The chaplain told him about an Alpha course which was beginning shortly (the Alpha course looks at questions about the meaning of life from a Christian perspective). The man said that he would like to take part and

this was agreed. At the end of the discussion, the chaplain thought that the man appeared fine, and was not troubled or at risk of harming himself.

48. One of the prisoners on Living Block 3 at the time, spoke to the man two days later and asked him how he was, to which the man replied that he was fine. The man went on to tell the other prisoner that he was serving a five year sentence which he was coping with. He also said that he had been in the therapeutic community, but did not like it as other prisoners told him what to do.

12 April 2006

49. At approximately 8.00am on Wednesday 12 April, the man's cell was unlocked and he immediately went downstairs to collect his breakfast from the servery. He asked whether there was any butter available and, when told no, took toast and boiled eggs and returned to his cell. The officer who supervised the serving of breakfast said that the man seemed quiet as usual but okay. The man did not eat the food, and it was found untouched later that morning.

50. After collecting his breakfast, the man returned downstairs to the communal area to make a telephone call to the house where his girlfriend was staying. The call lasted from 8.12am to 8.27am, and a man answered the telephone. The man who died asked to speak to his girlfriend but, in spite of holding on for 15 minutes, he was unable to talk to her. On listening to the recording of the call, my investigator thought that – perhaps unsurprisingly – the man sounded quite frustrated by the time it came to an end.

51. The man returned to his cell. Just before 8.30am, an officer gave him a movements slip to enable him to go to the gym that morning. She said that the man was standing beside the cell table, and took the slip from her without saying anything. She told my investigators that the cell door was ajar and his cell appeared normal. The period after 8.30am is a busy time on the wing with a lot of movement as men go to work, education or the gym. The investigators could find no-one who saw the man in the next half hour and it appears that at some point during those 30 minutes he shut his door and locked himself into the cell.

52. At 9.00am, the same officer went back round the landings to check that everyone who should have left had done so, and to lock up those remaining on the wing. When she reached the man's cell, Upper Exe 49, she saw that the door was locked, so she unlocked it and went in. She saw that the man had urinated, and was hanging from a ligature of shoe laces attached to a leg of his upturned bed. He had his back to the window on the far wall and was facing half left towards the basin.

    The Governor should conduct a risk assessment to consider having all beds bolted to the floor to reduce the possibility of them being used as a ligature point in future.

53. The officer immediately stepped back into the corridor and used her radio to call for urgent medical assistance for Exe 49. Then she returned to the man and, bracing her back against the wall, lifted him up to take the tension off the ligature.

54. Two officers were in a downstairs office and heard the call for assistance on the radio. They ran upstairs and were directed to the cell by prisoners who were in the corridor. They entered the cell and took hold of the man to assist the female officer bear his weight. Some prisoners were in and around the cell, and one brought a razor in an unsuccessful attempt to cut the ligature. One of the male officers told them to leave the cell, and a fourth officer arrived and moved the prisoners to the far end of the corridor.

55. A senior officer (SO) was the wing manager that day. When she heard the emergency call, she also went to the cell. Once there, she stood on a chair and tried to remove the ligature, but was unable to do so. She sent a fifth officer to fetch ligature scissors from the office and a laryngeal mask. (Ligature, or cut-down scissors have sharp blades and blunt ends and are designed to cut through ligatures. A laryngeal mask opens up a patient's airway to more efficiently deliver oxygen.) The SO then felt for a pulse but could not find one. At 9.02am, she radioed Communications to tell healthcare staff that oxygen was needed. Shortly afterwards, she asked an officer outside the cell to contact Communications to call for an ambulance. The Communications' log shows that the ambulance was called at 9.04am.

56. The fifth officer went to get the scissors from the emergency box on the wall of the wing office. However, the box was kept locked and he was unable to locate the key which was on its side. (The wing SO has since moved the key pouch from the side to the front of the box.) He then ran to the office in LB4, just across the entrance passageway from LB3, and asked the officer there for the cut-down scissors. The LB4 officer estimated that this was approximately 9.02am, and he took the scissors and ran to Exe 49. The ligature was cut and officers lowered the man to the floor. The LB4 officer checked the man's neck and leg for a pulse. When he did not find one, he started chest compressions.

57. Very shortly afterwards, two nurses arrived with the emergency bag and oxygen. They had been in the treatment room in the Healthcare Centre when the call for medical assistance was received. They took the bag with resuscitation equipment and an oxygen cylinder and went to LB3. On the way, one of the nurses asked Communications for any further information about the nature of the incident, but there was none. When they arrived at the cell, she observed that the man's pupils were fixed and dilated. She placed a mask over his nose and mouth, and attached it to an oxygen cylinder. Then she and the LB4 officer began to administer cardio pulmonary resuscitation (CPR). The officer performed 30 chest compressions, then paused as the nurses took turns to push oxygen through the mask into the man's lungs. Another officer took turns with the LB4 officer in doing the compressions. As they began CPR, one of the nurses asked for the defibrillator (a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart), and for more oxygen to be brought.

58. The SO took the man's arm and monitored it for a pulse. Two minutes later, a healthcare officer arrived with the oxygen and the machine from the treatment room in the healthcare centre. A nurse attached the defibrillator to the man and followed its instructions to continue the CPR. At 9.12am, the SO detected a faint pulse in the man's arm and, as his heart started to beat, the LB4 officer stopped administering chest compressions, and the nurses continued the oxygen therapy. Three minutes later the paramedics arrived and were briefed by Healthcare staff. The paramedics attached their own defibrillator to the man and put an endotracheal tube (similar to the mask used by the nurses, but going deeper into the airway) into his throat. The LB4 officer replaced the prison oxygen cylinder with one provided by the paramedics. The man then began to take breaths, but they were insufficient for him to breathe unaided. The paramedics took over the man's care and, at 9.37am, they took him down to the ambulance where they continued treatment to stabilise him. At 9.55am, the ambulance left the prison for Torbay Hospital, with two officers as escort.

59. As the paramedics prepared the man for the journey to the hospital, the SO began an Assessment, Care in Custody and Teamwork (ACCT) care plan for him. The ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give him the support he needs to help him through a period of crisis. The SO told one of the escorting officers to open the document as he was accompanying the man to hospital. Her forward thinking is to be commended as she set in place the support the man would have needed had he recovered and returned from the hospital.

60. Whilst the man was being resuscitated, members of the Care Team and chaplaincy went to the wing to offer support to staff and prisoners. Once the man had gone to hospital, two meetings for staff were held. Those meetings are discussed in detail in the next section of this report.

61. Staff then tried to contact the man's next of kin. When he arrived at Channings Wood, he had listed his girlfriend and parents, but did not provide telephone numbers for them and Directory Enquiries were unable to provide any information. Staff were still trying to find current numbers for his next of kin, when his mother rang the prison. She spoke to the visits clerk and asked to reschedule her visit booked for that afternoon. The clerk, realising that other staff were trying to contact her, alerted the duty governor who asked a member of the chaplaincy team to break the news of the man's attempted suicide and offer care and support. The clerk's initiative and efficiency is commendable and meant that the man's parents were contacted earlier than would otherwise have been the case.

62. The ambulance arrived at Torbay Hospital at 10.20am and the man, who was still unconscious, was taken to the resuscitation unit. An hour later, he was transferred to the Critical Care Unit, sedated and ventilated. The escorting officers informed the prison of the move. They were told that the man's next-of-kin had been informed and were on their way to the hospital. At 10.55am, the man was given a scan and at 12.15pm, he was x-rayed on the ward. His parents arrived at 1.30pm and went into the family room, where they were joined 15 minutes later by the chaplaincy staff member. They were informed that the scan showed some brain ischaemia (dead tissue) and that the prognosis was poor.

Unfortunately, despite the efforts of prison staff, paramedics and hospital staff, the man's condition did not change over the next 18 hours.

63. The acting governor decided that, given the seriousness of the man's condition, no restraints should be used. Two officers were always present and they completed a bedwatch log of events during the man's time in hospital. The escorts were also told to offer what support they could to his family.

64. At 8:35am the following morning, the prison chaplain arrived at the hospital to offer support to the man's family. Later, the acting governor also went to the hospital and spoke to the man's parents. By this time, his girlfriend had also arrived and was at the bedside. The consultant treating the man met the family twice during the morning, and the decision was made to reduce his medication and remove the ventilator. Afterwards the family remained at the bedside until the man died at 2.25pm.

65. The prisoners on Living Block 3 collected for a wreath for the man. Given that the man had only been there for eight days, they collected the impressive sum of £130. The prisoners who took it to the chaplain asked that, as well as a wreath, there should be a bouquet of flowers for his mother. On the Sunday after the man's death, prayers were said for him at the prison's church services. When the police released the cell, the chaplain blessed it before it was used again.

66. The man's parents asked the chaplain to conduct the funeral, which was held at a local Crematorium. At approximately the same time, another member of the chaplaincy team led a memorial service at the prison which about 20 prisoners attended.

67. After the funeral, the Governor and chaplain discussed the possibility of holding an exhibition of the man's poems and paintings with his parents. It was agreed that this would be a fitting celebration of the man's life. The exhibition opened in the prison chapel on 4 September and displayed approximately six paintings and 14 poems. The man's parents visited the exhibition during the first week, and had the opportunity to talk to some of the prisoners looking at their son's work. In November, the exhibition was displayed in Exeter Cathedral for a week.

ISSUES

The man's clinical care

68. During the six months the man spent in prison, he was treated for three separate conditions. The metal work in his back needed to be removed and the doctors contacted the surgeon who had carried out the original procedure two years earlier. The man was also referred to a dermatologist for a rash, and medication was prescribed.

69. Five days before the man hanged himself, he told the doctor he was depressed and sleeping poorly, and was prescribed anti-depressants. He held the medication in his possession, so it is not possible to establish whether or not he took it as prescribed. However, two days later, he spoke to the chaplain about starting an Alpha course and appeared to be in a positive frame of mind.

70. In her report (Annex 1), the clinical reviewer concludes that in both the treatment the man received and his resuscitation on 12 April, the care was appropriate.

The man's stay in the therapeutic community

71. When the man began the programme in the community, he was allocated another resident as his buddy. The buddy told my investigators that he felt the man enjoyed being in the community. He thought that the man appreciated its open atmosphere where residents could talk freely, both about the course and life in general. However, he added that the man was still a private person, who found it hard to trust others and difficult to talk about himself, his background and his drug use. Although he did open up to the residents, he was not comfortable with this aspect of the programme. He also had problems adjusting to two other aspects of the programme: timekeeping and the system of confrontations, which are an essential part of the regime.

72. The man struggled with punctuality throughout his time in the therapeutic community. Everyone who spoke to the investigators commented on the fact that he found it difficult to be where he ought to have been at the correct time. The man was regularly challenged about his time-keeping, and had a formal meeting where this was discussed.

73. The chaplain described him as a man with a creative personality, who might have had difficulty adjusting to a structured environment. The chaplain recalled that the man used to look into the middle distance as if his mind was on other things. This was echoed by the treatment manager, who said that the man was very polite but tended to be off on his own.

74. Members of staff who spoke to my interviewers doubted the man's motivation to participate in the therapeutic community. His drugs worker, who oversees the Induction phase of the programme, said that the man's motivation fluctuated during the programme, and at times his heart was not in it. He described the man as being caught between his past and the potential for achievement. However,

he said that at the end of the Orientation phase the man was beginning to adapt to the rules and regulations, including punctuality.

75. The man also struggled with the system of confrontation used in the therapeutic community. The rules are very detailed and demand a higher standard of behaviour than is normal in prison. Residents' behaviour is open to scrutiny all the time, and their behaviour is challenged by staff and by other residents. Many residents, and the man was no exception, find it hard to adjust to being confronted over such things as swearing or pushing past someone in the corridor.

76. However, the man did make a positive contribution to the therapeutic community, and residents and staff all spoke of his contribution in meetings. He quite readily offered his opinion and advice. By the time he finished Induction, he was described as a generous person and "a giver". A senior resident described the man's contributions as insightful, good at summing up an issue and sharing his opinion about possible actions. Staff said that sometimes his attitude, particularly at the beginning, could be described as sarcastic. However, they also said that he got on well with other residents

77. In conclusion, the man found it impossible to change his behaviour to conform to the very disciplined nature of the community. For someone who viewed himself as a hippy, the ethos and demands of the community would seem to have required too radical a shift in his thinking. The reports from the therapeutic community show how hard he tried to adapt to the programme's detailed and very demanding rules. This put him under a great deal of stress which added further to his problems. The strain showed during his family visits, one of which ended early because of his behaviour. By the time the man completed the second week of the Orientation phase, he had decided to leave the programme. Once his decision was made, he stuck to it, in spite of encouragement, support and motivation from staff and other residents.

Leaving the community

78. When the man decided to leave the programme, he was given the usual 48-hour period to reconsider his decision. During that time, both staff and prisoners spoke to him, trying to persuade him to stay in the community. After leaving, he spent a lot of time in his cell, which he is likely to have found frustrating as he needed always to keep his brain occupied. However, hen did not change his mind, and, although he remained on the same unit for almost three weeks, he was no longer a member of the therapeutic community.

79. Whilst a resident in the programme, the man had a well structured support system in place. When he left the programme, that support was no longer available to him. However, for the man, as for all prisoners in Channings Wood, there are a number of other sources of help and support. The prison has a personal officer scheme and a Samaritans supported Listener scheme in place for prisoners who are in distress or crisis and need to talk in confidence. The chaplaincy also offers support to prisoners who approach them. I am satisfied that, had the man wished to ask for help and support, there were a number of

options open to him. He spoke to the chaplain and consulted the doctor about feeling depressed. It was the man's decision not to approach anyone else.

80. He did have a plan of action for his return to a standard location. He discussed his next actions with his CARAT worker and identified education as his focus for the immediate future. At her suggestion, he spoke to the chaplain and arranged to begin an Alpha course. On Sunday 9 April, when he spoke to the chaplain, he appeared positive rather than someone at risk of self-harm.

81. There is no evidence available as to what caused his mood to change so radically over the next two days. Neither did he leave any indication of why he acted as he did.

Emergency response

82. When officers went to the man's aid, their first priority was to support his weight to ease the tension on the ligature. The next person to arrive tried to loosen the knots but without success, and so asked for the anti-ligature scissors to be collected from the cabinet in the downstairs office. The officer could not find the key to unlock the cabinet and, rather than waste time, ran to another office to ask for assistance. The second officer took the scissors, ran to the cell and successfully cut the man down.

83. All this activity meant that there was a short delay of three to four minutes. During the wait, three officers supported man to mitigate the effect of the ligature. If the first officers at the cell had been carrying anti-ligature knives, in all probability they would have been able to cut him down immediately. On this occasion, the outcome might not have been different.

84. The officers interviewed described their frustration at not being able to remove the ligature despite their best efforts. Prisoners on the wing were asked for craft knives, and one brought a razor. It would have been better for all concerned if officers had been properly equipped and able to sever the ligature without any delay.

85. I am pleased that the Governor and Safer Custody Manager have already taken steps to issue ligature knives to staff. At the time of drafting this report, 70 anti-ligature knives have already been ordered and criteria developed for their issue. All Principal and Senior Officers will carry them, as will other officers in direct contact with prisoners. The Prison Service is currently drafting a Prison Service Instruction that will make it a requirement for all officers and healthcare staff to carry anti-ligature knives.

    The Governor and Safer Custody Manager should arrange for the anti-ligature knives to be issued as quickly as possible and all recipients to be trained in their use.

86. When the female officer entered the man's cell at 9.00am, she immediately used her radio to call for emergency medical assistance and two nurses quickly responded. They arrived within a couple of minutes of the call and started

resuscitation. However, they would have been better prepared if they had known the nature of the emergency. One of the nurses told the investigator that, had they known that man had hanged himself, they would have taken additional oxygen and the defibrillator. As it was, both had to be requested once the nurses knew the nature of the emergency. A further benefit of preparatory knowledge would have been to allow the nurses to prepare mentally for the situation they faced. They would also have had time to alert the doctor at an earlier stage.

87. Since the man's death, the prison and senior healthcare staff have identified this issue and the Operational Manager is working with the Head of Healthcare to set in place a system of emergency call signs. These will mean that wing staff calling for emergency assistance will provide information about the type of emergency. They have also agreed that, in future, the doctor will be notified at an earlier stage.

The Governor should ensure that the system of emergency call signs is implemented as soon as possible, along with the requisite training for all staff.

Debrief meetings for staff

88. Once the man had been taken to hospital, there were a number of meetings for staff who found and resuscitated him. Prison Service Order (PSO) 2710 requires a hot debrief meeting for all staff who attend an emergency to be held as soon as possible after the event. Although three meetings were held later on 12 April, none fulfilled the requirements of the Order.

89. The first one was held on the wing very soon after the ambulance left the prison. The principal officer on duty and governor spoke briefly to staff to say well done and inform them that they must write a statement before leaving the prison. The staff who attended told the investigators that they did not find it beneficial. A number felt that it was too soon for them to be praised for their actions, particularly given the man's serious condition. They had no opportunity to go over what had happened and discuss the effectiveness of their response.

90. A few hours later, the governor who was in charge of the prison that day, met some of the staff involved in the resuscitation. Discipline staff and the care and chaplaincy teams were present at the meeting. Staff described this meeting as more helpful, as it was not immediately after the event and there was time to talk. However, healthcare staff were not present, and so staff did not have an opportunity to take part in a multi-disciplinary discussion about their response. The value of this meeting was reduced and again did not meet the requirements of the PSO.

The Governor should set in place procedures for holding a timely hot debrief for staff following a serious incident that comply with PSO 2710.

91. The prison has a care team, whose volunteer members provide welfare services for their colleagues. The head of the team plans to hold an in-depth debrief at a location outside of the prison for staff who would like to attend. The meeting will

be facilitated by a member of the Health and Welfare Service. This arrangement has been followed in the past and proved to be very beneficial for staff.

92. The senior managers of healthcare met the acting governor on 13 April and held a Significant Event Review which identified a number of issues, and they took immediately steps to improve their procedures. The need for emergency call signs and anti-ligature knives was recognised and staff were assigned to take forward the identified actions. I commend the speed with which these actions were taken.

Contact with the man's family

93. When the man was taken to Torbay Hospital, a member of the chaplaincy team went to meet and offer support to his parents. Another member of the team and the governor went the following day, and remained with the family until the man's death. Over the course of the following week, one of the chaplains contacted them every day, both to offer support and make arrangements for the funeral.

94. Another example of the prison's sensitive attention was that, when the Governor wrote to express her condolences, she used a blank card with flowers on the front, rather than writing a formal letter on Prison Service notepaper. It was also helpful that she informed the family of my investigation, including the name of my investigator, which effectively prepared the way for my staff.

95. The man's parents stressed to my family liaison officer how grateful they were to the chaplain for his kindness and support in the days following their son's death. They also appreciated his hard work in organising the exhibition of paintings and poems.

I commend the prison's sensitive, caring and professional contact with the man's parents

96. However, one of the issues raised by the man's parents was the manner in which other family members learned of his death. The Duty Governor followed the procedures set out for a death in custody, which include the routine publication of a press notice including details of the offence. This is standard practice for the prison or the Prison Service's National Operations Unit, and is usually done when it is confirmed that the family have been informed of the death. As the man's parents were present when he died, there was no need to notify them. Because they already knew, a press release was issued and the news was quickly reported in the media.

97. The man's parents had, not surprisingly, not had time to inform other family members, and so some learnt the news from Ceefax. This must have been a shocking way to learn of the death of a family member and must have added significantly to the distress. This is one of a number of instances where I understand that bereaved relatives have learned details of a death from Ceefax. It would clearly be helpful for next of kin to be advised at an early stage that a press notice will be issued and, as details of the death may appear in the local press and on Ceefax, for it to be suggested that they might want to contact other

family members quickly. I understand that staff in Prison Service headquarters are currently working to resolve this issue.

I recommend that Prison Service staff who break the news of a death to family members, also advise them that a press notice will be issued.

RECOMMENDATIONS AND GOOD PRACTICE

RECOMMENDATIONS

1. **The Governor should conduct a risk assessment to consider having all beds bolted to the floor to reduce the possibility of them being used as a ligature point in future.**

2. **The Governor and Safer Custody Manager should arrange for the anti-ligature knives to be issued as quickly as possible and all recipients to be trained in their use.**

3. **The Governor should ensure that the system of emergency call signs is implemented as soon as possible, along with the requisite training for all staff.**

4. **The Governor should set in place procedures for holding a timely hot debrief for staff following a serious incident that fully comply with PSO 2710.**

5. **I recommend that Prison Service staff who break the news of a death, also advise them that a press release will be issued.**

GOOD PRACTICE

6. **The Governor and Treatment Manager should commend the residents for the high standard of their reports.**

7. **I commend the SO for her forward thinking in opening an ACCT care plan for the man. I commend the clerk for his initiative and efficiency in passing the call from the man's mother call to the acting governor.**

8. **I commend the prison's sensitive, caring and professional contact with the man's parents.**