

**Circumstances surrounding the death of a male prisoner at  
Channings Wood on 22 January 2007**

**Report by the Prisons and Probation Ombudsman for  
England and Wales**

**July 2007**

This is a report of an investigation into the death of a 66 years old man who died of a heart attack on 22 January 2007 in his cell at HMP Channings Wood. He had been in custody more or less permanently for over 36 years.

I offer my sincere condolences to all those touched by his death.

The investigation was undertaken by my colleagues and I join them in thanking the Governor of Channings Wood and the appointed Liaison Officer, for their helpfulness and co-operation during this investigation.

The deceased was a life sentence prisoner who transferred to Channings Wood in 1997. Over the ten years he was there, he had very much made it his home and enjoyed the routine and personal security that Channings Wood afforded. I gather that he was well respected by staff and prisoners alike, and his death undoubtedly had an impact on many of them. Great care was taken by the staff at the prison to ensure he had a fitting memorial service, and it is perhaps testimony to how he was regarded that the service was so well attended.

My investigators were impressed by the way the man's death was handled at the prison. Staff ensured that he was treated with respect and dignity and that those affected by his death had the opportunity to speak about their feelings. I know that considerable effort went into attempts to trace a member of the deceased family to notify them of his death. Sadly, this was unsuccessful. I hope that, if a family member is ever traced, they can take comfort from the knowledge the deceased was treated with great sensitivity and decency. I hope too that this report will provide an insight into his life in prison and how he died. The man's ashes were buried at the nearby churchyard in the Parish of Ogwell and a headstone was kindly provided by the funeral director.

This investigation has highlighted four issues that the Governor may wish to consider.

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**Prisons and Probation Ombudsman**

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## SUMMARY

The deceased was convicted of murder in 1969 and received a life sentence. He served his sentence at a number of different prison establishments, finally transferring to HMP Channings Wood in 1997. He was a man who appeared to be content with the routine and regime at Channings Wood and had no desire to move to another prison.

The deceased worked on the gardens party until approximately six months before he died. In the summer of 2006, he applied for a transfer and began work in the main stores. He was described as a hard worker for whom nothing was too much trouble.

The man's medical record showed that he appeared to be in relatively good health and rarely had cause to visit the prison's healthcare department. However, on 19 March 2002, he attended healthcare and complained of chest pains. An echocardiogram (ECG) showed some abnormalities, and an ambulance was called. The man was taken to Torbay Hospital where he had further tests which showed he had had a heart attack. He remained in the Coronary Care Unit at the hospital for three days.

On his return to Channings Wood, he was seen by healthcare on 23 and 24 March 2002. He continued to be regularly monitored by healthcare who checked his blood pressure, heart rate and his medication. On January 2007, the deceased attended work in the main stores as usual. The stores Operational Support Grade (OSG) recalled that the man had looked well and had spent the morning helping clear out an old storeroom. So he had time to wash before lunch, he was allowed to leave work at 11.30 am. He collected his lunch and returned to his cell.

At approximately 1.40 pm, an officer unlocked the man's cell. As the officer pushed the door open, he felt some resistance and pushed his way inside. He saw the deceased feet on the floor and, realising something was wrong, manoeuvred himself into the cell. The officer saw the deceased lying on his left side on the floor. He radioed for assistance before attempting to put the man in the recovery position. Although not first aid trained, the officer could tell that the man had died.

Another officer arrived at the deceased cell, closely followed by a Health Care Senior Officer HCSO, who responded to the emergency call in his role as discipline officer, rather than as healthcare officer, as the call did not specify the type of emergency. The HCSO rang the communications room to request they call an emergency ambulance and then returned to the deceased. By this time, two more members of healthcare staff had arrived. They too were unaware of the type of emergency. One nurse ran back to healthcare to pick up the defibrillator. The deceased was carried outside his cell so there was more space to work on him, and resuscitation was attempted even though there were no signs of life. The nurse returned with the defibrillator about two minutes later and the staff continued to attempt resuscitation until the ambulance crew arrived and took over.

The deceased did not respond to the resuscitation attempts. He displayed no shockable heart rhythm, was very discoloured, and appeared to have been dead for some time. All parties therefore agreed to stop the resuscitation. He was placed on

the bed in his cell, covered by a blanket and the chaplain, who knew him well, said prayers. The prison doctor pronounced life extinct at 2.50pm.

The Governor and the chaplain visited each prisoner on the deceased block to inform them of his death and to offer support and the opportunity to talk. The Governor also posted a letter telling all prisoners that he had died and providing details of a memorial service. A debrief was held for the staff involved, and ongoing support was provided by the chaplaincy and Care Team.

Prison staff tried to locate the man's next of kin. However, he had received no letters or visits since before his arrival at Channings Wood, and his next of kin details in his prison record were out of date.

Over 70 people attended the man's memorial service which was held at the chapel in Channings Wood. He was cremated and his ashes were buried in the nearby churchyard at Ogwell. The undertaker provided a plaque for him and a tree in his memory is to be planted at the prison.

The post mortem examination revealed that the man had died from ischaemic heart disease and coronary artery stenosis.

## **THE INVESTIGATION PROCESS**

1. I appointed two colleagues to conduct the investigation on my behalf. Notices were issued to both prisoners and staff, inviting anyone who might have information relating to the man's death to make themselves known to the inquiry.
2. My investigators were given access to all the deceased prison records, including his medical records.
3. The next of kin details recorded on the deceased file had not been updated since his arrival at Channings Wood. He had received no letters, nor had any family visits, since 1992. Although the prison had made every possible effort to contact a family member, they were unsuccessful.
4. My investigators visited Channings Wood on 27 and 28 March 2007 to carry out interviews and visit the cell where the man lived and died. It was unfortunate that they were unable to speak to the Health Care Senior Officer, as he was one of the first officers to attend to the deceased. However the prison provided his statement that he made to the Governor and other witnesses provided a full account of the events of that day.
5. A clinical review of the man's health care whilst in custody was undertaken with the help of a panel by a Clinical Reviewer, Prison Health and Development Manager at Devon Primary Care Trust.

## **MP CHANNINGS WOOD**

8. HMP Channings Wood is a category C training prison situated in a rural area near Newton Abbot and built on the site of a former Ministry of Defence base. There are five main two storey Living Blocks with 112 cells in each block.
9. The prison takes men who have a wide range of sentences. It contains a specialist Therapeutic Community for tackling drug abuse and a vulnerable prisoners unit specialising in Sex Offender Treatment Programmes. The prison has 634 cells available and 33 of these can be doubled up to increase the capacity to accommodate 667 prisoners. All prisoners, unless medically unfit or of retirement age, are expected to work.

### **Healthcare**

10. The healthcare centre at Channings Wood operates from 8.00 am to 8.00 pm on weekdays and from 8.00 am to 5.00 pm at the weekend. General Practitioner surgeries are held Monday to Friday. A Coronary Heart Disease clinic is held. The deceased attended this regularly to have his blood pressure, cholesterol and Body Mass Index monitored and his medication reviewed. Prisoners who are assessed as suitable to hold their own medication collect their prescriptions from healthcare each month. Otherwise, they are collected on a daily basis.

### **Main Stores**

11. The purpose of the main stores is to receive and issue items such as stationery, staff uniform and cleaning materials. Prisoners unload deliveries, make up cleaning packs for wings and carry out general duties such as cleaning and tidying. The Head of Healthcare told my investigators that there is a system in place for assessing prisoners' suitability for all work, including the stores. Each area of work lists the type of tasks involved in that particular job, and the person making the assessment should decide whether a prisoner is capable and fit enough to carry out the work.

### **Emergency call system**

12. The emergency call system at Channings Wood has recently been reviewed. It was agreed that, rather than place the onus on the person making the call to assess the type of emergency, staff should describe the situation through the prison radio system, thereby allowing the appropriate staff to respond.

## KEY FINDINGS

13. At first glance, it seemed that there was very little to say about the man's life. By the time he arrived at Channings Wood in 1997, he appeared to have disengaged from life outside of prison and, to an extent, from that inside prison too. He had not received any letters or visits since 1992, and refused to take part in lifer reviews, parole reviews or participate in any offender treatment programmes.
14. However, after talking to staff about the deceased, my investigators found that a very different and more vivid personality emerged. He was described as a man who lived in the present rather than one who dwelt on the past, who liked his routines and was very comfortable with prison life and its regimes. He was also described as a sociable man who enjoyed football (he was a Glasgow Rangers supporter and had a flag pinned up in his cell). He had an interest in current affairs and read the Daily Telegraph every weekday. He also liked to complete puzzles and quizzes from newspapers he regularly borrowed from the chaplaincy and healthcare departments. The man attended the chapel everyday and, although he was Church of Scotland, attended almost every act of worship including Catholic Mass. He loved music and would play the organ in the chapel and his own organ in his cell (this has now been placed in the chapel). He wrote hymns to popular tunes which he regularly performed in the chapel, and could be heard whistling around the prison whilst he went about his daily routine. The man spent many years working in the gardens department at Channings Wood where both staff and prisoners would stop for a chat with him. A few months before he died, he applied for a change of employment and began to work in the main stores.
15. Although there seems to be a system to assess prisoners' fitness and suitability for work, the deceased was only interviewed by the Stores Officer. The Stores Officer asked whether he had attended a manual handling course, which he had done, and also whether he had any back injuries, which he had not. My investigators were told that the deceased was a hard worker and was always the first to volunteer to help. He seemed to be well liked by his colleagues in the stores, and by staff and other prisoners generally.
16. The deceased rarely troubled anyone and made few applications to be seen in healthcare. In 2001, he received treatment to his fingers when he trapped them between a board and a trolley, but that appeared to be the extent of his medical problems until 2002.
17. On 19 March 2002, the man complained to healthcare of pains in the centre of his chest that had come on the day before. His blood pressure and pulse were taken and showed a slightly high reading. An echocardiogram (ECG) was arranged and carried out later the same day. This showed some abnormalities, and so an ambulance was called to take him to Torbay Hospital. He was moved to the Coronary Care Unit where it was confirmed that he had suffered a heart attack. He returned to Channings Wood at 6.00 pm on 22 March and was seen in healthcare on 23 and 24 March. The hospital had prescribed the man's medication which was reviewed regularly by healthcare. After this heart attack,

he was regularly assessed at the prison's Coronary Heart Disease (CHD) Clinic, where his blood pressure, pulse and cholesterol would be checked and his medication reviewed. The deceased collected his medication monthly from healthcare. He carried a medication spray, but was rarely seen to use it.

18. On 8 April 2002, a Cardiac Rehabilitation Nurse contacted the prison's Physical Education Department to arrange some gym sessions. My investigators have been unable to establish whether the deceased had ever attended any of these sessions, but from the available paperwork it does not appear that he did so.
19. Apart from going to healthcare on 25 October 2004 for something in his eye, and one episode of dizziness and vomiting in December 2005, he did not present any further cause for concern until 22 January 2007.

### **22 January 2007**

20. The deceased attended work in the main stores as usual that morning. The Operational Support Grade (OSG) in charge of the stores remembered that the man appeared to be happy and well, and had been singing and whistling as usual. He assisted the OSG clear an old storeroom so that it could be used as a training cell. The OSG allowed the deceased to leave at 11.30am as it had been a dirty job and he wanted to allow time to wash before lunch. As usual, he took to his cell. (Prisoners were locked in their cells whilst they ate lunch.)
21. At approximately 1.40pm, an officer was responsible for unlocking prisoners on Living Block 2. When he came to unlock the deceased cell, the officer felt some resistance behind the door. He was concerned as usually the deceased came out of his cell as soon as it was unlocked.
22. The officer called to the deceased whilst trying to inch the door forward, and it was then that he saw the man's feet by the door. The officer immediately radioed for assistance and manoeuvred himself into the tight space between the door and sink. The deceased was lying on his left side on the floor, and the officer began to make space to put him in the recovery position. It appeared that the call for assistance was interpreted as a call for discipline staff rather than healthcare, and another discipline officer arrived next. The first officer told the second that he thought the man had died. Although the first officer was not currently first-aid trained, he told my investigators that he had seen many dead bodies during his career in the Marines and he noticed that the man had urinated.
23. Fortunately, the next to arrive was the HCSO who had responded in his role as discipline officer rather than as a healthcare officer. The HCSO immediately rang the Communications Room to ask that they call an emergency ambulance.
24. A nurse also responded to the emergency call together with the Head of Healthcare, although neither was aware of the type of call they were attending. Both believed it might be an assault on an officer as there had been some unrest amongst prisoners during the preceding fortnight.

25. When the nurse and Head of Healthcare arrived at the cell, the HCSO was already attempting to resuscitate the man. They asked that somebody run back to healthcare to collect the defibrillator. This took approximately two minutes. The healthcare staff observed that the deceased appeared discoloured and was lying in the recovery position. The Head of Healthcare suggested they take him onto the landing to give them more room to work. Prison Service Order 15/2006 says that, unless rigor mortis of the limbs has clearly set in, resuscitation should be attempted. As this was not the case, the Head of Healthcare and the HCSO took over attempting resuscitation. The nurse returned with the defibrillator which indicated that there was no shockable rhythm. The HCSO, Head of Healthcare and the nurse began Cardiopulmonary Resuscitation (CPR), alternating periodically between the tasks of breathing and compressions. They continued for approximately 15 to 20 minutes until the paramedics arrived.
26. The paramedics attempted to insert a line (Venflon) into a vein in the man's hand, but this was unsuccessful. They could not find a pulse, and there was no heart rhythm, so they checked with the healthcare staff and decided to stop working on him. The deceased body was returned to the bed in his cell and covered with a blanket. The chaplain attended and said prayers over his body. A doctor was asked to come to the prison and pronounced life extinct at 2.50 pm.
27. The Governor and chaplain visited each cell on the deceased block to inform fellow prisoners of his death. One young prisoner was particularly affected and an officer allowed him to go to the cell door to say goodbye.
28. A letter to all prisoners about the man's death was posted by the Governor. It also provided details of a memorial service. A debrief was held for staff, and ongoing support was provided by the chaplaincy and care team. The chaplains also made themselves available to prisoners who wished to talk.
29. Prison staff went to great lengths to try to trace the deceased next of kin. They tried the obvious routes, such as the local prisoner database and core records, but the address given for the man's brother was out of date. The deceased had not had any visits or letters since before he arrived at Channings Wood. Staff also contacted the police and his previous prison, but all attempts proved unsuccessful.
30. There seemed to be a general air of sadness about the man's death and it is a testimony to his popularity that over 70 people attended his memorial service. The chaplain took photographs of him lying in his coffin at the undertakers in case a member of his family was ever identified. The photographs were sealed and passed to the Deputy Governor and his belongings were stored. The deceased was cremated and his ashes buried in the nearby churchyard at Oghwell. The undertaker provided a plaque for him and a tree in his memory is to be planted at the prison.
31. The post mortem examination revealed that the man died from ischaemic heart disease and coronary artery stenosis.

## ISSUES

### Clinical care

32. The deceased had no history of recorded heart trouble until his heart attack in 2002. Healthcare quickly responded to his complaint of chest pains and tightness in his chest, and carried out an ECG the same day. They ensured the deceased was taken to hospital by ambulance and kept in contact to apprise themselves of his condition. Once he returned to Channings Wood, his blood pressure, cholesterol and pulse were regularly checked at the Coronary Heart Disease Clinic and his medication was reviewed.
33. The clinical review identified as good practice the fact that the deceased had been regularly reviewed as part of the Coronary Disease Clinic, and also noted that the medical records were well ordered and maintained.

### Emergency calls

34. The Head of Healthcare explained that, unlike most prisons, the emergency call system at Channings Wood does not identify the nature of the emergency. It is thought that staff would feel pressurised to assess the nature of the assistance which was required. I recommended in an earlier report in 2006 that a coded call system should be introduced, and I repeat the recommendation now.

**The Governor should reconsider the use of a coding system to alert staff responding to an incident to the nature of the emergency, and allow them to bring the necessary equipment.**

35. If such a system had been in place, healthcare staff would have been better prepared and equipped to respond to the discovery of the man, and would have known immediately that the defibrillator was required. As it was, there was some confusion as staff believed they were responding to a discipline incident. The clinical reviewer says that the emergency call did not identify the nature of the incident and that, whilst this did not materially change the outcome, the procedures require formalising for consistency in future cases.

### Assessment for work

36. Despite the deceased heart attack in 2002, it does not seem that he was properly assessed for his transfer to work in the stores although there does seem to be a system in place to do so.
37. The prison has since responded to this recommendation and confirmed that there is a system already in place, although it did not appear to have been implemented in this man's case. The system assesses a prisoner's suitability for work and re-assesses it when their work status changes.
38. The prison described a system where each main activity required of a particular job is broken down into its core components. When a prisoner is seen by a doctor, they identify any areas or components of work that may be unsuitable.

The prisoner is then allocated work based on this information. If a prisoner's work status changes for medical reasons they are reviewed and their labour status is re-categorised.

**The Governor should ensure that the existing system for assessing the fitness for prisoners to work is implemented in all work areas.**

#### **Attempts to trace next of kin**

39. Although the prison made every attempt to try to locate a member of the deceased family, this was unsuccessful. His next of kin details had not been updated since his reception into Channings Wood in 1997.
40. The prison has provided information that a system to update next of kin details is already in place. A general review of all next of kin records was carried out in May 2006 and again in May 2007. This is to be repeated annually. In addition, prisoners are invited to update their next of kin records at any time they choose to do so and a pro-forma is available for this purpose. It appears that Mr Donaldson chose not to update these details.

**The Governor should ensure a system is in place routinely to check and update prisoner's next of kin details.**

#### **First aid training**

41. The first officer to enter the man's cell, said that he had not received any first aid training since he joined the Prison Service and, had he attempted resuscitation, it would have been carried out incorrectly.
42. The prison provided information that first aid training is available to all grades of staff. This training, however, is specifically targeted towards all staff of Senior Officer grade, as this is the only grade of staff always guaranteed to be on duty at the prison.

**The Governor should ensure that a cross-section of discipline staff are up to date trained first aiders.**

#### **Allowing a prisoner to say goodbye**

43. If the officer who showed the humanity to allow a prisoner who was very close to the deceased to say goodbye can be identified, he or she should be commended. The officer was careful not to breach any rules and did not allow the prisoner to enter the cell. Nevertheless, his act showed compassion and a sense of understanding about the prisoner's feelings. Unfortunately, the interviewee who told investigators about this was unable to recall the officer's name.

## RECOMMENDATIONS

1. The Governor should reconsider the use of a coding system to alert staff responding to an incident to the nature of the emergency, and allow them to bring the necessary equipment.

**The prison accepted this recommendation and reconsidered the use of a coding system to alert staff to the nature of an emergency. However, after consideration they have decided to retain their current system.**

2. The Governor should ensure that the existing system for assessing the fitness for prisoners to work is implemented in all work areas.

**The prison accepted this recommendation. Although the system did not appear to be implemented in this particular case, one is already in place to identify suitable work allocation and to review any labour changes for prisoners.**

3. The Governor should ensure a system is in place routinely to check and update prisoners' next of kin details.

**The prison provided information that a system was already in place to annually update prisoners next of kin details.**

4. The Governor should ensure that a cross-section of discipline staff are up to date trained first aiders.

**The prison accepted this recommendation and added that first aid training is available to all grades of staff. Training is specifically targeted at Senior Officers, as a member of staff at this grade is always on duty in the prison.**