PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Channings Wood in August 2012

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of the investigation into the death of a man at HMP Channings Wood in August 2012. The man, who was 49 years old, was found dead in bed at about 8.40am. The post-mortem report concluded that the cause of his death was ischaemic heart disease and hypertension. I offer my condolences to his family and friends.

The investigation was led by one of my investigators. A review of the man's clinical care at Channings Wood was conducted by a clinical reviewer. Channings Wood cooperated fully with the investigation.

The man had been in prison since July 2006. He had suffered from heart related problems for some years but often did not take his prescribed medication and frequently self-harmed. He was under the care of the prison's doctor and psychiatrist and his conditions were generally well managed.

The post-mortem examination indicated that the man had taken some medication not prescribed for him, which might have exacerbated his heart condition. I recommend that the prison take a more active approach to dealing with the misuse of prescribed medication. However, overall I am satisfied that he received a reasonable standard of care during his time at Channings Wood. Good efforts were made by prison and healthcare staff to encourage him to take his medication, but his failure to do so increased his risk of early death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2013**

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SUMMARY

1. The man had been in prison custody since July 2006 after receiving an indeterminate sentence for public protection (IPP). He started to self-harm by making superficial cuts to his arms after the death of his sister in February 2006.

2. The man began his sentence at HMP Cardiff where a psychological assessment assessed him as having a low or borderline learning disability. He could not read or write. In 2008, he suffered a heart attack. He had high blood pressure (hypertension) and possible chronic obstructive pulmonary disease[1] (COPD). He said he heard voices. He was prescribed a number of medications to manage his physical and mental health.

3. The man transferred to Channings Wood in June 2009. He started to self-harm soon after by making superficial cuts to his arms. This continued intermittently throughout his time in custody and suicide and self-harm prevention procedures (ACCT[2]) were put in place to manage and support him. He said he had no intention of taking his life but often self-harmed when his mood was low. He kept himself occupied working on the wing which helped reduce his propensity to harm himself.

4. The man's physical and mental health problems were generally well controlled. However, from 2010, he began to stop taking his medication or took it only intermittently. He was seen frequently by healthcare staff, including nurses, doctors and a psychiatrist who warned him of the risks he was taking with his health by not taking his medication and this could cause his early death. However, he often ignored this advice.

5. On a morning in August 2012, the man was found dead in his cell. It was evident he had been dead some time so resuscitation was not attempted.

6. The investigation found that staff were responsive to the man's increasing needs and care was delivered sympathetically. We make recommendations about unlock procedures and contacting next of kin when a prisoner dies. We also recommend a more proactive approach in investigation drug misuse on the wings. Overall, we are satisfied that the man received an appropriate level of care and support at Channings Wood.

[1] Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases, including chronic bronchitis, emphysema.
[2] The Assessment, Care in Custody and Teamwork (ACCT) system is a Prison Service-wide process for supporting and monitoring prisoners thought to be at risk of harming themselves.

THE INVESTIGATION PROCESS

7. The investigator visited HMP Channings Wood on 31 August and met the Governor and other members of the management team, a member of healthcare staff and the prison family liaison officer. The investigator obtained copies of the man's prison and medical records.

8. Notices were issued to staff and prisoners at Channings Wood informing them of the investigation and inviting them to contact the investigator with information. There was no response to the notices.

9. The investigator interviewed prison and healthcare staff on 9 October 2012. Two further interviews were conducted by telephone on 18 October. The investigator gave the Governor initial written feedback after the interviews.

10. The medical director of NHS Devon, Plymouth and Torbay Care Trust (PCT) carried out a clinical review of the man's care at Channings Wood, taking account of the man's medical records and transcripts of interviews conducted by the investigator.

11. HM Coroner for Devon was informed of the investigation and provided a copy of the post-mortem report and a copy of a police statement from a prisoner at Channings Wood. This report has been sent to the Coroner to assist with his enquiries.

12. One of the Ombudsman's family liaison officers (FLO) contacted the man's family shortly after his death to explain the investigation process. The man's two sisters wanted more information about his cause of death. His youngest sister wanted to know why she was not informed of her brother's death sooner.

13. We received comments on the draft report from both family members. They commented that their brother had mental health problems and was refusing to take his medication. They believe that more should have been done to ensure he took this which could have included moving him to a suitable hospital. They were also concerned to see that there were drugs in his toxicology results which were not prescribed to him and which may have contributed to his death; and that he was not discovered sooner.

HMP Channings Wood

14. HMP Channings Wood is a category C prison in Devon. (All prisoners are allocated a security category based on factors including their offence, risk of escape and risk to the public if they did escape. Category C prisoners are those who, typically, could not be trusted in open conditions, but who are thought unlikely to escape). The prison holds a maximum of 731 prisoners.

15. Healthcare services are provided by the Devon Partnership Trust. There is nursing cover during the day between 5.00am and 7.45pm from Monday to Thursday, and until 5.00pm on Friday and at weekends. The GP service is provided by a company called Devon Doctors.

HM Inspectorate of Prisons (HMIP)

16. The most recent available inspection report is of a short unannounced follow-up inspection in July 2010 of a previous full inspection in 2007. The then Deputy Chief Inspector of Prisons, in the introduction to the report said that Channings Wood continued to be a "reasonable training prison, providing a generally safe and purposeful environment".

17. Inspectors commented that they found that healthcare was "better integrated into the work of the prison" than it had been in 2007, and that, overall, services were reasonably good.

Independent Monitoring Board (IMB)

18. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In its annual report for the year to 31 August 2012, the IMB was concerned about the quality of health care provision, which the Board considered did not meet the standards expected by the PCT. The IMB was particularly concerned that the required number of GP surgeries were not run so prisoners had long delays for appointments. We did not find that this man had delayed appointments.

Previous deaths at HMP Channings Wood

19. There were six deaths from natural causes at Channings Wood in the 24 months before the man's death. There were no similarities between the findings of this investigation and the investigations into those deaths.

KEY EVENTS

20. The man was born in December 1961 in Merthyr Tydfil. He had a learning disability and was unable to read or write. He had convictions dating back to 1979 and had been in prison a number of times. On 28 July 2006, he was sentenced to an indeterminate sentence for public protection (IPP) for a conviction of arson, and went to HMP Cardiff.

21. At Cardiff the man said he had started to self-harm in early 2006, after the death of his sister and heard voices telling him to cut himself. At Cardiff he repeatedly self-harmed by making superficial cuts to his arms, but without any apparent suicidal intent. ACCT procedures were often used to support him through periods of crisis. He had difficulties sleeping at night and suffered from depression for which he was prescribed medication.

22. A psychiatric report completed in July 2006 noted that the man did not suffer from any mental impairment, but had drug induced psychosis from his abuse of amphetamines and had a low to borderline learning disability.

23. In 2008, the man suffered a myocardial Infarction (a heart attack). He was diagnosed with hypertension and possible chronic obstructive pulmonary disease (COPD). He was prescribed medication to treat his heart condition. He had experienced seizures on two occasions, but no formal diagnosis was made about their cause.

Transfer to Channings Wood

24. The man transferred to Channings Wood on 24 June 2009. During a reception health screen his health conditions were noted, including high blood pressure, learning difficulties (including that he could not read or write) and a persistent cough. It was also recorded that he had had a heart attack at Cardiff and had self-harmed two weeks before his arrival. As a precaution, an ACCT was opened.

25. The man's medication was:
    - Citalopram 20mg daily (an anti-depressant)
    - Clopidogrel 75mg daily (to lower the risk of blood clots)
    - Ramipril 10mg daily (for heart failure, hypertension, stroke, heart attack)
    - Amlodipine 10mg daily (for high blood pressure and to prevent angina).
    - Atenolol 50mg daily (to treat high blood pressure and angina)
    - Aspirin 75mg daily
    - Simvastatin 60mg daily (a cholesterol lowering drug)
    - Ranitidine 150mg daily (used to treat ulcers and acid reflux)

26. The man had a single cell on Avon (A) wing and remained there throughout his time at Channings Wood.

27. Two days after arrival at Channings Wood, the man self-harmed by making superficial cuts to his left arm with a plastic knife. He was treated in the healthcare unit. Although he continued to make superficial cuts to his arms, prison staff said he settled well into the regime. The ACCT was closed in October 2009.

2010

28. By March 2010 the frequency of the man's incidents of self-harm had reduced. He was employed serving meals on the wing and also attended education sessions to address his lack of reading and writing skills.

29. In July, the man started one-to-one sessions with a forensic psychologist in relation to his offending behaviour. The mental health team reviewed him regularly because of his self-harming behaviour. In September, a nurse noted in his medical record that he engaged well with others and enjoyed his job on the wing. He told her he still had thoughts of self-harm, but he was able to control them better.

30. In October 2010, the man told the nurse that his medication for both his physical and mental ailments made him feel "groggy" and he wanted to stop taking them. He said his medication increased his feelings of wanting to self-harm. At the time, he had not taken his medication for two days and said his sleep had improved. The nurse explained the need to take his medication and the risks associated with his heart condition if he stopped but the man was unconcerned. His blood pressure reading was high, and he was referred to the doctor.

31. A doctor saw the man the same day, but he was insistent that that he did not want to take his medication. Another doctor saw him on 18 October about his refusal to take his medication and warned him of the high risk of experiencing a stroke or heart attack and that ultimately non-compliance would lead to his death. The doctor noted that the man was able to understand the situation and was not suicidal. He said he felt okay and maintained his stance. An ECG[3] was later carried out which showed no acute problems.

32. A psychiatrist saw the man on 27 October about his refusal to take his medication. She noted that he had the mental capacity to make treatment decisions about his health and was not suicidal. At the time, he had been prescribed trazodone for depression and anxiety which the psychiatrist confirmed would have contributed to his feeling groggy. She was content that he should stop taking trazodone but was concerned that he had not taken his medication for high blood pressure. The man said he would think about this and let the nurses know what he decided.

33. The next week, the man attended healthcare twice complaining of breathlessness. His blood pressure was still high. A nurse repeated the need for him to take his medication which he still had not taken. He said he would take the medication necessary for his heart but not anti-depressants. Despite this, he still continued not to take it. On 7 November, healthcare staff noted that the man's blood pressure was still high and the next day he agreed to take the medication necessary for his physical health.

34. By 27 November, the man was again not taking his medication. At his mental health review two days later, a nurse noted that he was pale and tearful and he said he had made superficial cuts to his arms two days earlier. He was not eating properly and felt unwell. He agreed to restart his medication for a trial

[3] ECG (electrocardiogram) is a test that measures the electrical activity of the heart.

period of two weeks. He was prescribed citalopram and an ACCT was opened to support him.

35. On 7 December, the psychiatrist examined the man who said his mood was low and that he heard voices telling him to self-harm. He had made superficial cuts to his arm the previous night and was still not sleeping well. He agreed to restart taking his antipsychotic medication as he realised it might help control the auditory hallucinations. He told the psychiatrist that there was no real trigger for his recent self-harm, other than he sometimes felt depressed.

2011

36. At the man's mental health review on 5 January 2011, he said his sleep had improved since being prescribed quetiapine[4] by the psychiatrist in December 2010. He said he still heard voices at night but was now able to ignore them and his mood was much better. The ACCT was closed on 19 January 2011. He had not self-harmed for some time and was fully compliant with his medication.

37. On 19 February, the man was found collapsed in his cell, fitting and foaming from the mouth. An overdose was suspected and he was taken to hospital from where he was discharged the same day after satisfactory completion of tests. An ACCT document was opened. He told a nurse the next morning that he had taken 20 trazodone tablets but would not say where they came from. He said he had taken the tablets to improve his mood not to harm himself. The ACCT was closed on 27 February.

38. In February and March 2011, the man was assessed by two independent learning disability hospitals in Wales, because there were no prison programmes suitable to reduce his risk to the public. Both concluded they could offer the man longer term psychological and pharmacological interventions aimed at addressing his risk factors and establishing a care pathway back to the community. A decision to transfer him to a hospital would have to be made by a learning disability consultant who was sent relevant reports. (The learning disability consultant later assessed the man on 2 August 2011.)

39. On 17 March, the man self-harmed by cutting his arm with a razor blade. He said he felt low and self-harmed to occupy his time when he was locked in his cell. He was given drawing materials to help distract him and he agreed to hand in his plastic cutlery after each meal and his razor blades after each use. He attended five further one-to-one sessions with the psychologist during March to help develop coping strategies to avoid self-harm. His mood appeared to improve and the ACCT document was closed on 14 April.

40. In June, the man stopped taking his medication again, although a nurse had reminded him many times about the importance of taking it. She was also concerned that he sometimes did not attend scheduled checks for basic health observations, such as blood pressure, pulse and weight to be taken and had also reminded him of how important it was to have his blood pressure checked regularly. He told a prison officer that he self-medicated but would not say

[4] Quetiapine is used to relieve the symptoms of schizophrenia, bipolar disorder, and other similar mental health problems.

anything more. A security incident report was submitted and he was to be monitored. By the end of June, he started to collect his medication sporadically and this continued for the rest of the year.

41. Over the Christmas the man's mood was low and he told staff he was having difficulties sleeping. He was temporarily prescribed zopiclone to help him sleep. On 30 December, he made cuts to his arm, and an ACCT was opened.

2012

42. After Christmas, the man's mood improved. He told officers that he had felt supported by the ACCT procedures. His ACCT was closed on 5 January 2012.

43. On 7 January, healthcare staff noted that the man was still taking his medication only intermittently and had not collected any for the previous three days. He told officers on his wing that he wanted to stop taking all his medication because it made him feel unwell. The next day the wing senior officer and a nurse spoke to the man and reiterated the risks to his health of not taking his medication.

44. On 11 January the man suffered two seizures, one in the morning and one in the afternoon. After the second seizure, he admitted to taking non-prescribed tablets (acupan) but said he had not intended to kill himself. A neurology[5] referral was made. During the rest of January, there continued to be concerns that the man was not taking his medication. On 1 February, he refused to attend hospital for his scheduled neurology appointment. The same day the learning disability consultant's psychiatric report was received, which concluded that the man was not suffering from any mental disorder as described under the Mental Health Act and a transfer to a secure hospital was not appropriate.

45. During February, the man again took his medication only intermittently despite attempts by prison and healthcare staff to encourage him. On 27 February, a doctor reminded him of the consequences of not taking his medication. The man said he was aware that he was putting himself at risk of a heart attack or stroke and could die.

46. On 6 March, at a healthcare review with a nurse, the man explained that he did not take his medication because it made him feel worse. The nurse suggested that the number of medications the man was prescribed should be reduced to improve his compliance. It was subsequently agreed that he should take just clopidogrel, ramipril and simvastatin.

47. On 24 March, the man had another seizure and fell and hit his head. Nurses found him in a dazed state and bleeding from a wound to his head. He was taken to hospital, where his wound was stitched and he returned to the prison the same day. A nurse examined him the next week and noted his head wound was healing well and he had no thoughts of self-harm. He was still refusing to take his medication and was encouraged to attend healthcare for regular blood pressure checks.

[5] Neurology (brain and nerve) conditions.

48. During April and May the man continued not to take his medication. The possibility of allowing him to keep his medication in his cell to improve his compliance was considered but the man did not want to do so. Nurses referred him to the doctor but he did not attend his appointments.

49. The man made superficial cuts to his arms twice in June. The cuts were cleaned and dressed and he was offered support by the nurse. He said his mood was low. Despite encouragement, he continued not to take his medication.

50. The Deputy Healthcare Manager saw the man a number of times. She described his acts of self-harm as very superficial but he was treated and offered counselling when needed. She had attempted to persuade him to take his medication and keep it in his cell but he refused, although he was fully aware that not taking his medication would lead to his death. She said when he felt particularly unwell, he would take his medication, but this lasted for only a few days.

51. On 9 July, the man refused to attend a hospital appointment for an EEG[6]. The next morning he was treated for superficial cuts he had made to his hand during the night. In the afternoon he asked a nurse for sleeping tablets. The doctor prescribed zopiclone for three days, Friday 13 July, Saturday 14 July and Sunday 15 July.

52. The psychiatrist reviewed the man's medical records with other healthcare colleagues that afternoon. A nurse said the man had told her that he had self-harmed because of the extra time in his cell due to early lock up at the weekends. He said he did not have auditory hallucinations and had no problems on the wing. Healthcare staff were to continue to monitor him and he was due to attend hospital on 18 July to have a 24hour blood pressure monitor fitted.

53. A doctor examined the man on 12 July as he had fallen and hit his head while painting. He appeared okay but still refused to take his medication, despite the doctor explaining the risks again. The doctor told him that raised blood pressure and dizziness might have contributed to his fall. As the man wanted to continue with his job he said he would improve his compliance with his medication. The doctor suggested his ramipril be increased over three days.

54. The man attended his hospital appointment on 18 July, but it was noted that he was still not taking his medication. The doctor reviewed the man's medication chart on 9 August, and again noted his non-compliance.

55. Personal officer[7] entries in the man's records repeatedly noted that he was committed to keeping himself busy on the wing with a job as a wing painter and in the servery. He often used his work as an excuse for not having time to collect his medication. An officer told the investigator that the man had a very good work ethic and interacted well with prison staff and prisoners.

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[6] Electroencephalography is a technique that records the brain's electrical activity and can test for epilepsy.

[7] Prisoners are allocated a personal officer to support them and be their first point of contact for any prison issued.

56. On 20 August the man attended a healthcare appointment with a nurse and again refused his medication. Two days later, the prison doctor noted that the man had not taken his ramipril since at least 21 July. The man told the doctor that he did not like queuing for medication. The deputy healthcare manager suggested to the man that he could be given a collection slip with a specific collection time of 9.00am each day, when there would be no queue. The man agreed this arrangement and a special collection slip was prepared, but he still did not go to collect his medication.

The day preceding the man's death and the day of the man's death

57. A prisoner in the cell opposite to the man said in his police statement that he had last seen him around 4.10pm at the servery. He said the man seemed okay and he was not concerned about him. The man returned to his cell around 4.30pm. All cells were locked by 5.00pm. No concerns were recorded on the wing for the evening.

58. An operation support grade (OSG) was on night duty and carried out a roll check not long after he came on duty at 8.00pm to check all prisoners were present in their cell. He recalled that he checked the man's cell at about 8.50pm when the man was lying on his bed in his kitchen "whites" (his servery uniform). The cell was light, his television was off and he appeared to be asleep. The OSG said the wing was quiet that night and the man did not use his emergency cell bell. Prisoners are not routinely checked through the night unless they are being monitored as at risk of suicide or self-harm, which the man was not.

59. At 6.00am the next morning, the OSG conducted the morning roll check. When he arrived at the man's cell, he was still lying on his bed, in his kitchen whites and appeared to be asleep. At the time, the OSG thought that he must have got up early, dressed and then gone back to sleep until it was time to start work. The cell was light, but the OSG gave no indication if this was because the cell light was on or if it was naturally light. He told the investigator that he was unsure whether or not the man was in the same position that he had seen him in the previous night, or whether he displayed any signs of life. The OSG completed his night duty shift at about 7.45am.

60. An officer unlocked prisoners on the man's landing, from around 8.00am. The officer told the investigator that he unlocked the man's door while he looked into his cell through the door observation panel and said good morning to him. The man did not respond, but the officer said that prisoners did not always reply. He believed that the man was okay, partly because his cell light was on and because he was dressed in his kitchen whites, while lying on the bed.

61. A short while after being unlocked, the prisoner from the opposite cell went to borrow a cup from the man. The man's door was slightly ajar and the prisoner pushed the door open. He found the man lying face down on the bed in his kitchen whites. The television was not on, which the prisoner said was unusual. He said the man's right arm looked bruised, there was no movement and he did not respond when he called his name. The prisoner immediately shouted for staff assistance.

62. Other prisoners on the landing became aware that something was wrong and alerted an officer who was in the wing office. The officer said he went quickly to the man's cell and, because he knew that the man suffered from seizures, he radioed for the healthcare team to attend. The time of the radio message was recorded as 8.40am, the same time as a general alarm button on the landing was pressed by a prisoner.

63. The officer found the man lying face down on his bed. He showed no signs of life, had no pulse, was not breathing and his body was cold and stiff. He was wearing his kitchen whites which the officer said he usually wore. The officer who had carried out the morning unlock arrived seconds after this officer and also checked and found no signs of life. The officer said he turned the man over to see whether emergency cardiopulmonary resuscitation could be carried out, but his body was stiff and he felt it would be inappropriate.

64. The deputy healthcare manager responded to the radio call and a prison officer helped her bring the medical emergency grab bag. On the way she requested more information from the Communications Room so she would have an idea of what type of emergency she was attending. She was told that it was an emergency code blue[8] so radioed a colleague to bring the defibrillator[9] to the wing.

65. The deputy healthcare manager arrived at the man's cell within a couple of minutes. She examined him and found he was unresponsive and his body was cold. He had pooling (an accumulation of blood) in his arms and rigor mortis[10] was present in his upper body. She agreed that it would be inappropriate to attempt resuscitation, as did a colleague who had arrived with the defibrillator. Other staff, including the duty governor, arrived at the cell and an ambulance was called at 8.43am. Paramedics arrived and at 9.01am confirmed the man's death.

After the man's death

66. Prisoners were informed of the man's death and offered support. The prison chaplain came to the man's wing to provide further support. Prisoners on open ACCTs were reviewed and reminded of the services available to support them.

67. A hot de-brief meeting was held at 12.10pm chaired by an operational manager to provide support for the staff who had attended the man's cell and give them the opportunity to talk about what had happened.

68. An officer was appointed as the prison's family liaison officer (FLO). An operational manager, who assisted the FLO, told the investigator that strenuous attempts were made to locate the man's next of kin. The person he had nominated had died while he was in custody. An alternative contact was sought, which included prison staff checking visits records, but they had no success. After some investigations, the man's two sisters were identified. They lived some distance from the prison in Merthyr Tydfil so the operational manager contacted HMP Cardiff (within an hour of the man's death) to see if

[8] Code Blue emergency is used in cases of serious life threatening emergency, eg prisoner not breathing, prisoner collapse.
[9] A defibrillator is a life-saving machine that gives the heart an electric shock in some cases of cardiac arrest.
[10] It takes the body approximately two to six hours to reach the stage of rigor mortis.

they could send a member of their staff to inform the man's family of his death. As a matter of routine, they contacted the local police in Wales, who then took on the responsibility of informing one of the man's sisters of his death later that day. His youngest sister had left that evening to go on holiday abroad and so was not told immediately.

69. The next day, the prison FLO spoke to the man's sister and also his niece. She also managed to speak to his sister who was abroad. She explained what had happened in relation to the man's death and what the next formalities would be. His family were offered a visit to the prison and condolence letters were sent. The FLO continued to liaise with the man's sisters and the funeral directors to arrange his funeral. The prison contributed towards the funeral costs, which was attended by prison staff. The man's personal property was returned to his family.

Post-mortem examination

70. The post-mortem report notes that the man died as a result of ischaemic heart disease with hypertension as a significant contributory factor.

71. The report also notes that a level of nefopam known also as aucupan (used for moderate pain relief) of 2.6ml was found in the man's blood. This was above the therapeutic range of 0.2ml, but well below the toxic level of 10ml. He was never prescribed nefopam and therefore must have obtained it illicitly. A side effect of nefopam is symptoms of tachycardia (increased heart rate). It is possible that the use of nefopam placed a strain on the man's damaged heart and contributed to his death.

ISSUES

Clinical care

72. The clinical review was conducted by the medical director of NHS Devon, Plymouth and Torbay Care Trust (PCT) who made no recommendations about the man's medical care. His report highlights that the man suffered from hypertension and ischaemic heart disease and died suddenly from natural causes. He notes that the medical care the man received while in prison was of an adequate standard and did not adversely affect him or contribute to his death.

73. The clinical review also highlights that there was clear evidence of regular reviews of the man's cardiovascular disease, and appropriate tests and investigations were undertaken. Healthcare staff made comprehensive notes about his lack of compliance with his medication and his mental capacity. The man had significant hypertension (high blood pressure) which was not appropriately adequately controlled because he chose not to take his prescribed medication. With his history of ischaemic heart disease, he was significantly more at risk of sudden death from a cardiac cause than an average person of his age. This was explained to the man many times and prison and healthcare staff also made good efforts and changed practices to try to encourage him to take his medication. In this respect we consider the man received a high standard of care.

Abuse of medication

74. There is anecdotal evidence that the man repeatedly obtained medication (aucupan) from other prisoners and took it. This could have had an adverse impact on his already damaged cardiac function. However, in the clinical reviewer's opinion, prison medical and nursing staff would not have changed the man's treatment regime even if they had been aware of this. There is no documented record that they considered his illicit drug use during his medical care.

75. The man repeatedly refused to say where he obtained the illicit medication from. Prison staff appropriately submitted security information reports when they received information of the man's illicit drug taking. Wing staff were then informed to be vigilant of any drug related issues on the wing and the man was to be monitored.

76. The trading and selling of prescribed medication is a problem in prisons and the man obviously had access to some acupan. The security department reported that in the two months before the man's death, there were no reports of illicit trading of acupan on his wing. Nor was there any record of him being involved in any incidents of concern. We note however, that there was little evidence of active attempts to try to investigate the source of the man's illicit medication, even after his death. The last inspection noted that although Channings Wood had a written drug supply reduction strategy, "it was little more than a list of available resources. Risks and issues particular to Channings Wood had not been identified, so no objectives or strategies had been set to address them." We make the following recommendation:

The Governor should ensure that the drug supply reduction strategy includes active measures to deal with the problem of illicit use of prescribed medication.

Suicide and self-harm monitoring

77. The man self-harmed on many occasions during his time in prison. The investigation found that prison and healthcare staff used ACCT procedures appropriately to support him when necessary. He also received frequent support in relation to his self-harm from nurses and a psychiatrist and psychologist.

Roll checks and unlock

78. Channings Wood's local roll check and unlocking procedure requires staff to conduct a body count check and does not refer to checking prisoners' welfare. When the man's cell was unlocked on the morning he was found dead, the officer did not obtain a response. When he was discovered later, it was apparent that he had been dead for some hours and he was likely to have been dead by the time of the roll check at 6.00am and at unlock at 8.00am

79. While we accept that a roll check is primarily for security purposes, the need to get a response from prisoners when unlocking cells is covered in the initial prison officer training. Further, Prison Service Instruction (PSI) 10/2011, requires there to be "clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock". There was no such system at Channings Wood. In this man's case a check would not have affected the outcome but in other circumstances it could be crucial. It also ensures that staff rather than other prisoners are the first to deal with any emergency. We therefore make the following recommendation:

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Contact with the man's next of kin

80. Channings Wood made strenuous efforts to find details of the man's next of kin and passed these to HMP Cardiff within an hour of his death. HMP Cardiff asked the local police to break the news. The man's youngest sister told the PPO FLO that she did not leave to go on holiday until later that evening but had not been informed of her brother's death before she went.

81. Prison Service Instructions require that after a death in custody, the deceased's next of kin should be informed of their death as quickly as possible and this should be done in person where possible, using staff from a different prison if necessary. Unfortunately, Channings Wood have no record of the time that police in Wales first contacted the man's family and have not been able to account for the delay after they agreed with Cardiff that they would inform his family. We do not criticise the decision to ask Cardiff prison to undertake this duty but the purpose was to avoid delay. We consider the prison should have established whether Cardiff prison or the police could pass on the news promptly and if not used an alternative means or carried out the task

themselves. Channings Wood did not monitor progress to ensure the news was broken to the man's family in a timely and appropriate manner.

82. We therefore make the following recommendation:

The Governor should ensure that after a death in custody appropriate arrangements are made to ensure the next of kin is informed as soon as possible and that a record is kept of when and by whom this is done.

Recommendations

1. The Governor should ensure that the drug supply reduction strategy includes active measures to deal with the problem of illicit use of prescribed medication.

   The National Offender Management Service accepted this recommendation, writing:

   "The policy is currently being updated by Head of Ops/Security to identify robust measures for the management of prescribed medication."

2. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

   The National Offender Management Service accepted this recommendation, writing:

   "Currently the local security strategy does not require that staff gain a response when unlocking the cell door. This stipulation will be added under:
   - Keys, locks and gates
   - Roll checks.

   Head of Ops/Security will draft a NTS to uniform staff ensuring that a response is gained when opening the door."

3. The Governor should ensure that after a death in custody appropriate arrangements are made to ensure the next of kin is informed as soon as possible and that a record is kept of when and by whom this is done.

   The National Offender Management Service accepted this recommendation, writing:

   "Residential managers to complete annual N.O.K. detail updates, to be entered on C-Nomis. Head of Operations/Security, will update contingency plans to ensure the next of kin are notified as soon as is possible. A record will be made to evidence when they were notified and by whom."