PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man whilst in the custody of HMP Channings Wood in September 2011

Report by the Prisons and Probation Ombudsman for England and Wales

May 2013

The man died in September 2011 at HMP Channings Wood. The post mortem examination confirmed that his death was caused by ischaemic heart disease (heart attack). I offer my condolences to his family and friends for their loss.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to review the man's clinical care in custody. I apologise for the delay in issuing this report.

The man was discovered collapsed on the floor of his cell early in the morning. It was apparent he had been dead some time. While I am satisfied that the man's death could not reasonably have been foreseen or prevented, the clinical reviewer suggests that the introduction of cholesterol testing and cardiovascular risk assessments might help identify those at risk of heart disease. Similarly, while nothing would have changed the outcome for the man, the investigation also found some weaknesses in emergency procedures at Channings Wood which need to be improved.

This report was shared with the man's sister at the draft stage; she did not make any comments. The service response to the recommendations is now included.

The 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 was found dead in his cell at HMP Channings Wood in September 2011. He was serving a sentence of six and a half years and had been released in May 2009. He was then recalled to prison in August 2009 after breaking the conditions of his release licence.

2. Although the man had a family history of heart failure he had not previously displayed any similar symptoms. On the evening before his death, he played in a football match, after which he returned to his cell. Staff who spoke to him were not concerned about him and he had not complained of feeling unwell.

3. On the day the man died, a night patrol officer looked into the man's cell during a normal early morning roll check. The staff member saw the man on the floor of his cell and summoned urgent assistance.

4. When prison staff entered the cell they found the man unconscious and showing no signs of life. It was evident to them that rigor mortis had set in, but despite this and on advice from the emergency services, they attempted resuscitation without success.

THE INVESTIGATION PROCESS

5. One of the Ombudsman's investigators began the investigation when she visited the prison on 14 September. The investigation was then carried forward by another investigator. On 22 and 23 November, he visited Channings Wood and met a number of staff involved in the emergency. Additionally, the investigator met the clinical reviewer. Before leaving the prison on 23 November, the investigator discussed his initial findings with a senior manager and suggested relocating a defibrillator in the prison.

6. One of the Ombudsman's family liaison officers contacted the man's next of kin and explained the role of this office and our investigation. The man's family said that they had no immediate concerns relating to his death. They said the prison had offered assistance with the cost of the man's funeral and returned all of his property. They were offered the opportunity to visit the prison. They had no questions for the investigator at that stage.

7. We regret the delay in issuing this report which was caused by work pressures and a change of responsibilities in this office.

HMP CHANNINGS WOOD

8. Channings Wood is a category C (medium security) training prison near Newton Abbott, in Devon. It has a maximum capacity of 731 prisoners. Healthcare staff work at Channings Wood during the day, but there is no inpatient facility and no nursing cover during the night.

Her Majesty's Chief Inspector of Prisons

9. In the introduction to the latest report on Channings Wood, following a short unannounced inspection between 5 and 8 July 2010, the then Deputy Chief Inspector said Channings Wood had sustained much of the good work previously identified, but there remained scope for improvement.

10. The report went on to say that Channings Wood continued to provide a generally safe and purposeful environment. However, there remained a need for more activities to ensure all prisoners were able to take part in regular work or training.

Independent Monitoring Board

11. Each prison has an Independent Monitoring Board (IMB) made up of unpaid members of the local community to ensure standards of care and decency are maintained. In the most recently published IMB annual report, covering the period from 1 September 2010 – 31 August 2011 the Board were generally positive about developments in the prison, In relation to healthcare they said that nurse led care was excellent but there was too much use of locum doctors. They reported ongoing difficulties with filling the places in the prison's drug therapeutic community but noted that prisoners who had completed the course were very positive about the work being done.

KEY EVENTS

12. The man lived in the London area. He had a criminal record dating back to 1984. Before his current sentence, he had been imprisoned on 11 occasions. The man had a history of drug misuse.

13. The man was last released from custody on licence on 22 May 2009. Release on licence means that the prisoner agrees to certain conditions and, providing he complies, remains in the community. If his licence conditions are broken, the licence can be revoked and the prisoner returned to prison custody.

14. Because the man had a history of drug misuse, a condition of his licence required him to live at a residential approved premises, (previously known as probation hostels) and undertake a drug rehabilitation programme. The man moved to approved premises in Plymouth for a fresh start. However, he was unable to maintain his abstinence and was recalled to prison on 1 August 2009. He was taken to HMP Exeter.

15. Soon after arriving at Exeter, the man was transferred to HMP Guys Marsh in Dorset. He remained there until 9 February 2010, when he moved to Channings Wood to participate in the Drug Therapeutic Community Programme (DTCP) an abstinence based residential programme lasting a minimum of ten and a maximum of 12 months.

16. In July 2010, the DTCP Treatment Manager recorded that progress on the programme had been difficult for the man. He wrote that the man could be polite, mature and a pleasure to speak to, and yet become frustrated and angry. He added that during the programme sessions, the man had been truthful about his “cravings surrounding drugs” but would still use threatening behaviour towards others if he did not get his own way. The DTCP Treatment Manager recommended that the man should see a bereavement counsellor to explore his emotions related to the loss of his parents. From DTCP Treatment Manager’s report, it appears the man agreed with that assessment. Unfortunately, the man’s motivation to continue with DTCP was short lived and he left the programme soon after.

17. On 30 March 2011, the Parole Board met to consider whether the man would be suitable for release once more on licence. (The Parole Board is an independent body that assesses prisoners subject to discretionary release to decide whether they can be safely released into the community.) The Board considered the man’s history of offending, the circumstances surrounding his previous recall, risk assessment and behaviour in prison. In concluding their report, the Board said that they could not recommend release as his risk was such that it could not be managed in the community at that time.

18. On 24 August 2011, the man agreed to join a voluntary drug testing programme which would require him to be tested for drugs regularly to help encourage abstinence. His first test was negative.

8 September 2011

19. The man lived on Living Block 3 (LB3.) Officer A, an officer on the LB3 who had known the man told the investigator that the man was polite and well respected by other prisoners. He said that the man regularly went to the prison gymnasium and on 8 September had been playing football. The officer said that he had seen the man after the game and that he had not complained of feeling unwell and appeared fine.

20. At about 8.20pm, an Operational Support Grade (OSG) started work as the night patrol officer on LB3. The OSG told the investigator that she arrived onto LB3 wing and received a handover from the day staff before they left the prison. They did not mention the man during the handover. The OSG then went to every cell to check each prisoner by looking through the observation panel. Although she could not specifically recall checking the man when she spoke to the investigator, she was clear that he had not been lying on the floor. There was nothing exceptional about her check. There was no requirement for the OSG to check prisoners again until 6.00am, during the early morning roll check. She confirmed during interview that there had been no reason to look into the man's cell during the night and that he had not pressed his cell bell to request assistance.

9 September

21. At about 6.00am the next morning, the OSG began looking in each prisoner's cell as part of the early morning roll check. When she arrived at the man's cell, she looked through the observation panel and saw him on the floor of his cell. The man was facing away from her in a kneeling position. The OSG tried to obtain a response by knocking on the door but got none. Realising something was wrong, she went to the wing office and telephoned for assistance. She returned to the man's cell.

22. The Senior Officer (SO) who was the manager on duty that night. Assisting her was Officer B. At interview, the SO said that at about 6.00am she was in one of the other wings when she heard a radio message asking her to go to LB3. She asked the radio operator if it was an emergency and was told that it was likely it was. At the same time, Officer B was at the main entrance to the prison. Having heard the radio message, he went to LB3. Officers C and D also went to the cell.

23. The SO and Officer B arrived at the cell and met the OSG. The SO looked into the cell. She thought that the man had fallen off the toilet, as he was face down and outstretched. She called out the man's name but got no response.

24. Officer B unlocked the cell door and went inside with the SO. He examined the man and checked for a pulse but could not find one. The officer told the investigator the man's arm was cold and when he tried to turn him over to carry out further checks he was unable to move him as his body was stiff. An

additional difficulty was that one of the man's arms was through a gap in the back of a chair and due to the stiffness could not be removed.

25. When asked by the investigator if he knew what rigor mortis was and whether it was present, Officer B agreed it was. (Rigor mortis is a recognisable sign of death which makes the body stiff and difficult to move.) The officer had wanted to turn the man over to perform cardiopulmonary resuscitation (CPR). (CPR is an emergency procedure involving chest compressions to maintain blood circulation and often breaths to push air into the patient's lungs.) Unable to move the man into the correct position, he attempted to perform compressions from the rear by pressing on the man's left shoulder.

26. The OSG used the wing office telephone to request an emergency ambulance. Prison records show that a telephone call was made to the emergency services at 6.05am. The SO spoke to the ambulance service and explained that rigor mortis was present and that the man's body was cold. She said that the emergency operator told her to continue CPR until paramedics arrived.

27. Officer D arrived and began assisting Officer B. She was followed shortly after by Officer C. The SO returned to the cell and told her colleagues what the emergency operator had said. Together, they managed to turn the man over onto his back and begin CPR. Officer C told the SO and Officer B to stop CPR as it was clear to her that the man had died. She told the investigator that the SO repeated what the emergency operator had advised and said that they must continue CPR. Officer C left the wing to await the arrival of the ambulance and escort the paramedics.

28. The ambulance crew arrived at about 6.28am and were taken to the man's cell. At 6.34am, after carrying out their own checks, the paramedics confirmed that the man had died and so no further attempts were made to resuscitate him.

Events following the man's death

29. The Governor obtained the man's next of kin details. The man's family lived in London, a considerable distance from the prison and the Governor decided to telephone them to break the news. Unfortunately, he was unable to make contact for a while, but did manage to speak to them later that day.

30. The Governor appointed a Family Liaison Officer (FLO). The FLO stayed in contact with the man's next of kin. However, due to their distance from the prison, the Governor contacted a prison closer to their address and asked the Governor at that prison to support the family until the FLO could travel to see them.

31. Staff reviewed all prisoners subject to self harm and suicide monitoring to ensure that they had not been adversely affected by the man's death. They also spoke to prisoners on LB3 to offer support. We were told by prison staff

that the local management team were supportive when the man died, but there was little contact from the prison's own local care team.

32. The post mortem report concluded that the man died as a result of ischaemic heart disease (a heart attack)

ISSUES

Clinical care

33. In his clinical review, the clinical reviewer found that the man was prescribed an appropriate detoxification regime when he was first recalled to HMP Exeter. Because of his misuse of drugs, appropriate vaccines for hepatitis were given.

34. The clinical reviewer found that, in Channings Wood, while the medical records relating to the man were "adequate", good practice would have included cardiovascular risk assessment which could include a cholesterol test. He thinks that these measures would reduce the number of deaths from cardiovascular disease. We make the following recommendation based on his findings:

    The Head of Healthcare at Channings Wood should introduce a cardiovascular risk assessment tool.

35. The Clinical GP Lead, Devon Prisons Health Partnership prepared a separate report about the man. They commented that when the man returned to prison custody in 2009, he tested positive for opiates and benzodiazepines (a drug used to treat anxiety and insomnia). He was given a course of lofexidine (used to alleviate the physical symptoms of heroin and opiate withdrawal) and nitrazepam (used to treat moderate to severe insomnia). While at HMP Exeter, healthcare staff noted that the man was a smoker and that his father had died of a heart attack. Like the clinical reviewer, they found very little else of significance in the man's medical record.

Emergency Response

36. There are a number of aspects to the emergency response that require closer examination.

Emergency Call

37. The OSG found the man at about 6.00am, and went to the office to telephone the control room. She then returned to the cell. The control room then transmitted a radio call to instruct the SO to attend the cell. Before doing so, the SO checked whether it was an emergency, as the call was unclear. Because the request transmitted on the radio network did not clarify the nature of the emergency, no emergency equipment was taken to the man's cell.

38. We have previously recommended the use of emergency codes at Channings Wood. A code system ensures that all staff attending the scene understand the nature of the emergency and bring appropriate equipment. The previous recommendation was accepted but managers then ultimately decided that it was unnecessary.

First aid training and equipment

39. The SO attended the cell and was joined by Officers B and C. Of the four members of staff at the scene, only Officer C was first aid trained. During previous investigations, we noted that Channings Wood prioritised the first aid training of senior officers, as there will always be a senior officer on duty. Officer B was the first officer to try to assist the man, but did not have up to date training. We do not criticise Officer B for attempting first aid. However, Officer B was put in this difficult situation precisely because he had not been trained in first aid and CPR.

40. A defibrillator gives automated instructions to the user and can deliver an electric shock to reset a heart rhythm if one is detected. In his clinical review, the clinical reviewer comments that it is generally accepted that rapid defibrillation within one minute has the highest chance of success.

41. The clinical reviewer was surprised to find that, although there were two defibrillators available in the prison, they were both kept in the prison healthcare department and not available in the residential areas. However, he stressed that even if there had been a defibrillator in the area when the man was found, it would not have affected the outcome, as death had occurred some time earlier.

42. The investigator spoke to the Governor about this during the investigation. As a result the Governor made arrangements for a defibrillator to be housed on the main accommodation units.

Resuscitation attempt

43. When the SO and Officer B entered the man's cell and checked his condition, it was evident to them that he had died. They found themselves in a very difficult situation. They both understood what rigor mortis was and were able to recognise its presence.

44. Having telephoned for an ambulance, the staff were told that CPR should be performed. Despite telling the operator that rigor mortis was present and knowing with some certainty that the man was dead, they did as instructed and continued CPR until paramedics arrived and took over.

45. The instructions given by the emergency operator conflict with Prison Service instructions which ask staff not to attempt resuscitation, if rigor mortis of the limbs has clearly set in. The officers therefore found themselves in a difficult and distressing situation, but followed the operator's instruction and performed CPR. We do not criticise the actions of staff in these circumstances. However, it is distressing and inappropriate for CPR to continue when someone is clearly dead.

46. There are areas for improvement relating to the emergency response. We make the following recommendations:

The Governor should introduce emergency radio code procedures to help ensure that those attending an emergency incident know what to expect.

The Governor should ensure that there are sufficient numbers of first aid trained staff on duty at night with ready access to emergency equipment including a defibrillator.

Breaking the news

47. Prison Service Order (PSO) 2710 “Follow up to Deaths in Custody” recommends that breaking the news of a death to the family is best done face to face. Another option is to ask a representative from the prison closest to where the family live to break the news. However, there are factors the Governor should consider, including distance from the prison and the possibility of the news being leaked by prisoners. The Governor was concerned that the man’s family might hear of his death from other prisoners or their families. Because the man’s family lived a long way from the prison, he decided to telephone them to break the news as soon as he could. This was then followed up by contact from the family liaison officer.

48. Breaking the news of a death in person is best practice but we are satisfied that this is not standard practice at Channings Wood, and that on this occasion there were sufficient reasons for this course of action.

RECOMMENDATIONS *(service response included below each)*

1. The Head of Healthcare at Channings Wood should introduce a cardiovascular risk assessment tool.
   Accepted: *There is a CHD risk assessment tool available within systm-one. A doctor is reviewing this tool to ensure that it meets the needs of our client group and that any resulting actions are then implemented. Concerns have been expressed that any clinical tool for assessing risk must have appropriate and robust follow up care available. Systm-One lead to work with clinical lead to ensure that risk assessment tool is suitable and that systems are in place for follow up.*

2. The Governor should introduce emergency radio code procedures to help ensure that those attending an emergency incident know what to expect.
   Accepted: *Channings Wood now use a code red and blue radio message system for those responding to an incident. NTS was published on 19 April 2012 and re-published on 18 March 2013.*

3. The Governor should ensure that there are sufficient numbers of first aid trained staff on duty at night with ready access to emergency equipment including a defibrillator.
   Accepted: *First Aid training for Night OSG's has commenced. This will ensure there are trained first aiders on nights. In addition, our custodial managers are now the Night Orderly Officers. We will ensure they are trained.*