

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Kemp a prisoner at HMP Channings Wood on 10 June 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Anthony Kemp was found hanged in his cell in the segregation unit at HMP Channings Wood on 8 June 2016. He was taken to hospital but he did not regain consciousness and died on 10 June. He was 54 years old. I offer my condolences to Mr Kemp's family and friends.

Mr Kemp was serving a life sentence. He was sixteen years past his minimum tariff, and frustrated about the parole process. In May 2016, for the first time, staff began to monitor him as at increased risk of suicide and self-harm.

Three days later, Mr Kemp was sent to the segregation unit after he had been charged with assaulting a member of staff. However, the investigation found no reasonable grounds for this decision and, further, found the management of the segregation unit and Mr Kemp's time there to be confused, with scant regard paid to local and national policies. These issues are of sufficient concern that I draw them directly to the attention of the Deputy Director of Custody for the South West for comprehensive investigation. Similarly, I draw the significant weaknesses in the management of Mr Kemp's healthcare during his time in the segregation unit to the attention of NHS England for their further review.

Mr Kemp's death was sadly predictable. Had suicide and self-harm monitoring procedures operated more effectively, staff could have made more informed decisions about how best to support him and the outcome might have been different. The prison did not properly address or mitigate his risk factors; the mental health team did not assess Mr Kemp; and there was no new assessment or review of the measures to manage his risk or of the exceptional circumstances of him being segregated, as his situation became more serious and his threats more credible.

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

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Summary

Events

1. Mr Kemp received a life sentence in May 1985, with a minimum tariff of 15 years. He was moved to Channings Wood on 26 November 2014.
2. Mr Kemp was frustrated with the parole process. A parole hearing scheduled for February 2016 was deferred, and he began to lose hope he would ever be released. On 31 May, staff discovered he had attempted to hang himself, and started suicide and self-harm prevention measures (known as ACCT). Two days later, Mr Kemp argued with the acting Governor and allegedly spat at him. Mr Kemp was placed on report and was moved to the segregation unit the next day.
3. ACCT procedures were stopped on 3 June. The adjudication for assault and abusive and threatening behaviour was heard on 4 June, and referred to the police. The next day, Mr Kemp began to refuse food and, on 6 June, he told staff he would be dead by 16 June, either through starvation or hanging. The ACCT was reopened.
4. On 8 June, while on the exercise yard, Mr Kemp became aware that he was going to be downgraded from enhanced to standard under the incentives and earned privileges (IEP) scheme. He became angry and refused to leave the exercise yard but eventually agreed to return to his cell. At around 3.39pm, Mr Kemp was found hanged in his cell. He had written on his wall that the acting Governor was to blame. Staff and paramedics were able to resuscitate Mr Kemp and he was taken to hospital. He never regained consciousness and, on 10 June at 12.38pm, the hospital recorded Mr Kemp had died.

Findings

5. The initial decision to segregate Mr Kemp was not justified and segregation reviews were inadequate. The operation of the segregation unit and the management of Mr Kemp during his time there was deeply unsatisfactory and paid scant regard to local and national policies both in relation to the process of segregation and the management of prisoners at risk of self harm and suicide.
6. Prisoners assessed as at risk of suicide and self-harm should be segregated only in exceptional circumstances. We found no evidence that exceptional circumstances had been identified in Mr Kemp's case, or that alternative options had been thoroughly considered and discounted.
7. Mr Kemp was very frustrated about his lack of sentence progression and told staff that he intended to kill himself. We consider that the prison failed to manage his risk of suicide or self-harm effectively and in line with national Prison Service instructions. Staff failed to fully assess his risk and failed to set appropriate caremap actions to reduce his risk of suicide and self-harm.
8. When ACCT procedures were restarted on 6 June, after Mr Kemp told an officer he would soon be dead, staff failed to reassess his risk and review and update his caremap actions. They also failed to assess whether there were exceptional circumstances that warranted Mr Kemp's continued segregation.

9. The clinical reviewer identified significant issues about the management of Mr Kemp's mental health. Healthcare staff had a number of opportunities to raise concerns about the potential impact of segregation on Mr Kemp's mental health, but did not. There is no evidence that a mental health referral or assessment of Mr Kemp's mental capacity was completed, even when he refused to eat or drink.

Recommendations

- The Deputy Director of Custody for the South West should review the operation of the segregation unit at Channings Wood to ensure it operates in line with national policy and guidance. He should seek to assure himself, in particular, that this is the case in relation to:
 - The admission of prisoners to the segregation unit and their continuing care and management in the unit;
 - The management of prisoners at risk of suicide and self-harm;
 - The use of special accommodation; and
 - The management of food refusal.
- The Deputy Director of Custody for the South West should further satisfy himself that the disciplinary investigations currently ongoing are adequate and sufficient to address the issues discovered by this investigation and the parallel police investigation.
- NHS England South West should review the actions of all healthcare staff involved in Mr Kemp's care within the segregation unit, in particular:
 - Assessments of fitness for segregation and for continued segregation.
 - Effective joint-working with other prison staff regarding sharing information on health needs and risks, and the management of food refusal
- The Governor should ensure that:
 - Staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:
 - All staff should have a clear understanding of their responsibility to share information about a prisoner's risk of suicide and self-harm and start ACCT procedures when appropriate.
 - Staff should set caremap actions that are aimed at reducing a prisoner's risk, which are reviewed and updated as necessary.

- Case reviews should be multi-disciplinary and take into account all known risk factors and triggers.
- A multi-disciplinary case review should be held within 24 hours of an ACCT plan being opened and when there is evidence of a significant change in risk.
- ACCT documents should be kept securely and should not be accessible to prisoners.
- Staff adhere to the local policy on IEP reviews.
- Staff fully understand and adhere to Channings Wood's 'The appropriate reporting / referral of crimes in HMP Channings Wood Protocol between: HMP Channings Wood, Devon and Cornwall Police, Crown Prosecution Service'.
- All staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.

The Investigation Process

10. The investigator issued notices to staff and prisoners at Channings Wood, informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.
11. The investigator visited Channings Wood on 15 June, and obtained copies of relevant extracts from Mr Kemp's prison and medical records. She spoke to staff in the segregation unit.
12. NHS England commissioned a clinical reviewer to review Mr Kemp's clinical care at the prison.
13. During August, the investigator interviewed nine members of staff and two prisoners at Channings Wood and another member of staff by telephone. In September, she interviewed another prisoner. She completed interviews with seven members of staff between March and May 2017. She had sight of interviews conducted by the Prison Service investigator.
14. We informed HM Coroner for Torbay and South West Devon District of the investigation who gave us the results of the post-mortem examination. We suspended our investigation in August 2016 pending the outcome of the police investigation and re-started it in January 2017, when we received confirmation from Devon & Cornwall Police that criminal charges would not proceed. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Kemp's family to explain the investigation. Mr Kemp's family did not have any specific questions.
16. Mr Kemp's family received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence.
17. The prison also received a copy of the report and identified no factual inaccuracies.

Background Information

HMP Channings Wood

18. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds approximately 700 men. While Mr Kemp was at Channings Wood, Dorset NHS University Foundation Trust provided health services at the prison. Since 1 April 2017, Care UK have been commissioned to deliver healthcare and they sub-contract Devon Partnership Trust to provide mental health care. On weekdays, there is nursing cover from 8.00am to 6.00pm. Devon Doctors provides an out of hours GP service.

HM Inspectorate of Prisons

19. The most recent inspection of Channings Wood was in October 2016. Inspectors reported the prison had regressed markedly since the last inspection and was a prison in decline. Safety was a significant concern and the quality of assessment, care in custody and teamwork (ACCT) case management documents and risk assessments for prisoners at risk of suicide or self-harm was very poor. Prisoners' intentions to self-harm were too easily dismissed and ACCT documents had been closed prematurely, and occasionally without justification. Inspectors identified the use of force and segregation was relatively low, but oversight was limited. They found too many prisoners were segregated pending adjudication hearings.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to August 2016, the IMB reported that there had been a substantial increase in the number of ACCTs and that too many of these offenders had to be located in the segregation unit, which was unsuitable.

Previous deaths at HMP Channings Wood

21. There have been five previous deaths at Channings Wood in the past two years, one of which was a self-inflicted death. There are no significant similarities with Mr Kemp's death. There has been another self-inflicted death since, in February 2017.

Assessment, Care in Custody and Teamwork

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
23. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

24. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 Safer Custody.

Segregation Units

25. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A manager, a member of the chaplaincy team and a member of the healthcare team should visit the segregation unit daily and speak to each segregated prisoner to check their welfare. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental well being of the prisoner and whether there are any apparent clinical reasons to advise against continuing segregation.
26. The segregation unit at Channings Wood comprises eight single cells and two holding cells. Each cell has an emergency call button which, when pressed, causes a light to flash outside the cell and a buzzer to sound, which can be heard throughout the unit.

Incentives and Earned Privileges Scheme (IEP)

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

Parole Board

28. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide whether they can safely be released into the community once they have served the minimum term imposed by the courts.

Key Events

29. Mr Anthony Kemp was sentenced to life imprisonment in May 1985, following his conviction for murder and a sexual offence. He was given a minimum term to serve of 15 years. Mr Kemp had no significant health issues when he arrived in prison and no history of suicide or self-harm.
30. Mr Kemp was transferred to an open prison on three occasions between August 2004 and 12 November 2014. Each time he was transferred back to a closed prison after displaying abusive behaviour. At one of the open prisons, he was also suspected of bringing drugs back into prison from town visits.
31. Mr Kemp was at Channings Wood between 8 November 2013 and 6 October 2014, when he was transferred to Leyhill open prison. He returned to Channings Wood on 26 November.
32. Mr Kemp's parole review hearing scheduled for 4 February 2016 was deferred after his legal representative raised concerns about a panel member's potential conflict of interest. A new date had not been set before Mr Kemp died.
33. In May, Mr Kemp's offender supervisor recorded Mr Kemp was agitated and said he withdrew his consent to engage with anything at the prison because he perceived the Parole Board to be incompetent and wanted to transfer to Lewes to be closer to his mother. Mr Kemp submitted a complaint to the Parole Board on 2 June but it had not responded before Mr Kemp died.

Events from 31 May 2016

34. On 31 May at around 8.30am in the prison grounds, an officer asked Mr Kemp why he had a towel around his neck. Mr Kemp showed him marks on his neck and said he had tried to hang himself with a cord from a window blind. Mr Kemp said he had nothing to live for and his only concern was his elderly mother.
35. The officer began ACCT procedures. He referred Mr Kemp to the mental health team and placed him on hourly observations. A nurse from the mental health team spoke to Mr Kemp at around 11.30am. He noted in the medical record that Mr Kemp moved between being angry and tearful about his length of time in prison and that he believed he had been 'stitched up' over his parole. The nurse said Mr Kemp was discussed at the mental health team's multidisciplinary team (MDT) meeting later that day and he assumed a follow up assessment would be arranged but there is no evidence this was ever done.
36. An officer carried out an ACCT assessment at 12.00pm on 1 June. Mr Kemp refused to engage. The immediate action plan, which should have been completed within one hour of the ACCT starting on 31 May, was timed and dated as 12.00pm on 1 June. The original ACCT was not provided to the investigator because it was missing. An investigation by a Supervising Officer (SO) concluded it was likely Mr Kemp had shredded it. A duplicate ACCT document was started at 5.00pm.
37. Two SOs were assigned as Mr Kemp's ACCT case managers. A SO chaired an ACCT review on 1 June at 12.10pm, along with a custodial manager and a

mental health nurse. Mr Kemp refused to attend. The review assessed that Mr Kemp was at a raised risk of suicide and self-harm, and observations remained hourly. The SO recorded on Mr Kemp's caremap that he should be considered for a transfer, an action for a prison manager. The prison manager told the investigator that a discussion had already been started about the possibility of Mr Kemp moving to another prison, although a move was unlikely as his parole review was outstanding.

38. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to Mr Kemp's calls. On 1 June, at around 2.55pm, Mr Kemp spoke to his mother for approximately three minutes. Mr Kemp told his mother he was angry at the parole process, did not want to be on an ACCT and being locked in his cell was bad for his mental health.
39. On 2 June at 10.15am, a SO chaired an ACCT case review, attended by an officer and Mr Kemp (a worker from safer custody contributed by telephone). The caremap was not reviewed or updated. Mr Kemp told the review he had no thoughts of suicide or self-harm. The review noted Mr Kemp appeared to be in a positive mood, and that he wanted the ACCT closed. The review panel assessed that Mr Kemp's risk of suicide or self-harm had reduced to low. His observations were reduced to two conversations during the day and three observations at night.
40. Later that afternoon, closed circuit television (CCTV) showed that Mr Kemp had a heated conversation with the acting Governor on Living Block Four (LB4). He told the investigator that Mr Kemp had previously asked about a missing radio and he told him the matter had been investigated by the security governor and was now closed. Mr Kemp became verbally abusive. He said he tried to reason with Mr Kemp and invited him into the office to discuss the matter calmly.
41. CCTV shows Mr Kemp shouting at the acting Governor at 2.21pm. He walked away from Mr Kemp and towards an office on the right of the corridor. At 2.22pm, Mr Kemp followed him down the corridor and as the Governor walked through the door into the office, Mr Kemp appeared to spit at him. The Governor told the investigator that saliva landed on his side, towards his lower back, but the CCTV is unclear. Mr Kemp later accused him of shutting the door on his hand, but CCTV shows this did not happen. No alarm was raised and the Governor did not react.
42. An officer told the investigator she had heard Mr Kemp and the acting Governor arguing and shouting at each other, so walked towards the office on LB4. She said she heard and saw Mr Kemp spit at him. The Governor asked her to escort Mr Kemp back to his cell, which she did. She said Mr Kemp was still annoyed but at no time posed a threat. A SO spoke to Mr Kemp to calm him down. He said he was later told that Mr Kemp would be moving to the segregation unit, on the acting Governor's instruction, but could not recall who told him.
43. The duty governor became aware of the incident about an hour after Mr Kemp had argued with the acting Governor. He and another senior manager were discussing Mr Kemp when the acting Governor entered the room. They both said the acting Governor wanted Mr Kemp segregated. The duty governor said

he told him that he did not think it was appropriate to do so, and staffing levels would make a move difficult. He said he was satisfied Mr Kemp, now locked in his cell, appeared calm and was not a control problem. He said the acting Governor appeared to accept this decision, but later said he would manage the situation the next day.

44. The acting Governor told the investigator that because the argument was very public, he felt he should enforce the zero-tolerance approach to violence and therefore decided to place Mr Kemp on report. He said he discussed Mr Kemp with the duty governor, and told him Mr Kemp might not manage on the wing and it may be best to move him to the segregation unit to avoid further problems, but no order was given. He said he was unaware that Mr Kemp was on an ACCT.
45. The Deputy Director of Custody for the South West instigated a prison investigation on 6 July 2016, led by a colleague, regarding the managerial decisions to segregate Mr Kemp, his continued segregation and management of the ACCT. The duty governor told him that at around 4.30pm, a routine management meeting was held. The acting Governor said Mr Kemp would be segregated at around 6 to 6.30pm when more staff would be available. The duty governor said he reiterated there was no need to move Mr Kemp and the acting Governor agreed, so Mr Kemp remained locked in his cell. The duty governor was not aware Mr Kemp was subject to ACCT procedures. The SO said he had arranged for staff to escort Mr Kemp to the segregation unit, but was then informed that he was to remain in his cell overnight pending adjudication.

Move to the segregation unit on 3 June

46. On 3 June, during the morning meeting, an operational manager said he was instructed 'in no uncertain terms' by the acting Governor, his line manager, to move Mr Kemp to the segregation unit, on good order or discipline (GOoD) grounds. He told the investigator that he did not challenge the order, and only later became aware from other colleagues that the acting Governor and the duty governor had had 'a heated conversation' about moving Mr Kemp to the segregation unit the day before. He said had he been aware of this discussion, he may have reacted differently to the acting Governor's instruction.
47. Mr Kemp had a healthcare appointment around 9.40am and went to the segregation unit at 10.05am. The SO said Mr Kemp was expecting to go to the segregation unit for his adjudication and was not a control problem. At 11.00am, Mr Kemp was escorted back to the healthcare unit as he claimed his hand had been injured the previous day. A nurse recorded he was given an ice pack. Mr Kemp returned to the segregation unit at 11.15am. Initially, when he was in a holding cell and told he was to be located in the segregation unit, Mr Kemp was angry and threw furniture around his cell, but eventually calmed down. CCTV footage was not provided to the investigator as Channings Wood had not recovered or downloaded the images before the recording device stopped working.
48. The operational manager completed the segregation record at 12.10pm and noted 'Placed on GOoD following abusive and unpredictable behaviour on LB4 on 2.6.16. This included spitting at the deputy governor. The acting Governor asked for him to be segregated on 3.6.16'. He suggested to the investigator that

the operational manager had added this line at some point after Mr Kemp's segregation and he had not given this instruction. The operational manager said emphatically that he did not do this and had completed the form at 12.10pm. A nurse completed the initial segregation healthscreen and assessed Mr Kemp's mental health would not be adversely affected. On the segregation observation record, the operational manager recorded that Mr Kemp said all governors were bullies and he would refuse food and fluid. No food refusal log was started.

49. In the segregation decision log, the operational manager recorded, 'acting Governor asked for him [Mr Kemp] to be segregated due to his behaviour' and that other locations were not appropriate due to Mr Kemp's 'current behaviour'. He noted that a mental health assessment (required within 24 hours) was 'TBA [to be arranged]' and that he had notified the SO at 12.00pm.
50. At 3.20pm, the SO chaired an ACCT case review, along with an officer and Mr Kemp. The review concluded that Mr Kemp no longer had thoughts of suicide or self-harm and that Mr Kemp said being in the segregation unit 'might do him some good and get his head together'. The ACCT was closed and a post-closure review scheduled for 10 June. The operational manager recorded on the segregation record at 12.10pm that Mr Kemp said he would not eat or drink.
51. At around 4.53pm, Mr Kemp spoke to his mother for approximately three minutes, and sounded much calmer than in his call on 1 June. He said he was in the segregation unit, that he was trying to get his radio back and that his hand had been slammed in a door (although was laughing and said it was all okay). He asked his mother to contact the police and ended the call by telling his mother he loved her. Mr Kemp requested the Samaritans phone at 7.05pm.
52. An officer issued Mr Kemp with two notices of report on 3 June at 8.00pm, for using threatening and abusive words or behaviour and committing an assault. The investigator was unable to establish why the report notices had not been issued the previous day. The operational manager said typically prisoners placed on report before teatime would be adjudicated on the next day, although not always. Throughout the night, Mr Kemp was observed every hour via CCTV.

Saturday 4 June

53. The operational manager chaired the adjudication hearing on 4 June. Mr Kemp pleaded not guilty and also alleged that he had been assaulted. He adjourned the adjudication. He recorded that both the alleged assault against the acting Governor, and Mr Kemp's allegation that he had been assaulted, were to be referred for a police investigation. Devon and Cornwall Police confirmed the alleged assaults were reported to them, by e-mail, at 9.32am on 8 June. He was unable to explain this delay. The acting Governor said he was not asked to give evidence at the adjudication, and was surprised that the matter had been referred to the police.

Sunday 5 June

54. On 5 June, Mr Kemp refused his lunch. He made a telephone call to his mother at 3.26pm, which lasted nearly 12 minutes. Mr Kemp told his mother that her letter had made him emotional and he thought he would have to spend at least

another five years in prison. He asked for the police to be involved. Mr Kemp seemed to move from finding his situation funny to sounding angry. He told his mother he was okay and ended the call. An officer recorded in the segregation observation book: 'tea served' at 4.15pm, but not whether Mr Kemp ate his meal.

55. There was a rooftop protest during the day by two prisoners. The operational manager was duty governor and said he contacted the acting Governor at home to discuss creating space in the segregation unit. He said the acting Governor told him that Mr Kemp was to remain in the segregation unit and so another prisoner was moved. The acting Governor told the investigator he never received a telephone call from him and did not give this order.

Monday 6 June

56. On 6 June, an officer recorded at 9.00am that Mr Kemp refused his breakfast and at 9.45am a nurse recorded that Mr Kemp would engage with healthcare monitoring as he was refusing food. A nurse made an entry on the medical record at 11.02am which notes 'Mr Kemp states that he feels like he is having a breakdown, refused a referral to m.h. [mental health] States that he will be dead by 16.06.16 ACCT has been reopened. Wants DNR [do not resuscitate] Tasked Dr. Has a bruise to right hand and middle knuckle'. The nurse told the investigator she had asked a visiting GP to go and visit Mr Kemp, although there is no entry in either the medical record or segregation log to support this. She said she believed the ACCT was going to be re-opened immediately, and assumed a prison officer in the segregation unit would do this.
57. At 12.52pm, the CCTV in the segregation unit was reported as faulty and a matter of urgency. The next day, an engineer from ADT attended and removed the recording hardware for repair. On 20 June, Channings Wood requested an update, and on 28 June, ADT reinstalled a working unit. The investigator was told by the Governor that the delay in repairing the system was unacceptable and should have been more robustly managed.
58. At 5.00pm, Mr Kemp's ACCT was reopened as Mr Kemp told an officer 'he would make sure he would not reach his 34th year in prison which would be on 16th July and he would either be "swinging" or starve himself to death'. Mr Kemp was to be observed half hourly until he had been assessed. Although the concern and keep safe form had been updated, an ACCT assessment was not carried out. Mr Kemp was observed at half hourly intervals until 11.00pm, thereafter he was observed each hour, on the hour, until 7.45am on 7 June, when half hourly observations resumed.
59. The Head of Safer Custody & Segregation reviewed Mr Kemp's segregation sometime after 5.30pm. He recorded Mr Kemp was to remain segregated because of his unpredictable and abusive behaviour on LB4 and pending a decision from the police in relation to Mr Kemp's allegation of assault.

Tuesday 7 June

60. On 7 June, an officer recorded on the segregation log that Mr Kemp refused his breakfast at 8.30am and recorded on the ACCT that Mr Kemp was emotional. A healthcare assistant recorded on the medical record at 9.13am that Mr Kemp told

him during his segregation round that he did not want to talk 'only to say that the fact he has tried to hang himself a few times indicates how he is feeling'. This conversation was not recorded on the ACCT document and there is no evidence that the healthcare assistant disclosed this to prison officers in the segregation unit.

61. At 10.30am, an officer asked Mr Kemp if he would like to speak to a Listener or Samaritans, but he declined. A member of the IMB visited the segregation unit and recorded in the segregation observation book at 11.00am, 'refusing to eat and drink. Adjudication adjourned (reason police involvement). Threatened to hang himself'. He told the investigator that he informed segregation and healthcare staff that he had genuine concerns for Mr Kemp's welfare and was reassured that segregation staff would observe him every half hour. He did not make an entry on Mr Kemp's ACCT. Mr Kemp declined his lunch at 12.00pm, and he was issued with the Samaritans phone.
62. The offender supervisor wrote a letter to Mr Kemp which said a recategorisation meeting was scheduled for 9 June, which would consider if he should remain in a category C prison, given his recent behaviour. He told the investigator Mr Kemp's security category would have been considered as part of the parole review as they had directed his return to closed conditions, but being placed on report required an immediate review. He said he explained the content and left the letter with a prison officer, probably sometime during the morning. There is no evidence in the segregation record, ACCT document or prison record that this letter was ever given to Mr Kemp.
63. At 2.50pm, Mr Kemp telephoned a female. He asked her to contact Devon and Cornwall Police and claimed the acting Governor had seriously assaulted him. He told her that he had not eaten, that he had not sworn at him and that the acting Governor was 'riding roughshod over staff'. Mr Kemp claimed to have cut his wrists, tried to hang himself three times and was 'in a bad way'. Mr Kemp sounded tearful and said he would not be granted parole and had 'nothing now'. The call ended after just over three minutes, when Mr Kemp said his telephone credit had run out.
64. Mr Kemp telephoned his mother at 2.55pm, and spoke to her for around four minutes. He told her he had been in the segregation unit for 14 days, had tried to hang himself six times but the radio cable had snapped. Mr Kemp asked his mother to contact Devon and Cornwall Police about the injury to his hand, was angry there were no photographs of his injury and that his radio was still missing. Mr Kemp was angry during the phone call, swore repeatedly about staff and his situation, but became tearful towards the end of the call. He told his mother he loved her and ended the call. This was the last telephone call Mr Kemp made.

Wednesday 8 June

65. Officer A noted on the segregation record that Mr Kemp had refused his breakfast and lunch. In Mr Kemp's ACCT record, the officer recorded that he remained upset at being in the segregation unit, but seemed to be more positive. Mr Kemp was observed on the hour and half hour.

66. A prison GP told the investigator that she saw Mr Kemp during her routine visit to the segregation unit in the morning, but was unsure of the time. This is not recorded on the ACCT or segregation log. She made a retrospective entry on the medical record at 1.55pm, and noted Mr Kemp showed her his hand but she had no concerns about it. She noted Mr Kemp told her he had not eaten for 3-4 days, that his weight should be monitored and that they would take routine blood tests to monitor his liver and kidney function, and blood sugar levels. She noted that Mr Kemp looked physically well and was not clinically dehydrated and she would discuss his case with the mental health team.
67. The operational manager made an entry on Mr Kemp's prison record at 8.45am to say he had asked the SO to review Mr Kemp as he no longer merited enhanced status (although the IEP policy states that any act of violence should mean a prisoner downgrades to basic). The SO asked Officer B to complete an IEP review to downgrade Mr Kemp to the standard regime.
68. Officer B went to the segregation to complete the IEP review, but said he did not speak to Mr Kemp, as another officer had told him Mr Kemp was on the exercise yard and was agitated. He told the investigator that he left the IEP documentation in the segregation unit, did not inform Mr Kemp he had been downgraded and planned to return after Mr Kemp's ACCT review. The Officer A told the investigator that Officer B gave her Mr Kemp's copy of the IEP decision, although she did see him talk to Mr Kemp briefly before he left the segregation unit.
69. According to the ACCT document, Mr Kemp went out onto the exercise yard at around 1.35pm. At 2.30pm, Officer A recorded that Mr Kemp was irate as he was unhappy that he had been downgraded to the standard IEP level and that he was still on the exercise yard at 3.00pm. Another officer thought he recalled Mr Kemp having a piece of paper in his hand on the exercise yard, but without CCTV the investigator was unable to establish exactly what happened or who told Mr Kemp about the IEP decision.
70. The Head of Safer Custody intended to complete the ACCT review with Mr Kemp, but he refused to leave the exercise yard. He spoke to him through the gate, but Mr Kemp continued to be abusive and made violent threats.
71. Two nurses arrived in the segregation unit for the ACCT review. One nurse told the investigator that he tried to calm Mr Kemp, but was unable to. He said segregation staff told him that Mr Kemp was angry Officer B had told him he had been downgraded to the standard IEP, and that the officer should have waited until Mr Kemp had left the exercise yard before being told. He could not recall who told him this.
72. The Head of Safer Custody completed the ACCT case review record at 3.00pm, and noted that two nurses had attended. Both nurses told the investigator they had not attended a review and maintained that there was no meaningful discussion about Mr Kemp. The Head recorded that Mr Kemp had refused to leave the exercise yard, that he was upset at being downgraded to standard IEP and increased his risk of suicide and self-harm to raised. He recorded that Mr Kemp would remain on half hourly observations and added an action to the

caremap for Officer A to provide information for Mr Kemp to appeal the IEP decision. The officer was not aware of this.

73. Mr Kemp agreed to return to his cell around 3.30pm. Because he had made threats that three staff would need to remove him from the exercise yard, the Head of Safer Custody instructed staff to remove the furniture (apart from the bed) from Mr Kemp's cell, along with his belongings, for safety reasons. He said this was a precautionary measure and did not in his view constitute special accommodation. Mr Kemp was escorted back to his cell, and grabbed his bedding when he entered. He was coughing as a result of shouting, but declined a drink. The Head went to the office, said he completed the ACCT document and intended to tell Mr Kemp his ACCT review would be held the next day.
74. Officer C returned to Mr Kemp's cell with the Head of Safer Custody (as there is no CCTV the investigator was unable to verify the exact time). The officer saw Mr Kemp was hanging by a bed sheet, attached to the light, and shouted for help. On the wall, Mr Kemp had used soap to write '[Acting Governor] lied. This is down to him'. According to the control room log, at 3.39pm, the Head used his radio to call a code blue, indicating a medical emergency, and an ambulance was requested immediately (South Western Ambulance Service confirmed they received a request for an ambulance at 3.39pm). They entered the cell, removed the ligature and put Mr Kemp on the floor. A prison manager (who used to be a paramedic) was in a cell a few metres away and responded to the request for assistance. They started CPR and used a portable defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest).
75. A nurse and a prison GP responded to the emergency code and assisted with CPR until paramedics arrived at 3.52pm. Paramedics resuscitated Mr Kemp and took him to hospital at 4.25pm. Mr Kemp remained in hospital, in intensive care. Officers escorted Mr Kemp but he was not restrained. Mr Kemp never regained consciousness and hospital staff recorded that he died at 12.38pm on 10 June.
76. A friend of Mr Kemp's who lived on the same wing as him, told the investigator he believed Mr Kemp had intended to kill himself before his altercation with the acting Governor. He did not tell staff about his concerns but he was aware Mr Kemp was on an ACCT.
77. A prisoner, who was in the segregation unit on 8 June, wrote to the investigator. He saw events from his cell window, which overlooked the exercise yard. He described Mr Kemp as angry and that he made threats to assault staff, who remained calm and tried to reason with him. He heard staff offer Mr Kemp a glass of water when he returned to his cell, which he refused. He then heard a code blue radio call and staff using resuscitation equipment. He said all the staff 'worked tirelessly' in an attempt to save Mr Kemp's life.

Contact with Mr Kemp's family

78. Prison Rule 22(1) states: 'Notification of illness or death' 22 (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.' The investigator was

unable to establish exactly when Mr Kemp's mother was first informed he had been taken to hospital. The Head of Safer Custody said that they believed the duty governor had co-ordinated the contact. He was not available for interview because he was on long-term sick leave.

79. Channings Wood appointed a family liaison officer. She contacted Mr Kemp's mother on 9 June at 6.20pm and arranged to meet her the next day at the hospital. Arrangements were made by the prison for a taxi to take Mr Kemp's mother and a friend to the hospital. Mr Kemp's mother was at the hospital when he died. Channings Wood contributed towards the costs of Mr Kemp's funeral, in line with national instructions.

Support for prisoners and staff

80. There is no evidence the duty governor held a debrief for all staff involved in the emergency response, a mandatory requirement set out in Prison Service Instruction (PSI) 08/2010 Post Incident Care. Some prison staff recalled speaking to him, but were unsure if this was a formal debrief. The Head of Safer Custody told the investigator he debriefed some of the staff involved individually, but it was not a collective discussion. Officer C, who knew Mr Kemp well and had attempted to resuscitate him, found out Mr Kemp died when he returned to work in the segregation unit and was shocked and upset. A nurse said he was aware some of the healthcare staff attended a debrief with their senior manager, but was upset that he had not been invited and did not feel well supported.
81. Channings Wood did not have an effective staff care team at the time of Mr Kemp's death, therefore no additional support was available. A Governor's Notice 187/2016 was issued on 23 June 2016, by the Governor, to confirm a staff care team would be reintroduced.
82. The prison posted notices informing other prisoners of Mr Kemp's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Kemp's death. There was no memorial service, as requested by Mr Kemp's mother.

Post-mortem report

83. A pathologist concluded that Mr Kemp had died from a lack of oxygen due to hanging. A toxicology report confirmed there were no illicit substances in Mr Kemp's blood at the time of his death.

Findings

Segregation

84. Prison Service Order (PSO) 1700 - *Segregation* states, 'Segregation should be used only as a last resort whilst maintaining a balance to ensure it remains an option for disruptive prisoners. This does include prisoners on an open ACCT plan, but only when they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate'. Prison Service Instruction (PSI) 64/2011 – *Safer Custody* states that prisoners on open ACCT plans must only be located or retained in segregation units in exceptional circumstances and that the reasons for segregation must be clearly documented and include other options that were considered but discounted.
85. In a Learning Lessons Bulletin we issued in June 2015, we examined learning from investigations into the self-inflicted deaths of prisoners who were segregated at the time of their deaths. We noted that segregation reduces some protective factors against suicide and should be used only in exceptional circumstances for those at risk of taking their own life. When prisoners at risk are held in segregation there are additional required safeguards, such as holding a mental health assessment within 24 hours. We found that often these procedures were not followed and this was also the case with Mr Kemp.

Decision to segregate Mr Kemp

86. Mr Kemp was subject to ACCT monitoring when the decision was taken to segregate him. He had also been placed on report pending adjudication. In Channings Wood's local segregation unit policy, issued in April 2016, it states 'Segregation prior to adjudication must only take place if the offender is refractory and a risk of committing further offences'. Mr Kemp's behaviour in prison had generally been good; he was an enhanced, category D prisoner who had not had a proved adjudication since February 2000. Mr Kemp was not refractory and quickly calmed down after his altercation with the acting Governor. There was no indication that Mr Kemp was a risk to others when the decision to segregate him was taken.
87. The duty governor stated he was asked by the acting Governor to locate Mr Kemp in the segregation unit but told him this was not appropriate. The operational manager told us that the following morning the acting Governor instructed him to segregate Mr Kemp, although this is denied by the acting Governor. We have no way of corroborating these discussions. We found no evidence of a change in Mr Kemp's behaviour overnight, which might have increased his risk to others and justified his segregation.
88. The decision log completed by the operational manager stated that the acting Governor had instructed him to segregate Mr Kemp. This does not constitute exceptional circumstances. No valid justification was given for segregating Mr Kemp while he was on an ACCT and there was no mention of alternative options considered.

Decision to continue Mr Kemp's segregation

89. The Head of Safer Custody & Segregation reviewed the case for Mr Kemp's continued segregation on 6 June, after the ACCT was reopened. In considering Mr Kemp's continued segregation, he made no mention of exceptional circumstances or alternative options. Too much emphasis appears to have been given to the acting Governor's status as a senior manager, rather than the context of the alleged assault.
90. A nurse noted on the segregation healthcare screen that she had no concerns Mr Kemp's mental health would deteriorate significantly if segregation continued, despite his comments that morning that he intended to kill himself and was refusing to eat and drink.
91. We conclude that the decision to segregate Mr Kemp was not justified, and the segregation reviews failed to identify that there were inadequate grounds to continue segregation. These decisions were contrary to national guidelines contained in PSO 1700 and PSI 64/2011.

Special accommodation

92. Special accommodation is a dedicated cell or improvised normal accommodation with any one (or more than one) of the following items removed in the interests of safety: furniture, bedding, sanitation. Special accommodation should only be used for the shortest necessary time, to prevent a violent or refractory prisoner injuring others, damaging property or creating a disturbance. The prisoner should be informed of the reasons why. PSO 1700, Chapter 7, clearly states that the duty governor (or Governor) must give authority before a prisoner is located in special accommodation.
93. When Mr Kemp returned from the exercise yard to his cell at around 3.30pm, on the Head of Safer Custody & Segregation's instruction, segregation staff removed Mr Kemp's belongings and furniture from his cell, apart from his bed. The cell then constituted special accommodation. Mr Kemp grabbed his bedding as he went into the cell, which staff did not challenge. The decisions to remove items from his cell and then return items were not recorded in either the segregation log or ACCT, and there was no signed authority for special accommodation to start. The Head said in interview that his decision was to ensure Mr Kemp had nothing to harm staff with, or to avoid difficulties in case he became refractory, and he did not believe his decision constituted special accommodation.
94. Our investigation highlighted a number of unsatisfactory segregation processes. There have been management changes at Channings Wood, and the investigator was told a review of segregation protocols has taken place with changes made to how prisoners in segregation on an ACCT are managed, including improved recording of decisions around exceptional circumstances.
95. We understand that the actions of the acting Governor and the Head of Safer Custody & Segregation (who have both been formally suspended from duty since

2 December 2016) and those of the operational manager, are already subject to a Prison Service investigation as detailed in PSI 06/2010 & AI 05/2010 *Conduct and Discipline*, which we would otherwise have recommended.

96. Nevertheless, given the range of significant and deeply embedded issues identified during this investigation, and the limited scope of the Prison Service investigation we make the following recommendation:

The Deputy Director of Custody for the South West should review the operation of the segregation unit at Channings Wood to ensure it operates in line with national policy and guidance. He should seek to assure himself, in particular, that this is the case in relation to:

- **The admission of prisoners to the segregation unit and their continuing care and management in the unit;**
- **The management of prisoners at risk of suicide and self-harm;**
- **The use of special accommodation; and**
- **The management of food refusal.**

The Deputy Director of Custody for the South West should further satisfy himself that the disciplinary investigations currently ongoing are adequate and sufficient to address the issues discovered by this investigation and the parallel police investigation.

Assessment and management of Mr Kemp's mental health and food/drink refusal

97. The clinical reviewer concluded that the physical healthcare Mr Kemp had at Channings Wood was equivalent to that he could have expected in the community. However, he had significant concerns about Mr Kemp's mental health care and concluded that the deterioration in Mr Kemp's mental health was not adequately assessed or considered. He identified that various members of the healthcare team should have raised concerns about Mr Kemp's placement in segregation, completed a mental health assessment and assessed his capacity when he refused to eat or drink, but they did not. He makes a number of specific recommendations, which we do not repeat, but that the head of healthcare should address.
98. Mr Kemp was refusing food and fluid from 4 June. PSI 64/2011 Chapter 10 – *Management of prisoners who refuse food and/or fluids and medical treatment* confirms that food and fluid refusal is not considered in law to be a form of self-harm, but that an ACCT may provide a useful way of recording the care offered and facilitate information sharing. Further, PSI 11/2012 *Incident Reporting* states after 72hrs food refusal is reportable to the National Operations Unit (NOU).
99. Guidance from the Department of Health states it is critical a thorough assessment of a person's mental capacity and nutritional status is undertaken immediately and there should be regular reassessments of the person's physical and mental state. Healthcare staff should have initiated and adhered to an appropriate protocol as soon as they were made aware of Mr Kemp's refusal to eat and drink. Healthcare staff failed to record his level of food and fluid intake

and to record Mr Kemp's weight, temperature, pulse, blood pressure and respiration rate so future observations could be compared.

100. When Mr Kemp was initially segregated and subject to ACCT, he should have had a full mental health assessment within 24 hours, but did not. A nurse recorded she had no concerns that Mr Kemp's mental health would be adversely affected, despite him being subject to ACCT. On 6 June, Mr Kemp told a nurse that he intended to take his own life before 16 June, and wanted to have a do not resuscitate order (DNR) in place. The healthcare team should have arranged an urgent assessment of his mental capacity to make such a decision, especially in view of his ongoing thoughts of suicide and self-harm. The nurse did not re-open the ACCT. This was a missed opportunity for safeguarding and reviewing the decision to continue segregation.
101. Dorset NHS University Foundation Trust conducted an investigation into the professional conduct of a nurse and his assessment of Mr Kemp's mental health. This investigation considered the findings of a root cause analysis investigation, completed by the Patients Safety Manager for Devon Prisons. The nurse was suspended from 23 September 2016 until 9 March 2017, when the investigation concluded there was no case to answer against him.
102. We found it surprising that it was only one nurse that was investigated, given the oversights by a number of healthcare staff. We make the following recommendations:

NHS England South West should review the actions of all healthcare staff involved in Mr Kemp's care within the segregation unit, in particular the adequacy of:

- **Assessments of fitness for segregation and for continued segregation.**
- **Joint-working with other prison staff regarding sharing information on health needs and risks, and the management of food refusal**

Assessment and management of Mr Kemp's risk of suicide and self-harm

103. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action to mitigate the risk. It directs that any member of staff who receives information or observes behaviour that may indicate a risk of suicide and self-harm should open an ACCT. Mr Kemp was frustrated at the parole process and began to lose hope that he would ever be released. From 31 May 2016, he became increasingly distressed and made attempts to hang himself.
104. Mr Kemp's original ACCT document, opened on 31 May went missing. A manager instructed the SO Martin to investigate and he concluded that Mr Kemp had shredded the ACCT. Mr Kemp, while working as a cleaner, had access to the shredder in the wing office but neither admitted nor denied he had shredded the document. Prisoners should not have access to sensitive ACCT documents.

105. On the morning of 6 June, a nurse recorded that Mr Kemp had told her he would be dead by 16 June, but she failed to reopen his ACCT. She noted that the ACCT had been reopened when it had not, and when asked about this, said she assumed a prison officer would do it. In fact, the ACCT was not reopened until six hours later when Mr Kemp told an officer that he planned to take his own life. Any delay in opening an ACCT in respect of a prisoner at risk could be critical and we are concerned that the ACCT was not reopened by the nurse. We are also concerned that staff did not hold an ACCT case review until 8 June, when it should have been held within 24 hours of the ACCT being reopened.
106. PSI 64/2011 states that ACCT case reviews must be multidisciplinary where possible. We would expect healthcare staff to attend all case reviews in respect of prisoners held in segregation. We are concerned that healthcare staff did not attend Mr Kemp's ACCT case review held shortly after his move to segregation on 3 June, particularly as a decision was made to close the ACCT at this review. Although prison records show that healthcare attended the ACCT review on 8 June, the nurses concerned told the investigator that no meaningful review was held. The Head of Safer Custody & Segregation held the review alone, while talking to Mr Kemp through the gate to the exercise yard.
107. The ACCT caremap was inadequate. Caremap actions should be tailored to the individual needs of the prisoner and be aimed at reducing risk. Mr Kemp's caremap had only one action, for the operational manager to consider a transfer to another prison. Staff failed to identify caremap actions to specifically address Mr Kemp's risk. There were no actions to address his refusal to eat or drink or his mental health.

Review of Mr Kemp's IEP status

108. On 8 June, Mr Kemp was told that he was to be downgraded from enhanced to standard on the IEP scheme. This appears to have been a significant trigger for Mr Kemp's anger and frustration. Channings Wood's local segregation unit policy states IEP reviews will be conducted when offenders move out of segregation. It is unclear why this policy was not followed in Mr Kemp's case. Staff gave varying accounts of what happened and how Mr Kemp may have become aware he had lost his enhanced status. The CCTV in the segregation unit had been broken since 6 June, so there is no way of corroborating what actually happened. However, regardless of who or how Mr Kemp found out that he was to be downgraded, it was clearly inconsistent with local policy.

Referral to the police of alleged assault against the acting Governor

109. There is a local protocol in place between Devon and Cornwall Police and Channings Wood, issued by the Governor in December 2015, regarding which offences are reportable to the police. The protocol states a crime should be reported within 48 hours of the offence, yet Mr Kemp's case was not referred until 8 June, four days after his adjudication hearing and six days after Mr Kemp allegedly spat at the acting Governor.
110. The protocol states 'All assaults on staff will be referred to the police for investigation and consideration for prosecution other than those less serious assaults, where there is little or no injury, which are more appropriately dealt with

at adjudication by the prison disciplinary system'. Devon and Cornwall Police confirmed unless there were aggravating factors, such as spitting where the prisoner knew they had an infectious disease (which Mr Kemp did not), they would expect a common assault of this nature to be dealt with internally at the prison. Devon and Cornwall Police had no record of any other common assault (spitting) cases being referred to them by Channings Wood in the previous twelve months. However, the prison police liaison officer identified three cases, all of which were referred back to the prison to deal with through the adjudication process and advice given that they were not reportable crimes, as per the protocol. The police had no recorded crime report of Mr Kemp's allegation he had been assaulted.

Staff Support

111. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or indeed good practice). It also provides those directly involved with an opportunity to process events. There is no evidence the duty governor held a debrief for all staff involved in the emergency response, which is a mandatory requirement set out in PSI 08/2010, *Post Incident Care*.

The Governor should ensure that:

Staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:

- **All staff should have a clear understanding of their responsibility to share information about a prisoner's risk of suicide and self-harm and start ACCT procedures when appropriate.**
- **Staff should set caremap actions that are aimed at reducing a prisoner's risk, which are reviewed and updated as necessary.**
- **Case reviews should be multi-disciplinary and take into account all known risk factors and triggers.**
- **A multi-disciplinary case review should be held within 24 hours of an ACCT plan being opened and when there is evidence of a significant change in risk.**
- **ACCT documents should be kept securely and should not be accessible to prisoners.**

Staff adhere to the local policy on IEP reviews.

Staff fully understand and adhere to Channings Wood's 'The appropriate reporting / referral of crimes in HMP Channings Wood Protocol between: HMP Channings Wood, Devon and Cornwall Police, Crown Prosecution Service'.

All staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.

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