Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Barber a prisoner at HMP Channings Wood on 19 May 2018

A report by the Prisons and Probation Ombudsman

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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*

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 Peter Barber died in hospital on 19 May 2018, after being found hanging in his cell at HMP Channings Wood eight days before. He was 63 years old. I offer my condolences to Mr Barber's family and friends.

Mr Barber had some risk factors for suicide, which prison staff identified, and he was monitored under Prison Service suicide and self-harm prevention procedures on several occasions. However, there was little to indicate that he was at heightened risk immediately before his death and I consider it would have been difficult for staff to have predicted his actions.

Although staff at Channings Wood offered Mr Barber support for his use of psychoactive substances (PS) and mental health issues, he declined. The investigation found that the care provided to Mr Barber was equivalent to that which he could have expected to receive in the community.

Channings Wood does not have an effective staff support team, something we have identified in previous investigations and which the prison needs to address.

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

Sue McAllister CB
Prisons and Probation Ombudsman **January 2019**

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Summary

Events

1. Mr Peter Barber was serving a sentence of six years and was transferred to HMP Channings Wood on 30 December 2015. He was due to be released in August 2018.

2. Mr Barber had a history of mental ill-health, although diagnoses varied over the years. He was regularly assessed and reviewed by the mental health team, but often refused to engage.

3. Mr Barber used psychoactive substances (PS) at Channings Wood and, from November 2016 onwards, he was found under the influence of PS on more than 10 occasions, in some cases being found unconscious. Despite staff giving him support and information about the danger of continued use, he refused to engage with substance misuse services.

4. On 11 May 2018, at around 12.49pm, an officer found Mr Barber hanging in his cell. Staff resuscitated him and paramedics took him to hospital. However, he did not regain consciousness and at 1.20pm on 19 May, hospital doctors pronounced he had died. No toxicology tests were performed so we do not know whether Mr Barber used PS prior to hanging himself.

Findings

5. Mr Barber was a regular user of PS. He was warned of the dangers and offered support, but declined it.

6. The clinical reviewer concluded that the care Mr Barber received for his physical and mental health, and use of PS, was equivalent to that which he could have expected to receive in the community.

7. Mr Barber had some factors that increased his risk of suicide and staff appropriately identified these and used Prison Service suicide and self-harm prevention procedures to support him. Although Mr Barber was sometimes described as being 'down' in the months before his death, neither staff nor prisoners thought he was at increased risk of suicide or self-harm and we consider that it would have been difficult for staff to have predicted that he would hang himself.

8. Mr Barber made a request to transfer to the Doncaster area in July 2017, to be closer to his mother, and was very disappointed when this was unsuccessful. The investigation found no evidence that anyone spoke to Mr Barber about his request and the reasons for his application, and there is no record of why his transfer request was unsuccessful.

9. A few hours before Mr Barber was found hanging, a resettlement worker assessed him and discussed his plans for release. She had not met him previously and, by her own admission, knew nothing about him as she did not look at his records beforehand. We consider this was poor practice. A more meaningful assessment, including exploring Mr Barber's concerns about being

closer to his mother, could have been carried out if his records had been checked beforehand.

10. We have previously made a recommendation to Channings Wood that it should establish an effective staff care team, and in a recent investigation, we also identified the need for improved staff support. Although Channings Wood accepted our recommendation to introduce a staff care team in July 2017, we found one had still not been established.

Recommendations

- The Governor should ensure that all applications for transfer, and the subsequent actions and decisions, are recorded on a prisoner's record.
- The senior case manager for Catch 22 at Channings Wood should ensure that case workers consult prisoners' records before conducting assessments.
- The Governor should ensure all staff, irrespective of status, position or experience, are offered formal support from the prison following a death in custody.

The Investigation Process

11. 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. No one responded.

12. The investigator Channings Wood on 24 May 2018, and obtained copies of relevant extracts from Mr Barber's prison and medical records and visited the wing where he lived.

13. NHS England commissioned a clinical reviewer to review Mr Barber's clinical care at the prison.

14. The investigator interviewed one prisoner on 24 May, and spoke to prisoners living on Mr Barber's wing. She interviewed eight members of staff on 27 June, and in addition, interviewed one prisoner and two members of staff by telephone.

15. We informed HM Coroner for Plymouth and South West District of the investigation. He confirmed the cause of death and we have sent the coroner a copy of this report.

16. The investigator contacted Mr Barber's nominated next of kin (a friend) and his family to explain the investigation. His next of kin did not respond and Mr Barber's family had no specific questions for the investigation to consider.

17. Mr Barber's family were received a copy of the initial report, but did not identify any factual inaccuracies.

18. The prison also received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

Background Information

HMP Channings Wood

19. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds approximately 700 men. Care UK provides general healthcare services, Devon Partnership Trust provides mental health services and EDP Drug and Alcohol provides substance misuse services. There is nursing cover from 7.30am to 6.00pm on weekdays and from 8.30am to 5.30pm on weekends. Devon Doctors provide an out of hours GP service.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Channings Wood was in October 2016. The Inspectorate reported that, overall, the prison had deteriorated since their last inspection in 2012. The Inspectorate found that over half the prison population said that it was easy to obtain illicit substances in the prison and the abuse of psychoactive substances (PS) was widespread. They noted that the availability of PS was a significant problem, which posed a threat to the safety of prisoners and the stability of the prison.

21. The Inspectorate found that most prisoners found that the support that they had received from the substance misuse team was helpful. They also found that substance misuse recovery plans were detailed and of high quality.

22. The Inspectorate found reintegration and resettlement planning, delivered by Catch 22 on behalf of the Devon and Cornwall community rehabilitation company (CRC), was reasonably good.

Independent Monitoring Board

23. 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 31 August 2017, the IMB found that illegal substances were very easy to obtain at the establishment and that some officers appeared to turn a blind eye to prisoners using PS in their cells. The Board noted that there had been an increase in violence and bullying, which was likely to have been caused by the smoking ban, although the delivery of smoking cessation programmes had greatly improved. The Board said it was too early to comment on the violence reduction plan introduced in May 2017.

24. The Board noted that a staff care team had not been established, despite a PPO recommendation having been accepted by the prison in July 2017.

Previous deaths at HMP Channings Wood

25. Mr Barber was the tenth prisoner to die at Channings Wood since May 2015. Of the previous deaths, three prisoners took their own lives, six died from natural causes and one died as a result of using PS. There have been two subsequent deaths: one from natural causes and one awaiting classification.

26. We have made previous recommendations about the need to support staff appropriately, which we repeat.

Assessment, Care in Custody and Teamwork

27. 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.

28. 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 (a 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.

29. 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*.

Incentives and Earned Privileges Scheme (IEP)

30. 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.

Psychoactive Substances (PS)

31. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

32. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

33. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

34. On 23 May 2015, Mr Peter Barber was remanded to HMP Bullingdon on burglary charges. This was not his first time in prison.

35. On 31 May, Mr Barber was placed on report for smoking cannabis. He started to refuse food in protest and between 4 and 11 June, staff supported him using Prison Service suicide and self-harm prevention procedures (known as ACCT).

36. On 28 October, Mr Barber was sentenced to six years in prison. He maintained his innocence and on 31 October, he refused food in protest at his sentence. Staff started ACCT procedures on 3 November, and stopped two days later when Mr Barber began eating.

37. Mr Barber was transferred to HMP Channings Wood on 30 December 2015. The Supervising Officer (SO) completed Mr Barber's induction to Channings Wood. On 5 January 2016, he recorded that Mr Barber said he did not want to be released at the half way point in his sentence (typically prisoners are released with licence conditions, under the supervision of the Probation Service) and wanted to spend his whole sentence in custody and that he was appealing his sentence. Over the next few months, prison staff noted that Mr Barber was polite, followed the prison regime and did not have any concerns. Mr Barber did not work as he was retired, but regularly attended the weekly pagan service.

38. On 11 May 2016, Mr Barber told the pagan chaplain, that he was not eating as he had had enough of life. She informed an officer who started ACCT procedures on 13 May. Mr Barber told prison staff he was a pagan, that he was 1000 years old, that his body was a vessel and that he did not care if he died. Mr Barber initially refused to allow healthcare to monitor him, but at an ACCT case review on 18 May, Mr Barber gave his permission to be monitored. Mr Barber said he viewed smoking, eating and drinking as one and because of the smoking ban (which came into effect on 9 May), did not feel like eating. Mr Barber told healthcare staff he would try using e-cigarettes.

39. On 24 May, Mr Barber was found to have illicit alcohol in his cell and placed on report. He was downgraded to the basic IEP level, and told staff that he had been bullied into looking after the alcohol. The next day at his adjudication hearing, Mr Barber told The Custodial Manager (CM) that he wanted to serve his entire six-year sentence in custody, and that he had had enough of the UK and would move to another country.

40. A SO held an ACCT case review later the same day. He recorded that Mr Barber was 'no longer on hunger strike' and had no thoughts of self-harm or suicide and the ACCT was closed. Safer custody identified that Mr Barber may need ongoing support, and he was regularly seen by safer custody orderlies (the orderlies are prisoners whose role is to see people who may need support regularly, if the prisoner is happy to engage with them). Mr Barber had regular contact with the safer custody orderlies throughout the remainder of his time at Channings Wood. Mr Barber was upgraded to standard IEP on 14 June.

41. Over the next few months, Mr Barber was recorded to be settled and compliant. He received a notice from the Court of Appeal on 23 September, informing him that his application to appeal his sentence had been refused.

42. On 7 October, Mr Barber told the CM that he had considered hanging himself as he was in debt. Staff started ACCT procedures. The next day, an officer completed a violence reduction (VR) assessment and Mr Barber was supported under violence reduction measures. The ACCT was closed on 17 October. A SO reviewed Mr Barber's violence reduction plan on 9 November, and he reported that everything had been resolved, that he had been overly anxious about the threat he felt and thanked staff for their support. Staff closed the VR plan.

43. On 28 November, an officer found Mr Barber under the influence of a psychoactive substance (PS) and he had to be carried back to his cell. Mr Barber was downgraded to basic IEP. The substance misuse team provided information about the risks associated with using PS, but Mr Barber declined any assistance from them.

44. On 15 December, a member of staff from the substance misuse team, met with Mr Barber as he had been found under the influence of PS. She recorded in his prison record that he had accepted a cigarette from another prisoner and did not care if it contained an illicit substance because he did not agree with the smoking ban. She recorded that Mr Barber described himself as immortal and said that he was 1000 years old. She was aware that Mr Barber had been referred to the mental health team. Mr Barber refused to engage with the substance misuse services and she provided him with harm minimisation information and some literature on safety. The next day Mr Barber was again under the influence of PS and placed on report. He refused to attend a PS focus group facilitated by the substance misuse team.

45. On 2 January 2017, a SO reviewed Mr Barber's IEP level and he was upgraded to standard.

46. On 19 January, a nurse recorded at 6.49pm, that Mr Barber was unconscious due to the effects of PS. He had a high pulse (tachycardia) and low oxygen levels and was given oxygen and had an electrocardiogram (ECG). Paramedics were called and a doctor from the local emergency department gave advice over the telephone. Mr Barber regained consciousness and although he remained tachycardic, it was deemed unnecessary for him to go to hospital.

47. The next day at 8.49am, a member of the substance misuse team, advised Mr Barber on the risks and potential harm of using PS. Mr Barber said he was very upset as his tobacco and sugar had been removed. Later the same day at 11.43am, an officer recorded on Mr Barber's prison record that he was suspected to be under the influence of PS, although Mr Barber said this was because of his diabetes. Later, at 1.24pm, another officer recorded that Mr Barber had been found on the stairwell of the wing under the influence of 'an unknown substance'. He noted, 'Healthcare attended and confirmed that he [Mr Barber] had taken something', but there is no corresponding entry on Mr Barber's medical record.

48. A prison GP, examined Mr Barber on 25 January. She recorded that Mr Barber spoke rapidly, that his accounts of his mistrust of the NHS and about his

sentence were difficult to follow and that he was possibly paranoid or had delusional thinking. She prescribed him diabetic medication (gliclazide) and folic acid.

49. On 3 February, Mr Barber was reported by an officer to be under the influence again, and he was downgraded to basic. His IEP status was reviewed on 17 February, and Mr Barber was upgraded to standard.

50. On 29 March and 1 April, Mr Barber was reported to be under the influence of PS. A member of staff from the substance misuse team, tried to engage with Mr Barber on 3 April, but he declined. She gave him some information leaflets on the risks of using PS.

51. On 1 May, Mr Barber was placed on report for possessing a homemade smoking pipe. He attended a smoker's support group on 4 May, where he reportedly engaged well, but he was removed on 8 May for trading nicotine patches.

52. On 2 June, Mr Barber was under the influence of PS and had to be placed into the recovery position. He was treated by healthcare staff and later downgraded to basic IEP. Mr Barber was invited to attend the PS intervention group, but declined.

53. On 23 and 26 June, Mr Barber was again under the influence of PS. On 28 June, after the pagan service, Mr Barber told the pagan chaplain that he was refusing his diabetes medication and refusing to eat. She informed the safer custody team. Safer custody orderlies met with Mr Barber several times over the next couple of days to provide additional support. Mr Barber told them he did not have any problems and they did not report any specific issues to the safer custody team.

54. On 7 July, Mr Barber was upgraded to standard IEP at 11.16am, but at 5.34pm he was under the influence of PS and downgraded back to basic. A nurse referred him to the mental health team.

55. On 12 July, Mr Barber told an officer that his younger brother had died unexpectedly.

56. On 13 July, a nurse recorded that he had completed a mental health assessment. He noted that Mr Barber had no thoughts of suicide or self-harm, but at times appeared delusional. He recorded that the findings from previous psychiatric assessments were still relevant but that, unless Mr Barber's presentation changed, there was no need for ongoing input from the mental health team.

57. Later, Mr Barber told the pagan chaplain that he wanted to transfer to Doncaster, to be closer to his elderly mother after his brother's death. She spoke to a SO in the Offender Management Unit (OMU) and he advised her to tell Mr Barber to submit a formal application for a transfer. An administrator in OMU told the investigator that he first received an application from Mr Barber on 18 July, asking for a transfer to the Doncaster area, but not to a specific prison. He told the investigator that he sent an acknowledgement in response to Mr Barber's transfer request, but these contacts were not recorded on Mr Barber's prison record.

58. Mr Barber received support from the safer custody orderlies on 10, 12, 13 17 and 19 July. He told them he hoped to move closer to his mother. On 20 July, the pagan chaplain spoke to Mr Barber after the pagan meeting. She recorded in his prison record that she was concerned for his physical health as he looked unwell and he said he had a stomach upset, but that he was also distressed and low because of his family circumstances. On 24 July, Mr Barber was under the influence of PS and downgraded to basic. He told staff he was very distressed about his brother's death and concerned for his mother. Mr Barber's IEP status was reviewed by a SO, but he remained on basic for a further seven days.

59. On 27 July, the pagan chaplain recorded she helped Mr Barber complete an application for a transfer, and that he continued to be distressed about his brother's death and the impact on his mother.

60. On 2 August, the pagan chaplain spoke to Mr Barber after the pagan service. Mr Barber said he was extremely distressed about his family circumstances, and she recorded in his prison record that she was shocked by how much weight he had lost. Mr Barber told her he was not willing to see healthcare staff, but she informed the safer custody team and OMU.

61. A SO reviewed Mr Barber's IEP status on 4 August. She noted there was no evidence Mr Barber had used PS and that he had attended bereavement counselling and he was upgraded to standard.

62. On 8 August, an officer saw Mr Barber being sick. He was examined the next day by a nurse and she advised Mr Barber to drink plenty of fluids. The prison GP examined Mr Barber on 10 August. She told wing staff to keep Mr Barber isolated in his cell for 48 hours to avoid infecting others and to call the out of hours doctor if his condition worsened. While having a blood test, Mr Barber told a healthcare assistant, that he had not taken his diabetic medication for three months. A GP reviewed Mr Barber on 11 August. His blood tests were abnormal, as expected, and Mr Barber agreed to engage with healthcare and started taking his medication. He was regularly reviewed over the next few months and although he reported feeling dizzy at times, his health improved.

63. On 18 August, an administrator in the OMU, informed Mr Barber he had submitted a transfer request to HMP Lindholme; this is recorded on PNOMIS. He told the investigator that a transfer request can take up to three months to get a response and that he 'would have' advised Mr Barber of this, although this is not recorded.

64. There is an entry on Mr Barber's prison record dated 6 September by the pagan chaplain, to say a transfer had been agreed for a move to Doncaster, but a further entry on 27 September by the administrator in the OMU to say Lindholme and Moorland had refused to accept Mr Barber. The administrator in the OMU told the investigator he sent an application to Moorland the same day, which is recorded on Mr Barber's prison record. This is the last entry relating to a possible transfer to the Doncaster area. Mr Barber submitted a further application to transfer to Moorland on 13 October, but this is not recorded on his prison record.

65. On 1 October, an officer recorded that Mr Barber's behaviour had 'vastly improved over the last few weeks' and that he had not been found under the influence of PS and looked healthier.

The move to the Vulnerable Prisoner Unit (VPU)

66. On 1 December, Mr Barber told prison staff that he was in debt (over tobacco) and requested vulnerable prisoner status. A SO placed three prisoners on report for going into Mr Barber's cell without his permission and taking his canteen. However, on 4 December, after Mr Barber moved to the VPU, he changed his statement to say he had given them permission and that he no longer had debt issues. The adjudications against the three prisoners were dropped. Mr Barber was placed on basic IEP for getting into debt.

67. Mr Barber did not attend a doctor's appointment on 13 December. He also failed to attend an appointment later the same day with a nurse about his non-compliance with medication.

68. On 19 December, staff were concerned that Mr Barber appeared to be low in mood and started ACCT procedures. However, at the initial assessment the same day, staff decided ACCT procedures were unnecessary and closed the ACCT. Two days later, Mr Barber was upgraded to standard IEP.

69. A nurse spoke with Mr Barber on 22 December, about his medication compliance. A nurse recorded that Mr Barber did not have any current thoughts about suicide or self-harm, but that he said he did not care if he died. She noted Mr Barber's mood was low, and he became emotional when talking about his family and said that he used PS as a way of managing. Mr Barber said he did not want to collect his medication. She referred Mr Barber to the mental health team.

70. On 28 December, a nurse completed a mental health assessment. He noted historical information from a psychiatric report and that Mr Barber did not present any differently to when he previously met him. He recorded that Mr Barber declined to complete a mental health questionnaire. The nurse recorded that Mr Barber had some 'strange points of view', that he used PS but had no current thoughts of suicide or self-harm. He recorded that Mr Barber would not receive any further input from the mental health team.

71. On 1 February 2018, an officer recorded Mr Barber had not eaten for a few days as he had flu, but refused to go to healthcare. He noted Mr Barber seemed 'very down' but did not have any thoughts of suicide or self-harm. He flagged his concerns to the safer custody team.

72. The next entry on Mr Barber's prison record is 8 March, when the pagan chaplain met with him. She noted he had started eating again, that they discussed his family and faith matters. She recorded she had no concerns about Mr Barber.

73. On 8 March, a prison GP recorded that Mr Barber had failed to attend for his annual blood tests and she was concerned about his mental health, although no-one had raised concerns with her directly. On 21 March, she recorded 'History - discussed his [Mr Barber] health issues, Diagnosis - Multi-disciplinary team meeting, Plan - to keep on list'.

74. On 28 March, Mr Barber's prescribed medications were stopped as he declined all medication. The prison GP recorded that she discussed the long-term implications for Mr Barber's health if he refused medication with him, and that he had the capacity to make the decision and that while he was content with her care, he distrusted the system. Mr Barber told her that he was planning on going abroad when released. This was the last meaningful contact Mr Barber had with healthcare staff, as he refused to attend any of the other five appointments booked.

75. 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 Barber's calls made between 13 April and 1 May, when he made his last call. In total he made six calls: a total of 22 minutes and six seconds. Mr Barber spoke to his mother and a friend and there is nothing in these calls that suggested he was in crisis or having any difficulties or problems at Channings Wood.

76. The pagan chaplain told the investigator that she saw Mr Barber for a chat in the VPU about once a fortnight and last saw him on 2 May. She said he was eating (which was a good sign as he would stop eating if things were not right) and he seemed quite cheerful. She had no concerns about him.

Friday 11 May 2018

77. On 11 May, at 10.28am, a resettlement case manager for Catch 22 working on behalf of the Devon and Cornwall CRC, recorded in Mr Barber's prison record that she had completed a resettlement review with him as he was due for release on 10 August. She noted, "Peter stated that he didn't care if he left custody and he could stay inside, as it didn't make a difference to him."

78. The resettlement case worker told the investigator that she had not previously met Mr Barber and had not read his records. She said that her interview was 'prisoner-led' and relied on Mr Barber's account of his situation, and that she would typically review a prisoner's records after the initial assessment. The resettlement case worker said she did not consider Mr Barber's comment about release to be anything other than him being dismissive of his situation. She did not consider Mr Barber to be at increased risk of suicide or self-harm.

79. Closed circuit television (CCTV) shows Mr Barber associating with other prisoners on his wing between 11.40am and 11.45am, when Mr Barber returned to his cell. A prisoner, went into Mr Barber's cell at 11.59am, for around a minute, and then left and returned to his own cell. He told the investigator that he was friends with Mr Barber and had spoken to him earlier around 11.20am, while they were in the lunch queue. He said he recalled asking another prisoner, a safer custody orderly, if he thought Mr Barber was alright, as he seemed 'a bit off'. Both prisoners had no concerns and thought Mr Barber was 'fine'.

80. The prisoner who entered Mr Barber's cell, said he went up to Mr Barber's cell around 12pm. He took his packet of crisps for him and Mr Barber gave him a biscuit. He said he wanted to discuss a library book he had read about an ancient symbolic language. He said when he went into Mr Barber's cell, he thought he had been smoking 'spice' (PS). He said there was some tissue paper in the cell

which had been burnt and some residual smoke. He said he did not comment and left the cell a short time later.

81. Mr Barber was last seen alive at 12.12pm when an officer completed a roll check and locked Mr Barber's cell.

82. CCTV shows an officer and a prisoner, distributing canteen (prisoners' purchases) during lunchtime when prisoners were locked in their cells. The bags of canteen were left outside the cells, before the officer opened each cell to hand over the bag and obtain a signature. The officer left a bag outside Mr Barber's cell at 12.47pm.

83. An officer can be seen going to each cell, opening the door and a prisoner had a form for each prisoner to sign when they had received their canteen. At 12.49pm, the officer arrived at Mr Barber's cell and opened the door. His reaction is one of shock, but he immediately used his radio to call a code blue medical emergency (indicating that a prisoner is unconscious or having difficulty breathing). Mr Barber was hanging in his cell, by a sheet attached to the window. South West Ambulance Service confirmed an ambulance was requested at 12.49pm.

84. A second officer responded to the emergency and he and the officer removed the ligature from Mr Barber. The officer told the investigator that the ligature was very thick and it was impossible to remove with his anti-ligature knife so he had to remove the ligature by hand. The two officers moved Mr Barber to the landing outside his cell at 12.51pm and started cardiopulmonary resuscitation (CPR).

85. A senior nurse and a responded to the emergency code and took over CPR at 12.53pm. A prison GP also responded to the code blue emergency and, by the time paramedics arrived at 1.09pm, Mr Barber had been resuscitated, but remained unconscious. He was taken by ambulance to hospital, where he remained on life support until he died at 1.20pm on 19 May. Restraints were never applied.

86. A note was found in Mr Barber's cell, written on the back of his Catch 22 appointment letter, saying, 'I'm sick of it all. Keep the garment?' The pagan chaplain told the investigator the 'garment' could be a reference to Mr Barber's body. She said, 'Pagan theology does allow for the body to be something we put on and off over a number of lives, and this was definitely part of Peter's understanding.'

Contact with Mr Barber's family

87. On 11 May, a CM (recorded under a different name in prison records), safer custody manager, told Mr Barber's nominated next of kin, a friend, that he had been taken to hospital. The next day police informed Mr Barber's mother. The prison appointed a member of staff as the family liaison officer (FLO) and she offered support to Mr Barber's family. The prison contributed towards the costs of Mr Barber's funeral, in line with national policy.

Support for prisoners and staff

88. The safer custody manager and the duty governor, held a debrief for prison staff involved in the emergency response. A member of the trauma support team facilitated a critical debrief on 31 May.

89. The prison posted notices informing other prisoners of Mr Barber'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 Barber's death.

Compassionate release

90. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. The application process for compassionate release was started on 14 May, after Mr Barber's condition did not improve. The process was not completed before Mr Barber died, but we are satisfied that the compassionate release process was appropriately followed.

Cause of death

91. A post-mortem investigation and toxicology tests were not completed. A hospital doctor recorded the cause of Mr Barber's death was hypoxic ischaemic encephalopathy and asphyxia (a lack of oxygen, due to hanging).

Findings

Management of Mr Barber's risk of suicide and self-harm

92. Prison staff started ACCT procedures on five separate occasions (three when Mr Barber refused food), the last of which was closed on 19 December 2017. However, although Mr Barber was sometimes described as being 'down' after that, neither staff nor prisoners thought Mr Barber was at increased risk of suicide or self-harm in the months before he died

93. The pagan chaplain (who knew Mr Barber quite well through his regular attendance at the pagan group) said that he stopped attending the group after he moved to the VPU but that she visited him for a chat once every two weeks and that another member of the pagan group also visited him regularly. She said she thought he did not like being in the VPU and, although he was a sociable man, he tended to stay in his cell reading books. He had previously been a man who could take care of himself and she thought being in the VPU made him feel old and vulnerable to bullying. She also thought he was unsure what kind of life awaited him on his release. However, she said he was very funny, told good stories and was engaging to talk to.

94. The pagan chaplain said it was a complete shock when she heard that Mr Barber had killed himself as she had seen no signs that he was at risk and it seemed so out of character as he had always spoken against suicide because of the distress it caused others. She said she was still 'astonished' and 'surprised'.

95. Although Mr Barber's mood was up and down, this seems to have been normal for him and Mr Barber gave no sign that he was in crisis before his death. We consider that it would have been difficult for staff to have predicted his actions.

96. Mr Barber declined to engage with general and mental health nurses at times, and frequently stated his mistrust of the healthcare system and prison authorities. However, there is evidence in Mr Barber's prison and medical records to demonstrate they all consistently attempted to provide him with support and advice, and his attitude did not prevent them attempting to engage Mr Barber throughout his time at Channings Wood.

Clinical care

97. The clinical reviewer, concluded that the clinical care provided to Mr Barber was equivalent to, and in some instances exceeded, that which he could have expected to receive in the community.

Mental health

98. Mr Barber's medical record contains evidence of comprehensive mental health assessments from the time he arrived in prison and on each subsequent transfer. Although in one instance Mr Barber refused to engage with an assessment, the clinical reviewer found there was no evidence this was detrimental to Mr Barber's well-being. Diagnoses varied from no mental health disorder to possible schizo-affective disorder (when a person experiences a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms,

such as depression or mania) or possible bi-polar affective disorder (when a person experiences periods of elation and depression). Mr Barber's capacity to make decisions around his engagement and treatment were recorded on most of these occasions; he was always assessed to have had capacity.

99. Mr Barber was diabetic, but he refused to take his medication for long periods. Healthcare staff frequently discussed how his diabetes could be better managed and the risks of not doing so. The clinical reviewer was satisfied that healthcare staff provided ongoing support to Mr Barber, although he did not always engage.

100. Mr Barber is documented to have refused food on a number of occasions, something he appeared to resort to when he felt a sense of injustice. Mr Barber's medical records document that a capacity assessment had been completed on each occasion, and that healthcare staff explained the consequences of his decision to refuse food. Prison and healthcare staff supported Mr Barber during the periods he refused to eat, and held regular reviews on each occasion.

Substance misuse

101. Mr Barber used illicit substances while in custody, and was often found under the influence of psychoactive substances. On two occasions he was reportedly in debt to other prisoners, and was supported on a violence reduction plan, with positive outcomes. Mr Barber moved to the VPU in December 2017, at his own request, because he was in debt. On each occasion Mr Barber was found under the influence, an appropriate assessment was undertaken by healthcare staff. On each occasion support and a referral to the substance misuse team were offered, but Mr Barber always declined**.**

102. The last recorded time Mr Barber was under the influence of PS was on 24 July 2017. Mr Barber's friend, who visited him shortly before he was discovered hanging, told the investigator he suspected Mr Barber had been smoking PS. The prison did not find any evidence in his cell and, because he died in hospital, a toxicology test was not completed so we are unable to confirm if he had used PS in the period before he hanged himself on 11 May.

Mr Barber's request to transfer to Doncaster

103. Mr Barber submitted several applications to transfer to the Doncaster area, but this request was not actively followed up. Mr Barber told the pagan chaplain he wanted to transfer to Doncaster to be closer to his elderly mother following his brother's death in July 2017, and she recorded this in his prison record.

104. There is no evidence that anyone spoke to Mr Barber from the OMU to ask why he wanted to transfer to a different area after his release. If they had they done so, his application may have been dealt with differently. As it was, it appears to have run into the sand and there is no evidence that staff pursued a transfer for Mr Barber with any persistence.

105. The OMU administrator, said he did not specifically remember the detail, but said that, in his experience, typically 80% of transfer applications and decisions

between prisons were conducted over the telephone and this could mean they were not always recorded.

106. The OMU administrator told the investigator he would normally attempt to record all contacts and correspondence on a prisoner's electronic record, but that the volume of his work meant this was impossible. He said that there had been several different heads of the OMU function in the preceding year, and finding an operational manager to escalate applications was difficult, unless a prisoner was particularly disruptive.

107. We do not know if the failure to secure a transfer had any impact on Mr Barber's mental health, but the pagan chaplain said he was 'really, really disappointed' and felt 'the system' had let him down. We therefore make the following recommendation:

The Governor should ensure that all applications for transfer, and the subsequent actions and decisions, are recorded on a prisoner's record.

Pre-discharge assessments

108. The resettlement case worker had not met Mr Barber before she completed a resettlement assessment on 11 May. She told the investigator she was new to her role and had had no formal training but had learned what was required by shadowing her colleagues. She confirmed that she did have access to prisoners' electronic records, but did not know about Mr Barber's history of ACCTs, his drug use or that he had asked to be moved closer to his mother. She accepted that accessing information before a resettlement interview would be beneficial and said that she would do so in future.

109. A senior case manager for Catch 22, told the investigator that training at Channings Wood for new staff was 'informal', but all Catch 22 staff were required to complete mandatory e-learning. He confirmed the initial pre-discharge assessments were prisoner-led, and said that information gained from them was then shared with offender managers in the community. He said that case managers would 'sometimes' look at prison records or have access to the OASys basic custody screening (an assessment of risks and needs) but that this depended on staff having sufficient time. He said gathering information was 'delve by exception'. He said that on occasion offender managers would respond to Catch 22 saying that the information they had obtained in their pre-discharge assessment was 'a load of rubbish', but that they were continuously trying to improve processes.

Mr Barber's comments to the resettlement case worker that he did not care if he was released were vague and we are satisfied that his actions a few hours later could not have reasonably been predicted. However, we consider that the resettlement case worker would have had a more meaningful interaction with Mr Barber if she had read his records and that any potential signs of increased risk of suicide and self-harm would have been easier to identify if she had had some knowledge about him. She might also have been able to support his transfer application. We, therefore recommend:

The senior case manager for Catch 22 at Channings Wood should ensure that case workers consult prisoners' records before conducting assessments.

Support for staff

110. PSI 08/2010 – *Post Incident Care,* states: *The Governor must have a local policy to identify the staff responsible for ensuring access to post incident care.* In an investigation into a previous death at Channings Wood, we identified there was no effective care team, and, in response, a Governor's Notice 187/2016 was issued on 23 June 2016 saying that a staff care team would be reintroduced. We found deficiencies in staff support during a subsequent death in February 2017, and this investigation found that Channings Wood still does not have an established staff care team.

111. We were told that efforts had been made to recruit staff care team members but, due to various difficulties including accessing Prison Service training, this had not happened. An acting prison manager, had been the only contact point for staff care team issues, and facilitated bimonthly meetings to discuss issues of well-being from September 2017. He told the investigator that these meetings were held in the chapel at lunchtime, and were advertised to all grades and disciplines by posters in communal areas.

112. Although most staff said they had felt well supported by their colleagues after Mr Barber's death, we have identified a number of concerns.

113. The officer who found Mr Barber, told the investigator that he remained working in the VPU, despite being the officer who discovered Mr Barber. He said that he was upset and shaken by events, and while he felt at the time he was able to continue, in hindsight he wished a decision had been made to remove him from duty, or at least to move him to work in a different area of the prison.

114. The pagan chaplain, said she was upset not to have been informed Mr Barber had been admitted to hospital as she would have liked to visit him. She was also upset that decisions about Mr Barber's funeral were not discussed with her sooner.

115. The resettlement worker, who met Mr Barber on the morning he was discovered, said she felt well supported by her Catch 22 colleagues, but had had no contact from prison managers to explain the investigation procedure after Mr Barber died.

116. The acting prison manager left the Prison Service in July 2018. The establishment of a staff care team will need to be addressed, to ensure there is effective support for all staff working at Channings Wood. We therefore make the following recommendation.

The Governor should ensure all staff, irrespective of status, position or experience, are offered formal support from the prison, following a death in custody.

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