

**Investigation into the circumstances surrounding the  
death of a prisoner  
at HMP Channings Wood in September 2006**

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

**May 2007**

This is the report of an investigation into the circumstances of the death of a prisoner who died at HMP Channings Wood in September 2006. He had been found hanging in his cell. He was 21 years old.

I would like to offer my personal condolences to the man's family and those touched by his death.

The investigation was undertaken by two of my colleagues. Both they and I would like to thank the Governor of Channings Wood and the appointed Liaison Officers for their kindness and cooperation during the course of our inquiries.

Like many people in prison, the man who died suffered with mental health problems. For the most part, he received a good level of support and care with these problems. However, the man became erratic in his compliance with his medication and this appears to have worsened his condition.

He withdrew from mental health services, and it seems likely he began to sell his medication. He also experienced long periods of inactivity in his cell. However, staff and prisoners were shocked by his death and did not realise how low the man had been feeling.

I make ten recommendations, largely concerning the care and monitoring of those on anti-psychotic medication and the transition of care between primary and secondary mental health teams in the prison.

I also highlight two areas of good practice and draw attention to the first-rate family liaison in the aftermath of the man's death.

Apparently self-inflicted deaths in category C training prisons like Channings Wood are relatively rare events. However, the man had many risk factors in common with prisoners who die in local and remand prisons: he suffered from a mental illness, he took his medication inconsistently, he heard voices, he had previously self harmed, and he enjoyed only a limited prison regime. The Prison Service may not directly be able to address the first four risk factors, but I am particularly concerned that the regime on the unit where he was held was so poor.

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**Prisons and Probation Ombudsman**

**May 2007**

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## SUMMARY

The man died in HMP Channings Wood in September 2006 at the age of 21. He was found hanging in his cell.

He had a long history of mental health problems. He had been in prison as both a juvenile and adult, and had previously made attempts on his life. After a brief period of release on licence, the man had been recalled to HMP Exeter on 6 February 2006. He was subsequently moved to Channings Wood on 11 May.

The man who died was based on Living Block 4 (LB4), where he rarely came to staff's attention. He chose not to work or take part in education. However, he attended regular appointments with a nurse from the mental health in-reach team.

On 17 June, the man cut his wrists. He was moved to Living Block 1 (LB1), Mersey side, which provides a supportive environment for prisoners who have difficulty in coping. On arrival, he became more erratic in terms of his compliance with medication and his attendance with the in-reach team. The in-reach worker felt this might be due to her challenging him more in the work they were completing. Eventually, the man chose to withdraw completely from in-reach services and was placed in the care of the primary care mental health staff. Regrettably, there are no notes in the clinical record from 27 July until his death. Healthcare staff were seeing him regularly when he collected his medication, but I have concerns as to the handover between primary and secondary mental health services.

There were conflicting reports as to why he did not always collect his medication. Some said he was forgetful, others that he did not like taking it. However, it was not formally recorded or followed up. Many said that he was trading medication for tobacco. There was also a suggestion that he was even trading his sandwiches for tobacco, contributing to weight loss in the last weeks of his life.

I judge that staff interacted well with prisoners on LB1, and they appeared to know the man. I am certain that he had staff with whom he could speak, although he was quite a private person. He was also unpredictable, and staff noticed that he was sometimes down but the next day could be upbeat. There was a noticeable difference when he took his medication.

There was very good communication between healthcare staff and staff on the Mersey side of LB1. However, the latter felt ill-equipped to deal with some of the mental health concerns presented. I recognise this is an issue across the prison estate.

Although the man did socialise with others, prisoners told my investigators that he would sometimes deliberately stay behind his door as he was concerned about the voices he sometimes heard. Combined with the limited regime, this meant that he was often in his cell for between 18 and 20 hours per day. This is cause for concern in a training prison. However, the Governor is aware of the issue and is planning to broaden the regime on the Mersey side of LB1. It is important that the Governor receives support from the Prison Service to do this.

On finding the man hanging, staff acted appropriately and contingency plans were followed. Prisoners were informed sensitively, with effort to contact his friends on other wings in person before the news was widespread.

The family liaison has been of a high standard. Breaking the news in person is best practice and the family were grateful for this. It was also felt that all the stress of arranging things was eased by the helpfulness of the prison who provided invaluable assistance during a very difficult time.

## THE INVESTIGATION PROCESS

I appointed two members of my office to conduct the investigation on my behalf. One of these investigators and one of family liaison officers visited Channings Wood where they met the Governor. On this initial visit, they were also given a tour of Channings Wood including the cell where the man had been found. They met with members of the local committee of the Prison Officers' Association (POA), the Independent Monitoring Board (IMB) and the prison's family liaison officer.

Notices were issued to both prisoners and staff, inviting anyone who might have information relating to the man to make themselves known to the inquiry.

My investigator and family liaison officer visited the man's sister to discuss family concerns and questions about the investigation. The family liaison officer also spoke with the man's mother by telephone. A number of issues were raised. These largely related to his medical condition and how well he was being treated. The man's family were concerned that prison might not have been the right place for him, and that he should have been treated in hospital. Concerns were raised about his medication and gradual deterioration, why he was not subject to more frequent monitoring and why the family had not been contacted when he had previously self harmed. The issues raised by the family have been considered throughout the report, or in separate correspondence with them.

The investigation team met with the police, who were very helpful in providing statements they had already taken from staff. The team itself interviewed prison staff and prisoners, both formally and informally. They also examined the man's prison record, medical records and a series of prison documents.

A clinical review of the man's healthcare in custody was undertaken jointly by the Prison Health and Development Manager at Devon Primary Care Trust, and the Medical Lead for Teignbridge from Devon Primary Care Trust. I am grateful to them both. The clinical review process included a panel review, with members from the prison, mental health in-reach services, members from Devon Primary Care Trust and the lead investigator from my office.

My investigators were unable to interview a key member of staff due to sickness. However, the nurse's notes were very comprehensive, and the investigating team and one of the clinical reviewers were able to speak with her manager.

## **The Man**

The man who died was born in October 1984. He was 21 years old when he died in September 2006. He was a bright person, but left school early at age 15. He enjoyed creative writing and had an appreciation for poetry. At one stage, he had hoped to study law.

He grew up in Blackburn with his mother, stepfather, and half brother, but moved to Tiverton to live with his sister in 2003. His grandparents also live in this area. He stayed with his sister for a while, but was then re-housed to a flat in Cullompton. It was here that he became involved with a group of offenders and drug users. He began using heroin at this time.

He was a vulnerable young man. He suffered with a personality disorder for which he needed to take regular medication (olanzapine – a psychotropic). A combination of non-compliance with medication, substance abuse and negative peer influence led to unpredictable behaviour, including offending. This, in turn, led to a series of convictions and periods in custody. During one of these periods (at HMP Exeter), he tried to take his own life.

After a period of custody, the man was released on licence in late January 2006. Following his release, his initial reporting was satisfactory and he was actively seeking employment and accommodation. However, concerns were soon expressed about non-compliance with his medication and he would not agree to a referral to psychiatric services for assessment. If he did not take his medication, he was liable to become angry and aggressive in addition to having suicidal thoughts. He failed to attend appointments with his supervising officer and breached the conditions of his licence. He was recalled to prison on 6 February 2006. He also received a further 18 months imprisonment on 15 March.

Despite his periods of quiet, the man was friendly and caring with a sharp sense of humour. He was well liked by those who knew him, and he is greatly missed by his family.

## **HMP CHANNINGS WOOD**

Channings Wood is a category C training prison, built on the site of a former Ministry of Defence base, and officially opened in July 1974. A building programme took place in the 1980s and early 1990s, adding further accommodation. The operational capacity is 667 men, serving a wide range of sentences. The prison contains a specialist Therapeutic Community for tackling drug abuse and a Vulnerable Prisoner Unit which specialises in Sex Offender Treatment Programmes.

The therapeutic community opened in November 1997. It is housed in one of the prison's living blocks, and currently has space for 65 men. It is a partnership between the Prison Service and Phoenix House, a national charity providing specialist treatment services for drug and alcohol users. The community offers an intensive, structured programme for prisoners who abuse drugs, staffed by prison officers and drugs workers, all of whom have had specialist training. It is designed to provide a safe environment with a highly structured daily routine, and demands a very high standard of behaviour from the residents in every activity.

## KEY EVENTS

Having been released at the end of January 2006, the man was recalled to prison for not complying with his licence conditions and received into Exeter prison on 6 February. He was seen by a nurse in reception who recorded that he had previously attempted suicide in October 2005. (The man's family told my investigators that he had also previously attempted to take his life in custody as a juvenile, although this was not known to staff at Channings Wood.) The nurse noted that he was not under a psychiatrist but was on medication for a mental health condition.

The man saw a doctor the following day. The doctor noted that he was on olanzapine medication. The man told the doctor that he had been diagnosed with personality disorder by a doctor in Exeter prison in November 2005. He also told him that at times he wanted to harm himself or others due to hearing voices, which he would try to ignore. However, since being on the medication he had not heard the voices. He maintained good eye contact throughout this consultation and showed a good sense of humour.

During his time at HMP Exeter, the man was seen regularly by a registered mental health nurse with the mental health in-reach team (MHIT). The man also kept busy by working in the kitchens. He was awaiting a move to Channings Wood, but in anticipation of the move he stopped working. However, the transfer took slightly longer than he had expected. The nurse noted in the man's clinical record on 28 April, that he was having "...some thoughts (of harming self or others), could be due to frustration of no movement to Channings Wood. Not occupied."

He was transferred to Channings Wood on 11 May. The man was seen by various professionals during his first few days. A resettlement needs assessment was completed by an officer who noted that the man had experienced mental health problems and depression, and had cut his wrists in October 2005. The officer wrote that the man had not harmed himself since. The man told the officer that he had some history of paranoid thoughts and aggressive thoughts towards others, but since being on medication he had been symptom-free since November 2005.

There are three entries in the clinical record on 11 May. They show that the man was on olanzapine medication, was physically fit and healthy, and had taken drugs in the past but never intravenously.

The man saw the doctor and told him that he had been under the care of a community psychiatric nurse. He told him of his previous self harm history, and that he smoked 1.2 ounces of tobacco daily. He also gave details of his last General Practitioner in the community. He reported that he had family support from his sister, grandmother, an ex-partner, and his daughter aged six years (we have been unable to confirm whether the man had a daughter. It is possible he was referring to an ex-partner's child to whom he was not the biological father.)

The following day, the Head of Healthcare noted that the man had been seeing a nurse from the MHIT. The same MHIT covers three prisons in the area. This meant that the man received a seamless transition of care from Exeter to Channings Wood.

The man was housed on Living Block 4 (LB4), a fairly large unit. The mental health nurse noted in the clinical record on 18 May that the man was having some violent thoughts. She concluded that he was bored and needed to work. She added that he was complying with his medication. The following week, the mental health nurse met with the man to complete a personal plan and she recorded his mental state as stable.

There are few notes in the man's wing history sheet from his time on LB4. It appears that staff had little interaction with him. Neither does his name appear in the observation book. He did not make applications to work or go to education. Neither did he make any complaints. My investigators spoke to one of his friends on LB4, who had known the man on previous sentences. He thought that the man was taking his medication and seemed all right.

There is a note on 29 May in the man's history sheet saying that he had been warned about having a sheet up at the window. The following week, he received a written warning for still being in bed at 10.30am with the curtains closed, having been verbally warned previously.

The man failed to attend an appointment with the mental health nurse on 7 June, but met with her the following week on 14 June. She noted that his thoughts of harming others had decreased.

In the early hours of 17 June, the man pressed his cell bell. A wing officer answered it. The man told the wing officer that he had cut his wrist but would say no more. At night, the prison is locked and the orderly officer is the only person with a full set of keys. The wing officer alerted the orderly officer and then returned to the man's cell, where the man told him he had cut the other wrist. The man was reluctant to talk, but eventually told the orderly officer, that he could not cope as other prisoners were putting him under pressure to bring in drugs through visits. The man would not name the prisoners. There are no healthcare staff on duty during the night at Channings Wood, and staff concluded that the cuts were not so serious as to warrant transfer to an outside hospital. The orderly officer asked the man if he would consider self harm if he moved him to Living Block 1. The man said he would not. The wing officer and the orderly officer opened an F2052SH document (used to monitor and support a person at risk of suicide or self harm. This has since been replaced by ACCT)). The orderly officer concluded that the man should be moved to LB1, that he should be encouraged to talk about his problems, and should have close contact with a personal officer. The orderly officer also advised that the level of observation and interaction should be every 15 minutes until the man fell asleep. He was then to be checked hourly.

LB1 has two wings. One side houses prisoners taking part in the drugs therapeutic community and the other, named Mersey, holds a mixture of prisoners. The man was located on the Mersey side.

A nurse saw the man in the morning. The man told the nurse that he had cut himself because he had "had enough". The wound on the man's right wrist required three sutures, but he was extremely anxious about the sutures and the nurse was only

able to insert two. The cut on the man's left wrist was superficial. Both wrists were cleaned and dressed.

Subsequently, a security information report (SIR) was submitted, suggesting the name of a prisoner that had been bullying the man. The man should have been interviewed to see if he would confirm the name, but there is no evidence that he was seen about this matter following 17 June. When other prisoners were asked about the prisoner alleged to have bullied the man, they all said they were friends and there was no problem between them.

An officer met with the man to induct him onto the wing and inform him about the regime. One of the fitness instructors also met with the man to discuss physical activities that would help alleviate stress. Although the man chose not to take part, I was pleased to learn that physical education staff are routinely considered and included in the treatment of those who are feeling depressed. This is good practice.

On 20 June, a case review was held and which was recorded in the F2052SH and clinical notes. It was well attended by a multi-disciplinary team consisting of a supervising officer, the Head of Healthcare, one of the prison chaplains, and the man himself. He was still feeling down, intermittently smiling but generally kept his head down, and would not maintain eye contact. The man said that he still had thoughts of self harm and suicide. He admitted that he had taken himself off his medication. He was reluctant to talk to staff and the Head of Healthcare recalled she made a number of suggestions as to how they could help him, or activities he could undertake. However, the man did not want to engage with staff at all. The members of staff at the case review reiterated the sources of support available and decided to keep the F2052SH open.

The clinical staff noted instances when the man had not collected his medication. The man did not attend appointments with a nurse on 28 or 29 June. She recorded that he had previously ceased taking olanzapine, and that had resulted in thoughts of harming others which he acted upon. During this week, staff also completed documentation regarding the man's sentence management dossier. The Head of Healthcare noted that the man had a chronic condition and needed ongoing support.

Another F2052SH case review was held on 2 July. Those present were the man, a nurse and an officer. They found that the man's attitude had greatly improved in the previous week. The man said he felt at ease and had made friends with other residents. He said the thoughts did come and go but he was feeling positive. He agreed to tell staff if his mood changed. The F2052SH was closed with the agreement that the man would approach wing and healthcare staff if he wanted to talk, and that he would find something constructive to do with his time. The same week, staff reviewed the man's Incentives and Earned Privileges status. This determines the range of facilities to which prisoners are entitled depending on their behaviour over a period of time. As the man had not been on the wing long, he remained at the middle level known as standard.

On 6 July, the man refused to see a nurse again. The nurse made a note that she would write to him. She recorded the need for the primary healthcare team in the prison to monitor his medication and mental state, and that she would see him again

if he deteriorated. The same day, wing staff called healthcare and asked a nurse to see the man as he was acting “funny” and might have been hearing voices. When the nurse attended, he said he had not had his medication. The nurse checked the prescription chart and noted that his medication was not due to be reissued until the following day.

After this, the man was due to collect his medication daily so that healthcare staff could check he was taking it. However, he did not always go to collect his medication. On 14 July, the man admitted to healthcare staff that he had not taken his medication for four days and was experiencing feelings of paranoia. This meant he had isolated himself to avoid incidents with others. The man agreed to collect olanzapine daily. He said that he would resume seeing a nurse when he felt a bit better. The man appeared to have dealt with this episode of paranoia appropriately, but healthcare staff noted that at times he could misinterpret others, turning exchanges with friends into feelings that they were out to get him. An officer made a note in the man’s wing history sheet that the man could potentially become dangerous if he did not take his medication.

A nurse made a further attempt to see the man, but he said that he was “not in the mood”. The man signed a statement to say that he did not want to see the nurse that day. The nurse made a note in the man’s clinical record: “due to angry attitude I will discharge from caseload. Primary care can deal with this prisoner.”

Staff also noted in the man’s wing history sheets that he needed to be reminded to collect his medication. During August, the man did so every day apart from two days. In these instances, there was no signature in the prescription chart or reason cited why the man did not take his medication.

Wing staff noted that the man could be “childlike”. At one point, the man complained that tobacco had been taken from his cell and he spoke to an officer about it. The officer noted that he found the man quite “a weak individual who finds jail hard going”. He made a further entry on 3 September: “no change in his immature behaviour – currently on medication which he states makes him forget things. He still fails to adhere to simple rules and procedures.” In interview, the officer told my investigators that he would often have to remind the man to do things. At times he would not be in his cell when it was time to lock the doors, and he would normally be found playing table football or chatting to other prisoners. The officer described the man as:

“... very placid guy, he never, I never heard him shouting and bawling, and to my knowledge he never got into any scrapes on the Wing, he was always well behaved, polite, again as I say he could be forgetful and he could ignore Wing rules, but I put that down to his you know, his mental state.”

Another officer described the man in this way:

“... he was very quiet but ... he did have a good sense of humour and he was always smiling and ... when you spoke to him you always thought ... there is something that he knows that you don’t and it is like a running joke almost ...

but sometimes he would become withdrawn and moody and sometimes he was quite happy and joking and laughing.”

Officers said that you could tell if the man had not taken his medication as he was more hyperactive. However, they put it down to him forgetting rather than a deliberate act. An officer explained that he knew the man had problems, and could sometimes hear voices, and commented how difficult it must have been for the man to be locked up for large parts of the day. In September, the man did not collect his medication on seven separate days, 1, 5, 7, 21, 22, 24 and 27 September.

On 27 September, the man was out of his cell and had gone to another prisoner’s window on LB4. The prisoner was due to be released soon, and the man asked if he would leave him his digibox. The prisoner said that the man had appeared normal and he would never have guessed that he intended to take his life.

A supervising officer saw the man at the evening meal and had a casual chat with him. She said he seemed normal and she had no idea that anything might be troubling him.

An officer was on duty from 8.00am till 9.00pm on 27 September. He remembered seeing the man in the morning when he was conducting his cell checks and that the man seemed fine. He told investigators:

“I can’t recall seeing him in the afternoon at all, or at tea time but in the evening I can remember he was downstairs playing table football as he normally was ... but he seemed okay, not a problem, he didn’t show any outward signs of anxiety ... I can’t honestly say I noticed any difference in him that day.”

The officer explained that all prisoners were locked behind their doors by about 7.40pm. The night staff would conduct a roll check at about 9.00 pm. On that night, it had been completed by an operational support grade officer (OSG) who noticed nothing unusual.

Unless a prisoner is subject to suicide/self harm risk procedures, staff would not visit their cell after lock-up except if they pressed their cell bell. The man did not press his cell bell during the evening of 27 September, but at some point during that time he wrote several notes. The man wrote to his family saying that he loved them and was sorry.

At approximately 6.40am on 28 September, the OSG was conducting the morning roll check on LB1. This entails checking that every prisoner is in their cell. When he came to the man’s cell, he opened the observation hatch and saw that the man was hanging from the window.

The OSG used his radio to contact the communications room to get help, but did not get an immediate response. As a result, he ran to the office downstairs to phone and then ran back to the man’s cell. At night, only the night orderly officer has keys to the whole prison, but individual officers and OSGs have a sealed pouch on their

belt containing a cell key. The OSG used this key to enter the man's cell. As he opened the door, other staff arrived.

Two officers were at the gatelodge nearing the end of their shifts when the phone call was received. They ran to LB1 as did the night orderly officer. The night orderly officer took the man's body weight, while an officer released the ligature. They were able to untie this manually without the use of ligature scissors. They laid the man on the top bunk. It was clear from the level of rigor mortis that the man had been dead for some time. For this reason, the night orderly officer requested an ambulance, but in line with local policy no attempt was made at resuscitation.

The ambulance was called at 6.50am. It arrived just before 7.00am. The paramedic assessed the man and pronounced him dead.

A chaplain was appointed as the prison's family liaison officer. He and the Governor visited the man's sister, who had been identified as his next of kin, to break the news of her brother's death.

All contingency plans were implemented and completed thoroughly. The Independent Monitoring Board told my investigators that the prison had not contacted them. The Head of Safer Custody was sure they had been informed, but there is no record of this. In the event, a member of the IMB arrived soon after the man was discovered.

A hot debrief was conducted.

Samaritans were notified and attended on the wing. The Head of Safer Custody arranged for the prisoners on LB1 to be told of the man's death individually. A supervising officer and a reverend knew that the man had friends on other wings and broke the news to them.

A memorial service was conducted by a reverend and was well attended.

## ISSUES

### *Disengagement from mental health services*

The clinical review explores the man's healthcare needs and disengagement from mental health services in some depth. This section of my report is therefore taken directly from the clinical review.

“the man's F2052SH was closed on 2 July, following a review where primary care staff were represented. There did not appear to be any communication later that week with the Mental Health In-Reach Team recorded. The notes did not indicate whether a full clinical suicide risk assessment was completed about his intentions to self harm or end his life at this time. This would have been helpful in objectively determining his level of risk to self.

the man did not attend In-Reach appointments on 28 and 29 June. On 6 July a nurse contacted the wing. The man refused to see her. She wrote to primary care staff asking them to monitor medication and his mental state, using a primary care assessment request. She stated she was willing to see him again should his presentation deteriorate. However, she also noted the probability that thoughts of harming others may well increase in frequency. Prisoners and staff had also noted some weight loss at this time. The decision to refer him to primary care, albeit nineteen days after an incident of self harm and where there was some evidence that he was demonstrating indicators of increased risk, was defended by the In-Reach team. Healthcare staff who knew the man did not perceive that he had any greater level of distress than he would usually present with. Best practice would suggest that agreement should have been sought from the receiving GP that s/he was willing to continue responsibility for the patient's care under those terms. The written referral was copied in the In-Reach notes, but not evident in the clinical record.

Primary care mental health staff have a monthly meeting with In-Reach colleagues and could not recall this case being discussed. There was an agreed protocol for the transfer of patient care between the In-Reach Team and primary care at the time of the incident. The focus on the meeting has changed from clinical supervision to a liaison meeting; although direct entries are rarely made in patient's clinical record.

Later on 6 July, a primary care nurse at the request of wing staff attended him. He was feeling 'funny' and may be hearing voices. He was requesting clarification about his medication, and appeared not to be due until the next day. However, the medication card was not available to confirm this. The Mental Health In-Reach Team further advised that he should not be given medicines in-possession and attend the dispensary on a daily basis for supervised consumption and monitoring. It would have been helpful to have a care plan or contingency in place should the man present with acute concerns.

The patient was seen on one occasion by a primary care nurse on 14 July, where his 'thoughts of paranoia' were discussed. He had not been consistently taking his olanzapine. He agreed to collect medication with some persuasion and intended to re-engage with the nurse, when he 'felt a bit better than he did then'. He appeared to be dealing with his paranoid feelings appropriately and was insightful. There were no further plans for a review and agreements seem to have been made with the patient in respect of medication compliance and attending Mental Health In-reach appointments with no means of checking them.

The man apparently declined In-Reach contact in the first week of July, although this was not documented at the time as to his reasons or an assessment of his mental state. No alternative arrangements were maintained to monitor him. Nothing was recorded in the medical record between 27 July and his death on 28 September 2006.

On 27 July, besides his reluctance to engage he was discharged because of his angry attitude. There is also an entry that states 'primary care can deal with him' which possibly indicates a level of frustration by the practitioner in her dealings with the man. There was a written report that primary care mental health nurses should monitor him and the Consultant Psychiatrist would review his medication in November 2006. There was no evidence that primary care nurses had made such a formal review.

It is apparent in the In-Reach notes that the nurse had continued to make contact with the man throughout the summer, and he was not compliant or frequently refused to see her. On 27 July, she reports that he had presented in an angry state escorted by primary healthcare staff and also appeared to have lost weight. She felt that he was finding making contact with his family and addressing the mental health dimensions of his offending behaviour too challenging. She also reports that there were no obvious signs of psychotic presentation. She regarded his thoughts of harming others within his control, but felt that he would offend in prison or on release. She also stated that she had not felt 'at risk' in the seven months contact she maintained with the patient.

On 27 July, wing staff were reminded by the nurse that should the patient not attend his appointment, he would not be given a further appointment by her. He was requested by a primary care Healthcare Officer to complete a disclaimer, confirming that he did not wish to be seen. There was no record of a mental state examination at this time. The nurse refers to weight loss observed in the patient since their last contact. Although the reason for his anger was not determined, it was assumed by the nurse that the patient did not 'like their boundaries set'. Other antecedents in the change in his presentation were not considered at this point."

The clinical review further summarises that the man withdrew from mental health in-reach services, and was monitored by primary care mental health nurses during two months prior to his death, but the clinical record did not report the regular contacts made during the issuing of medicines. Primary care nurses only recorded contacts

where there were specific issues of concern and it appears there were no significant issues. Attempts were made by Mental Health In-Reach staff to see the man, but he refused. He finally signed a declaration that he did not wish to see the mental health services (although his mental state was unclear, he presented as angry). There does not appear to have been a firm undertaking from primary care to take on the care responsibility once it had been referred back by Mental Health In-Reach.

I endorse the following recommendations from the clinical review:

**An agreed care plan should be made and endorsed by both primary care and secondary care mental health providers, outlining agreed actions and contingencies in light of any prospect of relapse or deterioration in presentation (providing a defined care pathway and route of referral).**

**Liaison meetings between primary and secondary care mental health practitioners should be properly minuted and patient related information recorded in a single medical record i.e. mental health records should not be duplicated.**

The clinical review also recommends that Mental Health In-Reach staff should be routinely involved in reviews of those subject to suicide and self-harm procedures. The knowledge and relationship a member of the In-Reach team has with their client, means they are integral to the care and quality of review that may take place. However, there are times when the suicide and self-harm documents need to be reviewed urgently and In-Reach staff may not be available. Indeed, in the man's case, members of the healthcare team were present at reviews and able to contribute. I make the following recommendation on the matter:

**Where a prisoner is under the care of the In-Reach team, that team must be notified and invited to attend ACCT/F2052SH reviews. Where it is not possible to attend the reviews, they should make themselves aware of the outcome of the review.**

Furthermore, I recommend that:

**The Governor and Head of Healthcare should consider the clinical review and the extent to which all the recommendations can be met.**

### ***Potential for transfer to hospital***

The man's family had understood that he had suffered with schizophrenia. They were concerned that prison might have been an inappropriate place for the man and that he should have been treated in a psychiatric hospital.

My investigator asked the clinical reviewers to explore this issue. They found that, although the man may have had a provisional diagnosis of schizophrenia at some point in his history, he certainly had a history and diagnosis of personality disorder since November 2005, with evidence of earlier referrals from 2003. The man's reports of hearing voices were not considered by clinicians as positive symptoms of psychoses, but more as internal dialogue reflecting his thoughts. He had been seen

by a Specialist Forensic Registrar in November 2005, and further reviewed in January 2006 where a diagnosis of schizophrenia was thought less likely than one of dissocial personality disorder. Olanzapine was prescribed to determine whether any improvement in auditory hallucinations was experienced, and increased in January 2006. Continuing In-Reach support was recommended as part of the treatment plan.

With regard to his mental health problems warranting a transfer from prison, it is difficult to determine this with hindsight. However, under the terms of the Mental Health Act, it is unlikely that the man presented with such acute symptoms that his transfer would have been supported given the indications that were recorded in the notes until July 2006. In the absence of a comprehensive clinical record in the two months prior to his death, it is impossible to make a further assessment.

### **Compliance with medication**

The man was prescribed olanzapine medication in an attempt to reduce his hearing voices. He did not always take his medication. The man's sister told my investigators that, outside prison, he had also not consistently taken his medication. Referring to a time when the man had stayed with her, the man's sister remembered how, without his medication, he could become unpredictable and easily lose control. That said, he would always warn her if he was close to losing control or could hear voices telling him to do things, and usually tried to remove himself from the situation. This behaviour was also confirmed by the man's friends at Channings Wood who said he had been close to losing control and taken himself back to his cell a number of times in the days prior to his death. The man's sister said that the man hated taking his medication as it made him feel like a zombie, forcing him to sleep all the time and giving him a terrible thirst. She commented how difficult it must have been for the man and how, at times, he must have felt like he had no quality of life with or without his medication.

The man's friend, another prisoner, said that he knew the man did not like taking his medication. The prisoner had known him for several years over different sentences, and had shared a cell with him at one point in Exeter. The prisoner said he could tell when the man was taking his medication as there was a marked difference in his demeanour. Taking his medication made the man more subdued and quiet.

At Channings Wood, the man was initially issued a week's dose of olanzapine and had kept it in possession. The Head of Healthcare explained that olanzapine has some sedative effects. As there is not 24 hour healthcare cover, it is preferable for those on medication with sedative effects to have the medication in possession. Otherwise, if they were to collect each dose from healthcare, they would need to take the medication earlier in the day when they were likely to feel tired after taking it. However, when the man became more erratic in taking his medication before and after the time of his self harm in June, they needed to reassess the situation. The Head of Healthcare explained that initially they tried to supervise the man swallowing his medication:

“However he would not take it and he was saying under no circumstances would he actually take them in that way. He did see his In-reach worker and it was also reviewed with ... the Primary Mental Health Team. They saw him

together and the deal was that he would take them away and then at least we had a hope he would take it.”

They agreed, therefore, that the man would collect one day’s medication at a time. This appeared to work and, from the end of July, the man was collecting his medication daily and only missing occasional doses.

The Head of Healthcare told my investigators that she decided to keep him collecting his medication daily, particularly once he disengaged from the Mental Health In-Reach team, as it ensured that he was at least seeing a member of healthcare staff daily. The Head of Healthcare said that, although the man was quiet, he did not appear to be experiencing his previous difficulties and maintained good eye contact when they met. The Head of Healthcare had previously worked at Exeter and had seen the man when he was more acutely unwell. She felt she had a good relationship and knowledge of him.

### ***Suspected trading of medication***

Several prisoners commented that the man had lost weight in the weeks before he died. One prisoner told my investigators that he overheard the man trading his medication for tobacco. Others were in no doubt he was trading medication and food. He would order sandwiches for his evening meal rather than a hot meal, and then trade them. Prisoners said the man liked to smoke, smoked quickly, and often ran out of tobacco. One thought he had moved to LB1 as he had got in debt by borrowing tobacco. My investigators explored the possibility that the man was being bullied in some way for his medication, but found no evidence to substantiate this. His friends and sister felt that he simply would not accept bullying, and was very capable of looking after himself.

The man was a heavy smoker. On reception, he told the doctor that he smoked 1.2 ounces of tobacco per day. As the man did not work or attend education, his weekly income was £5 per week. If the man was smoking the amount he claimed, he would need close to £5 per day. Even if he had over-estimated his consumption, this does give credence to the claims that he was trading for tobacco.

The man’s friends from LB1 also said that in the month before he died there was a change in his behaviour. They said that he began to distance himself more and stay behind his cell door rather than socialising. He also seemed to get “wound up” more easily. He had mentioned to some other prisoners that “he felt like killing someone”. Another prisoner recalled that he grew paranoid, thinking that others were talking about him. The man would then remove himself from the situation.

The man’s friends told my investigators that the man was not one to talk openly about his problems. He was also not the sort of person likely to confide in staff, although he did seem to get along with staff and could laugh and joke with them, particularly one officer. The prisoners said that, had he wanted to talk, they were sure some staff on the unit would have been happy to listen and try to help.

Throughout August, the man collected his olanzapine with regularity, missing only occasional doses. This pattern continued until 21 September, where he then took

only three of six doses until his death. The clinical review found that irregular consumption of olanzapine may contribute to swings in mood, although whether this was the case with the man is difficult to determine without objective evidence in the notes. It was suggested that the man “would not have derived any anti-psychotic benefits, but more a dampening down of arousal at times”. Missing the occasional dose may contribute to an increased level of arousal that may or may not be clearly observable in behaviour.

The man’s apparent trading was not disclosed to staff. They cannot, therefore, have been expected to know the extent of his non-compliance with his medication. However, there are several areas that can be improved to help monitor those on psychotropic medication. I endorse the following recommendations from the clinical review:

**Patients who are subject to psychotropic medication (and at risk of relapse) should have a care plan in their notes to confirm action in the event they miss or decline their medication.**

**A clear protocol should be established and used with regard to recording ‘refusals’ of medication and an agreed system of follow-up.**

**All patients on neuroleptic medication should be subject to a minimum of six monthly medication reviews by a suitably qualified and experienced practitioner.**

### ***Regime on LB1 – Mersey***

LB1 houses the drug therapeutic community. This is an intensive therapy environment, and a unit that Channings Wood is rightly proud of. However, due to insufficient take up of places on the unit, and competing population demands, it has been necessary to utilise the Mersey side of the unit for those who are not part of the therapeutic regime.

Several staff told my investigators that, because the wing was separate from the main prison, by default the Mersey side of LB1 was being used to house vulnerable prisoners who found it difficult to cope elsewhere. In reality, there was a real mixture of prisoners housed on the unit, including those who found it difficult in the main prison. Others were there as they had graduated from the therapeutic regime. Staff told my investigators they felt they were dealing with more and more cases of prisoners who were mentally ill.

The therapeutic part of LB1 needs to remain separate from the main part of the prison. However, as a consequence, although there are some employment and education opportunities for the non-therapeutic community prisoners, the availability of these activities is extremely limited.

The man’s friends told my investigators that the man was often in his cell for 19 hours a day. At times, he chose to remain in his cell instead of associating. But, in any event, the need for communal rooms to be used for therapy meetings meant there were limited association facilities on the unit.

There is no evidence that the man applied to attend education or work. However, it is evident that in previous periods in custody he had done so. It is mentioned several times in the notes made by the nurse how important it was for the man to keep busy. Long periods of inactivity clearly could be detrimental to his mental health. The Governor is well aware of this issue and told my investigators that she is negotiating contracts to create more employment and education opportunities on the wing.

**The regime for non-therapeutic community prisoners housed on LB1 should be improved as a matter of priority.**

### ***Crisis management***

An ambulance was promptly called at 6.50am on the morning of 28 September, and arrived at 7.00am. The man was pronounced dead where he had been found. In accordance with local and national policy, resuscitation was not carried out, given the appearance that the man had died some time earlier. (I entirely endorse this decision. It is respectful neither to the staff involved nor to the memory of the person who has died for resuscitation to be attempted when rigor mortis has clearly set in for some time.) Nevertheless, the man's family were understandably concerned to learn more exactly when he had died. Unfortunately, predicting a time of death is very difficult. Variants such as body weight and the temperature of the cell would have an effect. In general terms, it takes three to four hours after death for rigor mortis to set in, and it lasts for approximately 12 hours. All that it seems possible to say is that the man probably died in the late evening of 27 September or early morning of 28 September.

HMP Channings Wood has a policy in place to train Senior Officers in first aid, ensuring that an appropriately trained person is always on duty and able to respond to incidents as they arise. This is an intelligent use of resources and an example of good practice.

### ***Family liaison***

The man's sister was concerned that she had not been told that the man had self harmed in June. Prison Service Order (PSO) 2700, Suicide and self harm, states:

*“3.4 Follow-up actions, and care for prisoners who have self-harmed*

*3.4.3 After consultation with the prisoner, the nominated next of kin must be notified, unless:*

*There is a clinical reason not to, or;*

*If aged 18 and over, the prisoner does not consent, or;*

*The prisoner's support plan indicates otherwise (e.g. in the case of a prisoner who repetitively self-harms).”*

I acknowledge that the men at Channings Wood are adults and can make a decision whether to contact their family. Some may have unhappy family relationships or no

family to support them, or may not wish to upset them. However, the man said on several occasions that he had support from family members. I regret that, despite what PSO 2700 requires, the Prison Service, as a whole seems not to involve families in suicide prevention and support as much as it could.

**The Governor should remind staff to encourage prisoners on suicide prevention measures to speak with their supportive family members where appropriate. This should be included in the local suicide prevention policy.**

The news of the man's death was broken in person by the Governor and nominated family liaison officer.

The man's sister spoke very highly of the support she had received. The family liaison officer had accompanied her to view the man's body and stayed with her throughout. The prison was forthcoming in providing contact numbers and helped the man's sister identify and deal with the necessary paperwork, enabling her to quickly travel to Blackburn to break the news to her mother, step-father and half-brother.

The prison invited the family to visit the prison, where they were able to view the man's cell and speak with some of the man's friends on LB1 Wing. The family had appreciated this support.

**The family liaison officer should be commended for his work as the prison's family liaison officer.**

## **RECOMMENDATIONS**

An agreed care plan should be made and endorsed by both primary care and secondary care mental health providers, outlining agreed actions and contingencies in the light of any prospect of relapse or deterioration in presentation (providing a defined care pathway and route of referral).

Liaison meetings between primary and secondary care mental health practitioners should be properly minuted and patient related information recorded in a single medical record i.e. Mental Health records should not be duplicated.

Where a prisoner is under the care of the In-Reach team, that team must be notified and invited to attend ACCT reviews. Where it is not possible to attend the reviews, they should make themselves aware of the outcome of the review.

The Governor and Head of Healthcare should consider the clinical review and the extent to which all the recommendations can be met.

Patients who are subject to psychotropic medication (and at risk of relapse) should have a care plan in their notes to confirm action in the event they miss or decline their medication.

A clear protocol should be established and used with regard to recording 'refusals' of medication and an agreed system of follow-up.

All patients on neuroleptic medication should be subject to a minimum of six monthly medication reviews by a suitably qualified and experienced practitioner.

The regime for non-therapeutic community prisoners housed on LB1 should be improved as a matter of priority.

The Governor should remind staff to encourage prisoners on suicide prevention measures to speak with their supportive family members where appropriate. This should be included in the local suicide prevention policy.

The family liaison officer should be commended for his work as the prison's family liaison officer.

## **GOOD PRACTICE**

Physical education staff are routinely considered and included in the treatment of those who are feeling depressed. This is good practice.

Prioritising the training of senior officers in CPR, to ensure that an appropriately trained member of staff is always on duty, is an example of good practice.