Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Hatcher a prisoner at HMP Channings Wood on 5 August 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*

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

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

Mr James Hatcher died in hospital on 5 August 2018 after being found unconscious in his cell at HMP Channings Wood the previous day. He died from the effects of psychoactive substances (PS). He was 44 years old. I offer my condolences to Mr Hatcher's family and friends.

Mr Hatcher had a history of substance misuse and was a regular user of PS in prison. As a result, he was often in debt to other prisoners and said he felt threatened. Three days after Mr Hatcher arrived at Channings Wood, he was segregated after he smashed up and flooded his cell. He then refused to leave the segregation unit because he said he felt safer there and was away from the temptation of all the drugs available on the wing. However, on 4 August, he took PS which resulted in his death. Intelligence suggests that he obtained them from other prisoners in the segregation unit.

I am concerned that Mr Hatcher was able to obtain PS in the prison's segregation unit. I note that HM Inspectorate of Prisons and the Independent Monitoring Board have expressed their concern at the easy availability of drugs at Channings Wood. The prison will need to reassess their approach to reducing the supply of drugs in line with the Prison Service's recently published Prison Drugs Strategy.

The investigation found that staff tried to engage with Mr Hatcher to support him with his substance misuse and mental health issues, and that the care he received was equivalent to that he could have expected to receive in the community. However, we found some failings with the management of suicide and self-harm procedures, the emergency response and the prison's substance misuse policy.

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 **November 2019**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 7

Findings 11

Summary

Events

1. On 18 September 2017, Mr James Hatcher was sentenced to 40 months in prison for burglary and theft. He was moved to HMP Channings Wood on 14 June 2018.

2. Mr Hatcher had a history of substance misuse and mental health issues. On 15 and 16 June, he was found under the influence of psychoactive substances (PS).

3. On 15 June, staff started suicide and self-harm procedures (known as ACCT) when Mr Hatcher told staff he had thoughts of harming himself.

4. On 16 June, Mr Hatcher smashed up and flooded his cell. Staff moved him to the segregation unit the next day. At his ACCT review on 18 June, Mr Hatcher said he felt much safer in the segregation unit and his anxiety levels had gone down. Staff stopped ACCT monitoring.

5. Mr Hatcher remained in the segregation unit for the next seven weeks as he refused to move back to a standard residential wing. He said he felt safer and was away from all the drugs that were available on a standard wing.

6. On the morning of 4 August, Mr Hatcher complained of diarrhoea. A nurse gave him some medication. At around 3.00pm, an officer collected Mr Hatcher from the exercise yard and returned him to his cell. Mr Hatcher told the officer he had stomach pain but had taken some medication for it. Around 30 minutes later, the officer checked on Mr Hatcher and found him unconscious on the floor. He had vomited and was blue in colour.

7. The officer called to a colleague and asked him to radio a medical emergency code. The officer put Mr Hatcher in the recovery position and checked for a pulse but could not find one.

8. Healthcare staff arrived and started cardiopulmonary resuscitation (CPR) but they did not bring a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). A prison manager requested a defibrillator be brought from another area of the prison.

9. Ambulance paramedics arrived shortly afterwards and took over Mr Hatcher's care. The paramedics resuscitated Mr Hatcher and transferred him to hospital but he died the following day.

10. The post-mortem examination found that Mr Hatcher died from a lack of oxygen to the brain, which had been caused by taking PS.

Findings

11. Despite Channings Wood's attempts to reduce the supply of drugs into the prison, we are concerned that Mr Hatcher was able to obtain PS in the segregation unit. The prison needs to do more to reduce the supply and demand for drugs.

12. When Mr Hatcher was found under the influence of PS, staff failed to submit intelligence reports as they should have done. We found that the guidance to staff needs to set out more clearly the actions required when a prisoner is found under the influence.

13. We found that staff made efforts to engage Mr Hatcher on his substance misuse and mental health issues and that the care he received was equivalent to that he could have expected to receive in the community.

14. We found some deficiencies in the way ACCT procedures were managed. Case reviews were not multidisciplinary as they should have been and staff did not create a caremap. The post-closure interview was also completed late.

15. We found that there was no defibrillator located in the segregation unit and the healthcare staff did not bring one when they responded to the emergency call. A prison manager had to ask for one to be brought from another area of the prison. While we do not consider this affected the eventual outcome for Mr Hatcher, we are concerned that a delay in accessing the necessary emergency equipment could be significant in other cases.

Recommendations

- The Governor and Head of Security should review the protocol for the searching and supervision of prisoners where there is intelligence to suggest that illicit substances have been brought into the segregation unit.
- The Governor should ensure that the key drug issues at Channings Wood are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.
- The Governor and Head of Security should ensure there is a clear, written protocol in place so that staff are aware of the need to submit an intelligence report when a prisoner is found to be under the influence of an illicit substance.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that staff:
    - hold multidisciplinary ACCT reviews, with healthcare staff in attendance at first case reviews;
    - set effective caremap actions that are specific and meaningful, update them at each case review, and do not close the ACCT until all caremap actions have been completed; and
    - complete the ACCT post-closure interview within seven days of the ACCT being closed.
- The Governor and Head of Healthcare should ensure that the correct emergency equipment, including a defibrillator, is readily available on each unit or is brought to the emergency by healthcare staff.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

17. The investigator obtained copies of relevant extracts from Mr Hatcher's prison and medical records.

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

19. The investigator interviewed six members of staff at Channings Wood in October 2018. Another investigator subsequently took over the investigation.

20. We informed HM Coroner for Plymouth, Torbay and South Devon of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

21. We contacted Mr Hatcher's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Hatcher's mother did not raise any issues.

22. We shared our initial report with Mr Hatcher's mother. She did not raise any factual inaccuracies.

23. We shared our initial report with the Prison Service. They did not raise any factual inaccuracies.

Background Information

HMP Channings Wood

24. HMP Channings Wood is a category C training and resettlement prison near Newton Abbott in Devon. It has eight residential units holding up to 724 adult men. Care UK provides general healthcare and mental health services at the prison. The substance misuse service is provided in partnership with EDP Drug and Alcohol Services.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Channings Wood was in September 2018. Inspectors reported that, although some efforts had been made to improve standards at the prison since their last inspection in October 2016, these efforts were not coordinated and previous recommendations had not been implemented. Inspectors assessed the prison outcomes as not sufficiently good in all four areas of their healthy prisons test – safety, respect, purposeful activity and rehabilitation and release planning.

26. In the HMIP survey, 76% of prisoners (compared to 49% in similar prisons) said it was easy to get drugs and more than a quarter said they had developed a drug problem at Channings Wood. The most common drug was ‘Spice’ (PS). The positive mandatory drug test (MDT) rate, including PS, was 30%. Inspectors observed many prisoners under the influence of drugs during their inspection. They considered that inadequate supervision of prisoners provided opportunities for drug misuse and associated violence.

27. Inspectors noted that the prison’s strategy to tackle the significant drug problem lacked coordination and was not integrated across key functional areas. There was no coordinated effort and little vigour to implement and drive the drug and supply reduction strategy. Records indicated that there had been no drug strategy meetings between August 2017 and March 2018. The meetings had recently been reintroduced and were now taking place every two months, although attendance by the invited departments was inconsistent. Attendance by key departments at the monthly security meeting was also poor.

28. There were significant weaknesses in the physical security of the prison which exacerbated the risk of drug supply. There was public access around the prison’s perimeter and staff regularly intercepted illicit items thrown over the fence.

Independent Monitoring Board

29. 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.

30. In its latest annual report, for the year to 31 August 2018, the IMB expressed extreme concern at the presence and use of illegal substances which had escalated throughout the year. The Board noted that the easy availability of ‘Spice’ (PS) was often commented on by prisoners coming from other prisons.

The easy availability of illicit substances continued to create a culture of debt, bullying and violence at the prison.

31. The Board reported that, although there had been some improvement in staffing levels, high staff turnover, inexperienced staff, and constant changes to the senior management team were having a detrimental effect on the overall running of the prison.

Previous deaths at HMP Channings Wood

32. Mr Hatcher was the seventh prisoner to die at Channings Wood since August 2016. Of the previous deaths, two were self-inflicted, three were from natural causes and one was drug-related. There has been one further drug-related death since. In previous investigations we have identified deficiencies in ACCT management, notably that reviews were not multidisciplinary and caremaps were inadequate. We also found that staff were not submitting intelligence reports in relation to illicit drug use.

Assessment, Care in Custody and Teamwork (ACCT)

33. 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.

34. 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, multidisciplinary 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.

35. 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*.

Psychoactive substances (PS)

36. PS (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.

37. 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.

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

Segregation Units

39. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.

40. The unit at HMP Channings Wood is known as the Care and Separation Unit and has eight cells.

Key Events

41. On 18 September 2017, Mr James Hatcher was sentenced to 40 months in prison for burglary and theft. He was moved from HMP Dartmoor to HMP Channings Wood on 14 June 2018.

42. Mr Hatcher had a history of substance misuse and had previously engaged with the substance misuse service at Dartmoor.

43. When Mr Hatcher arrived at Channings Wood, his Person Escort Record (PER – a form that accompanies prisoners on all journeys between police stations, courts and prisons, which sets out the risks they pose) noted that Mr Hatcher was known to the mental health team at Dartmoor, that he had a history of violence, had assaulted staff and been involved in "dirty protests".

44. The reception officer at Channings Wood noted that Mr Hatcher said he had no thoughts of suicide or self-harm, but he said he wanted to be treated as a vulnerable prisoner. The reception officer noted that vulnerable prisoner status could not be considered until Mr Hatcher was reviewed by managers the following day, so Mr Hatcher was placed on a standard residential wing for the first night.

45. Around 7.45pm, Mr Hatcher pulled his toilet and sink from the wall, which caused flooding to the landing and cells below. He told staff he did this because the cell was in a mess and he did not want to be in there. Staff moved him to another cell, put him on a disciplinary charge and submitted an intelligence report.

46. On the morning of 15 June, Mr Hatcher was found to be under the influence of psychoactive substances (PS). No one submitted an intelligence report.

47. A nurse carried out Mr Hatcher's secondary health screening on 15 June. Mr Hatcher told the nurse that he was struggling with his mental health, had thoughts of cutting his wrists and needed to see someone. He also said he was using PS. The nurse noted that Mr Hatcher was presenting with low mood, anxiety and paranoia. He made a referral to the mental health and substance misuse teams and started suicide and self-harm procedures (known as ACCT).

48. On 16 June, staff found Mr Hatcher under the influence of PS. He was unfit to attend the ACCT assessment interview or first case review. A Supervising Officer (SO) chaired the review which was also attended by two officers. Staff assessed Mr Hatcher's risk as raised (on a scale of low, raised and high) and postponed the ACCT assessment interview to the next day. No one submitted an intelligence report.

49. Around 11.00pm on 16 June, Mr Hatcher demanded a television which staff refused because he was on the basic regime. He threatened to smash up his cell and a Custodial Manager (CM) instructed staff to remove the furniture. Mr Hatcher then flooded the cell and smeared excrement on the door.

50. On the morning of 17 June, staff moved Mr Hatcher to the segregation unit. Later that day, an officer held an ACCT assessment interview with Mr Hatcher. He told the officer that he suffered from anxiety and depression and he could not

cope on standard location. He said he was feeling more positive now that he was located in the segregation unit. The officer noted that Mr Hatcher had no thoughts of suicide or self-harm.

51. A prison manager chaired the second ACCT review later that day. It was also attended by two officers. The prison manager noted that Mr Hatcher believed he was under threat on the wing and his anxiety levels had reduced now he was in the segregation unit. Staff assessed Mr Hatcher's risk as low and scheduled the next review for the following day. The prison manager wrote on the ACCT paperwork that a caremap was not completed "due to segregation conditions".

52. The prison manager authorised Mr Hatcher's segregation. He noted on the form that Mr Hatcher was being monitored under ACCT procedures, but he was refusing to remain on his wing due to threats from other prisoners.

53. Another prison manager chaired the third ACCT review on 18 June. An officer and a mental health nurse also attended. Mr Hatcher said he wanted to transfer to HMP Winchester to be nearer to his mother, but he said he knew he had to improve his behaviour before this could happen. Staff assessed Mr Hatcher's risk as low and stopped ACCT monitoring. The prison manager noted on the ACCT paperwork that a post-closure review should take place by 2 July (it should in fact have taken place within seven days, by 25 June).

54. A substance misuse worker saw Mr Hatcher on the afternoon of 18 June. He noted that Mr Hatcher said he did not wish to engage with the substance misuse service as he would not be tempted to use PS while in the segregation unit.

55. On 22 June, an assistant psychologist and a consultant psychiatrist, discussed Mr Hatcher with three other members of the mental health team. They concluded that Mr Hatcher most likely suffered from social anxiety. A social worker in the mental health team, was asked to support Mr Hatcher with a one-to-one anxiety management intervention.

56. On 2 July, a prison GP was doing her rounds of the segregation unit when Mr Hatcher asked if he could speak to her privately. Mr Hatcher said that he was experiencing feelings of paranoia and this was getting him into trouble with other prisoners. He said he wanted to speak to someone from the mental health team. The prison GP considered that he was suffering from paranoia and anxiety. Mr Hatcher said he had previously taken antipsychotic medication and the prison GP prescribed these for him. The prison GP also made another referral to the mental health team.

57. On 4 July, Mr Hatcher refused to move from the segregation unit back to a standard residential wing, so he was placed on a disciplinary charge.

58. On 5 July, the mental health team discussed Mr Hatcher at a multidisciplinary team meeting. Staff noted that he had been in the segregation unit since his arrival and he was continuing to experience anxiety and fear due to drug debts. Mr Hatcher was allocated as his mental health support worker to provide support around his anxiety and PS use.

59. On 9 July, staff tried to return Mr Hatcher to his wing but he refused to move from the segregation unit.

60. The mental health support worker met with Mr Hatcher for the first time on 9 July. Mr Hatcher said he was feeling better now that he was on medication. He told her that he had not used PS for over three weeks. He said he wanted to stop using it but found it hard to resist when on the wing, which is why he wanted to stay in the segregation unit. Mr Hatcher said he wanted to move to a category B prison where it would be harder to get drugs. He said he had occasional thoughts of self-harm but no plans to act on them. The mental health support worker noted that Mr Hatcher scored highly on the generalised anxiety disorder assessment. She gave him some self-help guides and distraction packs and noted that she would review the level of intervention he needed with the mental health team.

61. A prison manager saw Mr Hatcher for his ACCT post-closure interview on 9 July. He recorded that Mr Hatcher refused to engage.

62. On 13 July, a prison manager authorised Mr Hatcher's continued segregation on the basis that he was refusing to move back to the wing. On 14 July, a nurse assessed Mr Hatcher as medically fit to be detained in the segregation unit.

63. On 16 July, the mental health support worker saw Mr Hatcher again. She noted that he appeared calm and engaged in the session.

64. On 23 July, Mr Hatcher asked a prison GP to increase his antipsychotic medication as he said he was still having paranoid thoughts. The prison GP increased the dosage from 5mg to 10mg and said she would review his medication again in two weeks.

65. On 30 July, a mental health support worker saw Mr Hatcher for a mental health review. She noted that their session focused on Mr Hatcher's self-esteem and negative thinking. She noted that he engaged well in the session and agreed to do the self-help guides. She wrote that Mr Hatcher would have a further review in four weeks.

66. Mr Hatcher also saw a prison GP on 30 July. He told her he was feeling better on the increased dosage of his medication and he felt his mood was more stable.

Events of 4 August 2018

67. On 4 August, a nurse saw Mr Hatcher during the routine segregation unit medication round. Mr Hatcher told the nurse that he had diarrhoea and needed some medication for it. The nurse continued with his rounds but returned around 11.00am and gave Mr Hatcher some medication. The nurse told the investigator that Mr Hatcher seemed fine and was grateful for the medication.

68. In the afternoon, Mr Hatcher went out for exercise. An officer collected Mr Hatcher from the exercise yard at around 3.00pm. Mr Hatcher told the officer that he felt unwell as his stomach was hurting him but said he had taken some medication for it. The officer locked Mr Hatcher in his cell. When he went back to check on him shortly after 3.30pm, he found him lying face down on the floor. Mr Hatcher was unconscious, he had vomited, and he was blue in colour.

69. The officer called his colleague and told him to radio an emergency code blue (indicating that a prisoner is unconscious, not breathing or is having breathing

difficulties and an ambulance must be called immediately). The incident log shows that the code blue was called at 3.36pm. The officer then put Mr Hatcher into the recovery position, cleared the vomit from his mouth and checked for a pulse but he could not find one.

70. A CM responded to the code blue and instructed staff to start cardiopulmonary resuscitation (CPR). The CM tried to locate a defibrillator, but she could not find one in the unit, so she radioed for one to be brought from elsewhere in the prison.

71. A nurse and a healthcare assistant arrived with an emergency bag around 3.39pm but they did not have a defibrillator with them. The nurse asked for a defibrillator, by which time the CM's earlier request had been met and a defibrillator was provided to the nurse. The nurse took over CPR, assisted by two officers. Staff continued with CPR until the ambulance paramedics arrived at 3.48pm. The paramedics took over advanced life support and transferred Mr Hatcher to hospital, but he died the following day at around 6.00pm.

Information received after Mr Hatcher's death

72. After Mr Hatcher's death, staff submitted intelligence reports suggesting that two prisoners who arrived in the segregation unit shortly before 4 August may have provided Mr Hatcher with illicit substances. When a prison manager searched Mr Hatcher's cell with the police, they found traces of a substance which they believed to be PS. The prison did not carry out an investigation into how Mr Hatcher obtained PS in the segregation unit, but one of the prisoners suspected of supplying the drugs was transferred to another prison.

Contact with Mr Hatcher's family

73. The prison's family liaison officer (FLO) contacted Mr Hatcher's mother by telephone to let her know that her son had been taken to hospital. The FLO and Deputy Governor visited Mr Hatcher's parents at home after he died. The prison contributed to the cost of Mr Hatcher's funeral in line with national guidance.

Support for prisoners and staff

74. After Mr Hatcher's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

75. The prison posted notices informing other prisoners of Mr Hatcher's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Hatcher's death.

Post-mortem report

76. The post-mortem report concluded that Mr Hatcher's death was due to hypoxic brain injury (lack of oxygen to the brain) caused by inhalation of synthetic cannabinoids (PS).

Findings

Availability of drugs at Channings Wood

77. Mr Hatcher died as a result of taking psychoactive substances (PS). He told staff that he knew he had a problem with PS, that he wanted to stop taking them and that he preferred being in the segregation unit because it was more difficult to access drugs there than on a standard residential wing. Following Mr Hatcher's death, intelligence was received that suggested two prisoners who had arrived in the segregation unit shortly before 4 August, and who were known to be involved in drug dealing within the prison, supplied Mr Hatcher with PS in the unit.

78. The Head of Security told the investigator that prisoners are thoroughly searched before being admitted to the segregation unit, but staff are unable to detect drugs that have been secreted inside prisoners' bodies. He said that drugs can be left in the exercise yard or shower area and these areas are not always supervised due to a lack of resources.

79. Prison staff suspect that Mr Hatcher collected PS from the exercise yard. Two prisoners had recently been moved to the segregation unit for dealing drugs on the wing. We consider there was a high possibility that these prisoners would attempt to smuggle drugs into the segregation unit. While we acknowledge the difficulties of detecting drugs secreted internally, we consider that the prison should do more supervision and searching where there is a strong suspicion that illicit substances have been brought into the segregation unit. We make the following recommendation:

    The Governor and Head of Security should review the protocol for the searching and supervision of prisoners where there is intelligence to suggest that illicit substances have been brought into the segregation unit.

80. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern at the easy availability of illicit substances at Channings Wood. The prison has taken steps to try to reduce the supply of drugs, including the use of drug dogs and improved processes to reduce the number of parcels being thrown over the prison's perimeter walls. However, Mr Hatcher's death demonstrates that further efforts are needed.

81. Channings Wood is not alone in facing this problem, drug use is a serious problem across much of the prison estate. The PPO has called for HMPPS to publish national guidance to prisons providing evidence-based advice on what works, and we welcome the fact that such guidance was issued in April 2019, together with a strategy to reduce the supply of and demand for drugs in prisons.

82. In relation to reducing the supply of drugs, the new strategy says:

    > "Every prison is different and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in

identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

83. We, therefore, make the following recommendation:

The Governor should ensure that the key drug issues at Channings Wood are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.

Substance misuse and mental health

84. We found that staff offered Mr Hatcher opportunities to engage with support services to address his substance misuse and mental health issues, and that this support was offered in a timely manner. The clinical reviewer concluded that Mr Hatcher received a standard of healthcare equivalent to that which he could have expected to receive in the community.

85. The Head of Security told the investigator that staff should submit an intelligence report when a prisoner is suspected of being under the influence of an illicit substance. However, we found no written guidance on this in the prison's Substance Misuse Strategy or Supply Reduction Strategy. On the two occasions when Mr Hatcher was suspected of using PS at Channings Wood, we found no evidence that staff submitted an intelligence report. We therefore make the following recommendation:

The Governor and Head of Security should ensure there is a clear, written protocol in place so that staff are aware of the need to submit an intelligence report when a prisoner is found to be under the influence of an illicit substance.

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

86. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, says that ACCT case reviews should be multidisciplinary where possible, and that healthcare staff should always attend the first case review. The PSI also says that a caremap should be completed at the first case review. The caremap should give detailed and time-bound actions aimed at reducing the risk posed by the prisoner. The PSI includes a mandatory action for a post-closure review to be held within seven days of an ACCT being closed. The post-closure interview must review the caremap and the progress made by the prisoner since the ACCT was closed.

87. We have some concerns about the management of the ACCT procedures when staff monitored him from 15 to 18 June.

88. While we accept that Mr Hatcher was unable to attend the first ACCT review on 16 June due to being under the influence, the review still took place in his absence, so healthcare staff should have attended but they did not. The second review on 17 June was not multidisciplinary as it was only attended by prison staff. The third review on 18 June was appropriately attended by a member of the mental health team and a decision was made to stop ACCT monitoring.

Therefore, of the three ACCT reviews, only one was multidisciplinary and the first ACCT review was not attended by healthcare.

89. No caremap was completed during the first ACCT case review. At the second review, a prison manager recorded on the ACCT paperwork that there was no caremap "due to segregation conditions". We do not consider segregation to be a justifiable reason for not completing a caremap.

90. The post-closure interview should have taken place within seven days of the ACCT being closed but a prison manager, scheduled it to take place by 2 July. It did not in fact take place until 9 July so it was completed two weeks late.

91. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that staff:

- **hold multidisciplinary ACCT reviews, with healthcare staff in attendance at first case reviews;**
- **set effective caremap actions that are specific and meaningful, and update them at each case review; and**
- **complete the ACCT post-closure interview within seven days of the ACCT being closed.**

Emergency response

92. When a CM responded to the code blue and realised there was no defibrillator available, she immediately called for one to be brought to the unit. A nurse and a healthcare assistant responded to the code blue but they did not have a defibrillator with them. As the CM had already requested one, we are satisfied that a defibrillator became available very quickly and there was no significant delay that affected the eventual outcome for Mr Hatcher.

93. However, we are concerned that a defibrillator was not immediately available in the segregation unit and that the healthcare emergency responders did not bring one with them or ask for one to be brought to the unit before they arrived. The clinical reviewer also commented on this. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that the correct emergency equipment, including a defibrillator, is readily available on each unit or is brought to the emergency by healthcare staff.

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