

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Carpenter a prisoner at HMP Woodhill on 18 August 2018

A report by the Prisons and Probation Ombudsman

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 Christopher Carpenter was found dead in his cell at HMP Woodhill on 18 August 2018. He died from the effects of psychoactive substances (PS). He was 34 years old. I offer my condolences to Mr Carpenter's family and friends.

Mr Carpenter had a history of substance misuse and was a regular user of PS in prison. As a result, he found himself in debt to other prisoners and told staff he felt under threat.

I am concerned that Mr Carpenter was able to obtain PS with apparent ease. Woodhill needs to do more to address the supply of drugs.

The investigation found that staff did not always act in accordance with the prison's substance misuse policy when Mr Carpenter was suspected of being under the influence of drugs. It also identified failings in the management of violence reduction procedures, an issue we have raised with Woodhill before.

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

December 2019

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Summary

Events

1. Mr Christopher Carpenter was recalled to prison on 18 July 2018 and moved to HMP Woodhill on 20 July. Mr Carpenter had a history of alcohol and substance misuse. He also took prescribed medication for anxiety and depression.
2. On 23 July, Mr Carpenter was suspected of being under the influence of an illicit substance. He was assessed by healthcare staff, including a mental health nurse, but he did not want to engage with them and said he had not taken anything.
3. On 1 August, Mr Carpenter was again suspected of being under the influence. He refused to be assessed by healthcare. Staff submitted an intelligence report.
4. On 4 August, Mr Carpenter told a prison officer that he owed a debt from when he was previously at Woodhill. He said he needed to pay £50 into a bank account. Mr Carpenter told the officer that he did not feel threatened. The officer submitted an intelligence report.
5. On 15 August, Mr Carpenter told an officer that a named prisoner had threatened him with a bladed weapon. He said that the prisoner had given him until 17 August to pay the money he owed him. He asked to move to a different unit. The officer submitted an intelligence report.
6. On 16 August, Mr Carpenter gave an officer details of the prisoners he owed money to. He wrote a note saying he feared for his safety and wanted to move to the Vulnerable Prisoners' Unit. The officer submitted an intelligence report.
7. On 17 August, staff offered to move Mr Carpenter to a different unit, but he refused this. Later that day, staff saw prisoners gathering outside Mr Carpenter's cell attempting to collect the debts he owed them. The officer submitted an intelligence report.
8. At around 10.30am on 18 August, staff saw a makeshift rope made of knotted sheets being used to pass packages between Mr Carpenter's cell and the cell below. Staff entered Mr Carpenter's cell, took the rope and put it in an evidence bag with the intention of passing it to the Dedicated Search Team (DST). They also submitted an intelligence report.
9. At approximately 3.20pm, an officer found Mr Carpenter collapsed in his cell and called for healthcare assistance. A nurse arrived and called a code blue over the radio (a medical emergency code which tells the control room that a prisoner is unresponsive and not breathing and that an ambulance should be called immediately) and staff started cardiopulmonary resuscitation (CPR). The prison doctor arrived and noticed signs of illicit drug use within the cell. Mr Carpenter's cellmate told staff that Mr Carpenter had been using psychoactive substances (PS). Staff continued with CPR until the ambulance paramedics arrived and took over around 3.35pm. The paramedics were unable to resuscitate Mr Carpenter and, at approximately 4.16pm, recorded that he had died.

Findings

10. Staff submitted an intelligence report when Mr Carpenter was suspected of being under the influence of PS on 1 August but failed to submit an intelligence report when he was suspected of being under the influence on 23 July, as they should have done.
11. We were unable to establish whether the rope seen between Mr Carpenter's cell and the cell below was being used to pass drugs. We are satisfied that staff responded appropriately. However, we are concerned that Mr Carpenter was able to obtain PS in the prison and consider Woodhill needs to do more to address the supply of drugs.
12. Woodhill did not manage Mr Carpenter in line with its own Violence Reduction Strategy. Mr Carpenter provided staff with the names of those who were allegedly threatening him, but we found no evidence that his allegations were fully investigated or that he was offered appropriate support.
13. We found that staff made efforts to engage Mr Carpenter 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.

Recommendations

- The Governor and Head of Security should ensure that staff submit an intelligence report when a prisoner is suspected of being under the influence of an illicit substance.
- The Governor should identify and address the key weaknesses in reducing the supply of drugs at Woodhill and revise the local drugs strategy in light of the findings.
- The Governor should ensure that all incidents of violence are investigated in accordance with PSI 64/2011 and Woodhill's own Violence Reduction Strategy, including providing feedback on the investigation to the victim and ensuring that details of the investigation are appropriately documented.
- The Governor should ensure that apparent victims of bullying are effectively supported and protected with meaningful long-term solutions which address their individual situation.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Carpenter's prison and medical records. A second investigator subsequently took over the investigation.
16. NHS England commissioned a clinical reviewer to review Mr Carpenter's clinical care at the prison.
17. We informed HM Coroner for Milton Keynes of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. We wrote to Mr Carpenter's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Carpenter's mother appointed a solicitor to act on the family's behalf but the solicitor did not raise any specific questions.
19. We shared our initial report with the solicitor representing Mr Carpenter's family. The solicitor provided feedback and identified factual inaccuracies which has resulted in changes to the final report. The solicitor raised other issues which did not affect the factual accuracy of the report and these have been addressed in separate correspondence.
20. We shared our initial report with the Prison Service. The Prison service did not point out any factual inaccuracies.

Background Information

HMP Woodhill

21. HMP Woodhill in Milton Keynes is a complex institution known as a 'core local' prison. It combines a local prison function for just over 600 men with a high security responsibility, holding a small number of category A prisoners, most of whom are going through the court process or have been recently convicted. In addition, the prison operates a close supervision centre (CSC), a specialist facility for some of the country's most disruptive prisoners.
22. Central and North-West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides mental and physical healthcare, including end of life and palliative care.
23. As part of HM Prison and Probation Service's estate transformation, HMP Woodhill was due to become a category B training prison in 2018. At the time of writing (October 2019) this has not yet happened.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Woodhill was in February 2018. Inspectors were concerned that a third of prisoners said they felt unsafe at the time of the inspection and more than half said they had felt unsafe at some point during their stay. Inspectors reported that levels of violence had increased and were higher than at other local prisons. The response to violence required improvement: while most incidents were investigated, the challenge and monitoring of perpetrators on residential units was poor. Support for victims of bullying and violence was also underdeveloped. Inspectors were concerned that the analysis of violence was unsophisticated and there was no strategic plan to reduce it.
25. Inspectors reported that over half of respondents to their survey said that illicit drugs were easily available at Woodhill. The mandatory drug testing positive rate was lower than at other local prisons and mostly concerned tradeable medication and psychoactive substances (PS), but the prison's supply reduction strategy and action plan were weak and out of date. Staff submitted a large amount of intelligence to the security department, mainly around preventing the trafficking of drugs, telephones and preventing disorder. This intelligence was analysed promptly but there were some delays in carrying out intelligence-led searches and few suspicion drug tests were carried out.

Independent Monitoring Board

26. 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 May 2018, the IMB reported levels of violence were high. The use of PS had been controlled with front end and targeted searching but remained a disruptive force when accessed by prisoners. Healthcare services had performed well against challenging staffing problems.

Previous deaths at HMP Woodhill

27. Mr Carpenter was the 13th prisoner to die at Woodhill since August 2016. Of the previous deaths, four were self-inflicted, seven were from natural causes, and one was a homicide. There have been four deaths since, all self-inflicted.
28. In a previous PPO investigation, we identified that victims of bullying were not being properly supported in line with Woodhill's Violence Reduction Strategy.

Psychoactive substances (PS)

29. 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.
30. 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.
31. 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.

Key Events

32. Mr Christopher Carpenter was sentenced to 40 months in prison on 19 June 2015 for threats to kill and possession of a bladed article. On 3 March 2017, he was released on licence but was recalled on 7 April after breaching his licence conditions. He was released on licence for the second time on 19 June 2018 but was recalled on 18 July. He was moved to HMP Woodhill on 20 July.
33. A nurse carried out Mr Carpenter's reception healthcare screening on 20 July. The nurse noted that Mr Carpenter had a personality disorder and had a history of substance misuse. She noted that he had previously self-harmed but had no current thoughts of suicide or self-harm. The nurse referred Mr Carpenter to the GP to prescribe his medication and made a referral to the substance misuse service. A prison GP prescribed Mr Carpenter 20mg of Fluoxetine (for treating depression) and 10mg of Olanzapine (an antipsychotic drug also used to alleviate the symptoms of emotionally unstable personality disorder (EUPD)).
34. On 21 July, Mr Carpenter had a secondary healthcare screening with a prison GP. Mr Carpenter said that he drank eight cans of lager a day and was dependent on cannabis. The prison GP noted that Mr Carpenter had a diagnosis of EUPD but had no symptoms of psychosis or any other mental health illness. He concluded that Mr Carpenter did not require alcohol treatment but referred him for a substance misuse psychosocial intervention.
35. Mr Carpenter also had a mental health review with a nurse manager on 21 July. She noted his previous mental health and substance misuse issues. She also noted he was rational and aware of his surroundings at the time of her review. The nurse manager noted that, given Mr Carpenter's complexities, he should be offered a full mental health assessment, have his medication reviewed by the psychiatrist, and be taken onto the mental health team's caseload.
36. On 23 July, a mental health nurse went to Mr Carpenter's cell to carry out a mental health assessment but found him to be under the influence of an illicit substance. She was unable to carry out the assessment but she informed the prison staff that he was under the influence and asked a healthcare assistant to carry out regular observations on him. She recorded in Mr Carpenter's medical notes that his mental health assessment would need to be rescheduled.
37. On 29 July, Mr Carpenter requested an asthma inhaler because his breathing was uncomfortable. A healthcare assistant noted that he was recorded as being asthmatic so she asked the doctor to prescribe him one. The doctor prescribed an inhaler for Mr Carpenter on 30 July.
38. On 1 August, an officer found Mr Carpenter under the influence of psychoactive substances (PS). A nurse attended but Mr Carpenter refused to be assessed. He returned to his cell where staff observed him every 15 minutes. The officer submitted an intelligence report.
39. On 2 August, Mr Carpenter handed a note to an officer, saying that he was under threat on House Unit 4A due to debts. He said he was going to be seriously assaulted and requested a move to House Unit 2A where he felt he would be

safe until he could be moved to another prison. The officer submitted an intelligence report.

40. On 4 August, Mr Carpenter told an officer that he had a debt of £50 from a previous time at Woodhill. The officer recorded in his prison record that he told her he felt okay as he was sorting it out. He said he had to pay the money into a bank account but he did not give the officer any further details. The officer submitted an intelligence report.
41. On 13 August, Mr Carpenter had a mental health assessment with a nurse. He told her that he previously self-harmed and he had been an inpatient at a psychiatric hospital. He said he had fluctuating moods and paranoia at times, but he had no current thoughts of suicide or self-harm and he was managing well with his mental health medication. The nurse recorded that Mr Carpenter told her he was focusing on the end of his sentence and planning for the future.
42. On 15 August, Mr Carpenter told an officer that another prisoner had threatened him with a blade. He gave the officer the name of the prisoner and said the prisoner had given him two days to pay the debts he owed him. Mr Carpenter asked for a move to House Unit 2A. The officer made a note in the wing observation book and submitted an intelligence report.
43. On 16 August, Mr Carpenter wrote a note to staff saying that he was in debt to other prisoners on House Unit 4A and on other House Units around the prison. He said he was being bullied and had been threatened with a knife which he believed would be used on him if he had not paid his debt by the following day. He asked for help as he feared he was going to be seriously assaulted and said he would not be any trouble if he moved to the Vulnerable Prisoners' Unit (VPU). Mr Carpenter said he would provide staff with any information they needed to know. Staff submitted an intelligence report.
44. On 17 August, an officer recorded that staff offered to move Mr Carpenter to House Unit 3A but he refused, saying he would rather stay where he was. Later that day, staff saw several prisoners at Mr Carpenter's cell door trying to collect the money he owed them. An officer noted that Mr Carpenter asked to stay locked in his cell for his own safety. The officer recorded this information in the wing observation book and in Mr Carpenter's prison record. He also submitted an intelligence report.

Events of 18 August

45. At around 10.30am, two officers saw a makeshift rope made of knotted bedsheets outside the window of Mr Carpenter's cell which was being used to pass packages between his cell and the cell below. An officer told the investigator that he and the second officer went into Mr Carpenter's cell to remove the rope but he could not remember if anyone was in the cell at that time or if he spoke to Mr Carpenter or his cellmate. He said the rope had the remains of two plastic bags still attached to it but, at that point, he was not concerned about what the packages may have contained. Both officers removed the rope, placed it in an evidence bag and put it in the wing office with the intention of handing it to the Dedicated Search Team (DST) later that day.

46. An officer made a note in the wing observation book and submitted an intelligence report. A Custodial Manager (CM) told the investigator that a security analyst would look at the information contained in the intelligence report and decide whether the DST would be required to carry out a cell search. The CM said that a cell search would most likely have taken place later that day or the following day. He did not consider that more immediate action would have taken place in these circumstances.
47. An officer told the investigator that staff had been planning to move Mr Carpenter to the VPU that day as he had agreed to speak to them about other prisoners who had been threatening him and supplying drugs within the prison. The officer said that one of the prisoners suspected of supplying drugs was Mr Carpenter's cellmate so staff were trying to arrange the move discreetly.
48. CCTV shows Mr Carpenter's cellmate leave the cell at 10.26am. Mr Carpenter was then taken out of his cell at 10.42am while staff went in to remove the rope. He went back into the cell at 10.43am and did not leave again. Mr Carpenter's cellmate returned to the cell at 11.24am for less than one minute. He returned again at 11.31am for less than two minutes, before returning permanently at 11.53am. No other movements to or from the cell were seen on CCTV.
49. At around 3.15pm, an officer went to Mr Carpenter's cell to get him to complete the relevant paperwork for the move to the VPU. When he looked through the hatch, he could see Mr Carpenter's legs sticking out from behind the bed, but he could not see the rest of his body. Mr Carpenter's cellmate told an officer that Mr Carpenter was under the influence. The officer said that, as he was on his own, he did not go into the cell but he went to the office where he called healthcare to ask them to check Mr Carpenter and he asked an officer to accompany him to the cell. Both officers and a nurse went into the cell around 3.20pm and found that Mr Carpenter was unconscious and unresponsive. One of the officers asked the nurse to call a code blue (a medical emergency code which tells the control room that a prisoner is unresponsive and not breathing and that an ambulance needs to be called immediately) while he and the second officer pulled Mr Carpenter out of the cell. A SO arrived and started cardiopulmonary resuscitation (CPR) assisted by other prison staff.
50. A nurse and a prison GP responded to the code blue call immediately and assisted with resuscitation attempts. Another nurse arrived shortly afterwards. The prison GP found an empty asthma inhaler along with burnt silver foil with an unknown substance on it.
51. Staff continued with CPR until paramedics arrived at approximately 3.35pm. Paramedics noted that there were no signs of life at any point during CPR. At 4.16pm, they confirmed that Mr Carpenter had died.

Information received after Mr Carpenter's death

52. After Mr Carpenter's death staff found pieces of paper in his cell containing various bank details and mobile numbers, indicating that he was in debt to others.
53. Mr Carpenter's mother said she had been concerned about her son's safety when she spoke to him on the phone the night before he died. She said she phoned the prison switchboard and was put through to someone but she was only able to leave a voicemail message as no one answered. The prison provided the investigator with a copy of the Safer Custody team's telephone call log but this did not include any calls from Mr Carpenter's mother. Mr Carpenter's mother did not know if she was put through to the Safer Custody team or to any other department within the prison, but she said no one from the prison returned her call. It has not been possible to establish where Mr Carpenter's mother left a message or what happened to the message afterwards. We also do not know if the information she wanted to share with the prison would have affected the eventual outcome for her son.

Contact with Mr Carpenter's family

54. The prison's family liaison officers (FLO), a Supervising Officer (SO) and an officer, visited Mr Carpenter's mother at home at approximately 9.50pm to let her know that her son had died. The prison contributed to the cost of Mr Carpenter's funeral in line with national guidance.

Support for prisoners and staff

55. After Mr Carpenter'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.
56. The prison posted notices informing other prisoners of Mr Carpenter'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 Carpenter's death.

Post-mortem report

57. The post-mortem report concluded that Mr Carpenter's death was caused by the effects of synthetic cannabinoids (PS).

Findings

Substance misuse

58. Mr Carpenter died from the effects of psychoactive substances (PS). He had a history of substance misuse and on two occasions at Woodhill, on 23 July and 1 August, staff suspected that he was under the influence of PS.

59. Woodhill's Substance Misuse Policy says that staff should submit an intelligence report when a prisoner is suspected of being under the influence of an illicit substance. Staff submitted an intelligence report on the second occasion when Mr Carpenter was suspected of being under the influence of PS, but not on the first occasion. We make the following recommendation:

The Governor and Head of Security should ensure that staff submit an intelligence report when a prisoner is suspected of being under the influence of an illicit substance.

60. On the morning of Mr Carpenter's death, officers saw a makeshift rope being used to pass packages between Mr Carpenter's cell and the cell below. Officers took the rope from Mr Carpenter's cell but there were no packages attached to it at that time.

61. As this incident occurred shortly before Mr Carpenter was found collapsed in his cell, we looked at the possibility that illicit drugs had been passed to him from the cell below. However, it has not been possible to establish whether drugs were passed as the rope and packages were not analysed. An officer and a CM said that prisoners often pass items to each other, such as tea bags, sugar and magazines, so we cannot say whether the rope was being used to pass illicit drugs.

62. An officer placed the rope in an evidence bag, recorded this in the wing observation book and submitted an intelligence report. The officer said that he intended to hand the evidence to the DST as staff had some concerns that Mr Carpenter's cellmate was involved in supplying illicit drugs within the prison. He said that he expected the DST would carry out a cell search later that day or the following day. A CM agreed it was unlikely that any action would happen before that time. We found that the officer's actions were in line with Woodhill's Local Security Policy and Prison Service Instruction (PSI) 07/2016: Searching of the Person. We therefore make no recommendation.

63. HM Inspectorate of Prisons has expressed concern at the easy availability of illicit substances at Woodhill. The prison has taken steps to try to reduce the supply of drugs by introducing wider use of CCTV, improved searching of prisoners using technology, such as X-ray machines and the Body Orifice Scanning System (BOSS) chair, as well as the use of detection dogs for both prisoners and visitors. However, Mr Carpenter's death demonstrates that further efforts are needed.

64. Woodhill is not alone in facing this problem, drug use is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies.

However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works, and we welcome the fact that such guidance has now been issued, together with a strategy to reduce the supply of and demand for drugs in prisons.

65. 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.”

66. We, therefore, make the following recommendation:

The Governor should identify and address the key weaknesses in reducing the supply of drugs at Woodhill and revise the local drugs strategy in light of the findings.

Violence reduction

67. Woodhill’s Violence Reduction Strategy says that all incidents of assault must be entered onto the incident reporting system. All staff, including healthcare, involved with prisoners should record key contacts with them, particularly information on risk of harm to/from others, on the prison record case notes system. It goes on to say that staff must ensure that where there are clear indications that a prisoner has been, or is likely to be, involved in acts of violence that the risk of such occurrence is reported to a relevant manager.

68. There were four occasions when Mr Carpenter told staff that he feared for his safety on House Unit 4A. He told staff that he had been threatened with a knife and provided the names of those who were threatening him. Staff also witnessed prisoners gathering outside Mr Carpenter’s cell attempting to collect debts that he owed them. Although staff correctly documented Mr Carpenter’s allegations and submitted intelligence reports, we found no evidence that any action was taken to challenge the perpetrators or to offer Mr Carpenter appropriate support.

69. We make the following recommendations:

The Governor should ensure that all incidents of violence are investigated in accordance with PSI 64/2011 and Woodhill’s own Violence Reduction Strategy, including providing feedback on the investigation to the victim and ensuring that details of the investigation are appropriately documented.

The Governor should ensure that apparent victims of bullying are effectively supported and protected with meaningful long-term solutions which address their individual situation.

Clinical care

70. We found that staff offered Mr Carpenter 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 Carpenter received a standard of healthcare equivalent to that which he could have expected to receive in the community.

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