Circumstances surrounding the death of a male prisoner at HMP Channings Wood on 10 January 2006

Prisons and Probation Ombudsman for England and Wales

July 2006

This prisoner was 54 years old when he died of a heart attack on 10 January 2006 in his cell at HMP Channings Wood. This is a report into the circumstances surrounding his death.

I join my investigator and Family Liaison Officer in offering our sincere condolences to the man's family and friends.

One of my senior investigators carried out the investigation. He and I would like to thank the Governor of Channings Wood for making the necessary facilities available and for the invaluable help and support of the prison's Liaison Officer.

In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment the prisoner received while in custody. I am grateful to the Director of Professional Practice at Teignbridge Primary Care Trust (PCT), for her assistance with this.

I make a total of six recommendations, four of which derive from the clinical review. The investigation also revealed flaws in the roll check procedures at Channings Wood but, as these are being addressed separately by the Governor, I have not needed to make formal recommendations to ensure they are remedied.

Notwithstanding those flaws in procedures, I should also refer here to the warm words of the prisoner's daughter for the way she was treated by the prison.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2006**

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Summary

1. The prisoner was remanded into prison custody on 26 November 2004, having been charged with the murder of his wife. He remained on remand at HMP Exeter until his appearance at Plymouth Crown Court on 4 July 2005, where he was found guilty of manslaughter and sentenced to six years imprisonment. He returned to Exeter, pending allocation to a suitable establishment.

2. The prisoner had a lengthy history of health problems which I identify in greater detail in my report.

3. Whilst in custody, the prisoner instructed his solicitor to draw up a living will. On 16 May 2005 his solicitor issued the Medical Officer at Exeter with a copy of the will. The solicitor asked this Medical Officer to place the living will into the prisoner's medical record. The will gave specific instructions which again I identify in more detail later in this report.

4. Whilst at Exeter, the prisoner was monitored under the Prison Service's F2052SH, Self Harm at Risk Form procedures, as he was thought to be at risk of self harm.

5. On 15 July, the prisoner was transferred to HMP Channings Wood as a category C prisoner. On 31 December 2005, he was found collapsed in his cell (D14) in Living Block Three (LB3). The prison's healthcare manager attended, administered first aid and carried out medical observations. She wanted to discuss the prisoner's symptoms with the duty doctor and, as the prisoner was not in a life threatening position, she left him to rest in his cell in the company of another prisoner. However, about 20 minutes later, and before she had contacted the doctor, the prisoner collapsed again. The healthcare manager returned to find that he was complaining of chest pains and that his condition had deteriorated.

6. The prisoner initially refused medical intervention. However, after a discussion with the healthcare manager and duty governor, he agreed to be transferred to a hospital, where he was admitted as an emergency patient. He remained in hospital until 5 January 2006, when he was considered well enough to return to prison.

7. At 7:50am on 10 January, an officer was carrying out a roll check. When he looked into cell D14 through the door observation panel, he saw the prisoner lying on the floor. He attempted to obtain a response by banging the cell door and calling out the prisoner's name, but without any success. He summoned assistance from a second officer, who was also in the wing, and then entered the cell. The second officer called for further assistance, using her prison radio. Healthcare staff attended and requested an emergency ambulance. They checked for signs of life, but sadly there were none.

8. At 8:05am, the paramedics arrived at the prisoner’s cell. After carrying out their own examination, they pronounced him dead at 8:10am.

9. The autopsy report completed by a Home Office pathologist at Devon and Cornwall Constabulary, records the cause of death as Myocardial Infarction (MI). MI is commonly known as a heart attack.

Conduct of the Investigation

10. Once my office had been notified of the prisoner's death, the investigation was allocated to a senior investigator. He asked the prison's Governor to forward the man's prison and medical record in order to determine the level of investigation required. After examining the records, the investigator travelled to the prison to interview a number of prison officers and medical staff.

11. On 17 January, the investigator forwarded the prisoner's medical records to the Director of Professional Practice at Teignbridge Primary Care Trust (PCT), for her to undertake a clinical review into the care and treatment the prisoner received whilst in custody. The Director of Professional Practice confirmed that she had received the medical records on 20 January and understood what was required.

12. One of my Family Liaison Officers (FLOs) contacted the prisoner's daughter on 30 January, as she had been identified as his next of kin. It was explained that I would be investigating her father's death, and she was invited to ask any questions for consideration by the investigator. My Family Liaison Officer also wrote to the prisoner's daughter, summarising her earlier telephone call.

13. My investigator opened the investigation on 13 February 2006 at the prison, by meeting with the Governor. Also at the meeting were:

    The Prison's Liaison Officer

    A Chairperson from the Independent Monitoring Board

    Prison Officers' Association (POA) Secretary

    Director of Professional Practice at Teignbridge PCT

    Healthcare Governance Manager, Teignbridge PCT

    Prison Service Healthcare Cluster Manager for Dartmoor, Exeter and Channings Wood

14. The investigator explained the investigation procedure and agreed with the Director of Professional Practice at Teignbridge PCT that the clinical review would be completed by 6 March. After the meeting he visited the wing and cell where the prisoner had collapsed. He later went to the prison's Healthcare Centre and Induction Unit.

15. On 14 February, the investigator began interviewing staff identified as having knowledge of events, and completed his interviews on 16 February. He interviewed a total of eleven staff, including the prison doctor.

16. My investigator held a meeting with the Governor on 16 February and gave feedback on his findings, which were all accepted.

The Prisoner

17. Unfortunately, very little is known about the man at the centre of this report other than he had two sons and a daughter and that, prior to being sentenced to imprisonment, he lived in Devon.

18. His daughter told my FLO that she had only traced and got to know her father in the final eight months of his life. Although this was a short time, she was pleased to have had the opportunity to have known him.

19. The prisoner had a long medical history, including being diagnosed as having Type 2 Diabetes, Coronary Artery Disease and Hypercholesterolemia.

HMP Channings Wood

20. Channings Wood is a category C training prison, situated on the outskirts of Newton Abbott, Devon. Category C is defined as "*prisoners who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt".*

21. The prison was built on the site of a Ministry of Defence base and opened in July 1974. Additional living accommodation was added in 1991. It has an operational capacity of 667, and accommodates adult male sentenced prisoners serving up to and including life imprisonment.

F2052SH/ACCT

22. F2052SH is the procedure used by the Prison Service to monitor a prisoner thought to be at risk of self-harm. An F2052SH booklet can be opened by any member of staff who has a concern. Once the document has been opened, the prisoner is invited to meet with a multi disciplinary team, to discuss and plan any support required. (The system is currently being replaced across the Prison Service estate with the Assessment, Care in Custody and Teamwork (ACCT) procedure, which builds upon the F2052SH arrangements and involves the prisoner in greater detail in the decision making and care planning process.)

23. Channings Wood has a Suicide Prevention Co-ordinator and she has responsibility for the F2052SH procedures at the prison. At the time of writing this report, the prison had not yet moved over to ACCT.

Bedwatch

24. "Bedwatch" is the term used by the Prison Service to describe the supervision of a prisoner who has been admitted into hospital. The level of supervision is determined by a risk assessment, but will normally involve at least two officers being at the bedside throughout the stay in hospital. Additionally, the prisoner may be handcuffed to an officer, subject to a security risk assessment process.

Night Procedures

25. During the night, the majority of staff on duty at Channings Wood are Operational Support Grades (OSGs) and are generally referred to as night patrols. They do not carry the normal security keys which would be available to staff on duty during the day time period. However, they do carry a cell key which is held securely in a sealed pouch. The pouch is attached to their belt and only opened in the event of an urgent need to enter a cell. The night patrol is responsible for checking the security of the

cell doors, answering any emergency cell call alarms and carrying out routine patrols of the accommodation area.

26. At strategic points in the living blocks, there are a number of magnetic strips that are secured to the wall. As each night patrol arrives on duty, and providing the place of work for the night is within a living block, an electronic recording device is issued. When placed against the metal strip, the recorder notes that the night patrol has been to the area. The action is commonly known as "pegging". At the end of the night duty, the recording device is attached to a computer and the recorded information downloaded. The pegging routine does not require the night patrol to check the prisoners, and is simply confirmation that the living block has been patrolled.

Roll Checks

27. In order to carry out a roll check, the officer or night patrol is required to see the prisoner through the cell door observation panel to ensure that the prisoner is there. It is only when the individual living block rolls agree with the total prison population that the prison is unlocked, thus enabling prisoners to leave their cells.

Prison Service Orders (PSOs)

28. PSOs contain instructions to governors, with any mandatory instructions appearing in italics. They are given an individual order number and title, along with an implementation date. Governors issue their own local policy to implement the PSO and, unless they have been given the authority not to carry out a mandatory action, they must comply with the instructions.

29. PSO 2710, Follow Up to Deaths in Custody, has recently been re-issued, with an implementation date of 4 January 2006. It contains instructions and immediate action to be taken following a death in custody, including a number of mandatory instructions.

30. Channings Wood's own local instruction, "Handling a death in custody", relating to PSO 2710, has not been updated since 2002, but does broadly follow the re-issued PSO. The local instruction's "introduction" identifies six factors that staff are required to be aware of regarding the death of a prisoner. For the purpose of this report, I highlight the first factor only:

- *Death must **never** be assumed. Resuscitation should be attempted. Only a doctor can certify death.*

31. The local instruction gives further guidance to individual staff in the form of action sheets. Action sheet number one entitled "Person Discovering" lists ten instructions. Again for the purpose of my report, I highlight just one of the action points, number five, which also reminds the reader about rigor mortis:

- *if the prisoner is not breathing, attempt resuscitation unless rigor mortis of the limbs has clearly set in.* (Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death, making it virtually impossible to bend the wrists, elbows, or knees.)

Critical incident de-brief

32. PSO 8150, Prison Service Post Incident Care for Staff, advises governors that a critical de-brief should take place about one week following any serious incident. Critical de-briefs allow staff to share their perceptions, thoughts and feelings about what has occurred, and they are facilitated by two trained staff from other establishments. It is a confidential environment for staff to deal with the impact of what has happened upon themselves, and is managed by the Staff Care and Welfare Service.

Key findings

Events prior to 10 January 2006

33. The prisoner was sentenced to six years imprisonment on 4 July 2005, having been found guilty of the manslaughter of his wife. Following his court appearance, he was returned to HMP Exeter, having been there on remand since 26 November 2004.

34. On the day of his first remand to Exeter (26 November 2004), the prisoner had been placed on F2052SH monitoring due to concerns that he would harm himself by not taking his medication in order to elevate or drop his sugar levels, inducing a diabetic coma. The monitoring procedure changed during the time the prisoner was at Exeter with the F2052SH document being replaced with the ACCT document.

35. On two occasions between November 2004 and July 2005, whilst still at Exeter, the prisoner submitted advance directives refusing food, fluids and medical intervention in respect of his health care needs. The medical notes indicate that he would not follow the medical advice to control his diabetes with medication and, on occasions, his angina.

36. On 16 May 2005, the prisoner gave instructions via his living will (which had been placed in his medical record) that his life could be shortened by the specific refusal of treatment under the following circumstances:

    - *"advanced disseminated malignant disease (e.g. cancer that has spread considerably)*
    - *"severe immune deficiency (e.g. Acquired Immune Deficiency Syndrome)*
    - *"advanced degenerative disease of the nervous system (e.g. advanced Parkinson's Disease)*
    - *"severe and lasting brain damage due to injury, stroke, disease or other cause*
    - *"advanced dementia, whether Alzheimer's, multi-infarct or other, resulting in very limited awareness of the immediate environment and inability to initiate simple tasks*
    - *"any other condition of comparable gravity*
    - *"[If] I have become unable to participate effectively in decisions about my medical care*

- *[If] Two independent physicians (one a consultant) are of the expert, considered opinion, after full examination of my case, that I am unlikely to make a substantial recovery from illness or impairment involving severe distress or incapacity for rational existence."*

37. The prisoner added the following further directions:

    - *"I am not to be subjected to any medical intervention or treatment (aimed at prolonging my life) such as life support systems, artificial ventilation, antibiotics (i.e. to control infection) artificial feeding, whether enteral or parenteral (tube feeding into the stomach or into a vein), invasive surgery, dialysis (e.g. using a kidney machine), or blood transfusion*:

    - *"I do not wish to be resuscitated if I enter a vegetative state due to my diabetes*

    - *"I do not wish to be resuscitated if I enter a coma due to my own actions in refusing insulin or food or water*

    - *"I do not wish for any person's consideration to be taken about my care."*

38. Healthcare staff had all been briefed about the living will and made aware of the specific wishes, contents and action to be taken.

39. On 15 July 2005, the prisoner was transferred as a category C prisoner to Channings Wood. At the time of his transfer he was being monitored under the ACCT procedures.

40. The Suicide Prevention Co-ordinator (SPC) for the prison is a female senior officer. She told my investigator that she was notified by reception staff that the prisoner had arrived at Channings Wood with an open ACCT form in place. She made a telephone call to Exeter and spoke to a member of the healthcare staff. The person she spoke to was able to update her as to why the prisoner was being monitored.

41. The Suicide Prevention Co-ordinator was told that, at one stage, the prisoner had been monitored hourly, due to his not taking his medication. This meant that they would check on him every hour, and staff would wake him during the night to be certain that he was alive.

42. As the ACCT procedures had not been introduced at Channings Wood, the file was closed, and replaced with the F2052SH monitoring document.

43. Following his reception into Channings Wood, the prisoner was initially allocated to the induction unit where he remained for about seven days, before moving to Living Block 3 (LB3). After he had been in LB3 for a few days, the Suicide Prevention Co-Ordinator telephoned the officers for an update on his behaviour. She was told that he had settled down well. My

investigator found the SPC pro-active and dedicated to her role at Channings Wood.

44. On 18 July, the prisoner attended an F2052SH review board which had been called to discuss and assess his risk of self harm. The board agreed that the prisoner no longer presented a risk of self harm and the file was closed. I judge this to have been the appropriate action.

45. Between July and 31 December, the prisoner was seen by medical staff on 12 occasions for a variety of reasons: difficulty in coping, blood tests, mental health referral, bereavement counsellor, insulin therapy and non-compliance with insulin therapy. On 10 October 2005, medical staff discussed the consequences of his continued refusal to take medication, the validity of the living will, and whether the prisoner had the mental capacity to validate the will. Further discussions took place with the man himself on 10 November and 16 December regarding his medication and refusal to consent to any treatments.

46. On 31 December, the prisoner collapsed in his cell. The prison's head of healthcare, went to the cell and carried out medical examination observations. She recorded the prisoner's blood pressure as 110/80, and his pulse as 92. His neurological observations were normal, pupils equal and dilating.

47. After examining the prisoner, the prison's head of healthcare was satisfied that his condition was not life threatening, and suspected that it might be linked to his diabetes. However, she wanted to speak to a doctor and ask his opinion. The doctor was on call and not in the prison, and she therefore needed to leave the prisoner in order to use a telephone. She arranged for another prisoner to sit with him in his cell, and agreed that she would return once she had spoken to the doctor.

48. About 20 minutes after leaving the cell to telephone the doctor, the head of healthcare was called back to the prisoner as he was complaining of chest pain. She returned to his cell, found that his condition had deteriorated significantly, and requested an emergency ambulance. Additionally, she asked for emergency medical equipment to be brought from the healthcare department, including a defibrillator. (Defibrillators are only used on non responsive and non breathing patients, and are attached to the patient to analyse the heart pattern. If necessary, the machine instructs trained users to shock the patient. In this man's case, the machine was not required as he was breathing and responsive, and was only requested as a precaution.)

49. The prisoner said that he would not accept any medication, or transfer to hospital. The head of healthcare explained that it was his right to refuse medication but, should he become unconscious, she would have to intervene and if necessary attempt resuscitation as his living will did not cover the circumstances of his current medical condition.

50. The duty governor also attended and told the prisoner that, if he refused to go to hospital, there would be no alternative other than to send him to Exeter for admission into their hospital wing. Having been given the options, the prisoner said that he did not want to go to Exeter and agreed to be taken to hospital as an emergency patient, where he was subsequently admitted.

51. Throughout his stay in hospital, the prisoner was supervised by two officers at all times. He was handcuffed according to the normal routine for a category C prisoner, but the handcuffs were removed to allow examinations to take place.

52. Whilst in hospital and following a prolonged period of chest pain, the prisoner consented to undergo a coronary angiography. Coronary angiography is an X-ray examination of the blood vessels or chambers of the heart. A small tube (catheter) is inserted into a blood vessel in the groin or arm. The tip of the tube is positioned either in the heart or at the beginning of the arteries supplying the heart, and a special fluid called a contrast medium or dye is injected. The fluid is visible by X-ray, and the pictures that are obtained are called angiograms. The procedure revealed long standing occlusion (blood clot) of the prisoner's right coronary artery. He was prescribed Ciopidogrel 75mg for six months, Asprin 75mg, Ezetimibe 10mg, Adizen XL 240 mg and Nicorandil 10mg. The medication was appropriate for someone with such a cardiac condition. A further review was planned for three months following discharge from hospital, which sadly was not possible.

53. The prisoner was considered well enough to be discharged from hospital and he returned to prison on 5 January 2006.

54. On 8 January, the second officer spoke to the prisoner and asked him how he was feeling after his short stay in hospital. She had been one of the officers on bedwatch duties when he was in hospital. The prisoner told her he was feeling fine, but said that if it happened again he hoped that it would be fatal. She believed that he was referring to his suspected recent heart attack. She said that she told him not to be silly, but the prisoner said that this was what he wanted. The officer described the prisoner as being happy and chatty, adding that he did not change his opinion and did not wish to be resuscitated. She told my investigator that his comments did not give her any impression that he was at risk of self-harm, but were more an expression of how he hoped things would go in the future.

55. Some time between 7:30pm and 7:45pm on 9 January, at the end of the evening association period, the prisoner was locked into his cell (D -14, a single occupant cell). A third officer was responsible for locking the prisoner into his cell, and said at interview that he did not have any concerns about the prisoner or his health.

56. At 9:00pm an OSG started duty in LB3 as the night patrol, and took over from the officers who had been on duty during the day. He said that, when

taking over from the day staff, he checks the roll for himself. Unlike the officers on duty during the day, he is not required to sign for the total roll in the wing diary.

57. The OSG began his first pegging round at 10:30pm, with a further peg at 11:45pm.

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58. My investigator examined the pegging information for the night period and found that no further pegs were recorded until 6:35am on 10 January (a gap of almost seven hours). The investigator carried out a test of the equipment, and examined the records for nights before and after 10 January to ensure that there were no similar occurrences. His examination found the equipment to be in good working order and no similar gaps in the records.

59. My investigator asked the OSG to describe how he carried out his pegging duties. He said that there was no set, pre-determined route to follow, but that he would usually follow the same route each time. He told the investigator that he is required to carry out a minimum of four pegging rounds per night, but usually pegged at least five times per night.

60. The investigator showed the OSG the pegging record for the night, and asked if he was able to explain the gap in the recordings. He was unable to offer an explanation, but stressed that he had carried out the pegging as required. He said at interview that sometimes the recorders produce different sounds when activated, and that he is not always certain that the equipment is working correctly. My investigator asked him if he had suspected the equipment as being faulty that night, and if so, had he reported it. He said that he had not reported a fault with the equipment.

61. At 6:00am the OSG carried out a roll check and confirmed to the duty manager that the roll was correct. My investigator asked him to describe how he carried out his roll checks. He said that when he looked into the cells, he used the ambient lighting rather than the in cell light. However, if the ambient light was not bright enough, he would switch the light on very briefly. He said that he would not necessarily look at the prisoner in person, but would accept what appeared to be someone in bed as being the prisoner.

62. My investigator asked the OSG if he could recall seeing the prisoner when he carried out the roll check. He said that he could not remember, as he did not know him. The investigator asked him if he would have noticed a prisoner lying on the floor. He said that he had not noticed anything, and would not necessarily look to the floor if he could see what he believed to be a person in bed.

63. A fourth officer came on duty at 7:30am and took over responsibility for LB3. He did not carry out his own roll check as this was not required by the

prison procedures. The local procedure for further roll checks is that they should take place when additional officers arrive on the living block, usually about 7:45am.

64. At approximately 7:45am, along with colleagues, the officer who carried out the roll check began the routine roll check of LB3. The officer was responsible for Lower Dart which is the ground floor accommodation area of LB3. When he arrived at cell D -14, he switched the in cell light on as the cell was in darkness. He saw the prisoner lying on the floor with his head partially under the bed frame. He attempted to obtain a response by kicking the door and calling out the prisoner's name but without success. He immediately left the area and summoned assistance from a second officer who was also in the living block preparing to unlock a number of prisoners for work in the kitchen servery. The officer who carried out the roll check said at interview that he told the second officer he thought the prisoner was dead.

65. Both officers returned immediately to the prisoner's cell. The officer who carried out a roll check unlocked the cell door and was the first person to enter the cell followed by the second officer.

66. The officer who carried out a roll check said that he pinched the prisoner's leg in an attempt to obtain a response from him, but this was unsuccessful. He said that he could see that the prisoner's mouth and eyes were open and added that his skin was cold when he touched it.

67. The second officer said that she checked the prisoner's wrist for a pulse, but could not detect one. Additionally, she said that his body was cold, blue, and she believed rigor mortis had set in. My investigator asked if either she or the officer who carried out the roll check had moved the prisoner's body and was told that they had not. He asked the officer to explain how she would come to the conclusion that rigor mortis had set in. The officer said that the prisoner's skin was tight, and that he looked stiff. She added that she had seen a small amount of blood under the bed which had come from a cut to the prisoner's head. The post mortem report has concluded that the injury was consistent with a terminal fall.

68. My investigator interviewed both officers separately. He asked them if, once they had established that there were no signs of life, they had carried out Cardio Pulmonary Resuscitation (CPR). Both officers said that they had not, as they were certain that the prisoner was dead and believed rigor mortis had set in. They were also asked if they were aware of PSO 2710, and the local instruction, "Handling a Death in Custody". They both said that they had not read the local instruction or PSO, but would know where to find them.

69. The investigator asked the second officer if she had taken the decision not to carry out CPR as a result of her conversation with the prisoner a few days earlier. She said that, at the time, she was unaware that it was the prisoner who had been found collapsed, and did not recognise him until

after the healthcare staff arrived. Once she realised who it was, she recalled saying to herself that he had got his wish. At interview, she said that she wanted to move the prisoner onto the bed as he was cold

70. At approximately 7:47am the second officer used her prison radio to request urgent medical assistance. Two Healthcare Officers (HCOs) responded to the call and, after collecting an emergency equipment bag, went directly to LB3. At the same time, the second of these two HCOs used his prison radio to request an ambulance to be called. The first HCO said that, when they arrived at the cell the officers were outside, and the only person in the cell was the prisoner himself.

71. The two HCOs entered the cell and checked for any signs of life, but sadly found none. The first HCO said that the prisoner was not breathing and that he appeared lifeless. He described the prisoner's skin complexion as pale white in colour, eyes open with fixed dilated pupils and skin cold to the touch. He added that there were clear signs of pooling of blood at the lowest points of the body. (Pooling of the blood occurs when the heart has stopped beating, and gravity draws the blood over a period of hours to the lowest point.)

72. My investigator asked the first HCO if either he or the second HCO had attempted CPR, to which he replied no. He said that it was their joint clinical opinion that the prisoner was dead, and that it would not have been decent to attempt resuscitation. When asked if rigor mortis had set in, he said that he did not believe it had.

73. The investigator asked both Healthcare Officers if the prisoner's living will had affected their decision not to carry out CPR. The second HCO said that he was aware of the living will, but was not sure if the will was still valid as the prisoner was being seen by the Mental Health Community Inreach team due to his continued refusal of medication. The first HCO said that he was also aware of the living will. He said that, at the time, he was unsure if the will was still valid as the prisoner had been accepting treatment during his recent spell in hospital. They both agreed that their decision not to commence CPR was a clinical decision, and had nothing to do with the living will.

74. In response to the earlier request for an ambulance, paramedics arrived at the prisoner's cell at 8:06am and carried out their own checks, including connecting an electrocardiograph machine to the prisoner, which did not detect any sign of life. The Ambulance Service "Recognition of Life Extinct" report shows that paramedic staff recorded that pooling was evident, and that death was recognised at 8:10am. After completing their report, the paramedics left the prison at 8:35am.

75. The prison's liaison officer (a principal officer) arrived at the cell shortly after the paramedics. My investigator asked him if the prisoner's bed had been slept in, as he wanted to try and establish if the prisoner had gone to bed, or

had died before going to bed. He said that the bed was made, but could not determine whether the bed had been slept in or not.

76. At 8:40am the Prison Medical Officer for Channings Wood, arrived at the prisoner's cell. He had been telephoned at home and asked to attend the prison. He confirmed the prisoner's death at 8:45am.

77. My investigator asked him for an opinion as to the time of death. He said that, in his opinion, death had occurred somewhere between two and six hours prior to his confirming death. He added that it was notoriously difficult to determine the time of death, as the local environment would have a significant effect on the body temperature. He confirmed that there were no signs of rigor mortis.

78. The investigator asked the doctor for an opinion about CPR not being carried out. He said that, in his opinion, the decision taken not to attempt resuscitation was correct as the prisoner had been dead for some time.

79. On the day that the prisoner died, a consultant at South Devon Healthcare NHS Trust wrote to the Prison Medical Officer for Channings Wood offering his diagnosis of the prisoner's condition. His diagnosis was that the prisoner had:

- *Previous myocardial infarction*
- *Three vessel coronary disease*
- *Systemic hypertension*
- *Diabetes*
- *Hypercholesterolemia.*

80. In his letter, which was not received into the prison until after the prisoner's death, the consultant said that the prisoner had not been taking any medication for the last few months. He added that the prisoner had been offered coronary angiography, and had accepted this, but the prisoner had made it very clear to him that he would not contemplate bypass surgery in the event of cardiovascular collapse during procedure. Cardiovascular collapse is when the heart collapses and the entire cardiovascular system shuts down.

81. On 30 January one of my FLOs contacted the prisoner's daughter, as she had been identified as the next to kin. The daughter described the support from the prison as superb, especially from the prison's FLO and the chaplain. She said that they had taken her to see her father in hospital and had been excellent in supporting her following his death. She asked the chaplain to perform the funeral service, which he did. She said that the Governor also arranged to pay the funeral costs. This is in keeping with PSO 2710 "Follow up to deaths in custody". I welcome the Governor's

actions and that of her staff. I am very pleased to be able to report the positive comments made by the prisoner's daughter which reflect well on the prison and the Prison Service as a whole.

82. The prisoner's daughter asked if there was any link between the care her father received in hospital and his death. The clinical review covers this issue.

83. Additionally the daughter asked if I could confirm if all of her father's property had been returned to her, and if it was possible to trace a card that had not been returned. My investigator has established that no further property remains at either Channings Wood or Exeter, and I understand the Liaison Officer has confirmed that no other property has been stored at the Prison Service store in Branston.

84. With regard to the card, my investigator has located a card which was sent to the prisoner on 9 January 2006. Unfortunately, it would appear that it is not the one referred to by the prisoner's daughter.

85. My investigator examined whether PSO 8150, "Prison Service Post Incident Care for Staff", had been followed by the governor. He found that the critical incident de-brief had not taken place within the recommended seven day time scale. He discussed the finding with the governor and was assured that it was due to take place, but had been delayed pending the completion of the investigator's interviews with prison staff.

86. The Director of Professional Practice at Teignbridge PCT carried out the clinical review of the care and treatment received by the prisoner whilst in custody.

87. She said that the prisoner was diagnosed as having Type 2 Diabetes, Coronary Artery Disease and Hypercholesterolemia. The review notes that between November 2004 and July 2005, whilst at Exeter prison, the prisoner had submitted two advance directives refusing food, fluids and medical intervention in respect of his health care needs. He demonstrated non compliance with all medicine regimes for his diabetes and, on occasions, for his angina.

88. Additionally, the clinical review has identified that medical staff had raised concerns at the prisoner's mental state and his ability to actively explore the living will. The concerns resulted in an assessment being made of the prisoner's mental state by a consultant forensic psychiatrist through the prison's Inreach Mental Health Worker.

Issues considered in the investigation

Pegging

89. I am satisfied that the apparent failure by the OSG to carry out pegging from 11:43pm on 9 January 2006 through until 6:35am, 10 January 2006, had no bearing on when the prisoner was found. However, the finding was reported to the Governor, and she has instructed a member of her management team to carry out an investigation under the Prison Service's own investigation process.

Roll Checks

90. In his evidence, the OSG said that he would accept what appeared to be a person in bed as being the prisoner. Based on his assumption that the cell is occupied by a prisoner, he will confirm the roll as being correct.

91. The current practice of allowing the night patrol officer to leave the prison before the living block roll has been confirmed as being correct is flawed. Equally, I judge that the practice of a night patrol officer accepting the roll from the daytime staff without being required to sign and confirm the roll for themself, to be bad practice.

92. I am not satisfied that the roll-check procedures at Channings Wood are sufficiently robust to ensure that an individual member of staff confirms and signs for their roll. There are obvious security implications which have been discussed with the Governor, and she intends to expand her terms of reference in relation to the internal investigation relating to the OSG. I welcome the Governor's approach to my investigator's findings. This has removed the necessity for me to make formal recommendations on this issue.

CPR

93. Channings Wood Local Instruction, "Handling a Death in Custody" instructs staff: "*death must never be assumed. Resuscitation should be attempted. Only a doctor can certify death*." Additionally, it says: "*if the prisoner is not breathing, attempt resuscitation, unless rigor mortis of the limbs has clearly set in.*"

94. From the description given by the first officers to enter the prisoner's cell, it would appear evident that he was dead. They said that he was cold to the touch, blue in colour, with no pulse, and eyes and mouth open. The second officer believed that rigor mortis had set in, but confirmed that she had not attempted to move the prisoner's limbs, and had based her assessment on her observation that he looked stiff.

95. Both the second officer and the officer who carried out a roll check confirmed that they had not read either PSO 2710 or the local instruction, “Handling a death in custody”.

96. The two HCOs are both trained nursing staff and, although not medically qualified to assess death, were of the opinion that to attempt resuscitation would not have been decent. They made a clinical decision based upon their own examination, which included observing pooling of the blood, and decided that the prisoner had died.

97. The prison medical officer said that, in his opinion, the prisoner had been dead for some time, and the decision taken not to attempt resuscitation was correct, as it would have been evident that the prisoner was dead. However, he did confirm that rigor mortis had not set in which means that the instructions contained in PSO 2710 and the local instructions should have been followed. He added that the ambient temperature in the room would have an effect on the onset of rigor mortis. In this man’s case, the cell was warm which could delay the process.

98. I believe that the officers and healthcare staff were correct in not attempting resuscitation, as the prisoner was clearly dead and had been so for some time. To proceed with any form of resuscitation attempt, in order to satisfy the instructions contained in PSO 2710 and the local instruction, would indeed have been indecent.

I make the following recommendations, all of which have been accepted by the Prison Service:

All staff should be reminded of PSO 2710 and Local Instruction “Handling a Death in Custody” and be given clear guidance on the checks that need to be made in order to establish rigor mortis.

Local instruction, “Handling a Death in Custody, 2002” should be re-published in line with PSO 2710. The Governor should review that section of the instruction on when resuscitation should be attempted.

Living Will

99. It is clear that the prisoner’s living will had been discussed amongst the healthcare teams at both HMP Exeter and HMP Channings Wood, and a copy of the will was lodged in his medical notes. However, his wishes were not known to anyone outside of the healthcare team, as the healthcare manager believed that the will was not valid as the prisoner had been accepting treatment, and she was in the midst of checking its validity.

100. I am satisfied that the second officer and the officer who carried out a roll check were unaware of the exact contents of the prisoner’s living will, and therefore could not have let his wishes affect their own judgement. I am also satisfied that the two HCOs did not take into account the living will

when they jointly agreed not to attempt resuscitation. I believe that their decision was correct and proper in the circumstances they faced.

101. With specific reference to the second officer, I am satisfied that her conversation with the prisoner two days prior to his death did not affect her decision not to attempt CPR. She was quite clear at interview that she had not realised who had been found collapsed, as she was unable to recognise the prisoner's face at the time.

Clinical review

102. The Director of Professional Practice at Teignbridge PCT said that she had no doubt that the care and treatment the prisoner received was reasonable and appropriate, given the circumstances and presentation of the patient. However, she added that the quality and presentation of the prisoner's medical documentation was variable, making assessment more difficult.

103. Her review also highlights the difficulty that can occur should there be conflicting policies and guidelines for healthcare and prison staff respectively. The use of living wills within a secure environment is an example in point.

104. The Director of Professional Practice makes four recommendations which will need to be considered by the prison and the PCT:

Note-keeping in the inmate medical records should be legible, with the name and designation of the practitioner making the entry.

Training needs to be carried out on record keeping and documentation presentation.

Consideration should be given to develop a programme for staff on the use of living wills in a secure environment, and availability of a policy that supports staff on the implementation.

All staff are made aware of the legal aspects of record keeping and the need for it to be collated and stored in chronological order, to support implementation of care.

Recommendations

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Clinical Review Recommendations

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2. Training needs to be carried out on record keeping and documentation presentation.

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4. All staff are made aware of the legal aspects of record keeping and the need for it to be collated and stored in chronological order, to support implementation of care.