

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Stevens a prisoner at HMP Channings Wood on 6 January 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Michael Stevens died in hospital on 6 January 2016. He was found hanging in his cell at HMP Channings Wood on 4 January. Mr Stevens was 26 years old. I offer my condolences to Mr Stevens' family and friends.

On 4 January, prisoners on Mr Stevens' wing discovered that during the commission of the offence for which he was imprisoned, an elderly woman had been hurt. A group of prisoners confronted Mr Stevens, and one threw some punches at him. Mr Stevens told a prison officer that he needed to move wings for his own safety. The officer advised him to lock himself into his cell to ensure he was safe, while officers considered his request. Less than an hour later, a prison officer went to speak to Mr Stevens and found him hanging. He called for assistance and prison officers kept Mr Stevens alive until paramedics arrived and transferred him to hospital. Mr Stevens died two days later.

While there were omissions in Mr Stevens' healthcare, I do not consider that prison officers could have predicted or prevented his actions on 4 January. When he disclosed that he felt threatened, staff reacted appropriately and were in the process of addressing his concerns. The investigation found that he gave no indication that he was at risk of harming himself.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

June 2017

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Summary

Events

1. Mr Stevens was remanded to HMP Exeter in September 2015. As the warning form that accompanied him recorded he had said he was feeling suicidal, the prison officer who saw him in reception opened Prison Service procedures to support prisoners at risk of harming themselves. (These are known as ACCT.) He had an initial health screening and said that he had taken an overdose three weeks earlier. He said he had mental health issues and was referred to the mental health team. He told a mental health nurse that previous incidents of self-harm had been fuelled by drink and drugs.
2. In early October, a doctor prescribed Mr Stevens a course of anti-depressants. He was not judged to require ACCT support any longer and the mental health team said that he did not need to be under their care. On 20 November, Mr Stevens was convicted of robbery and sentenced to nine months imprisonment.
3. On 27 November, Mr Stevens was transferred to HMP Channings Wood. At an initial health screening at Channings Wood, Mr Stevens told the nurse that he was teetotal, had never undergone any treatment from a psychiatrist, and had no mental health issues. A prison doctor confirmed Mr Stevens' prescription of anti-depressants without seeing him. From 30 November to 29 December, Mr Stevens' medical record contained 41 blank entries. The Head of Healthcare told the investigator the entries indicated that he did not collect his medication on those dates.
4. On 29 December, in a routine search, prison officers found a bottle of fermenting liquid in Mr Stevens' cell. He was moved to another wing. On the afternoon of 4 January 2016, prisoners on Mr Stevens' wing found out that when he had committed his offence, an elderly woman had been hurt. A group of them confronted him and one prisoner threw some punches, connecting with Mr Stevens twice. Mr Stevens approached a prison officer and said that he needed to leave the wing for his own safety. As it was nearly time for prisoners to be locked in their cells for the night, the officer told Mr Stevens to return to his cell where he would be safe. (Prisoners are able to lock themselves in.) The officer said that he and his colleagues would take his request forward. The officer told his two colleagues on the wing what had happened. They agreed that once prisoners were locked away they would speak to Mr Stevens and decide how to proceed. In the interim, both officers confirmed that Mr Stevens was well.
5. Shortly after the prisoners had been locked up, a prison officer went to collect Mr Stevens to take him to the office to discuss his situation. When he arrived at the cell, he saw Mr Stevens hanging. He called for assistance and went into the cell, where he supported Mr Stevens' body until colleagues arrived. They cut Mr Stevens down, and worked to revive him until ambulance staff arrived and took over. Mr Stevens was transferred to hospital but died on the morning of 6 January.

Findings

6. Prison officers could not have predicted Mr Stevens' actions. When he informed them that he needed to leave the wing, there were no indications that he was in danger of harming himself, only that he felt under threat. Officers acted promptly to address his concerns. When they found him hanging, attempts at resuscitation were good. Prison officers managed to keep Mr Stevens alive until the ambulance crew arrived and transferred him to hospital.
7. When Mr Stevens arrived in Channings Wood, the nurse who conducted his initial health screening did not have access to his medical records. She was therefore reliant on his version of his medical history. The doctor confirmed his prescription of anti-depressants without seeing him.
8. Mr Stevens did not collect his medication on a number of occasions throughout December, but this was not referred to a doctor in line with Channings Wood's stated policy. His ongoing need for anti-depressants was not assessed.
9. When Mr Stevens was found hanging, staff acted quickly and correctly. There was, however, a short delay in calling the correct emergency code.

Recommendations

- The Head of Healthcare should ensure that all newly arrived prisoners have an appropriate health screen that properly reviews their medical history, including access to their medical records and the offence with which they were charged.
- The Head of Healthcare should ensure that prisoners are offered a secondary health screening in line with PSO 3050, *Continuity of Healthcare for Prisoners*.
- The Head of Healthcare should ensure that prisoners' medication is properly monitored. When a prisoner does not collect his medication on a regular basis this fact should be referred to a doctor.
- The governor should ensure that all staff are aware of and use the appropriate emergency response code in a life-threatening situation.

The Investigation Process

10. 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 hm. No one responded.
11. The investigator visited Channings Wood on 19 January. He obtained copies of relevant extracts from Mr Stevens' prison and medical records. He interviewed six members of staff and two prisoners at Channings Wood in April.
12. NHS England commissioned a clinical reviewer to review Mr Stevens' clinical care at the prison. The investigator and clinical reviewer conducted joint interviews of medical staff at Channings Wood. They were unable to interview the nurse who conducted Mr Stevens' initial health screening as she was absent on long-term sick leave.
13. We informed HM Coroner for Plymouth, Torbay and South Devon of the investigation. He sent the results of the post-mortem examination and we have given the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Stevens' mother to explain the investigation and to ask if she had any matters the family wanted the investigation to consider. Mr Stevens' family wanted to know details of the assault on Mr Stevens by another prisoner. Mr Stevens' family received a copy of the initial report, and did not offer any comment.

Incentives and Earned Privileges (IEP) Scheme

15. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Assessment, Care in Custody and Teamwork (ACCT)

16. 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.
17. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
18. 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Background information

HMP Channings Wood

19. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds over 700 men. Dorset NHS University Trust provides health services at the prison. On weekdays nursing cover is provided between 8.00am and 6.00pm and there is an out of hours, community GP service.

HM Inspectorate of Prisons

20. The most recent inspection of Channings Wood was in September 2012. Inspectors reported that violence was low and prisoners felt mainly safe. Healthcare was noted as being reasonable, with reception screenings described as thorough. The administration and management of medication was generally good.

Independent Monitoring Board

21. 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 August 2015, the IMB reported that the members of the healthcare team were working under extreme pressure. There were with problems with the dispensing of medication and queues formed regularly. Assaults had increased since the previous year.

Previous deaths at HMP Channings Wood

22. Mr Stevens was the first person to take his own life at Channings Wood since 2013. There has since been a further death but this has no similarity to that of Mr Stevens.

Key Events

23. Mr Michael Stevens was remanded to HMP Exeter on 21 September 2016. It was his first time in prison. Escort staff warned prison staff that Mr Stevens had said that he was feeling suicidal, so prison officers opened Prison Service suicide and self-harm prevention procedures. These procedures are known as ACCT (Assessment, Care in Custody and Teamwork). A nurse conducted a reception health screening, noting that he had taken an overdose of painkillers three weeks earlier. Mr Stevens denied having any thoughts of self-harm but had scratches on his arms. He did not require a detoxification programme. Mr Stevens also had a first night immediate risks and needs assessment which noted that, while he had no thoughts of self-harm at that time, he did have a history of self-harm. He also had a history of mental illness, and was referred to the mental health team. His cell sharing risk assessment judged him to be at standard risk.
24. A member of the mental health team saw Mr Stevens the following day. She found no evidence of depression or psychosis, and concluded that Mr Stevens did not appear to have any mental health issues. Mr Stevens denied any thoughts of self-harm. At an ACCT review that day Mr Stevens again gave assurances that he had no thoughts of harming himself. He said that previous instances of self-harm had been fuelled by alcohol and drugs. He presented as intelligent, but was socially isolated with little contact from outside prison
25. A note made on Mr Stevens' medical record on 29 September recorded that he had superficial scratches on his arm. He said he made these scratches because he was frustrated. The following day Mr Stevens said that he had swallowed a razor blade. He said he had had his tobacco stolen and had not received a smoker's pack. He was coughing up blood, and staff took him to hospital until he was cleared to return to prison later that day.
26. On 6 October, Mr Stevens saw a prison doctor because of neck pain. During the consultation the doctor thought that he would benefit from anti-depressants and prescribed a course of sertraline (used to treat a variety of conditions including depression and anxiety). At an ACCT review on 8 October, Mr Stevens seemed more settled now that he was on medication. The mental health team had confirmed that he did not need to be under their care. At the next review, on 13 October, staff reported a vast improvement in his behaviour and attitude. He was sharing a cell with someone he knew, his medication had been addressed to his satisfaction, and he had no thoughts of self-harm. Staff removed Mr Stevens from ACCT management procedures.
27. On 15 October Mr Stevens was convicted of robbery.
28. On 29 October, Mr Stevens told a prison doctor that he was "not getting on well" with setraline and requested an alternative form of medication. The doctor changed his prescription to mirtazapine. On 20 October, at Mr Stevens' post closure ACCT interview he presented a reduced risk of self-harm and the ACCT remained closed.
29. On 20 November, Mr Stevens attended court following his conviction for robbery. He was sentenced to nine months imprisonment. On 27 November, he was

transferred to Channings Wood. The escort papers noted that Mr Stevens had recently been under ACCT management.

30. At Channings Wood, an officer took Mr Stevens through the reception process. Mr Stevens said he had no concerns and no thoughts of harming himself. A nurse conducted Mr Stevens' reception health screening. He told her that he had never received medication for mental health problems, was not on medication, and had never been treated by a psychiatrist. (This was untrue.) He said he did not drink, and that he had no thoughts of self-harm. On 30 November, a prison doctor confirmed Mr Stevens' prescription of mirtazapine. He did not see Mr Stevens.
31. On 1 December, Mr Stevens saw his offender supervisor. (Offender supervisors help prisoners with sentence planning and liaise with probation staff in the community.) He later saw a worker from the resettlement team. Mr Stevens had reached the point in his sentence when he could apply for home detention curfew but told both his offender supervisor and the worker that he was concerned that outstanding charges which were pending, and possible problems with the address he had provided, might count against him. He said that he had a 20 month old daughter but anticipated difficulties in being granted access after leaving prison. He remained in touch with his mother but not with his father or sister.
32. On 10 December, Mr Stevens learned that the police were to issue a summons relating to his outstanding charge of causing serious injury by dangerous driving. He subsequently received a summons to appear in court on 8 January.
33. On 23 December, prison officers were conducting cell checks on Mr Stevens' wing, and found a container of fermenting liquid in his cell. They placed Mr Stevens on report, and referred the matter to the independent adjudicator. Mr Stevens was downgraded to the basic level of the incentives and earned privileges scheme (IEP), and was moved from LB2, the enhanced prison wing, to LB3.

4 January

34. On 4 January, at 4.22pm, an officer unlocked the cell doors on Mr Stevens' landing. CCTV footage shows that at 4.37pm another prisoner went into Mr Stevens' cell, cell D-07. Other prisoners were standing outside the cell looking in, and two prisoners went in. The prisoner subsequently told police that he had assaulted Mr Stevens. That day, prisoners had learned that in committing his offence, Mr Stevens had knocked over an elderly woman. He said that an elderly relative of his had been hurt in a similar incident, and he was angry. He said that he threw some punches at Mr Stevens, of which at least two connected. He and the other prisoners then left the cell.
35. Shortly after this, Mr Stevens pressed his cell bell and Officer A responded. Mr Stevens was in his cell with the door locked. She asked him if he was alright, and he said he was, although she thought he looked a little annoyed. He said he wanted to collect his meal, so she unlocked his door.

36. After Officer A left, Mr Stevens came out of his cell. CCTV shows another prisoner berating him and pointing at him aggressively.
37. At approximately 5.00pm, Mr Stevens went to a wing office and spoke to Officer B. He said that he had been assaulted and needed to move off the wing. The officer advised him to return to his cell where he would be safe. (Prisoners are able to lock their cell doors, and while officers are able to unlock them, other prisoners are not.) The officer told him that officers would take his request forward. He asked whether Mr Stevens wanted him to escort him to his cell, but Mr Stevens declined, saying he wanted to collect his meal himself.
38. Officer B noted this exchange in the wing observation book. He also noted that details of Mr Stevens' offence had appeared in the newspaper that day, and a prisoner from his local area had identified Mr Stevens. He told two officers what Mr Stevens had told him. He said that Mr Stevens should be locked in his cell once he had collected his meal. Soon after this Mr Stevens came to the office with his meal and asked for an officer to open his cell door. Officer A took him to his cell and asked whether he was alright. Mr Stevens said he was fine. Officer A remained on the landing to ensure that Mr Stevens was not harassed, and moved other prisoners away when they gathered outside his cell. After Officer A left the wing, CCTV footage shows that a prisoner went to Mr Stevens' door and spoke to him for about two minutes through the closed door.
39. The three officers then discussed what Mr Stevens had told Officer B. Prisoners were very shortly to be locked in their cells for the night at 5.45pm so they decided to wait until all prisoners were locked in before bringing Mr Stevens out of his cell to find out more information about what had happened, and to explore what support they could offer him. Officer A noted this in the wing observation book.
40. At 5.45pm, Officer A called for all prisoners to return to their cells and locked their doors. Having checked on Mr Stevens, she had no concerns about him at this point.
41. A prisoner in one of the cells opposite that of Mr Stevens said that, after being locked away for the night, he heard the sound of material being ripped. He thought Mr Stevens might have been making 'a line' - something prisoners use to pass items to each other between their windows when locked in their cells.
42. At 6.00pm, Officer C went to the landing to ensure that other prisoners were not verbally abusing Mr Stevens. The landing was quiet.
43. At approximately 6.20pm, Officer C went to unlock Mr Stevens to bring him to the office to discuss his situation. He opened the cell observation panel and saw Mr Stevens hanging from his cell window bar by a ligature made from a torn bed sheet. He pushed the general alarm button on the wall by Mr Stevens' cell door then unlocked the door. An operational support officer (OSG) was working in the control room and announced over the radio that there was an emergency on LB3 landing. The prison's radio system shows that the alarm was activated at 6.22pm.

44. Officer C lifted Mr Stevens to take the weight off the ligature and supported Mr Stevens. Officer A heard the alarm and ran to the cell. CCTV footage shows that she arrived within one minute. She used her anti-ligature knife to cut Mr Stevens down. They lowered him to the bed and Officer C checked for breathing and a pulse. Unable to find any, they lowered him to the floor and began to perform cardiopulmonary resuscitation (CPR).
45. Other prison officers arrived and Officer B used his radio to ask for urgent assistance and for any available healthcare staff to go to the landing. About thirty seconds later, Officer C used his radio to say that they required an ambulance. Twenty seconds after this, the orderly officer in charge of the prison that night arrived and used his radio to call a code blue emergency, meaning that a prisoner was unconscious or having difficulty breathing. He confirmed that it was a code blue emergency and that he was on the telephone to the ambulance service. He said that there were no healthcare staff in the prison. The prison officers moved Mr Stevens out of his cell and onto the landing to allow more room to provide first aid, and continued to perform CPR. They applied a defibrillator and continued to try to resuscitate Mr Stevens until ambulance staff took over. At approximately 7.38pm they transferred Mr Stevens to the ambulance and took him to hospital.

Contact with Mr Stevens' family

46. When Mr Stevens was taken to hospital, prison staff contacted his family, who also went to the hospital. After discussions with medical staff, Mr Stevens' life support was switched off and he died on the morning of 6 January. His family was with him when he died.
47. In line with prison service guidance, Channings Wood offered a contribution towards the cost of Mr Stevens' funeral.

Support for prisoners and staff

48. After Mr Stevens was taken to hospital, one of the prison's managers 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.
49. The prison posted notices informing other prisoners of Mr Stevens' death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Stevens' death.

Post-mortem report

50. The post-mortem report showed that Mr Stevens died from hypoxic/ischaemic brain injury as a result of hanging. Toxicology reports indicated that he had no alcohol or detectable illicit drugs in his system.

Findings

Assessment of risk

51. Mr Stevens had previously been managed under ACCT procedures, although not at Channings Wood. In interview, Officer B said that, when Mr Stevens told him that he had been assaulted and wanted to move off the wing, he did not consider opening ACCT procedures. Although Mr Stevens said he was under threat, he had no reason to think that he had any intention of harming himself as Mr Stevens gave no indication that that was the case. Officer A said that Mr Stevens appeared calm, and when she asked him if he felt alright, he said that he was. There were no indications that he was in crisis or required immediate support. There was no previous intelligence to indicate that Mr Stevens had been the subject of any bullying or threats.
52. When Mr Stevens approached Officer B, there was less than an hour until prisoners were to be locked into their cells for the night. He told Mr Stevens to lock himself in his cell for the time being where he would be safe, and that he and his colleagues would address his request. He offered to escort Mr Stevens back to his cell in case he felt under immediate threat, but Mr Stevens declined. He then informed his colleagues and made a note in the wing observation book. Staff discussed what to do, and decided that, as it was so close to the time for prisoners to be locked away, they would wait and speak to Mr Stevens after that and decide how to proceed from there. In the meantime, both Officer C and Officer A checked on Mr Stevens.
53. The decisions taken by wing staff were reasonable. They noted the issue raised by Mr Stevens in the wing observation book, then further noted what they intended to do. They intended to bring Mr Stevens to their office to discuss his problems within an hour of his asking for help, and, in the meantime, staff checked on his wellbeing. They could not have anticipated his actions.

Emergency response

54. When Officer C found Mr Stevens hanging, he immediately pressed the alarm and went into Mr Stevens' cell. Unable to cut Mr Stevens down alone, he rightly supported his weight while awaiting assistance, which quickly arrived. Thereafter the attempts to resuscitate Mr Stevens were correct, even though medical staff had already left the prison for the day. The clinical reviewer noted that resuscitation attempts by prison staff successfully kept Mr Stevens alive until ambulance crew arrived and took over. Ambulance service records noted that resuscitation by prison officers before ambulance staff arrived was very good.
55. In line with Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, Channings Wood operates a medical emergency code system to ensure that staff communicate the nature of the emergency, and that an ambulance is called automatically. Code blue indicates a prisoner who is unconscious or having trouble breathing. When he found Mr Stevens, Officer C did not use an emergency code, which meant that an ambulance was not immediately requested. A minute later, Officer B radioed for healthcare staff to attend the wing, but healthcare cover had finished for the day. Approximately 30 seconds after that Officer C said on the radio that they needed an ambulance

and this was followed closely by the orderly officer confirming that it was a code blue emergency. By this time the OSG in the control room had correctly called the emergency.

56. Officer C admitted in interview that he panicked. Even so, he pressed the emergency alarm, went into Mr Stevens' cell, and supported his bodyweight until help arrived. The delay in calling for an ambulance was minimal, but in emergency situations time can be crucial. We make the following recommendation:

The Governor should ensure that all staff are aware of and use the appropriate emergency response code in a life-threatening situation.

Healthcare

57. When Mr Stevens arrived at Channings Wood he underwent an initial health screening. The nurse who conducted the screening did not have access to Mr Stevens' previous medical records. She was therefore reliant on Mr Stevens' account of his medical history. As well as telling her that he did not drink - which was not true. He also said that he had no previous mental health issues. This was also not the case: in recent months he had taken an overdose, swallowed razorblades, had been managed under ACCT procedures and was on a current course of anti-depressants. The nurse had no way of knowing this, and therefore was not best-placed to assess him. Channings Wood do not offer secondary health screenings, so no medical staff assess newly-arrived prisoners with the benefit of subsequent access to their medical records. The doctor confirmed his prescription of anti-depressants without seeing or assessing Mr Stevens.
58. Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, provides guidance on healthcare. It is important that prisoners are given a proper health screening where staff are in a position to assess their mental and physical health. The PSO states that within a week of the first reception assessment all prisoners should be offered a general health assessment. Channings Wood did not offer prisoners a secondary health screening as a matter of policy.
59. The clinical reviewer noted that relying on prisoners to provide accurate information about their health is not sufficient. Nurses performing initial health screenings should be able to access previous records. We make the following recommendations:

The Head of Healthcare should ensure that all newly arrived prisoners have an appropriate health screen that properly reviews their medical history including access to their medical records and the offence with which they were charged.

The Head of Healthcare should ensure that prisoners are offered a secondary health screening in line with PSO 3050, *Continuity of Healthcare for Prisoners*.

60. In Exeter a doctor prescribed Mr Stevens anti-depressants. When he arrived in Channings Wood his prescription was confirmed. However, his medical record contains 41 entries dating between 30 November and 29 December that indicate

that Mr Stevens did not collect his medication, although none of them explicitly state this. The Head of Healthcare said that the prison's protocol is that if a prisoner does not collect his medication for three consecutive days this should be brought to the attention of a doctor. Mr Stevens apparently did not collect his medication through most of December, but this fact was not referred to a doctor. We make the following recommendation:

The Head of Healthcare should ensure that prisoners' medication is properly monitored. When a prisoner does not collect his medication on a regular basis this fact should be referred to a doctor.

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