

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Steven Bennett a prisoner at HMP Channings Wood on 3 February 2019

**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*



© Crown copyright 2018

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Steven Bennett was found dead in his cell at HMP Channings Wood on 3 February 2019. He was 53 years old. I offer my condolences to Mr Bennett's family and friends.

Mr Bennett died from the effects of psychoactive substances (PS), which had been made worse because Mr Bennett had a serious lung condition.

The investigation found that the clinical care provided to Mr Bennett was of a good standard and at least equivalent to that which he could have expected to receive in the community.

Mr Bennett was found dead in his cell by a prisoner, shortly after 9.00am. The morning roll check that should have been carried out at 8.30am was not done, even though an officer signed to say he had done the check. An officer unlocked Mr Bennett's cell shortly before 9.00am but did not even look into the cell. The correct procedure is for officers to get a response from the prisoner at morning unlock.

These failings meant that Mr Bennett was discovered later than he should have been. I am satisfied that they did not affect the outcome, as Mr Bennett had been dead for some time when found, but such delays could be critical in other cases and it is important that unlock procedures are carried out correctly so that any welfare needs are identified.

I am concerned that Mr Bennett seemed to have easy access to PS at Channings Wood. I understand that the prison has recently revised its local drugs strategy to address its key drug issues and I hope that this will mean that drugs are less readily available in future.

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**

## **Contents**

Summary .....	1
The Investigation Process .....	3
Background Information .....	4
Key Events .....	7
Findings.....	13

# Summary

## Events

1. Mr Steven Bennett was serving a sentence of five years for burglary. He was moved to HMP Channings Wood on 25 September 2017.
2. Mr Bennett had a long history of substance misuse. He also had chronic obstructive pulmonary disease (COPD – a group of serious lung conditions including chronic bronchitis and emphysema). He received daily support from healthcare staff.
3. During his time in prison, staff suspected Mr Bennett continued to use illicit substances and possibly traded his prescribed medication with other prisoners, but there was no evidence. Mr Bennett declined to engage with substance misuse services.
4. On 3 February 2019, at around 9.02am, a prisoner found Mr Bennett unresponsive in his cell and told staff. Staff attended and radioed a medical emergency code at 9.05am. There were clear signs that Mr Bennett had been dead for some time so staff did not attempt to resuscitate him. At 9.40am, a paramedic confirmed his death.

## Findings

5. The clinical reviewer found that the care Mr Bennett received for his physical and mental health, and substance misuse, was equivalent to that which he could have expected to receive in the community.
6. We are concerned that Mr Bennett had access to PS. However, the prison has recently revised its local drugs strategy to ensure that its key drug issues are addressed. We have not therefore made a recommendation about this.
7. The 8.30am roll check was not completed on the morning Mr Bennett was found dead, even though an officer signed to say it had been. If the roll check had been done, Mr Bennett would have been discovered earlier (although it would not have affected the outcome as Mr Bennett had been dead for some time when he was found shortly after 9.00am). Disciplinary action was taken against the officer concerned.
8. The officer who unlocked Mr Bennett's cell shortly before 9.00am did not check on his welfare as he should have done, which meant that no one realised that Mr Bennett was dead until the prisoner next door discovered him. Although this made no difference to the outcome for Mr Bennett, it could be critical in other cases and it is important that prison staff carry out unlock procedures correctly so that any welfare needs are identified.
9. Prisoners remained on the landing, freely moving around the vicinity of Mr Bennett's cell, for over 20 minutes after he had been discovered. This was not acceptable.

## Recommendations

- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Governor should ensure operational managers are familiar with local contingency plans after a death in custody and they ensure the immediate area is cleared of all but essential staff and the integrity of the scene is preserved.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at Channings Wood, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Bennett's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Bennett's clinical care at the prison.
13. Mr Bennett was thought to have died from natural causes. However, when the results of the post-mortem were received and showed he died because of drug use, the investigation transferred to a second investigator.
14. The second investigator interviewed three members of staff and one prisoner on 5 June and interviewed one member of staff by telephone. The clinical reviewer interviewed two members of healthcare staff by telephone.
15. We informed HM Coroner for Plymouth and South West District of the investigation. He gave us the cause of death. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers wrote to Mr Bennett's family to explain the investigation. They did not respond.
17. The prison received a copy of the report and did not identify any factual inaccuracies.

# Background Information

## HMP Channings Wood

18. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds approximately 700 men. Care UK provides general healthcare services, Devon Partnership Trust provides mental health services and EDP Drug and Alcohol provides substance misuse services. There is nursing cover from 7.30am to 6.00pm on weekdays and from 8.30am to 5.30pm on weekends. Devon Doctors provide an out of hours GP service.

## HM Inspectorate of Prisons

19. The most recent full inspection of HMP Channings Wood was in September 2018. Inspectors reported that, although some efforts had been made to improve standards at the prison since their last inspection in October 2016, these efforts were not coordinated and previous recommendations had not been implemented. Inspectors assessed the prison outcomes as not sufficiently good in all four areas of their healthy prisons test – safety, respect, purposeful activity and rehabilitation and release planning.
20. In the HMIP survey, 76% of prisoners (compared to 49% in similar prisons) said it was easy to get drugs and more than a quarter said they had developed a drug problem at Channings Wood. The most common drug was ‘Spice’ (PS). The positive mandatory drug test (MDT) rate, including PS, was 30%. Inspectors observed many prisoners under the influence of drugs during their inspection. They considered that inadequate supervision of prisoners provided opportunities for drug misuse and associated violence.
21. Inspectors noted that the prison’s strategy to tackle the significant drug problem lacked coordination and was not integrated across key functional areas. There was no coordinated effort and little vigour to implement and drive the drug and supply reduction strategy. Records indicated that there had been no drug strategy meetings between August 2017 and March 2018. The meetings had recently been reintroduced and were now taking place every two months, although attendance by the invited departments was inconsistent. Attendance by key departments at the monthly security meeting was also poor.
22. HMIP carried out an independent review of progress at Channings Wood on 1 to 3 July 2019. Inspectors found that the prison had responded positively to the findings and recommendations from the September 2018 inspection and had moved ahead in the great majority of areas where weaknesses had been identified. Good progress had been made on ensuring all incidents of drug misuse, violence and self-harm were reported. However, insufficient progress had been made on ensuring MDT and suspicion drug testing were adequately resourced so that all testing could be undertaken within required timescales. Inspectors noted, however, that there had been improved effectiveness in the overall work to reduce the supply of illegal drugs.



## Independent Monitoring Board

23. 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 August 2018, the IMB welcomed improved staffing levels, but noted their concern about the lack of experienced staff.
24. The Board found that the long-term consequences of the smoking ban had become ever more apparent with the increase in drug use. The Board noted the addictive and often dangerous nature of 'Spice' (PS) was evident in a large part of the prison and that it was easily available. Despite numerous preventative strategies, and some significant successes, PS had 'an insidious hold over many men, creating a culture of debt, bullying and violence which has on occasion spread to prisoners' families outside'.
25. The Board found overall that morale within the healthcare department had improved. There was now a dedicated mental health manager and the stepped care model had been introduced whereby mental health needs were assessed and given the appropriate attention. In addition, daily reflection meetings involved all the staff in the discussion of newly assessed cases. This care programme approach included links to relevant agencies on release

## Previous deaths at HMP Channings Wood

26. Mr Bennett was the eighth prisoner to die at Channings Wood since February 2017. Of the previous deaths, two prisoners took their own lives, three died from natural causes and two died because of using PS. There has been one self-inflicted death since.
27. We have made previous recommendations about the need to address the availability of illegal drugs at Channings Wood.

## Psychoactive Substances (PS)

28. Psychoactive substances (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.
29. 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.

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

## Key Events

31. On 2 May 2017, Mr Steven Bennett was released from HMP Exeter on licence. On 11 May, he was recalled after he committed a further burglary offence and was taken back to Exeter. He was sentenced to five years imprisonment for this new offence on 13 June.
32. Mr Bennett had spent much of his adult life in custody. In 1991, he was diagnosed with skin cancer on his face and had radiotherapy treatment. Mr Bennett had reconstruction surgery on his nose in 2000, but his illness returned in 2016. In April 2017, Mr Bennett was given a terminal prognosis of 'many months to a few years'. In 2013, Mr Bennett was diagnosed with chronic obstructive pulmonary disease (COPD – a group of serious lung conditions including emphysema and chronic bronchitis) and he experienced breathing difficulties which progressively got worse. Mr Bennett had a long history of drug misuse.
33. While at Exeter, Mr Bennett had comprehensive healthscreens, received appropriate medication and his COPD treatment plan was regularly reviewed. Staff noted he was polite, respectful and followed the wing regime. There were no recorded instances of him being under the influence of illicit substances after he had been recalled.

## Channings Wood

### 2017

34. Mr Bennett was moved to HMP Channings Wood on 25 September 2017. An officer completed Mr Bennett's induction. He noted that Mr Bennett said he had no issues, no thoughts of suicide or self-harm and that on Mr Bennett's Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons that sets out the risks they pose), he had a history of involvement with drugs while in prison.
35. In October, Mr Bennett applied for his enhanced IEP status which wing staff supported. He was upgraded on 8 November and, on 23 November, Mr Bennett was moved to Living Block 2 (LB2) the enhanced wing. On 18 December, Mr Bennett was told that he would not be considered for open conditions (category D) because of his history of non-compliance.

### 2018

36. Throughout 2018, Mr Bennett continued to comply with the prison regime. He was not able to participate in employment or many of the wing activities, due to his physical illnesses and breathing difficulties. There were regular multidisciplinary team meetings held where the clinical care and support that Mr Bennett required was discussed.
37. On 29 May, Mr Bennett was suspected to be under the influence of psychoactive substances (PS, often known as 'Spice'). Although there is no entry on his prison record, a nurse made an entry in Mr Bennett's medical record the next day and noted staff had been told by other prisoners on the wing that Mr Bennett was

using PS. The nurse also noted that Mr Bennett had been using nebulisers more frequently and a prison GP had given him advice on how he should use these. The nurse noted that he would discuss Mr Bennett with a prison GP. Later, at 3.55pm, a prison GP noted in Mr Bennett's medical record that he was suspected to have been under the influence of PS, that Mr Bennett was 'seemingly playing staff off against each other' and not using his medication as prescribed and that he would be discussed at a multidisciplinary team meeting.

38. On 7 June, staff submitted an intelligence report (IR) as Mr Bennett had been associating with a prisoner known to distribute PS. On 2 September, staff submitted an IR after there was an altercation between Mr Bennett and other prisoners while they were queuing to receive their medications. On 14 September, staff submitted a further IR that noted Mr Bennett was possibly selling, or being bullied, for his pain relief medication (pregabalin – a highly tradeable drug in prison).
39. Over the next few months, Mr Bennett's physical health deteriorated. A prison GP was concerned his skin cancer had returned, he had an admission to hospital because of breathing difficulties related to his COPD and he was losing weight. Mr Bennett was examined by hospital specialists and was prescribed pain relief and nutritional drinks. The prison GP reviewed him regularly.
40. On 10 October at 11.58am, a safer custody administrator recorded on Mr Bennett's prison record that she had been chasing healthcare and the mental health team since July, for information to support Mr Bennett being a high-risk cell sharing risk assessment (CSRA) and that he should be given a single cell because of his health needs. She updated this entry on 30 October, that she had received comments and passed the CSRA form to a Custodial Manager (CM) to authorise Mr Bennett as a standard risk. However, despite the CSRA risk assessment, Mr Bennett was located in a single cell on the ground floor of LB2.
41. On 29 October, staff submitted an IR which noted Mr Bennett was suspected of selling his prescription medication for PS, and that he had previously been suspected of doing so.
42. On 14 December at 11.41am, a prison GP completed a routine review of Mr Bennett's health. She noted that he appeared anxious, struggled to keep focused on the conversation, that he had a fixation with the number 2 and that his ideas had been stolen by big corporations to counter terrorism. She diagnosed hypomanic behaviour and she referred Mr Bennett for an urgent mental health assessment. She was concerned that Mr Bennett's cancer had spread to his brain and requested urgent blood tests. She informed prison staff of her concerns about his grandiose behaviour. She discussed Mr Bennett's symptoms with a consultant psychiatrist and then prescribed Mr Bennett with antipsychotic medication (10mg olanzapine).
43. On 17 December, a social worker from the mental health team, completed a comprehensive mental health assessment. She noted that Mr Bennett said he had used PS every day until his cancer diagnosis in 2016. Mr Bennett said that he no longer used PS regularly, but on occasion would smoke a cigarette passed around on the wing to tell other prisoners if it contained PS but said he had not done this recently. A social worker noted that Mr Bennett had delusional and

racing thoughts and that he had disclosed that his son had been sent to prison (and had accrued drug debts) and the stress of learning this information coincided with him becoming more agitated. The social worker diagnosed that Mr Bennett was having a manic episode and placed Mr Bennett on the care programme approach (CPA - used to support those with complex mental health needs).

44. On 19 December, a prison GP reviewed Mr Bennett. He said that he felt calmer and other prisoners had commented that he seemed less irritable, but that he thought the effects of his medication were wearing off. The prison GP increased the dose of his olanzapine to 15mg. The prison GP referred Mr Bennett for an urgent head scan. Mr Bennett had the scan two days later, but there had been no change in his clinical condition and the hospital confirmed that the cancer had not spread to his brain.
45. On 26 December, staff submitted an IR that said Mr Bennett had been receiving money into his account from other prisoners' families and that it was suspected he was buying and selling prescription medication.
46. On 30 December at 11.22am, an officer recorded in Mr Bennett's prison record, 'Polite individual. No concerns on the wing. Gets on well with his peers. Unfit to work due to poor health which he doesn't help.' This was the last entry made in Mr Bennett's prison record before he died.

## 2019

47. On 8 January 2019, a member of staff from the mental health team, reviewed Mr Bennett's mental health. He said that he felt calmer since taking olanzapine and that his mental health was stable. Mr Bennett reflected that he thought it may have been triggered by the news of his son, and that his moods fluctuated and that he thought he may have a multi-personality disorder. Mr Bennett said that he felt better and had received good news about his physical health. She recorded that Mr Bennett was to be reviewed by Dr Fee on 11 January.
48. On 10 January, a prison GP reviewed Mr Bennett. She noted that he reported that he 'still feels speeded up' and that he still had some delusional thoughts and grandiose behaviour.
49. The next day a prison GP assessed Mr Bennett. The prison GP noted there were no signs of psychotic symptoms, but that Mr Bennett still presented as manic with pressured speech and expansive ideas. The prison GP noted that Mr Bennett reported feeling better since he started his olanzapine medication, which the prison GP continued with a view to reassessing Mr Bennett in a couple of months.
50. On 21 January, a nurse reviewed Mr Bennett's mental health. The nurse recorded that Mr Bennett spoke about some bizarre situations (an anti-terrorist shield he had made) and that he had magazines wrapped around his body which he told the nurse was a knife-proof jacket. Mr Bennett said he was anxious about his pregabalin medication being reduced, about being released and that his main concern was his accommodation. The next day, the nurse noted in Mr Bennett's medical record that he had arranged for Mr Bennett to be reviewed by

a prison GP on 1 March and that he would continue to be monitored by healthcare staff as part of the CPA.

51. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to the calls Mr Bennett made between 26 January and 2 February, when he made his last call. In total he made 12 calls, totalling over two and a half hours, to his daughter and mother and he also left several voicemail messages for his brother. Mr Bennett typically spoke about what he had been doing in prison, that he was looking forward to seeing his family and his plans when he was released. During a telephone call on 26 January, Mr Bennett told his mother that other prisoners were being aggressive and demanding his medication but laughed and said he had punched the last person that asked for his medication. Mr Bennett did not sound concerned. Mr Bennett went on to say that he had not abused prescribed medication and had not used PS in over a year. Mr Bennett told his mother he was 'coming off' pregabalin.
52. On 31 January, Mr Bennett spoke to his mother and during the conversation reassured her that he had 'not used drugs for ages'.
53. On 2 February at 9.30am, Mr Bennett spoke to his mother for around 20 minutes. During the call Mr Bennett was trying to encourage his mother to go out and they began to have a disagreement about the fact she would not ask for help. Mr Bennett became frustrated and said he was upset and the call ended abruptly. Mr Bennett then contacted his brother and left a voicemail asking him to help their mother. Mr Bennett contacted his mother again at 11.26am, and he apologised and told her that he loved her. Mr Bennett attempted to contact his brother again at 1.48pm, and left a long message asking him to help their mother. This was the last call Mr Bennett made.
54. An officer spoke to Mr Bennett several times during the day. He said Mr Bennett had asked about his medication and for a temporary ID card as he had lost his. The officer said Mr Bennett seemed no different from previous interactions and did not make him aware of any issues or concerns.
55. Mr Bennett was last seen alive at 5.15pm when an officer completed a roll check. The officer said Mr Bennett's cell door was wide open, he entered and saw Mr Bennett asleep in his chair and locked the cell door. An officer completed a roll check at 7.30pm.

### **Sunday 3 February**

56. Closed circuit television (CCTV) shows an Operational Support Grade (OSG), started his morning roll check at around 5.45am. (CCTV footage shows the time as 6.01am, but the CCTV timestamp was 16 minutes slow.) The OSG used his torch while opening the observation panels of each cell to complete his checks. However, when he arrived at Mr Bennett's cell he did not use his torch. CCTV shows he remained outside Mr Bennett's cell for 37 seconds, and he appeared to be looking through the observation panel. He continued his checks on the opposite side of the landing, using his torch each time he opened the observation panel.



57. The OSG told the investigator that Mr Bennett must have had his night light on if he had not used his torch. He said he could not see Mr Bennett at first, but then realised he was sitting in his chair, asleep. He said he watched him to check he was not about to fall, but then was satisfied he was not going to and had no concerns.
58. An officer started his early shift at around 7.40am and took over from the OSG. The officer signed the roll sheet at around 8.30am, but CCTV shows that he did not complete this check.
59. At around 8.50am, an officer started to unlock cells on LB2 Lower Severn. CCTV shows the officer unlocked Mr Bennett's cell without looking through the observation panel or entering the cell, and then quickly moved to the next door.
60. CCTV shows a prisoner in the cell next door, came out of his cell at 9.00am, put his jacket on and went to Mr Bennett's cell. The prisoner knocked on Mr Bennett's door, walked away, but returned around a minute later when he entered the cell. At 9.02am, he left the cell and quickly walked towards the wing office to tell them that Mr Bennett was unresponsive.
61. CCTV shows around 9.04am, two officers accompanied by the prisoner, returned to Mr Bennett's cell. The officers entered Mr Bennett's cell and found him slumped forward in his chair (the chair was facing away from the cell door). An officer said an area of skin around Mr Bennett's lower back where his clothing was raised, was mottled and blue. The officer could not get a response from Mr Bennett and said that he was cold, stiff and there were no signs of a pulse or breathing.
62. The other officer immediately used his radio to call a code blue medical emergency (indicating that a prisoner is unconscious or having difficulty breathing) at 9.05am. South West Ambulance Service records confirm this was the time the ambulance was requested.
63. A nurse and a healthcare assistant responded to the emergency code. They arrived at Mr Bennett's cell at 9.08am and, as it was clear Mr Bennett was dead, they did not start cardiopulmonary resuscitation (CPR). The nurse recorded that Mr Bennett was slumped forward with his head and hands touching the floor and that there were obvious signs Mr Bennett had been dead for some time: he had rigor mortis, his blood had pooled due to no circulation and he was very cold. Due to rigor mortis, Mr Bennett was not moved.
64. Paramedics attended, assessed Mr Bennett and recorded he was dead at 9.40am. Paramedics noted that there were obvious signs Mr Bennett had been dead for some time.

### **Contact with Mr Bennett's family**

65. The Deputy Governor travelled to London to break the news of Mr Bennett's death to his daughter. The prison later appointed a CM as the family liaison officer (FLO), and she contacted Mr Bennett's daughter the next day to offer her condolences and provide ongoing support. The prison contributed towards the costs of Mr Bennett's funeral, held on 28 February, in line with national policy.

### **Support for prisoners and staff**

66. A prison manager spoke to all the staff involved in the emergency response, including healthcare staff. Staff told the investigator that they felt well supported, although they would have liked to have had more information about the process after a death in custody.
67. The prison posted notices informing other prisoners of Mr Bennett's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Bennett's death. The prisoner said he felt well supported by staff.

### **Post-mortem report**

68. A post-mortem examination and toxicology tests concluded that Mr Bennett died because he used PS, while suffering from severe COPD.



# Findings

## Drugs strategy

69. Mr Bennett died from the effects of PS. On several occasions, staff suspected that Mr Bennett was using PS, but they had no evidence. They submitted intelligence reports on each occasion in line with the prison's Substance Misuse Strategy. Mr Bennett denied using PS and declined to be referred to substance misuse services.
70. Channings Wood has a comprehensive Substance Misuse Strategy dated 2018/2019 and a Supply Reduction Strategy dated June 2018, which are reviewed and updated annually. The strategies set out the objectives to prevent supply and reduce the demand for illicit substances. A drug supply reduction action plan is completed and reviewed each month and sets out the targets for cell searches, visitor and staff searching and the process for referring those found under the influence of illicit substances to substance misuse services.
71. Since Mr Bennett's death, Channings Wood have introduced further measures to prevent illicit drugs entering the prison. In addition to extra security fencing to prevent prisoners gaining access to the perimeter fence to collect packages that have been thrown over, mail is now photocopied when intelligence suggests PS is being sent in. A radio 'code orange' announcement has been introduced which prompts staff to lock all gates when a package is thrown into the prison, which has led to the recovery of parcels of drugs and mobile phones and Channings Wood have held several drug amnesties. Channings Wood provided evidence that since these additional measures have been put in place, the number of positive drug tests has reduced.
72. Six months before Mr Bennett's death, another prisoner at Channings Wood died from the effects of PS. Following our investigation into that death, we recommended that the prison should identify its key drug issues and revise its local drugs strategy to address them by September 2019. The prison told us in response that the local drugs strategy had been reviewed and revised in September and will be reissued in October. We therefore make no recommendations.

## Clinical care

73. The clinical reviewer concluded that the care provided to Mr Bennett for both his physical and mental health was of a good standard and at least equivalent to that which he could have expected to receive in the community.

## *Physical health*

74. The clinical reviewer found that throughout his time at Channings Wood prison doctors provided an appropriate level of care. There is evidence of swift action to refer Mr Bennett for routine as well as urgent hospital care when the circumstances warranted this. The management of his COPD was found to be in line with NICE guidelines and prescription medications were in keeping with current best practice.

## *Mental health*

75. Mr Bennett was physically frail and he experienced traumatic childhood flashbacks, as well as having a long history of imprisonment. During a previous sentence he had been assessed for psychiatric help. In December 2018, a prison GP acted promptly when it became evident that Mr Bennett had developed mania and she appropriately prescribed medication (olanzapine) to ease Mr Bennett's symptoms after seeking advice from a consultant psychiatrist.
76. Mr Bennett was also assessed by an assistant psychologist on 8 January, who started a secondary care mental health referral. A prison GP assessed Mr Bennett on 11 January 2019, and a psychiatry care plan was started which remained at the time of Mr Bennett's death.

## **Roll check**

77. An officer did not complete the roll check on the morning of 3 February, despite signing the roll sheet at 8.30am to say he had completed the check. If the officer had completed the roll check, Mr Bennett would have been discovered sooner. However, this would not have changed the outcome as there were obvious signs, he had been dead for some time when he was discovered shortly after 9.00am. Channings Wood have already investigated the officers' actions, under the terms of PSI 06/2010, *Conduct and Discipline*, which we would otherwise have recommended. The Officer was issued with a Final Written Warning on 16 May.

## **Unlock procedures**

78. Prison Service Instruction 75/2011 Residential Services states:

"Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable..."

"[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."
79. On 3 February, when an officer unlocked Mr Bennett's cell, he should have checked his welfare and obtained a response from him. The officer said he was aware that best practice at unlock was to obtain a response from each prisoner, but that the regime was running late and he was keen to unlock prisoners as quickly as possible. The officer said he believed that a roll check had already been completed around half an hour earlier, when prisoners should have been checked so he did not envisage there would be any problems.
80. Prisoners interviewed said being asked for a response in the morning differed across houseblocks, and that some officers did, but not all. Having spoken to many officers, the investigator concluded that it was accepted practice for staff at Channings Wood not to routinely obtain a response from prisoners when unlocking cells and some officers did not know they were required to do so.

**The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.**

### Incident management

81. CCTV footage shows prisoners remained on the landing for over 22 minutes, and could move around, often close to Mr Bennett's cell, despite staff standing outside. An officer told the investigator that he had asked some prisoners to clear the landing, but said he was focused on what was happening to Mr Bennett. A CM said in his written statement he instructed A Senior Officer (SO) to remain at Mr Bennett's cell and to keep a log of events. A CM said he also covered the windows and observation panel to preserve Mr Bennett's dignity. However, there did not seem to be a coordinated response by staff to clear the landing or ensure prisoners did not loiter in the immediate area near Mr Bennett's cell.
82. It is important that, where a death occurs inside the prison, the immediate area is kept clear of people other than essential members of staff, and the integrity of the scene is preserved. We therefore make the following recommendation:

**The Governor should ensure operational managers are familiar with local contingency plans after a death in custody and they ensure the immediate area is cleared of all but essential staff and the integrity of the scene is preserved.**

### Support for staff

83. PSI 08/2010 – Post Incident Care, states: The Governor must have a local policy to identify the staff responsible for ensuring access to post incident care. In an investigation into a previous death at Channings Wood, we identified there was no effective care team, and, in response, a Governor's Notice 187/2016 was issued on 23 June 2016 saying that a staff care team would be reintroduced. We found deficiencies in staff support during subsequent deaths in February 2017 and May 2018.
84. We found that Channings Wood has now established a Post-Incident Care Team comprising of twelve trained members of staff from various areas across the prison, including healthcare. Some staff we interviewed during the investigation into the circumstances surrounding the death of Mr Bennett said they would have liked more information and support regarding the investigation. All staff were offered formal support.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations