

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Connor Blampey a prisoner at HMP Channings Wood on 28 January 2018

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mr Connor Blampey died on 28 January 2018 at HMP Channings Wood due to sudden death associated with the use of synthetic cannabinoids. Mr Blampey was 21 years old. I offer my condolences to Mr Blampey's family and friends.

Mr Blampey had a significant history of drug abuse. I am concerned that while Channings Wood has taken steps to reduce the supply and demand for drugs, on the facts of this case these have not been sufficient. I am concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In my view there is now an urgent need for national guidance on the best measures to combat this serious problem. I have recently made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service.

Although staff offered Mr Blampey support and made him aware of the dangers of using illicit substances, I am concerned that only a limited number of prisoners have had access to a Psychoactive Substance Awareness Group, despite these drugs being widely available in the prison. I am also concerned that two officers did not submit intelligence reports about Mr Blampey's use of illicit substances which meant that appropriate action to address this could not be considered.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

February 2019

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Summary

Events

1. On 26 August 2017, Mr Connor Blampey was remanded to HMP & YOI Exeter on suspicion of theft and violent offences. On 27 September, he was sentenced to 30 months imprisonment.
2. On arrival at Exeter, Mr Blampey admitted to a history of substance misuse so a nurse referred him to the Integrated Substance Misuse Service (ISMS). Mr Blampey refused to engage with ISMS.
3. On 12 January 2018, Mr Blampey was moved to HMP Channings Wood. On arrival, he changed his next of kin from a friend to his mother. During an initial health screen, Mr Blampey denied using drugs in the last month and refused a referral to ISMS. However, on 15 January, Mr Blampey told an administrator that he wanted to engage with ISMS.
4. On 18 January, a substance misuse recovery worker saw Mr Blampey for an ISMS induction. He confirmed that he wanted help and said that the main substances he misused were Valium, stimulants, cannabis and alcohol. The recovery worker reminded him of the risks of using drugs. He considered Mr Blampey was at risk from overdose through poly-substance use, particularly from benzodiazepine and alcohol, so planned for him to attend sessions on the risks associated with depressant substances. These sessions had not taken place before Mr Blampey's death.
5. At approximately 11.15am on 28 January, an officer saw Mr Blampey walking unsteadily when collecting his lunch. The officer visited Mr Blampey's cell and found an adapted inhaler, which he thought was a sign that Mr Blampey had been using psychoactive substances (PS).
6. Later that day, the officer and a senior officer visited Mr Blampey's cell and spoke to him about the dangers of using PS. After leaving Mr Blampey's cell, the officers completed a referral to the ISMS team but did not submit an intelligence report.
7. At 7.26pm, an officer looked through Mr Blampey's observation panel, as part of a roll check, and saw him lying on the floor directly against the cell door. The officer called Mr Blampey's name and kicked the cell door but he did not respond. A minute later, the officer asked for assistance because Mr Blampey was unresponsive, and four officers responded. The officers opened the anti-barricade door (the cell door opens outwards after certain parts of the door are removed) and found that Mr Blampey was not breathing and had vomited profusely. The officers started cardiopulmonary resuscitation (CPR) and a control room operator immediately called for an ambulance.
8. Paramedics reached Mr Blampey at 7.38pm and they took over the resuscitation attempt. However, they were unable to resuscitate him and a paramedic declared Mr Blampey's death at 8.00pm.

Findings

Substance misuse

9. Mr Blampey had a significant history of alcohol and drug abuse. Numerous substance misuse and prison staff tried to engage with and support him. We agree with the clinical reviewer that Mr Blampey's substance misuse care was equivalent to that which he could have expected to receive in the community.
10. We acknowledge that Channings Wood has taken significant steps to reduce the supply and demand for drugs in the establishment, which include regular amnesties, increased searching of staff and ISMS visits to Mr Blampey's former wing to highlight the risks of using drugs. However, we are concerned that these steps have not proved to be enough and we are particularly concerned that limited resources have been allocated to a PS Awareness Group, despite the apparent scale of the problems posed by PS.

Intelligence

11. While we note that two officers spoke to Mr Blampey about his illicit drug use, we also note that they did not submit intelligence reports about this. This limited the prison's understanding of the scale and nature of illicit drug use by prisoners.

Emergency response

12. The officer who found Mr Blampey could not tell whether he was unconscious and not breathing, as he was lying against the door. On that basis, we agree that it was appropriate that the officer did not call a code blue emergency and did not enter the cell on his own.

Family liaison

13. Mr Blampey changed his next of kin from a friend to his mother but his electronic prison record was not updated. Although Mr Blampey's mother was correctly contacted when he died, we are concerned that this information was not immediately updated.

Staff support

14. Following Mr Blampey's death, two officers and a member of the prison's care team did not attend the hot debrief. We consider that all staff involved in an incident should attend a hot debrief and we are also concerned that the lack of a member of the care team delayed the provision of formal support to one of the officers.

Recommendations

- The Governor and Head of Healthcare should take steps to enable more prisoners to attend the Psychoactive Substance Awareness Group sessions.
- The Governor should ensure that staff submit intelligence reports about the use or trafficking of drugs, in line with national guidelines.

- The Governor should ensure that details for a prisoner's next of kin are recorded on reception and promptly added onto their NOMIS prison record.
- The Governor should ensure that all managers follow the national guidelines for dealing with a death in custody or serious incident, including that:
 - A debrief is held promptly after the death of a prisoner and that all staff that are involved and a member of the care team are invited.
 - A member of the care team will ensure staff are aware of the support mechanisms available and how to access them.
 - All staff directly involved in an incident should complete Incident Report Forms as soon as possible.

The Investigation Process

15. 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 him. No one responded.
16. The investigator visited Channings Wood on 5 February 2018. He obtained copies of relevant extracts from Mr Blampey's prison and medical records, and interviewed one prisoner.
17. NHS England commissioned a clinical reviewer to review Mr Blampey's clinical care at the prison.
18. The investigator interviewed ten members of staff at Channings Wood on 20 and 21 March. The clinical reviewer accompanied the investigator for two of the interviews. The investigator also interviewed another member of staff by telephone on 7 March.
19. We informed HM Coroner for Torbay and South West Devon District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. One of the Ombudsman's family liaison officers spoke to Mr Blampey's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted more information on what happened to Mr Blampey on 28 January and how he was found. She also asked some questions that are not relevant to the circumstances of Mr Blampey's death, and which have been answered in separate correspondence.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.
22. Mr Blampey's mother received a copy of the initial report. The solicitor representing Mr Blampey's mother wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Channings Wood

23. 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 provides an out of hours GP service.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Channings Wood was in October 2016. The Inspectorate reported that, overall, the prison had deteriorated since their last inspection in 2012. The Inspectorate found that over half the prison population said that it was easy to obtain illicit substances in the prison and the abuse of psychoactive substances (PS) was widespread. They noted that the availability of PS was a significant problem, which posed a threat to the safety of prisoners and the stability of the prison.
25. The Inspectorate found that new arrivals received at the prison received information about the dangers of PS and that most prisoners found that the support that they had received from the substance misuse team was helpful. They also found that substance misuse recovery plans were detailed and of high quality.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 August 2017, the IMB found that illegal substances were very easy to obtain at the establishment and that some officers appeared to turn a blind eye to prisoners using PS in their cells. The IMB was concerned that the substance misuse team had reduced in size and that changes to the regime impacted on prisoners attending substance misuse programmes and interventions.

Previous deaths at HMP Channings Wood

27. Mr Blampey was the 11th prisoner to die at Channings Wood since January 2015, but the first to die due to using illicit substances. There has been one subsequent death due to a prisoner taking their own life. We have made a previous recommendation about supporting staff appropriately after a death.

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 26 August 2017, Mr Connor Blampey was remanded to HMP & YOI Exeter on suspicion of theft and violent offences.
32. On arrival at Exeter, Mr Blampey listed a friend as his next of kin. During the induction process, a nurse performed an initial health screen on Mr Blampey and he admitted to a history of substance misuse, including abusing diazepam (a tranquilliser, also known as Valium) and ecstasy. She tested Mr Blampey's urine and found it was positive for benzodiazepine (tranquilliser) but negative for all other substances so referred him to the Integrated Substance Misuse Service (ISMS).
33. Later that day, a substance misuse nurse practitioner saw Mr Blampey, who said that he only misused benzodiazepine and alcohol. He took his basic observations and gave advice on the dangers of drug use.
34. From 26 August, staff submitted six intelligence reports that Mr Blampey was thought to be under the influence of an illicit substance on three occasions, thought to be supplying drugs on two occasions and thought to be trafficking illicit items between wings on one occasion. In response to these intelligence reports, staff referred Mr Blampey for a mandatory drug test and performed a cell search.
35. Between 27 and 31 August, various ISMS staff checked on Mr Blampey's withdrawal from drugs, and gave him advice and support.
36. On 5 September, an ISMS recovery worker asked Mr Blampey whether he wanted to engage with them but he refused as he said he wanted to wait until sentenced. Mr Blampey said that he was not using illicit substances on the wing but might use benzodiazepine if available. He explained the dangers of using illicit substances to Mr Blampey.
37. On 14 September, a nurse examined Mr Blampey after another prisoner had bitten him. She considered that he had used psychoactive substances (PS) because he slurred his words, had bloodshot eyes and walked unsteadily. After checking his basic observations, she asked officers to check on him and for ISMS to review him.
38. On 17 September, a nurse examined Mr Blampey after officers thought that he was under the influence of an illicit substance. Mr Blampey refused any help and only her his pulse rate. She considered that he had misused PS so an officer placed Mr Blampey on report. During the adjudication hearing, held on 6 October, Mr Blampey was found guilty and was given an additional sentence of 16 days imprisonment.
39. On 22 September, an ISMS recovery worker asked Mr Blampey whether he wanted to engage with them but he refused. She told Mr Blampey how he could engage with ISMS in the future.
40. On 27 September, Mr Blampey was sentenced to 30 months imprisonment for his offences.

41. On 23 October, a nurse checked that Mr Blampey had swallowed his medication but found that he had stored it in his right cheek. She challenged Mr Blampey, who proceeded to swallow the tablets. She also recorded that an officer placed Mr Blampey on report for trying to divert his medication, though there was no record that this happened.
42. On 28 November, an officer placed Mr Blampey on report for being in possession of two “herbal substances”. During the adjudication hearing, held on 12 January, Mr Blampey was found guilty and was given an additional sentence of 18 days imprisonment suspended until June 2018.
43. On 23 December, a locum GP stopped Mr Blampey’s trazodone prescription (used to treat major depressive disorder) after an officer saw him passing the medication to another prisoner. He spoke to Mr Blampey about this, though he denied it and wanted his prescription restored.
44. On 8 January 2018, an administrator reviewed Mr Blampey’s security category as he had turned 21 years old two days earlier. She recommended that he was classified as a category C prisoner (prisoners who cannot be trusted in open conditions but who are unlikely to try to escape).
45. Four days later, Mr Blampey was moved to HMP Channings Wood. On arrival, he listed his mother as his next of kin but no one updated his electronic prison record. During the induction process, a nurse performed an initial health screen on Mr Blampey, who denied using drugs in the last month and refused a referral to ISMS. However, on 15 January, Mr Blampey told an administrator, that he wanted to engage with ISMS. She allocated Mr Blampey to a substance misuse recovery worker.
46. On 17 January, a pharmacy technician saw Mr Blampey about his stopped trazodone prescription. He felt that he should receive the prescription again so she referred him to a prison GP.
47. On 18 January, the substance misuse recovery worker saw Mr Blampey for an ISMS induction, who confirmed that he wanted help and that the main substances he misused were Valium, stimulants, cannabis and alcohol. He also said that he was suffering with depression and wanted to be referred to the mental health team. During the induction, he noted that Mr Blampey presented as sober and there were no indications that he had recently used any substances.
48. He assessed that Mr Blampey was at risk from substance misuse in prison, as he had previously overdosed using PS, so reminded him of the risks of using drugs. He also assessed that Mr Blampey was at risk from overdose through poly-substance use, particularly from benzodiazepine and alcohol, so planned for him to attend sessions on the risks associated with depressant substances. He planned for Mr Blampey to finish the risk awareness sessions by 18 March, though they had not started before he died, and to see him again on 19 April. He also referred Mr Blampey to the mental health team but they did not see him before he died.

49. On 24 January, a prison GP saw Mr Blampey to discuss his trazodone prescription. Mr Blampey said that it helped him when he felt low in mood or anxious so she decided to restart it, though he would not be allowed to keep it in his possession. She also referred Mr Blampey to the mental health team but they did not see him before he died. She told the investigator that Mr Blampey spoke proudly about being “clean” during the discussion.

Events of 28 January 2018

50. At approximately 11.15am on 28 January, an officer saw Mr Blampey collect his lunch from the servery and noticed that he seemed unsteady on his feet. The officer visited Mr Blampey in his cell and found an adapted inhaler and paperclips placed into one of the electricity sockets. He thought that these were signs that Mr Blampey had been using drugs so he took the inhaler and asked Mr Blampey to remove the paperclips. He left Mr Blampey’s cell and spoke to a Senior Officer (SO) about what he had found.
51. At approximately 11.30am, the officer and SO visited Mr Blampey’s cell and spoke to him about the dangers of using PS. The officer and SO told the investigator that Mr Blampey appeared to understand what they were saying and that he answered their questions without slurring his words.
52. After leaving Mr Blampey’s cell, the officer added an entry to Mr Blampey’s electronic prison record and completed a referral to the ISMS team. He told the investigator that he intended to hand deliver Mr Blampey’s referral the following morning because that was the earliest that someone from ISMS would be in the prison. The officer and SO also told the investigator that they did not place Mr Blampey on report or submit an intelligence report.
53. At approximately 4.20pm, the officer saw Mr Blampey talking to another prisoner, who he also suspected of using PS that day. He spoke to both prisoners and reiterated the dangers of using PS.
54. The investigator reviewed CCTV footage that overlooked Mr Blampey’s cell and saw that he briefly left his cell at 5.07pm. Mr Blampey walked normally to a gated doorway, appeared to pass something to another person (only their arms were seen on the footage) and then walked back into his cell. Mr Blampey did not leave his cell again and the officer locked his cell door at 5.08pm. The CCTV footage, provided to the investigator, cannot be played between 5.26pm and 5.55pm.
55. The CCTV footage shows that, at 7.24pm, an officer started a roll check on Avon Wing to check that all prisoners were present and to check on their welfare. Two minutes later, he reached Mr Blampey’s cell, looked through the observation panel and saw him lying on the floor directly against the cell door. He called Mr Blampey’s name and kicked the cell door but he did not respond. At 7.27pm, he asked for assistance because Mr Blampey was unresponsive. An officer arrived first, quickly followed by two other officers and a prison manager.
56. The officers tried to open Mr Blampey’s cell door but he was blocking the door from opening wide enough to allow access. An officer collected a key from the wing office, which allowed the officers to open the anti-barricade door (the cell

door opens outwards after certain parts of the door are removed). The officers entered Mr Blampey's cell and found that he was not breathing and had vomited profusely. The officers started cardiopulmonary resuscitation (CPR) and attached a defibrillator but it did not detect a shockable heart rhythm and advised to continue CPR.

57. The prison manager asked for an emergency ambulance and a control room operator immediately called for an ambulance. The South Western Ambulance Service log confirmed that they received the call at 7.29pm. Paramedics reached Mr Blampey at 7.38pm and they took over the resuscitation attempt. They gave him adrenaline but they were unable to resuscitate him and a paramedic declared Mr Blampey's death at 8.00pm.

Contact with Mr Blampey's family

58. Following Mr Blampey's death, the head of reducing reoffending checked his prison records and found that he had listed two people as his next of kin, his mother and a friend. He decided that the document listing Mr Blampey's mother as his next of kin had been completed more recently and that contact should be made with her.
59. At 10.40pm, a deputy governor visited the home address of Mr Blampey's mother to break the news of his death and to offer his condolences and support. Mr Blampey's mother agreed to contact his other next of kin.
60. On 29 January, the prison appointed a prison manager as the prison's family liaison officer. At 2.30pm, shortly after being appointed, she telephoned Mr Blampey's mother to offer her condolences and support.
61. She continued to support Mr Blampey's mother and other family members until his funeral. Mr Blampey's funeral was held on 15 February 2018 and the prison paid for the costs of the funeral in line with national instructions.

Support for prisoners and staff

62. After Mr Blampey's death, the head of reducing reoffending debriefed three of the members of 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 did not attend the debrief but offered support by telephone and text message.
63. The prison posted notices informing other prisoners of Mr Blampey's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Blampey's death.
64. Staff from the prison's Safer Custody department and ISMS team also spoke to the prisoners that lived on Mr Blampey's wing to offer them support and advice on the risks from PS.

Post-mortem report

65. The post-mortem report concluded that Mr Blampey's death was sudden death associated with the use of synthetic cannabinoids (PS), which toxicology tests

detected in his blood and urine. The pathologist found evidence that some of Mr Blampey's stomach content entered his lungs, a terminal event in individuals suffering with reduced consciousness caused by use of synthetic cannabinoids.

Findings

Substance misuse

66. On arrival into custody, Mr Blampey had a significant history of alcohol and drug abuse. During his time in custody, numerous substance misuse staff attempted to engage with and support Mr Blampey, though he often refused their offers. In January 2018, after arriving at Channings Wood, Mr Blampey accepted support from the ISMS team and they acted quickly in allocating him to the substance misuse recovery worker. We are satisfied that the substance misuse recovery worker saw him promptly, warned him about the dangers of using drugs and created a suitable recovery plan, which included planning for him to attend sessions on the risks from depressant substances.
67. On the day of his death, an officer and a SO spoke to Mr Blampey about his illicit drug use and warned him about the dangers. The officer also removed drug-related items from Mr Blampey's cell. Overall, we agree with the clinical reviewer that Mr Blampey's substance misuse care was equivalent to that which he could have expected to receive in the community.
68. During the investigation, senior managers explained the steps that Channings Wood had taken to reduce the supply of drugs into the establishment. These included regular amnesties, increased searching of staff entering the establishment and an increased security presence during weekend family visits.
69. We also note that following Mr Blampey's death, the ISMS team visited his former wing to highlight the risks of using drugs in an attempt to reduce the demand for illicit substances, particularly PS. The substance misuse lead nurse also told the investigator that the ISMS team holds a weekly PS Awareness Group, though due to staff shortages only ten to 14 prisoners can attend, at any one time. The Group is a rolling three-week course. In the most part, we are satisfied that Channings Wood has taken such steps as it can to reduce the supply and demand for drugs, though we are concerned that so few prisoners can attend the PS Awareness Group, despite HM Inspectorate of Prisons finding that PS was easily available and abuse was widespread. We make the following recommendation:

The Governor and Head of Healthcare should take steps to enable more prisoners to attend the Psychoactive Substance Awareness Group sessions.

Intelligence

70. While we note that an officer and a SO spoke to Mr Blampey about his illicit drug use, we also note that they did not submit intelligence reports about Mr Blampey's use of PS. By failing to do so, they limited the prison's understanding of the nature, scale and scope of illicit drug use and the drug supply routes. This is particularly concerning given the head of security, told the investigator that Channings Wood did not have a full intelligence picture when Mr Blampey died. We make the following recommendation:

The Governor should ensure that staff submit intelligence reports about the use or trafficking of drugs, in line with national guidelines.

Emergency response

71. Prison Service Instruction (PSI) 03/2013, 'Medical Emergency Response Codes', contains a mandatory instruction that staff must call a code blue if a prisoner is not breathing or is unconscious.
72. PSI 24/2011, 'Management and Security of Nights', states that staff have a duty of care to prisoners and that preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be immediate danger to life then a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.
73. When an officer checked on Mr Blampey, he found that he was lying against the cell door. Mr Blampey's position meant that the officer could not tell whether he was unconscious or not breathing. As he was only sure that Mr Blampey was unresponsive, he asked for assistance from his colleagues rather than calling a code blue emergency. He also did not enter Mr Blampey's cell on his own.
74. The first officer to respond told the investigator that Mr Blampey was "literally right up against the door curled in a ball" and that "you couldn't see anything sort of skin-wise of him to be able to see how he was". An officer agreed with the other officers and told the investigator that Mr Blampey was "slumped right behind the door".
75. As an officer could not accurately tell whether Mr Blampey was unconscious and not breathing, we agree that it was appropriate that he did not call a code blue emergency and did not enter the cell on his own.

Family liaison

76. PSI 07/2015, 'Early Days in Custody', sets out the guidance and mandatory actions for prison staff to follow when prisoners arrive at and are inducted into a new prison. This includes that the name and contact details of the prisoner's next of kin must be recorded in their core record and on their electronic prison record.
77. When Mr Blampey arrived at Channings Wood, he decided to change his next of kin from a friend to his mother. A member of staff recorded this on Mr Blampey's induction paperwork but his electronic prison record was not updated. While we are satisfied that the head of reducing reoffending correctly decided that Mr Blampey's mother was his next of kin, we are concerned that the prison did not follow the provisions of PSI 07/2015 and that they risked disregarding Mr Blampey's choice about his next of kin. We make the following recommendation:

The Governor should ensure that details for a prisoner's next of kin are recorded on reception and promptly added onto their NOMIS prison record.

Staff support

78. PSI 08/2010, 'Post Incident Care', and PSI 64/2011, 'Management of Prisoners at Risk of Harm to Self, to Others and from Others (Safer Custody)', set out the actions that should be taken following a death in custody. This includes that all staff involved in an incident and a member of the care team must attend a hot debrief. The care team member should ensure that staff are aware of all the support mechanisms available to them. PSI 64/2011 also says that staff directly involved in an incident must complete Incident Report Forms as soon as possible.
79. Following Mr Blampey's death, the head of reducing reoffending held a hot debrief with three officers. An officer and a prison manager did not attend as they were helping the police. The Head of Reducing Reoffending passed on information about the support mechanisms that were available but we note that no one from the care team attended the hot debrief. An officer told the investigator that, in the days that followed Mr Blampey's death, a member of the care team contacted her by telephone and text message but there was little face to face contact. She said that it took some weeks for her to get the formal support that she needed.
80. While we appreciate that officers needed to help the police after Mr Blampey had died, we believe that officers not involved in the emergency response should have been used to allow an officer and a prison manager to attend the debrief. We are also concerned that no one from the care team attended the debrief to give immediate and ongoing support, and that this prevented all the officers from quickly accessing the support that they needed. We also note that none of the officers completed Incident Report Forms to record their involvement in the emergency response. We make the following recommendation:

The Governor should ensure that all managers follow the national guidelines for dealing with a death in custody or serious incident, including that:

- **A debrief is held promptly after the death of a prisoner and that all staff that are involved and a member of the care team are invited.**
- **A member of the care team will ensure staff are aware of the support mechanisms available and how to access them.**
- **All staff directly involved in an incident should complete Incident Report Forms as soon as possible.**

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