Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Terence Devereux, a prisoner at HMP Channings Wood, on 24 May 2020

## A report by the Prisons and Probation Ombudsman

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## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO


## WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Terrence Devereux was found hanged in his cell at HMP Channings Wood on 24 May 2020. He was 31 years old. I offer my condolences to his family and friends.

Staff monitored Mr Devereux under suicide and self-harm prevention procedures (known as ACCT) three times at Channings Wood. Although staff generally managed ACCT procedures well, I am concerned that caremap actions were not properly recorded. It is not the first time that I have identified deficiencies in Channings Wood's ACCT procedures. The Prison Group Director for Devon and North Dorset will need to address this issue urgently.

I note that it is possible that the very restricted regime imposed during the COVID-19 pandemic may have affected Mr Devereux's mood and would have made it more difficult for staff to pick up on any signs that his mood might have been deteriorating.

I am also concerned that when staff found Mr Devereux hanging, they did not call a medical emergency code or provide the correct location of the cell. This caused an unnecessary delay in Mr Devereux receiving emergency medical treatment, although this is unlikely to have affected the outcome for him.

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** **March 2021**

# Contents

# Summary

## Events

1. On 2 March 2019, Mr Terrence Devereux was remanded into custody at HMP Exeter, charged with attempted robbery. (He was subsequently sentenced to three years in prison on 7 August.) Mr Devereux had schizoaffective disorder and frequently harmed himself in prison. He also had a history of substance misuse and took psychoactive substances (PS).

2. On 6 September, Mr Devereux moved to HMP Channings Wood. Over the next six months, his mood fluctuated frequently and resulted in several incidents of self-harm. He continued to use PS and prison staff managed him under suicide and self-harm prevention procedures (known as ACCT) on three occasions.

3. On 30 March 2020, a supervising officer chaired an ACCT case review. He noted that Mr Devereux did not report any thoughts of suicide or self-harm and said that his PS use had decreased. Attendees assessed him as a low risk of suicide and closed the ACCT document. Over the next eight weeks, prison staff monitored Mr Devereux on a weekly basis as part of his post-closure planning.

4. At 8.27pm on 24 May, an officer who was completing prison officer entry level training (POELT) looked through Mr Devereux's cell observation panel to conduct a roll check and saw him apparently kneeling on the floor. He moved to the next cell but returned around 20 seconds later to check on Mr Devereux again. He then noticed a ligature around his neck. At 8.29pm, the POELT officer requested assistance and provided his location. He then opened the cell door and assessed the situation before cutting the ligature.

5. In the meantime, a custodial manger and three officers went to the location provided by the POELT officer and found that the cell was empty. They made their way across the house block to where they suspected he was and found Mr Devereux on the floor of his cell. The custodial manager requested an ambulance and asked officers to move Mr Devereux onto the landing. He started cardiopulmonary resuscitation (CPR) and applied a defibrillator.

6. Paramedics arrived and continued with resuscitation efforts but at 9.21pm, pronounced that Mr Devereux had died.

## Findings

7. Mr Devereux had a history of mental ill health and substance misuse problems and his mood fluctuated frequently. We are satisfied that the prison showed concern and compassion and tried to support his best interests.

8. While staff mostly managed Mr Devereux's ACCT procedures well and continued to monitor him in the post-closure period, we are concerned that they did not always set clear or meaningful caremap actions. We have raised concerns about ACCT management at Channings Wood before and urgent action is now required to address the issue.

9. We note that, like other prisoners, Mr Devereux was subject to a very restricted regime at this time because of the COVID-19 pandemic and was spending up to 23 hours a day alone in his cell. This may have affected his mood and would have made it more difficult for staff to pick up on any signs that his mood might have been deteriorating.

10. While we are satisfied that the POELT officer acted appropriately by returning to check on Mr Devereux and entering the cell, we are concerned that he failed to call a medical emergency code and provided an incorrect location. This caused a four-minute delay in calling an ambulance. Although calling an ambulance sooner is unlikely to have changed the outcome for Mr Devereux, in other cases, it could be critical.

11. The clinical reviewer concluded that the clinical care that Mr Devereux received at HMP Channings Wood was equivalent to that which he could have expected in the community. However, we are concerned that healthcare staff did not conduct a secondary health screen within a week of his arrival.

## Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review.

- The Prison Group Director for Devon and North Dorset should assure herself that meaningful action is being taken to ensure that ACCT procedures at Channings Wood improve.

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff promptly use an emergency code to communicate the nature of the emergency and provide their correct location.

- The Head of Healthcare should ensure that healthcare staff offer all prisoners a full general health assessment within a week of their arrival, in line with PSO 3050.

- The Governor should ensure that a copy of this report is shared with the POELT officer and a supervising officer and that a senior manager discusses the Ombudsman's findings with them.

# The Investigation Process

12. 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.

13. The investigator obtained copies of relevant extracts from Mr Devereux's prison and medical records.

14. The investigator interviewed eight members of staff between 7 and 8 July. NHS England commissioned a clinical reviewer to review Mr Devereux's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the restrictions in place during the COVID-19 pandemic.

15. We informed HM Coroner for Exeter and Greater Devon District of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Devereux's mother to explain the investigation and to ask if there were any matters they wanted the investigation to consider. Mr Devereux's mother wanted to know

    - how did this manage to happen;
    - what was known about Mr Devereux's state of mind before his death;
    - was there evidence of drug misuse before his death;
    - when was his medication last given;
    - why was his medication stopped;
    - why was he not on suicide watch; and
    - should he have been in the medical unit?

    We have addressed these concerns in this report.

17. Mr Devereux's mother received a copy of the initial report. She did not raise any further issues or comment on the factual accuracy of the report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

# Background Information

## HMP Channings Wood

19. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds approximately 700 men. Care UK provides healthcare and 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

20. The most recent full inspection of HMP Channings Wood was in September 2018. Inspectors reported that some efforts had been made to improve standards since their last inspection in October 2016 but they were not co-ordinated, 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.

21. 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 understanding the drivers of self-harm and an action plan had been produced. However, the actions were not consistently carried out or updated regularly.

## Independent Monitoring Board

22. 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 2019, the IMB reported that although the prison had made reasonable progress to identify and support prisoners who self-harmed, they remained concerned by the number of self-harm incidents. The IMB welcomed the addition of several drug supply reduction measures but remained concerned about the availability of PS and the limited number of suspicion-based drug tests due to resourcing issues.

## Previous deaths at HMP Channings Wood

23. Mr Devereux was the eighth prisoner to die at Channings Wood since May 2018. Of the previous deaths, two prisoners took their own lives, three died from natural causes and two were drug-related. We have previously made a recommendation about the management of suicide and self-harm prevention procedures which Channings Wood agreed to implement.

## Assessment, Care in Custody and Teamwork (ACCT)

24. ACCT is the Prison Service care planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent a prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

25. 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 on the caremap have been completed. 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.

# Key Events

26. On 2 March 2019, Mr Terrence Devereux was remanded to HMP Exeter, charged with attempted robbery.

27. Mr Devereux had schizoaffective disorder (a condition where psychotic and mood disorder symptoms present together, or within a two-week period). He was prescribed a zuclopenthixol (an antipsychotic), which he took by slow-release depot injection every two weeks. Mr Devereux had a history of substance misuse and frequently took illicit psychoactive substances (PS) in prison.

28. On 7 August, Mr Devereux was sentenced to three years in prison and returned to Exeter. A nurse saw him for a review and recorded that he did not report any thoughts of suicide or self-harm.

29. On 10 August, Mr Devereux took an overdose of paracetamol but refused to go to hospital for treatment. He signed a medical disclaimer and prison staff started suicide and self-harm prevention measures (known as ACCT). On 15 August, prison staff stopped ACCT monitoring as Mr Devereux presented as more settled and was consistently taking his medication.

**HMP Channings Wood**

30. On 6 September**,** Mr Devereux was moved to HMP Channings Wood. At an initial reception screen, a nurse recorded that he had a history of mental health and substance misuse problems. Mr Devereux did not report any thoughts of suicide or self-harm and she referred him to the mental health and substance misuse teams. However, there is no record of a secondary health screen.

31. On 10 September, a secondary care mental health nurse visited Mr Devereux to conduct a review. She recorded his diagnosis of schizoaffective disorder and noted that he did not report psychotic symptoms. Later that day, a drug recovery worker conducted a welfare check after staff observed Mr Devereux under the influence of PS. Mr Devereux told her that his cellmate was a PS user and that he found it difficult to resist. The mental health nurse provided harm minimisation advice and referred him to the PS support group.

32. On 12 September, a drug recovery worker reviewed Mr Devereux's substance misuse records from the previous six months and conducted an initial assessment. She noted that Mr Devereux spoke openly and recognised that he needed to change his thinking about drugs. They agreed a recovery care plan, which included in-cell work and attending group work.

33. On 5 October, prison staff started ACCT procedures after Mr Devereux made superficial cuts to his arms and legs. The following day, a supervising officer chaired a first ACCT case review which a member of healthcare staff attended. He noted that Mr Devereux said that he had self-harmed due to feeling bored, struggling to sleep and having a PS debt of £35. Attendees assessed his risk of suicide as low and added four actions to the caremap, which included checking his prison employment status and arranging a mental health review.

34. On 13 October, Mr Devereux handed a letter to staff asking to remain in his cell as he had been assaulted. Officers reviewed the wing CCTV footage but saw no evidence of an assault. Later that day, officers found Mr Devereux hanging by a ligature in his cell and he was taken to hospital. He returned to prison the next day and staff moved him to the vulnerable prisoner unit (VPU) for his own safety.

35. On 16 October, a prison manager chaired an ACCT case review. He recorded that Mr Devereux presented with a brighter outlook and said that he would try to stay off drugs. One action was added to his caremap: purposeful activity to keep occupied.

36. On 8 November, a supervising officer chaired an ACCT case review which a prison psychiatrist, attended. Mr Devereux said that he had stopped taking his depot injection in the community but had started it again in prison and felt it was helping him to manage his psychotic thoughts. The psychiatrist suggested that Mr Devereux should also re-start sodium valproate to help stabilise his moods. However, Mr Devereux often failed to collect it from healthcare staff.

37. On 9 November, a supervising officer chaired an ACCT review and recorded that Mr Devereux engaged well. Mr Devereux said he was willing to meet with a family support worker for support with his complex family situation and to explore the possibility of contacting his son. However, there is no record that staff added these actions to the caremap.

38. On 18 November, a supervising officer moved Mr Devereux to a safer cell (a cell designed to minimise ligature points) on the VPU after he told staff that he had thoughts of self-harm. The next day, a supervising officer chaired an ACCT case review and recorded that Mr Devereux told attendees that he had tried to hang himself overnight. He said that he had stopped taking PS and identified feelings of withdrawal as a possible trigger.

39. On 13 January 2020, a supervising officer chaired an ACCT case review which the mental health nurse attended. Mr Devereux reported feeling more settled since he had left the main wing and said that he was doing a media studies course. The supervising officer noted that Mr Devereux had set days for his depot injections which really made a difference to his mood. Attendees assessed his risk of suicide as low and agreed to stop ACCT monitoring.

40. On 14 January, the family support worker saw Mr Devereux for an initial family support session and recorded that he had not had contact with his son for seven years due to his drug use. The next day, she contacted Mr Devereux's mother who told her that he would have had contact with his son, if he had not gone back to prison. The family support worker noted that she had told Mr Devereux that it would take a long period of abstinence and a change in his behaviour for him to establish contact.

41. On 21 January, a supervising officer chaired an ACCT case review which two members of mental health staff attended. The supervising officer recorded that staff had re-started ACCT monitoring overnight after Mr Devereux said that he was hearing voices and wanted to 'end it all'. Mr Devereux told attendees that he was no longer hearing voices and that although he still had some PS debt, he should have cleared it by the end of the week. Attendees assessed his risk of suicide as low and set his ACCT observations at one an hour.

42. On 22 January, a supervising officer chaired an ACCT case review. He recorded that Mr Devereux had a good support network of staff around him and said that he was hoping to be released on Home Detention Curfew (HDC, a scheme that allows prisoners to be released early to a suitable address with an electronic tag) in June. Attendees assessed his risk of suicide as low and placed the ACCT document into an extended period of post-closure to allow him access to weekly support.

43. At 8.31pm on 2 February, a custodial manager noted that an officer had re-started Mr Devereux's ACCT procedures after he told him that he was going to drink water until it caused him to self-harm. The custodial manager requested hourly ACCT observations and a review the next day.

44. On 3 February, a supervising officer chaired an ACCT case review which a mental health nurse attended. A supervising officer recorded that Mr Devereux said that he felt bored in his cell and had not been showering which had annoyed him. She contacted the activities' department and they told her that they had removed him from the media course for missing too many sessions. Mr Devereux told attendees that he did not want to live in a safer cell any longer and the mental health nurse agreed that it would be appropriate from him to move. Mr Devereux did not report thoughts of suicide or self-harm and attendees agreed to put the ACCT procedures into a post-closure period. He moved to a standard single occupancy cell on 26 February.

45. On 9 March, a supervising officer conducted a post-closure review and noted that given Mr Devereux's mental health history, the ACCT would remain in a post-closure period until a supervising officer who worked on the wing could review it. On 16 March, a supervising officer saw Mr Devereux for a post-closure review and closed the ACCT.

46. On 10 March, a drug recovery worker conducted a 13-week substance misuse review and recorded that Mr Devereux engaged well and spoke proudly about having stopped using PS for two weeks and being debt-free. She recorded that he had completed the relapse prevention workbook in full, attended all his counselling sessions and completed all his in-cell work. At 12.45pm on 23 March, an officer started ACCT procedures after Mr Devereux made several superficial cuts to both his arms. At 2.15pm, a safer custody administrator conducted an ACCT assessment and noted that it was the first time that Mr Devereux had harmed himself in around four to five weeks. Mr Devereux said that he was struggling to budget his money and became stressed when he could not buy 'caps' (nicotine capsules for electronic cigarettes). He said that he was struggling from PS withdrawal and was finding it hard to say no.

47. Immediately afterwards, a supervising officer chaired a first ACCT case review which an officer, the safer custody administrator and a mental health nurse attended. Mr Devereux told attendees that he had developed a low mood after taking PS which led to him cutting his arms. He said that he was in debt to the value of £4 but would clear it that week. Mr Devereux did not report any thoughts of suicide or self-harm but attendees decided to keep hourly ACCT monitoring in place for a period of stability. They identified boredom and a lack of income as an issue and added one action to the caremap: apply for a prison job.

48. On 30 March, a supervising officer chaired an ACCT case review which an officer attended. Healthcare staff did not attend but a nurse provided an update before the meeting. The supervising officer recorded that Mr Devereux engaged well and did not report any thoughts of suicide or self-harm. He said that he had 'sorted' his debt and that his PS use had declined. Attendees assessed him as a low risk of suicide and put the ACCT into a post-closure period.

49. On 7 April, a supervising officer conducted an ACCT post-closure review and recorded that due to Mr Devereux's fluctuating risk of harm to himself, the ACCT would stay in in post-closure until he, as the case manager, decided to close the ACCT procedures.

50. On 9 April, the drug recovery worker temporarily closed Mr Devereux's substance misuse file due to COVID-19 regime restrictions. She noted that she would send him a letter to explain the situation and outline his outstanding recovery plan objectives.

51. On 14 April, a supervising officer conducted a post-closure review and extended the post-closure review period for another two weeks to ensure there was further stability for Mr Devereux.

52. On 28 April, a supervising officer conducted a post-closure review and recorded that due the current COVID-19 pandemic, he had decided to extend the review period for another two weeks. Later that day, a nurse saw Mr Devereux for a review and recorded that he presented as stable and that he did not display signs of intoxication. Mr Devereux did not report any thoughts of suicide or self-harm and she gave him a distraction pack.

53. On 12 May, a physical education instructor (PEI) conducted an ACCT post-closure review and noted that Mr Devereux would remain in post-closure for another week as he was struggling with the reduced regime. (Prisoners were subject to a very reduced regime at this time in response to the COVID-19 pandemic.) The PEI suggested that he should find something to occupy his mind during the extended period he spent in his cell and suggested that he considered reading a book.

54. On 15 May, a mental health nurse attended a CPA review meeting and the prison psychiatrist joined by telephone. Mr Devereux told staff that he had not used PS for two weeks and that he was having paranoid thoughts in the days leading to his depot injection. He said that he was due to be released on HDC to a probation approved premises in July but would prefer to live with his mother. The prison psychiatrist recorded that Mr Devereux had failed to accept that his substance use may have triggered his paranoia and that staff would need to refer him to a community mental health team before release.

55. On 19 May, a supervising officer conducted an ACCT post-closure review and noted that Mr Devereux's risk of suicide and self-harm had been 'fairly stable' recently. He recorded that as Mr Devereux's mood was liable to fluctuate, the ACCT would remain in extended post-closure.

56. On 21 May, a nurse reviewed Mr Devereux having liaised with a probation officer. She explained why he had to live at an approved premises and told him that if he engaged with his licence conditions, the possibility of staying with his mother would

be re-assessed. Later that day, a nurse gave Mr Devereux his fortnightly depot injection.

57. On 22 May, an officer visited Mr Devereux on behalf of the prison's safer custody department to conduct a random check as he was classified as a vulnerable prisoner. He recorded that Mr Devereux said that he was okay but did not want to engage in conversation.

## Events of Sunday 24 May

58. At 6.50pm, an officer looked through Mr Devereux's cell observation panel to conduct a roll check. She told the investigator that he was sitting on his bed and said "yes" when she asked if he was okay.

59. At 8.27pm, an officer who was completing prison officer entry level training (POELT) and had been assigned operational support grade (OSG) duties, looked through Mr Devereux's cell observation panel to conduct a roll check. He saw Mr Devereux in a kneeling position on the floor at the back of his cell, closed the panel and moved to the next cell. Around 20 seconds later, he returned to Mr Devereux's cell to check on him and saw that he had a ligature around his neck that he had attached to the window fitting.

60. At 8.29pm, the prison officer entry level training radioed to request assistance and to inform staff that a prisoner was hanging. He gave his location as house block 1, Thames, cell 44. He then broke the security seal on his key pouch, opened the cell door and stood in the doorway while he assessed the situation. Having assured himself that Mr Devereux was hanging, he cut the ligature and checked him for a pulse.

61. In the meantime, a custodial manager, a supervising officer and two officers arrived at Thames, cell 44, and found that it was empty. They made their way across the living block to Mersey, where the other cell 44 was located, and found Mr Devereux slumped on the floor against the back wall of his cell, with the ligature that had just been cut, still around his neck.

62. At 8.33pm, the custodial manager requested an ambulance and asked officers to remove the ligature and to move Mr Devereux onto the landing for easier access. He then started cardiopulmonary resuscitation (CPR) and requested a defibrillator. The defibrillator did not identify a shockable pulse and advised to continue CPR. Healthcare staff were not available as the emergency took place out of hours.

63. The first ambulance reached the prison at 8.40pm and paramedics arrived at Mr Devereux's cell at 8.46pm. The paramedics took over the resuscitation effort and pronounced that Mr Devereux had died at 9.21pm.

64. Mr Devereux had left a note in his cell that said he was "sick of the smell of the world" and just wanted to die.

## Contact with Mr Devereux's family

65. That evening, the prison appointed a custodial manager as the family liaison officer. She noted that there were security markers for the address meaning police involvement was required. At around midnight, the custodial manger and the governor arrived with the police at the address that Mr Devereux had provided for his mother, who was his named next of kin, but she no longer lived there. The police identified another address about 16 miles away and offered to ask local police officers to attend. The custodial manager told us that they accepted the offer because they were conscious of the time and did not want his family to find out that he had died from prisoners with access to illicit mobile phones. The police broke the news to Mr Devereux's mother in the early hours of the morning.

66. At 12.25pm on 25 May, the custodial manager phoned Mr Devereux's mother and left her a voicemail. At 7.15pm, she returned a call from Mr Devereux's sister and offered her condolences and support. Mr Devereux's sister asked to be the main point of contact as her mother was upset and angry. The custodial manager made several attempts to contact Mr Devereux's mother and sister over the following weeks and wrote to his mother on several occasions offering support. She did not receive a response.

67. The prison contributed to the cost of Mr Devereux's funeral, in line with national policy.

## Support for prisoners and staff

68. After Mr Devereux's death, a prison manager debriefed the staff involved in the emergency response to offer support. The staff care team also offered support.

69. The prison posted notices informing other prisoners of Mr Devereux'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 Devereux's death.

## Post-mortem report

70. A post-mortem examination found that Mr Devereux died of suspension by ligature. Toxicology analysis of Mr Devereux's blood did not identify any illicit substances, including PS, but did find higher levels of zuclopenthixol than generally seen in therapeutic use. However, the report concluded that the increased blood concentration could have occurred after Mr Devereux died.

## Events after Mr Devereux's death

71. On 3 June, staff submitted an intelligence report indicating that five prisoners had bullied Mr Devereux. It is alleged that they were selling him PS at an extortionate rate and manipulating him to damage property.

72. On 4 June, the prisons safer custody department received an anonymous letter from a prisoner stating that Mr Devereux was being bullied and threatened over a PS debt he owed. The letter says that prisoners got Mr Devereux hooked on PS, charged him twice the normal price, put pressure on him to pay and planned to

enter his cell and assault him. It also says that the prisoners forced Mr Devereux to damage his cell and to throw items out of the window to take £5 off his debt.

# Findings

## Managing risk of suicide and self-harm

73. Mr Devereux was monitored under ACCT procedures on three occasions at Channings Wood and spent a significant amount of time in a safer cell. For the most part, prison staff managed the ACCT process well. The case reviews indicate that they made concerted efforts to work with Mr Devereux to reduce his risk and that healthcare involvement in the process was frequent. Both prison and healthcare staff demonstrated compassion and understanding and tried to support Mr Devereux by referring him to various programmes.

74. When Mr Devereux presented as emotionally stable, prison staff stopped ACCT procedures. However, they took the unusual step of monitoring him weekly by extending the post-closure period because Mr Devereux was struggling with the very restricted regime during the COVID-19 pandemic. Mr Devereux's ACCT had been in post-closure for around nine weeks when he died and there was no evidence to suggest that he was at an increased risk of suicide. A supervising officer told the investigator that he did not notice anything unusual about Mr Devereux in the days following his post-closure review on 19 May and that staff did not report any concerns. We are satisfied that staff acted appropriately and could not reasonably have predicted Mr Devereux's actions.

75. However, we note that, like other prisoners, Mr Devereux was spending up to 23 hours a day in his cell – a single cell in his case – at the time, without access to his normal activities and that this may have been particularly difficult for a prisoner who was subject to mood disorders. Although an officer checked Mr Devereux on behalf of the prison's safer custody department two days before his death, his contact with wing staff would have been much reduced and it would therefore have been more difficult for staff to pick up on signs that his mood might be deteriorating.

76. Although the prison received intelligence after Mr Devereux had died indicating that he may have been bullied over PS debt, there is no record that he reported any concerns about debt in the weeks leading to his death. A supervising officer told us that staff regularly spoke to Mr Devereux about debt and helped him to spread his vape capsules across the week so that he would be less tempted to borrow from prisoners. However, he also said that Mr Devereux did not view debt as an issue and was not keen to engage in a debt management programme. We note that Mr Devereux did not mention debt in his suicide note. We are satisfied that prison staff offered appropriate support to Mr Devereux.

77. However, despite the positive work, we are concerned that not all caremap actions set for Mr Devereux were sufficient. PSI 64/2011 on safer custody states that completing a caremap is an integral part of the ACCT process and that it must reflect the prisoner's needs, level of risk and the triggers of their distress. The PSI also notes that a caremap should be tailored to the individual needs of the prisoner and be time-bound.

78. Prison staff did not add any actions to the caremap between 16 October 2019 and 11 February 2020. Although staff identified several actions and arranged for these to take place, such as meeting with the family support worker and offering Mr

Devereux support with debt management, they did not include these in the caremap despite indicating that it had been updated. A supervising officer told us that he did not always add to the caremap and may have recorded that he had updated it in error. He also said that he did not add debt management to the caremap as it was an ongoing issue and would have prevented staff from closing the ACCT document. We consider that staff should have at least set a time-bound action to discuss debt management with Mr Devereux and ensured the caremap was updated.

79. Channings Wood have previously accepted our recommendations intended to address the quality of ACCT procedures but we are concerned that we have again identified deficiencies in this report. In response to a previous investigation, the prison told us in November 2019 that they had appointed a full-time custodial manager to Safer Custody and that part of their role was to ensure ACCT compliance. They also said that ACCT documents were scrutinised at monthly Safer Custody meetings to provide assurances that staff used them correctly.

80. While we recognise that Channings Wood has made positive steps to improve ACCT management, we are concerned that six months after having implemented these changes, our investigation of Mr Devereux's death shows that caremaps continue to be inadequate and that the prison's response to our previous recommendation does not appear to have been entirely effective. We therefore consider that urgent action is now required to ensure that ACCT procedures improve. We make the following recommendations:

**The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review.**

**The Prison Group Director for Devon and North Dorset should assure herself that meaningful action is being taken to ensure that ACCT procedures at Channings Wood improve.**

## Roll check

81. The purpose of a roll check is to ensure that all prisoners are accounted for and to check that they are alive and well. When a POELT officer carried out a roll check at 8.27pm, he noticed that Mr Devereux was kneeling on the floor beside his bed and moved to the next cell. He told the investigator that he suddenly thought that something was not quite right, so he returned to Mr Devereux's cell to check on him again. He said that it was at this point that he saw a ligature around his neck. While this caused a delay of around 20 seconds, we are satisfied that he acted appropriately in the circumstances.

## Emergency response

82. PSI 03/2013 on medical response codes requires prisons to have a two-code medical emergency response system. Channings Wood's local policy instructs staff to use a medical code blue to indicate an emergency when a prisoner is unconscious, or has breathing difficulties. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for staff to attend with the appropriate equipment.

83. The POELT officer responded swiftly when he saw that Mr Devereux had tied a ligature around his neck. He broke the security seal on his key pouch, entered the cell after risk assessing the situation and cut the ligature. While we are satisfied that this action was appropriate, we are concerned that the requested assistance instead of calling an emergency medical code. This meant that staff did not call an ambulance or collect a defibrillator until the custodial manger asked them to. This caused a delay of around four minutes. The POELT officer told the investigator that he was aware of the local emergency response policy and that, in hindsight, recognised that he should have radioed a code blue.

84. We are also concerned that the POELT officer gave an incorrect location over the radio. This meant that responding staff went to the wrong cell, adding to the time it took for them to reach Mr Devereux and to request an ambulance. The POELT officer told us that he mistakenly provided the wrong location in the heat of the moment. While we appreciate that finding a prisoner in these circumstances is distressing, it is essential that staff provide correct information.

85. Although calling an ambulance sooner is unlikely to have changed the outcome for Mr Devereux, in other cases, it could be critical. We therefore make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff promptly use an emergency code to communicate the nature of the emergency and provide their correct location.**

## Clinical care

86. The clinical reviewer concluded that the healthcare that Mr Devereux received at HMP Channings Wood was equivalent to that which he could have expected to review in the community. Mental health staff reviewed him frequently, attended ACCT reviews, completed comprehensive mental health assessments and spoke to him on several occasions about the negative effect of his substance misuse on his mental health. There was, however, one aspect of Mr Devereux's care that the clinical reviewer considered required improvement, namely that healthcare staff did not complete a secondary health screen.

87. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners requires that newly arrived prisoners should be offered a general health assessment in their first week. This did not happen. While we recognise that a mental health nurse and a recovery worker reviewed Mr Devereux within his first week, it was particularly important for healthcare staff to have conducted a secondary health screen to ensure that he received prompt and appropriate support.

88. We are satisfied that, overall, the clinical care that Mr Devereux received at Channings Wood was of a satisfactory standard. However, we make the following recommendation:

**The Head of Healthcare should ensure that healthcare staff offer all prisoners a full general health assessment within a week of their arrival, in line with PSO 3050.**

## Learning Lessons

89. We have identified a number of concerns in this report. We consider it is important that staff learn from our findings. We recommend the following:

**The Governor should ensure that a copy of this report is shared with the POELT officer and a supervising officer and that a senior manager discusses the Ombudsman's findings with them.**

## Inquest

90. At the inquest, which took place on 6 May 2025, the Coroner concluded that Mr Devereux died as a consequence of suspension by ligature.

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