Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Thomas, a prisoner at HMP Risley, on 20 August 2017

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 Thomas was found unconscious in another prisoner's cell at HMP Risley on 17 August 2017. He was taken to hospital but died on 20 August of severe brain injury due to lack of oxygen. He was 36 years old. I offer my condolences to Mr Thomas's family and friends.

Other prisoners said that Mr Thomas had been smoking psychoactive substances (PS) when he fell unconscious, and it appears highly likely that illicit drug use played a part in Mr Thomas's death. He had a history of self-harm, substance and alcohol misuse but had successfully completed an alcohol dependency programmes in custody before relapsing on release. After recall to custody about two months before his death, he began to use psychoactive substances (PS).

I am concerned that Risley's approach to Mr Thomas's illicit drug use was over-punitive and was not balanced by supportive measures (such as referral to substance misuse support services) or by recognition of his personal vulnerability. As a result, Mr Thomas experienced a very restricted regime, with no television and little time out of his cell, in the weeks before his death and this may have made him more, rather than less, likely to use P to alleviate boredom.

Like many prisons, Risley faces significant problems controlling the supply of and demand for PS and other drugs. I am concerned that individual prisons are being left to develop local strategies which risk being ill-formed, overly punitive or unable to draw on the learning of others. In my view, there is now an urgent need for national guidance on the best measures to combat this serious problem. We have previously made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service. We have also written to the Prisons Minister setting out our concerns at the number of drug-related deaths in custody.

I hope that the learning from this and similar investigations informed HMPPS' Drug Strategy which I was pleased to see published in Spring 2019.

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 **July 2019**

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Summary

Events

1. On 10 May 2013, Mr James Thomas was sentenced to eight years and three months imprisonment for attempted robbery. He was released on licence from HMP Humber on 6 April 2017 but he was recalled to custody four weeks later after breaching his licence conditions. He was moved to HMP Risley on 19 May.

2. On 27 July, Mr Thomas was found under the influence of psychoactive substances (PS). The prison GP wrote to him outlining the dangers of PS but he was not referred to the substance recovery service for support. His level of privileges under the incentives and earned privileges (IEP) scheme was reduced to basic, he was placed on Tackling Anti-Social Behaviour (TAB) monitoring and charged with a disciplinary offence under prison rules.

3. On 17 August, Mr Thomas told a substance recovery worker that he had smoked PS but wanted to stop. He said the basic regime meant he did not have a television and he was using PS because he was bored. She said she would bring some word puzzles the next day to occupy his mind.

4. At about 5.20pm on 17 August, a prisoner told an officer that Mr Thomas needed staff assistance. The officer found Mr Thomas in another prisoner's cell lying on his back, unresponsive. The officer radioed a medical emergency code and began CPR. Healthcare staff and ambulance service staff attended and continued resuscitation. Mr Thomas's heart responded and he was taken to hospital but did not regain consciousness. Medical tests showed he had suffered serious brain injury due to lack of oxygen. Mr Thomas was pronounced dead at 5.27pm on 20 August.

Findings

5. Mr Thomas received limited help for substance misuse from the drugs and alcohol recovery service at Risley. At the time of Mr Thomas's death, clinical healthcare services and substance misuse support services used separate information recording systems. This meant that although he was a client, substance recovery workers did not know he had twice been found under the influence of PS. Since October 2017, however, the substance recovery team has had access to the clinical information system, and we have not, therefore, made a recommendation about this.

6. We are concerned that Risley took a variety of disciplinary actions against Mr Thomas but these were not balanced by supportive measures to tackle his illicit drug use (for example, referral to support services or recognition of his vulnerability).

7. Sanctions applied to reduce the supply of illicit drugs at Risley showed insufficient distinction between users and dealers. The cumulative effect of sanctions under disciplinary procedures, TAB (usually used for victims or perpetrators of bullying rather than drug use) and IEP meant that Mr Thomas experienced a very limited regime. Paradoxically, this may have made it more likely that Mr Thomas would use

PS to alleviate the boredom caused by such a regime. We are concerned that the lack of effective and intelligent managerial oversight led to inflexible use of punishments on minimal information and was not tailored to Mr Thomas's individual needs.

Recommendations

- The Governor of HMP Risley should ensure that staff are aware of their responsibilities in operating the Tackling Anti-Social Behaviour and Incentives and Earned Privileges strategies in relation to illicit drug use and that measures taken are proportionate to the individual prisoner.

- The Governor of HMP Risley should ensure that staff always make a referral to drug treatment services when a prisoner is found to be under the influence of PS.

The Investigation Process

8. HMPPS notified us of Mr Thomas's death on 20 August 2017

9. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact her. One prisoner made contact.

10. The investigator visited Risley on 24 August and 21 September 2017 and on 11 January and 5 February 2018. She obtained copies of relevant extracts from Mr Thomas's prison and medical records.

11. The investigator recorded interviews with nine members of staff and one prisoner. She also spoke to several officers while visiting D wing and a CGL recovery service manager. One prisoner declined to be interviewed and one member of staff did not make himself available for interview.

12. In February 2018, the investigator spoke to the Governor about the inconsistencies of TAB monitoring, the disciplinary approach to illicit drug use and missed opportunities in maintaining substance misuse support.

13. NHS England commissioned a clinical reviewer to review Mr Thomas's clinical care at the prison. He interviewed five members of staff jointly with the investigator.

14. The investigation was suspended in February 2018 while we awaited toxicology results and a cause of death. The investigation was resumed in July 2018.

15. We informed HM Coroner for Cheshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Thomas's brother, to explain the investigation process and to ask if he had any matters he wanted the investigation to consider. He asked what had happened to his brother about three weeks before his death as he had not contacted their mother since that time, which had been unusual. He described his brother as very gullible and vulnerable to drug use because he would readily do anything anyone asked him to do.

17. Mr Thomas' brother was given a copy of our initial report. He did not make any further comment. HMPPS also received a copy and did not identify any factual inaccuracies.

Background Information

HMP Risley

18. HMP Risley is a medium security prison on the outskirts of Warrington, holding convicted men. Primary care healthcare services are provided by Bridgewater Community NHS Foundation Trust, mental health services are provided by Greater Manchester Mental Health Trust. Drug and alcohol misuse services are provided by CGL Recovery Service (Change, Grow, Live).

HM Inspectorate of Prisons

19. The most recent inspection of HMP Risley was in June 2016. Inspectors reported that almost two-thirds of prisoners said it was easy to obtain drugs, compared to 40% in comparable prisons. There was evidence that the availability of psychoactive substances (PS) was undermining prisoner well-being and was a major challenge to the prison's stability, but the problem was being confronted with some meaningful work. There were not enough full-time activity opportunities and the regime was restricted. Inspectors said there was a reasonable strategic action plan to tackle this. Healthcare was adequate. Substance misuse services were good and the range and content of interventions was excellent and delivered by a skilled drugs team.

20. Most prisoners said the incentives and earned privileges scheme had not helped them to change their behaviour. The number of prisoners on the basic level of IEP had trebled since the last inspection in 2013 and there was not enough focus on the underlying causes of poor behaviour. Inspectors noted that oversight was inadequate and they were not confident that reviews for prisoners on the basic level were sufficiently robust or that behaviour improvement targets were set and implemented appropriately.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2017, the IMB reported that a reduction in staffing levels had impacted on the running of the prison. It described Risley as a safe environment despite the lack of drug detection dogs and high levels of substance misuse which caused disruption.

Previous deaths at HMP Risley

22. Mr Thomas's was one of three deaths at Risley in 2017. The previous death of a prisoner in March 2017 was attributed to synthetic cannabinoid (PS) toxicity and we were concerned in that case at the apparent ease with which PS could be obtained. We have since investigated a death in March 2018 which also appears to have involved psychoactive substances.

Psychoactive Substances (PS)

23. Psychoactive substances, previously known as ‘legal highs’ are an increasing 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.

24. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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.

25. 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. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

26. On 10 May 2013, Mr James Thomas was sentenced to eight years and three months imprisonment for attempted robbery and sent to HMP Manchester. He moved to HMP Everthorpe in June 2013 and began an alcohol dependency programme. In March 2014 he was transferred to HMP Humber and continued addressing his offending behaviour.

27. In March 2017, Mr Thomas's application for parole was approved. On 9 March, he discussed with his offender supervisor how he would handle a temptation to drink on release. He was adamant he would be able to have only one drink as he knew that returning to Approved Premises (formerly known as a probation hostel) under the influence of alcohol would risk recall to prison. On 6 April, Mr Thomas was released from prison.

28. He failed to return to the Approved Premises on 7 May and his offender manager was unable to contact him. He returned on 9 May and a breathalyser test indicated that he had been drinking alcohol. His licence was revoked for missing a probation appointment, failing to reside in the AP, failing to make contact and alcohol misuse. He was taken into custody by the police and on 10 May, he was returned to HMP Manchester.

29. Mr Thomas told a healthcare assistant (HCA) during an initial health screen that he had cut his right wrist three weeks before as he suffered from Post-Traumatic Stress Disorder due to experiencing sexual assault as a child. He said he had not harmed himself in prison for several years and did not have current thoughts of suicide or self-harm. The HCA referred him to the mental health team. He was given an alcohol screening test to gauge his level of alcohol dependence. As he showed mild to moderate signs of withdrawal, he was referred to a doctor for a detoxification assessment.

30. Mr Thomas saw a locum GP on 10 May. He told the GP he had been drinking three litres of cider a day in the community and had 'sniffed' some cocaine the previous week. He prescribed a Librium detoxification programme to begin the following day.

31. On 11 May, Mr Thomas saw a substance misuse practitioner. He told her he had drunk three three-litre bottles of cider every day between the period of his release and his recall to prison. He said he did not take PS, had taken cocaine recently and was not known to mental health services but would like to be as he had experienced childhood trauma. She noted that he had a stutter and referred him to the mental health team regarding the abuse he had experienced.

32. Mr Thomas was monitored by substance misuse healthcare staff for five days. Although Mr Thomas told a nurse practitioner, that he felt the detoxification had finished too quickly, the nurse recorded that he was satisfied that there were no clinical concerns and that Mr Thomas appeared stable and did not raise any immediate mental health concerns. On 18 May, another nurse reviewed Mr Thomas's notes and assessed he was medically fit for transfer to another prison. He was transferred to HMP Risley on 19 May.

HMP Risley

33. On reception at Risley, a nurse carried out a new prisoner health check. She noted Mr Thomas's history of deliberate self-harm and referred him to the mental health team due to his history of anxiety and depression linked to past trauma. On 23 May, after discussion of his case at the single point of referral meeting, he was referred to CGL, the drug and alcohol service, and placed on the waiting list for counselling. He was discharged from the mental health in-reach service.

34. On 23 May, Mr Thomas's offender manager in the community, completed a recall assessment of Mr Thomas's risks of offending and harm on OASys, the offender management system used by prison and probation services. She noted that he spoke with a stutter and had been bullied at school, partly due to his speech impediment. She assessed that that he was prone to being easily led by his peer group due to his learning disability, pronounced stutter and his experience as a victim of bullying in the past. She noted he was easily influenced by others and would try to impress those he chose to associate with. He appeared vulnerable and would let others take advantage of him, which would place him at risk of re-offending.

35. On 8 June, a prison GP saw Mr Thomas at a routine GP appointment following transfer. The prison GP told the investigator and clinical reviewer at interview that Mr Thomas had presented as happy to engage, alert with good eye contact and no thoughts of self-harm or suicide, but the results of two questionnaires he completed showed he had mild to moderate depression and anxiety. He prescribed an antidepressant and arranged to see Mr Thomas in four weeks' time.

36. On 6 July, a prison GP saw Mr Thomas who appeared well with no obvious signs of depression or thoughts of self-harm. He did not make a follow-up appointment and explained to Mr Thomas he could request one if he needed to. The prison GP did not repeat the questionnaires, which he said would be his usual practice, as he was confident that Mr Thomas did not present with any significant depressive symptoms.

37. The CGL substance recovery co-ordinator, met with Mr Thomas on 5 June. He told her he did not use drugs but had problematic alcohol use as he used drinking to cope with traumatic events he experienced as a child. He said he could cope in prison but struggled without boundaries and support. She gave him a booklet on alcohol to complete in his cell and return. Mr Thomas returned it partially completed on 20 July with a note saying he needed help with completing it.

38. On 27 July, a Supervising Officer (SO) found Mr Thomas in his cell apparently under the influence of PS. A nurse examined Mr Thomas and found his pupils were enlarged, slow to react and he appeared to be under the influence. Due to his speech impediment she did not consider it fair to determine whether his speech was slurred due to the effect of PS or not. She wrote in his clinical records that she would liaise with a doctor as to whether Mr Thomas was suitable to keep antidepressant medication in his cell.

39. A SO placed Mr Thomas on report for breaching Prison Rule 51, paragraph 5, on the grounds that he "intentionally endangered the health and safety of others or was reckless as to whether health or personal safety was endangered" and also downgraded him from entry level to basic, the lowest level of IEP. He also initiated

Tackling Anti-Social Behaviour (TAB) monitoring and wrote on the monitoring booklet that it was for “4 weeks min”. The SO submitted an intelligence report but did not refer Mr Thomas for substance misuse support.

40. The SO did not make himself available for interview so we do not know why he initiated TAB monitoring (which is usually used for perpetrators or victims of bullying) in response to Mr Thomas’s drug taking.

41. On 28 July, a GP reviewed the nurses note about Mr Thomas possibly being under the influence of PS. He decided that Mr Thomas could continue taking an antidepressant and issued a standard letter to him warning of the dangers of using PS.

42. Mr Thomas’s disciplinary hearing took place on 29 July. The record of the hearing states that Mr Thomas refused to attend but said, “I’m guilty,” and that the hearing proceeded in his absence. The SO and nurse’s accounts were read out. The senior manager who conducted the hearing wrote in the record that he took into account it was Mr Thomas’s first finding of guilt. He imposed a punishment of 28 days stoppage of earnings at 50%, 28 days loss of association, no access to gym for 28 days and no television for 28 days.

43. A SO conducted a TAB review on 3 August. She did not record whether Mr Thomas attended the review or who else was present. She noted that on 1 August Mr Thomas was not wearing his basic prison uniform so he would remain on the basic regime and be reviewed in a weeks’ time. She set a behavioural target for him to wear the basic kit at all times.

44. On 10 August, the SO held another TAB review. She recorded that Mr Thomas did not attend due to the wing being locked down. As Mr Thomas was observed by staff not wearing his basic uniform on 7 August, the SO said he should remain on basic and be reviewed on 17 August. The SO acknowledged to the investigator that the entries written by her and other officers in Mr Thomas’s TAB document were limited in detail.

45. On 12 August, an unnamed officer wrote in Mr Thomas’s TAB booklet “under influence again!”. An intelligence report submitted on the same day named Mr Thomas as one of up to 12 prisoners who went into a cell on D wing on 11 July and appeared to be under the influence of PS. He was not placed on report or referred to substance misuse services.

46. Mr Thomas’s substance recovery worker, arranged to see him on 15 August but they were unable to meet as the wing was locked down, so she spoke to him through his door. He said he was okay and the meeting was rearranged for 17 August.

17 August 2017

47. A SO reviewed Mr Thomas’s behaviour on 17 August. She recorded that Mr Thomas was not present at the review but did not say why. In response to his alleged use of PS on 12 August, failure to wear the correct clothing and turning up late for roll checks, she decided that TAB monitoring would continue.

48. At 10.30am, the CGL substance recovery co-ordinator, met with Mr Thomas, noticed that he was wearing prison clothing and asked why. He replied that he was on basic for smoking PS. She told the investigator she was unaware before this that he had been downgraded to basic or that he had been suspected of PS use. They discussed harm reduction and his areas of risk which were boredom, being easily led by others and managing triggers and cravings. Mr Thomas said he was smoking PS twice a week. They agreed that he would aim to stop smoking it for the week as he hoped to be off basic the next week. She said she would bring some word puzzles the next day to counter boredom as she had run out of them. He agreed to attend weekly alcohol and PS groups (these are group sessions designed to raise awareness of the effects of PS and offer harm reduction advice) and she made the referrals and returned at 3.45pm to give him a relapse prevention booklet which he accepted.

49. A prisoner on D wing, told the investigator that Mr Thomas and two other prisoners entered his cell at about 4.40pm when staff unlocked the wing in the afternoon for association (a period of time when prisoners are free to visit each other's cells). The prisoner said they all smoked PS with a pipe. He described Mr Thomas as a vulnerable person who did not have many friends. Mr Thomas would chat with him and seemed friendly but had not been in his cell before. He thought he came because of the two prisoners he was with.

50. The prisoner recalled feeling 'high' and then passing out. He said when he woke up, another prisoner was lying on his bed and Mr Thomas was lying on his back on the floor with his eyes open. The prisoner on the bed checked Mr Thomas's pulse and said he thought he was dead. He told another prisoner to get an officer and they both left his cell.

51. An officer was approached by a prisoner on D wing who said a prisoner needed some help. The officer went upstairs to cell 2-08 North accompanied by two other officers. They found Mr Thomas lying on the cell floor in a crucifix position with three or four prisoners in the cell, one of whom said Mr Thomas had hit his head. An officer asked them to leave and checked for Mr Thomas's pulse but could not find one. An officer radioed an emergency code and began CPR with another officer. An officer remained outside the door to prevent prisoners trying to get back in the cell.

52. Shortly before Mr Thomas was found, a prisoner on B wing had collapsed after suspected PS use. An ambulance had been called at 5.15pm but was stood down after the prisoner recovered consciousness. An officers request for an ambulance was, therefore, initially confusing for the ambulance service.

53. A nurse was the first healthcare member of staff to arrive. She put defibrillator pads on Mr Thomas's chest but no shock was advised. Paramedics arrived with an emergency doctor and managed to detect a heartbeat. Mr Thomas was stabilised and was taken to hospital. He did not regain consciousness and died on 20 August at 5.30pm with his family present.

Contact with Mr Thomas's family

54. A senior manager contacted Mr Thomas's mother to say that her son had been taken to hospital. A Family Liaison Officer (FLO) was appointed to ensure that Mr

Thomas's family were able to visit him in hospital. The prison contributed to the cost of the funeral in line with national guidelines.

Support for prisoners and staff

55. After Mr Thomas's death, staff involved in the emergency response had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

56. The prison posted notices informing prisoners of Mr Thomas'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 the death.

Post-mortem report

57. Mr Thomas died as a result of a hypoxic brain injury (serious brain damage as a result of a lack of oxygen to the brain). He did not suffer a head injury. Toxicology tests did not detect PS or alcohol. However, this may be because Mr Thomas was in hospital for three days before his death, allowing time for illicit substances to pass through his system. The pathologist concluded "it is highly likely that after consuming Spice [PS] he suffered a cardiac arrest due to a fatal synthetic cannabinoid."

Findings

Effective communication between information systems

58. Mr Thomas received limited help for substance misuse, partly because he did not disclose his PS use immediately to his recovery co-ordinator. In addition, the system for picking up new referrals relied on CGL's attendance at the prison's morning meeting to learn about any prisoner found under the influence the day before.

59. At the time of Mr Thomas's death, clinical healthcare services and substance misuse support services used separate information recording systems and CGL staff would have to ask a member of the healthcare team to access SystmOne (the healthcare system) on their behalf, which was not always practical. This meant healthcare staff were unaware of Mr Thomas's contact with substance misuse support services.

60. Although Mr Thomas was a CGL client, substance recovery workers did not know Mr Thomas had twice been found under the influence of PS as they did not have access to other information recording systems and it was not mandatory to notify them if a prisoner was discovered using or under the influence of PS. It was only when Mr Thomas's recovery co-ordinator noticed he was wearing different prison clothing and asked why that she found out Mr Thomas had been downgraded to basic as a direct result of PS use.

61. Since October 2017, the substance recovery team has access to SystmOne, the clinical information system. This is a positive and long overdue development.

Illicit substances

62. Risley told us they held monthly drugs strategy meetings to discuss intelligence and identify areas of weakness around the prison to prevent the trafficking of drugs. While we accept that Risley has a drugs strategy in place and staff are working hard to implement it, it is clear that more needs to be done to reduce the supply and the demand for PS.

63. We recognise that this is a serious problem across much of the prison estate, not just Risley. In our view there is an urgent need for national guidance to prisons from HMPPS about best practice in reducing the supply of and demand for drugs, including PS. We have raised our concerns with the Prisons Minister and with the Chief Executive Officer of HMPPS who has committed to producing a national strategy for dealing with illicit drugs in the autumn of 2018.

Risley's response to use of psychoactive substances

64. We are concerned that staff took a variety of disciplinary actions against Mr Thomas but these were not balanced by supportive measures to tackle his illicit drug use (for example, by referral to support services) or recognition of his vulnerability.

65. On the first occasion Mr Thomas was thought to be under the influence of PS, staff chose a punitive approach of charging him under prison disciplinary rules and placing him on the basic IEP level. It was the first time since Mr Thomas began his sentence in 2013 that he had been placed on report and we question whether his punishment was proportionate.

66. The cumulative effect of a combination of sanctions under disciplinary procedures, TAB and IEP meant that Mr Thomas experienced a very limited regime from 27 July until his death. Mr Thomas's offender manager recognised that being bored placed him at risk of further offending behaviour. The loss of association, gym, television and half of any earnings stripped him of most, if not all, opportunities to use his time productively and may have increased the likelihood that he would fill the void by using PS.

67. We do not understand why Risley used TAB procedures for prisoners found taking PS. TAB procedures are usually initiated for the perpetrators or victims of bullying. In this case they appear to have been used in the same way as the IEP system to address poor behaviour.

68. Risley's IEP policy dated December 2015 says that the basic regime has no minimum or maximum time scales and that clear and realistic targets should be discussed with the prisoner to assist them to progress. However, Mr Thomas's TAB booklet had a minimum time of four weeks written on the cover and, with the exception of the review which took place on the same day he was found unconscious, the reviews were perfunctory.

69. We note that a SO said at interview that prisoners could see their TAB documentation if they wished, but never asked to do so. Although Mr Thomas was shown in the documentation as having attended the TAB reviews, he does not appear to have been invited to any of the reviews. There were a series of missed opportunities to involve agencies, such as CGL recovery co-ordinators or his offender manager, to introduce a rehabilitative aspect into Risley's approach to the use of PS. In our view, the lack of effective and intelligent managerial oversight led to inflexible use of punishments on minimal information and was not tailored to Mr Thomas's individual needs.

70. In addition, the punitive approach was not balanced by supportive measures to help Mr Thomas tackle his drug misuse. Although he was on the waiting list for counselling to explore his childhood trauma, he did not receive it in the three months he was at Risley. His family and his offender manager considered he was vulnerable, eager to please and easily led but there is no evidence that any action was considered to support Mr Thomas in this respect.

The Governor of HMP Risley should ensure that staff are aware of their responsibilities in operating the Tackling Anti-Social Behaviour and Incentives and Earned Privileges strategies in relation to illicit drug use and that measures taken are proportionate to the individual prisoner.

The Governor of HMP Risley should ensure that staff always make a referral to drug treatment services when a prisoner is found to be under the influence of PS.

Inquest

12. The inquest, heard in August 2024, concluded that Mr Thomas's death was drug related.

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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T l 020 7633 4100