Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gavin Cox, a prisoner at HMP Wymott, on 14 October 2023

A report by the Prisons and Probation Ombudsman

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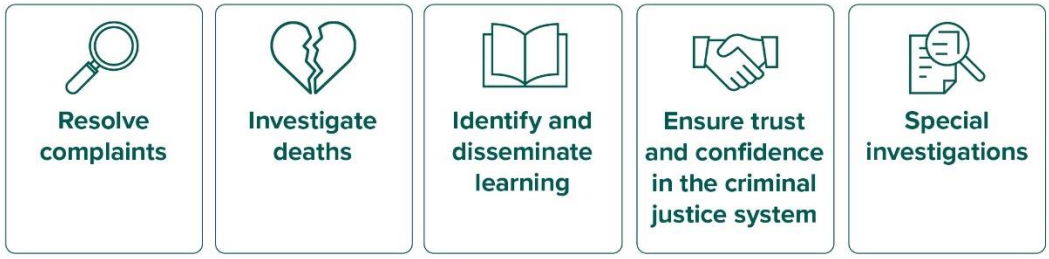
OUR VISION

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 Gavin Cox died in hospital on 14 October 2023, after he was found hanging in his cell at HMP Wymott the previous day. He was 47 years old. I offer my condolences to his family and friends.

Mr Cox was the third prisoner at Wymott to take his own life since October 2020. There was another self-inflicted death the day before Mr Cox died but the two men were in different parts of the prison and were unknown to each other.

Mr Cox had been in prison since 2001 and had a long history of drug use. He had twice been returned from open to closed conditions due to his drug use. He admitted illicit drug use to both a substance misuse nurse and a psychologist but there was no formal process for the sharing of information about illicit drug use between healthcare staff and prison staff.

On 12 October, Mr Cox was assaulted by another prisoner, probably linked to drug debt. However, he gave no indication to staff or other prisoners that he was worried about his safety or at risk of harming himself.

I am satisfied that staff could not have foreseen Mr Cox's actions.

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

Adrian Usher
Prisons and Probation Ombudsman **June 2024**

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Summary

Events

1. On 26 October 2001, Mr Gavin Cox was convicted of murder and sentenced to life imprisonment.

2. Mr Cox had a long history of substance misuse. On two occasions, in 2020 and 2022, he was moved to open conditions but was then returned to closed conditions because of his drug use. He arrived at HMP Wymott on 21 December 2022.

3. The Parole Board considered Mr Cox's case in May 2023. They asked for a psychological risk assessment and the case to be resubmitted later in the year. In June, Mr Cox told a nurse that he had been using cannabis. In September, he admitted to a psychologist that he used drugs regularly. He said that he did not feel ready to be released and would need a lot of support.

4. On 12 October, Mr Cox was assaulted by another prisoner. A nurse assessed him, and staff opened a Challenge, Support and Intervention Plan (CSIP – violence reduction measures used to support perpetrators and victims of violence). Neither staff nor prisoners who spoke to Mr Cox later that day thought that he showed any signs of having been badly hurt or upset, and none had any concerns that he might pose a risk to himself.

5. After prisoners were unlocked on the morning of 13 October, two members of staff and a prisoner spoke to Mr Cox. At 8.22am, an officer looked into his cell and saw him hanging. She called for assistance, and staff started CPR. At 8.34am, staff asked the control room to call an ambulance. Ambulance paramedics arrived and took Mr Cox to hospital. He died at 1.44pm the next day.

6. Mr Cox left a letter addressed to the Governor, which said that he was frustrated that he had not been able to overcome his addictions and that drugs were available on the wing.

Findings

7. Mr Cox gave no indication to staff or his peers that he was at risk of suicide or self-harm. We are satisfied that staff could not have foreseen his actions.

8. The clinical reviewer concluded that the care Mr Cox received at Wymott was of a good standard and equivalent to that which he could have expected to receive in the community.

9. Although Mr Cox told healthcare staff that he was using illicit drugs, they did not pass this information on to prison staff. Had wing staff been aware, they could have provided additional support and monitoring.

10. When the officer found Mr Cox hanging, she did not use a medical emergency code as she should have done. This resulted in a 12-minute delay in calling an ambulance. However, staff started CPR promptly and the clinical reviewer was

satisfied with how it was delivered. We cannot say whether the delay in calling the ambulance affected the outcome.

Recommendation

- The Head of Healthcare should agree a pathway of information sharing with prison staff when prisoners disclose substance use.

The Investigation Process

11. HMPPS notified us of Mr Cox's death on 16 October 2023.

12. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator visited Wymott on 24 October. He obtained copies of relevant extracts from Mr Cox's prison and medical records.

14. The investigator interviewed eight members of staff and two prisoners at Wymott between October 2023 and April 2024.

15. NHS England commissioned an independent clinical reviewer to review Mr Cox's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

16. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Cox's father to explain the investigation and to ask if he had any matters he wanted us to consider. He had no questions but requested a copy of our report.

18. We shared our initial report with HMPPS and the prison's healthcare provider. HMPPS pointed out one factual inaccuracy, which has been amended in this report.

19. We sent a copy of our initial report to Mr Cox's father. He did not notify us of any factual inaccuracies.

Background Information

HMP Wymott

20. HMP Wymott is a medium security prison in Lancashire for adult men. Most prisoners are serving sentences of four years or longer. Specialist wings include two psychologically informed planned environment (PIPE) units for prisoners with personality disorders. Healthcare services are provided by Greater Manchester Mental Health NHS Trust. There is 24-hour nursing cover.

HM Inspectorate of Prisons

21. The most recent HMIP inspection of Wymott was in December 2023. They found that drugs were too easily available. While fewer prisoners than average said that they felt unsafe, debt and drugs were factors in incidents of violence. Feedback on Wymott's PIPE units was positive.

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 May 2023, the IMB reported concerns at the rise in violence and self-harm associated with drugs, bullying and debt.

Previous deaths at HMP Wymott

23. Mr Cox was the 25th prisoner to die at Wymott since October 2020. Of the previous deaths, 22 were from natural causes and two were self-inflicted.

Key Events

24. On 26 October 2001, Mr Gavin Cox was convicted of murder and sentenced to life imprisonment. He had a history of substance misuse and was prescribed methadone (a medicine to treat heroin dependency) and was taken onto the substance misuse team's caseload. He completed offending behaviour courses in prison but continued to struggle with drug dependency and involvement in the prison drug culture.

25. In July 2020, Mr Cox was moved to an open prison (with lower security) but was returned to closed conditions after he was found under the influence of drugs. In March 2022, he was again moved to open conditions but was returned to closed conditions on 21 December after concerns about his drug use and failure to engage with substance misuse services. He was sent to HMP Wymott.

26. Mr Cox said that he wanted to go to the Psychologically Informed Planned Environment Unit (PIPE units are progression units to allow prisoners to progress through a pathway of interventions to support personal development). He moved there on 23 January 2023. An officer introduced herself as Mr Cox's key worker (a named officer who engages more closely with prisoners and acts as first port of call for any queries). They met regularly, and Mr Cox engaged well.

27. On 10 May, the Parole Board considered Mr Cox's case. They asked for a psychological risk assessment to be prepared before they held a hearing. This was scheduled for September.

28. On 30 June, Mr Cox disclosed to a substance misuse nurse that he had been using cannabis. She referred him for a medication review but did not share this information with prison staff. When interviewed, she said that during her seven years at Wymott, she had never shared disclosures about substance use with prison staff, as that was not part of the agreed process.

29. On 28 August, the key worker had a key work session with Mr Cox. They discussed him moving to the prison's therapeutic community, but he said that he did not want to go. He did not like it there and had issues with a prisoner who was also located there.

30. On 14 September, a forensic psychologist saw Mr Cox to discuss the risk assessment she was preparing for the Parole Board. During the interview Mr Cox was agitated and said he felt unable to express himself clearly. She asked if he had taken any substances, and he said he had not.

31. On 19 September, the psychologist saw Mr Cox again. He did not recall parts of their previous interview and admitted that he had smoked cannabis the night before the interview. She went over the process and ensured that he had a full understanding of it. Mr Cox said that he did not feel ready to be released and as such did not see any benefit in returning to an open prison. He felt overwhelmed at the thought of living in the community without substances and would need a lot of support. His preference would be to go to a rehabilitation centre. He also said that he did not see that he was benefiting from being on the PIPE unit, where he was

using substances regularly. There is no evidence that she discussed Mr Cox's admission with prison staff, or that any particular action was taken as a result.

32. On 23 September, the key worker had a key work session with Mr Cox. He was positive and focused on progression. The Parole Board was due to consider his case and he said that if they recommended that he be released he wanted to go to a rehabilitation centre.

33. On 29 September, staff submitted Mr Cox's dossier to the Parole Board. A hearing was to be scheduled for a later date, of which Mr Cox would be informed in due course.

34. On 1 October, staff gave Mr Cox a random search for drugs. They did not find anything unauthorised.

Events of 12 October

35. On 12 October, an officer noticed that Mr Cox had blood on his mouth. He took Mr Cox into a private room and asked what had happened. Mr Cox said that while moving rubbish bags in the E and F wing foyer someone had approached him from behind and punched him. He said he did not see who did it. The officer explained that he would ask someone from the healthcare team to come and assess him, and that he would open a Challenge, Support and Intervention Plan (CSIP – violence reduction measures used to support perpetrators and victims of violence). In interview, the officer said that Mr Cox did not seem concerned for his safety and he did not think that he needed the support of ACCT procedures. The officer submitted an intelligence report, made a note in the wing observation book, and asked the security department to check CCTV for the assault.

36. A nurse assessed Mr Cox. He had a swollen lip but did not have any dizziness, headache or blurred vision. In interview, she said that Mr Cox did not appear to be upset or anxious, and she had no reason to have any further concerns for his wellbeing.

37. A fellow prisoner who was a friend of Mr Cox, spoke to him that afternoon. In interview he said that they spoke about Mr Cox being assaulted, but that he seemed untroubled by it. He said he had no reason to be concerned about Mr Cox. Another prisoner and friend of Mr Cox also said that when he spoke to him that afternoon he saw no indication that Mr Cox was a risk to himself.

38. The officer later saw Mr Cox when he collected his evening meal from the surgery. He was interacting with other prisoners, and he had no concerns about him.

39. On the evening of 12 October, two officers distributed canteen (food and toiletry items that prisoners had ordered) on Mr Cox's landing. They noted no cause for concern.

Events of 13 October

40. Shortly before 8.00am on 13 October, Officer A unlocked the prisoners on Mr Cox's landing. When he unlocked Mr Cox's cell, he opened the door and spoke to Mr Cox.

In interview, he said that he did not recall what Mr Cox said, but he had no concerns.

41. CCTV shows that two minutes later, Officer B spoke to Mr Cox. In interview, she said that she had been asked to tell Mr Cox that he did not need to clean certain areas that morning (as the perpetrator of the assault against Mr Cox, who had been identified following a review of CCTV, was being taken to the segregation unit that morning and would have to walk through an area that Mr Cox usually cleaned). Shortly after, a fellow prisoner spoke to Mr Cox through his open door, but without entering the cell. (The prisoner declined to be interviewed as part of this investigation.)

42. At 8.22am, Officer B went back to Mr Cox's cell. In interview, she said that she went back to tell him about some jobs he could do. She opened the observation panel on Mr Cox's cell door and saw him hanging. She pressed the general alarm on her radio and shouted for colleagues. Two officers who were nearby were the first to respond. They went into the cell, cut the ligature, lowered Mr Cox to the floor and began CPR.

43. Other staff arrived, including healthcare staff, and continued with CPR. At 8.34am, they asked for further healthcare staff to attend, and for the control room to call an ambulance. Staff continued to provide medical aid until joined by ambulance paramedics. They transferred Mr Cox to an ambulance and on to hospital at 9.50am.

44. Mr Cox left a letter addressed to the Governor. He referred to his frustration at his inability to overcome his addiction problems, as well as problems with drugs on the unit.

45. Mr Cox died in the Intensive Care Unit of the Royal Preston Hospital at 1.44pm on 14 October.

Contact with Mr Cox's family

46. When Mr Cox was taken to hospital, a family liaison officer (FLO) was appointed. She identified Mr Cox's father as his next of kin and informed him that Mr Cox was in hospital.

47. When Mr Cox died, hospital staff informed Mr Cox's father. The FLO subsequently spoke to him. The prison arranged and paid for Mr Cox's funeral.

Support for prisoners and staff

48. When Mr Cox went to hospital, the Head of Cat C Residential and Care and Separation Unit spoke to all staff who were involved in the emergency response and offered support. After Mr Cox's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

49. The prison posted notices informing other prisoners of Mr Cox's death and offering support. A Custodial Manager arranged a meeting to inform prisoners on Mr Cox's

wing that he had died and of support that was available. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Cox's death.

Post-mortem report

50. The post-mortem report concluded that Mr Cox died from hanging. No toxicology tests were carried out.

Findings

Assessment of risk

51. None of the staff or prisoners who saw Mr Cox after he was assaulted on 12 October had any concerns about him. They did not think he appeared scared for his safety or that he posed any risk to himself.

52. An intelligence report submitted after Mr Cox's death indicated that he may have been in debt. This was suggested as the reason that he had been assaulted on 12 October. Wymott has a debt policy, but there had been no recent intelligence prior to 12 October to suggest that Mr Cox was in debt. Nor had he complained to staff that he was in debt.

53. In the letter Mr Cox wrote, addressed to the Governor and found after he was taken to hospital, he said he was frustrated that he had not been able to overcome his addictions and that drugs were available on the wing. There is no evidence that prison staff had ever suspected Mr Cox of being under the influence of illicit substances or involved in illicit drug use (we discuss the issue of information sharing in a following section). Mr Cox was engaged with the substance misuse team. We do not think that prison staff had reason to consider his substance misuse problems to be a risk factor for suicide.

54. We are satisfied that Mr Cox gave no indication to staff that he was scared for his safety or at risk of harming himself imminently before his death and that staff could not have foreseen his actions.

Clinical care

55. The clinical reviewer concluded that the care Mr Cox received in Wymott was of a good standard and equivalent to that which he could have expected in the community. She found that he received appropriate care and treatment for his substance misuse issues.

Information sharing on drug use

56. On 30 June, Mr Cox disclosed to a substance misuse nurse that he had been using cannabis. She did not report this to prison staff. On 19 September, Mr Cox told a psychologist that he had been using substances regularly. She also did not report this to prison staff.

57. Mr Cox was under the care of the substance misuse team and was prescribed methadone to treat his heroin dependency. He had signed a substance misuse compact as part of his recovery and intervention plan to say that he would not use illicit substances. Healthcare staff told us that if a prisoner disclosed drug use and a test confirmed this, they would issue a warning and adjust medication as necessary. They said they would not routinely tell prison staff as sharing of information was permitted only for safeguarding reasons or where there was a risk to self or others. The clinical reviewer found that there was no formal pathway of how or when information relating to illicit substance use should be shared.

58. While Mr Cox was already engaged with and receiving support from the substance misuse team, it is important that prison staff are also aware of admissions of illicit drug use so that intelligence is fed into the prison's drug strategy. Had Mr Cox's key worker or staff on his wing been aware, they could have provided additional support and monitoring. We make the following recommendation:

    The Head of Healthcare should agree a pathway of information sharing with prison staff when prisoners disclose substance use.

Emergency response

59. Prison Service Instruction 03/2013 requires governors to have a medical emergency response code protocol in place so that the nature of the medical emergency is communicated efficiently. This ensures that staff respond quickly with the relevant equipment and there are no delays in calling an ambulance. As is usual, Wymott use code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner has severe bleeding. The control room should call for an ambulance immediately when a code is called.

60. When Officer B found Mr Cox hanging at 8.22am, she called for assistance but did not call a code blue. This meant that an ambulance was not called. It was not until 12 minutes later that staff asked the control room to call for an ambulance.

61. In interview, Officer B said that her focus was on cutting down Mr Cox and starting CPR and in the heat of the moment, she forgot to call a code blue. We note that staff started CPR quickly and the clinical reviewer was satisfied with how it was delivered. We cannot say whether the delay in calling the ambulance affected the outcome.

62. We are satisfied that Officer B was aware of the medical emergency code protocol and that it was an oversight on her part due to the adrenaline of having to deal with an unexpected and distressing situation. Further, it has been acknowledged by HMPPS nationally that policy and practice with regard to calling ambulances in precisely circumstances such as these, is not optimal. At a conference hosted by the PPO on 7 January 2024 and attended by HMPPS and representatives from the Ambulance Service, HMPPS made a commitment to tangible improvements in this policy area. In those circumstances we make no recommendation.

Inquest

63. At the inquest, held from 23 to 26 September 2024, the jury concluded that Mr Cox died by suicide.

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