Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Johnpaul Digweed, a prisoner at HMP Garth, on 13 April 2024

A report by the Prisons and Probation Ombudsman

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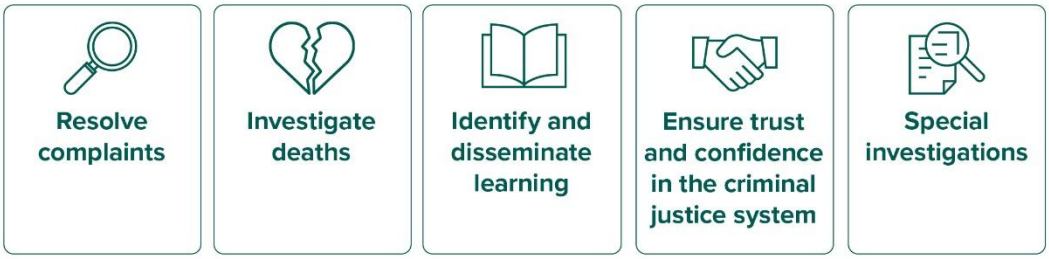
OUR VISION

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 Johnpaul Digweed died after being found hanged in his cell on 13 April 2024 at HMP Garth. He was 36 years old. I offer my condolences to Mr Digweed's family and friends.

Mr Digweed was in the early years of a twenty-five year sentence for drug supply. There was significant evidence that he was involved in prison drug culture and he was found in possession of a mobile phone numerous times. I did not find any evidence that he was at heightened or imminent risk of suicide when he died. However, information received after he died suggested his sentence was putting his relationship under strain and he might have been worried about money.

I am concerned that there is a widespread issue at Garth with prisoners blocking their observation panels and that staff do not always follow local guidance when completing routine checks and welfare checks. The prison has taken some steps to address this but more needs to be done. I cannot say whether this would have changed the outcome for Mr Digweed but it would have led to his earlier discovery.

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 **August 2026**

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Summary

Events

1. On 11 March 2021, Mr Johnpaul Digweed was remanded to HMP Liverpool charged with conspiracy to supply class A drugs. It was his first time in custody. He had misused cocaine and ecstasy in the community. He had no significant history of mental or physical health issues and no significant history of attempted suicide or self-harm. Mr Digweed also spent time in HMP Forest Bank and HMP Leeds. He consistently denied any thoughts of suicide or self-harm. Intelligence was received at each prison that he was involved in prison drug culture. In December 2021, he told his partner in a phone call that he would hang himself if he received a thirty-year sentence. This is the only reference in his prison record to suicidal thoughts.

2. On 24 June 2022, Mr Digweed was sentenced to 25 years in prison and on 8 July he transferred to HMP Garth. Throughout his time in Garth, the prison received significant intelligence that he was involved in organising drone deliveries of drugs and other illicit items and on six occasions he was found with a mobile phone in his possession.

3. Between 21 and 24 September 2023, Mr Digweed was suspected to be under the influence of an illicit substance. Mr Digweed tested positive for cocaine. During this period Mr Digweed harmed himself by making superficial cuts to his chest. He also injured himself by kicking his door. He was offered support from the substance misuse team but declined to work with them. His emails from this period indicated that his relationship with his partner was breaking down. There is no evidence that staff considered starting Prison Service suicide and self-harm support procedures, known as ACCT.

4. On 27 September, staff removed Mr Digweed's prison laptop after they noticed he had damaged the screen. A prison disciplinary hearing (adjudication) was opened and adjourned. The hearing was not completed before Mr Digweed died and he did not receive a replacement laptop meaning he had less control over ordering items from the prison shop, adding credit to his prison telephone account, choosing meals and making applications as prisoners without laptops must use kiosks on the wing. (He complained about this in March 2024 and was told that he could not have a replacement until his adjudication had been heard.)

5. On 10 March 2024, Mr Digweed asked to be assessed for attention deficit hyperactivity disorder (ADHD). A nurse replied that this would not be possible as he had no indications it was necessary.

6. Mr Digweed's prison telephone calls from 9 April – 12 April indicated that his relationship with his partner was under strain. After his death, police confirmed this and that he might have been worried about money. Staff and prisoners that knew him well said that he appeared in a good mood and his normal self on 12 April.

7. Mr Digweed was last seen alive during a routine count of prisoners at 7.39pm on 12 April. At 5.17am on 13 April, his observation panel was covered during the early morning routine roll check. It was still covered at a welfare check at 9.07am. The staff responsible for checking him took no action. At about 11.30am, an officer

unlocked Mr Digweed but did not look into his cell. Shortly afterwards, Mr Digweed was found by a prisoner hanged by a sheet from a light fitting. Officers cut the ligature and started cardio-pulmonary resuscitation (CPR). Nurses attended and asked staff to stop CPR when they discovered unequivocal evidence that Mr Digweed had died. Paramedics attended and confirmed death soon afterwards.

Findings

8. Mr Digweed had no significant history of attempted suicide or self-harm and relatively few factors that indicated he might be at risk. Overall, there was no indication that he was at heightened or imminent risk of harming himself in the period leading to his death.

9. There is no evidence that ACCT monitoring was considered as it should have been after Mr Digweed behaved uncharacteristically over a period of three or four days in September 2023, despite him making made superficial cuts to his chest and injuring his ankle and foot repeatedly kicking his cell door. This was a missed opportunity to identify risk.

10. The roll check, welfare check and unlocking of Mr Digweed's cell were not completed in line with national or local guidance. We are satisfied that the prison has dealt with the individuals making the checks but we are concerned there is a more widespread problem with how staff respond to finding covered observation panels at Garth and that this means checks are not being done properly and records are not accurate.

11. Mr Digweed was without a prison laptop for over six months before he died. This impacted on his ability to control aspects of his daily prison life and might have negatively impacted his mental health and ability to maintain family ties. A backlog of prison adjudications meant that he was unable to complete the first step in the process for obtaining a replacement.

12. Garth's rural location, large perimeter, proximity to several major roads and high number of prisoners associated with organised crime means that it is especially vulnerable to drugs being brought in by drone. We are satisfied that the prison is considering new measures to combat this threat.

13. The clinical reviewer concluded that the healthcare Mr Digweed received for his physical health was responsive and equivalent to that he would have received in the community. She concluded his mental healthcare was moderate and only partially equivalent on the basis that he was not reviewed after harming himself in September 2023 and the nurse responding to his request for an ADHD assessment showed insufficient clinical curiosity.

Recommendations

- The Governor should introduce a robust quality assurance process until he is satisfied there is not a systemic issue with false entries.

- The Governor should evidence how the prison will monitor the challenging of blocked observation panels to ensure compliance with local processes.

- The Governor should introduce a robust quality assurance process to satisfy himself that that all staff look through the observation panel before unlocking cells.
- The Governor should set out how he intends to reduce the number of unheard adjudications.

The Investigation Process

14. HMPPS notified us of Mr Johnpaul Digweed's death on 13 April 2024.

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

16. The investigator visited HMP Garth on 22 April 2024. She watched CCTV during the opening visit. She obtained copies of relevant extracts from Mr Digweed's prison and medical records. She also obtained body worn video camera (BWVC) footage and radio communications from 13 April 2024 and Mr Digweed's prison account telephone calls. As of October 2024, the prison were unable to provide Mr Digweed's cell bell records due to technical difficulties.

17. The investigator interviewed six members of staff and three prisoners at Garth between April and July 2024. She obtained further information from the Head of Drug Strategy, the Deputy Governor, the Head of Healthcare and Lancashire police.

18. NHS England commissioned a clinical reviewer to review Mr Digweed's clinical care at the prison. The clinical reviewer and investigator interviewed the healthcare staff together.

19. 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.

20. The Ombudsman's office contacted Mr Digweed's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Digweed's mother raised some issues with us at initial report stage via her solicitor that we have dealt with in separate correspondence.

Background Information

HMP Garth

21. HMP Garth is a category B training prison and holds long-term and life-sentenced prisoners. It is part of the Long-Term High Security Estate (LTHSE). Greater Manchester Mental Health NHS Foundation Trust provides physical health, mental health, social care and clinical substance misuse treatment. Delphi Medical is subcontracted to provide psychosocial substance misuse services. Prisoners live in single cells.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Garth was in November 2022. Inspectors reported that a key concern was the availability of drugs. The mandatory drug testing rate was high and searching procedures were insufficient. Links with the police were good and the police had led some effective work to reduce drugs and illicit items getting into the prison via drone. There was interagency work to manage gangs and work to tackle staff corruption was very good.

23. The leadership team was committed to improving the standard of keywork and 92% of prisoners surveyed had a named keyworker, although sessions rarely happened at the required frequency and some entries were superficial. Time out of cell was inadequate and there were frequent wing lockdowns due to staff shortages.

Independent Monitoring Board

24. 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 November 2023, the IMB reported that the prison had made significant changes to its security measures which had improved the finding of illicit items, however the prison still had significant issues with drugs. Drone activity was a particular problem. Staff patrols inside and outside the gate had proved effective and windows damaged in order to receive parcels were quickly replaced.

25. The IMB raised a number of other concerns, including staff recruitment and retention. Staff shortages meant constant regimes changes which was unsettling for prisoners. The keyworker system was not working effectively.

Previous deaths at HMP Garth

26. There were 11 deaths in the three years before Mr Digweed died. Three of these were self-inflicted, two were drug related and six were from natural causes. Our investigation into a self-inflicted death in August 2023, found that a routine check of prisoners had not taken place and the record falsified. An officer also did not respond appropriately to finding the prisoner's observation panel was blocked.

As of end September 2024, there had been three further deaths at the prison: one self-inflicted, one from natural causes and one suspected to be drug related. Our investigations into these deaths were ongoing at the time of writing.

Incentives and Earned Privileges (IEP) scheme

27. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Laptops

28. Since July 2022, all prisoners at Garth have been given the opportunity to have a laptop in their cells and sign a compact agreeing to abide by the rules outlined in the Laptop Control Framework. The laptops are used to order items from the prison shop, add credit to their prison telephone account, choose meals and make applications (prisoners without laptops must use kiosks on the wing). There is limited access to YouTube on the laptops where prisoners can watch films uploaded by the prison.

Assessment, Care in Custody and Teamwork (ACCT)

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

30. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan 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

31. On 11 March 2021, Mr Johnpaul Digweed was remanded to HMP Liverpool charged with supplying class A drugs. It was his first time in prison. During a Probation Service assessment Mr Digweed admitted historic use of cocaine and ecstasy in the community. He had no significant history of mental or physical health issues.

32. Mr Digweed told a nurse at an initial health assessment that he had no current or previous issues with drugs, suicide or self-harm or his mental health. The nurse noted he seemed settled and stable and was not on any medication.

33. On 12 March, the prison received intelligence that Mr Digweed was involved in the prison's drug culture. The same day he told a nurse at a secondary health assessment that he had been diagnosed with schizophrenia as a teenager, had stopped taking medication for this at 18 and had not had contact with mental health services since. He also said he had taken an overdose "years ago" after which he saw a psychiatrist once but received no follow up care. Mr Digweed answered some short verbal questions designed to assess whether he had anxiety or depression and scored zero for both.

34. In July, staff suspected Mr Digweed was using cannabis. In September, intelligence indicated that he was still running his drug trafficking operation in the community using an illegal mobile phone and in October intelligence indicated he was involved in organising deliveries of drugs to the prison by drone.

35. On 2 November, Mr Digweed moved to HMP Forest Bank. On 12 November, an intelligence led search of his cell found a mobile phone and charger (each time staff found a mobile phone or illicit items, they were confiscated).

36. On 22 November, Mr Digweed moved to HMP Leeds after he attended court and Forest Bank was full and unable to accept him back. On 29 November, Mr Digweed self-referred to the mental health team. He said he had seen another prisoner trying to cut his throat and it was affecting his sleep, mood, appetite and ability to cope. Mr Digweed had to isolate in his cell for a few days as his cellmate had COVID-19 and he did not receive a mental health assessment before he returned to HMP Liverpool after a court appearance on 6 December.

37. At Liverpool he told a nurse at an initial health assessment that he felt traumatised after seeing a prisoner cut his neck in the wing showers at Leeds. He declined mental health intervention and said he was aware how to self-refer. He denied any thoughts of suicide or self-harm.

38. On 8 December, Mr Digweed told his partner in a prison telephone call that he was worried about the length of sentence he might receive and said he would hang himself if he was sentenced to 30 years. Staff listened to a recording of this call and submitted an intelligence report. They did not note any details in Mr Digweed's general prison record or take any further action.

39. On 3 February, 9 March and 22 April 2022, officers found mobile phones during searches of Mr Digweed's cell. He was charged with breaking prison rules and found guilty at a prison disciplinary hearing (known as an adjudication).

40. On 24 June, Mr Digweed was sentenced to 25 years for several counts of supplying class A and class B drugs. He told a nurse on 27 June that he felt he was coping well despite the length of his sentence and was spending as much time as possible in the gym.

HMP Garth

2022

41. Mr Digweed moved to HMP Garth on 8 July 2022. He told a nurse that he had no current or previous issues with drugs, suicide or self-harm or his mental health. The nurse noted he seemed in good spirits and had no long-term physical health conditions.

42. On 12 July, officers found a mobile phone, SIM card and charger during their search of Mr Digweed's prison property received from HMP Liverpool. The same day, Mr Digweed told a member of the prison's drug and alcohol team that he did not want to work with them. On 16 July, Mr Digweed moved from the induction unit to C Wing. On 23 August, Mr Digweed gained enhanced level on the Incentives and Earned Privileges (IEP) Scheme, meaning he had access to additional privileges such as visits, access to the prison shop, and more opportunity to earn money.

43. On 14 September, Mr Digweed was sent a DVD player that was found to have Wi-Fi capability and he was not allowed to keep it in possession. The next day he tested negative in a random drug test. On 16 September, officers noted his cell smelled of cannabis and was full of smoke. A member of the substance misuse team visited him a couple of days later in response, but Mr Digweed again declined to work with them and refused harm minimisation advice.

44. On 28 September, Mr Digweed had a keywork session with an officer. The officer said he was a regular C Wing officer on Mr Digweed's landing right up until he died. He was Mr Digweed's dedicated keyworker but also saw Mr Digweed every day he was on duty. He said Mr Digweed was always very polite to him and seemed to get on well with everyone. He knew Mr Digweed had family and was in regular contact with them but Mr Digweed never talked to him about any personal issues he had.

45. On 1 November, the security department received intelligence that Mr Digweed and a number of other prisoners might have access to a mobile phone.

2023

46. On 6 February 2023, a prison offender manager (POM), completed a Probation Service risk assessment. She reported that Mr Digweed said he was coping well in prison. He said he had good and bad days was not feeling depressed or like harming himself. His relationship was "up and down" but he kept in contact with his family on a daily basis. Mr Digweed said he thought he might have attention deficit hyper-activity disorder (ADHD – people with this condition may be restless, have trouble concentrating and act on impulse) but had not been diagnosed. The POM noted there was no evidence that Mr Digweed was at risk of suicide and self-harm. She said he appeared settled and planned her next significant contact with him for June 2023 when he was due for a review of his security category.

47. On 13 February, Mr Digweed tested negative after a mandatory drugs test (MDT). On 5 April, he was given a job in the kitchens.

48. On 3 June, Mr Digweed told an officer during a keywork session that he was very happy with his job and also enjoyed going to the gym. On 14 June, Mr Digweed again tested negative after an MDT. Mr Digweed told his dedicated keyworker at successive keyworker sessions on 17 June and 17 July that he was happy and had no issues.

49. On 20 July, staff found a mobile phone in Mr Digweed's cell during an intelligence-led search. He was demoted to basic level of the IEP Scheme for 28 days and sacked from his job in the kitchens.

50. On 24 August, the security department received intelligence that Mr Digweed was overheard discussing receipt of a parcel of contraband.

51. Mr Digweed's security record indicated that he had several episodes of disruptive behaviour between 21 and 24 September and that wing staff had commented that this was out of character for him. At about 3.00am on 24 September, the night orderly officer called a nurse to Mr Digweed's cell after he was observed under the influence of an illicit substance suspected to be a psychoactive substance (PS) and had made cuts to his chest. The nurse recorded that the cuts appeared to be superficial and the cell was not safe to enter due to the PS smoke. Mr Digweed was placed on hourly observations for the rest of the night. There is no evidence that staff considered starting Prison Service suicide and self-harm monitoring (known as ACCT) in line with national guidance.

52. At 5.47am, the C Wing night patrol officer recorded that Mr Digweed had pressed his cell bell, shouted, kicked his door and smashed the glass in his observation panel during the night. At 7.00am, an officer reported seeing Mr Digweed throwing the contents of his cell out of his broken window. At 9.23am, another officer noted that Mr Digweed had been disruptive all night, was clearly under the influence of an unknown substance and had been taken to the segregation unit.

53. A nurse examined Mr Digweed's foot and ankle after he injured it kicking his door in the night. He said wing staff thought Mr Digweed was under the influence of cocaine. The nurse told the orderly officer (the officer in charge of running the prison regime) that Mr Digweed needed to go to hospital to have his foot examined. The orderly officer said he did not have enough staff on duty to enable a hospital escort that day but would arrange it for the next day.

54. The same day, Mr Digweed's prison emails indicated he had received videos via a mobile phone and had argued with his partner because of the content of these. Officers searched his cell and found the mobile phone and a charger. Mr Digweed attended hospital the next day, 25 September, to have his foot examined.

55. On 26 September, a member of the prison's drug and alcohol team spoke to Mr Digweed following the incident on 24 September. Mr Digweed said the incident was a "one off" and he did not want any intervention or support. Mr Digweed was not seen by the mental health team following his self-harm and there is no evidence that anyone considered whether Prison Service suicide and self-harm monitoring (known as ACCT) was appropriate for Mr Digweed.

56. On 27 September, staff removed Mr Digweed's prison laptop after it was noticed that he had damaged the screen. He was charged with damaging prison property and a prison disciplinary hearing was opened and adjourned. The investigator was informed that there was a significant backlog of adjudications at the time and this hearing was not completed before Mr Digweed died. In the meantime, he had no access to a laptop and had to use the wing kiosk.

57. On 2 October, results of tests on Mr Digweed's urine sample provided for a mandatory drug test on 19 September were positive for cocaine.

58. On 31 October, Mr Digweed tested negative in a random drug test.

59. On 1 November, CCTV showed that four prisoners entered Mr Digweed's cell. Staff subsequently discovered Mr Digweed with injuries consistent with him being slashed with a blade. Mr Digweed insisted to staff that he had fallen and would not consent to photographs of his injuries or any other action being taken. The prison informed the police but the investigation was not proceeded with because Mr Digweed refused to cooperate.

60. Mr Digweed's security file indicated that the incident was thought to be drug debt and gang related. A nurse assessed Mr Digweed's injuries. He said Mr Digweed had several slash wounds to the top of his left arm, left elbow and the left side of his chest which he closed with staples or steri-strips and dressed.

61. On 8 November, an officer considered whether Mr Digweed required support under Prison Service violence reduction and anti-bullying measures (using a challenge, support and intervention plan - CSIP). The officer noted that the prisoners suspected of assaulting Mr Digweed were associates of a prisoner thought to be in debt to Mr Digweed. He said Mr Digweed continued to insist that he sustained his injuries falling over in his cell. Mr Digweed had been out on the wing during social time and had not had any further issues. The officer concluded that Mr Digweed did not need ongoing support via CSIP procedures but that staff should continue to monitor him via keywork sessions.

62. On 6 and 18 November, the security department received intelligence that Mr Digweed had a mobile phone. On 20 November, he started a job in one of the prison workshops. On 21 November, Mr Digweed told an officer during a keywork session that he was happy and settled and had no issues.

63. On 26 November, staff searched Mr Digweed's cell and found a mobile phone and charger after the security department received intelligence that Mr Digweed had received a mobile phone via a drone a couple of nights before. On 30 November, intelligence indicated Mr Digweed once again had a mobile phone.

64. On 27 December, Mr Digweed was sacked from his job for refusing to attend.

2024

65. On 6 January 2024, the security department received intelligence that Mr Digweed was involved in organising drone deliveries to the prison of contraband including mobile phones. On 24 January, another mobile phone and charger was found in his

cell and on 30 January further intelligence indicated that Mr Digweed received mobile phones via drones and had threatened other prisoners.

66. On 22 February, an intelligence report showed that certain prisoners on C Wing, including Mr Digweed, were making about £400,000 - £500,000 every couple of months from the proceeds of contraband sent into the prison by drone. The security department assessment acknowledged that there was significant drone activity in and around the prison at that time and windows had been compromised in order to receive packages brought by drone.

67. Mr Digweed's dedicated keyworker spoke to Mr Digweed during a keywork session on 28 February. He noted that Mr Digweed's regular possession of unauthorised articles was preventing him from getting a job in the prison. Mr Digweed told him he had no issues or concerns, was happy on the wing and enjoyed using the gym.

68. On 10 March, Mr Digweed self-referred to the mental health team and asked for a test to see if he had attention deficit hyperactivity disorder (ADHD). A nurse replied that this would not be possible as he had no previous history of ADHD and there was no current need. The nurse was on maternity leave during the investigation, and we did not interview her.

69. On 18 March, officers found another mobile phone in Mr Digweed's cell during a search of the wing.

70. On 25 March, Mr Digweed submitted a complaint form asking for a replacement laptop. He said he had made several requests to wing staff for one and that not having one was affecting his mental health and impacting on his ability to keep in contact with his family and friends.

71. On 1 April, the Digital and Communications Manager replied to Mr Digweed's complaint about not having a prison laptop. She said that the process outlined in the laptop compact was that prisoners that damage their laptops are subject to the prison disciplinary process and are not considered for replacement laptops until the outcome of the hearing. She said she was unable to issue Mr Digweed with a new laptop because he had not had his adjudication. She reminded Mr Digweed where he could access support for his mental health and noted that he could access the kiosk on the wing to top up his prison telephone account.

72. The Digital and Communications manager told the investigator that there was a backlog of adjudications at Garth. As a result the digital team would have reviewed Mr Digweed's case at the beginning of May because they reviewed all cases where the adjudication had not taken place within eight months of the laptop being removed. These reviews took account of the prisoner's behaviour including whether they had been found with weapons, unauthorised items or under the influence of illicit substances. They also liaised with the mental health team and spoke to wing staff.

73. Mr Digweed's dedicated keyworker said Mr Digweed's lack of laptop meant that he was increasingly using his cell bell to ask officers to let him out to use the wing kiosk. He said he thought that Mr Digweed might have been using this as an excuse to be let out of his cell more often. On one occasion two or three weeks before he died, he refused to unlock Mr Digweed to let him use the kiosk. He said that the

next time he saw Mr Digweed out of his cell, Mr Digweed had been “a bit volatile” towards him and not his usual polite self. Mr Digweed had later apologised to him.

74. The investigator listened to recordings of Mr Digweed’s prison telephone calls from 9 April – 11 April. He spoke several times to his partner and to a female relative. In his calls with his partner, it appears that their relationship is under strain. In contrast, during his calls to a female relative, Mr Digweed sounded in a good mood and laughed and joked throughout. At 10.05pm on 11 April, Mr Digweed told her he had “a few years left in me”. The call ended with both agreeing to speak the following day.

75. Mr Digweed spoke to his partner at 10.45pm on 11 April. He tried to speak to his son, but he was too tired. His partner asked whether he wanted her to visit him the following Sunday and Tuesday because it was expensive to get to the prison. Mr Digweed told her not to come at all. He said visits were a waste of time, there was nothing to do in the visits hall and they spoke every day on the phone. Mr Digweed complained about another prisoner. He said he was not feeling well, wanted to spend as much of the next day in bed as possible and wanted some ear plugs as people on the wing were noisy.

76. At 9.15am on 12 April, Mr Digweed phoned his partner briefly. He said he had a cold and as she was about to go to work they agreed to speak later. This was his last prison telephone call.

77. The investigator was provided with the investigation report completed for the Coroner by Lancashire police. Mr Digweed’s partner told them that Mr Digweed phoned her from a mobile phone at about 1.30pm. She said Mr Digweed was drunk and told her that he had had “a couple” and “felt better after a drink”. She said she told him he should not call her in that state and to leave her alone and call her back when he had sobered up. This was the last time they spoke. She said Mr Digweed called her again but she did not answer. Mr Digweed’s partner said this was a minor argument compared with some of their previous ones. She said Mr Digweed had given her no indication that he was feeling low or suicidal. She thought he might have been stressed about money issues but could not be certain. She knew him to drink alcohol when stressed.

78. Mr Digweed’s dedicated keyworker said he saw Mr Digweed before he was locked in his cell that evening. Mr Digweed was cooking chips and gave him one to try. He said Mr Digweed was in his usual good spirits and laughing and joking.

79. CCTV showed that Mr Digweed went into his cell for the night at 5.06pm. At 5.07pm, an officer locked his door. Staff checked Mr Digweed, in line with routine checks of all prisoners, at 5.17pm and 7.39pm and noted no concerns. From the CCTV footage, these checks appear to have been done correctly and Mr Digweed’s observation panel was not obstructed.

80. A prisoner said he had met Mr Digweed in HMP Liverpool in 2021. He thought Mr Digweed’s mental health was deteriorating in the period leading to his death and he was using more cocaine. He thought Mr Digweed was good at “putting a mask on” and hiding his feelings. On 12 April, the prisoner said that Mr Digweed had appeared to be in a good mood and his normal self.

81. Another prisoner had known Mr Digweed for almost two years. He said that Mr Digweed was always smiling and laughing and playing jokes on other prisoners. He seemed to get on well with everyone. He said Mr Digweed had been frustrated at being without a prison laptop and this had impacted on his ability to contact his family. He had spent a lot of time on basic regime due to being found in possession of mobile phones and this meant he did not have a TV to distract him during long hours locked in his cell. The prisoner said he did not notice any change in Mr Digweed's mood or behaviour and he had seemed his normal self. On 12 April, he said that Mr Digweed had seemed in a good mood before being locked in his cell and had cooked some food for himself and some others.

82. Another prisoner lived in the cell next door to Mr Digweed and said he was very good friends with him. He said Mr Digweed enjoyed taking cocaine in prison and could get hold of it relatively easily, although it was harder to get drugs in Garth than in other prisons he had been in. He did not think Mr Digweed was in debt or under pressure because he was in "the right circle". Mr Digweed got on with everyone and he thought if he had any issues they came from outside the prison. He said he had seemed his usual self in the period before he died.

Events of 13 April 2024

83. The investigator watched CCTV, body worn video camera footage (BWVC), listened to radio traffic and obtained information from North West Ambulance Service. She was also provided with the prison's internal investigation into whether staff discharged all their duties in respect of the 13 April roll checks and welfare checks on Mr Digweed. The following account has been taken from all these sources. The timings have been taken from CCTV.

84. At 5.17am, an operational support grade (OSG) completed a routine count of prisoners on C Wing (known as the morning roll check). The OSG told the senior prison manager conducting the internal investigation that Mr Digweed's observation panel was covered. She knocked on the door and used her torch to try to see into the cell. On her third knock she said she heard Mr Digweed respond "Yo! Yeah, yo!" and so moved on to the next cell. At the time of interviews, the OSG was subject to the prison's internal investigation and was not interviewed.

85. At 9.06am, an officer checked Mr Digweed as part of a welfare check on every prisoner. He opened the observation panel but did not look into the cell. He told the senior prison manager that he saw the observation panel was covered, knocked on the door and thought he had got a verbal response from Mr Digweed but could not be certain. He signed the welfare daily check sheet to confirm that all welfare checks had been completed correctly. The officer resigned from the Prison Service before interviews took place and we did not interview him.

86. At 11.28am, an officer unlocked Mr Digweed's cell door for lunch. He did not look through the observation panel or the cell door before or after doing so. At 11.31am, A prisoner went into Mr Digweed's cell and discovered him hanged by a sheet from the cell light fitting. He left the cell immediately and raised the alarm. The officer who unlocked Mr Digweed's cell door entered the cell first. He turned on his BWVC and radioed in quick succession for emergency assistance and a code blue (an emergency code used when a prisoner is having difficulty or has stopped breathing)

before cutting the ligature and placing Mr Digweed on the floor. A supervising officer (SO) arrived and the officer asked her to start cardio-pulmonary resuscitation (CPR). The SO did so, despite being in obvious distress. At the time of our investigation, the officer was on long term sickness absence following serious injuries received in an assault and was not interviewed.

87. North West Ambulance Service records showed that, following the code blue, the control room officer immediately rang 999 and informed the emergency call handler that Mr Digweed was not breathing and an ambulance was dispatched with the highest priority.

88. At 11.35am, a nurse and other healthcare staff arrived and asked for Mr Digweed to be moved on to the landing to allow more room to work on him. The nurse said she arrived to

89. a chaotic scene because prisoners were out of their cells and clearly very upset. She completed some initial checks and found she was unable to insert an airway into Mr Digweed's mouth because his jaw was too stiff. She then noticed other signs unequivocally associated with death, including blood pooling, and instructed the staff to stop CPR.

90. Paramedics arrived at the prison at 11.42am and at 11.51am, confirmed that Mr Digweed had died. Their report noted rigor mortis and blood pooling were obvious indications that Mr Digweed had been dead for some time.

Information received after Mr Digweed's death

91. The same day the prison received intelligence from prisoners that Mr Digweed was "wanted" by organised crime gangs outside the prison and was worried about debts.

92. The prison discovered a mobile phone during a search of Mr Digweed's cell after he died, which they passed to Lancashire police. The Lancashire police report showed that Mr Digweed and his partner had exchanged a number of text messages between 10-12 April. These indicated they were arguing about their relationship, money and visits. In several of the messages Mr Digweed referred to being "sick of" things and said that he could not be bothered any more.

Contact with Mr Digweed's family

93. The prison appointed an officer as family liaison officer. The officer and another trained family liaison officer travelled to Mr Digweed's mother's home and broke the news of his death in person. The officer maintained contact with Mr Digweed's mother and returned his property to her. This included tracking down some of Mr Digweed's property (as requested by his mother) to HMP Leeds. The prison made a financial contribution to Mr Digweed's funeral in line with national guidance.

Support for prisoners and staff

94. A prison manager 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.

95. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

96. The prison posted notices informing other prisoners of Mr Digweed's death, and offering support. The prison delivered postvention support from Listeners supported by safer custody staff. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Digweed's death. The prisoners we interviewed said they felt supported after Mr Digweed died.

Post-mortem report

97. The pathologist gave the cause of death as hanging. The Coroner did not request toxicology tests.

Inquest

98. The Coroner's inquest concluded on 24 June 2026 and determined that Mr Digweed had died from suicide by hanging. The jury found that there were missed opportunities to assess Mr Digweed's mental health and provide appropriate support. Routine checks were not carried out as they should have been and these gaps in care possibly contributed to Mr Digweed's death. Following the inquest, the Coroner issued the Governor of Garth with a Report to Prevent Future Deaths under Coroner's Regulation 28.

Findings

Assessment of risk of suicide and self-harm

99. Mr Digweed had few risk factors that indicated he might be at risk of suicide or self-harm. Apart from a self-reported overdose "years ago", he had no history of attempting suicide and, aside from making superficial cuts while apparently under the influence of illicit substances in September 2023, no history of self-harm. He had no significant history of mental illness aside from an episode in his teens after which he saw a psychiatrist a single time.

100. The clinical reviewer concluded that Mr Digweed's self-harm in September 2023 was unusual and should have been regarded as a new risk. It does not appear that he was seen by the mental health team in response to this or that anyone considered whether he required support under ACCT procedures in line with national guidance. Due to the amount of time between this and Mr Digweed's death, we have not made a recommendation but the Governor will wish to assure himself that ACCTs are opened after a prisoner self-harms.

101. In addition, when Mr Digweed's prison emails were interrogated around this time and found to indicate that he had a mobile phone, his cell was searched but no one appears to have considered that his emails also indicated that his relationship was in crisis. Relationship breakdown is a known risk associated with suicide and self-harm in prison. This was a missed opportunity to explore whether Mr Digweed's behaviour was explained by this and whether he needed extra support or was at further risk of harming himself.

102. There is significant evidence that Mr Digweed was involved in prison drug culture and he was found several times in possession of a mobile phone. The investigator was informed by a prisoner during the investigation that a mobile phone cost about £10,000 in the prison at the time Mr Digweed died. There is a strong possibility that his involvement in drug culture might have led to him being in debt. Although Mr Digweed had apparently been the victim of an assault in November 2023, subsequently there was no evidence that Mr Digweed was being bullied or was vulnerable in prison. He was at the outset of a very long sentence and on 8 December 2021, he confided to his partner that he was worried about the length of sentence he would receive and would hang himself if he received 30 years. This was contained in his security record and was the only identified reference to suicide in his prison record.

103. Mr Digweed consistently refused the opportunity to engage with the drug and alcohol support team at Garth and maintained to his dedicated keyworker, who knew him well, that he was happy on the wing and had no issues. Although one of his friends believed that his mental health was deteriorating in the period leading to his death all agreed that he appeared in a good mood the day before he died and that he was his normal self. None thought he was vulnerable in prison and all were very shocked by his death.

104. We have seen no evidence that staff should have assessed Mr Digweed as at heightened or imminent risk of suicide in the period leading to his death or at any other time in prison. We do not consider that staff could have predicted or

prevented his death. Information gathered after his death by the police indicates that his relationship was under strain and he might have been worried about money.

Roll checks, welfare checks and blocked observation panels

105. In January 2024, the Governor at Garth issued an order reminding staff of the mandatory actions they should take when discovering that a prisoner had covered their observation panel. The order reiterates the guidance set out in Prison Service Instruction (PSI) 74/2011, *Residential Services*, that if staff find observation panels obstructed, they must try to get a verbal response from the prisoner and try and see through the sides or top of the door if possible. If the prisoner does not respond to requests to remove the obstruction, staff must radio for assistance to enter the cell, or if they feel there is a risk to life, to make a dynamic risk assessment whether to enter the cell alone. Staff must not leave the cell door unless it is to raise the alarm. Staff must challenge the prisoner after the event and manage them through the IEP scheme and/or the adjudication policy.

106. At the same time, the Governor issued an order on welfare checks. This instructed staff that best practice during a welfare check was to ensure they had full sight of the prisoner and gained a verbal response from them.

107. Mr Digweed's observation panel was covered when the OSG checked all prisoners at 5.17am on 13 April 2024. She told the prison's internal investigation that Mr Digweed verbally responded to her. His observation panel remained covered at 9.06am when an officer checked Mr Digweed. He said he thought he got a verbal response from Mr Digweed but he could not be sure.

108. The prison conducted an internal investigation into the roll check, welfare check and unlock of Mr Digweed on 13 April. The investigation found that the OSG and officer should face disciplinary hearings. The officer resigned during the internal investigation and the OSG received a formal written warning to remain on her file for 12 months. We are satisfied that the Governor has dealt with this matter and make no further recommendation about individual staff.

109. In our investigation into a self-inflicted death at Garth in August 2023 we found that a roll check had not been completed and the record falsified and that an officer did not respond appropriately to finding the prisoner's observation panel was blocked. It is evident from the prison's investigation that there remains a more widespread problem with covered observation panels and this has impacted on the effectiveness of roll checks and welfare checks and the accuracy of records. The staff interviewed were aware of the local instructions but admitted that they did not follow them that morning. We note that the roll was certified correct and the welfare check log signed for despite no one seeing Mr Digweed alive and well in his cell that morning. We informed police about this matter which they decided not to investigate.

110. As a result of Mr Digweed's death the prison reviewed their local security instructions and the Governor introduced an extra roll check to be completed by day staff at 7.45am. We welcome the action taken so far but we are concerned that they do not fully address the underlying issues of staff failing to complete roll checks and welfare checks in accordance with guidance yet signing to say that they have. We make the following recommendations:

The Governor should introduce a robust quality assurance process until he is satisfied there is not a systemic issue with false entries.

The Governor should evidence how the prison will monitor the challenging of blocked observation panels to ensure compliance with local processes.

Welfare checks at unlock

111. The Prison Officer Entry Level Training (POELT) manual instructs staff to physically check that prisoners are present in their cells before they unlock the door. PSI 75/2011 requires all prisons to have a clearly understood system in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. The PSI deems it unacceptable for staff completing morning unlock not to notice that a prisoner has died overnight.

112. CCTV showed that the officer did not look through the observation panel of Mr Digweed's cell before unlocking his door for the first time on 13 April. The officer was investigated as part of the prison's internal investigation into checking and unlocking practice that morning. The investigation concluded that there was no policy stating that a prisoner must be observed through the observation panel prior to unlocking a cell door (although it was acknowledged that it was good practice to check the well-being of prisoners at this time) and recommended that the officer receive advice and guidance.

113. It is fundamental to prisoner safety that staff always satisfy themselves that each prisoner is alive and well before they unlock their cell door. Equally, it is fundamental to staff safety and the security of the prison that staff satisfy themselves that the prisoner is not intending to harm them once the door is unlocked. We make the following recommendation:

The Governor should introduce a robust quality assurance process to satisfy himself that that all staff look through the observation panel before unlocking cells.

Confiscation of laptops

114. The HMPPS Laptop Control Framework sets out the process for what should happen when a prisoner is suspected of damaging their laptop. The first step is that the prisoner should be charged with breaking prison rules within 48 hours of the damage being discovered. All other steps follow from the outcome of the ensuing adjudication. There is a tariff of fines according to the nature of the damage to the machine. Depending on the circumstances prisoners are then given an opportunity to pay a percentage of the fine and receive a new laptop.

115. We understand the need for such a process given the high cost of replacing such items and a need to discourage their abuse. With increased time in cell caused by staff shortages at Garth, the laptops are even more important to providing prisoners with some control over their daily lives and helping them maintain contact with friends and family. Maintaining family ties is known to reduce risk of suicide and self-harm. Mr Digweed was clearly able to maintain some contact with his family via illegal mobile phone but his ability to easily make orders, applications and arrange

prisoner telephone credit without having to wait until he was unlocked would have been very much reduced.

116. The backlog of adjudications at Garth meant that Mr Digweed was unable take the first step in the process of regaining a laptop through no fault of his own. This must have been deeply frustrating, and we know he complained that it affected his mental well-being. His friends also thought his lack of laptop impacted him negatively.

117. We are concerned that Mr Digweed was not the only prisoner to find himself in this position. In July 2024, there were 26 prisoners at Garth whose laptops had been removed due to damage. We understand that the digital team would have automatically reviewed Mr Digweed's case at the beginning of May if his adjudication had not been heard but we consider eight months an unacceptably long time for someone to wait without having the opportunity to make their case or pay a fine and receive a new machine.

118. We understand that the reason for the backlog in adjudications includes those referred to the police for further investigation and the high number of ongoing charges that must be opened within a certain period of the charge being laid. The Governor has recently asked a senior manager to hear extra adjudications to try to reduce the backlog and we consider that hearings that materially affect individual prisoners' daily lives, such as those relating to laptop damage, should be heard as a priority. We make the following recommendation:

The Governor should set out how he intends to reduce the number of unheard adjudications.

Supply of drugs and other illicit items

119. There is a significant amount of evidence that Mr Digweed was involved in organising deliveries of contraband items via drone and this is the most likely source of the number of mobile phones that were found in his possession at Garth. Garth's rural location, large perimeter, proximity to several major roads and high number of prisoners associated with organised crime means that it is especially vulnerable to drugs being brought in by drone. We are aware that the prison has been working with another prison facing similar issues and that two significant initiatives are at an early stage. The prison has asked that we do not set these out in detail to limit outside knowledge of their proposed countermeasures.

120. We note that the prison has made significant progress in the last two years in terms of enhancing gate security, banning paper from entering the prison and increasing searching and drug testing. In January 2023, the prison received a diagnostic support visit from HMPPS substance misuse team who produced a detailed action plan. A further support visit is planned for the coming months. In October 2024, a new dedicated drug strategy manager was appointed with a remit for reviewing all the processes and overall strategies for dealing with supply, demand and supporting/challenging prisoners.

121. We are satisfied that the prison remains alive to the threat from drugs to the safety and security of the establishment and the prisoners within it and that they are

continuing to innovate in terms of measures to reduce this threat. We make no recommendation.

Clinical care

122. The clinical reviewer concluded that the healthcare Mr Digweed received for his physical health and substance misuse was responsive and equivalent to that he would have received in the community. She concluded his mental healthcare was moderate and only partially equivalent. This was on the basis that Mr Digweed was not reviewed after harming himself in September 2023. In addition, the nurse responding to Mr Digweed's request for an ADHD assessment showed insufficient clinical curiosity and should have explored why he considered that he needed one.

123. The clinical reviewer also concluded that Mr Digweed's actions on 13 April were not foreseeable.

Good practice

124. As well as investigating fatal incidents, the PPO investigates prisoner complaints, the majority of which relate to lost property. We understand what a challenge locating missing items is, especially high value ones. The officer appointed as family liaison officer provided an excellent standard of family liaison and showed admirable tenacity in locating Mr Digweed's missing watch in one of his former prisons and returning it to his mother. This is an example of good practice for which she should be commended.

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