Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Reece Pryce, a prisoner at HMP Five Wells, on 25 December 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 Reece Pryce died from the use of psychoactive substances (PS) on 25 December 2024 at HMP Five Wells. He was 23 years old. I offer my condolences to Mr Pryce's family and friends.

Mr Pryce had a history of substance misuse but declined support when he arrived at Five Wells. Around two weeks before he died, his urine tested positive for PS. Staff referred him to the substance misuse team but he was not seen before he died. While it is likely that Mr Pryce would have declined support, it should nevertheless have been offered. I have recommended a review of whether the existing system of sharing positive drug test results is sufficiently robust.

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 **September 2025**

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Summary

Events

1. On 29 December 2023, Mr Reece Pryce was recalled to prison. On 25 October, he was moved to HMP Five Wells.

2. Mr Pryce had a history of substance misuse. On 30 October, a substance misuse worker recorded that Mr Pryce had declined support from the substance misuse team but knew how to self-refer if he changed his mind.

3. On 9 December, Mr Pryce provided a urine sample for a mandatory drug test (MDT). A week later the prison was notified that the urine sample tested positive for drugs. Staff placed Mr Pryce on a disciplinary charge and emailed the substance misuse team.

4. On 20 December, during a key worker session, Mr Pryce told his key worker that he had no issues with drugs and did not need any support.

5. At around 2.00pm on 25 December, two officers went to Mr Pryce's cell to tell him about the regime that would be running that afternoon. When they opened Mr Pryce's door, they saw him lying face down and unresponsive on the floor. They radioed a medical emergency code.

6. Healthcare staff responded and told the officers to start CPR. Staff continued CPR until paramedics arrived and took over. At 3.17pm, paramedics pronounced life extinct.

Findings

7. When Mr Pryce's urine tested positive for drugs in December, staff sent an email to the substance misuse team. However, the team said they did not see the email due to staff shortages and no one from the substance misuse team saw Mr Pryce before he died.

8. While it appears likely that Mr Pryce would have declined support from the substance misuse team, support should have been offered in line with the prison's local policy.

Recommendations

- The Director and the Head of Healthcare should ensure that the process in place to inform the substance misuse team when a prisoner has a positive MDT is sufficiently robust and that it is audited frequently to check it is working effectively.

The Investigation Process

9. HMPPS notified us of Mr Pryce's death on 25 December 2024.

10. The investigator issued notices to staff and prisoners at HMP Five Wells informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

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

12. NHS England commissioned an independent clinical reviewer to review Mr Pryce's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with seven members of staff.

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

14. The Ombudsman's office contacted Mr Pryce's aunt to explain the investigation and to ask if she had any matters she wanted us to consider. She asked us if Mr Pryce's medical record went with him to Five Wells, about his weight loss medication and what happened to his antidepressant medication. We have addressed these issues in the report.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS. They found no factual inaccuracies. They provided an action plan which is annexed to this report.

16. We sent a copy of our initial report to Mr Pryce's next of kin. Mr Pryce's next of kin raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence.

Background Information

HMP Five Wells

17. HMP Five Wells is a category C prison in Wellingborough and is the UK's first purpose-built resettlement prison. It opened in 2022 and is operated by G4S. Practice Plus Group provides healthcare services 24 hours a day. Practice Plus Group also provides mental healthcare and substance misuse services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Five Wells was in January 2024. Inspectors reported that the availability of illegal drugs had the potential to undermine the stability of the prison. The rate of positive drug tests was too high and there was too little support to reduce the demand for illegal substances.

19. The ingress of drugs and other illegal items was a constant challenge which undoubtedly contributed to debt and associated violence. Leaders were tackling these issues robustly and were working proactively with the police and local community.

20. Inspectors also reported that the drug testing regime was comprehensive. A range of tests were completed in addition to the random testing programme. Suspicion tests based on intelligence were completed promptly and yielded good results. The positive mandatory drug test (MDT) rate averaged around 30% but had been as high as 41% and was consistently among the highest in the comparator group. While tackling the supply of illegal substances was a priority, not enough was being done to address the demand for drugs or to provide more support for drug users.

21. In November 2024, a review of progress visit took place. Inspectors reported that drugs were still a huge problem, and the rate of self-harm in the prison was the highest of all similar prisons.

22. Inspectors concluded that overall, there was some commendable progress, and firm foundations were being set for a safer and more purposeful prison.

Independent Monitoring Board

23. 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 March 2024, the IMB said it continued to be seriously concerned about the number and range of illicit items found in the prison. Drugs appeared to be routinely available, random drug tests had consistently resulted in a positive rate of at least 25% throughout the year, and efforts to reduce the ingress (dog patrols, increased randomised searching, additional drug testing) appeared to have had only modest or temporary success.

Previous deaths at HMP Five wells

24. Mr Pryce was the fifth prisoner to die at Five Wells since December 2021. Three of the previous deaths were from natural causes and the cause of one death remains unknown. There are no similarities between the findings from our investigation into Mr Pryce's death and the findings from our investigations into the previous deaths.

Psychoactive substances (PS)

25. The term psychoactive substances (PS) is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazene) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

26. PS 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 these substances 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, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key Events

27. In September 2022, Mr Reece Pryce was convicted of burglary and theft. He was sentenced to 29 months in prison. He was released from prison on 13 December 2023 to an approved premises. (Approved premises, formerly known as probation or bail hostels, have probation staff onsite and provide an enhanced level of supervision and support.)

28. On 29 December, Mr Pryce was recalled to prison after staff found him with drugs and he absconded. He was arrested and sent to HMP Norwich.

29. Mr Pryce had a history of drug use both in prison and in the community. When he arrived at Norwich, he was offered support for his drug use and regularly attended the substance misuse clinic.

30. Staff found drugs in Mr Pryce's cell on two occasions in February 2024, and they found 12 litres of fermenting liquid in his cell in August. (Illegally brewed alcohol is often linked to the drugs trade as it can be used to extract illicit substances that have been soaked into materials such as paper.)

31. On 17 and 19 September, staff recorded that Mr Pryce was walking around his cell in a zombie like state and appeared to be under the influence of illicit substances. Staff carried out a cell search and found modified vape capsules, tobacco and a large quantity of tablets.

32. On 20 September, a substance misuse worker saw Mr Pryce. He recorded that he spoke to Mr Pryce through his cell door and discussed the dangers of using illicit substances. He recorded that he gave Mr Pryce harm reduction advice.

33. On 23 September, staff found Mr Pryce under the influence again.

34. On 2 October, the substance misuse worker saw Mr Pryce at the substance misuse clinic. Mr Pryce admitted to using psychoactive substances (PS) occasionally. The substance misuse worker recorded that they discussed harm reduction, drug tolerance and overdose risks. Mr Pryce said that he did not need any further contact with the substance misuse team but was aware of how to contact them should he need to do so.

HMP Five Wells

35. On 25 October, Mr Pryce was moved to HMP Five Wells.

36. A nurse completed Mr Pryce's initial healthcare screen. She noted that Mr Pryce was obese and that he was prescribed Orlistat (a weight loss medication). Mr Pryce told the nurse that he had a history of substance misuse and that he had recently used 'Spice' (a type of PS). Mr Pryce declined a referral to the substance misuse team.

37. On 28 October, a nurse recorded that while being on weight loss medication Mr Pryce had gained weight. Mr Pryce had been told that he had to lose weight in the first three months, or the medication would be stopped. Mr Pryce had gained weight so the nurse stopped his medication and referred him to the GP.

38. On 30 October, a substance misuse worker noted that Mr Pryce had declined support from the SMS team. She recorded that Mr Pryce would have naloxone training and receive a naloxone kit before he was released from prison.

39. On 8 November, a nurse recorded that she saw Mr Pryce as staff suspected he was under the influence of illicit substances. She noted that Mr Pryce had glazed eyes and that staff had opened a Wellbeing Intervention Support Plan (WISP – prisoners suspected of being under the influence are monitored for four hours to check for any signs of deterioration and if there are none, the WISP is closed). However, the prison had no evidence of a WISP for Mr Pryce and shared details of a different Mr Pryce for whom a WISP had been opened that day. It appears that the nurse made an entry in the wrong medical record.

40. On 9 December, staff called Mr Pryce for a Mandatory Drug Test (MDT). A week later, a report from the laboratory confirmed that Mr Pryce's urine tested positive for PS. Staff placed Mr Pryce on a disciplinary charge for failing the drug test and a prison manager held a disciplinary hearing. The prison manager told Mr Pryce that he would lose his canteen (ability to buy items from the prison shop) and association for 21 days, however, this punishment would be suspended for three months and would only be activated if Mr Pryce had another disciplinary hearing.

41. On 16 December, an officer recorded that Mr Pryce went into the cell of another prisoner and punched him multiple times. Mr Pryce was downgraded to basic regime and moved to the motivational engagement unit (MEU), a landing for prisoners on basic regime. (Prisoners that are on basic level are not allowed a television in their cell, they have less money to spend at the prison canteen and their association time is reduced to far less than those prisoners that are on standard or enhanced level.)

42. On 20 December, an officer saw Mr Pryce for a key worker session. Mr Pryce told the officer that he had no issues with drink or drugs.

Events of 25 December

43. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 2 September. She also obtained information from East of England Ambulance Service. The following account has been taken from all sources.

44. At around 2.00pm on 25 December, two officers went to each prisoner's cell to tell them what activities they could expect that afternoon. When the officers got to Mr Pryce's cell, they opened the door and saw Mr Pryce lying face down on the floor. He was unresponsive with a tampered vape in his hand. One of the officers radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately). Both officers went into the cell and tried to rouse Mr Pryce. They did not get a verbal response but said that they could feel a faint pulse. Both officers continued to try to rouse Mr Pryce.

45. A minute or so later healthcare staff arrived and told the officers to start CPR. Prison staff and healthcare staff continued resuscitation efforts until paramedics arrived at 2.25pm and took over.

46. At 3.17pm, the paramedic pronounced life extinct.

Contact with Mr Pryce's family

47. At around 4.00pm, a prison manager appointed two officers to visit Mr Pryce's next of kin to break the news of his death. They both went to Mr Pryce's aunt's address to break the news.

48. On 27 December, another officer took over the role as family liaison officer (FLO). She maintained contact with Mr Pryce's family and offered ongoing support. The Prison Service contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

49. After Mr Pryce's death, the Director of Five Wells 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.

50. The prison posted notices informing other prisoners of Mr Pryce's death and offering support. The prison also deployed Listeners to the wing to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Pryce's death.

Post-mortem report

51. The post-mortem report concluded that Mr Pryce died from the use of PS.

Findings

Substance misuse

52. Mr Pryce had a history of illicit substance misuse both in prison and in the community. However, he told staff at Five Wells that he did not have a drug problem and declined support.

53. When Mr Pryce's urine sample tested positive for PS, prison staff emailed the substance misuse team on 16 December to tell them. Due to staff shortages the email was not seen until 23 December, and no one from the substance misuse team saw Mr Pryce before he died. Although Mr Pryce had a history of declining support, it is nevertheless important to follow the prison's local policy and offer intervention and harm minimisation advice whenever a prisoner is suspected to have used illicit substances. We recommend:

    The Director and the Head of Healthcare should ensure that the process in place to inform the substance misuse team when a prisoner has a positive MDT is sufficiently robust and that it is audited frequently to check it is working effectively.

Clinical Care

54. The clinical reviewer concluded that the care Mr Pryce received at Five Wells was equivalent to that which he could have expected to receive in the community. The clinical reviewer made one recommendation about the referral process to the substance misuse team following a positive MDT, which we have included above. She made no other recommendations.

Drug strategy at Five Wells

55. Five Wells' current Drug Strategy, dated November 2023-2024, sets out the actions that the prison has taken and plans to take to reduce the supply of drugs, reduce demand and promote user recovery. It says that the strategy is renewed annually, though as of June 2025, there is no updated strategy. We have been told it is still in draft and due to be issued shortly.

56. Random mandatory drug test results suggest that drug use has fallen since the start of the year. Results for the first quarter of 2025 show that the positive rate was 40% in January, falling to 24% in February and 19% in March. In March, 94% of positive drug tests contained synthetic cannabinoids (PS).

57. The Head of Drug Strategy told us that evidence suggested the main type of drugs prisoners used at Five Wells was PS. In January 2025, 125 prisoners were found under the influence. However, there is nothing specific in the drug strategy that targets the supply and demand for PS. The Head of Drug Strategy also told us that a route of entry for drugs is by drones. There is nothing in the drug strategy that details what Five Wells is doing to prevent drones. While we do not make a recommendation, the Director will wish to note this finding.

Director to note

58. After an incident it is best practice for staff to write a detailed statement setting out their involvement. The investigator asked the prison liaison officer for statements from staff involved on multiple occasions. The liaison officer said that she had asked staff and when they had not responded she had escalated to senior managers but had not had any reply. The investigator has still not received any statements. We bring this issue to the Director's attention.

Inquest

59. At the inquest, held on 17 March 2026, the jury concluded that Mr Pryce died by misadventure.

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