Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan Harding, a prisoner at HMP Parc, on 8 January 2023

A report by the Prisons and Probation Ombudsman

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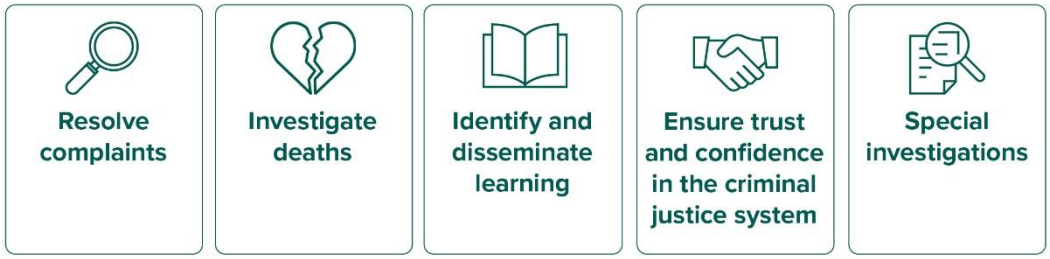
OUR VISION

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 focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.'

Mr Ryan Harding died in his cell on 8 January 2023 at HMP Parc. The pathologist gave a narrative cause of death noting that Mr Harding's was a sudden unexpected death of a person with epilepsy and who had used synthetic cannabinoids and a synthetic opioid (protonitazene). Mr Harding was 26 years old. I offer my condolences to his family and friends.

Mr Harding had no recorded history of drug misuse while at Parc, but another prisoner told us that he had been using psychoactive substances (PS) when locked in his cell. I note that Mr Harding's toxicology report also indicates that he might also have used an unprescribed opioid medicine that he had presumably obtained from another prisoner.

Mr Harding was the first of two prisoners at Parc to die after using synthetic cannabinoids and a synthetic opioid in January 2023. There were two other deaths in the preceding three years following PS use and, alarmingly, four deaths possibly following PS use by prisoners in Parc in February and March 2024 (awaiting confirmation of the cause of death from the Coroner). HMPPS Substance Misuse Group visited Parc in January 2023 and again in April 2024. Their report evidenced significant amounts of PS in Parc and found that many improvements were needed to reduce supply and demand. The prison has introduced new measures in response and work is ongoing. I acknowledge that this is an area with constantly evolving challenges and more can always be done. However, there are a number of factors that mean that PS is likely to be especially prevalent at Parc and I am extremely concerned that unless more is done to reduce the supply and demand for drugs at the prison, more prisoners will die there.

Nationally, there has been increasing awareness and concern about the high toxicity of synthetic opioids, known as nitazenes, including protonitazene, and which are often mixed with other PS or drugs. I am concerned about the grave consequences for Mr Harding, as well as several other prisoners whose deaths we are also investigating. I note that Parc has established several methods of engaging with prisoners about substance misuse and I encourage staff to use those mechanisms to alert prisoners to the significant risks of using drugs potentially laced with these substances. I remain concerned that medication queues are not being adequately supervised.

Although it did not affect the outcome for Mr Harding, the officer who unlocked his cell on 8 January did not check his welfare, so his death was discovered by his cellmate.

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 **October 2024**

Contents

Summary

Events

1. On 18 October 2021, Mr Ryan Harding was recalled to prison for allegedly assaulting and threatening to kill family members. His original sentence was a three-year sentence of imprisonment for possession of cocaine with intent to supply. He was later sentenced to a further 20 months for assault by beating.

2. Mr Harding was initially sent to HMP Swansea and transferred to HMP Parc on 30 November. At an initial health screening, Mr Harding reported a history of cannabis use, but he said he had no current problem with drugs or alcohol. He was not assessed as needing any substance misuse support. Mr Harding also reported that he had been diagnosed with epilepsy in 2018, following a head injury.

3. On 19 December, Mr Harding was assaulted by another prisoner and suffered a broken nose. Mr Harding told staff that the incident was due to a vape debt.

4. At 8.07am on 8 January 2023, an officer unlocked Mr Harding's cell but did not speak to him or his cellmate and instead continued unlocking other cells. At 8.26am the officer returned to Mr Harding's cell to remind him and his cellmate that it was time for work and the officer continued with other duties. Mr Harding's cellmate went to wake Mr Harding and realised that he was dead. The cellmate went to the wing office to tell staff.

5. Officers went to the cell and, after checking Mr Harding for a pulse, began cardio-pulmonary resuscitation (CPR), continued by a nurse. Ambulance paramedics arrived at 8.53am and instructed staff to stop CPR as Mr Harding was dead.

6. Post-mortem examination found that Mr Harding had synthetic cannabinoids and a synthetic opioid in his system. He also had a low level of an unprescribed opioid painkiller in his system. The pathologist gave a narrative cause of death relating to Mr Harding's epilepsy and the presence of these drugs.

Findings

7. There were no recorded incidents of Mr Harding using illicit substances while at Parc and he was not engaged with the prison substance misuse team.

8. Medication queues are not sufficiently supervised.

9. Mr Harding's death was one of a number of other deaths at Parc following illicit drug use.

10. The officer who unlocked Mr Harding on the morning of 8 January did not check his welfare as he should have done.

Recommendations

- The Director should ensure that officers supervise medication queues appropriately to limit opportunities for diversion of medication.

- G4S should pursue with HMPPS the provision of enhanced gate security at Parc, including deployment of additional staff, use of X-ray scanners, more thorough searching of bags and use of drug detection dogs.

- The Director should consider carefully and set out what further action he intends to take in the case of omissions in unlock procedures.

The Investigation Process

11. HMPPS notified us of Mr Harding's death on 8 January 2023.

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

13. The investigator obtained copies of relevant extracts from Mr Harding's prison and medical records. He also obtained CCTV and recordings of Mr Harding's telephone calls. He obtained Parc's Drug Strategy and reports from HMPPS Substance Misuse Group following visits to Parc in January 2023 and in April 2024.

14. The investigator interviewed four members of staff and two prisoners at Parc on 18 April 2023. He interviewed three further members of staff by telephone on 28 April and 9 May.

15. Healthcare Inspectorate of Wales commissioned a clinical reviewer to review Mr Harding's clinical care at Parc. The investigator and clinical reviewer conducted joint interviews with the clinical staff.

16. We informed HM Coroner for South Wales Central 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. We contacted Mr Harding's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Harding's mother asked if her son's death was caused by a drug overdose. We have addressed this question in our report.

18. Mr Harding's mother asked a further question which we have answered in separate correspondence.

19. We shared our initial report with HM Prison and Probation Service (HMPPS) and with the solicitors acting for Mr Harding's family.

20. HMPPS identified one minor factual inaccuracies, which we have corrected in this report.

21. The solicitors acting for Mr Harding's family did not inform us of any factual inaccuracies.

Background Information

HMP Parc

22. HMP Parc is a medium security private prison run by G4S. It holds adult and young adult remand and convicted men. It also has a unit for a small number of young offenders under the age of 18. Since 15 December 2022, healthcare services have been provided by Cwm Taf Morgannwg University Health Board. A local GP practice provides a daily clinic and out of hours cover.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Parc was in June and July 2022. Inspectors found that relationships between staff and prisoners were generally good, but the delivery of key work to support and develop prisoners was limited to those deemed the highest risk. Inspectors reported that the availability of drugs continued to be a key concern and that 49% of prisoners said that it was easy to get drugs at Parc, compared to 32% at similar prisons. However, inspectors also noted that prison leaders understood the risks that illicit drugs posed and were proactive in their efforts to tackle the threat, which included the appointment of dedicated staff to analyse intelligence reports, dedicated staff for search operations and joint work with the police to target staff corruption.

24. Inspectors noted that Dyfodol, the substance misuse service, was well integrated at the prison and worked closely with the drug strategy manager to ensure that substance misuse was a consistent strategic priority. Inspectors noted that all new arrivals at Parc were screened in reception for drug and alcohol issues and saw clinical prescribers as necessary. All prisoners who were suspected of using psychoactive substances continued to be seen for support.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2022, the IMB noted that the reporting year coincided with the second year of the COVID-19 pandemic during which the Board was operating with just two full members which restricted active monitoring across the prison. Within that context, the IMB noted that the level of drug use across the prison was hard to monitor, although there continued to be the presence of drugs and other illicit items. The IMB noted that staff worked diligently to limit the supply of drugs, including use of a body scanner in reception, thorough searching of property, scanning of letters and use of drug dogs.

Previous deaths at HMP Parc

26. Mr Harding was the 18th prisoner to die at Parc since January 2020. Of the previous deaths, two were drug related and in a death from unknown causes, the prisoner had some drugs in his system that might have caused or contributed to his death. Of the other deaths, 13 were from natural causes and one was self-inflicted.

27. In our investigation into a death in August 2020, we found that there was no check on the prisoner's welfare when he was unlocked in the morning. That prisoner was also found at post-mortem examination to have PS in his system.

28. In our investigation into a death in April 2022, following use of a synthetic cannabinoid, we found that the prisoner had also taken unprescribed medication that he had presumably obtained from another prisoner. We had not issued our report into that investigation by the time of Mr Harding's death. In June 2023, we recommended that Parc's drug strategy was updated and included measures to address the diversion of prescribed medication.

29. There was a further death at Parc ten days after Mr Harding's death. That prisoner also died after using both synthetic cannabinoids and a synthetic opioid, combined with use of an unprescribed medicine.

30. Between February and May 2024, there were four further deaths at Parc where illicit substances might have played a part. The investigations into these deaths were still at an early stage in August 2024 when we released this report. In early June, the Director of Parc stood down from her role and a new Director was appointed.

Psychoactive substances (PS)

31. The term psychoactive substances 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.

32. 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 worker scheme

33. The key worker scheme was introduced in the men's prison estate in 2018. It provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

34. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression

Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

35. On 18 October 2021, Mr Ryan Harding was recalled to prison charged with violent offences against family members. He had been released on licence just over six weeks earlier while serving a three-year sentence for possession of cocaine with intent to supply. Mr Harding was taken to HMP Swansea and was later sentenced to 20 months for assault by beating.

36. Reception staff at Swansea started Prison Service suicide and self-harm monitoring (known as ACCT), as Mr Harding had told police officers that he would kill himself. He appears to have settled quite quickly after this and staff closed the ACCT on 8 November.

37. On 30 November, Mr Harding was moved to HMP Parc. At Parc, a reception nurse noted that Mr Harding had a history of cannabis use, but he said he had no current problems with drugs or alcohol and so he was not referred to the prison substance misuse service. Mr Harding said that he had no thoughts of suicide or self-harm. He also said that he had been diagnosed with epilepsy in early 2018.

38. After seeing the reception nurse, one of Parc's doctors prescribed Levetiracetam for epilepsy, Quetiapine for schizophrenia and bipolar disorder, and Soprobec for asthma.

39. At a follow-up healthcare assessment on 2 December, Mr Harding said that he had suffered a head injury in January 2018 that had caused bleeding on the brain. A previous entry in Mr Harding's healthcare record noted that the brain injury led to his diagnosis of epilepsy.

40. On 7 February 2022, staff recorded that Mr Harding was working hard as the head cleaner on Parc's A1 wing.

41. In early September, Mr Harding moved to B4 wing. He told an officer that he had no drug or alcohol issues and, at a key worker interview on 8 September with a Prison Custody Officer (PCO), said that he felt safe on B4. He said that his mental health was the best it had ever been and that he wanted to get a job as a cleaner. He later started work as a cleaner on B4.

42. On 19 December, Mr Harding was seen leaving a neighbouring cell with blood dripping from his face and he appeared unsteady on his feet. Mr Harding said that he had been assaulted by another prisoner due to a vape debt. He was sent to hospital where an X-ray confirmed that his nose was broken. His wound was treated, and he returned to Parc the same day.

43. The prisoner who assaulted Mr Harding was moved to the segregation unit and the police were informed. Mr Harding was offered the opportunity to move to a different wing, but he declined the offer as he said he felt safe on B4. (A managerial report included an erroneous entry that this was the second time Mr Harding had been assaulted on B4; this was the only time he was assaulted.) There is no evidence that staff explored the debt issue any further.

44. On 29 December, Mr Harding went to hospital, where his nose was placed back in alignment. On return to Parc, a nurse noted that Mr Harding was in a good mood and was happy with his appearance following the realignment of his nose.

45. On the afternoon of 7 January 2023, Mr Harding telephoned his mother. He said that he had no problems and asked her to send him some money. They also spoke about his release from prison in around seven weeks. Mr Harding also made two calls to a friend, and they chatted about general matters. Mr Harding said that he had started an anger management course and again mentioned his release in seven weeks. The investigator's opinion was that Mr Harding seemed in a good mood.

46. At 8.40pm on 7 January, PCO A checked Mr Harding's cell during the final routine check of the day. The PCO noted nothing of concern. He told the investigator that he was very systematic in the way he carried out these checks and he would not move away from cells until he had obtained a clear sight of the prisoners and was satisfied he had no concerns. He could not specifically remember what Mr Harding was doing at the time.

Events of 8 January

47. The following account is taken from CCTV footage, prison documents, staff reports and interviews with witnesses.

48. At 5.10am, PCO A carried out an early morning routine check and again, although he could not specifically remember what Mr Harding was doing at the time, noted no concerns.

49. At 7.13am, PCO B went to Mr Harding's cell to carry out another routine check. He told the investigator that Mr Harding and his cellmate were in their beds, and both appeared to be sleeping.

50. At 8.07am, PCO B unlocked cells on B4, including Mr Harding's cell. He said that he had said good morning when he unlocked the door and might have popped his head into the cell, but he acknowledged that he did not wait for a response from the prisoners as he should have done.

51. At 8.12am, another prisoner, who worked as a barber, briefly went into the cell to ask the cellmate if he wanted a haircut. The prisoner told the investigator that Mr Harding was in bed but seemed to be in an unusual half sitting position. He asked the cellmate if Mr Harding was okay, and the cellmate said that he was still sleeping. The prisoner also told the investigator that Mr Harding had been using Spice (a slang term for PS), but he used it while in his cell so staff would not know. In contrast, the cellmate told the investigator that he was unaware that Mr Harding had been using drugs.

52. At 8.26am, PCO B went into Mr Harding's cell and came out 12 seconds later. He told the investigator that he went to the cell to remind Mr Harding and his cellmate that it was time for work (both prisoners worked as wing cleaners). He said that he thought that the cellmate was washing himself and Mr Harding was still in bed.

53. The cellmate told the investigator that after the PCO reminded him that it was time for work, he went to wake Mr Harding. When he tried to wake him, it seemed that he was dead. At 8.28am, he left the cell and went to the wing office to alert the staff.

54. PCO B and PCO C were in the wing office when the cellmate came to tell them that there was something wrong with Mr Harding.

55. At 8.29am, both PCOs went to the cell. PCO B said that when he got close to Mr Harding, he saw that his skin was blue. He told PCO C to lock away the other prisoners. He checked Mr Harding for a pulse but found none. He noted that Mr Harding's body was cold to the touch, and he began CPR. As he was on his own, he did not move Mr Harding from his bed at that point. After giving a number of chest compressions, he realised that his first action should have been to radio a code blue emergency (to indicate a prisoner is unconscious or having breathing difficulties). He briefly stopped CPR to radio the emergency. Control room staff immediately requested an ambulance.

56. A nurse and a healthcare assistant arrived at 8.31am. The nurse instructed that Mr Harding should be moved to the floor and, on checking Mr Harding, noted that his lips were cyanosed (blue in colour), that his skin was cold and clammy, and that rigor mortis was present (rigor mortis is stiffening of the muscles and normally sets in between two and six hours after death). She tried to insert an airway tube to deliver oxygen but could not do so as Mr Harding's jaw was clenched tight. PCO B said that it was only when he helped move Mr Harding to the floor that he realised that his entire body was solid with rigor mortis.

57. The nurse noted that a defibrillator instructed that no shock should be given so staff continued giving CPR. At 8.53am, paramedics got to the cell and checked Mr Harding for any heart activity. At 8.57am, paramedics pronounced that Mr Harding had died.

Contact with Mr Harding's family

58. Parc appointed a family liaison officer (FLO). Mr Harding had named a friend as next of kin and, accompanied by one of the prison's deputy director's, the FLO went to the friend's address at 11.50am where she broke the news of Mr Harding's death. At 12.20pm, the FLO and the Deputy Director went to Mr Harding's parents' home. Upon their arrival, Mr Harding's mother was on the telephone to Mr Harding's friend, who had already broken the news.

59. Parc contributed to the cost of Mr Harding's funeral in line with national instructions.

Support for prisoners and staff

60. After Mr Harding's death, Parc's Head of Security 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.

61. Parc posted notices informing other prisoners of Mr Harding's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Harding's death.

Post-mortem report

62. Toxicological investigation of Mr Harding's blood and urine samples detected the presence of his prescribed medicines at a therapeutic level (therapeutic level refers to the level prescribed to treat an illness). Toxicological investigation also found that Mr Harding had a low blood concentration of buprenorphine, a strong synthetic opioid painkiller, which had not been prescribed to him. Mr Harding also had several synthetic cannabinoids (PS) in his system which the toxicologist suggested were of recent use. Tests also found low levels of another form of synthetic opioid (protonitazene) in his system. In his concluding remarks, the toxicologist noted that it was not clear whether his findings would contribute to Mr Harding's death, however toxicity from synthetic cannabinoid or synthetic opioid use must be considered.

63. Mr Harding's post-mortem examination identified no evidence of natural disease to account for his death but said that a seizure related death could not be excluded at that time. The pathologist noted that further examinations would need to be conducted before any attempt could be made to formulate a cause of death.

64. In a supplementary report the pathologist noted that the factors that could have been of significance in Mr Harding's death were his history of epilepsy, apparently following head injury, the toxicological findings and Hashimoto's thyroiditis (an autoimmune disease when the body makes antibodies that attack the cells in the thyroid). The pathologist wrote that it was well recognised that a sudden and unexpected death can occur in those with a history of epilepsy but also noted that Mr Harding had apparently been seizure free for several years and the toxicological examination showed presence of a therapeutic level of his anticonvulsant medicine (Levetiracetam).

65. The pathologist wrote that Hashimoto's thyroiditis had been suggested as a possible explanation for sudden unexpected deaths, but he did not consider that he could attribute Mr Harding's death to that cause as there were other competing potential causes of death. The pathologist acknowledged the toxicologist's conclusions, although he noted that the concentration of synthetic opioid was much lower than in cited deaths from mixed drug toxicity.

66. The pathologist concluded that in these circumstances, he could not give a precise cause of death and instead gave a narrative conclusion, listing the conditions that might have played a part. He therefore concluded Mr Harding's was, "*1a. Sudden unexpected death in a man with epilepsy (following head injury), and Hashimoto's thyroiditis, who had been exposed to synthetic cannabinoid receptor agonists and protonitazene."*

Findings

Mr Harding's substance misuse

67. When Mr Harding arrived at Parc in November 2021, he said that he had a history of cannabis use, but also said that he had no current problems with drugs. There were no recorded instances of Mr Harding being seen under the influence in his 13 months at Parc, so there was no apparent reason for him to be offered support from Dyfodol. We note a prisoner's evidence that Mr Harding had been using Spice but had been using it in a way to ensure staff would not know. Mr Harding's cellmate said he was unaware that Mr Harding used drugs.

Drug strategy at Parc

68. Parc's drug strategy for 2022/2023 noted that PS continued to be an ongoing area of concern. The strategy document reports on a research project that identified three main reasons why people in custody used PS, which were to cope with thoughts and feelings, to manage boredom and to self-medicate psychological symptoms. The project highlighted the need to focus on improving how prisoners cope with being in prison, with particular focus on prisoners aged 31 to 40 as they were the dominant users. The strategy made clear that reducing the supply of and trafficking of illicit items, including substances, was critical. It noted that traditional methods of supply, such as throw-overs, staff corruption and visits, continued, but there had been increased use of drones in recent years and a significant increase in PS sprayed paper through internal mail. In response to these risks, Parc upgraded the CCTV coverage of the external perimeter, had invested in drone detection technology, had installed a Rapiscan device (which detects drugs) to check mail and were awaiting a body scanner. The strategy noted that in addition to preventing drugs getting into the prison, intelligence gathering was critical in limiting trafficking through targeted searching including use of drug detection dogs.

69. Parc's strategy for 2023/2024 was broadly similar to the previous year's strategy. It noted that there had been a worrying increase in PS incidents in early 2023, with concern that in addition to synthetic cannabinoids, synthetic opioids (such as protonitazene) were also coming into the prison. The strategy noted that the increase, together with two deaths from apparent substance misuse in January 2023 (including Mr Harding's death), had resulted in the development of a PS action plan. Specific actions within the action plan included proactive provision of harm reduction advice, advertising of Dyfodol services, an amnesty for prisoners to hand in drugs and the issue of a notice to prisoners warning of the dangers of protonitazene.

Measures to reduce supply and demand for drugs in place at Parc before Mr Harding's death

70. Newly arrived prisoners at Parc were subject to full searches, including through the X-ray body scanner and all prisoners were subject to lower level searching through the day.

71. Intelligence led searching of prisoners and their cells for illicit items was conducted daily.

72. From late 2022, Parc reviewed the process for prisoner visits from the point of entry up to the visits hall and had a dedicated search team with drug dog support focusing on social visits. As part of the review Parc submitted a business case for a second X-ray body scanner to be used on prisoners following a visit.

73. All prisoner mail was photocopied, and all legal mail was tested with the Rapiscan. Parc had also established links with the Regional Organised Crime Unit and, in partnership with them, conducted a number of joint operations targeting specific areas of drug supply including via social visits, via kitchen staff and via officers. The Regional Organised Crime Unit also provided specific intelligence to Parc to assist with specific targeted searches of prisoners' cells.

Advice to prisoners

74. In December 2022, Parc published a notice to prisoners about new forms of PS that were being found in prisons in South Wales that contained synthetic cannabinoids and synthetic opioids. The notice explained that these substances were up to 200 times stronger than morphine and their use had caused many deaths. The notice gave advice on how prisoners could keep safe and was published for prisoners to access on the self-service kiosks. Further notices were published in 2023 as other, even stronger, forms of PS became available. Following feedback from a prisoner council meeting, Parc moved to publication of information on PS developments through paper notices directly delivered to each prisoner. In addition, Parc engaged in television and radio interviews with local media on the dangers associated with the developing forms of PS and prisoners were told of the dates and times of the programmes.

Actions taken after Mr Harding's death

75. Following Mr Harding's death and another apparently drug related death 10 days later, Parc requested support from HMPPS' National Drug Strategy team. The Substance Misuse Group (SMG) visited Parc in January 2023. Key points noted by SMG included that:

- Parc's Head of Drug Strategy had a clear focus and was delivering positive work.
- Parc had a comprehensive drug strategy with links to the debt strategy.
- Parc's analysts produced good information on the current risk of drugs based on evidence from security reporting systems.
- The substance misuse team supported prisoners found to have used drugs.
- PS was reported as the prominent drug of choice.
- The price of PS at Parc was considerably lower than the national average.
- The low price of PS at Parc suggested that a considerable supply was available.
- Parc did not have a specific PS strategy.
- Parc received a good service from local police, but there was potential for improvement in the working relationship.

- The main way PS was getting into the prison was likely to be via prisoner admissions, with supply via confidential legal correspondence (Rule 39 letters) and legal visits, together with staff corruption also being likely routes. Parc's intelligence collection did not focus on these areas.
- Intelligence gaps that needed to be explored were paper based PS (including PS on books) and PS on clothing.
- The number of parcels entering Parc was a particular concern.
- There was limited intelligence on PS coming in via the outer walls and fencing and it was likely that this would become an increased avenue for supply as security in other areas was tightened.
- Parc did not have an enhanced searching area for staff and visitors.
- There appeared to be a punitive approach to substance misuse at Parc and the prison would benefit from development of a rehabilitative approach.

76. SMG made 15 recommendations (some of the recommendations were for actions already being undertaken at Parc). Actions introduced at Parc following the SMG report included improvement to CCTV coverage of the perimeter wall, consideration of enhanced drone detection equipment, use of an X-ray body scanner to check prisoners following social visits, allowing prisoners to receive just one package of property within 28-days post-conviction and all clothing received from the community to be washed before being given to the prisoner.

77. In April 2024, SMG made a follow-up visit to Parc as part of the response offered following the series of deaths at the prison in early 2024, some of which were found to be drug related. SMG noted that it was evident that Parc had used the information from the 2023 visit to reflect on areas of illicit substance supply reduction. However, SMG found that since the previous visit, the price of PS had reportedly fallen considerably which suggested that a sizeable supply was available. SMG noted that the entrance gate had previously been identified as a vulnerability, and on this visit they considered that searching practices were poor with minimal attention paid to the contents of bags. SMG also noted a potential problem with the body scanner used to check newly arrived prisoners.

78. SMG noted that Parc's Drug Strategy Lead, together with other senior managers had been extremely proactive in trying to combat use of illicit substances, including the new threat from nitazenes.

79. SMG spoke to prisoners who consistently said that the main driver for drug seeking behaviour was boredom and constant changes in the consistency of regime delivery. SMG understood that prisoners who were not employed and not in education only received a maximum of 90 minutes out of their cells each day. SMG also spoke to staff from Dyfodol and made physical observations across the prison. In their summary of findings, SMG found that Parc had many staff dedicated to roles involving drug strategy and security and who were clearly committed to delivering a safe, secure and stable environment. However, SMG also found that while there was a lot of good individual work being driven by the Drug Strategy Lead, Parc would benefit from closer strategic alignment between departments. SMG also found that staffing levels and associated regime changes were impeding drug strategy delivery and potentially increasing demand for illicit substances.

80. SMG made five recommendations, including the need for closer strategic alignment between security, safety and drug strategy; for promotion of the drug strategy in helping deliver key messages, and for a review of medication administration.

81. In response to SMG recommendations, Parc developed an action plan that included improved use of technology to identify and remove substances from circulation, improved management of intelligence to better understand supply routes of substances and how to reduce supply, to commence installing improved cell windows to reduce conveyance of substances via drones and throw-overs and to improve support and education of prisoners. Parc also developed a specific action plan aimed at improving recruitment and retention of staff.

82. We fully recognise the significant challenges inherent in preventing drugs entering Parc. PS is especially prevalent in category C prisons because their lower security measures and stable population allows for the maintenance of distribution networks. In addition, Parc has a large population, has a large perimeter and is situated in an open and accessible semi-rural area close to the M4 making it vulnerable to throw-overs and drones (although we understand that both throw-overs and use of drones at Parc has diminished in recent times). The illicit drugs market in prison is controlled by organised crime gangs and the scale of the problem requires a co-ordinated approach, which Parc fully recognises and has been doing. Although it is clear that some very good work is being done at Parc, including the analysis of intelligence and the system for checking the validity of legal mail, the threat from drugs is constantly evolving and more can always be done. We expect the Director to maintain focus on all actions needed to reduce supply and demand for drugs.

Diverted medication

83. Mr Harding had buprenorphine (also known as subutex) in his system when he died which had not been prescribed to him. At Parc, subutex is always prescribed not-in-possession, meaning it is dispensed daily to the prisoner at the medication hatch. We do not know how Mr Harding obtained the subutex, however if he obtained it from a prisoner being prescribed this medicine that would mean that the other prisoner would have concealed the tablet in his mouth without detection and which he subsequently gave or sold to Mr Harding.

84. In our investigation into a death from PS in April 2022, we found that the prisoner had also obtained and used an unprescribed medicine that he had presumably obtained from another prisoner. In July 2023, Parc responded to our recommendation on diverted medication to say that training sessions had been delivered to staff focusing on supervision of medication queues and responding to medication diversion. It is disappointing to note that when SMG visited Parc in April 2024, they found that prisoners receiving medication on A and B wings were not being observed by officers. Instead, medical staff had to distribute medication alone, and to attempt to check that the medication had been taken correctly, which was made more difficult by the pharmacy security barrier.

85. In our investigation into a death at Parc ten days after Mr Harding's death, the prisoner had again been able to obtain medication not prescribed to him. The Director will need to consider urgently our concerns and those made by SMG on the lack of officer supervision of medication queues. The Director will be aware of the

grave dangers associated with prisoners obtaining and using non-prescribed medication, and in particular when those medicines are combined with other medicines or illicit drugs. We make the following recommendation:

The Director should ensure that officers supervise medication queues appropriately to limit opportunities for diversion of medication.

Entrance gate

86. Among its findings SMG noted that Parc's entrance gate was vulnerable with poor searching practices of visitors and their bags. PPO investigators who have visited Parc would concur with this assessment. They were searched in what they considered was a narrow corridor and two of the investigators who visited on separate occasions did not consider that their bags had been searched thoroughly. We make the following recommendation:

G4S should pursue with HMPPS the provision of enhanced gate security at Parc, including deployment of additional staff, use of X-ray scanners, more thorough searching of bags and use of drug detection dogs.

Key-worker scheme

87. Mr Harding had just seven key worker meetings in his 13 months at Parc. The Head of Rehabilitation told the investigator that Parc delivered the key worker scheme on a priority group and non-priority group basis. Priority group prisoners were those who had been identified as being vulnerable and they received weekly key worker sessions. With non-priority group prisoners, Parc aimed to deliver monthly key worker sessions.

88. Mr Harding would have been in the non-priority group so should have received monthly sessions. The Head acknowledged that Parc had not always been able to achieve their target for delivery of sessions due to operational reasons. He said that it was possible that further key worker sessions had been offered to Mr Harding which he declined, although in that case staff should have made a record of the interaction. He provided data to show that in the first six months of 2024, Parc achieved 95% of the target for delivery of key work sessions to priority group prisoners and we note that delivery remained consistent across the six-month period. For non-priority group prisoners Parc achieved 104% of the target delivery, although we note a significant drop in performance in June 2024 where Parc achieved 73% of target delivery. As Parc is now delivering key work sessions at a reasonable level we make no recommendation, however the Director will wish to ensure that the prison maintains performance in this important area of prisoner support.

Unlock procedures and wellbeing checks

89. Prison Service Instruction (PSI) 75/2011 on residential services says that it is unacceptable that the PPO has identified cases where prisoners had died overnight but staff unlocking them had not noticed that they had died.

90. The local security strategy at Parc includes that when cells are unlocked in the morning, staff are required to make a welfare check of the prisoners including obtaining an oral response from each prisoner.

91. When PCO B unlocked Mr Harding and his cellmate at 8.07am on 8 January, both prisoners were in bed and, after saying good morning, he moved to the next cell without gaining a response. Prison guidance says that staff should check on a prisoner's welfare at unlock by getting a response from them and the PCO accepted that he was aware of this requirement and gave no clear explanation for why he failed to do so that morning.

92. When Mr Harding was discovered unresponsive 25 minutes later, rigor mortis was established (this typically starts several hours after death). It is likely, therefore, that the delay made no difference in Mr Harding's case. However, in other circumstances the failure to get a response at unlock could lead to a delay in identifying that a prisoner needs medical attention or a threat to the security of the prison.

93. Parc's present and previous Heads of Security told the investigator that Parc had reissued the instruction to staff on unlock procedures and reminders on the process had been given at safety meetings. Parc had also introduced enhanced managerial checks on daily compliance with the instruction, including checks of CCTV. The Head of Safer Custody told the investigator that despite the reissue of notices to staff, omissions on welfare checks were still occurring, although the majority of omissions were during afternoon unlock.

94. As staff at Parc continue to disregard instructions on unlock procedures we recommend that:

    The Director should consider carefully and set out what further action he intends to take in the case of omissions in unlock procedures.

Clinical care

95. The clinical reviewer concluded that Mr Harding's care at Parc was of a standard equivalent to that which he could have expected to receive in the community. He noted that chronic disease management reviews of Mr Harding's conditions of epilepsy and asthma appeared to have been managed appropriately.

96. The clinical reviewer identified two minor concerns in Mr Harding's care, neither of which were directly linked to his death. The first concern was that Mr Harding's baseline observations of pulse, blood pressure and oxygen saturation were not taken at his initial health screening (we recently made the same recommendation in the case of another death at Parc). The second concern was with the management of a foot wound that Mr Harding suffered in December 2021. The clinical reviewer has made linked recommendations which the Head of Healthcare will wish to address.

Inquest

97. An inquest held on 19 January 2026, concluded that Mr Harding’s death was a sudden unexpected death in a man with epilepsy (following head injury), and Hashimoto's Thyroiditis, and who had ingested Synthetic Cannabinoid Receptor Agonists, Protonitazene and buprenorphine.

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