

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Mather a prisoner at HMP Garth on 30 September 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Martin Mather was found hanged in his cell on 30 September 2016 at HMP Garth. Mr Mather was 29 years old. I offer my condolences to Mr Mather's family and friends.

I do not consider that Mr Mather was appropriately supported after telling a supervising officer he had got himself into debt at the beginning of September, and I am not satisfied that Garth properly investigated the extent of the threat against him or considered the risks of self harm to which he was exposed.

More generally, the investigation found worrying accounts of drug misuse, debt and violence and Mr Mather's death is one of three recent deaths at Garth that appear to involve significant drug and debt issues. The Governor must act proactively to reduce the availability of drugs within the prison, tackle the levels of violence and provide support to those who are vulnerable as a result.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

June 2017

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Summary

Events

1. On 26 April 2010, Mr Martin Mather was remanded to HMP Altcourse charged with murder. He was sentenced to life imprisonment on 15 November 2010. He had made a number of suicide attempts in the past. He transferred to HMP Garth on 10 March 2011. Mr Mather seemed to settle well at Garth and had a good job.
2. On 20 July 2016, a chaplain told Mr Mather his father had died. A nurse practitioner and a chaplain both saw Mr Mather on 28 July and thought he was coping. They did not think that he was in low mood or at risk of suicide or self-harm.
3. At the beginning of September, Mr Mather told staff that he was in debt for drugs and had started using when his father died. Prisoners told us Mr Mather had used subutex (an opioid used to address withdrawal symptoms) for some time, but took more after his father's death. Mr Mather told staff he was not suicidal but he named two prisoners who were putting pressure on him to pay them. Staff arranged a wing move on 3 September. No other support measures were put in place.
4. On 30 September, at 8.26am, an officer found Mr Mather hanged from his light fitting, called a code blue emergency. Other staff arrived quickly with a defibrillator. It took nurses over six minutes to arrive and there was a five minute delay in calling 999. Staff and paramedics were unsuccessful in their attempts to resuscitate Mr Mather.

Findings

Drugs, bullying and violence reduction

5. Prisoners told us it is easy to get drugs at Garth. This drug misuse is closely associated with violence, bullying and debt. Garth did not make sufficient attempts to follow up Mr Mather's disclosure about being in debt and feeling threatened. Moving wings did not resolve his problems.

Assessing the risk of suicide and self-harm

6. Staff do not appear to have engaged with Mr Mather after he moved to C wing to see how he was settling, whether the debt had followed him from D wing or whether he needed support. Outwardly, he appeared well.
7. Information about Mr Mather's drug and debt issues should have been followed up more effectively. No one tried to assess whether he was at risk of suicide or self-harm after he moved wings.

Checking prisoners' well-being at unlock

8. Garth has no instruction about the importance of staff receiving an acknowledgement from prisoners at morning unlock. The officer unlocking Mr

Mather did not see him and we cannot know whether Mr Mather was already suspended at this time.

Emergency response

9. PSI 03/2013, *Medical Emergency Response Codes*, states that when a medical emergency is called over the radio network, an ambulance must be called immediately. We were told that code blue emergency messages can be a daily occurrence at Garth and are used when someone is suspected of having taken a new psychoactive substance (NPS). The ambulance is often stood down in this situation.

Resuscitation

10. Officers carried out compression-only resuscitation while waiting for nursing staff to arrive. The officer who found Mr Mather was prepared to give breaths had a disposable mask been available to him. He said he had previously requested one. We agree with the clinical reviewer that it would have been preferable for rescue breaths to be given alongside chest compressions.

Family liaison

11. There was a long delay in notifying Mr Mather's niece of his death. In part, this was because the prison had the wrong person listed as next of kin. Many prisoners at Garth are serving long sentences and keeping an up to date record of next of kin is important.

Recommendations

- The Governor should ensure that all information indicating bullying and intimidation is effectively coordinated and fully investigated; that alleged perpetrators are appropriately challenged; and that apparent victims are effectively supported and protected with meaningful long term solutions, which address their individual situation.
- The Governor should review the supply reduction strategy to help reduce the supply of and demand for new psychoactive substances and other drugs, and that staff are vigilant to signs of misuse and know how to respond when a prisoner appears to be under the influence of substances.
- The Governor should ensure that, in line with the Expectations Policy, residential landing officers understand their responsibilities, take time to try to get to know their prisoners and make regular entries in prisoners' case notes.
- The Governor should ensure that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them.
- The Governor should ensure that when unlocking or locking a cell door, staff check that prisoners are safe and that there are no immediate issues that need attention.
- The Governor should ensure control room staff call 999 immediately when an emergency code is called and ask for an ambulance.

- The Governor and Head of Healthcare should ensure that there are sufficient properly equipped and trained first aid staff at all times.
- The Governor should ensure that annual updates of next of kin details, including name, telephone numbers and addresses are requested from prisoners and noted in their NOMIS prison record.

The Investigation Process

12. The initial 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.
13. The investigator visited Garth on 5 October. She obtained copies of relevant extracts from Mr Mather's prison and medical records.
14. Another investigator subsequently took responsibility for the investigation. She interviewed 11 members of staff and seven prisoners at Garth on 23 and 24 November 2016. Four more staff provided written answers to questions.
15. NHS England commissioned a clinical reviewer to review Mr Mather's clinical care at the prison and he conducted joint interviews with clinical staff.
16. We informed HM Coroner for Preston of the investigation. He gave us the results of the post-mortem and we have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Mather's niece to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. Mr Mather's niece did not have any specific questions.
18. Mr Mather's family received a copy of the initial report. They had no further comments or questions about the report.

Background Information

HMP Garth

19. HMP Garth holds around 850 men, many serving indeterminate sentences for public protection, life sentences or other long sentences. Lancashire Care Foundation Trust provides health services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Garth was conducted in January 2017. Inspectors have not yet published their report but provided early feedback to us. They said levels of violence were high and had increased three fold since the last inspection, and many violent incidents were linked to drugs, debt and gangs. Too many incidents were serious. A substantial number of prisoners feared for their safety and sought sanctuary in the segregation unit and the residential support unit. Too many prisoners felt unsafe. In their survey, more than a third of prisoners said that they felt unsafe at the time of the inspection and over two thirds had felt unsafe at some time.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest published annual report, for the year to November 2015, the IMB reported concerns about the staffing levels in the prison, the number of illicit mobile phones and the proposed smoking ban due to be implemented across the prison estate. The IMB requested that consideration be given to extending the use of patrol dogs to assist with order and control, and felt there was a need to improve funding for education and workshops.

Previous deaths at HMP Garth

22. Since the beginning of 2016 there have been five other deaths at Garth. Two men died within six weeks of Mr Mather's death and these three deaths all appear to have significant issues relating to drugs, debt and violence in common.

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as being at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011, *Management of prisoners at risk of harm to self, to others and from others*.

New Psychoactive Substances (NPS)

24. New psychoactive substances, previously known as 'legal highs', are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood

pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

25. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
26. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

27. On 26 April 2010, Mr Martin Mather was remanded to HMP Altcourse, charged with murder. Mr Mather told the reception nurse he was prescribed diazepam to calm his nerves and was referred for a mental health assessment. On 28 April, Mr Mather told a mental health nurse that for several months he felt he had gone "bonkers" and struggled to control his anger. Mr Mather said he had seen a psychiatrist when he was 12 years old because his mother thought he was sniffing marker pens. He said he had had no involvement with mental health services since then. Mr Mather said he did not take drugs and had no history or current thoughts of suicide or self-harm.
28. On 15 November 2010, Mr Mather was sentenced to life imprisonment with a minimum tariff of 17 years to serve. Mr Mather's OASys assessment (an offender assessment system which assesses risk and the likelihood of reconviction) included information that he had attempted suicide on more than one occasion when he was 13 and 14 years but he did not tell his parents about these attempts. Mr Mather said he had had suicidal thoughts in relation to what he had done but the counselling he had while on remand had been useful.
29. On 10 March 2011, Mr Mather transferred to HMP Garth and a routine referral was made for him to see the mental health team. On 12 May, Mr Mather saw a nurse, disclosed feelings of anxiety and low mood, being paranoid and anxious and said he had used amphetamines and cannabis to help him cope. Mr Mather said he did not have any suicidal feelings or thoughts of self-harm. A generalised anxiety questionnaire completed by Mr Mather scored 16, indicating "severe difficulty". Follow up appointments focused on reducing his anxiety and improving sleep and, by 20 June, Mr Mather described sleeping well with fewer anxious thoughts generally. Mr Mather missed some appointments over the next few months and, in October 2011, was discharged from the mental health team.
30. Over the next few years, Mr Mather appeared settled at Garth. He had no significant medical issues. Officers described him as hard working, reserved, and polite and said he did not seem to get into any trouble.
31. The Head of the Drug Recovery Services at Garth said Mr Mather undertook drug treatment and became a peer mentor, supporting others in their drug recovery. In December 2014, Mr Mather decided to stand down from this role. (This was not particularly unusual, having been a mentor for a year.) As far as she was aware, he continued to live drug free in the prison.
32. In January 2016, the offender supervisor wrote an entry in Mr Mather's case notes stating that she would follow-up a psychological assessment that had been commissioned because Mr Mather still had no memory of committing his offence. We cannot see anything further to suggest any assessment took place. However, a categorisation review meeting decided that Mr Mather should remain a category B prisoner because his risk of harm to others had not sufficiently reduced, and he had not completed any offending behaviour programmes.
33. From Easter 2016, Mr Mather was one of four trusted prisoners working in the stores area of the 'Speedy' workshop, which repairs, cleans and refurbishes power tools for Speedy. He was responsible for checking items in and out, and

quality-checking the work done. Trusted prisoners are not under the supervision of the workshop instructors and instead work alongside an officer support grade and a representative from Speedy.

34. At the beginning of July 2016, an extension socket went missing from the workshop. Mr Mather took responsibility for this and later returned it. He told friends he had taken it to sell to pay off some of his debts. On 12 and 19 July, his wages were reduced to the basic rate of £11.
35. No adjudication charges were brought against Mr Mather. There is no reference to the socket going missing on Mr Mather's NOMIS case notes and we only found out about it from talking to other prisoners.
36. On 20 July 2016, a chaplain told Mr Mather his father had died. His death had not been expected. He arranged for Mr Mather to speak to his brother by telephone and afterwards Mr Mather returned to D wing. He offered further support from himself or his colleagues at any time.
37. A Supervising Officer (SO) spoke to Mr Mather about his father's death. Mr Mather said he would like to attend the funeral and arrangements were made for him to do so. He described Mr Mather as a quiet, polite man who would engage in conversation with staff, but was also guarded about what he told them. When he spoke to Mr Mather after his father's death he said he did not portray any outward emotion. He explained the support the chaplaincy team was able to offer and Mr Mather said he would talk to him if he needed to.
38. An officer said this was the only period when Mr Mather seemed low. He said the officers on D wing kept more of an eye on him following his father's death. Mr Mather continued to go to work and carried on as normal.
39. On 28 July, Mr Mather saw a nurse and they spoke about him being an organ donor for his mother who needed a lung transplant. Mr Mather told him his father had recently died and that his mother was the only family he had left. He asked Mr Mather how he felt within himself and whether he had any thoughts of self-harm, but he replied that he was well. He did not think he appeared low in mood. The same day, a chaplain also saw Mr Mather and thought he was coping well. He said the chaplaincy offered a specific bereavement counselling service, accessible to all prisoners. Mr Mather did not apply for counselling at any time.
40. On 29 July, Mr Mather attended his father's funeral, escorted by officers. On his return, the SO spoke to him again and thought he was coping. He saw no evidence that Mr Mather was using drugs, either before or after his father's death. He said Mr Mather did not behave erratically and always went to work.
41. At the beginning of September, Mr Mather asked to speak to the SO and told him that he had got into debt for drugs. Mr Mather said he had been clean for a while, but had accepted a 'freebie' from a dealer after his father's death. This led to more drugs and getting into debt, although he did not say how much this was for. Mr Mather told him he took subutex and sometimes New Psychoactive Substances (NPS). He asked to move off D wing. The SO said they spoke about the drug recovery service and a possible move to the residential support unit (RSU), but Mr Mather did not want to move there. At the time, the only

space on the main residential units was on C wing. The SO said they discussed the potential problems of moving there because of its proximity to D wing (the two wings are next door to each other) but Mr Mather said the debt would follow him anywhere he moved. He had associates on C wing and would feel safe there until he could address the problem of the debt.

42. The SO and Mr Mather also discussed his recent bereavement and how he had dealt with it. Mr Mather felt he had let himself down by using drugs again. The SO asked about suicide and feelings of self-harm, but Mr Mather said he had no thoughts of either. He said that notwithstanding Mr Mather's bereavement, there was nothing about what he said, his tone or demeanour that suggested he needed to open an ACCT document, and he did not do so.
43. The SO made no entry in the wing observation books for C or D wing about a move, but said he spoke to the supervising officer on C wing. He made an entry in Mr Mather's NOMIS case notes and wrote an intelligence report. In the latter, he recorded that Mr Mather was in drug debt and named two prisoners who were putting pressure on him. He expected that this would be picked up by the safer custody department and investigated further.
44. Mr Mather told his friend that he was well and did not want bereavement counselling. His friend said that Mr Mather always took drugs, but now used more to mask how he felt and to avoid dealing with the impact of his father's death. Mr Mather never spoke about ending his life or being unable to cope, but a few days before he moved to C wing, his friend said he found him sitting in his cell with his head in his hands.
45. On 3 September, Mr Mather moved to C wing. C wing is a normal residential unit that accommodates about 132 prisoners. There are no entries about Mr Mather in C wing's observation book until the day he died. There are no entries in Mr Mather's NOMIS case notes during his month on C wing. He continued to work in the Speedy workshop.
46. We listened to some of Mr Mather's telephone calls. The last calls he made were at the beginning of September. On 3 September, he spoke to his mother and said he had hit his hand on a wall when he lost his temper. Mr Mather told her he did not have much money and she offered to send some. They also talked about the transplant his mother was hoping to have. On 5 September, Mr Mather spoke to his brother, who lived at the same address as his mother. His brother said he had sent a letter and postal order. They spoke about his brother being added to Mr Mather's list of visitors, to enable him to visit him at Garth.
47. During the evening of 29 September, a prisoner spoke to Mr Mather and did not think he appeared low or struggling to cope. Another prisoner said he also spoke briefly to Mr Mather, as Mr Mather asked whether he had any tobacco. He said there was no indication that Mr Mather was depressed, or of anything untoward. Another prisoner who lived a few cells away from Mr Mather said that Mr Mather offered him some of his meal that evening. He said this is not unusual and prisoners regularly offer their food to each other if they do not like a particular meal. He gave Mr Mather a cigarette. At around 7pm, everyone was locked in their cells for the night.

48. On 30 September, at 8.06am, an officer took the bolts off the cell doors on the second floor landing. (The cells have an additional bolt on each door, which is taken off before the cell door is unlocked with a key.)
49. An officer used her keys to unlock each cell on the spur. She looked very briefly through the door flap of each cell, including that of Mr Mather. She said she did not see Mr Mather but looked in long enough to know he was not at the door.
50. At 8.25am, an officer began a 'labour sweep', where those expected to attend work or education are chased up. When he reached Mr Mather's cell a minute later, he saw Mr Mather hanging from the light fitting. He called a code blue emergency radio message, then went back into the cell with a colleague. They cut the ligature, made from torn bedsheet, laid Mr Mather on the floor and he began chest compressions. He said Mr Mather looked pale. An officer brought the defibrillator within a minute. More staff arrived, including a SO.
51. The orderly officer arrived at 8.29am. He said code blue and code red emergencies are called quite frequently, sometimes every day, but he knew from the tone of the officer's voice that the situation was serious. When he reached the cell, the defibrillator was already in use and the officer was doing chest compressions.
52. The emergency response nurse was distributing treatments on the other side of the prison. She and the Head of Healthcare reached Mr Mather's cell six and a half minutes after the code blue was called. She said that Mr Mather was still warm and his skin colour was normal. Another nurse arrived soon afterwards, carrying the emergency bag. More healthcare staff arrived and continued resuscitation efforts. They gave Mr Mather oxygen. The defibrillator did not administer any shocks, indicating that it could not find any heart rhythm.
53. Garth's control room recorded making a 999 call at 8.28am. The North West Ambulance Service recorded the 999 call at 8.31am. The first ambulance reached Garth at 8.54am and paramedics reached Mr Mather's cell at 9.02am. They moved him onto the landing to have more space to carry out advanced life support techniques. A second ambulance arrived at 9.02am and the crew reached Mr Mather at 9.14am. The paramedics and nursing team continued to try and resuscitate Mr Mather, giving him adrenalin and fluids. However, at 9.25am, Mr Mather was pronounced dead.
54. Mr Mather left a note in his cell saying that he wished his personal items to be destroyed, any money to go to his niece and for his body to be cremated. There was also a letter dated 9 September 2016 addressed to 'X' within which Mr Mather explained his feelings on finding out his father had died. He said he had taken "anything" he could get his hands on and the previous Wednesday had tried to end his life because he "could not cope" anymore. (The prison had no knowledge of any attempt.) Mr Mather went on to say he had moved to C wing, stopped taking drugs, his head was "in a better place" and he was "sorting a few things out".

Contact with Mr Mather's family

55. A supervising officer and a chaplain left Garth at 10.20am to travel to the address in Wales of Mr Mather's partner. (His partner was listed as next of kin in his prison records.) Mr Mather's partner said they had ended their relationship some time ago and suggested the prison inform Mr Mather's niece instead. The two staff returned to Garth, found an address for his niece and set out again at 3.00pm to travel to her home, about an hour away. Mr Mather's niece was not at home, but returned a little later and they broke the news of her uncle's death. The staff offered condolences and support.
56. The supervising officer kept in contact with Mr Mather's niece and Garth offered help with funeral arrangements, contributing to the costs, in line with national instructions.

Support for prisoners and staff

57. After Mr Mather's death, the Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising. The staff care team offered support. The second paramedic team raised concerns about their access into the prison and the time it took them to reach Mr Mather once inside the prison gates.
58. The prison posted notices informing other prisoners of Mr Mather'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 Mather's death.

Information from prisoners after Mr Mather's death

59. A prisoner thought Mr Mather began using drugs again (mainly subutex) in 2014, and could afford this from his wages. He said Mr Mather took more drugs when his father died, struggled to pay for them and got into debt. He said he had been told by other people that Mr Mather owed between £800 and £1,800 but the debt grew each week with 'interest'. He said that from July, Mr Mather was "always off his face". He wondered whether Mr Mather moved to C wing to end his life, although he only raised this on one occasion saying "I wish I was fucking dead". He said he thought this was a joke.
60. Another prisoner said Mr Mather regularly took drugs (always subutex) in the 18 months he knew him. He thought Mr Mather had paid his debt off before he died and did not feel that it contributed to Mr Mather's decision to end his life. He believed that his father's death was the main factor.
61. Another prisoner said that, like all prisoners, Mr Mather had to wear a mask of normality all day, every day, because in prison, you could not be seen to be weak. Other prisoners also thought Mr Mather took subutex while in Garth and said his debt on D wing would follow him to C wing. One said he did not think it was a large debt – perhaps £150 to £200 - but said Mr Mather was being pressured to pay it off. Another said Mr Mather never seemed low or depressed, although he did sometimes appear anxious.

Post-mortem report

62. A post-mortem examination found that Mr Mather died from asphyxiation due to hanging. Toxicology tests found no evidence of drugs (including synthetic cannabinoids - NPS) or alcohol.

Findings

Drugs, bullying and violence reduction

63. All the prisoners we spoke to at Garth told us that drugs are easily available and we were told that it is very difficult to get out of debt because 'interest' keeps being added. Mr Mather found himself in debt and unable to navigate a way out. He did not want to go onto the residential support unit and did not ask the drug recovery service for help.
64. Garth has a violence reduction policy which states that Safer Custody is responsible for recording, monitoring and investigating acts of violence. Safer Custody should liaise with security to ensure information is shared where appropriate. The policy states that every violent incident, including threats of violence, will be investigated, and that victims should be offered support.
65. When, on 2 September, Mr Mather told his wing supervising officer he had got himself into debt and asked for a wing move, a SO wrote an intelligence report recording the names of two prisoners. He should have also completed a violence reduction referral form and noted it in the wing observation book. No one from the safer custody team looked into the issue or investigated the allegations further. The only response to Mr Mather reporting that he was under threat was to move him to the neighbouring wing. More could have been done to support him in the forthcoming weeks.
66. Mr Mather was not offered a Challenging Anti-social Behaviour (CAB) support plan, Garth's scheme under which a plan is opened with the prisoner's agreement and informs staff that the prisoner feels under threat and needs heightened observations and a possible change of routine.
67. Garth's violence reduction strategy states that prisoners identified as bullies will be challenged. Yet no one spoke to the two prisoners named by Mr Mather, investigated the allegations or managed them under violence reduction procedures. Several prisoners told us the threats to Mr Mather did not stop when he moved to C wing.
68. We do not consider that Garth made sufficient efforts to resolve Mr Mather's disclosure about being in debt and feeling threatened. Had this been followed up when he moved to C wing, it would have become apparent that this move had not resolved his problems. The alleged perpetrators were not challenged and the links between bullying and suicide and self-harm were not identified and considered fully. We make the following recommendations:

The Governor should ensure that all information indicating bullying and intimidation is effectively coordinated and fully investigated; that alleged perpetrators are appropriately challenged; and that apparent victims are effectively supported and protected with meaningful long term solutions, which address their individual situation.

The Governor should review the supply reduction strategy to help reduce the supply of and demand for new psychoactive substances and other

drugs, and that staff are vigilant to signs of misuse and know how to respond when a prisoner appears to be under the influence of substances.

Assessing the risk of suicide and self-harm

69. PSI 64/2011 *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, lists a number of risk factors and triggers that increase prisoners' risk of suicide, including hopelessness, impulsiveness, a life event and lack of social support. The instruction goes on to list a number of triggers – an event that sets a course of action in motion. Some possible triggers are bereavement of family or close friends, and substance misuse or detoxification.
70. Staff judgement is fundamental in assessing the risk of suicide. The system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. It is not an exact science, but we are concerned that staff simply did not communicate with Mr Mather after he moved to C wing and relied completely on the fact that he appeared outwardly well.
71. Garth told us they do not have a personal officer system but are introducing a landing officer scheme. Garth's Expectations Policy states that landing officers should introduce themselves to their prisoners at the earliest opportunity and make an entry in NOMIS case notes at least monthly, and preferably more often. There are two entries in Mr Mather's case notes by a D wing officer in the summer, but very few entries in general. His entries use words such as "polite", "attends work" and "never a problem to staff" but do not demonstrate that an actual conversation took place. Mr Mather does not appear to have been allocated a new landing officer when he moved to C wing.
72. Entries in the wing observation books and information from prisoners suggest high levels of threat and violence on both wings. While we note that Mr Mather was a private and guarded person, information about his drug and debt issues could have been more effectively identified, coordinated and followed up. It appears that no one asked him how he was, how he was settling on C wing, whether the debt he had accumulated had followed him, whether he needed bereavement support, whether he felt under pressure and whether he wanted CAB support. Had support been given, the increased staff contact and observation may have given him the opportunity to discuss his distress. There is little evidence of staff engaging with Mr Mather other than superficially. As a consequence, opportunities were missed to assess whether Mr Mather was at risk of suicide or self-harm after he moved from D wing.
73. We do not consider that Garth assessed or managed Mr Mather's risk effectively and make the following recommendations:

The Governor should ensure that, in line with the Expectations Policy, residential landing officers understand their responsibilities, take time to try to get to know their prisoners and make regular entries in prisoners' case notes.

The Governor should ensure that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them.

Checking prisoners' well-being at unlock

74. Garth did not have a detailed instruction to staff about the importance of receiving a clear acknowledgement (movement, eye contact or dialogue) from prisoners at morning unlock.
75. An officer said she did more than most, in that she looked through the door flap to check the prisoner was not waiting to rush out as soon as the door opened. She agreed at interview, however, that her check was not a well-being check, and that she did not actually see Mr Mather when she unlocked him on 30 September, and he may have already been suspended. We cannot know whether it would have made a difference to the outcome, had Mr Mather been found or checked at this time.
76. Garth told us it was in the process of writing an instruction requiring officers to check the well-being of each prisoner at morning unlock. The prison gave us a copy of a notice to prisoners, dated November 2016, informing them that officers will require a verbal response from the prisoner when unlocking cells from 20 December 2016 onwards. In view of this, we make no recommendation.

Emergency response

(i) Nurse response

77. It took six and a half minutes for nursing staff to reach Mr Mather after the code blue emergency was called. The designated response nurse was at the far end of the prison dispensing treatments. There are only two radios between all nursing staff at Garth, which means that another nurse may be closer to an emergency, but unaware of it. A manager told us that six more radios have been ordered, which will mean more nursing staff can be made aware of medical emergencies within the prison in future.

(ii) Calling 999 and communicating with the ambulance service

78. There was a delay of five minutes between the code blue radio message at 8.26am and the 999 call at 8.31am. PSI 03/2013, *Medical Emergency Response Codes*, states that when a medical emergency is called over the radio network, an ambulance must be called immediately. Garth's local instruction 106/15, issued in August 2015, repeats this advice to staff.
79. An officer in the control room said code blue emergency messages are a regular occurrence at Garth, sometimes called once or twice a day, because they are used when someone is suspected of having taken NPS. A custodial manager said that in most cases of NPS use, the ambulance is stood down. The officer said the ambulance service does not respond well to Garth ringing up with no information other than that a code blue has been called, and he and his colleagues feel unprofessional when they are unable to give the call handler the information needed to prioritise the call.
80. In line with national policy, 999 should continue to be called by control room staff as soon as a code red or blue emergency message is issued. We make the following recommendation:

The Governor should ensure control room staff call 999 immediately when an emergency code is called and ask for an ambulance.

Resuscitation

81. Officers carried out compression-only resuscitation (that is, no mouth-to-mouth resuscitation was given). The clinical reviewer observed that while chest compression only is common practice in many situations, Resuscitation Council (UK) Guidelines 2015, state that:

“CPR providers trained and able to perform rescue breaths should perform chest compressions and rescue breaths where the [Emergency Medical Service] response interval is prolonged. Only if rescuers are unable to give rescue breaths should they do compression-only CPR”

82. An officer said he was prepared to give breaths, had a disposable mask been available to him and said he had previously requested one. It took over six minutes for nursing staff to reach Mr Mather because they were at the opposite end of the prison when the code blue was called. While it is not possible to say whether this would have changed the outcome for Mr Mather, we note the view of the clinical reviewer that disposable CPR masks should be available on the wings for staff trained in CPR techniques. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there are sufficient properly equipped and trained first aid staff at all times.

Family liaison

83. There was a long delay in notifying Mr Mather’s niece of his death. In part, this was because the prison had an ex-partner listed as the next of kin and they visited her address first. However, many prisoners at Garth are serving long sentences, including life. Keeping next of kin information up to date is important, as relationships often change over time. There should be annual requests for prisoners to provide updates or confirmation that nothing has changed.

The Governor should ensure that annual updates of next of kin details including name, telephone numbers and addresses are requested from prisoners and noted in their NOMIS prison record.

Clinical review

84. The clinical reviewer said Mr Mather received some counselling support during his early period in custody, although not to the extent or duration recommended by NICE guidelines. He felt that screening and outcome measures needed improvement. He thought Mr Mather should have been referred for a mental health assessment when he was seen on 28 July 2016. His father had recently died and this, alongside Mr Mather’s previous history of anxiety, should have led to a referral. He acknowledged, however, that Mr Mather did not display any overt signs of anxiety or depression and would have been aware how to seek support had he wanted to. His review made recommendations which the Head of Healthcare should take forward.

85. The clinical reviewer concluded that although opportunities were missed to identify and manage Mr Mather's anxiety and depression, his care and treatment was equivalent to that he could have expected in the community.

**Prisons &
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