Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Jerome Jones a prisoner at HMP Stoke Heath on 27 October 2017

A report by the Prisons and Probation Ombudsman

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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*

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 Jones died at HMP Stoke Heath on 27 October 2017 from a sudden cardiac arrest, probably due to the effects of taking a psychoactive substance (PS). He was 26 years old. I offer my condolences to Mr Jones' family and friends.

In May 2017, I recommended that Stoke Heath review their already good strategy to reduce drug supply and demand to see if there were any further measures they could take. They did this and I consider that they are responding swiftly and proactively to the constant challenge presented by PS and have good support systems for prisoners at risk.

Mr Jones was found seriously unwell due to the effects of PS on two occasions before his death. Despite these two serious warnings he continued to use PS. I consider that Mr Jones was offered appropriate support and advice on the dangers of PS use at Stoke Heath and that the prison took reasonable measures to keep him safe.

I am increasingly concerned by the number of deaths I investigate in which PS has played at least some part. Mr Jones' death is another example of how dangerous PS is and how even prisons that we judge have effective measures in place to reduce PS use, are struggling. I will be raising my concerns with Ministers.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **July 2018**

Contents

Summary

Events

1. On 4 January 2017, Mr Jerome Jones was remanded to HMP Birmingham. He had a history of substance misuse and congenital heart disease. On 5 July, he was sentenced to three years, nine months imprisonment for burglary and on 27 July, he was transferred to HMP Stoke Heath. It was his third custodial sentence.

2. Mr Jones was found under the influence of a psychoactive substance (PS) on 14 August and 30 August. On 7 September, he agreed to work with the Forward Trust (which provides support for prisoners with substance misuse issues). He appeared to be engaging well with relapse prevention work but, on 20 October, he was found unresponsive and bluish in colour after taking PS again and was resuscitated by prison nurses. In addition to his case working sessions, Mr Jones received awareness training and advice on the dangers of using PS after every incident.

3. On 27 October, Mr Jones was found unresponsive in his shared cell after other prisoners alerted staff. His cellmate said that he had been unresponsive for an hour before the alarm was raised. The emergency response was prompt and paramedics attended. Mr Jones was pronounced dead shortly after arriving at hospital the same night.

4. The post mortem gave Mr Jones' cause of death as sudden cardiac death. Toxicology showed the presence of PS which the pathologist felt on the balance of probability had directly contributed to Mr Jones' death.

Findings

5. Stoke Heath's drug strategy is comprehensive and we are satisfied that they respond swiftly and proactively to reduce the supply and demand of PS.

6. Mr Jones was found seriously unwell due to the effects of PS on two occasions before his death. Despite these two serious warnings, he continued to use PS. We consider that Mr Jones received appropriate support and advice on the dangers of using PS at Stoke Heath, and that the prison took reasonable measures to protect him.

7. We are increasingly concerned by the number of deaths we investigate in which PS has played at least some part. Mr Jones' death is another example of how dangerous PS is and how even prisons that we judge have effective measures in place to reduce PS use, are struggling. The Ombudsman will be raising her concerns with Ministers.

8. Mr Jones' mother was upset that when she visited Mr Jones' cell it had been cleaned and painted. We consider that it is important that the next of kin be offered the opportunity to see the deceased's cell before it is emptied and cleaned.

Recommendations

- **The Governor and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that the control room calls an ambulance immediately an emergency medical code call is received.**
- **The Governor should ensure that the family liaison officer offers the next of kin the opportunity to see the cell before it is emptied and cleaned.**

The Investigation Process

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

10. The investigator visited Stoke Heath on 9 November 2017. She obtained copies of relevant extracts from Mr Jones' prison and medical records, copies of relevant prison policies and watched CCTV footage from 27 October. She interviewed three prisoners and five members of staff at Stoke Heath on 27 October and 14 December 2017.

11. NHS England commissioned a clinical reviewer to review Mr Jones' clinical care at the prison. She spoke to two nurses by telephone.

12. We informed HM Coroner for Shropshire, Telford and Wrekin of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of our family liaison officers contacted Mr Jones' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Jones' mother asked why the prison had painted Mr Jones' cell before she had visited it and why he had not been watched more closely after he took PS on 20 October and had to be resuscitated.

Background Information

HMP Stoke Heath

14. HMP Stoke Heath is a medium secure prison in Shropshire with accommodation for about 782 adult and young adult men. Healthcare is provided by Shropshire Community Health NHS Trust. The Forward Trust provides services and support for prisoners with substance misuse issues.

HM Inspectorate of Prisons

15. The last inspection of HMP Stoke Heath was in April 2015. Inspectors reported a significant problem with illegal substances which was partly responsible for high levels of violence. The prison actively tackled these complex issues, including psychoactive substances, and there was a good strategic approach to supply reduction. The drugs suspicion testing programme was insufficiently resourced. Prisoners had too little to occupy themselves constructively and this also fostered drug misuse and associated violence. Overall, the prison had weathered the pressures on the prison system better than most of those inspected in 2015.

Independent Monitoring Board

16. 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 their latest annual report, for the year to August 2017, the IMB reported that the prison had experienced an increase in the use of PS. The security team had been pro-active in trying to reduce the amounts of illicit items entering the prison and had liaised with the local police to check visitors. This had resulted in a number of arrests and successful prosecutions.

Previous deaths at HMP Stoke Heath

17. Mr Jones was the fourth prisoner to die at Stoke Heath in 2017. The others died of natural causes and there are no similar issues with Mr Jones' death. In our investigation into a death in December 2016, we recognised that the prison had a proactive drug strategy but recommended they revisit it to see if even more could be done. As a result, the prison revised their Drug Reduction strategy in October 2017.

Psychoactive Substances (PS)

18. 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 PS 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.

19. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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 PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

20. HMPPS 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 HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Incentives and Earned Privileges (IEP) Scheme

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

Key Events

22. On 4 January 2017, Mr Jerome Jones was remanded to HMP Birmingham. He had a history of substance misuse, congenital heart disease, bowel problems, asthma, depression and anxiety. Mr Jones completed a methadone detoxification programme. On 5 July, he was sentenced to three years nine months imprisonment for burglary and was returned to Birmingham. It was his third custodial sentence.

23. On 27 July, Mr Jones transferred to HMP Stoke Heath. His person escort record (PER) which accompanied him listed his physical and mental health issues. Mr Jones was allocated a single cell on G Wing because of his bowel problems. On 28 July, he turned down the opportunity to work on his substance misuse issues with the Forward Trust (who provide support for substance misusers).

August 2017

24. On 14 August, Mr Jones was found under the influence of PS. The wing observation book described him as "staggering with slurred speech and red eyes". Mr Jones was downgraded to the basic level of the incentives and earned privileges (IEP) scheme for 28 days and had to give up his single cell. Staff completed a suspicion form for a mandatory drug test. A peer supporter from the Forward Trust visited him on 17 August in response to this incident, but Mr Jones again turned down the opportunity to work with them.

25. On 22 August, an officer from the safeguarding team spoke to Mr Jones because staff suspected he was in debt for drugs and under threat from other prisoners when he moved between G Wing and education. Mr Jones confirmed that three prisoners from his home area were intimidating him in education. He described the issues as gang related and said that the three prisoners were aware of his offence, which had been committed in their home area. A peer supporter from the Forward Trust visited Mr Jones a third time on 24 August in response to these concerns and to give Mr Jones harm minimisation and PS awareness advice.

26. On 28 August, Mr Jones moved to E Wing, a standard wing. On 30 August, his cellmate pressed the emergency bell after Mr Jones took PS using a vaping inhalator. Officers called a nurse, who found Mr Jones lying on his bed, bluish in colour, with his eyes rolling. He responded to touch but was unable to speak. She gave him oxygen and Mr Jones returned to normal after about ten minutes. Officers removed the vaping inhalator and other items from Mr Jones' cell.

September 2017

27. The Forward Trust received a referral for Mr Jones on 4 September. On 7 September, a Forward Trust case worker saw Mr Jones for a triage appointment. They discussed the heightened risks to Mr Jones of PS given his pre-existing heart condition and the various ways Mr Jones could minimise harm to himself.

28. On 11 and 12 September, another case worker from the Forward Trust completed both parts of a more detailed assessment with Mr Jones. Questionnaires on depression and anxiety showed Mr Jones had minimal

symptoms of depression but severe anxiety. She said Mr Jones was keen to start work with her and they agreed a care plan to begin relapse prevention work. He admitted that he could be very impulsive and this led to him making negative choices. She sent him an in-cell workbook and said she would review his care plan with him on 18 October. She referred him to the mental health team for his anxiety and to the GP for a blood borne virus (BBV) screen.

29. On 13 September, a mental health nurse assessed Mr Jones in his cell. Mr Jones denied having been under the influence of PS on 28 August and said that he had "lost his head". He wanted to engage with mental health services but did not want to talk that day. He denied feeling suicidal or wanting to harm himself.

30. On 26 September, Mr Jones returned to the standard level of the IEP scheme after serving his 28 days on basic level.

October 2017

31. On 11 October, a nurse completed a specialist mental health assessment with Mr Jones. Mr Jones said he did not feel that his current dose of mirtazapine (an anti-depressant) was enough. He said he never felt tired and this affected his sleep pattern. He had stopped smoking, felt healthier and was enjoying going to the gym. He had also started working with the Forward Trust. He denied feeling hopeless or wanting to harm himself. She concluded she could not find evidence of mental illness. She sent a referral to the GP asking him to increase Mr Jones' mirtazapine and booked him a follow up appointment in two weeks.

32. On 18 October, Mr Jones attended his care plan review with a case worker. They went through his in-cell workbook and Mr Jones said he was happy with his progress towards the goals they had set. He had just been made a wing cleaner and felt he was in control and "on the up".

33. On 20 October, Mr Jones' cellmate pressed their cell bell. Officers radioed a code blue emergency (indicating that a prisoner is unconscious, not breathing or is having breathing problems), and two nurses found Mr Jones unconscious in the recovery position on the floor of his cell. Mr Jones remained unresponsive for about 15 minutes and became conscious just before paramedics arrived. He said he had taken PS using a vaping inhalator. Officers checked Mr Jones every half an hour throughout the night but he did not suffer any further ill effects.

34. On 25 October, a case worker saw Mr Jones and reiterated the PS awareness and harm minimisation information. They discussed the impact of using PS on his damaged heart. Mr Jones said his "head went" after receiving news that a close family member had died and he had used PS to try to block the bad news out. Mr Jones was tearful and frightened by the fact he had needed resuscitation. He said the wing officers were being supportive and he had not lost his cleaning job.

35. That afternoon, a nurse saw Mr Jones for his planned mental health review. Mr Jones said he was feeling sad because his aunt had died. He said his recent experience with PS had scared him because of his congenital heart problems. He told her that he would not take PS again. Mr Jones had not received the increased dose of mirtazapine that she had recommended to the GP so she sent

the GP a task on SystmOne to do this when his prescription was due to renew. Mr Jones said he was tearful about his aunt but denied feeling like harming himself.

36. At 4.36pm, 4.56pm and 5.10pm, on 27 October four different prisoners (two on B wing and two on Mr Jones' landing) were found under the influence of PS. None of them needed medical attention but all were checked more frequently as a result. Intelligence received later indicated that the PS had come in to the prison with new receptions from Birmingham on 26 October.

Emergency response

37. Officer A worked an overtime shift on E Wing starting at 5.10pm on 27 October. He was briefed about the two prisoners who had been under the influence of PS and told to check them regularly. CCTV showed that at 7.16pm, the emergency bell in the cell next door to Mr Jones was pressed. He responded to the bell at 7.17pm and a prisoner told him that there was a problem in Mr Jones' cell. He looked through the observation flap and saw Mr Jones apparently sitting up in bed on the top bunk and his cellmate sitting in a chair watching television. The cellmate told him he needed to get healthcare for Mr Jones because he had not had a response from him for over an hour.

38. Officer A radioed for the emergency response nurse at 7.18pm. He then asked the cellmate to nudge Mr Jones to see if he was asleep. The cellmate replied, "I'm not touching him, are you mad?" He told the cellmate to turn on the cell light and was able to see immediately that Mr Jones was slumped to one side with his eyes wide open and his tongue sticking out. He was grey and had blue lips. The officer radioed a code blue emergency at 7.19pm and asked for permission to enter the cell. He was told to wait for staff who were almost with him.

39. The Custodial Manager said he, his three response officers and two nurses were already on their way to E Wing in response Officer A's first emergency call. They were on the education corridor close to E Wing and started running. The Custodial Manager said because they were so close he told Officer A to wait for them before going in to the cell.

40. The Custodial Manager opened Mr Jones' cell door at 7.21pm. He said he thought immediately that Mr Jones had died. A nurse and an officer left to collect the emergency bag from the healthcare department. The Custodial Manager asked his response officers to take the cellmate to another cell and he and Officer A moved Mr Jones to the floor. A nurse and Officer A began cardiopulmonary resuscitation (CPR). The Custodial Manager radioed the communications room to make sure an ambulance had been called. At 7.23pm, the nurse and officer returned with the emergency equipment and they gave Mr Jones oxygen via a bag and mask and attached a defibrillator. The defibrillator instructed them to continue CPR.

41. Paramedics arrived at 7.35pm and took over. West Midlands Ambulance Service records showed that the first paramedic team were with Mr Jones 13 minutes after the emergency call from the prison. Working back from 7.35pm, this means Stoke Heath called an ambulance at 7.22pm, about three minutes after Officer A

radioed code blue. Paramedics took Mr Jones to hospital at 8.39pm, but he was pronounced dead shortly after 9.00pm.

Contact with Mr Jones' family

42. The prison began trying to contact Mr Jones' next of kin once they received confirmation he had died. The death in custody contingency plans show that they had some trouble contacting Mr Jones' mother because the contact details supplied by Mr Jones were not accurate. The West Midlands police managed to find Mr Jones' mother's address and broke the news of his death at 2.09am. The prison family liaison officer and a custodial manager visited Mr Jones' mother and other family members the next day, 28 October.

43. The prison contributed towards the costs of Mr Jones' funeral in line with national guidance.

Support for prisoners and staff

44. A governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The cellmate was given another cell and Prison Service suicide and self-harm monitoring (known as ACCT) procedures were opened to support him.

45. The prison posted notices informing other prisoners of Mr Jones' 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 Jones' death. All three prisoners interviewed told the investigator that they had received support from the prison.

Post-mortem report

46. The post mortem report gave Mr Jones' cause of death as sudden cardiac death. The toxicology showed Mr Jones had taken synthetic cannabinoids (a form of PS). The pathologist added that "on the balance of probability" the toxic effects of the synthetic cannabinoids had directly contributed to Mr Jones' death by triggering a fatal cardiac arrhythmia (abnormal heart rhythm) on his already damaged heart.

Findings

Psychoactive substances at Stoke Heath

47. We examined Stoke Heath's drug supply and reduction strategy in our investigation into the death of a prisoner in December 2016. We concluded that they had good measures in place to respond to the challenges of illicit substances including PS, but recommended they review their strategy to see if further measures were possible.

48. Stoke Heath completed their review in October 2017 and published a revised strategy in November 2017. Additionally, on 20 November 2017, the Governor issued a revised Notice to Staff on incident management of prisoners suspected of taking PS. They adopted various measures including:

- In June and September 2017 new posters on PS risks and harm minimisation were put on each wing and leaflets dropped in every cell. (The investigator saw these on her visit to E wing on 9 November.)
- In July 2017, referrals to the Forward Trust were taken from the daily briefing sheet to ensure that contact was made with every prisoner suspected of using PS.
- In August 2017, staff began photocopying prisoner mail in response to an increase in PS sprayed on to letters. Staff also telephone solicitors to confirm that all Rule 39 (legally privileged confidential mail) is legitimate.

We are satisfied that Stoke Heath have responded swiftly and proactively to the evolving challenges of PS supply and demand.

Psychoactive substances in all prisons

49. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS was then a source of increasing concern in prisons. Not only does PS use have a profoundly negative impact on physical and mental health, but trading these substances can lead to debt, violence and intimidation. Mr Jones' death is a clear example of how dangerous PS is, and illustrates why prisons must do all they can to eradicate its use.

50. We have now investigated a significant number of deaths where PS has been a factor and we are very concerned that even prisons that we judge have effective measures in place to reduce PS use, are struggling. The Ombudsman will be raising her concerns with Ministers.

Substance misuse support offered to Mr Jones

51. In accordance with local policy, Mr Jones was offered the opportunity to work with the Forward Trust on his substance misuse issues when he arrived at Stoke Heath. He was also offered the same opportunity every time he was found under the influence of PS. Mr Jones accepted this help on 7 September and began working on relapse prevention with a case worker. Mr Jones regularly received PS awareness and advice about the impact of using PS on his already damaged

heart. On 30 August and 20 October, Mr Jones was found seriously unwell due to the effects of PS. Despite these two serious warnings, he continued to use PS.

52. We consider that Mr Jones was offered appropriate support and advice on the dangers of PS use at Stoke Heath and that the prison took reasonable measures to keep him safe.

Emergency response

53. Prison Service Instruction 03/2013 requires governors to have a two code medical emergency response system based on the instruction. As is usual, Stoke Heath use code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

54. Overall the emergency response was very prompt. It appears, however, that Mr Jones had stopped breathing for too long for resuscitation to be successful.

55. We are concerned though that an ambulance was only called once the Custodial Manager radioed the control room to check it had happened, rather than immediately Officer A radioed code blue. In cases where a person has stopped breathing, prompt resuscitation is crucial. Mr Jones received prompt emergency aid from staff and it is unlikely that the small delay in calling an ambulance made a difference to the outcome for him. However, such a delay could be critical for other prisoners in life-threatening situations.

The Governor and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that the control room calls an ambulance immediately an emergency medical code call is received.

Painting Mr Jones' cell after he died

56. Mr Jones' mother told our family liaison officer that she was upset that the prison had painted and cleaned her son's cell before she visited it in November 2017. We were told by the prison that prisoners on E Wing were keen to make the cell as nice as possible. While we understand that the gesture was intended to be kind, visiting the last place a loved one was alive while there are still signs of their recent life can be an important part of the grieving process and next of kin should be given the choice to see the cell as it was.

The Governor should ensure that the family liaison officer offers the next of kin the opportunity to see the cell before it is emptied and cleaned.

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