Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Billy Watts a prisoner at HMP Garth on 27 May 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.

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

Mr Billy Watts was found hanged in his cell at HMP Garth on 27 May 2017. He was 47 years old. We offer our condolences to his family and friends.

Mr Watts was involved in the drugs culture at Garth leading to incidents of violence, both as a victim and as a perpetrator, but he gave little indication that he was at risk of suicide. We are concerned about the apparent widespread availability of illicit substances, including NPS, at the prison and the culture of bullying and violence to which they give rise.

Although it did not make a difference to the outcome for Mr Watts, staff missed opportunities to check on his safety and welfare on the morning he was found dead and failed to use an emergency medical code. We are concerned that we again found failings at Garth in checking on the welfare of prisoners at unlock and inappropriate attempts at resuscitation on discovery of a death in custody.

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**

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Summary

Events

1. In July 2004, Mr Billy Watts was convicted of murdering his partner and received a life sentence, with a minimum tariff of 15 years.

2. Mr Watts spent the first 12 years of his sentence at HMP Gartree, where he used illicit drugs and often traded prescribed medication. He was also involved in violent incidents, both as a victim and a perpetrator. In May 2016, he asked to be transferred to another prison as he no longer felt safe at Gartree because of drug debts.

3. In July 2016, Mr Watts was transferred to HMP Garth, where he continued with the same behaviours as at Gartree: using drugs, building debts, being assaulted and assaulting others. He was found a number of times with illicit alcohol (hooch), which he apparently held for other prisoners to help pay off his debts.

4. In the week of 22 May 2017, Mr Watts failed to attend work three times. One of his friends said that he was scared to leave the wing because of debts he owed to prisoners on other wings. However, none of his friends believed that he was at risk of harming himself.

5. On the morning of 27 May, one of Mr Watts' friends found him hanged in his cell. Officers responded and healthcare staff tried to resuscitate him. When paramedics arrived and checked Mr Watts, they instructed staff to stop resuscitation efforts as he was clearly dead and rigor mortis was present. Mr Watts' post-mortem examination concluded that he died of asphyxia, caused by hanging.

6. Mr Watts left a long suicide letter in his cell. He wrote that he had decided to take his life not because of bullying or debts but because he was fed up and had simply had enough of life.

Findings

7. Mr Watts had no history of self-harm in prison and there was little to suggest to prison staff that he was at risk in the period before he died. However, there is evidence that his mood was lower than usual and we would have expected officers to explore his reasons for not attending work in his final week.

8. New psychoactive substances (NPS) were found in Mr Watts' system after his death, and we are concerned about the availability of NPS and other illicit substances at Garth. The consequences for safety and order and the risks posed to prisoners and staff are again apparent in this case.

9. On the morning that Mr Watts was found hanged in his cell, he had covered his observation panel. Staff failed to try to obtain a response from him or report the incident as they should have done. While it did not affect the outcome for Mr Watts, staff failed to follow correct procedures for checking on Mr Watts' welfare on the morning of 27 May.

10. An officer failed to use a medical emergency code.

11. Healthcare staff attempted resuscitation until paramedics instructed them to stop 13 minutes later as there were signs of rigor mortis.

12. The clinical reviewer found that some of Mr Watts' care at Garth was not of an appropriate standard. She noted the delay in him being referred to the prison's substance misuse unit and was concerned at the decision to prescribe him in-possession medication despite his history of trading medication. She has made a number of recommendations which the Head of Healthcare will need to address.

Recommendations

- The Governor should ensure that when prisoners fail to attend work, they are asked to explain their reasons and appropriate action is taken in response.
- The Governor should ensure that:
    - there are effective supply and demand reduction strategies to help reduce the availability of illicit drugs, including NPS;
    - staff are vigilant to signs of their use and know how to respond when a prisoner appears to be under the influence of such substances;
    - there is a coordinated approach to identifying indicators and risks of bullying and violent behaviour, including the impact of illicit substances and associated debt; and
    - all allegations of violence, intimidation or bullying are taken seriously and investigated appropriately.
- The Governor should ensure that all staff are reminded that if they discover an obscured observation panel, they should immediately ask the prisoner to remove the obstruction and they should take appropriate action if the prisoner does not respond.
- The Governor should ensure that all staff are aware of and use the appropriate emergency response code when they discover an apparent medical emergency.
- The Head of Healthcare should ensure that, in accordance with European Resuscitation Council Guidelines, healthcare staff fully understand the circumstances in which resuscitation is inappropriate and are confident about applying the guidance on resuscitation appropriately.

The Investigation Process

13. The original 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.

14. The original investigator visited Garth on 8 June 2017. She obtained copies of relevant extracts from Mr Watts' prison and medical records, she met the Governor and spoke to the prisoner who found Mr Watts.

15. The investigation was subsequently reallocated to a second investigator and he interviewed 15 members of staff and six prisoners.

16. NHS England commissioned a clinical reviewer to review Mr Watts' clinical care at the prison. The second investigator and clinical reviewer jointly interviewed the clinical staff.

17. We informed HM Coroner for Chorley of the investigation who sent the results of the post-mortem examination. We have given the Coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Watts' father, to explain the investigation. Mr Watts' father asked why his son was transferred to Garth and whether his son had been told that he would not be able to return to his local area on release from prison.

Background Information

HMP Garth

19. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Greater Manchester Mental Health NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust provide health services. Nurses are on duty between 7.00am and 9.00pm every day. Chorley Medics provide a service outside these times. GP clinics are held every day, normally from 9.00am to 1.00pm but occasionally from 1.00pm to 5.00pm. There is no inpatient unit.

HM Inspectorate of Prisons

20. The most recent inspection of Garth was in January 2017. Inspectors noted that since their inspection in 2014, levels of violence had increased substantially, with many incidents linked to drugs and debt. Inspectors found that the drug strategy committee was much improved, that security and intelligence flows were reasonably good, and the strategic approach to combating drug supply was improving. However, despite a coordinated effort to reduce drug supply and demand, very high levels of drug finds and positive random mandatory drug test rates indicated a high level of availability of illicit drugs, diverted medication and illicitly brewed alcohol. Inspectors noted that the availability of NPS was particularly problematic, and was linked to medical emergencies and prisoner debt and violence.

Independent Monitoring Board

21. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year ending November 2016, the IMB wrote that it was seriously concerned about the dramatic increase in the use of NPS including the practice of testing a new batch of substances on weaker prisoners or those in debt. The IMB noted a significant rise in violent incidents, with an 85 per cent increase in the number of prisoner on prisoner assaults over the previous three years.

Previous deaths at HMP Garth

22. Mr Watts' death was the fourth self-inflicted death at Garth since August 2015. In a previous investigation, we found that the prisoner had been concerned about drug-related debts and that an officer had failed to check the prisoner when unlocking his cell in the morning. In another investigation, we found that staff attempted resuscitation despite the presence of rigor mortis. In two investigations, we found that there was a delay in informing the next of kin about the death. Garth accepted our findings and agreed to implement all our recommendations. We acknowledge that at the time of Mr Watts' death, Garth would not have had sufficient time to implement our recommendation about attempts at resuscitation.

Incentives and Earned Privileges scheme

23. 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.

NPS

24. NPS 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. HM Prison and Probation Service (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 NPS are included in the testing process.

Key Events

Background

27. In February 2004, Mr Billy Watts was arrested on suspicion that he had killed his partner. At the time of his arrest, Mr Watts had seriously harmed himself and needed immediate hospital treatment and subsequent surgery. On 19 July, Mr Watts was convicted of murder and received a life sentence, with a minimum tariff of 15 years.

28. Mr Watts spent the first 12 years of his sentence at HMP Gartree, where he was frequently caught using illicit drugs and was involved in violent incidents, both as a perpetrator and as a victim, mainly due to debts. He was involved in selling his prescribed gabapentin tablets. (He was prescribed gabapentin for long standing pain from the injuries he sustained in 2004.)

29. In March 2015, Mr Watts told a nurse that his sister had died. In recent years, his mother and brother had also died. Mr Watts said that in "losing more and more people around him", he needed to build his support networks.

30. On 11 January 2016, Mr Watts was treated for a head wound after he used a razor blade to try to remove a cyst from his forehead.

31. In May 2016, Mr Watts told an officer that he had been assaulted due to a long-standing tobacco debt and he was concerned for his safety. He asked to move to the segregation unit, where he remained for the next two months. He said that he only felt safe while locked in his cell and that he wanted to move to another prison.

HMP Garth

32. On 14 July 2016, Mr Watts was transferred to HMP Garth. He told the reception nurse when he arrived that he had never harmed himself in prison and that he had no thoughts of suicide or self-harm. Mr Watts was prescribed gabapentin which he was allowed to keep and administer (his records contain no evidence that staff assessed his risk of doing so). Mr Watts was given a cell on C Wing.

33. In mid-September, Mr Watts failed a drugs test and he told a nurse that he was dependent on opiates and had drug debts. He asked to go on a methadone maintenance programme. The nurse arranged to review Mr Watts a week later and referred him to Garth's drug and alcohol service.

34. On 23 September, the nurse reviewed Mr Watts and noted that he had no signs of opiate toxicity. She arranged to see him a week or two later.

35. On the same day, a worker from the drug and alcohol service saw Mr Watts. He told her that alcohol was not a problem for him but that he had used drugs since his teenage years. She noted that Mr Watts was approaching the end of his sentence and they discussed his options on release. Mr Watts complained about difficulty sleeping so she referred him to the sleep clinic. She agreed to see him again in three months.

36. On 4 October, Mr Watts saw a nurse due to facial swelling and a bruised eye. He said that he had been assaulted due to drug debts. He said that he used subutex daily, which he funded with his canteen and by "doing favours" around the wing. He again asked to be prescribed methadone but the nurse noted that Mr Watts had no signs of opiate dependency and she told him that he needed to test positive for opiates a number of times before he could be prescribed methadone.

37. Mr Watts was prescribed methadone from 25 October, after he tested positive for opiates. He started on a daily dose of 10ml, which was increased and maintained at 20ml daily.

38. In mid-October and late December, Mr Watts was found with containers of illicit alcohol (hooch) which he said that he was holding for other prisoners. His incentives and earned privileges (IEP) level was reduced to basic for 28 days.

39. On 21 November, Mr Watts saw a therapist from the sleep clinic but he said that he did not need their help.

40. On 30 December, Mr Watts saw a healthcare assistant. She noted that Mr Watts had a black eye which he said he received because of an overdue debt. She noted that Mr Watts had trouble sleeping and that his mood was low. She also noted that he had no current thoughts of suicide or self-harm. Mr Watts said that had been offered a home with his father after his release but he seemed reluctant to accept it as he would be "known" in the area.

41. On the afternoon of 21 January 2017, an officer found Mr Watts under the influence of NPS, with several prisoners watching him. The officer noted that he believed that Mr Watts had been given the substance without his knowledge. Mr Watts was taken back to his cell and a nurse was called to check his clinical observations.

42. During January 2017, there were two further occasions when Mr Watts was found under the influence of an illicit substance. He also tested positive for NPS and was again found with hooch. Mr Watts' IEP level was again reduced to basic.

43. Mr Watts' personal officer on C Wing said that he spoke to Mr Watts about being found with hooch and Mr Watts had said that he was being bullied into holding it for other prisoners, whom he would not name. His personal officer said that Mr Watts got on well with other prisoners, seemed settled on the wing and never indicated that he was at risk of suicide or self-harm.

44. Another officer on C Wing told the investigator that Mr Watts mixed with a small cohort of peers who were involved in the brewing and consumption of hooch. He said that he had sometimes noticed bruises on Mr Watts' face but Mr Watts had never reported feeling threatened or in need of protection. He said that there was nothing to suggest that Mr Watts was at risk of suicide.

45. On 2 March, Mr Watts was observed on CCTV, assaulting another prisoner and he was punished through the IEP scheme. Mr Watts said that he no longer felt safe on C Wing and at his request, he was moved to E Wing the next day.

46. On 23 March, a substance misuse nurse noted that Mr Watts had missed an appointment with them. Mr Watts gave an explanation but the team believed that he was deliberately not engaging with the process. Several days later, Mr Watts tested positive for benzodiazepines and methadone.

47. On 24 April, the worker from the drug and alcohol service reviewed Mr Watts who said that he had a lot on his mind. He did not say more about this. He said that he had problems sleeping but was much more settled on E Wing than he had been on C Wing.

48. On 27 April, Mr Watts tested positive for NPS. Six days later, he had to leave his workshop as he appeared under the influence of an unknown substance.

49. On 16 May, the worker from the drug and alcohol service and a healthcare assistant reviewed Mr Watts again. The drug and alcohol worker noted that Mr Watts was using illicit drugs, including NPS, in addition to his prescribed medication. She noted that Mr Watts had been warned that if he continued to use illicit substances, his prescribed methadone would be rapidly reduced and then stopped. Although she advised Mr Watts about drug overdose and told him to stop using NPS as it might kill him, Mr Watts said that his only fear was not having NPS. She referred him to the sleep clinic again, and noted that Mr Watts was in a very low mood and had "entrenched drug seeking behaviour". She told the investigator that while Mr Watts was in a low mood that day, it was due to his lack of sleep and was in the context of his usual mood. She said that she never believed that Mr Watts was at risk of harming himself. (The sleep clinic did not receive her referral until after Mr Watts' death.)

50. In the week commencing 22 May, Mr Watts failed to attend work on three afternoons. A prisoner, who was a friend of Mr Watts, told the investigator that Mr Watts was worried about leaving E Wing due to debts.

51. A healthcare assistant saw Mr Watts for the last time when she helped dispense his medication on 26 May. He asked for some more paint for his 'painting by numbers' book. The healthcare assistant said that Mr Watts seemed well that day and he did not indicate that he might harm himself.

52. The investigator spoke to six prisoners who knew Mr Watts. All said that Mr Watts got on well with most of the prisoners and that he was not scared of other prisoners. A prisoner said that Mr Watts had drug debts, although other prisoners were also in debt to him. Several of the prisoners had heard that Mr Watts had said in his final weeks that he would kill himself but no one took the comments seriously or reported them to officers. A prisoner said that he had spoken to Mr Watts until the cells were locked on the afternoon of 26 May and Mr Watts had been his usual self.

53. The evidence from officers on E Wing was similar to that given by officers on C Wing: that Mr Watts got on well with most of the other prisoners but only tended to speak to officers for help with minor matters. None of the officers thought that Mr Watts was at risk of suicide or self-harm.

54. An operational support grade (OSG) was responsible for E Wing on the night of 26 May. He carried out an evening roll check after arriving for duty at about

8.00pm. The OSG told the investigator that he looked into all the cells but said that he would not have spoken to Mr Watts as he was not being monitored under suicide and self-harm procedures, known as ACCT.

27 May

55. At 6.05am on the morning of 27 May, the OSG commenced his morning roll check. CCTV footage showed that he went from cell to cell, checking prisoners by opening their observation hatches. When he reached Mr Watts' cell, he appeared to make a slight hand movement before looking up at the cell number. He told the investigator that Mr Watts had obscured his observation panel and he had intended to return to Mr Watts' cell after completing his roll check to check Mr Watts again. He forgot to do so and after completing his shift, he went home. He acknowledged that when he first saw the obstruction, he should have tried to get a response from Mr Watts by kicking his door and calling to him and that he should have reported the problem straightaway if Mr Watts had failed to respond.

56. At 8.50am, Officer A unlocked the cells on Mr Watts' half of the landing. The CCTV footage showed that he did not look through any of the observation panels when unlocking the doors. At 8.55am, a prisoner went into Mr Watts' cell and saw him hanging. He shouted to officers for help.

57. Officer A and Officer B were nearby and went straight to Mr Watts' cell. Mr Watts was at the back of the cell, hanging from a ligature tied to the television stand. Officer A cut the ligature and Officer B radioed the orderly officer and healthcare team to ask for immediate assistance. Healthcare staff asked if it was a medical emergency code blue (to indicate a life-threatening situation, where a prisoner is unconscious or has significant breathing problems) or code red (to indicate the prisoner has lost a significant amount of blood. Officer B said it was more serious than that but did not specify a code.

58. Officer B told the investigator that he understood the medical emergency codes and said that it seemed clear that Mr Watts was dead so it was not a 'life threatening' situation and a code blue would not apply. Neither Officer B nor Officer A attempted cardiopulmonary resuscitation (CPR).

59. A nurse said that when healthcare staff heard the radio call, they asked whether it was a code blue or code red so that they would know the nature of the emergency. As they received no clarification, four healthcare staff went to the wing, with relevant equipment for both types of emergency. The nurse said that when they examined Mr Watts, they found that he was not breathing, he had no pulse and his eyes were fixed and dilated. He said that neither he nor his colleagues were certain that Mr Watts was dead so they started CPR and continued until paramedics arrived 13 minutes later. He said that the paramedics advised to stop CPR as Mr Watts had clear signs of rigor mortis.

60. Mr Watts left a long suicide letter in which he wrote that his decision to take his life was not due to bullying, the few debts he had or issues with the officers or the prison. He wrote that he had simply had enough of life, that he felt he had served enough time for his offence and, as a result, no longer owed anything to anyone. Mr Watts wrote that he intended to take his life that night between 11.00pm and 11.45pm.

Contact with Mr Watts' family

61. Mr Watts' next of kin was his father, who lived in Yorkshire. None of Garth's trained family liaison officers were on duty on 27 May and none were available when the prison tried to contact them by telephone. Garth then contacted three prisons close to the family home. HMP Wakefield initially indicated that they might be able to help but later informed Garth that they would not be able to do so. Despite the fact that prison contingency plans say that notification of a death in custody must be delivered by a trained family liaison officer, the duty governor at Garth decided to send untrained staff, the Safer Custody Manager and a prison chaplain, to break the news. They left the prison at around 2.30pm and reached the family home at about 4.30pm. Mr Watts' father was at home and the staff told him what had happened. In line with national instructions, Garth contributed to the funeral expenses.

Support for prisoners and staff

62. The duty governor debriefed staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

63. The prison posted notices informing other prisoners of Mr Watts' death. The chaplains offered support to prisoners who knew Mr Watts and staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected.

Investigations by the prison

64. In the days following Mr Watts' death, the Governor commissioned investigations into the apparent failures by the OSG and Officer A to check Mr Watts' wellbeing on the morning of 27 May. The investigations resulted in written warnings to both.

Post-mortem report

65. Mr Watts' post-mortem examination concluded that his cause of death was asphyxia, caused by hanging. The pathologist noted a deep ligature mark on his neck. The pathologist also noted the presence of old well-healed scars, including on his wrists that were suggestive of self-harm wounds. Toxicology results found methadone (consistent with the level prescribed for methadone maintenance therapy) and synthetic cannabinoids (NPS) in Mr Watts' system after his death.

Findings

Work attendance in final week

66. Mr Watts failed to attend work on three afternoons in the week before he died. Another prisoner said that this was because Mr Watts was scared to leave the wing. Staff told the investigator that if a prisoner refused to attend work without a valid reason, a supervising officer should speak to them to find out why they did not attend. There is no record that anyone spoke to Mr Watts about his reasons for not attending, and staff did not, therefore, know whether he had any particular concerns. Staff missed an opportunity to check on Mr Watts' wellbeing and we make the following recommendation:

The Governor should ensure that when prisoners fail to attend work, they are asked to explain their reasons and appropriate action is taken in response.

Illicit drugs, including NPS, and culture of violence

67. Post-mortem investigations found evidence that Mr Watts had used synthetic cannabinoids (NPS). While Mr Watts' suicide letter dismissed that he was in significant debt or was in fear of being bullied, we are concerned that Mr Watts was able to obtain NPS and that its use might have influenced his mood and actions on 27 May. We note the findings of HMIP and the IMB on the prevalence of NPS and other illicit substances and their impact on the safety, debt, violence and good order at Garth. Mr Watts' records show that he had a long history of drug use, both in the community and in prison, and was often in debt, involved in violent incidents, was sometimes found apparently under the influence of an illicit substance, including NPS, and was found with hooch.

68. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with the use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS, the need for more effective drug supply reduction strategies and better monitoring by drug treatment services. We do not consider that Garth took sufficient action to address these issues and risks in Mr Watts' case.

69. While Garth has an NPS strategy, it is under review as the prison does not consider it to be as effective as it should be. We make the following recommendation:

The Governor should ensure that:

- **there are effective supply and demand reduction strategies to help reduce the availability of illicit drugs, including NPS;**
- **staff are vigilant to signs of their use and know how to respond when a prisoner appears to be under the influence of such substances;**
- **there is a coordinated approach to identifying indicators and risks of bullying and violent behaviour, including the impact of illicit substances and associated debt; and**

- **all allegations of violence, intimidation or bullying are taken seriously and investigated appropriately.**

Roll check and discovery of death

Early morning roll check

70. When the OSG completed his roll check on E Wing at 6.05am on 27 May, he checked the prisoners by opening their observation panels. However, Mr Watts had obscured his observation panel and the OSG did not try to obtain a response from Mr Watts or report the incident. He said that he had intended to return to Mr Watts' cell after checking all the other cells but he forgot to do so. While the OSG was subject to a disciplinary investigation by the prison which resulted in a written warning, we make the following recommendation:

    The Governor should ensure that all staff are reminded that if they discover an obscured observation panel, they should immediately ask the prisoner to remove the obstruction and they should take appropriate action if the prisoner does not respond.

Checking prisoners at unlock

71. Following a number of deaths at Garth in 2016, the Governor introduced a system for welfare checks at morning unlock at around 8.00am. The notice to staff said that with effect from 20 December 2016, staff should ensure that they open observation panels and obtain a verbal response from each prisoner. A prisoner told the investigator that at the time of Mr Watts' death, most officers did not open observation panels before unlocking cell doors in the morning.

72. When Officer A unlocked Mr Watts' cell at around 8.50am on 27 May, he did so without checking on Mr Watts' wellbeing or checking on any of the other prisoners who he unlocked on the same landing. Officer A was subject to a disciplinary investigation by the prison which resulted in a written warning. In addition, the Governor circulated a further notice to remind officers of the importance of checking on prisoners' welfare at unlock. We therefore make no recommendation.

Use of emergency codes

73. When Mr Watts was discovered hanged in his cell, Officer B did not use a medical emergency code blue as he said that it was not a "life-threatening" incident as he believed that Mr Watts was already dead. His failure to use the emergency code system meant that healthcare staff had to respond without knowing the nature of the incident. As a result, four healthcare staff responded with both types of emergency bags of equipment; that for prisoners with significant breathing problems and that for prisoners with blood loss.

74. Prison Service Instruction (PSI) 3/2013 on medical emergency response codes, issued in February 2013, requires Governors to have a protocol to provide guidance to staff on how to communicate the nature of a medical emergency efficiently so that staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. While we are satisfied that on this

occasion, the failure to call an appropriate emergency code did not lead to any undue delay in the emergency response, we make the following recommendation:

The Governor should ensure that all staff are aware of and use the appropriate emergency response code when they discover an apparent medical emergency.

Resuscitation

75. When officers went into Mr Watts' cell, they did not attempt resuscitation as it seemed clear to them that he had been dead for some time. However, when healthcare staff arrived, they tried to resuscitate Mr Watts until paramedics arrived and instructed them to stop as Mr Watts was dead and there was evidence of rigor mortis.

76. In September 2016, the National Medical Director at NHS England wrote to the Heads of Healthcare for prisons in England and Wales to introduce new guidance to support staff on when not to perform CPR. This guidance was designed to address the issue of inappropriate resuscitation after a sudden death in prison and was taken from the European Resuscitation Council Guidelines 2015 which state: "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines give examples of futility as including the presence of rigor mortis. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased.

77. Following a recommendation about a previous death, Garth reminded its staff of the circumstances in which resuscitation is inappropriate and gave guidance to staff at morning meetings and training events. While the nurse who attended and the Head of Healthcare said that they were aware of the guidelines, they indicated in their interviews with the investigator that they were not comfortable making the decision not to resuscitate as they were trained to preserve life. We appreciate that it is a difficult decision to make not to resuscitate but we note the clarity of the guidance sent to prisons.

78. We note that the commissioners at NHS England have reissued guidance to Bridgewater Community Healthcare NHS Trust about when resuscitation is not appropriate. The guidance includes that resuscitation should not be attempted when rigor mortis is established. Given that, although healthcare staff were aware of the guidance, they proceeded, inappropriately, to attempt resuscitation, we make the following recommendation:

The Head of Healthcare should ensure that, in accordance with European Resuscitation Council Guidelines, healthcare staff fully understand the circumstances in which resuscitation is inappropriate and are confident about applying the guidance on resuscitation appropriately.

Clinical care

79. The clinical reviewer found that some of Mr Watts' care in Garth was not to the standard that he could have expected to receive in the community. She found that Mr Watts received appropriate monitoring and support once in contact with the substance misuse team but that, based on his history, he should have been

referred to the substance misuse service when he first arrived at the prison two months earlier.

80. The clinical reviewer was also concerned that doctors had repeatedly prescribed medication without seeing Mr Watts and without reviewing his suitability to have in-possession medication, despite his long history of substance misuse, including trading his prescribed gabapentin. The clinical reviewer did not consider that there was a robust and consistent process for sharing information between health professionals and, potentially, with the wider prison on matters such as illicit drug use.

81. The clinical reviewer acknowledged the useful role played by the healthcare assistants involved in Mr Watts' care but noted the clinical risk that they were supervised by a registered nurse. The clinical reviewer made a number of recommendations about prescribing decisions and information sharing between teams. She asked the Head of Healthcare to ensure that all healthcare staff were familiar with the circumstances where resuscitation should be initiated and/or sustained. The Head of Healthcare will need to address these recommendations.

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Independent Investigations

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