Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Luke Jones a prisoner at HMP Berwyn on 31 March 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Luke Jones died in hospital on 31 March 2018 after being found unresponsive in his room at HMP Berwyn earlier that day. He died of an acute cardiac episode, caused by using psychoactive substances (PS). He was 22 years old. I offer my condolences to Mr Jones' family and friends.

Mr Jones had a history of mental health problems and substance misuse. He self-harmed frequently and was managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) on several occasions. Mr Jones said he used PS as a coping mechanism. He received support from the mental health team and Substance Misuse Services (SMS) but continued using PS.

My investigation found that Mr Jones received appropriate support under ACCT and with his substance misuse issues and I am satisfied staff responded appropriately on the occasions when Mr Jones was found under the influence of PS. However, I am concerned that PS is so readily available at Berwyn and the scale of the problem appears to overwhelm the efforts which can be taken locally.

Berwyn has a well-articulated local drug strategy that it is working to implement but I am concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In my view there is now an urgent need for national guidance on the best measures to combat this serious problem and I have made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service in a previous investigation. I have also written to the Prisons Minister setting out my concerns at the number of drug-related deaths 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.

Sue McAllister CB
Prisons and Probation Ombudsman **December 2018**

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Summary

Events

1. Mr Luke Jones was sent to prison in February 2016 and was serving a four-year sentence for robbery. He was moved to HMP Berwyn on 12 April 2017.

2. Mr Jones had a history of mental health issues and substance misuse. He was a frequent user of psychoactive substances (PS) in prison, which he said he used as a coping mechanism. He was supported by the mental health team and Substance Misuse Services (SMS). Mr Jones self-harmed on a number of occasions and was managed under suicide and self-harm prevention procedures (known as ACCT) on seven occasions at Berwyn. He was being monitored under ACCT on the day he died.

3. Mr Jones was found with a noose round his neck on 26 March 2018 and, as a result, he was monitored under constant supervision between 26 and 30 March. On 30 March, observations were reduced to four an hour, and on the afternoon of 31 March, observations were set at two an hour.

4. On 31 March, Mr Jones was locked in his room at 5.00pm. An officer checked him at 5.33pm and recorded he was watching television and appeared to be in good spirits. At 6.07pm, the same officer returned to his room to check on him and saw him lying on the floor, unresponsive. The officer immediately used his radio to inform the control room that there was an emergency code blue (which indicates that a prisoner is unconscious or not breathing).

5. Staff responded quickly and started cardiopulmonary resuscitation (CPR). Paramedics arrived at 6.27pm and transferred Mr Jones by emergency ambulance to Wrexham Maelor Hospital. However, he did not respond to treatment and was pronounced dead at 7.20pm.

6. The post-mortem examination found that Mr Jones died of an acute cardiac episode, which was caused by PS use. PS was detected in his blood when he died.

Findings

7. Mr Jones received good clinical care which was equitable to the care he would have expected to receive in the community.

8. When Mr Jones was found to be using PS, staff challenged his behaviour and supported him in line with the prison's drug strategy. Nevertheless, Mr Jones continued to use PS despite being made aware of the dangers and despite losing privileges.

9. We are concerned at the availability of PS at Berwyn. Despite a comprehensive local drugs strategy, more needs to be done to limit supply and demand. In our view there is now an urgent need for HMPPS to issue national guidance on this to prisons, rather than leaving individual establishments to develop their own local strategies on a piecemeal basis.

10. We found that for the most part staff managed the ACCT procedures very well and that the decision to stop constant supervision on 30 March was a reasonable one. We feel obliged to note that on the afternoon of 31 March, Mr Jones should have been observed twice an hour. Checks were made at 4.30pm, 5.00pm, 5.33pm and 6.07pm. Within any one-hour period, there should have been two checks, so they did not quite meet the frequency required. However, we accept they were only slightly out and we consider it unlikely that this made a difference to the outcome for Mr Jones.

11. Mr Jones died of an acute cardiac episode caused by his PS use. It is tragic that, despite their best efforts, staff were unable to prevent this sadly predictable outcome.

Recommendations

- The Governor should ensure that ACCT checks are carried out at the agreed frequency and that they are at unpredictable times.

The Investigation Process

12. The investigator, issued notices to staff and prisoners at HMP Berwyn informing them of the investigation and asking anyone with relevant information to contact him. Six prisoners wrote to the investigator to say that they had known Mr Jones. He responded to all letters and invited the prisoners to meet him when he visited Berwyn. However, only two prisoners chose to except the offer, and when the investigator met them, neither had any relevant knowledge of Mr Jones.

13. The investigator obtained copies of relevant extracts from Mr Jones' prison and medical records.

14. The investigator interviewed seven members of staff at Berwyn on 23 May and 20 June 2018.

15. Healthcare Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Jones' clinical care at the prison. He attended all interviews with the investigator.

16. We informed HM Coroner for North Wales of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers, contacted Mr Jones' family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The family have asked:

    - What was the prison doing to help Mr Jones with his drug use?
    - Were suicide and self-harm prevention procedures followed appropriately?
    - Was Mr Jones at risk from other prisoners?

18. Mr Jones' family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

19. The initial report was shared with the HMPPS. HMPPS have pointed out some factual inaccuracies and this report has been amended accordingly. They have also indicated the actions taken in respect of the recommendations made, and the action plan is attached as an additional annex.

Background Information

HMP Berwyn

20. HMP Berwyn is a newly built prison in Wrexham, North Wales, which can hold up to 2,106 men. It opened on 27 February 2017.

21. Betsi Cadwaladr University Health Board (BCUHB) runs healthcare services at the prison. GP services are provided by Gables Medical Offender Health Ltd which includes an out of hours provision. Healthcare services are in operation from 7am to 8.30pm Monday to Friday and from 8am to 6pm on weekends and bank holidays.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons has not yet inspected HMP Berwyn.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In their report for the year ending 28 February 2018, the IMB for Berwyn said '… the board has very real concerns at the ingress of illicit drugs, which appear to be readily available within the establishment and would ask that all steps are taken to minimise the issue ...'.

Previous deaths at HMP Berwyn

24. Mr Jones' death was the first death of a prisoner at HMP Berwyn. There has been one death since, from natural causes.

Assessment, Care in Custody and Teamwork

25. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive Substances (PS)

26. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a genuine problem across the prison estate. They are difficult to detect and can affect people in several 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.

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

28. 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.

Key Events

29. Mr Luke Jones was remanded to HMP Altcourse in February 2016, charged with robbery. He was found guilty and sentenced to four years in custody in March 2016. He was transferred to HMP Stoke Heath on 18 March 2016 and then to HMP Berwyn on 12 April 2017.

30. On arrival at Berwyn, Mr Jones had an initial health screen completed by a nurse. He told her that he sometimes felt depressed and sometimes had panic attacks and asked to be referred to the primary care mental health team.

31. On 19 April, Mr Jones was seen by a Staff Nurse, who was a member of the primary care team. Mr Jones said that he felt that his mood was very changeable, and that he felt okay at times but very low in mood at other times and this change could happen very quickly. Mr Jones told the staff nurse that he had thoughts of self-harm and suicide, but was unaware of anything that had triggered this, although he said that it had been worse since arriving at Berwyn. Mr Jones described feeling irritated by others and how he had recently thrown objects at his cellmate as a result, and had now moved to a single cell. A Staff Nurse started suicide and self-harm monitoring procedures (known as ACCT).

32. Over the next few days, Mr Jones was seen on five occasions by staff from healthcare and the mental health team. It was recorded that he was awaiting a full assessment by the mental health team, but stated that he had no imminent thoughts of self-harm and was feeling better. On 21 April, a Nursing Sister, chaired an ACCT case review with Mr Jones. The review was attended by a Healthcare Assistant (HCA), Custodial Manager (CM), and two officers.

33. The Nursing Sister recorded that Mr Jones spoke openly about his recent issues and although he stated he would not harm himself, he did disclose that he had suicidal thoughts of either hanging or cutting himself. Mr Jones said that he would be starting in education the following week, doing Welsh and maths. He spoke about his family, telling staff that his mother lived in Birmingham and his father lived in Llandudno, and he was close to both parents. Mr Jones said that he was looking forward to starting education but spoke about the lack of work and things to do. It was recorded that Mr Jones had ten months of his sentence to serve and would be accepting of input from mental health services. He told the review that he thought that he might have bipolar disorder.

34. The review decided that the ACCT should remain open due to recent negative thoughts, and another review would take place on 26 April. It was also recorded that mental health welfare checks had been scheduled for the weekend to provide additional support. Mr Jones said that he was grateful for this and gave assurances that he felt much better and felt able to speak with people should he need to.

35. On 25 April, a Staff Nurse, from the mental health team, met with Mr Jones to complete a mental health assessment. She recorded that Mr Jones had fleeting thoughts of killing himself and feeling depressed. He said that some days he could not get out of bed and he would become angry and agitated at times. Mr Jones said that there was a family history of bipolar disorder and depression. He also said that while in custody, three members of his family had passed away.

Mr Jones said that he had not been under the care of the mental health team prior to arriving at Berwyn, but had tried counselling which had not worked for him.

36. Mr Jones said that he had been drinking alcohol heavily from the age of 12 and smoked cannabis from the age of 10. He said that he had also tried cocaine, ecstasy and amphetamines. He said that he had last used cannabis the night before he was sentenced. The Staff Nurse offered to refer Mr Jones to Substance Misuse Services (SMS), however he declined this, saying that he had done this before and knew how to self-refer to the service

37. Mr Jones said that he had taken an overdose at the age of 16, but had not self-harmed since then. He denied any thoughts or intentions to self-harm at that time, although this had fluctuated over the past week. The Staff Nurse recorded that a follow up appointment to look at mindfulness and other coping techniques would be made for Mr Jones.

38. A senior registered psychologist, was asked to engage with Mr Jones and complete work with him around coping techniques. She explained that when she first engaged with Mr Jones, he appeared ashamed that he was on an ACCT. Mr Jones also told her that he had also recently suffered a bereavement with the death of his aunt, and this had brought back memories of his grandmother's death, when he was nine; she had been his primary care giver, and he had found her body. The senior registered psychologist, said that in her view this had triggered Mr Jones' recent issues.

39. On 3 May, Mr Jones attended an appointment with GP at Berwyn. He recorded that Mr Jones had been experiencing low mood for the past seven to eight months, and that some days were worse than others. Mr Jones said that he felt irritable and had poor concentration. He also reported that his appetite was 'hit and miss' with his sleep pattern being erratic. He recorded that Mr Jones had been self-harming and had suicidal thoughts, and as a result he was subject to ACCT procedures. He diagnosed Mr Jones with possible depression, and prescribed citalopram (an antidepressant).

40. The senior registered psychologist said that she began seeing Mr Jones more frequently in May because there were few prisoners at Berwyn at that time. She said that around this period, Mr Jones spoke of using psychoactive substances (PS) in the community and told her that he had always 'managed' himself with substances. He said that he had mainly used cannabis and "mamba" (a PS). Mr Jones told her that he had always used illicit substances while he was in custody, and that he did so as a coping mechanism to 'kind of chill him out' and help him manage. Mr Jones said that he had kept his use 'under the radar' and would use at night when he was alone. Mr Jones did not say that he had used since arriving at Berwyn, but told her that he had lots of emotions and did not know how to manage them.

41. In addition to ACCT case reviews, Mr Jones was seen almost daily by a member of healthcare or the mental health team. On 22 May, a prison GP increased Mr Jones' dose of citalopram from 20mg to 40mg per day. On 25 May, a consultant psychiatrist, assessed Mr Jones along with healthcare assistant (HCA). Mr Jones told the consultant psychiatrist, that he had been hearing voices and had

been in “a dark place” after the recent deaths of his aunt, grandmother and cousin. Mr Jones again said that he had not previously had contact with mental health services.

42. Mr Jones told the consultant psychiatrist that he had smoked cannabis from the age of ten, but said he had not done so since arriving at Berwyn. He also said that he had previously used amphetamines and PS, but did not specify whether he had used these while in custody. Mr Jones also said that while at Stoke Heath he had been drinking “hooch” daily and prior to this period of custody had been dependent on alcohol. (Hooch is the term given to fermenting liquid made illicitly by prisoners.)

43. Mr Jones described his mood as “improved" and "just normal”. The consultant psychiatrist diagnosed Mr Jones as having an emotionally unstable personality disorder, and agreed with him that he should continue with citalopram and he would additionally prescribe 50mg amisulpride (an antipsychotic.) He also referred Mr Jones to the prison’s psychology team, to address his coping skills and emotional regulation. He wrote that he did not plan to see Mr Jones again unless there was a clinical need.

44. ACCT monitoring continued until 31 May. In total nine case reviews were held. Each review was attended by Mr Jones and both healthcare and mental healthcare staff. The ACCT was closed on 31 May, when Mr Jones appeared to be making satisfactory progress. Mr Jones was monitored under ACCT procedures on six further occasions between 2 June and 31 March 2018. ACCT observations were changed dependent on the risk with which he presented, which fluctuated. All reviews were attended by mental health and healthcare staff in addition to prison staff and psychology staff who were working with Mr Jones, and plans to support him were regularly updated.

45. Mr Jones continued to receive daily support from the mental health team. On 29 June, Mr Jones attended a further appointment with the consultant psychiatrist and his amisulpride was increased to 100mg.

46. Over the next six weeks, Mr Jones continued to require regular support from the mental health team. On 10 August, the consultant psychiatrist assessed him again. Mr Jones told him that he was no longer hearing voices but felt that his depression was worse. He said that he had been working as a wing cleaner but had given up this job recently, and now spent his time watching television, which he enjoyed. Mr Jones told the consultant psychiatrist that he telephoned his mother daily and spoke positively about plans for his future. Mr Jones attributed his recent self-harm to the voices he had been hearing and frustration, and said that self-harming relieved his stress. Mr Jones told the consultant psychiatrist that he started self-harming in this prison as he did not have "access to loads of tablets". He did not specify what tablets he was referring to.

47. The consultant psychiatrist recorded that he intended to reduce Mr Jones’ citalopram to 20mg for one week and then discontinue it, but start Mr Jones on venlafaxine (an antidepressant) simultaneously for one week and increase to 150mg daily. He recorded that he would see Mr Jones again if it was felt that there was a clinical need.

48. Mr Jones appeared to make some progress, gaining employment in the prison kitchens. However, he also began to become non-compliant with medication and this resulted in further periods of self-harm and continued ACCT monitoring.

49. On 27 September, Mr Jones' offender supervisor, his probation officer and the senior registered psychologist, met with Mr Jones so that his probation officer could meet him for the first time and discuss release plans. It was noted that Mr Jones had worked well with the senior registered psychologist, although he said that he had some trouble processing information, saying that he understood the beginning and end of sentences but missed the bits in the middle.

50. Due to this his offender supervisor recorded that Mr Jones would be asked to demonstrate his understanding in future meetings. It was recorded during the meeting that Mr Jones was currently 'in a better place' despite having been 'up and down' in his moods throughout his time at Berwyn. It was recorded that he had been placed on report numerous times for violence and aggression and had been self-harming on a regular basis. She recorded that when taking his medication (anti-anxiety, antidepressants and antipsychotics) Mr Jones was more stable.

51. Over the weekend of 15-16 October, Mr Jones was found to be under the influence of illicit substances and required treatment from nursing staff. He admitted to using PS and an intelligence report was submitted. On 16 October, a prison GP recorded that he was carefully considering if continuation of Mr Jones' medication was in his best interest in view of his use of PS. He wrote that it was a case of balancing the risk of self-harm as consequence of a possible deterioration in mental health without medication, against the risks for Mr Jones of using PS alongside prescribed medication. The prison GP indicated that he intended to discuss the matter with the consultant psychiatrist the following day. The consultant psychiatrist recommended that medication be continued for the time being, given Mr Jones' self-harm history.

Further concerns about Mr Jones using PS were raised by staff on 22, 23 and 24 October, all recorded in intelligence reports. His medication was not dispensed on 22 October after Mr Jones was found under the influence of PS – he had vomited and was found slumped against the door of his room.

52. On 24 October, the prison GP again wrote that there was increasing concern about Mr Jones' lack of insight into the dangers of his PS use alongside his antipsychotic medication. He recorded that the ongoing PS use suggested that the balance of risk was becoming more in favour of stopping medications in view of the potential harmful interactions with illicit substances.

53. The consultant psychiatrist was updated on Mr Jones' continued illicit drug use and recorded on 26 October that Mr Jones' antipsychotic medication should be discontinued, until he had a two-week period free from illicit drug use, evidenced by a drug test. He said that a further psychiatric review should only be booked once Mr Jones provided a negative drug test, so that an accurate mental health assessment could be conducted.

54. Also, on 26 October, Mr Jones physically assaulted a member of prison staff and was moved to the segregation unit. There is no evidence that he was under the

influence of PS or other illicit drugs at that time. He remained in segregation for 24 hours before returning to the residential wing.

55. At an ACCT review on 29 November, Mr Jones disclosed that he was using PS on a daily basis.

56. Mr Jones' behaviour had deteriorated since arriving at Berwyn, with assaults on staff and PS use, resulting in additional days being added to his sentence. His offender supervisor told the investigator that Mr Jones would have initially been due for release in February 2018, but because he had received additional days for poor prison behaviour, this date had been pushed back to 29 August.

57. On 8 February 2018, Mr Jones was found by staff to be under the influence of an illicit substance, later confirmed by a mandatory drug test to be PS. Staff submitted intelligence reports and placed Mr Jones on report.

58. On 8 March, Mr Jones met the senior registered psychologist for a routine one-to-one session. She recorded that it was great to see Mr Jones doing so well, he was enjoying working in the kitchens and finding it helpful to be so busy. She recorded that his attitude was very positive and, although his mood was still up and down, he provided examples of things that had gone wrong and how he had handled them much more effectively.

59. On 13 March, Mr Jones had a disagreement with a fellow prisoner in the kitchens and a fight took place. This resulted in the kitchen area being damaged and Mr Jones was removed from his employment. He was also placed on the basic regime for 14 days as part of Berwyn's violence reduction policy. Mr Jones made superficial cuts to his arm and ACCT monitoring was started on 14 March for the seventh time.

60. On 15 March, in the absence of the senior registered psychologist, a psychologist went to see Mr Jones after he had asked to speak with someone in psychology. Mr Jones told her that he had recently been sacked from his job in the kitchens for fighting. He said that someone had been trying to take his coffee and when he turned his back they had attacked him with steel toecap boots. Mr Jones said that his job had been helpful in enabling him to achieve more stability, lessening his need for medication and more importantly his desire for PS. Mr Jones said that he had been moved off A Lowers (residential unit) to B Lowers (residential unit) and that he had his adjudication for fighting the following morning. The psychologist encouraged Mr Jones to use the coping strategies that the senior registered psychologist had taught him as a means of coping with the next few days.

61. The psychologist also recorded that she later spoke with kitchen staff who told her that Mr Jones had been more involved in the fight than he had led her to believe and that it was currently not an option to re-employ him. Despite this, the staff did acknowledge that working in the kitchens had been having a positive impact on Mr Jones up to that point.

62. The senior registered psychologist went to speak with Mr Jones when she returned from holiday on 20 March. Mr Jones told her that he was coping better than he had done previously when he had unwelcome news, and he was thinking

of his family to motivate himself, but was struggling with paranoia. Mr Jones said that he had stopped using ‘spice’ (PS) and he felt that PS had previously stopped his paranoia. The senior registered psychologist agreed with Mr Jones that at his next ACCT review he should ask to be referred to the psychiatrist for his medication to be reviewed. Mr Jones spoke about not having anything to keep him occupied and she recorded that she would consider the possibility of him becoming the psychology orderly (cleaner), as a means of keeping him busy.

63. Later that day, Mr Jones demanded that his ACCT be closed, and when this did not happen, he told staff that he had taken 32 paracetamol tablets. An ACCT review was convened and the senior registered psychologist attended. She told the investigator that Mr Jones had sent her a message via unilink. (Each prisoner at Berwyn has a restricted laptop in their room operated by unilink, enabling them to access offending behaviour / educational work, and send and receive applications from departments around the prison.)

64. The senior registered psychologist said that Mr Jones had said that he had taken an overdose and would ‘keep cutting his throat, until he died, as he had, had enough.’ On receiving this, she said that she went across to the wing, as she felt that Mr Jones’ ACCT observations would need increasing. However, when she saw Mr Jones, she said that his mood was okay, although he was clearly frustrated. She said that he was not despondent or hopeless as he had been in the past. Mr Jones said that he was unhappy that he had been told by staff that he would have his ACCT reviewed that afternoon so it could be closed, and this had not happened. She said that he was also frustrated after being locked in his room all afternoon. She asked Mr Jones what he had meant when he said, ‘he had had enough.’ Mr Jones said that he was referring to having had enough of staff making promises and then not seeing them through.

65. Mr Jones said that he did not want his observations to be increased as this interfered with his sleep, and he assured custodial manager, who was chairing the ACCT review, and the senior registered psychologist that it was not necessary. He told the staff that he would not do anything to harm himself, and he was told by the senior registered psychologist that he would start as the orderly in psychology department the following morning. She said that after reviewing Mr Jones she was happy that his observations remained hourly, and he appeared buoyant when she left.

66. Mr Jones began working in the psychology department as planned, but on 22 March, received news that his mother was unwell. An ACCT review was convened and observations remained at hourly. On 23 March a member of the team, offered Mr Jones the opportunity to attend chapel, and the chaplaincy team would facilitate a telephone call to his mother. However, Mr Jones declined.

67. Later that morning, Mr Jones cut his arm, and refused treatment and refused to attend an ACCT review. His observations were increased to every 30 minutes. The senior registered psychologist, visited Mr Jones during the afternoon, and Mr Jones said that the chaplaincy team had confirmed that his mother was being treated for cancer, but he did not have any other details. He said that he wanted the chaplaincy team to speak with her again to get more information as he felt, if he spoke with her, she would know he was not alright and therefore she would

worry. Further ACCT reviews were held on 24 and 26 March, but on both occasions, he refused to attend and observations remained every 30 minutes.

68. At 11.00am, on 26 March, Mr Jones was found with a ligature made from torn bedding wrapped around his neck. This was observed by staff completing routine ACCT observations and they intervened. Because of his actions and concerns about his heightened risk, Mr Jones was placed on constant supervision and moved to the constant supervision cell, on Alwen residential unit.

69. The senior registered psychologist visited Mr Jones later in the afternoon, and recorded that his mood was very low, and that Mr Jones stated that he wished staff had let him die. The mental health team confirmed that an urgent referral would be made for Mr Jones to see the psychiatrist, and she planned to see him again the following day. She also attended an ACCT review, where it was agreed that the constant supervision should remain in place.

70. A member of the chaplaincy team, also spoke with Mr Jones, and he asked him to contact his mother. He recorded that he offered Mr Jones the opportunity to speak with his mother himself, but he said that he preferred the chaplaincy team to do it instead. He said that Mr Jones' mother was very candid and told him that he could share with Mr Jones that her cancer had returned and she was having further tests. She said that although her condition was serious, she had not been told that it was terminal. He recorded that he reassured Mr Jones that there were positives for his mother, and Mr Jones thanked him for contacting her.

71. An ACCT review was held on 27 March, chaired by the Head of the Offender Management Unit (OMU,) and attended by a custody manager, two officers, safer custody, a staff nurse from the mental health team, and the senior registered psychologist. It was recorded that Mr Jones was 'visibly down' and affected by his mother's illness. Mr Jones was said to be showing signs of anxiety and paranoia and, while able to focus on the future, his ability to engage with the review team drifted in and out. The review recorded that while there was some progress from the previous day, from Mr Jones' own admission, he still presented as a risk of suicide. The review concluded that constant supervision would remain in place, but some personal items would be returned to him, to provide more normality. Further ACCT reviews took place on 28 and 29 March.

72. The review on 29 March took place in the psychology department. The review was chaired by the Governor and attended by the custody manager, an officer, and the senior registered psychologist. It was recorded that Mr Jones presented as much better in his mood, and was said to be chatty, open, honest and engaged well. Mr Jones told the review team that he would like to move to Bala residential unit, as this was where he would feel safest. The team explained that Mr Jones would need to be settled before any onward move could take place.

73. Mr Jones said that it had been arranged for him to attend the chapel that afternoon to telephone his mother, and he was taking a friend for support. Mr Jones told the review that he was worried about this and that his mood might 'take a dip' afterwards, and he might need added staff support. It was confirmed that the GP would be seeing him about medication, but this was unlikely to happen until after the bank holiday weekend. Mr Jones said that he agreed he needed medication to feel stable, but he also said that he understood that such

medication might also initially make him feel low, and he needed to be prepared for this. The review recorded that Mr Jones' outlook and attitude were mature and he wanted to progress. It was agreed that due to the telephone call, constant supervision would remain in place for the time being.

74. A member of the chaplaincy team facilitated the telephone call between Mr Jones and his mother later that afternoon. He recorded that Mr Jones was unable to speak with his mother, but did speak with his brother, and he said that he felt reassured after doing so. Mr Jones also asked for a further opportunity to speak with his mother.

75. At 4.00pm on 30 March, an ACCT review was held, chaired by the Head of Safety, and attended by two custody managers, and an officer. It was recorded that Mr Jones engaged well and spoke about being unhappy that he was on constant supervision due to the lack of privacy. He told the review that he had been worried about his mother, but having spoken with his family and obtained more information, he felt reassured. The review recorded that, although Mr Jones' risk had not changed significantly, he was much happier. It was agreed that observations would be changed to four an hour, but Mr Jones would remain in the constant supervision room, to enable the transition while still managing the risk.

76. On 31 March, an officer, was on duty on Alwen unit and spoke with Mr Jones. She told the investigator that she knew about Mr Jones, because of his previous poor behaviour, but that she had built up a good rapport with him when she had completed a few duties as the constant supervision officer earlier that week. She said that while on constant supervision, Mr Jones had the option of leaving his room during association periods, but he also had other prisoners visit him in his room during these periods.

77. The officer said that on 31 March, Mr Jones seemed upbeat. She said that initially Mr Jones had spoken of moving back onto Bala unit, and staff had been concerned about him moving over as it was felt PS was more widely available there. She said that staff were also keen for Mr Jones to remain on Alwen as it is a close-knit community and he had a network of people that she believed were quite sensible and offering Mr Jones good support. She said that she had spoken with Mr Jones and explained that in her view he would be better to remain on Alwen and he had agreed.

78. The officer said that during the afternoon she escorted Mr Jones over to the chapel, as another telephone call to his mother had been arranged. She said that it was a pleasant day and they had a chat as they walked across, and Mr Jones raised no concerns. Unfortunately, when they arrived at the chapel, nobody from chaplaincy was there, and she said that she initially thought that Mr Jones would be devastated that he could not make his telephone call. Despite her initial concerns, she said that he took it well, saying, 'Doesn't matter, does it Miss, because it has been nice to go out and just have a walk.' The officer told the investigator that Mr Jones' reaction demonstrated to her that he was in a much better place than he had previously been during the week.

79. At 3.30pm, the Head of Safety chaired an ACCT review with Mr Jones, attended by a custodial manager (CM) on Alwen Unit, and an officer. Mr Jones was

recorded as engaging well in the review and said that he had decided that he would rather remain on Alwen. Mr Jones told the review that he felt in a much better place than he had been, and his level of support was discussed. It was agreed with Mr Jones that his observations would be reduced to two an hour, and he would continue to stay in the constant supervision room until another room on the unit became available. Mr Jones was recorded as being happy with the outcome of the review.

80. The officer locked Mr Jones back in his room that evening at 5.00pm, after he had collected his evening meal. She said she spoke with him briefly as she was due to be working in another area the following day and would not see him again over the weekend. She said that Mr Jones had decided that he was staying on Alwen unit and was in good spirits. The officer told Mr Jones that she would be working elsewhere and was then away for a week, but she would see him when she returned to see how he was progressing. She said that Mr Jones thanked her for her support and hoped she had a nice holiday. She said that when she left Mr Jones she had no reason to be concerned about his well-being. Mr Jones was checked again at 5.33pm, by another officer, who recorded that Mr Jones was watching television and appeared in good spirits.

81. At 6.07pm, the officer returned to Mr Jones' room to complete a further ACCT observation. When he looked into the room through the observation panel, He said that he could not immediately see Mr Jones, but he then noticed him lying on the floor, unresponsive. He immediately used his radio to inform the control room that there was an emergency code blue (which indicates that a prisoner is unconscious or not breathing).

82. Two other officers were both working on Alwen and responded to the emergency radio call. The officer who found Mr Jones, and a second officer went into the room and said that Mr Jones was 'slumped' against the far wall with his head on his chest. They attempted to get a response by calling his name and checked for breathing. The officer said that at this point Mr Jones was breathing, although it was very shallow, and the officers placed Mr Jones into the recovery position.

83. Two nurses were both on duty and heard the emergency call at 6.08pm and responded immediately, taking with them the emergency medical bag. As they made their way to Alwen, they were updated over the radio that Mr Jones was unconscious, but had shallow breathing. On entering Alwen unit, one of the nurses collected the emergency resuscitation bag from the wing medical treatment room, and the other nurse went straight to Mr Jones' room, arriving at 6.13pm.

84. Due to Mr Jones' size and the limited space within the room, the nurses asked the officers to move him onto the landing, so that treatment could be provided more efficiently. Once on the landing the nurses assessed Mr Jones and identified that his airway was blocked with vomit and that turning his head had little effect. The nursing staff then attempted to insert an airway, but said that this was also ineffective as it filled with vomit. The nursing staff continued to attempt to create an airway, and while they were doing so Mr Jones, stopped breathing, and cardiopulmonary resuscitation was started at 6.18pm. Oxygen was provided to Mr Jones via a mask, but this was also affected by large amounts of vomit. A

defibrillator was attached to Mr Jones and this delivered three shocks, before the arrival of paramedics.

85. First responder paramedic, arrived at Mr Jones' room at 6.27pm. She exchanged the prison defibrillator for her own, and this indicated no shockable rhythm, and CPR continued. She inserted a cannula into Mr Jones' arm to enable drugs to aid resuscitation to be administered. Two further ambulances arrived and paramedics continued to treat Mr Jones. He was then placed on a stretcher and transferred by emergency ambulance to hospital, accident and emergency (A&E) department, arriving at 7.14pm.

86. Treatment was handed over to the doctor in charge of A&E, and efforts to resuscitate Mr Jones continued. Mr Jones was pronounced dead at 7.20pm.

87. After Mr Jones' death, PS residue was found on pieces of paper and a milk carton in his room.

Contact with Mr Jones's family

88. The prison appointed a family liaison officer (FLO) and she visited both of Mr Jones' parents on 31 March. She told the family of Mr Jones' death and provided as much information as was known at the time. The prison contributed to Mr Jones' funeral, in line with national guidance.

Support for prisoners and staff

89. After Mr Jones' death, the duty 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.

90. 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.

Post-mortem report

91. The post-mortem found no evidence of bruising or injury to Mr Jones' neck from the self-harm incident on 26 March, and no evidence of any natural underlying disease that could have caused Mr Jones' death.

92. Toxicology tests showed that Mr Jones had PS in his system when he died. The post-mortem report concluded that Mr Jones died from ventricular cardiac arrhythmia (rapid, erratic heartbeat leading to a cardiac arrest) caused by PS use.

Findings

Clinical care

93. The clinical reviewer concluded that overall Mr Jones received good care by the prison healthcare service which was equitable and, in many ways, more rapid than the care he would have expected to receive in the community. He received a wide range of inputs from healthcare and there was good multi-disciplinary involvement in his care, including input from mental health and forensic psychiatry. There were no avoidable delays in the emergency response on the day of his death.

94. The clinical reviewer was satisfied that the decisions to stop Mr Jones' prescribed medication when he was using PS were made after consideration of the balance of risks posed by the interaction of the medication and PS, and not on the basis of a blanket policy.

Tackling illicit drug use

95. Mr Jones had a history of using PS, and spoke openly about taking PS in conversations with staff. Intelligence suggested that Mr Jones involvement in certain incidents, such as assaults on staff was initiated as a means of payment for PS. However, the prison had no evidence to substantiate this, other than the knowledge that Mr Jones was a PS user.

96. Berwyn has a Supply Reduction Strategy issued in April 2018. The prison also has a PS-specific policy in draft form that complements the overarching strategy. The PS strategy is designed to deal with PS use in a supportive manner while still applying disciplinary measures but ensuring that the good order of the prison and support for those with drug issues work in tandem.

97. Mr Jones was offered support from Substance Misuse Services (SMS), although he did not always agree to engage, and had regular engagement with the prison's psychology and mental health team who provided both advice and support with his PS use. Prison staff also provided advice and guidance, reminding Mr Jones of the potential dangers of PS use. Mr Jones was also offered the opportunity to move to other areas of the prison where availability of drugs was considered to be lower. Intelligence reports about Mr Jones' drug use and suspected drug use were also regularly submitted by wing staff, and Mr Jones was subject to mandatory drug testing, which confirmed his use of PS. We are satisfied that Mr Jones was offered appropriate support and that staff responded appropriately when he was found under the influence of drugs.

98. Betsi Cadwaladr University Health Board, the healthcare provider at Berwyn, has a policy to withhold all non-essential medication for 24 hours if illicit drug taking is suspected until a doctor can complete a medication review. This is to avoid any adverse effects of taking prescribed and non-prescribed drugs together. We are satisfied that this policy was applied correctly to Mr Jones, and doctors subsequently decided to stop his antipsychotic medication when they became aware that he was using PS.

99. Berwyn holds monthly Drug Strategy meetings involving key stakeholders including Primary Care and SMS. Discussions are also held between the Head of Drug Strategy, SMS team and family members in some of the psychosocial intervention work that takes place. Berwyn has said that there are also plans to have a monthly SMS stand in the Visitors' Centre so that families can discuss concerns with health professionals and access support services.

100. Berwyn has developed an action plan designed to ensure that tackling drugs and PS remain a key focus for the establishment. This is a live action plan that aims to contribute actively to the reduction in both the supply and demand for PS. New actions are added at any time in response to the changing need and environment. This is developed, managed and reviewed through the monthly drug strategy meetings.

101. Berwyn recognises that a key route of illicit substances into the establishment is by way of impregnated paper (Mr Jones was known to use this technique). In response to this threat the prison purchased two Rapiscan itemiser machines. This enables all incoming mail to residents to be swabbed and the swabs analysed on the itemisers. Any mail testing positive for illicit substances is then withheld. This system is currently in a three-month trial phase which started on 4 September 2018.

102. Berwyn also recognises that, if this has a significant impact on the supply of illicit substances through prisoners' mail, will most likely result in alternative routes such as visits or 'throw overs' becoming more popular. In response to this the Dog Section at Berwyn has increased by one handler. This now gives a resource of three dog handlers providing drug dog cover of two passive drug dogs and two active drug dogs, with a third passive dog awaiting training. The increased team means that the prison can provide greater searching cover for social visits, including the ability to conduct evening and weekend visit searching.

103. While we accept that Berwyn has a drug strategy in place and staff are working hard to implement it, Mr Jones was apparently able to obtain and use PS without difficulty at Berwyn and continued to do so despite being made aware of the dangers and despite losing privileges. It is clear, therefore, that more needs to be done to reduce not just the supply but also the demand for PS.

104. Berwyn is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO considers that there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

105. In a recent investigation, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of drug-related deaths she was investigating. The Chief Executive has told us that HMPPS plan to issue a national drug strategy in the autumn of 2018. We therefore make no recommendation.

Management of Mr Jones' risk of suicide and self-harm

106. Prison Service Instruction (PSI) 64/2011 on safer custody, sets out how prisoners considered at risk of self-harm and/or suicide should be supported and managed. Mr Jones was monitored under ACCT procedures on seven occasions while at Berwyn, and was being monitored at the time of his death.

107. The investigation found that on all occasions that Mr Jones was subject to ACCT monitoring, staff at Berwyn adhered fully to prescribed policy and that procedures were initiated and followed to a high standard. Case reviews were held regularly, completed on time and always attended by a multidisciplinary team of people who were involved directly with Mr Jones.

108. We conclude that on the most part ACCT procedures were managed appropriately and very effectively and that Mr Jones received a high level of support from staff. We feel obliged to note, however, that on the afternoon of 31 March, Mr Jones should have been observed twice an hour. He was checked at 4.30pm, 5.00pm, 5.33pm and 6.07pm. Within any one-hour period, there should have been two checks, so these timings did not quite meet the frequency required. However, we accept that they were only slightly out and consider it unlikely that this affected the outcome for Mr Jones.

109. There is nothing to suggest that Mr Jones' death was anything other than accidental. We consider that the decision to stop constant supervision on 30 March was a reasonable one, and that staff could not have foreseen the events that occurred on 31 March.

110. Nevertheless, given the need for diligent and effective compliance with ACCT procedures and the significant risks attached to not doing so, we make the following recommendation:

The Governor should ensure that ACCT checks are carried out at the agreed frequency and that they are at unpredictable times.

Prisons &
Probation
Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141