Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ross Hopkins a prisoner at HMP Parc on 8 October 2016

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 Ross Hopkins was found hanged in his cell at HMP Parc on 7 October 2016. He never regained consciousness and died in hospital the next day. Mr Hopkins was 34 years old. I offer my condolences to Mr Hopkins' family and friends.

Despite having a number of risk factors for suicide and self-harm, Mr Hopkins was not assessed as being at risk of suicide by staff at Parc. However, Mr Hopkins effectively hid his true intentions from both staff and other prisoners. As a result I do not criticise the prison for this decision-making.

However, the investigation did identify some weaknesses in Mr Hopkins' care at Parc. In particular, illicit substances are evidently a serious problem at the prison and Mr Hopkins' apparent involvement with them went unaddressed. It is also disappointing that staff relied on remote and impersonal communication of decisions about who he could contact in the community which had implications for his welfare. Although the emergency response was swift, there was a delay in providing sufficient information to the 999 operator for them to deploy an ambulance. Lastly, it is unsatisfactory that Mr Hopkins' next of kin details were not kept up to date.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2017**

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Summary

Events

1. Mr Ross Hopkins was remanded into custody on 29 September 2015 charged with robbery and firearms offences. A restraining order was also issued at the same time, preventing him from contacting his mother until 2020. On 22 October, Mr Hopkins was sentenced to seven years imprisonment. On 6 November, he transferred to HMP Parc.

2. Mr Hopkins settled well at the prison, worked hard and was promoted to head cleaner. He caused no management issues for the first seven months he was at Parc. Between June and September 2016, three intelligence reports were submitted indicating that Mr Hopkins' mood had become more changeable and that he may have been involved in drug use and/or supply. Some staff and prisoners told the investigator that they thought that Mr Hopkins was using New Psychoactive Substances (or NPS) and/or subutex (an opioid used to treat drug withdrawal).

3. On 20 September, security staff listened to Mr Hopkins' most recent telephone calls. These indicated that he had been telephoning his grandfather in order to speak to his mother, thereby contravening the restraining order. Mr Hopkins was therefore no longer allowed to call this number, but no one informed him of this in person. Security staff also instructed that Mr Hopkins should be drug tested and his cell searched. This did not occur. At this point, no one spoke to Mr Hopkins regarding his suspected involvement in drug misuse or contacted drug misuse services.

4. During this time, Mr Hopkins was also undergoing tests for stomach problems. He told his mother that he was not satisfied with his medical care and was in pain, but staff were not aware of this. Some prisoners and one member of staff said that Mr Hopkins' moods became more changeable during September and October and he became increasingly withdrawn. Prisoners later told a member of staff that on 7 October Mr Hopkins had given away his canteen to other prisoners to whom he was in debt due to his drug use. However, no one suspected Mr Hopkins posed a risk to himself.

5. On 7 October, a Prison Custody Officer (PCO) unlocked Mr Hopkins' cell and found he had hanged himself. Along with two prisoners, he cut Mr Hopkins down and began cardio-pulmonary resuscitation (CPR). Another member of staff radioed a code blue emergency and staff responded. An ambulance was requested immediately but there was a delay of seven minutes before the ambulance was despatched. Mr Hopkins was taken to hospital where he never regained consciousness and died the following day.

6. When contacting Mr Hopkins' family, the Director of HMP Parc acted on incorrect information about his nominated next of kin and contacted Mr Hopkins' grandfather rather than his mother. Mr Hopkins family were with him when he died.

Findings

Assessment of Risk

7. Mr Hopkins' seemed to cope well during his time at Parc and we are satisfied that staff could not have reasonably predicted that he was at risk of suicide. Although a note found after his death revealed that he could no longer envisage a future for himself, Mr Hopkins concealed his intentions from those around him.

Telephone calls

8. We are concerned that no one spoke to Mr Hopkins in person about the appropriate removal of his grandfather's number from the list of those he was allowed to call. Other prisoners we spoke to indicated that he was particularly upset by this as it coincided with the anniversary of his brother's suicide.

Substance misuse

9. Intelligence suggesting that Mr Hopkins was potentially involved in drug use was confirmed by the toxicology report. Limited action was taken in response to this intelligence. We believe that Parc needs to take a more robust approach to reducing the supply and demand for drugs.

Communication with Welsh Ambulance Service

10. We are concerned that there was a delay of around seven minutes before the ambulance was despatched to Parc due to prison staff giving insufficient information to the 999 operator.

Family liaison

11. Parc should ensure that next of kin details are kept up to date and that staff know where to access this information.

Recommendations

- The Director should ensure that all decisions which could affect a prisoner's welfare are explained in person and any impact on the prisoner is assessed and recorded.
- The Director and Head of Healthcare should ensure that there is an effective strategy to reduce the supply of, and demand for, drugs, and that staff are vigilant for signs of their use and are briefed how to respond when prisoners appear to be under the influence of drugs.
- The Director and Head of Healthcare should ensure that staff provide sufficient and accurate information to the local ambulance service to allow them to deploy an ambulance without delay.
- The Director should ensure that next of kin details are clearly recorded and kept updated for all prisoners, including in their electronic record, and that staff are aware of where to access these details.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact her. No one responded. She obtained copies of relevant extracts from Mr Hopkins' prison and medical records.

13. The investigator interviewed eight members of staff and three prisoners at HMP Parc in November 2016. She interviewed an additional prisoner by telephone.

14. Healthcare Inspectorate Wales reviewed Mr Hopkins' clinical care at the prison. Their representative, the clinical reviewer, attended some of the interviews with the investigator.

15. We informed HM Coroner for Bridgend and Glamorgan Valleys of the investigation. He sent us the toxicology report and we have given the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Hopkins' mother, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked the following questions:

    - Why were Mr Hopkins' privileges taken away after he was seen passing a parcel with three other prisoners? Was this parcel recovered? What was in it?
    - If the parcel was not recovered, what could have been in it? Could it have been illegal drugs?
    - Why was Mr Hopkins not being monitored using Prison Service suicide and self-harm prevention procedures?
    - Why did staff not follow-up Mr Hopkins' missed medical appointments?

17. Mr Hopkins' mother received a copy of the initial report. She did not make any comments.

18. HM Prison and Probation Service (HMPPS) also received a copy of the report. They accepted all the recommendations. They also pointed out some factual inaccuracies which have been amended accordingly.

Background Information

HMP Parc

19. HMP Parc is a local prison operated by G4S on behalf of the HM Prison and Probation Service (HMPPS, formerly the National Offender Management Service (NOMS)). It holds approximately 1,750 men including adults and young adults both convicted and on remand and has a unit for around 60 young people under 18 years old. There is 24-hour general healthcare and a local GP practice provides GP services, including out of hours cover.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Parc was conducted in January 2016. Inspectors reported that Parc was a large and complex prison, which had strong and consistent leadership. They noted that relationships between staff and prisoners were positive, and that staff were approachable. The personal officer scheme worked well and staff had a good knowledge of prisoners in their care.

21. They also noted that, in terms of the overall safety and stability of the prison, the availability of NPS, along with other drugs, was having a negative influence. Inspectors concluded that the prison was making efforts to deal with the problem and the drug and alcohol strategy was well managed.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2016, the IMB was concerned about the level of drug misuse at Parc.

Previous deaths at HMP Parc

23. Mr Hopkins was the sixteenth prisoner to die at Parc since the start of 2014 and the fifth apparently self-inflicted death. There have since been two more deaths due to natural causes. In both this, and in a previous investigation, we identified an issue regarding the availability of NPS and other drugs in the prison and the lack of a robust approach to tackle their supply and use.

New Psychoactive Substances (NPS)

24. New psychoactive substances, previously known as ‘legal highs’ are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

25. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence.

The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

26. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

27. Mr Ross Hopkins was remanded into custody at HMP Swansea on 29 September 2015 for robbery and firearms offences. His escort record noted that he had tried to hang himself a month earlier. He said he had no current thoughts of suicide or self-harm. On the same day, the magistrates' court issued a restraining order relating to a separate matter prohibiting Mr Hopkins from contacting his mother until 2020.

28. Following Mr Hopkins' conviction on 9 October, the court adjourned for a pre-sentence report. This detailed that Mr Hopkins felt depressed but had not sought treatment and that both his father and brother had committed suicide some years previously. On 22 October, Mr Hopkins was sentenced to seven years imprisonment. His conditional release date was 20 April 2019.

29. On 6 November, Mr Hopkins transferred to HMP Parc. During his induction, he recorded his mother as his next of kin. Entries in Mr Hopkins' record over the next six months indicate that he had settled well, regularly attended the gym, was employed first as a wing cleaner, then promoted to head cleaner, and worked exceptionally hard. Another prisoner told the investigator that Mr Hopkins had said that he worked so hard as he needed to keep busy so that he did not think about the length of his sentence.

30. Mr Hopkins was randomly drug tested on 23 June. The result was negative. This standard test did not include NPS at the time.

31. On 14 August, Mr Hopkins asked to see healthcare staff as he had swollen testicles. He refused to see the nurse when she arrived. On 23 August, staff searched Mr Hopkins' cell as part of the random searches which take place at Parc. No unauthorised items were found. On 30 August, Mr Hopkins made an application to see a doctor. This appointment was scheduled for 6 September and Mr Hopkins was informed.

32. On 6 September, Mr Hopkins was unable to attend his doctor's appointment due to an incident on the wing. When a Prison Custody Officer (PCO) asked him to return to his cell later that day, he refused. She told the investigator that Mr Hopkins had started mixing with a different group of prisoners who were known to be involved with drugs in the prison. She noted that Mr Hopkins' moods were much more changeable, which she attributed to drug use.

33. On 7 September, Mr Hopkins told wing staff he needed to see a doctor urgently. A doctor assessed him later that day. He told the doctor he had felt "something pop" when he was going to the toilet three weeks earlier, his testicles had swollen, he had an unsettled stomach and was not eating since he was afraid to do so. Mr Hopkins consented to an abdominal examination but refused a testicular examination, saying that these symptoms had settled. The abdominal examination was normal and the doctor advised Mr Hopkins to start eating properly again. She also weighed him and ordered blood tests.

34. A PCO told the investigator that she was aware that Mr Hopkins was having some issues with his stomach and sometimes missed work, as he said he was ill. She said that Mr Hopkins became more argumentative with her, whereas in the

past he had always been polite. When she spoke to Mr Hopkins about this he said he was stressed and waiting for his test results.

35. On 9 September, Mr Hopkins telephoned his mother, using his grandfather's number. He told his mother he was annoyed, as he said he had waited three weeks for a doctor's appointment and now had to wait for his test results. They discussed his plans for release in the future.

36. On 14 September, a PCO observed Mr Hopkins and other prisoners passing small wraps between them. She submitted an intelligence report. She also noted that other prisoners on the wing seemed under the influence of drugs and recommended that those involved should have a mandatory drug test.

37. On 15 September, Mr Hopkins telephoned his mother, using his grandfather's number. He told her that he did not feel any better, had been in considerable pain and had lost weight. He said that staff were aware of this and ignored him. He told his mother he had been waiting for four weeks for a doctor's appointment. None of the staff and prisoners the investigator spoke to said they had noticed Mr Hopkins being in pain, nor had he told them he was. Mr Hopkins did not attend an appointment that afternoon for a review of his blood test results.

38. On 16 September, the security manager recommended that the information from the incident on 14 September should be passed to the wing manager to ensure cell searches were carried out and the prisoners involved were drug tested. She also requested that the drug strategy manager be informed and that all those named on the security report should have their last telephone calls listened to. The security intelligence analyst advised the relevant people of these requests. There is no evidence that Mr Hopkins was drug tested, referred to substance misuse services or had his cell searched.

39. On 20 September, security staff listened to Mr Hopkins' most recent telephone calls. They noted that on several previous occasions he had been speaking to his mother using his grandfather's number. They removed this telephone number from the list of those Mr Hopkins was allowed to call, because of the restraining order in place that prevented him from contacting his mother. Mr Hopkins was informed of this by an electronic message that he accessed by logging onto a computer on the wing. Although Mr Hopkins' offender manager and the wing manager were also informed, there is no evidence that anyone spoke to him about this in person.

40. On 27 September, a doctor met Mr Hopkins to review his blood test results, which were normal. Mr Hopkins told the doctor he was concerned about his weight loss. He decided that Mr Hopkins should be weighed by healthcare staff on a weekly basis. He told the investigator that Mr Hopkins should have booked these appointments with a nurse himself. He had no concerns that Mr Hopkins presented a risk to himself. He told the investigator that Mr Hopkins did not appear to be in pain. Mr Hopkins did not attend a GP follow-up appointment on 6 October.

41. Some staff and prisoners told the investigator that, during September and October, they noticed Mr Hopkins was losing weight. A prisoner who also worked on the servery noticed that Mr Hopkins was not requesting full portions

over this period. He also said that during this time Mr Hopkins' emotions became very changeable. He felt that Mr Hopkins had had enough of being in prison and he began to stay in his cell a lot more. Other prisoners also told the investigator that Mr Hopkins became increasingly withdrawn. He told two prisoners near the beginning of October that it was the anniversary of his brother taking his own life, which he was finding particularly difficult, as he could not speak to his family. However, no one the investigator spoke to thought that Mr Hopkins presented a risk of harm to himself.

42. The investigator asked staff and prisoners whether they were aware of Mr Hopkins using drugs. Some staff, including an operational manager, were unaware of Mr Hopkins using any drugs. Others, such as his personal officer and two PCOs, believed he might have been, but thought that this issue had been addressed by submitting intelligence reports to the security department. Most of the prisoners the investigator spoke to thought that Mr Hopkins was using NPS, with one saying that his use increased in October. Some thought he was also using subutex.

7 October 2016

43. On 7 October, a prisoner told the investigator that Mr Hopkins was very emotional. He had told him he had "had enough" and could not face another two and a half years in prison. Mr Hopkins had taken everything off the walls in his cell and told him he was going to paint it. He was finding it particularly hard that he could not telephone his family anymore. However, he did not think Mr Hopkins posed a risk to himself. Another prisoner said that he had been laughing with Mr Hopkins that morning and he seemed his usual self.

44. On 7 October around 2.30pm, prisoners were unlocked and given their canteen (items, including food and toiletries, which prisoners can order on a weekly basis). A prisoner told the investigator that Mr Hopkins gave away his canteen, which amounted to £4.95 worth of food, to around five prisoners to whom he was in debt. He said Mr Hopkins seemed annoyed but he had often done this before.

45. A prisoner was having a shower at about 3.50pm as were other prisoners, including Mr Hopkins, in the other cubicles. He said they were all laughing and joking. Another prisoner said Mr Hopkins left the shower, went to his cell and closed the door behind him. The prisoner who lived in the cell next door to Mr Hopkins heard his cell door close at around 4.00 to 4.10pm. A prisoner said another prisoner working on the servery went to Mr Hopkins' cell at about 4.25pm but could see only the toilet door in Mr Hopkins' cell through the observation panel. The prisoner returned to the servery.

46. At around 4.30pm, a PCO began unlocking prisoners for dinner. At 4.40pm, the PCO unlocked a prisoner's cell and then that of Mr Hopkins'. The PCO told the investigator that when he first looked into the cell he did not register what he could see. The prisoner, who was standing next to him, said "he's hanging". The PCO said that Mr Hopkins was hanging from the toilet door by a heavy duty fabric strap which prisoners used in the gym for weight lifting. He was slumped onto the floor.

47. The PCO went into the cell, along with the prisoner, and they both supported Mr Hopkins' weight. He pressed the personal alarm button on his radio indicating there was an emergency. This sounded on all radios and the control room then specified the location of the emergency over the radio network. Another prisoner went into the cell and pulled off the strap from Mr Hopkins' neck and lifted it over his head. The PCO laid Mr Hopkins on the floor. A wing manager then arrived at the cell and radioed a code blue emergency. This indicates a medical emergency in circumstances such as when a prisoner has breathing difficulties, has collapsed, or is unconscious. Staff should respond immediately by taking emergency medical equipment to the scene and the prison should call an ambulance automatically. The control room immediately telephoned an ambulance. The control room log indicates it was 4.41pm.

48. The control room transferred the call to the wing; staff who spoke to the operator were unable to give them details of what had happened. Four minutes into the call, prison staff indicated that a defibrillator was being used. The Welsh Ambulance Service told the investigator that this was not enough information for the operator to despatch an ambulance. It took seven minutes for prison staff to inform the operator that a prisoner had hanged himself. This delayed the despatch of an ambulance until 4.48pm.

49. Meanwhile, the wing manager had asked a member of staff to fetch the defibrillator which they did from the wing office. Having confirmed that there were no signs of life, the PCO began chest compressions and a prisoner administered breaths to Mr Hopkins, initially without a facemask. A nurse arrived within a minute of the code blue call and took over administering breaths. Another nurse arrived soon after and deployed the defibrillator, which advised not to administer an electric shock. Staff took it in turns to do chest compressions and more nurses and prison staff arrived to assist. At 4.57pm, the paramedics arrived at Mr Hopkins' cell. They took over CPR and took Mr Hopkins to hospital.

50. Once at hospital, Mr Hopkins was sedated and put on life support. On 8 October, Mr Hopkins' life support machine was turned off and he was pronounced dead at 2.55am.

51. A diary found in Mr Hopkins' cell after his death, noted the dates and causes of the deaths of members of Mr Hopkins' family and friends. There were also a number of suicide notes, one of which indicated that he felt responsible for his cousin dying when he was six years old, and this had led to his substance misuse issues. Mr Hopkins wrote that he was looking forward to dying so that he could apologise to his cousin.

52. Another letter found in his cell indicated that a complaint he was drafting was being submitted for the third time, and the pain he was suffering was unacceptable. He wrote that he had been buckled over in pain for three weeks, had asked wing staff to book him a doctor's appointment but that they had forgotten to do so. Prison staff told the investigator that Mr Hopkins had not submitted any complaints while at Parc.

53. A PCO told the investigator that after Mr Hopkins died, prisoners told her that he had given his canteen to two prisoners on 7 October. Other prisoners were annoyed by this as they had believed these prisoners to be Mr Hopkins' friends.

The investigator was not aware of this information before interviewing them. Neither admitted that Mr Hopkins had given them his canteen that day, although one had told the investigator that Mr Hopkins had given his canteen to other prisoners.

Contact with Mr Hopkins' family

54. After Mr Hopkins was taken to hospital, staff told the Director of the prison that his ex-partner was his next of kin. This had been the case during a previous prison sentence but unknown to her, on reception at Parc, Mr Hopkins had listed his mother as his next of kin. She tried to telephone Mr Hopkins' ex-partner a number of times but received no reply. She was aware of the restraining order preventing Mr Hopkins contacting his mother, so said she did not want to break the news to her.

55. The Director therefore telephoned Mr Hopkins' grandfather, who passed on the information to Mr Hopkins' mother. She met Mr Hopkins' family at the hospital around 8.00pm. The next day, the family liaison officer was with the family at the hospital when Mr Hopkins' life support machine was switched off. The prison contributed to Mr Hopkins' funeral costs in line with Prison Service instructions.

Support for prisoners and staff

56. After Mr Hopkins' death, the Director 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.

57. A wing manager spoke to each prisoner on the wing individually after Mr Hopkins' death. The prison also posted notices informing other prisoners of Mr Hopkins' 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 Hopkins' death.

Post-mortem report

58. We have not yet received the post-mortem report but the preliminary cause of death was recorded as hanging. The toxicology report indicated that Mr Hopkins tested positive for subutex and negative for NPS.

Findings

Assessment of Mr Hopkins' risk of suicide and self-harm.

59. Mr Hopkins consistently said he had no thoughts of suicide and self-harm. He was a hard-working and sociable prisoner. While some staff and prisoners noticed a change in him in the weeks leading up to his death, no one believed that he posed a risk to himself, and his death came as a shock to all those who knew him. He wrote notes to his family informing them that he had decided to kill himself but Mr Hopkins successfully concealed his intention from those around him.

60. There were factors which went to Mr Hopkins' risk of suicide: he had a history of attempted suicide, he was separated from his partner, his brother and father had committed suicide, he misused subutex and he had lost social support in his last weeks when, because of his abuse of the telephone system, he could no longer telephone his grandfather and, the restraining order prevented contact with his mother. However, not all of these issues were immediately apparent to staff and those which were did not present acutely, so we do not consider they warranted Mr Hopkins being assessed as posing a risk to himself. In these circumstances, we conclude it was reasonable that Mr Hopkins was not managed within Prison Service suicide and self-harm prevention procedures. Healthcare Inspectorate Wales (HIW) concurs with this view.

Clinical care

61. In the weeks before he died, Mr Hopkins told his mother that he was waiting for doctors to review his case and that he had been in pain. In a letter found in his cell after his death, Mr Hopkins noted that he was in pain and claimed that prison staff had forgotten to book him healthcare appointments. Some prison staff the investigator spoke to were aware Mr Hopkins was having medical tests but believed he was satisfied with the treatment he was receiving. All staff members and prisoners whom the investigator spoke to said that they were unaware that Mr Hopkins had been in pain.

62. The clinical manager told the investigator that if there were urgent concerns about a prisoner, or if he was suffering acute pain, then he would be able to see a doctor the same day. She also indicated that Mr Hopkins would have been able to apply for an urgent doctor's appointment himself on the wing computers.

63. HIW concluded that Mr Hopkins' healthcare was timely and appropriate. He refused a testicular examination on 14 August and 7 September and missed appointments with a GP on 15 September (which was rebooked for 27 September) and 6 October. We have not seen any evidence that Mr Hopkins communicated he was in pain or was unhappy with his medical care. We concur with HIW's opinion that the level of care Mr Hopkins received was satisfactory and equivalent to that he could have expected to receive in the community.

Telephone calls

64. Staff removed Mr Hopkins' grandfather's number from his list of permitted numbers on 20 September. Mr Hopkins had used this telephone number to contact his mother, in breach of the restraining order, on a number of occasions. While we recognise this was necessary in light of the order, we are concerned that no one spoke to Mr Hopkins about this in person and he was informed only by means of an electronic message. Mr Hopkins did not receive any visits at Parc and so telephone calls were his only means of family contact. A member of staff should have discussed the removal of his grandfather's number with him and assessed its potential impact. Other prisoners said that this had upset him, particularly as he could not speak to his family around the anniversary of his brother committing suicide at the beginning of October. We make the following recommendation:

The Director should ensure that all decisions which could affect a prisoner's welfare are explained in person and any impact on the prisoner is assessed and recorded.

Substance misuse

65. The toxicology report found that Mr Hopkins tested positive for subutex. It found no evidence of NPS. Most of the prisoners the investigator spoke to thought that Mr Hopkins was using NPS, and one said his use had increased in October. Prisoners also said that he gave away his canteen on 7 October because he was in debt due to drug use.

66. While the PCOs the investigator spoke to suspected that Mr Hopkins was using drugs and submitted intelligence reports on this basis, the operational manager was unaware of this. This is concerning, particularly in light of the intelligence in September that Mr Hopkins had been seen passing wraps to other prisoners, and the recommendation that he was drug tested and his cell was searched. This did not happen. There is also no evidence that anyone discussed a referral to substance misuse services with Mr Hopkins. Mr Hopkins was only drug tested once, in June 2016. This was a random test and did not include NPS. The result was negative. His cell was also randomly searched in August and no unauthorised items were found.

67. At their most recent inspection in January 2016, HM Inspectorate of Prisons reported that illicit drugs were readily available at Parc. In July 2015, we published a Learning Lesson Bulletin about deaths associated with use of NPS. We identified 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. It is important that prisons do all they can to address the use of illicit drugs. We make the following recommendation:

The Director and Head of Healthcare should ensure that there is an effective strategy to reduce the supply of, and demand for, drugs, and that staff are vigilant for signs of their use and are briefed on how to respond when prisoners appear to be under the influence of drugs.

Communication with Welsh Ambulance Service

68. The control room telephoned 999 as soon as the code blue was called, one minute after staff found Mr Hopkins. It then took seven minutes for prison staff to tell the operator that Mr Hopkins had hanged himself. This delayed an ambulance being despatched until this point. The Welsh Ambulance Service told the investigator that the 999 operator has to complete a template before he or she despatches an ambulance. Since Mr Hopkins' death (although not on account of it), the Service has changed this template so that if the operator is told a person is not breathing, an ambulance is despatched immediately. (Prison staff had only told the operator a defibrillator was being used four minutes into the call.)

69. While we recognise that a number of staff were correctly focused on Mr Hopkins himself when the 999 call was transferred to the wing, any member of staff not involved in CPR could have relayed the relevant information to the 999 operator in a more timely manner. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff provide sufficient and accurate information to the local Ambulance Service to allow them to deploy an ambulance without delay.

Family liaison

70. Until informed by the investigator, the Director was unaware that when Mr Hopkins transferred to Parc in November 2015 he had named his mother as his next of kin. She had asked staff to check all available records when Mr Hopkins was taken to hospital, but they had informed her that Mr Hopkins' ex-partner was listed as his next of kin. This had been the case on his reception to HMP Swansea in September 2015 and remained noted on his electronic record. She told the investigator that even if she had known his mother was listed as his next of kin she would nevertheless have attempted to contact Mr Hopkins' ex-partner first, due to the restraining order in place. However, she said she probably would have contacted his mother next.

71. Mr Hopkins' mother was unhappy that the Director had broken the news of Mr Hopkins' hospitalisation to her 83 year old father, who was alone at home. She felt that the police should have attended her house to tell her. While we accept that the Director was trying to act in the best interests of all those concerned, and in very difficult circumstances, it is unfortunate that the electronic records had not been updated with information from Hopkins' induction records. She should have contacted Mr Hopkins' mother first. Since time was critical, a telephone call was quickest way of doing this. We make the following recommendation:

The Director should ensure that next of kin details are clearly recorded and kept updated for all prisoners, including in their electronic record, and that staff are aware of where to access these details.

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