Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Jones a prisoner at HMP Garth on 22 November 2018

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 Andrew Jones died on 22 November 2018 having been found hanged in his cell in HMP Garth. He was 37 years old. I offer my condolences to Mr Jones' family and friends.

Mr Jones was being managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) until 10 days before his death. I am concerned that the day before he died, Mr Jones was moved to a new wing where staff did not know him, without a proper risk assessment and without information about his history being shared. I am also concerned that he was kept confined to his cell without any of the safeguards that should be afforded to prisoners who are segregated from other prisoners.

The prison officer who conducted the roll check on the evening of 22 November did not see Mr Jones as he should have done. Mr Jones was found dead about an hour later.

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 **November 2019**

Contents

Summary

Events

1. Mr Andrew Jones had been in prison since 2011, serving a 14-year sentence. He had a history of substance misuse and mental health issues.

2. Mr Jones arrived at HMP Garth in March 2016. He was initially located in the therapeutic unit in order to address his drug problems but had to leave after threats from other prisoners. He moved to the Residential Support Unit (RSU) which houses prisoners who are under threat for various reasons.

3. Mr Jones displayed challenging behaviour in the unit: he regularly refused to comply with rules or to attend work, and he also self-harmed at times, although his self-harm was not life-threatening. He was managed under Prison Service procedures to support those at risk of suicide and self-harm (known as ACCT) on several occasions. He most recent ACCT was closed on 12 November.

4. On 21 November, Mr Jones was aggressive to staff and was placed on a disciplinary charge. The RSU manager decided that he no longer merited a place in the RSU. Mr Jones was moved to another wing and kept locked in his cell pending his disciplinary hearing.

5. The disciplinary hearing which should have happened the following day (22 November) did not take place. Mr Jones remained in his cell. The officer who carried out the roll check at about 7.00pm did not check on Mr Jones.

6. When night staff came on duty, the officer who carried out the next roll check at about 8.00pm could not see Mr Jones as he had covered the observation panel in his cell door. She called for assistance. When assistance arrived, the officers opened the inundation point in the cell door and saw Mr Jones hanging. They went into the cell and began attempts at resuscitation.

7. Nurses joined the efforts to resuscitate Mr Jones until ambulance paramedics arrived and took over. At 9.03pm, on 22 November, they pronounced Mr Jones dead.

Findings

Assessment of risk

8. Mr Jones was managed under ACCT procedures at times after he self-harmed, normally by cutting. His most recent ACCT had been closed on 12 November following a multi-disciplinary review. We consider that the closure was premature as not all the caremap actions had been completed.

9. A known trigger for Mr Jones' self-harm was spending long periods in his cell, without a television. A known protective factor was the support of his brother, who was also in the RSU. We consider that when Mr Jones was moved out of the RSU and confined to his cell on another wing, staff should have considered how this might affect his risk of suicide and self-harm. At the very least, staff on

the new wing should have been told that he had recently been under ACCT management.

Mr Jones' removal from the RSU

10. The prison's internal review into Mr Jones' removal from the RSU found deficiencies. Although there was a process to be followed, it had fallen into disuse, and there were inconsistencies in its application. Healthcare staff, who knew Mr Jones, did not know that he had been moved out of the unit, and no consideration was given to whether he would need additional support on his new wing.

Drug misuse

11. Mr Jones had a history of drug use and took drug rehabilitation courses in prison. There is no evidence to suggest that he was using illicit drugs when he died.

Segregation

12. It is common practice at Garth for all prisoners placed on disciplinary charges for aggressive behaviour to be confined to their cells pending the disciplinary hearing. Although this amounts to segregation under the Prison Rules, Mr Jones did not have the safeguards available to prisoners who are segregated in the segregation unit, as he should have done.

13. Mr Jones' initial disciplinary hearing was not held the following day as planned, and he was not given an explanation for the delay.

Roll check

14. The prison officer who conducted a roll check at 7.00pm on 22 November did not check on Mr Jones' wellbeing as he should have done.

Emergency response

15. When the prison officer carrying out the roll check at 8.00pm was unable to gain a response from Mr Jones, she did not wait for assistance at the cell door in line with local instructions. Assistance was not immediately forthcoming, and she had to follow up her request.

Healthcare

16. The clinical reviewer found that the management of Mr Jones' physical healthcare needs was appropriate. He was given a good deal of mental health support. The emergency response was appropriate and, overall, he received healthcare equivalent to that which he could have expected in the community.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidance, including that an ACCT is not closed until the caremap actions have been completed.

- The Governor should ensure that there is a recognised process for deselecting prisoners from the Residential Support Unit. This should take into account a prisoner's history and risk factors, and this information should be shared with receiving staff so that any support that might be required can be considered and put in place.
- The Governor should ensure that the segregation of prisoners pending adjudication is properly authorised, and that health, safety and wellbeing assessments are carried out, in line with PSI 17/2006.
- The Governor should ensure that adjudication hearings are held in line with guidance.
- The Governor should ensure that all staff understand their responsibility to check prisoners' wellbeing during roll checks.
- The Governor should ensure that when staff find an observation panel covered and the prisoner fails to respond, they follow local instructions by remaining at the cell door and radioing for assistance, which should be provided as soon as possible. The Governor should consider how best to remind staff of these instructions and establish a way to monitor compliance.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded and the investigator interviewed him.

18. The investigator visited Garth in December 2018 and February 2019. He obtained copies of relevant extracts from Mr Jones' prison and medical records.

19. The investigator interviewed five members of staff and two prisoners at Garth.

20. NHS England commissioned a clinical reviewer to review Mr Jones' clinical care at the prison. They and the investigator conducted joint interviews of healthcare staff.

21. We informed HM Coroner for Preston and West Lancashire of the investigation. The Coroner gave us the results of the post-mortem examination. We sent the Coroner a copy of the initial report, and he raised some concerns. These have been considered and as a result some changes have been made to this final report. Some concerns have been explained in separate correspondence.

22. The investigator contacted Mr Jones' father to explain the investigation and to ask whether he had had any matters he wanted the investigation to consider. Mr Jones' father wanted to know if there were any indications that his son had taken any drugs. Mr Jones' father received a copy of the initial report and did not offer any further comments.

Background Information

HMP Garth

23. HMP Garth is a Category B training prison holding up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Bridgewater Trust provides health services, while NHS Greater Manchester Mental Health Trust provides the mental health team, which provides an integrated clinical substance misuse and mental health service.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Garth was conducted in December 2018 and January 2019. Inspectors found the prison significantly improved from their last inspection, despite the serious challenges it faced. There were still a number of prisoners who reported feeling unsafe and the impact of illicit drugs was described as severe. Use of segregation was high, as were levels of self-harm, but strategic management had improved.

Independent Monitoring Board

25. 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 November 2017, the IMB reported that the prison was improving. Prisoners were treated fairly, and with dignity. Support was available for them if they needed it.

Previous deaths at HMP Garth

26. Mr Jones was the thirteenth prisoner to die at Garth since January 2016. Six of the previous deaths were due to natural causes.

27. In a previous investigation, we found that an officer had failed to check the prisoner when unlocking his cell in the morning. In two other investigations, we found that staff did not follow proper procedures when a prisoner obscured his observation panel. We made a recommendation about this in February 2018 and the prison told us in response that they reminded staff in March about the correct procedures. We repeated this recommendation in April 2019, adding that the Governor should consider how best to remind staff as the previous methods did not seem to have worked. The prison responded in June 2019 that they had issued a Governor's order containing mandatory instructions for staff to follow, reinforcing the requirement that staff should only leave the cell door if they are not carrying a radio and need to physically summon assistance. All operational staff had been made aware of this order via electronic internal mail and via staff briefings and meetings. Where staff fail to follow these instructions, they may be subject to an internal investigation, which could then lead to disciplinary procedures. We were also told that Garth was developing a communications policy which will give greater assurance that important communications reach their intended recipients and are understood.

28. Since Mr Jones' death there have been a further three deaths. These are still being investigated.

Assessment, Care in Custody and Teamwork

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

30. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Residential Support Unit (RSU)

31. Garth has a Residential Support Unit for prisoners who cannot live on normal prison wings but who do not need to be housed in the Vulnerable Prisoners Unit (which is used to house prisoners convicted of sex offences). Prisoners in the RSU include those whose offences might make them vulnerable to attack from other prisoners (such as those who have committed offences of violence against older people), prisoners who have accrued debts, and those who are victims or bullying or are under threat. The RSU runs a normal regime, with prisoners able to work in the RSU's own workshops and to take exercise without mixing with the general prisoner population.

Incentives and Earned Privileges (IEP) Scheme

32. 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.

Disciplinary charges

33. Prison Rule 53 covers disciplinary charges. The Rule states that other than in exceptional circumstances, every charge laid against a prisoner should be first inquired into not later than the next day (assuming it is not a Sunday or public holiday). The Rule also states that a prisoner who is to be charged with an offence against discipline may be kept apart from other prisoners pending the Governor's first inquiry.

Segregation

34. Prison Service Instruction (PSI) 17/2006 contains guidance on segregation. The PSI says that:

"A doctor or registered nurse must complete the Initial Segregation Safety Screen within 2 hours of the prisoner being segregated. This screen must be completed for all prisoners held in:

- The Segregation Unit
- Special Accommodation …
- Any other segregated environment within the prison

It must also be completed for any prisoner placed in segregation to await adjudication for longer than 4 hours."

35. Guidance on segregation is also contained in Prison Service Order (PSO) 2000. The PSO states that, pending adjudication, a prisoner may be segregated on the authority of the Governor, delegated to any manager.

36. In 2015 we published a Learning Lessons bulletin that highlighted the potentially damaging effects of segregation on prisoners who may be at risk of suicide or self-harm.

Psychoactive Substances (PS)

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

38. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

39. HM Prison and Probation (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 NOMS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

40. In 2011, Mr Andrew Jones was sentenced to eight years imprisonment. In 2015, he received an extended sentence of 14 years for wounding with intent, robbery, burglary and witness intimidation.

41. Mr Jones said that since the age of 16 he had only spent two years out of prison. His records showed a history of substance misuse, including heroin, crack cocaine and subutex, and most of his offending behaviour was linked to his drug use. Mr Jones also had a history of mental health issues and had been prescribed medication for this.

42. Mr Jones had been managed under Prison Service procedures for those at risk of suicide or self-harm (known as ACCT) on a number of occasions. This was either because he harmed himself or was thought to be vulnerable to doing so. In July 2015, he cut himself. In August 2015, he threatened to harm himself if not given the medication he wanted. In October 2015, he was supported because he was low in mood. In November 2016, he cut himself. In May 2017, he said he felt like harming himself. In November 2017, and again in May 2018, he cut himself.

43. Mr Jones had been in Garth since March 2016. He had been housed in the therapeutic unit, where he had been addressing his drug problems and received positive feedback for his contributions. During a group therapy session, however, he openly challenged other prisoners on the unit who he said were dealing drugs. As a result of this, threats were made against him and at the end of 2017, he was moved to the Residential Support Unit.

44. Mr Jones' brother was also in the RSU, which helped Mr Jones to settle. However, Mr Jones' behaviour was challenging.

45. In May, he refused to attend a sentence-planning meeting. On 29 May, he complained of toothache and was given packets of paracetamol and nurofen. He took them all at once. He was kept under observation by healthcare staff but did not need to go to hospital. ACCT procedures were opened again but Mr Jones refused to engage with the process. He said that he was in pain from a wisdom tooth extraction and took the pills to stop the pain, not to take his own life. He denied having any drug issues.

46. In June, Mr Jones was promoted to the standard level of the Incentives and Earned Privileges (IEP) scheme but was warned that if he did not behave in an acceptable way he would be put back onto the basic level. Throughout the month, Mr Jones' record shows numerous reports of him not attending work.

47. In July, Mr Jones complained of chest pains. Healthcare staff assessed him and gave him an electrocardiogram (ECG). He did not need hospital treatment.

48. On 24 September, Mr Jones was put on a disciplinary charge for picking up a television to assault a member of staff who was restraining another prisoner.

Throughout October, his record shows frequent negative entries for not attending work, for being late for roll checks, and for ignoring staff instructions.

49. On 26 October, Mr Jones did not respond during a roll check and had obscured his observation panel. Staff opened his door and found that he had cut his arm. Mr Jones seemed low in mood and did not want to talk about his self-harm but said that he had been locked in his cell all day. ACCT procedures were begun.

50. At an ACCT review the following day, Mr Jones engaged well. He said that he was frustrated at being on the basic level of the IEP scheme. His medication for arthritis had been reduced and he said was in a lot of pain as a result and unable to attend work. This meant that he was given warnings and remained on the basic IEP level. Healthcare staff agreed to arrange for a doctor to review his medication and to assess his capacity to attend work. Mr Jones said that he cut himself when he was feeling low but he did not wish to end his life. He said he had his brother on the wing to talk to, as well as being in regular contact with his father. Staff ensured that he was aware of the support available to him and kept ACCT procedures in place with at least two observations per hour.

51. On 29 October, Mr Jones refused to attend an ACCT review. An entry on his record that day notes that he had received warnings over the last week for not attending work. He therefore remained on the basic IEP level.

52. On 30 October, staff held an interim ACCT review, following the death of a prisoner Mr Jones knew. Mr Jones said that he was sad about the death but was able to talk to his brother and to other prisoners. He could also speak to staff, to members of the chaplaincy, or to Listeners (prisoners trained by the Samaritans to provide peer support) should he need to. He did not feel that he needed to at that time. He said he did not feel like harming himself, and staff lowered the level of observations to at least one per hour.

53. On 1 November, after he was locked into his cell for the night, Mr Jones made two small cuts to his arm. A nurse went to his cell, but Mr Jones refused treatment. She told the investigator that the cuts were not serious, and she was not concerned that he refused treatment. Nonetheless, staff raised his level of observations to at least two per hour.

54. The next morning, staff held an ACCT review because of Mr Jones' self-harm the previous night. Mr Jones offered a lot of reasons for harming himself, citing lack of a shower, being on the basic IEP regime which meant not having a television, and not having enough pain relief medication. A nurse said in interview that Mr Jones was appropriately dressed, co-operative, and apparently in a normal mood. He said he was well and appeared to be so. The cuts were superficial and were not an attempt to take his own life.

55. Mr Jones' record shows that on 3 November he was given a warning under the IEP scheme. He had been late back to his cell for lock up every night that week, despite being warned, and was not adhering to the RSU regime. His personal officer made a note on his record on 5 November that Mr Jones continued to push boundaries with staff and had little interaction with them.

56. On 5 November, Mr Jones attended an ACCT review. He engaged well. He was still concerned about his medication but healthcare staff were arranging physiotherapy to see if that helped Mr Jones with his pain management.

57. On 6 November, Mr Jones refused to attend work. Healthcare staff assessed him but refused to provide a permit for him to miss work. Despite this, he still refused to go and was issued with an IEP warning. An officer noted on his record that Mr Jones had been given a clear warning that he needed to adhere to the unit regime or risk being moved out of the RSU. Mr Jones had to attend work, and if he was unwell, he needed to attend work and report sick once there.

58. A note on Mr Jones' record on 10 November showed that he continued to push boundaries with his behaviour, was again late for lock up with no valid reason and appeared to show little regard for the unit's regime.

59. At an ACCT review held on 12 November, Mr Jones was positive and engaged well. Staff noted that all the issues on the caremap had been addressed: he was engaging well with the mental health team, was awaiting an appointment with the psychotherapist, he was on the waiting list for physiotherapy, and was willing to go to remedial gym if this could be arranged. He had been put on the standard IEP level and was pleased to have his television back. He appeared focused on the future, had not self-harmed in over two weeks, and firmly denied any current thoughts of self-harm or suicide ideation. A nurse said told the investigator that she was satisfied during the review that Mr Jones did not pose a risk to himself. Staff agreed that ACCT procedures could be closed.

60. An officer held a post-closure review on 19 November and noted that Mr Jones had engaged reasonably well. He was still having some issues with his medication but was pleased to be off the basic IEP regime and said he had no thoughts of harming himself.

61. At 9.30am on 21 November, Mr Jones became aggressive while out on the wing. He picked up a "wet floor" sign and hit it against a door, before turning towards staff while still holding the sign. Prisoner officers restrained him, and he was placed on a disciplinary charge. The RSU manager decided that in light of this incident, combined with his behaviour over recent weeks, Mr Jones no longer merited a place in the RSU. The decision was taken to transfer him to C wing.

62. An officer escorted Mr Jones to C wing and handed him over to a Supervising Officer (SO). Because he was on a disciplinary charge and was awaiting a disciplinary hearing, Mr Jones was to remain in his cell under Prison Rule 53 pending the adjudication hearing.

63. An officer told the investigator that he gave Mr Jones his meals in his cell on 21 November. He said Mr Jones seemed in good spirits. He was talkative and thanked the officer for bringing his food. The officer said that he was not aware of any previous issues of self-harm and saw nothing to make him concerned at the time.

Events of 22 November

64. On the morning of 22 November, an SO gave C Wing staff a briefing and explained that Mr Jones was on Rule 53. Standard practice on the wing meant

that, in view of this, Mr Jones would remain in his cell until the adjudication hearing.

65. An officer spoke to Mr Jones at approximately 11.24am. Mr Jones asked about his adjudication. The officer said that if it had not taken place that morning, he presumed that the adjudication would be held that afternoon. The officer told the investigator that Mr Jones did not seem to be stressed or anxious and just wanted to know how things stood. The officer saw no reason to be concerned about him.

66. At 5.02pm, the officer and two other prison officers took Mr Jones his evening meal. He did not raise any issues with them and the officer said that there was nothing in Mr Jones' behaviour that caused him any concern.

67. At 7.10pm, all prisoners were locked into their cells for the night. Staff then began roll checks. The officer was responsible for checking the cells on Mr Jones' landing. CCTV footage shows that at 7.19pm he arrived at Mr Jones' cell. The officer checked that the door was locked and moved towards the next cell. He paused, then turned back and closed the door's observation panel, which was slightly ajar, and checked that the door's lower bolt was locked. He then moved on to the next cell. He did not look through the observation panel. At 7.23pm, An officer went along the landing ensuring that all cell doors were secure.

68. Night staff took over from day staff and, at approximately 8.00pm, an officer began a roll check of Mr Jones' landing. CCTV footage shows that she reached Mr Jones' cell at 8.05pm. Mr Jones' observation panel was blocked and she was unable to see into the cell. She spent over a minute at the door, checking around the door with her torch and kicking it, trying to elicit a response. Failing to get any, she requested assistance on her radio and moved on, continuing her roll count.

69. At 8.11pm, the officer returned to the cell, and looked at the observation panel but was still unable to see into the cell or gain a response from Mr Jones. She went to the wing office and telephoned the control room to confirm that she needed assistance. She was told assistance was coming.

70. At 8.17pm, she returned to the cell with two other officers. Still unable to see through the observation panel, an officer opened the inundation point (a small porthole in the door that can be used to insert a hose in case of fire) and looked in. He saw Mr Jones hanging by a ligature tied to the light fitting.

71. Prison officers only carry cell keys in a sealed pouch at night for use in emergencies. An officer broke the seal on her pouch and opened the door. All three officers entered the cell. An officer cut the ligature and lowered Mr Jones to the floor. He used his radio to call a code blue emergency (meaning a prisoner having difficulty or not breathing). This prompted the control room to automatically call an ambulance while the officers performed cardiopulmonary resuscitation (CPR) in an attempt to revive Mr Jones.

72. A nurse and an Assistant Nurse Practitioner responded to the code blue call and arrived at the cell at 8.21pm. They joined the prison officers in attempting to resuscitate Mr Jones, providing oxygen and applying a defibrillator (a machine

that, in certain circumstances, can apply electric shocks to restart the heart). The defibrillator could not detect a heartbeat, so they continued CPR until ambulance staff arrived at 8.39pm and took over. They moved Mr Jones out of his cell to provide more space, but at 9.03pm he was pronounced dead.

Post-mortem report

73. The post-mortem report showed that Mr Jones died as a result of asphyxiation by hanging. Toxicology tests did not detect any drugs in Mr Jones' system.

Contact with Mr Jones' family

74. An officer was appointed as family liaison officer (FLO), and identified Mr Jones' father as his next of kin. Because of the distance to his home, she contacted the West Midlands Police, who went to Mr Jones' father's address and informed him of his son's death. Prison staff informed Mr Jones' brother the following morning and offered him support.

75. In line with Prison Service guidance, Garth offered a contribution to the cost of Mr Jones' funeral.

Support for prisoners and staff

76. After Mr Jones' death, one of the prison's managers, 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.

77. 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

Findings

Assessment of risk

78. Mr Jones had a history of self-harm (none of which had been life-threatening), and was frequently managed under ACCT procedures, most recently in May 2018 and from 26 October to 12 November 2018. He had a number of risk factors for suicide and self-harm: he said he was in constant pain from arthritis and that he found it difficult to cope when he was locked in his cell for long periods on the basic regime without a television. The support of his brother, who was in the same unit, was identified as a protective factor.

79. His most recent ACCT was closed at an ACCT review on 12 November. The review was multi-disciplinary, with the wing manager and a nurse who were both familiar with Mr Jones in attendance. Mr Jones was described as relaxed and content for ACCT procedures to be closed and said that he had no thoughts of harming himself or plans to end his life. The nurse confirmed in interview that all present were content that it was safe to end ACCT procedures.

80. However, we are concerned that, although the review panel concluded that all the caremap actions had all been achieved, this was not the case. The outstanding actions were for Mr Jones to see a psychotherapist and a physiotherapist, to start remedial gym to help with his pain and to have his pain relief medication reviewed. Although appointments had been made, Mr Jones had not seen the psychotherapist or physiotherapist and had not started remedial gym, and his issues with his pain relief medication had not been resolved. PSI 64/2011 says that an ACCT should not be closed until all the actions on the caremap have been completed and we, therefore, consider that it was premature for Mr Jones' ACCT to have been closed on 12 November. We recommend:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidance, including that an ACCT is not closed until the caremap actions have been completed.

81. On 21 November, Mr Jones was placed on a disciplinary charge and moved to a different wing. This meant that he would be confined to his cell (a known trigger for his self-harm) and would be deprived of the support of his brother (a known protection factor, although in interview his brother said that in recent weeks they had grown more distant). In our view, staff should, therefore, have considered whether it would be appropriate to open another ACCT to provide support when he moved.

82. We recognise that Mr Jones' behaviour had been poor for some time and that he had been warned that he would be removed from the RSU if it did not improve. We do not say that he should not have been moved out of the unit, but we are concerned that the potential risks of doing so were not considered and that nothing was put in place to mitigate them.

83. At the very least, staff in the RSU should have informed staff on Mr Jones' new wing that he had a history of self-harm, that he had only come off an ACCT nine days earlier, and that spending long periods in his cell was a trigger factor.

84. The prison's internal review after Mr Jones' death noted that the RSU manager said in interview that he was aware that there was a process for deselection from the unit. This involved the prisoner being discussed at a Population Management Committee meeting. These are multi-disciplinary meetings, which allow wider consideration of the factors around a prisoner's care.

85. However, the RSU manager told the prison's internal review that he understood the deselection process had fallen into disuse. He said that the last time he had instructed one of his staff, a SO, to raise the issue of deselection at the Population Management Committee meeting, he had been told that this was not necessary. The RSU manager said he subsequently discussed this with his manager, and was told that if he wanted to remove a prisoner from the unit he was allowed to do so without referring them to a meeting.

86. The prison's internal review found that other managers and staff were unaware that there was a process for removing a prisoner from the unit at all. However, we found that the minutes of the Population Management Committee meeting on 19 November 2018, contain discussion of another prisoner's removal from the RSU, suggesting different approaches by different staff.

87. It appears that because the decision to remove Mr Jones from the RSU was taken by an individual manager, wider issues were not taken into account. As Mr Jones was not under ACCT management procedures at the time, staff in the receiving wing, who did not know him, were unaware of his history of self-harm.

88. Mr Jones was in the RSU because he had been under threat, but there is no evidence that anyone checked whether he might also have been vulnerable on C wing. The orderly officer (manager in charge of the day-to-day running of the prison) was interviewed for the internal investigation. He said that he was aware that Mr Jones had been deselected from the RSU but not of any further detail. He said he was therefore was unable to judge the necessary level of risk assessment, and did not ask for one to be made. Healthcare staff who had been working with Mr Jones, who might have been able to raise or consider the risks involved, were not made aware of his move. Nobody seemed to have considered whether he might need any structured support, whether under ACCT procedures or otherwise, in moving to a normal prison wing after a long period in specialist areas. We make the following recommendation:

The Governor should ensure that there is a recognised process for deselecting prisoners from the Residential Support Unit. This should take into account a prisoner's history and risk factors, and this information should be shared with receiving staff so that any support that might be required can be considered and put in place.

Segregation

89. The prison's internal review found that it was common practice at Garth for prisoners who had been put on a disciplinary charge for threatening or aggressive behaviour to be confined to their cells pending the adjudication hearing. Mr Jones was placed on a disciplinary charge because of his aggressive behaviour on the morning of 21 November. When he arrived on C wing, both the officer who escorted him and the officer who received him

assumed that, because it was common practice in the prison, Mr Jones would be locked in his cell until the adjudication hearing. They were both interviewed for the prison's internal investigation. They were unable to recall the exact words they used, but the result was that it was accepted that Mr Jones would be confined to his cell.

90. Although PSI 17/2006 permits this, it makes it clear that this amounts to segregation and that a prisoner who is confined to his cell on a wing is entitled to the same safeguards as if he had been located in the segregation unit. These safeguards include:

- the completion of a safety algorithm;
- authorisation of the segregation by a senior manager;
- assessment by healthcare staff to ensure that the prisoner will not be adversely affected by being segregated; and
- regular checks.

91. We are concerned that, although Mr Jones was technically segregated on C wing, he was not protected by the safeguards that apply to segregated prisoners. The duty Governor was not informed that Mr Jones was being confined to his cell, nor was his authority sought. There is no record of who authorised his segregation; and he was not assessed by medical staff to see whether he would be affected by being isolated in this way.

92. We make the following recommendation:

The Governor should ensure that the segregation of prisoners pending adjudication is properly authorised, with health, safety and wellbeing assessments carried out, in line with PSI 17/2006.

93. When Mr Jones was put on a disciplinary charge on 21 November, his initial hearing should have been held the following day. This was Mr Jones' expectation. The adjudication, however, did not take place on 22 November. The prison were initially unable to explain why Mr Jones did not have his adjudication hearing that day. In response to our initial report, they have said that there were unavoidable operational reasons for the delay.

94. An officer told the investigator that Mr Jones did not appear anxious or distressed about the delay. In response to our initial report, the prison has provided documentation showing that Mr Jones was informed of the delay to his adjudication hearing. We make the following recommendation:

The Governor should ensure that adjudication hearings are held in line with guidance.

Roll check

95. An officer who had only been a prison officer for four months at the time, did not check on Mr Jones' wellbeing when he conducted the roll check at about 7.00pm. He said that although he knew that in theory he should have done, he was not

aware that it was a practice that was observed at Garth. He accepted that he did not see Mr Jones when he conducted the roll check on 22 November.

96. We understand that the officer is subject to a disciplinary investigation, so we make no recommendation. We are, however, concerned that he had gained the impression from other staff that it was not necessary to carry out visual checks on prisoners during roll checks. We make the following recommendation:

The Governor should ensure that all staff are familiar with their responsibility to check prisoners' wellbeing during roll checks.

Emergency response

97. When an officer was unable to get a response from Mr Jones, she did not know that he had a history of self-harm and had recently been on an ACCT. She did not know that on 26 October, less than a month earlier, when he covered his observation panel and did not respond during a roll check, he was found to have self-harmed. He was not under ACCT management, and we accept that the officer had no reason to be unduly concerned at that stage - although it should always be a cause for some concern when a prisoner, particularly an unknown prisoner, covers his observation panel. She requested assistance. Having finished her roll check, she then returned and, when still unable to get a response from Mr Jones, she checked that assistance was on its way.

98. National guidance for entering cells at night states that, for security reasons, officers should not enter cells alone except for preservation of life. We accept that without being able to see into the cell, the officer could not have known whether it was safe for her to enter. As soon as it was apparent that there was an emergency, the staff went in and tried to revive Mr Jones.

99. However, a staff information notice, issued in March 2018, says that if a prisoner's observation panel is covered and staff are unable to get a response from the prisoner, they should remain at the cell door and radio for assistance. The officer did not stay outside Mr Jones' cell.

100. By the time an officer returned to the cell, the assistance she had requested had still not arrived. She left the cell again in order to use the telephone to follow up her request for assistance. Both these factors led to a delay in staff entering Mr Jones' cell.

101. In April 2019, we made a recommendation to the Governor of Garth to ensure staff comply with local instructions when they find cell observation panels blocked. The prison has since told us that steps have been taken to ensure that this happens. We nonetheless repeat that recommendation:

The Governor should ensure that when staff find an observation panel covered and the prisoner fails to respond, they follow local instructions by remaining at the cell door and radioing for assistance which should be provided as soon as possible. The Governor should consider how best to remind staff of these instructions and establish a way to monitor compliance.

Drug misuse

102. Mr Jones had a history of drug use and had undertaken drug rehabilitation programmes in prison. The clinical reviewer noted that staff were aware of Mr Jones' history of substance misuse. It was recorded in his medical record, discussed in ACCT reviews, and discussed within, and between, the physical and mental healthcare teams.

103. Mr Jones' brother said that he had heard that Mr Jones had tried to buy some drugs shortly before he died. There is no intelligence to verify this.

104. Mr Jones' father said he had heard a rumour that someone had passed drugs to his son under his cell door the night that he died. Examination of CCTV footage shows no evidence to support this.

105. There is no evidence to suggest that Mr Jones was using illicit substances at the time of his death. There were no drugs or signs of drug use found in Mr Jones' cell after he died, and post-mortem toxicology tests did not detect any illicit drugs in Mr Jones' system.

Healthcare

106. The clinical reviewer concluded that the assessment and management of Mr Jones' physical healthcare needs were appropriate and timely. His physical healthcare medications were prescribed appropriately.

107. The mental health team provided appropriate assessment and support, with nurses, psychological wellbeing practitioners and a psychiatrist being involved in his ongoing care. Mr Jones underwent a cognitive behavioural therapy programme. His care was discussed in multi-disciplinary team meetings.

108. The physical and mental healthcare teams shared information about Mr Jones. He was involved in decision-making processes relating to his care.

109. The emergency response was appropriate and timely. Emergency equipment was maintained and readily available.

110. The clinical reviewer concluded that Mr Jones received healthcare equivalent to that which he could have expected to receive in the community.

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