

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Imre Thomas, a prisoner at HMP Garth, on 12 September 2019

**A report by the Prisons and Probation Ombudsman**

## 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 Imre Thomas died on 12 September 2019 at HMP Garth. A cause of death has not yet been ascertained but a toxicology examination identified that Mr Thomas had used a potentially fatal quantity of tramadol (a strong opiate-based painkiller) before his death, along with several other illicit prescription medications that might have enhanced its toxic effects. He was 45 years old. I offer my condolences to Mr Thomas's family and friends.

There is substantial evidence that Mr Thomas often used illicit prescription medication and psychoactive substances (PS) in prison. The ease and frequency with which he was seemingly able to obtain these drugs is concerning. There were also missed opportunities to review Mr Thomas's prescribed medication.

I have asked Garth to conduct a local investigation into allegations that Mr Thomas appeared to be under the influence of drugs when he was locked in his cell on the night before he died, without healthcare staff being informed or any welfare checks undertaken.

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**

**July 2020**

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# Summary

## Events

1. In January 2014, Mr Imre Thomas was remanded in custody to HMP Cardiff. He was later sentenced to 14 years in prison. In July 2017, Mr Thomas was transferred to HMP Garth.
2. In August 2017, a prison GP referred Mr Thomas to an orthopaedic surgeon to review a long-standing hand injury which caused Mr Thomas pain. The initial appointment in November 2017 was cancelled by the prison because they had insufficient staff to escort him to hospital. Eight further appointments were cancelled for various reasons over the next two years and Mr Thomas did not see a specialist before he died.
3. In December 2017, Mr Thomas was prescribed dihydrocodeine (a strong opioid-based painkiller) for the pain from the hand injury.
4. In December 2018, Mr Thomas was transferred to HMP Swansea under the accumulated visits scheme. Prison staff at Swansea identified that he had hidden his dihydrocodeine in his cell, presumably to trade with other prisoners, rather than taking it as prescribed. A prison doctor therefore stopped the prescription.
5. On 22 January 2019, Mr Thomas was transferred back to Garth. He was prescribed co-codamol as an alternative to dihydrocodeine but did not take it and told healthcare staff that he was using illicit opioid-based medications instead. On 22 March, a prison doctor re-prescribed dihydrocodeine.
6. Over the following months, prison staff recorded numerous items of security intelligence that Mr Thomas was using or supplying illicit prescription medication and drugs. During this time, he worked intermittently with the prison's substance misuse service. He was referred for one medication review, which he did not attend, and no one therefore considered whether to make changes to his dihydrocodeine prescription.
7. At around 5.50am on 12 September, an officer conducting a count of prisoners spent around 40 seconds looking into Mr Thomas's cell through the observation panel. He returned around 13 minutes later, and spent nearly two minutes looking into the cell before concluding he had seen Mr Thomas move.
8. At around 7.45am, a supervising officer (SO) briefed staff when they came on duty for the day. Some staff present later wrote statements saying that the SO had said that Mr Thomas was under the influence of drugs when he was locked in his cell the previous evening. The SO, and another officer present when the cells were being locked, told us that this was not correct.
9. At around 8.10am, an officer unlocked Mr Thomas's cell and found that he had died. Staff did not attempt to resuscitate him as it was clear he had been dead for some time.

## Findings

10. We are concerned about the frequency and ease with which Mr Thomas was able to obtain illicit prescription medication and psychoactive substances (PS) at Garth.
11. The use of such drugs alongside dihydrocodeine carries significant risks, and we are concerned that intelligence that Mr Thomas was using illicit medication and PS was not properly followed up through medication reviews.
12. The clinical reviewer concluded that some of the clinical care Mr Thomas received was not equivalent to that which would have been received in the wider community, notably the overall care he received in respect of safe effective pain management, numerous cancelled hospital appointments and the failure to review his medication. However, she did not consider that any of these omissions contributed directly to Mr Thomas's death.
13. There are different accounts of what happened when Mr Thomas was locked in his cell on the evening of 11 September and what was said at the briefing the following morning. We have asked Garth to conduct a local investigation into the allegation that Mr Thomas was under the influence of drugs when he was locked in his cell.
14. We are also concerned that the night patrol officer did not enter Mr Thomas's cell or call for medical assistance on the morning of 12 November, when he had concerns for his welfare.

## Recommendations

- The Governor and the Head of Healthcare should ensure that prisoners attend their booked hospital appointments and, if a cancellation is unavoidable, the next appointment is given priority.
- The Head of Healthcare should ensure that prescribing of opiate based medications is consistently informed by the NHS England Secure Prisons Prescribing Formulary and the local agreed pain pathway.
- The Head of Healthcare should ensure that all prisoners who are prescribed opiate-based medication have a medication review when there is intelligence that they might have used illicit drugs.
- The Governor should inform the Ombudsman of the findings of the internal investigation into the events on the evening of 11 September, and of any action taken as a result.
- The Governor should ensure that staff responsible for completing roll checks take appropriate action if they have concerns about the wellbeing of a prisoner.
- The Governor should ensure that a copy of this report is shared with an officer and that a senior manager discusses the Ombudsman's findings with him.

## The Investigation Process

15. 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 wrote to us as a result.
16. The investigator obtained copies of relevant extracts from Mr Thomas's prison and medical records.
17. The investigator interviewed 11 members of staff at Garth in October. NHS England commissioned an independent clinical reviewer to review Mr Thomas's clinical care at the prison.
18. We informed HM Coroner for Preston and West Lancashire of the investigation. The Coroner gave us the results of the toxicology. We have sent the Coroner a copy of this report.
19. The Ombudsman's family liaison officer contacted Mr Thomas's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Thomas's next of kin asked whether he was able to obtain his medication in prison as she thought he had had difficulty doing so in January/February 2019.
20. We shared the initial report with Mr Thomas's next of kin. She did not make any comments.
21. We also shared the initial report with HM Prison and Probation Service (HMPPS). They identified one factual inaccuracy, and we have amended this report accordingly.

## Background Information

### HMP Garth

22. HMP Garth holds up to 846 prisoners serving sentences of four years or longer or indeterminate sentences. Lancashire Care Foundation Trust provides health services.
23. The upper floors of B Wing are a residential support unit for prisoners who cannot be held with the general prison population due to fears for their safety for reasons such as debt or gang-related threats. The lower floor is the Beacon Unit, an intervention service for prisoners diagnosed with personality disorder whose offence, or risk of reoffending, is understood to be due to personality-related needs. The Beacon Unit holds up to 48 prisoners.

### HM Inspectorate of Prisons

24. The most recent inspection of HMP Garth was in December 2018 and January 2019. Inspectors reported that the prison had a well-thought out approach to supply reduction but prisoners found it far too easy to obtain illicit drugs. A survey conducted by inspectors found that 60 per cent of prisoners found it easy to obtain drugs, and over a quarter of prisoners had developed a drug problem at the prison.
25. Inspectors reported that security and substance misuse services worked well together to address drug issues, and the introduction of a dedicated search team was effective in enabling intelligence-led target searching. However, they noted that many initiatives to reduce illicit drug use had not been fully embedded and suspicion drug testing had reduced.

### Independent Monitoring Board

26. 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 2018, the IMB reported that Garth had a good drugs strategy. However, they reported that drug use remained a problem at the prison, along with bullying and violence associated with this.

### Previous deaths at HMP Garth

27. Mr Thomas's death was the ninth at Garth since September 2017, and the third related to apparent drugs toxicity.
28. Our investigation into the death of a prisoner in November 2018 highlighted that drugs were readily available at Garth. We recommended that suspected users of illicit drugs were referred to the substance misuse team, and that the prison identify the key drug issues and amend the local drugs strategy accordingly. Garth accepted our recommendation and responded that they would review the substance misuse strategy to ensure local issues were identified and addressed.

29. Another prisoner died at Garth about 10 weeks after Mr Thomas. The cause of his death has not yet been determined but toxicology tests showed that he had taken illicit psychoactive substances (PS) immediately before his death.

### **Psychoactive Substances (PS)**

30. PS (formerly known as 'new psychoactive substances' (NPS) or 'legal highs') are a serious 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 PS to precipitate or exacerbate the deterioration of mental health, and they are linked to suicide or self-harm.
31. 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.
32. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

## Key Events

33. On 9 January 2014, Mr Imre Thomas was remanded in custody to HMP Cardiff, charged with wounding and causing grievous bodily harm. He was later sentenced to 14 years in prison.
34. Mr Thomas had been to prison several times before. He had a long history of drug misuse, including intravenous heroin use in the community.
35. On arrival at Cardiff, he told healthcare staff that he had been diagnosed with schizophrenia and had been prescribed olanzapine (an antipsychotic medication) in the community.
36. In July 2014, Mr Thomas was transferred to HMP Parc. He stopped taking olanzapine shortly afterwards, and reported that his mental health had been good since.
37. On 3 July 2017, Mr Thomas was transferred to HMP Garth. Shortly afterwards, he was prescribed naproxen (an anti-inflammatory medicine used to relieve pain) for long-standing pain from a hand injury. In September, this was changed to co-codamol and, in December, to dihydrocodeine (a strong opioid-based painkiller for moderate to severe pain).
38. In August 2017, a prison GP referred Mr Thomas to an orthopaedic hand surgeon for his hand injury. The initial appointment in November 2017 was cancelled by the prison because they had insufficient staff to escort him to hospital. A total of nine orthopaedic appointments were scheduled between November 2017 and 12 September 2019, but none took place: three were cancelled by the hospital, four were cancelled by the prison and two were refused by Mr Thomas.
39. On 14 March 2018, a prison GP assessed Mr Thomas, who spoke about an assessment he had received privately from a clinical psychologist a few months earlier. Mr Thomas refused to allow the assessment findings to be added to his prison medical record. The prison GP recorded that the psychologist gave a diagnosis of schizophrenia and paranoid psychosis, and dissocial and emotionally unstable personality disorders. (Individuals diagnosed with personality disorders may find it difficult to cope with demanding situations or may struggle to interact with other people.)
40. On 17 March, a mental health nurse assessed Mr Thomas. He told her that he felt anxious and asked to see a psychiatrist to consider restarting olanzapine. Mr Thomas denied experiencing any symptoms of schizophrenia such as hallucinations or delusional beliefs.
41. On 29 June, a psychiatrist assessed Mr Thomas. He recorded that Mr Thomas's mental health was stable, with no evidence of psychotic symptoms. He noted that Mr Thomas had a diagnosis of personality disorder. He discharged Mr Thomas from the psychiatry caseload.
42. On 20 November, prison staff referred Mr Thomas to the Beacon Unit at Garth (which provides interventions for prisoners diagnosed with personality disorders).

Beacon Unit staff later assessed Mr Thomas and offered him a place on the unit, which he would take up when a space became available.

### **HMP Swansea**

43. On 20 December, Mr Thomas was transferred to HMP Swansea under the accumulated visits scheme. (Where prisoners are in a prison a long way from their family, they can save up their visits allowance for up to six months and then transfer on a temporary basis to a prison nearer their home to receive their accumulated visits over a month.)
44. On 14 January 2019, prison staff found that Mr Thomas's urine sample for a mandatory drugs test had been contaminated by bleach. They charged him with an offence against prison discipline. The next day, prison staff searched Mr Thomas's cell and found illicit buprenorphine (Subutex, a heroin substitute medication) and cocaine. They also found a bag of dihydrocodeine tablets, indicating that Mr Thomas had 'diverted' this medication when he was given it. (Mr Thomas was required to collect dihydrocodeine every day and take the tablet in front of a prison nurse. Prisoners may pretend to have taken their medication and hide it to trade illicitly with other prisoners or to stockpile it for their own use, a practice known as 'diversion'.) As a result, a prison doctor stopped Mr Thomas's dihydrocodeine prescription.
45. On 18 January, Mr Thomas told prison staff that he would hang himself because his medication had been stopped. They began Prison Service suicide and self-harm prevention procedures (known as ACCT).

### **HMP Garth**

46. On 22 January, Mr Thomas was transferred back to Garth. A nurse assessed him, and noted that his only current medication was levothyroxine (medication for an underactive thyroid which Mr Thomas had taken for a number of years). Two days later, prison staff closed ACCT procedures.
47. On 25 January, Mr Thomas told, a mental health nurse that his dihydrocodeine had been stopped, that he was in pain and that he thought he might be addicted to dihydrocodeine. She recorded that he was in a highly anxious state.
48. On 28 January, he told a pharmacy technician that he was addicted to dihydrocodeine and was going 'cold turkey' (slang for withdrawal symptoms) since it had been stopped.
49. On 1 February, a prison GP reviewed Mr Thomas. He recorded that Mr Thomas said his dihydrocodeine was stopped at Swansea "for no reason" and that he was now experiencing pain. He prescribed co-codamol, an alternative painkiller.
50. On 7 February, a nurse noted that Mr Thomas was not collecting the co-codamol as he wanted dihydrocodeine instead. The next day, Mr Thomas told a nurse that he was using illicit dihydrocodeine for pain control. She gave him advice about the risk of overdose and advised him to book a GP appointment to review his medication.

51. On 25 February, Mr Thomas moved to the Beacon Unit. On the same day, Mr Thomas told the substance misuse service that he did not wish to work with them.
52. On 6 March, Mr Thomas did not attend a GP appointment to review his medication. On 11 March, he told a nurse that he was taking illicit tramadol (a strong, opiate based painkiller) for pain relief. He requested another GP appointment, which was subsequently arranged.
53. On 22 March, a prison GP reviewed Mr Thomas. He noted that Mr Thomas was waiting to see a hand surgeon. He planned to await the surgeon's opinion and then review Mr Thomas's pain medication. In the meantime, he agreed to Mr Thomas's request to restart dihydrocodeine.
54. On 16 April, an officer recorded that he believed that Mr Thomas was dealing drugs on the Beacon Unit. A month later, an officer recorded that he had received information that Mr Thomas was bringing drugs onto the Beacon Unit and bullying vulnerable prisoners for their prescription medications. The officer recorded that Mr Thomas regularly seemed to be under the influence of drugs.
55. In June, prison staff recorded four pieces of intelligence that Mr Thomas was supplying and using drugs.
56. In July, prison staff recorded eight pieces of intelligence that Mr Thomas was involved in the supply of illicit drugs on the Beacon Unit. They recorded that he appeared to be under the influence of drugs on seven separate days in the month. Mr Thomas did not usually disclose what drugs he had taken.
57. On 3 July, a prison GP recorded that he had reviewed Mr Thomas's medication. He did not see Mr Thomas and did not make any changes to his prescription.
58. On 10 July, Mr Thomas attended a meeting with the Phoenix Futures substance misuse service (which provides advice, information and support on substance misuse to prisoners through one-to-one sessions or group work). During the meeting, Mr Thomas spoke about his recent drug use and was given in-cell work to do to record this.
59. On 19 July, prison staff called healthcare as Mr Thomas appeared to be under the influence of drugs and was slurring his words. A nurse saw him in his cell and took his observations.
60. On 20 July, an officer recorded that Mr Thomas was clearly under the influence of drugs, looking unwell and with twitching arms. He recorded that Mr Thomas said he had taken tramadol and pregabalin (medication for epilepsy, anxiety and nerve pain) the day before.
61. A nurse saw him and Mr Thomas complained of feeling unwell and said he thought he had a chest infection. She took his observations, advised him to contact healthcare if he had any further concerns, and arranged for his observations to be checked again in the evening.
62. A Healthcare assistant (HCA) went to Mr Thomas's cell in the evening to repeat the observations. Mr Thomas was asleep and, when woken up, he refused to have his observations done.

63. On 21 July, an HCA tried to take Mr Thomas's observations again, but he refused, saying he felt fine and did not need healthcare.
64. On 23 July, the clinical lead for the Beacon Unit, chaired a review of Mr Thomas's placement on the unit. The panel discussed Mr Thomas's recent drug use and his motivation for using illicit substances, including as a means of coping with stress in custody and with his relationship with his family. They also noted that Mr Thomas said that he used illicit medication because his current prescription was not sufficient. The panel agreed that Mr Thomas should stay on the Beacon Unit on a modified treatment plan.
65. On 25 July, a psychologist working on the Beacon Unit, telephoned a mental health practitioner to discuss Mr Thomas's use of illicit prescription medication. She subsequently requested that a GP appointment be booked for Mr Thomas.
66. On 17 August, an officer, who was Mr Thomas's keyworker, recorded that Mr Thomas appeared to be less involved in the supply and use of drugs since his placement review. He noted that Mr Thomas did not seem committed to the psychology groups he attended on the Beacon Unit, often leaving them early.
67. On 19 August, Mr Thomas did not attend the GP appointment that had been booked to discuss and review his medication.
68. On 21 August, Mr Thomas was reviewed by a Phoenix Futures intervention worker. He said that he did not want to work with the clinical team at Garth but wanted to obtain support for his substance misuse through peer support group work.
69. On 28 August, Beacon Unit staff recorded that Mr Thomas appeared to be under the influence of drugs. The next day, they again recorded that he appeared to have used illicit substances.
70. On 1 September, his keyworker recorded that Mr Thomas appeared to have reverted to his previous behaviour, using and supplying drugs. He recorded that Mr Thomas denied any wrongdoing, and dismissed allegations of being under the influence as simply the effects of tiredness and stress.
71. On 6 September, an officer recorded that Mr Thomas was clearly under the influence of drugs. He recorded that he saw Mr Thomas being passed medication from another prisoner, and that Mr Thomas laughed when challenged about it. A nurse attended the Beacon Unit to assess Mr Thomas but he refused to allow her to examine him or take his clinical observations.
72. On 9 September, the keyworker recorded that Mr Thomas's attitude was deteriorating and he constantly appeared to be under the influence of drugs. He noted that Mr Thomas's behaviour was having a negative effect on other prisoners in the Beacon Unit who were getting involved with his "wheeling and dealings", leading to debt and bullying issues.
73. Mr Thomas's next of kin told us that he telephoned her a few days before he died. She said that his speech was slurred but he sounded upbeat. Mr Thomas told her he had been coughing up phlegm and suggested that this might have been caused by his vape pen.

## 11 September

74. At the start of the day, a Custodial Manager (CM) briefed staff working on the Beacon Unit. In his statement following Mr Thomas's death, the CM recorded that he reminded staff of the importance of calling healthcare staff whenever a prisoner was found under the influence of drugs. The CM recorded that he highlighted this at the briefing as he was concerned about Mr Thomas's recent drug use. He said that staff said in response that prisoners often refused to be seen by healthcare staff, but that he explained that healthcare staff should be asked to attend, not only because of the duty of care to prisoners, but also so that any prescribed medication could be withheld if necessary to avoid a toxic mix.
75. A nurse administered Mr Thomas's morning medication. She recorded that he felt unwell and looked pale. She advised Mr Thomas to attend the healthcare unit but he did not do so.
76. Mr Thomas then attended a substance misuse group work session led by an intervention worker. She recorded that they discussed drug harm reduction, and that Mr Thomas said he wanted to continue attending support groups.
77. The clinical lead for the Beacon Unit chaired a meeting to review Mr Thomas's placement on the Beacon Unit, which Mr Thomas chose not to attend. The panel agreed to end Mr Thomas's place on the Beacon Unit due to his recent drug use and frequent failure to engage with groups and interventions.
78. After the meeting, a member of the panel spoke to Mr Thomas and explained the reasons for his deselection. She told us that he was initially defensive but came to accept the reasons, and that it was agreed that he would continue to live on the Beacon Unit until alternative accommodation was identified for him.
79. CCTV shows that a SO and an officer escorted Mr Thomas to his cell at around 7.15pm, and locked him in for the night. Both told us that Mr Thomas was locked in his cell slightly later than other prisoners as he had been finishing his laundry. Both said that he was in a good mood and was laughing and joking with them, and the SO said he was talking about the possibility of moving to a prison in Wales to be nearer his family now that he had been deselected from the Beacon Unit.

## 12 September

80. At around 5.50am, his keyworker completed a count of prisoners. CCTV shows that he spent around 42 seconds at Mr Thomas's cell before continuing with his count. The officer told us that Mr Thomas was lying with his lower back and legs hanging off the bed. He said that he thought he saw Mr Thomas move and thought that he was asleep.
81. At around 6.03am, his keyworker returned to check Mr Thomas. He spent one minute and 45 seconds at Mr Thomas's cell. The officer said that he rattled the bolt on the cell door and thought that he saw Mr Thomas move slightly in response. He told us that he was therefore content that Mr Thomas was well.

82. At around 7.45am, the SO briefed the operational and clinical staff who were to work on the Beacon Unit that day. In a statement completed after Mr Thomas's death, the Lead Occupational Therapist and Team Leader of the Beacon Unit, recorded that the SO told the staff that Mr Thomas had been "under the influence" on the evening of 11 September. The Lead Occupational Therapist recorded that the SO said that they did not contact the healthcare team as Mr Thomas had previously refused to see them. She subsequently told us that someone present at the briefing (she could not remember who) said that Mr Thomas "looked like he had drunk 12 pints".
83. The Deputy Team Leader on the Beacon Unit also wrote a statement after Mr Thomas's death in which he provided a similar account of the briefing to the Lead Occupational Therapist. He recorded that it was the SO who made the comment about Mr Thomas appearing as though he had "drunk 12 pints".
84. We put these statements to the SO and the officer. Both reiterated their accounts that Mr Thomas was late to his cell because he was busy completing laundry, and both said that he was not under the influence of drugs when they locked him up. The SO told us that he could not recall saying anything at the briefing about Mr Thomas being under the influence of drugs the previous evening.
85. In an additional statement submitted to us after his interview, the SO wrote that he now recalled briefing staff that morning about a batch of PS being on the unit. He added that he made a remark "with light humour" that "if we end up escorting Mr Thomas back to his cell because he's looking like he's had a few pints, we'll know that [PS] is on the unit". The SO wrote that this comment related to events a few days earlier when Mr Thomas had appeared to be under the influence of drugs, and not to events on 11 September.

### **Emergency response**

86. At around 8.10am, two officers began unlocking prisoners. An officer saw Mr Thomas lying on the floor of the cell. He did not respond when she called his name. She opened the cell door and found that he had vomited on the bed and floor. She radioed a medical emergency code blue, indicating a life-threatening situation. She told us that Mr Thomas was very rigid to touch and that rigor mortis appeared to be established. Prison and healthcare staff did not therefore attempt resuscitation. Paramedics later confirmed that Mr Thomas had died.

### **Contact with Mr Thomas's family**

87. Mr Thomas had named his next of kin in his prison records. Due to the distance from Garth to her address, prison staff contacted a prison near to her house and asked them to break the news of Mr Thomas's death to her. On 12 September, a family liaison officer at this prison visited Mr Thomas's next of kin and informed her of his death.
88. A SO was appointed family liaison officer at Garth. She contacted Mr Thomas's next of kin on 13 September, and visited her on 17 September. Garth contributed to the costs of Mr Thomas's funeral in line with Prison Service instructions.

### **Support for prisoners and staff**

89. After Mr Thomas's death, a CM 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 Thomas's death, and offering support.

### **Post-mortem report**

91. The cause of death was not available when we issued our report. Post-mortem toxicology tests found that Mr Thomas had taken a potentially fatal amount of tramadol before his death. He had also taken gabapentin, pregabalin, diazepam, mirtazapine, amitriptyline and quetiapine (none of which were prescribed to him), as well as dihydrocodeine (which he was prescribed).
92. Pregabalin and gabapentin are used to treat anxiety, epilepsy and nerve pain; diazepam is a tranquiliser; mirtazapine is an antidepressant; amitriptyline is a pain killer; and quetiapine is an anti-psychotic. These drugs are only available on prescription. Some are addictive and they are all widely abused and traded in prisons.
93. The toxicologist commented that all these medications might enhance the toxic effects of tramadol, further increasing the risk of death.

# Findings

## Availability of illicit drugs

94. Toxicology tests identified that Mr Thomas had used several illicit prescription medications before his death. While we cannot be sure how Mr Thomas obtained them, it is possible they were diverted and traded by other prisoners who were prescribed these medications. It is a cause for real concern that Mr Thomas was able to obtain such a wide range of illicit medications at Garth.
95. Mr Thomas's prison records, as well as interviews with staff who knew him, show that he frequently used illicit substances. As well as illicit prescription medication, Mr Thomas was also known to use PS frequently. We note that HM Inspectorate of Prisons, in their inspection of January 2019, found that prisoners found it too easy to obtain illicit drugs at Garth.
96. HM Prison and Probation Service issued a Prisons Drug Strategy in 2019 to provide guidance to Governors on how to tackle the issue of drug use in prisons. Every prison was required to revise their local strategy by September 2019. Garth's revised strategy, dated 31 August 2019, sets out aims of addressing supply and demand reduction, providing effective advice, treatment and support for prisoners, and responding to local and national drug trends. It also identified that the secretion and diversion of prescription medication remained a significant problem.
97. In the light of the publication of this revised strategy only a few days before Mr Thomas's death, we make no recommendation. However, the prison must continue to work hard towards reducing supply and demand and look after prisoners affected by drug use and its consequences.

## Mr Thomas's substance misuse risk

### *Pain management*

98. Mr Thomas had an old hand injury that caused him pain. He was prescribed dihydrocodeine for the pain, before it was appropriately stopped at HMP Swansea in January 2019 when he was found to have diverted it.
99. On his return to Garth, he asked for the dihydrocodeine to be re-prescribed and said that he had been using it illicitly instead. A prison GP initially prescribed co-codamol as an alternative painkiller but Mr Thomas told healthcare staff that he was not taking it as he preferred dihydrocodeine. He also said that he was using illicit opiate medication instead of his prescribed co-codamol. He subsequently agreed to re-prescribe dihydrocodeine.
100. The clinical reviewer is concerned that the decision to re-prescribe dihydrocodeine was taken approximately six weeks after co-codamol was prescribed and in the context of Mr Thomas refusing to take the co-codamol. The clinical reviewer recognised the very difficult balance for clinicians in achieving effective pain control in patients for whom pain is chronic and often intertwined with complex psychological issues. However, she noted that Mr Thomas had diverted his dihydrocodeine rather than take it in January 2019 and

that he continued to take other illicit medicines. Dihydrocodeine is widely abused and traded in prisons and it is possible that Mr Thomas was displaying drug-seeking behaviour when he asked for it to be re-prescribed.

101. The clinical reviewer noted that Mr Thomas had been on a relatively low dose of co-codamol, and there was therefore scope to increase the dose of co-codamol before switching to a different drug. This would have been in line with the Pain Management Formulary for prisons (issued by NHS England in October 2017).

### *Missed hospital appointments*

102. The clinical reviewer was also concerned that decisions about Mr Thomas's pain management should have been informed by a specialist evaluation of Mr Thomas's hand pain, but that healthcare staff did not ensure that this took place. Mr Thomas was initially referred to an orthopaedic hand surgeon on in August 2017. The initial appointment in November 2017, was cancelled by the prison due to insufficient escort staff and eight further appointments were cancelled for various reasons. There was therefore no opportunity for specialist clinical evaluation, including consideration of Mr Thomas's suitability for surgery.

### *Failure to review Mr Thomas's prescription*

103. Mr Thomas continued to use illicit medication and PS persistently after he was re-prescribed dihydrocodeine, and he was found under the influence of drugs on many occasions. He was referred for one mandatory drugs test, in June but there is no evidence that this was completed or that there were any further referrals. Prison Service Order (PSO) 3601 on mandatory drug testing states that any prisoner reasonably suspected of misusing drugs, or in whose cell drugs are found, may be required to provide a sample for drug testing at any time.
104. The prison GP told us that any prisoner suspected of using PS and who is prescribed medication such as dihydrocodeine should have their prescription stopped immediately or after one warning because of the risk of combining dihydrocodeine and PS. He said that his view was that Mr Thomas's prescription should have been stopped some time before his death. As it was, Mr Thomas did not attend an appointment booked for a medication review in August 2019, and his prescription continued.
105. The clinical reviewer considered that the prescribing of dihydrocodeine should have been re-considered in the light of Mr Thomas's continued use of illicit opioids. She found that this did not happen because of inadequate information sharing.
106. The clinical reviewer concluded that the overall care Mr Thomas received in respect of safe effective pain management, the numerous failed hospital appointments and the failure to conduct follow-up monitoring observations, was not of the required standard and therefore not equivalent to that which would have been received in the wider community. However, she did not consider that any of these omissions contributed directly to Mr Thomas' death.

107. We agree with the clinical reviewer that there were missed opportunities to consider, address and review Mr Thomas's illicit drug use and dihydrocodeine prescription. We make the following recommendations:

**The Governor and the Head of Healthcare should ensure that prisoners attend their booked hospital appointments and, if a cancellation is unavoidable, the next appointment is given priority.**

**The Head of Healthcare should ensure that prescribing of opiate based medications is consistently informed by the NHS England Secure Prisons Prescribing Formulary and the local agreed pain pathway.**

**The Head of Healthcare should ensure that all prisoners who are prescribed opiate-based medication have a medication review when there is intelligence that they might have used illicit drugs.**

### Night of 11 September 2019

108. We are concerned about the suggestions that, before Mr Thomas was found dead on the morning of 12 September, a SO told staff that he had been under the influence of drugs when he was locked in his cell on the previous evening. If Mr Thomas was under the influence, healthcare staff should have been asked to see him to check his wellbeing. However, the SO and an officer deny that Mr Thomas was under the influence of drugs when they locked him up, or that the SO said that he had been. CCTV shows that Mr Thomas walked back to his cell that evening without appearing to need support.

109. We have asked Garth to conduct a local investigation into the events of 11 September. This investigation is currently ongoing. We make the following recommendation:

**The Governor should inform the Ombudsman of the findings of the internal investigation into the events on the evening of 11 September, and of any action taken as a result.**

110. Following Mr Thomas's death, Garth issued a Governor's Order (19/008) reminding staff of the actions they should take when a prisoner presents as though they may be under the influence of drugs. These actions include informing healthcare staff of the symptoms and maintaining welfare checks while waiting for their arrival.

### Roll check

111. The purpose of a roll check is to ensure that all prisoners are accounted for, but staff are also expected to take action if they have any concerns about a prisoner's safety or welfare when conducting a roll check. National instructions in PSI 24/2011 say that staff have a duty of care to prisoners, to themselves and other staff. The preservation of life must take precedence over the usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own.

112. From the officers' descriptions of Mr Thomas when he was found at around 8.10am, it is likely that rigor mortis had begun to occur. Rigor mortis can set in from within two to six hours of death. It is therefore possible that Mr Thomas was already dead or close to death when an officer carried out the earlier roll check at about 6.00am.
113. The keyworker spent around 42 seconds at Mr Thomas's cell at 5.50am, and one minute and 45 seconds at 6.03am. He said that he thought he saw Mr Thomas move on both occasions, and was therefore content that he was well. However, the time the officer spent looking into Mr Thomas's cell, and the fact that he felt it necessary to return to the cell to check again, suggests that he had real doubts about Mr Thomas's wellbeing. We consider that he should have erred on the side of caution and should have either entered the cell himself to check on Mr Thomas or called for healthcare and other assistance and entered the cell with other staff.
114. While we cannot be sure whether more thorough checks on Mr Thomas's wellbeing would have affected the eventual outcome, it is possible they may have done. We make the following recommendation:

**The Governor should ensure that staff responsible for completing roll checks take appropriate action if they have concerns about the wellbeing of a prisoner.**

**The Governor should ensure that a copy of this report is shared with the officer and that a senior manager discusses the Ombudsman's findings with him.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations