

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Evans a prisoner at HMP Cardiff on 12 October 2017

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 Paul Evans died on 12 October 2017 at the University Hospital of Wales, while a prisoner at HMP Cardiff. He died of pneumonia and hypoxic brain damage which was caused by cardiac arrest following the use of a synthetic cannabinoid. Mr Evans was 49 years old. We offer our condolences to Mr Evans' family and friends.

We are satisfied that Mr Evans received good care at Cardiff, equivalent to the care that he could have expected to receive in the community.

We are concerned that Mr Evans was apparently able to obtain psychoactive substances without difficulty at Cardiff. While the prison has taken measures to tackle the issue, the investigation found some inconsistencies at the prison between policy and practice and Cardiff should ensure that staff are implementing the local drugs strategy effectively. We are increasingly concerned by the number of deaths we investigate in which PS has played at least some part. Mr Evans' death is another example of how dangerous PS is and how even prisons that we judge have effective measures in place to reduce PS use, are struggling.

We are concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In our view there is now an urgent need for national guidance on the best measures to combat this serious problem. We have already made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service. We have also written to the Prisons Minister setting out our concerns at the number of drug-related deaths in custody.

Sue McAllister CB
Prisons and Probation Ombudsman

January 2019

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Summary

Events

1. On 17 August 2017, Mr Paul Evans was sentenced to 26 weeks in prison for driving offences. He was sent to HMP Cardiff.
2. Mr Evans had epilepsy, angina and high blood pressure and a history of drug and alcohol misuse, depression and self-harm. He was referred to the mental health team but subsequently discharged, and a substance misuse worker spoke with him. He took appropriate medication which GPs at Cardiff continued to prescribe.
3. On 18 August, prison staff found Mr Evans unconscious in his cell. They put him in the recovery position and called for medical assistance. A nurse gave Mr Evans oxygen and he regained consciousness. It transpired that both Mr Evans and his cellmate had taken 'spice', a psychoactive substance (PS). Prison staff kept both Mr Evans and his cellmate under regular observation.
4. On 7 September a nurse examined Mr Evans after he reported chest pains during the night. His vital signs and breathing were normal as were the results of an electrocardiogram (ECG), a test of the rhythm and electrical activity of the heart. Mr Evans said he was anxious after hearing that his step-daughter had self-harmed.
5. On 11 October at 10.15pm, a member of staff radioed a code blue medical emergency after Mr Evans' cellmate discovered him unconscious and was unable to rouse him.
6. Prison and healthcare staff attended and an officer in the control room called an ambulance. Mr Evans had no pulse and was not breathing. Staff began cardiopulmonary resuscitation and gave him oxygen. They attached a defibrillator until the arrival of the paramedics at 10.30pm.
7. Mr Evans was taken to hospital by ambulance but did not regain consciousness. On 12 October at 4.33pm a hospital doctor pronounced Mr Evans dead.
8. Mr Evans' cellmate said that Mr Evans had taken a psychoactive substance on the day that he later found him unconscious. A post-mortem examination found that the cause of death was pneumonia and hypoxic brain damage, caused by cardiac arrest following the use of a synthetic cannabinoid (PS).

Findings

9. We are satisfied that the clinical care Mr Evans' received at Cardiff was equivalent to that he could have expected in the community.
10. There is evidence to suggest that Mr Evans' illicit drug use on the day of his death was not a one-off occurrence, and that he was misusing drugs at Cardiff in the period before his death.

11. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern about the availability of drugs at Cardiff. Given his history of drug use in the community, Mr Evans was clearly vulnerable to misusing drugs in this environment. Mr Evans' cellmate told us that Mr Evans had used PS at Cardiff on more than one occasion and that PS was a real problem that staff did not seem to know how to manage. We are concerned that Mr Evans was able to access illicit drugs so easily and that, despite healthcare staff treating Mr Evans for PS use two months earlier, there is no evidence that he was tested or monitored.

Recommendations

- The Governor of Cardiff should ensure there are effective supply and demand reduction strategies to help eradicate the availability of psychoactive substances, and that staff are vigilant to signs of their use and know how to respond when a prisoner appears to be under the influence of such substances.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Cardiff informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator visited Cardiff on 18 October 2017. They obtained copies of relevant extracts from Mr Evans' prison and medical records and interviewed his cellmate.
14. The investigator interviewed five members of staff when he returned to Cardiff on 21 November 2017.
15. The investigation was suspended on 29 November while we awaited toxicology results and a cause of death. The investigation was resumed on 26 June 2018.
16. The investigator interviewed four members of staff via telephone on 31 July and 14 August 2018.
17. Healthcare Inspectorate Wales commissioned a clinical reviewer to review Mr Evans' clinical care at the prison.
18. We informed HM Coroner for Bridgend and Glamorgan Valleys of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
19. The investigator wrote to Mr Evans' father and to his partner to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They did not respond to our letter.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Cardiff

21. HMP Cardiff holds around 800 men, mostly from South East Wales. Many of the prisoners come from local courts on remand. Cardiff and Vale University Health Board is responsible for delivering primary, physical and mental health services at the prison. There is a 22-bed healthcare centre providing 24 hour nursing care and a full time doctor's service available between 8.00am and 5.00pm every weekday and 24-hour on-call provision.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Cardiff was conducted in August 2016. Inspectors found that the healthcare was reasonably good. Despite staff vacancies, there were sufficient well-led health services. The Inspectorate found that very few prisoners complained about healthcare as there were only 47 complaints within the previous six months. They said that the health centre, including inpatient unit, was clean and had excellent clinical facilities on two floors.
23. Inspectors found an increased availability and use of psychoactive substances, which inevitably led to an increase in violence and unpredictable behaviour. Although 49% of prisoners said it was easy to obtain illegal drugs, psychoactive substances were not included within the mandatory drugs test at the time of inspection.

Independent Monitoring Board

24. 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 31 August 2017, the IMB reported that since the implementation of the non-smoking policy in March 2016, the smoking of other substances, including psychoactive substances, had increased. The prison management had adopted a more robust attitude towards illegal substances, including more penalties for possession.

Psychoactive Substances (PS)

25. Psychoactive substances (formerly known as 'new psychoactive substances' 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 precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
26. 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.

27. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Previous deaths at HMP Cardiff

28. Mr Evans was the fifth prisoner to die at Cardiff since January 2016. There are no significant similarities between the previous deaths and that of Mr Evans.

Key Events

29. On 17 August 2017, Mr Paul Evans was sentenced to 26 weeks in prison for driving offences. He was sent to HMP Cardiff where he had served several previous sentences.
30. At his initial health screen Mr Evans told a nursing assistant that he had epilepsy, angina and high blood pressure and had suffered previous heart attacks. He had a history of illicit drug and alcohol misuse, depression and self-harm. On examination Mr Evans showed mild symptoms of drug and alcohol withdrawal. Healthcare staff advised him to stay in the healthcare centre but he refused and signed a disclaimer. Instead he went on a standard wing in a double cell.
31. Healthcare staff contacted Mr Evans' community GP who faxed a list of his current medication. They also referred him to the primary care mental health team.
32. On 18 August, a prison GP reviewed Mr Evans' medication which included medication for heart disease and epilepsy. He noted the list of regular repeat medications which Mr Evans continued to have prescribed during his time at Cardiff and which he kept 'in possession'. A nurse completed a second reception screen. They noted that Mr Evans' withdrawal symptoms were less severe than the previous day and he appeared fit and well. On being asked, he denied any mental health issues or thoughts of self-harm.
33. Mr Evans had initial contact with the Substance Misuse Team (known as Dyfydol) in a routine consultation given to all prisoners, offering the opportunity to engage with the service. He was referred to a Dyfydol worker.
34. At 11.31pm, a nurse responded to a medical emergency call after prison staff found Mr Evans unconscious in his cell. By the time of their arrival, staff had put Mr Evans in the recovery position and he had regained consciousness. The nurse checked his vital signs and gave him oxygen. After about 25 minutes he was able to sit up and said he felt much better. It transpired that both Mr Evans and his cellmate had taken 'spice' (a form of PS). Prison staff kept both Mr Evans and his cellmate under regular observation and told them to alert staff if their condition worsened.
35. Mercury reports are completed by prison staff to share information or intelligence about prisoners. They can be completed for various reasons, including bullying, mobile phone use and illicit drug production and/or use. The Mercury reports are shared with the security department, which then decides on the best course of action. There is no evidence that a Mercury report was completed about Mr Evans taking PS on 18 August.
36. On 22 August an Offender Intervention Worker from Dyfydol, spoke with Mr Evans about drugs, tolerance levels and overdose. They gave him leaflets and details about where help and support could be accessed. However, Mr Evans said that he did not want to engage further with the service.

37. On 23 August, at a meeting of the prison primary mental health care team, Mr Evans was discussed as a consequence of the referral at his initial health screen. This was a multidisciplinary team meeting and included the consultant psychiatrist. No acute mental health problems were identified and Mr Evans was discharged from further mental health care.
38. On 7 September at about 8.14am, a nurse examined Mr Evans after he reported having chest pains during the night. Mr Evans described pain in the centre of his chest and in his arms. His vital signs were normal and he did not have breathing difficulties. He told the nurse that he thought it might be anxiety as his partner had told him earlier that his step-daughter had self-harmed.
39. Mr Evans had an ECG, a test of the rhythm and electrical activity of the heart, later that morning. The results showed no acute changes and no evidence of a new cardiac episode.

Events of 11 October

40. On 11 October at 4.24pm, Mr Evans spoke to his partner on the telephone. He said he had collapsed in his cell and hit his head on the pipes. He said he had a lump on his head and said the fall must be something to do with “not getting enough oxygen”.
41. At 10.13pm, Officer A responded to a cell bell activation from cell A3-07, a double cell occupied by Mr Evans and his cellmate.
42. Mr Evan’s cellmate told the Officer A that he was concerned about Mr Evans who was lying on the lower bunk unresponsive. Officer A asked the cellmate to shake Mr Evans’ shoulders, which he did. Mr Evans remained unresponsive.
43. At 10.15pm, Officer A radioed a code blue emergency to signify a medical situation where a prisoner is unconscious or not breathing. Control room staff called an ambulance and prison and healthcare staff made their way to the cell.
44. Officer B was the first officer to arrive, only a few seconds later. Officer C joined him shortly after. Officer B looked through the cell observation panel and could see Mr Evans lying on his back on the bottom bunk with his head to one side. He could see fluid, possibly vomit, on Mr Evans’ pillow. Officer B banged on the cell door and asked his cellmate to shake him. Mr Evans did not respond.
45. As required by local policy, Officer B radioed a Custodial Manager (CM) requesting permission to enter the cell. Permission was given straight away and Officer B unlocked the cell and, together with Officer C and others, went inside.
46. Officer C removed Mr Evans’ cellmate from the cell. Officer B went straight over to Mr Evans. He checked his neck and wrist for a pulse but felt nothing. He also pinched Mr Evans’ toe. Mr Evans did not respond but Officer B did notice a very small rise and fall of his chest. Officer B described his

complexion as pale, almost white, and his lips blue. On the bunk, next to Mr Evans' head, Officer B saw part of an inhaler with some tin foil over the top. He thought it looked like it had been used as a pipe to smoke.

47. A nurse and the CM arrived and the CM confirmed with the control room that they had called an ambulance. The nurse examined Mr Evans who was motionless, not breathing and had no pulse. They described his face and fingers as white but his skin, from his neck to his waist and down his arms, as flushed. He was warm to touch but his pupils were fixed and dilated.
48. Under the nurse's supervision, the officers lifted Mr Evans onto the floor. They began chest compressions and gave him oxygen. A Healthcare Assistant arrived and took over chest compressions while the nurse put defibrillator pads on Mr Evans' chest. No heart rhythm was detected. Officers and healthcare staff continued to give cardiopulmonary resuscitation, or CPR, until paramedics arrived, shortly after 10.30pm.
49. The paramedics took over, assisted by healthcare staff and some cardiac output was established. Mr Evans was transferred to an ambulance which left the prison at 11.10pm and took Mr Evans to the University Hospital Wales.
50. Mr Evans did not regain consciousness. On 12 October at 4.33pm, a hospital doctor pronounced Mr Evans dead.

Contact with Mr Evans' family

51. On 11 September at about 11.50pm, a CM telephoned Mr Evans' partner and explained that he had been taken to hospital and was in a serious condition. They advised to her to make her way to the hospital.
52. The next morning, the prison appointed a prison officer as the family liaison officer (FLO). At 9.30am the FLO attended the hospital where he initially spoke to members of Mr Evans' family, including his father and brother. They were at Mr Evans' bedside and the FLO believed them to be his nominated next of kin. The FLO explained that he was there to offer support.
53. Shortly afterwards, the FLO met and spoke with Mr Evans' partner and explained his role to her. He stayed at the hospital throughout the day. Mr Evans remained in the critical care unit and the FLO helped facilitate visits of family and friends. At the request of the family, the FLO stayed with them when the police interviewed them.
54. Mr Evans did not regain consciousness and at 4.33pm a prison doctor declared him dead. Mr Evans' partner agreed that the family should deal with the funeral arrangements and the FLO explained that the prison would continue to offer support and would contribute towards the funeral costs. The FLO stayed in contact both with the family and with Mr Evans' partner. They visited the family home several times to assist with the funeral arrangements and to return Mr Evans' property.

55. Subsequently, there were some disagreements between Mr Evans' family and his partner, putting the FLO in a difficult position. They remained impartial and continued to liaise with both sides.
56. Mr Evans' funeral was held on 26 October and the prison contributed toward the cost in line with Prison Service instructions.

Support for prisoners and staff

57. After Mr Evans' death a prison manager, 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.
58. The prison posted notices informing other prisoners of Mr Evans' 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 Evans' death.
59. Immediately after officers entered the cell to deal with Mr Evans, his cellmate was moved to a room nearby, used by officers as a tearoom. An officer stayed with him to offer support. Shortly afterwards, officers moved the cellmate to a different room and prison Listeners (prisoners trained by Samaritans to offer support) joined him.
60. Officers returned the cellmate to the cell he shared with Mr Evans after Mr Evans had been taken to hospital. Mr Evans' cellmate told the investigator that he felt uncomfortable going back into the cell but a CM and Officer C both said that they discussed this with him at the time and that he did not object or raise any concerns.

Post-mortem report

61. A post-mortem examination later found no evidence that Mr Evans had suffered a head injury when he fell and banged his head on the day of his death. The pathologist concluded that Mr Evans had coronary artery disease but that this was "insufficient in isolation to provide an explanation for death". The post-mortem found that Mr Evans died from pneumonia and hypoxic brain damage, caused by cardiac arrest following use of a synthetic cannabinoid.

Findings

Clinical care

62. Mr Evans was at Cardiff for less than two months and had only limited contact with healthcare staff. At his initial health screens healthcare staff identified his issues of heart disease, high blood pressure and epilepsy, previous drug and alcohol misuse and a history of depression and self-harm. Healthcare staff referred him to the mental health team and a worker from the drug misuse services spoke to him but he declined any further intervention. The prison contacted his community GP about his medication which they then continued to prescribe and review.
63. A nurse responded promptly on 18 August when staff found Mr Evans collapsed after taking PS and, on 7 September, when he reported chest pains, he was treated appropriately.
64. The clinical reviewer concluded that the clinical care Mr Evans received at Cardiff was equivalent to that he could have expected to receive in the community.

Psychoactive substance misuse

65. HMPPS Wales drug and alcohol strategy aims to use a 'whole prison' approach to aid reduction in supply and demand, and provide effective treatment to prisoners. The document states that there needs to be effective cross-department communication and adequate purposeful activity for prisoners. Effective ways to reduce the supply and demand include, intelligence sharing, searching of prisoners and cells, drug testing, effective use of the privileges scheme, adjudications and referrals to the Dyfydol service.
66. HMP Cardiff also has a local drug strategy policy, which states: HMP Cardiff is committed to significantly reducing the access to and demand for drugs by offenders. It aims to achieve this by developing constructive regimes that provide both opportunities to challenge and address drug misuse and incentives to change behaviour and accept support. The supply and possession of illicit drugs will not be tolerated within HMP Cardiff. All persons found in possession of, or testing positive via mandatory drug testing for illicit drugs will face disciplinary or criminal procedures. Suspicion testing or targeted testing will be conducted on receipt of an Application for Mandatory Drug Testing on grounds of reasonable suspicion, authorised by the Head of Security, as set out in national guidelines. The security department on receipt and analysis of security intelligence initiates this process.
67. The Head of Security told the investigator that he was confident that the drug strategy policy is implemented effectively within Cardiff. He said that there are drug strategy meetings and the prison is responding to the changes in which PS enters the prison. For example, PS was being sprayed onto paper correspondence coming into the prison. To tackle this, the prison now employs a member of staff to photocopy all correspondence. Prisoners then

receive a photocopy of their mail. The Head of Security said that although this is a resource-intensive solution, it has had a significant impact on PS coming into the establishment.

68. Mr Evans was known to have substance misuse issues and was clearly vulnerable to misusing drugs in this environment. The day after he arrived at Cardiff, healthcare staff responded to a code blue emergency and treated Mr Evans for the effects of using PS. Although he was appropriately referred to the Dyfydol service and refused to engage, there is no evidence that a Mercury report was completed. Without effective information sharing, the security department missed an opportunity to build up a profile of supply and use, and therefore could not implement observations, searches or testing. This was also a missed opportunity for disciplinary consequences to Mr Evans, to try and deter him from using PS.
69. It is not clear how many other times Mr Evans used PS. His cell mate said that Mr Evans had used PS on more than one occasion and all day on 11 October. He remarked on how much Mr Evans used PS, considering that he had a heart problem.
70. The PPO's Learning Lessons Bulletin on PS, published in July 2015, set out why PS are a source of increasing concern in prisons. There is emerging evidence that PS posed dangers to both physical and mental health. In addition, trading these substances can lead to debt, violence and intimidation. In our Annual Report for 2016/2017 we noted that the number of deaths where the use of PS may have played a part continued to rise and that there was a greater need than ever for more effective drug supply and demand reduction strategies, including better monitoring by drug treatment services and effective violence reduction strategies.
71. We accept that Cardiff has a drug strategy in place and staff are working hard to implement it and introduce new measures to reduce the supply of PS. However, Mr Evans was apparently able to obtain and use PS without difficulty (including on the day of his arrival at Cardiff) and continued to do so despite being made aware of the dangers. Cardiff is not alone in facing this problem. It is a serious problem across much of the prison estate. The PPO's view is there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works. The PPO made a recommendation to the Chief Executive of HMPPS to issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS. While they wait for the national guidance to be issued, staff at Cardiff should continue to implement their local guidance and staff should ensure they produce Mercury reports for all suspicions and instances of PS use. We make the following recommendation:

The Governor should ensure that staff are aware of their responsibilities in effectively implementing the drug reduction strategy to help reduce the availability of psychoactive substances.

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