Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Ware a prisoner at HMP Parc 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*

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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 Matthew Ware died on 22 November 2018 after he was found hanged in his cell at HMP Parc. The post-mortem toxicology test results confirmed the presence of psychoactive substances (PS) in his system when he died. Mr Ware was 44 years old. I offer my condolences to his family and friends.

Mr Ware was monitored under suicide and self-harm prevention procedures (known as ACCT) from 7 November until his death. However, staff did not appropriately operate some basic aspects of these procedures.

Mr Ware had back pain and sciatica and said that he used PS to cope with the pain. He accumulated debt as a result of his substance misuse. I am concerned that there was insufficient recognition in his ACCT management that these issues affected his wellbeing and increased his risk of suicide and self-harm.

Although the emergency response was swift when Mr Ware was found hanged, there was a delay in removing the ligature from Mr Ware's neck because none of the staff had an anti-ligature knife.

It is extremely troubling that Mr Ware was able to obtain PS with ease at Parc, even though staff knew about his substance misuse issues. HM Inspectorate of Prisons and the Independent Monitoring Board have also reflected that PS use is widespread at Parc. Mr Ware's death came just four days after another prisoner died there from PS toxicity. Parc will need to reassess their approach in line with the Prison Service's recently published Prison Drugs Strategy.

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 2019**

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Summary

Events

1. On 31 July 2015, Mr Matthew Ware was sentenced to nine years in prison for wounding with intent and common assault. He had a history of chronic back pain and substance misuse. He was found under the influence of psychoactive substances (PS) on numerous occasions and despite staff intervention and support, he continued to misuse drugs.

2. On 4 June 2018, Mr Ware was transferred from HMP Bristol to HMP Parc. He regularly complained that his back pain and sciatica affected his mobility. He suggested that he took PS as it helped reduce his pain. Mr Ware's use of PS resulted in him being in debt to other prisoners. Staff referred him to the substance misuse team on 27 July but no one saw him before he died.

3. Mr Ware's medical records indicated that he sometimes did not collect his prescribed pain relief because of his pain. He was referred to a physiotherapist but there is no evidence that healthcare staff created a care plan to assist with his mobility and ensure that he could collect his medication and attend appointments.

4. On 7 November, staff started ACCT procedures after Mr Ware made cuts to his left arm. Staff agreed to check on him at least twice an hour under ACCT procedures. They continued to monitor him until his death, and completed two ACCT reviews.

5. On 22 November, staff checked Mr Ware's cell at 7.44am and found him hanged, using a ligature made from bedsheets. Staff radioed a medical emergency code blue, and the control room called an ambulance promptly. There was a slight delay in removing the ligature from Mr Ware because none of the prison staff had an anti-ligature knife. Healthcare and prison staff tried to resuscitate Mr Ware. When the paramedics arrived, they took over his care but pronounced at 8.22am that he had died.

Findings

Management of risk of suicide and self-harm

6. When Mr Ware harmed himself, staff appropriately monitored him under ACCT procedures. However, there were deficiencies in the way they did so. Staff failed to appoint an ACCT assessor to assess Mr Ware, and his assessment was subsequently completed by the ACCT case manager. While the ACCT caremap highlighted that Mr Ware had mobility problems, it did not indicate whether or how staff addressed his issues. It also made no mention of Mr Ware's known substance misuse and debt problems.

Debt problems

7. Staff did not record every occasion that Mr Ware reported having drug debts, and they did not consistently submit information to the security team.

Anti-ligature knives

8. Although the emergency response was swift, none of the staff who attended had an anti-ligature knife to cut the ligature.

Family liaison

9. Following Mr Ware's death, the prison failed to keep in contact with his family in a timely manner or appoint a deputy family liaison officer.

Clinical care

10. The clinical reviewer found that the care that Mr Ware received at Parc was equivalent to that which he could have expected to receive in the community.

11. However, despite his known physical health problems which affected his mobility, there is little evidence that prison and healthcare staff worked jointly to create a careplan to ensure provisions were made for him to collect his medication and/or attend healthcare appointments when he was experiencing difficulties.

12. Despite Mr Ware's recognised substance misuse problem, no one from the substance misuse team offered him any support after he was referred to them on 27 July.

Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that:
  - staff have a clear understanding of their responsibilities and roles when assessing a prisoner's risk;
  - staff hold multidisciplinary ACCT reviews which involve staff who contribute to a prisoner's care;
  - case managers complete ACCT caremap actions and chart the progress of each action and when it is completed; and
  - all staff undertake ACCT observations as directed, actively engage with prisoners being monitored and promptly record their contact.
- The Director should ensure that staff report and record all instances of drug debt, including submitting information to the security team, and take action, where appropriate.
- The Director should ensure that the key drug issues at Parc are identified and that the prison's local drugs strategy is revised by September 2019 to address these issues.
- The Director should ensure that all staff carry an anti-ligature knife at all times when on duty.
- The Director and the Head of Healthcare should ensure that prisoners' mobility needs are assessed promptly, risks identified and a plan formalised to address any needs.

- The Head of Healthcare should ensure that healthcare staff provide a clear and accurate record of reasons for a prisoner's non-attendance at healthcare appointments in their medical records, and that non-attendance is followed up.
- The Head of Healthcare should ensure that when primary healthcare staff attend a PS incident, they promptly notify the SMOS team.
- The Head of Healthcare should ensure that healthcare staff record their interactions with prisoners identified as having a substance misuse problem on the SystmOne medical record, even when prisoners decline clinical intervention.
- The Director should ensure that when a prisoner dies in custody, a trained deputy family liaison officer is promptly appointed to provide continuity of contact and support in the absence of the family liaison officer.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Ware's prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Ware's clinical care at the prison.

16. The investigator interviewed 9 members of staff at Parc, jointly with the clinical reviewer.

17. We informed HM Coroner for Cardiff, Bridgend and Glamorgan Valleys of the investigation. He gave us the results of the toxicology result but the post-mortem examination was not available. We have sent the Coroner a copy of this report.

18. We contacted Mr Ware's mother to explain the investigation. She raised a number of concerns, including that her son had had back pain. She was aware that he had accumulated large debts in prison to obtain drugs which he said helped with his back pain. She said that she had regularly received telephone calls from Mr Ware and other prisoners during his last two months in Parc, asking her to pay his drug debts. Mr Ware's mother said that she had told him several times to ask prison staff for help because he had threatened to end his life on more than one occasion. She wanted to know what medication Mr Ware was prescribed at Parc. She was also disappointed that the prison had not responded in a timely manner to correspondence from her about returning her son's property. We have addressed Mr Ware's mother's concerns in this report and by separate correspondence.

19. Mr Ware's mother received a copy of the draft report. She pointed out some factual inaccuracies. This report has been amended accordingly. Mr Ware's mother also raised a number of issues/questions that do not impact on the factual accuracy of this report.

Background Information

HMP Parc

20. HMP Parc is a medium security prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under the age of 18.

21. G4S Medical Services provide primary physical and mental health care services. There is 24-hour general healthcare and palliative care facilities. A local GP practice provides GP services, including a daily clinic and out-of-hours cover. Three healthcare staff are located in the prison at night.

HM Inspectorate of Prisons

22. The most recent inspection of Parc was in January 2016. Inspectors found that more needed to be done to address not only actual levels of violence, but the sense among prisoners that they were in an unsafe prison. They said that that the seemingly ready availability of psychoactive substances (PS) such as Spice (a synthetic drug that mimics the effects of cannabis), was having a severely negative influence on the safety and stability of the prison.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 28 February 2018, the IMB reported that the introduction of paramedics had increased the efficiency of the healthcare department and freed up the availability of GP appointments. They were concerned that the level of violent incidents and substance misuse at Parc remained high. In common with other prisons, they noted that the level of drugs, particularly PS, entering the prison presented a continual and intractable challenge.

Previous deaths at HMP Parc

24. Mr Ware was the tenth prisoner to die at HMP Parc since November 2016, and the first prisoner to have taken his life in this period. Since Mr Ware's death, two prisoners have died from natural causes. After the death of a prisoner in 2016, Parc agreed to implement our recommendations about improving the operation of ACCT procedures and how staff respond to PS use. We have also made a previous recommendation about how the prison should respond to emergencies, and Parc agreed to implement it.

Assessment, Care in Custody and Teamwork

25. 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.

26. 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 multidisciplinary reviews, involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the caremap actions 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.

Psychoactive Substances (PS)

27. 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.

28. 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.

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

Key Events

30. On 9 November 2014, Mr Matthew Ware was arrested and charged with the offence of wounding with intent and common assault. He was remanded to HMP Hewell and was later transferred to HMP Cardiff.

31. Mr Ware had a history of chronic back pain, sciatica (pain affecting the sciatic nerve which extends from the lower back down the back of each leg) and substance misuse. He had been diagnosed with a personality disorder and had taken several overdoses. He was prescribed antipsychotics and medications for his back pain.

32. On 31 July 2015, Mr Ware was sentenced to nine years in prison.

33. Mr Ware was transferred to HMP Bristol on 8 May 2018. On 1 June, healthcare staff reviewed his ongoing back pain and referred him for physiotherapy. They agreed to consider referring him to a spinal unit if his pain did not improve.

HMP Parc

34. On 4 June, Mr Ware was transferred to HMP Parc, and staff noted at reception that he was at the highest level of the Incentives and Earned Privileges (IEP) scheme: enhanced. (The IEP scheme is a prison management tool designed to promote responsible behaviour through rewards.)

35. A nurse completed Mr Ware's reception health screen. She noted that he had no thoughts of suicide or self-harm and no mental health concerns, but was prescribed a number of medications: diclofenac (to reduce inflammation and pain), levothyroxine (to control an underactive thyroid gland), gabapentin (to treat nerve and neuropathic pain), omeprazole (for gastroesophageal reflux) and quetiapine (an antipsychotic). Mr Ware asked to see a prison GP about his back pain.

36. A prison GP then reviewed the nurse's notes on SystmOne, the prison's electronic medical record, and noted that Mr Ware did not always collect his medication and had also diverted and concealed medication at previous prisons. She prescribed short doses of his medication (gabapentin, levothyroxine, omeprazole and quetiapine) until an appointment was made to review them in full.

37. Mr Ware was sent to the induction wing. During his substance misuse induction, Mr Ware told staff that he had used heroin and crack cocaine but not since 2014.

38. On 6 June, Mr Ware moved to a standard residential wing.

39. On 14 June, a prison GP saw Mr Ware. He noted that Mr Ware had been prescribed duloxetine (for his sciatica) at Bristol but he had not yet started taking it. He instead prescribed naproxen (an anti-inflammatory drug used to treat pain) and co-codamol (for pain relief) and noted that he would review how Mr Ware responded and that Mr Ware was not to keep and administer his medication himself. Mr Ware told the doctor that he was not always able to work because of his back pain.

40. An offender supervisor met Mr Ware on 20 June. Mr Ware told him that he was happy at Parc but did not intend to comply with his sentence plan as he was not guilty of the offences for which he was convicted.

41. On 22 June, Mr Ware did not attend his healthcare appointment. There is no evidence to explain why not.

42. On 23 June, security intelligence reports noted that there had been a few occasions when staff had noticed a strong smell of smoke coming from Mr Ware's cell. It was agreed that staff would monitor Mr Ware and arrange for him to complete a mandatory drug test (MDT).

43. On 25 June, prison pharmacist noted in Mr Ware's medical records that healthcare staff had asked her to re-prescribe Mr Ware's medication for sciatica as he continued to have significant pain. She noted that she referred Mr Ware to, a prison physiotherapist, for an assessment.

44. On 28 June, Mr Ware did not attend a GP appointment. There is no evidence to explain why not. On 5 July, Mr Ware did not attend a healthcare appointment. Records again do not give a reason.

45. A prison GP saw Mr Ware on 9 July. Mr Ware complained that the co-codamol and naproxen had not reduced his sciatica. He said that he had taken pregabalin in the past which had helped. However, the prison GP said that she would instead increase his gabapentin dose. The next day, an offender supervisor examined Mr Ware and agreed that he should undertake rehabilitation exercises in the gym to reduce his back pain.

46. On 16 July, an offender supervisor noted that Mr Ware had apparently disclosed to a member of the chaplaincy team that he illicitly used subutex (an opioid) to manage his sciatica and as a result, he had accumulated debts to other prisoners. The unit manager spoke to Mr Ware about managing his debt. A security information report was submitted which noted that consideration would be given to relocating Mr Ware to another wing.

47. On 18 July, prison records noted that Mr Ware had failed a MDT (taken on 12 July) for synthetic cannabinoids (PS), subutex and opiates. Mr Ware was removed from his workplace and given a warning.

48. On 19 July, a prison GP reviewed Mr Ware's medication because of the known risks of taking prescribed medication and illicit drugs. It was recorded in Mr Ware's medical records that he had failed to attend a number of healthcare appointments. She discussed Mr Ware with a prison GP who stopped Mr Ware's co-codamol prescription immediately. They decided to reduce his gabapentin and quetiapine doses gradually, with a view to stopping them by 28 July. It was agreed that Mr Ware would continue to be prescribed naproxen.

49. On 20 July, while escorting Mr Ware to a discipline hearing (which was adjourned), staff found that he had a homemade weapon. Mr Ware said that he had accumulated debts to two prisoners of between £450-£500 for drugs (subutex and PS), and would have used the weapon against them.

50. The security team completed an investigation and took action against the two named prisoners. Mr Ware was relocated to another unit. He told them that he had pressured his mother to pay his debts but was unable to resolve his issues with prisoners in his former unit. He admitted that he would continue using PS on his new wing, and that it was inevitable that he would accumulate more debt. Staff offered him advice about debt management and substance misuse. Mr Ware was given a warning for carrying a weapon and was referred to his offender supervisor to arrange substance misuse support.

51. On 21 July, a mental health nurse saw Mr Ware after he asked to see the healthcare team. He told her that he had negative thoughts which he believed resulted from his medication being stopped suddenly. He asked for his medication to be reinstated. She told him to make an appointment to see a prison GP about this. Mr Ware said that he had no thoughts of suicide or self-harm.

52. On 23 July, staff submitted an intelligence report which noted that Mr Ware had reported difficulties with his mental wellbeing (paranoid delusions) and that he was violent when he used PS. A manager saw Mr Ware about his concerns. She advised him of the risks to his health if he used PS. The nurse discussed Mr Ware with wing staff and booked a mental health appointment for him.

53. The offender supervisor contacted the Substance Misuse Offender Supervisor (SMOS) team about Mr Ware. He noted that Mr Ware had continued to misuse drugs in prison despite the risks and asked if they would support him.

54. That evening, healthcare staff recorded that Mr Ware had been caught trying to conceal his medication underneath his tongue. A security intelligence report was submitted and a prison GP was alerted.

55. On 24 July, a prison GP reviewed Mr Ware's medical record. She noted that she did not need to change his medication because he was already on reducing doses of gabapentin and quetiapine which would soon end.

56. That day, the SMOS team manager told the offender supervisor that Mr Ware would be allocated a substance misuse offender supervisor. On 27 July, prison records noted that the substance misuse offender supervisor was assigned as Mr Ware's SMOS. (Despite this, the investigator found no evidence that Mr Ware received support from the SMOS team before he died.)

57. At a disciplinary hearing on 28 July, Mr Ware was found guilty of having an improvised weapon and failing a MDT, and his canteen, private cash spend and television were taken from him until 10 August. On 30 July, staff reduced Mr Ware's IEP level from enhanced to basic because of his recent poor behaviour.

58. On 3 August and 5 August, Mr Ware failed to attend the treatment hatch to collect his medication. No reason was recorded.

59. On 9 August, a nurse reviewed Mr Ware's mental health. Mr Ware said that he felt violent and aggressive and was struggling to cope with his sentence. He felt that his anger management had worsened since his quetiapine was stopped. A Threshold Assessment Grid assessment (TAG, a brief assessment of the severity of an individual's mental health problems) scored Mr Ware as having

moderate mental health needs. He was offered group interventions for anxiety but he said that he posed a risk of harm to others. Mr Ware was advised to apply for a medication review but he said he did not want to attend the healthcare unit as he might encounter other prisoners. The nurse concluded that he had no immediate mental health concerns but he had substance misuse and anger management issues. Mr Ware was unwilling to address these issues, which meant that it was not likely that his antipsychotics would be reinstated. The nurse told Mr Ware to apply for assistance with his primary mental health needs if he changed his mind.

60. On 11 August, a prison custody officer (PCO) noted in Mr Ware's prison records that his behaviour had been positive. On 13 August, staff reviewed Mr Ware's IEP and reverted it standard level.

61. Healthcare staff recorded on 14 August that Mr Ware had submitted a complaint that he could not attend healthcare appointments because he was scared that other prisoners assault him because of his issues with them. Healthcare staff noted that they had emailed, an operational manager about this, and asked if staff could support Mr Ware when attending the healthcare unit.

62. On 15, 17, 19 and 21 August, Mr Ware did not attend the treatment hatch to collect his medication. No reason was recorded.

63. On 21 August, Mr Ware attended his appointment with a prison GP escorted by a prison officer. The prison GP noted that Mr Ware had failed to attend a number of healthcare appointments for hepatitis treatment (on 26 July, 7 and 13 August) because he said that he was worried about being attacked by other prisoners. He said that his problems started when his quetiapine and gabapentin were stopped. The prison GP noted that Mr Ware had not been diagnosed with a serious mental illness although he had been prescribed antipsychotics for his personality disorder. She said that his medication would not be re-prescribed due to the risks while using PS. Mr Ware said that he had had back pain and sciatica for four months and without the gabapentin medication, he might "lash out" at others due to his pain. She told Mr Ware that he would have to stop using PS and provide negative MDTs. She prescribed naproxen and paracetamol for pain relief and noted that Mr Ware was on the pain clinic's waiting list.

64. On 26, 28 and 30 August, Mr Ware failed to attend the treatment hatch to collect his medication. No reason was recorded.

1 September

65. A nurse recorded that when Mr Ware attended the treatment hatch, he appeared frustrated. Mr Ware said that he had constant pain in his legs and no one was listening to him. He feared that he would have to take drastic action to get help. She told Mr Ware that she would ask a nurse to review him as soon as possible.

66. That night, a mental health nurse spoke to Mr Ware who believed that his pain was caused by a trapped nerve. The nurse gave Mr Ware some paracetamol and added his name to the healthcare clinic for the next day.

67. The mental health nurse examined Mr Ware in the healthcare clinic on 2 September. Mr Ware said that he had pins and needles in his right leg which

had worsened over the last week. He said that he was in “agony”. She made an appointment for him to see a prison GP on 5 September.

68. A PCO told the investigator that Mr Ware lived on the third landing. He said that staff had offered to relocate Mr Ware to a ground floor cell because of his mobility problems but he refused. Mr Ware had said that Parc should have referred him to hospital.

69. On 4 September, Mr Ware failed to attend the treatment hatch to collect his medication. No reason was recorded. On 5 September, a prison GP noted that Mr Ware did not attend his GP appointment. Mr Ware had apparently told wing staff that he was unable to get out of bed or walk because of his back and sciatica pain. The prison GP noted that an MRI scan would be completed if Mr Ware’s problems did not improve. He prescribed co-codamol.

70. On 6 September, wing staff telephoned the healthcare team to tell them that Mr Ware had not collected his medication because he was unable to walk due to his sciatica. They asked if a member of the healthcare team could bring Mr Ware’s medication to him. (There is no evidence to indicate whether this was done.)

71. On 10 September, Mr Ware again did not attend a healthcare appointment. It was noted that he refused to attend. On 11 September, healthcare staff recorded that Mr Ware had cancelled his appointment and refused to attend. On 16 September, Mr Ware failed to collect his medication. His records do not explain why not.

72. On 21 September, healthcare staff recorded that Mr Ware did not attend his GP appointment because of his ongoing back issues as he was unable to get out of bed. On 25 September, a prison physiotherapist assessed Mr Ware and gave him stretching and low intensity cardiovascular exercises to complete in his cell as Mr Ware refused to go to the gym.

73. Mr Ware failed to attend a GP appointment on 28 September and 17 October. His records do not explain why not.

74. On 13 October, a PCO recorded in Mr Ware’s prison records that she introduced herself to him as his personal officer. Mr Ware said that he had had a few issues but that these had been resolved. He said that he felt much happier and would tell staff if he had concerns.

75. On 24 October, Mr Ware submitted an application to see a prison GP. He said that he had been in “extreme pain for months as he can’t [sic] get to a GP appointment”. Healthcare staff told Mr Ware that the prison GP did not see prisoners on the wing and that if he had mobility issues, staff could provide a wheelchair to escort him to the healthcare unit.

76. On 26 October, Mr Ware failed to attend the treatment hatch to collect his medication and on 28 October, he failed to attend a GP appointment. No reasons were recorded.

77. At 2.05am on 29 October, Mr Ware complained that he had a headache caused by his back pain. The nurse gave him paracetamol and ibuprofen and he was added to the healthcare list to be seen by the prison paramedic. The prison

paramedic saw Mr Ware during the day, and gave him paracetamol and ibuprofen for his sciatica and advised him to stay mobile.

78. In his police statement, a PCO recalled that at the beginning of November, Mr Ware had passed a note to him during the morning checks asking to be moved to a different wing because he was in debt to prisoners and was scared of being attacked. A PCO told the investigator that Mr Ware refused to provide details about his debts. That day, Mr Ware told a PCO that he was happy on the wing and did not want to be moved. Mr Ware told a PCO that his mother had settled his debts. (Although there were many references in Mr Ware's security file about debts that he had accumulated in prison, there is no evidence that staff completed a security intelligence report about this incident, and it was not noted in his prison records.)

79. On 2 November and 4 November, Mr Ware failed to attend the treatment hatch to collect his medication. No reason was recorded.

80. On 5 November, a PCO noted that Mr Ware was doing well on the wing. He was given a job as a therapeutic cleaner, which he said that he enjoyed, despite his ongoing back pain.

81. On 6 November, a PCO found Mr Ware under the influence of PS and called a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties). A prison paramedic attended Mr Ware's cell. Mr Ware's speech was slurred and he was unsteady on his feet. The paramedic opened a PS log to monitor Mr Ware. (A PS log monitors a prisoner over a four-hour period, or longer, as healthcare staff direct.) Staff reduced Mr Ware's IEP level to basic as a result of his poor behaviour. A member of staff from the mental health reviewed Mr Ware's medication and stopped his prescription of co-codamol because of the health risks of mixing this with PS use.

82. At 10.30am on 7 November, a PCO started suicide and self-harm prevention procedures, known as ACCT after Mr Ware made cuts to his forearm with a razor blade. Mr Ware handed the blade to staff. Staff initially monitored Mr Ware twice an hour and staff were required to have two conversations with him during the day and one at night. Mr Ware said that he harmed himself because of his ongoing back pain and because he did not have a television while he was on basic IEP level. He said that he intended to start a hunger strike. When a nurse attended the unit to treat his wound, Mr Ware refused treatment. Staff opened a food refusal log to keep track of Mr Ware's daily food intake.

83. That evening, a nurse recorded that when Mr Ware attended the treatment hatch, he told her that he had refused food because staff had taken his television. He was also upset that his co-codamol had been stopped.

84. A PCO told the investigator that he had many conversations with Mr Ware about his substance misuse. Mr Ware told him that he did not intend to stop smoking PS because he believed that it helped reduce his back pain and worked far better that any pain relief that the prison could offer.

85. On the morning of 8 November, a nurse noted that when Mr Ware attended the treatment hatch, he had a razor blade in his mouth. (His records do not refer

again to the razor blade.) He said that he wanted to see a prison GP about his back pain. A nurse asked the in-house paramedic to review Mr Ware. When he examined him, he noted that Mr Ware had not completed his physiotherapy exercises. Mr Ware said that he would slit his own throat when he next saw the pharmacist. This information was passed to the healthcare and unit staff and the security and safer custody teams.

86. Shortly afterwards, an operational manager completed Mr Ware's ACCT assessment. Mr Ware said that he had constant back pain, was at the end of his "rope" and was self-medicating to reduce his pain. The operational manager noted that Mr Ware wanted to see a prison GP, and that an appointment would be booked. He also noted that staff should allow Mr Ware to have extra time out of his cell for exercise to ease his pain.

87. An operational manager then chaired Mr Ware's first ACCT case review. A nurse attended. They confirmed that a wheelchair would be made available to escort Mr Ware to his GP appointment. Mr Ware understood that if he continued to self-medicate with illicit substances he would remain on basic IEP level but said that he would find it difficult. Although there is no evidence that staff considered whether to provide Mr Ware with a television, the panel agreed to let him out of his cell for short, additional periods during the day to improve his mobility. Mr Ware was happy with this gesture. He said that he had no current thoughts of suicide or self-harm but sometimes did when his mood was low. The panel did not change Mr Ware's ACCT observations and noted his risk level of suicide and self-harm as low.

88. The review panel did not record a date for Mr Ware's next ACCT review. His caremap noted that Mr Ware should book a GP appointment, that staff should allow him time out of his cell to walk and that he should adhere to the basic regime.

89. That afternoon, a PCO noted in the ACCT record that Mr Ware again refused to see the nurse to treat his cuts and refused to eat.

9– 21 November

90. On 9 November, a PCO recorded in the ACCT record that Mr Ware had told him that it was his third day of food refusal, and although he wanted to die, he did not have the "guts" to cut his own throat so a hunger strike was the alternative. Despite this, Mr Ware attended his job as a therapeutic cleaner.

91. Mr Ware submitted an application to see a healthcare professional. He said that he was in severe pain, caused by a spinal problem. Healthcare staff noted that a GP appointment was made and that Mr Ware had been on the pain management clinic's waiting list since August 2018.

92. Mr Ware telephoned his mother at 12.54pm, and told her that it was the third day of his hunger strike. They talked about his debts to other prisoners. His mother said that she had paid all his debts and told the prisoner who called her not to extend Mr Ware's credit. Mr Ware said that other prisoners were laughing at him because of his debt and he was unable to retaliate because he was in constant

pain. He said that he could not complete his sentence, and was telling his mother in case something happened to him.

93. That evening, a PCO noted in the ACCT record that although Mr Ware's food was brought to his cell, he refused it. However, shortly afterwards, Mr Ware asked for some food, and staff brought him a tray of chips which they saw him eat.

94. When staff unlocked Mr Ware's cell at 8.30am on 11 November, he declined to have his breakfast. A nurse spoke to him about his refusal of food and water and suggested that he should discuss his issues at his next GP appointment, scheduled for 13 November.

95. A prison paramedic later examined Mr Ware and noted that his health observations were in the normal range. Mr Ware said that he was still in a lot of pain because of his back. He noted that Mr Ware needed a wheelchair to attend the healthcare unit.

96. On the morning of 12 November, a prison paramedic examined Mr Ware as part of his food refusal observations. He noted no concerns and Mr Ware's health observations remained in the normal range. Staff recorded in Mr Ware's ACCT record that he again ate his evening meal at 5.25pm. This meant that Mr Ware had eaten food on the third and sixth day of his hunger strike.

97. On 13 November, Mr Ware did not attend his GP appointment or collect his medication. His records do not explain why not, although a PCO recalled that Mr Ware missed his GP appointment because no staff were available to collect him with a wheelchair from the wing. Mr Ware later refused his lunchtime meal but shortly afterwards, staff gave him food at his request.

98. At 3.13pm, Mr Ware made a brief telephone call to his mother. He asked her why she had not sent him any money that week. She told him that she had not been well but had sent him money that morning. Mr Ware told her that it was his seventh day of his hunger strike although he had eaten the previous night and was seeing the doctor later that day. Mr Ware pleaded with his mother to buy him vapes but she refused.

99. On the morning of 14 November, Mr Ware failed to attend the treatment hatch to collect his medication. His records do not explain why. In the evening, Mr Ware told staff that he was hungry and he asked for some food. Staff raised no concerns about Mr Ware the next day.

100. On 16 November, Mr Ware left his cell to do his job as a therapeutic cleaner. At 11.15am, an operational manager chaired an ACCT review, assisted by a nurse. Mr Ware said that his mood was low because he was in constant pain. He wanted to see a prison GP to review his medication. The panel told Mr Ware that a healthcare runner (a prison officer who escorts prisoners to and from healthcare appointments) would be told that Mr Ware needed to be escorted to the healthcare unit in a wheelchair. Mr Ware said that the time he was allowed out of his cell had helped his back pain. The review panel made no changes to Mr Ware's ACCT observations and scheduled his next review for 22 November.

101. Staff recorded that Mr Ware ate his lunch. At 1.51pm, Mr Ware phoned his mother. He told her that he had a cut next to his left eye and needed seven stitches. (There is no record of such an injury in Mr Ware's prison or medical records.) His mother said that she was fed up with him always ringing her with problems. Mr Ware told his mother not to respond to texts that she had received from other prisoners.

102. Shortly after speaking to his mother, Mr Ware told a PCO that he was in a bad way and needed to leave the unit as soon as possible. No further information was recorded about this conversation.

103. On 17 and 18 November, Mr Ware continued to complain that he suffered from back pain. He also failed to collect his medication. His records do not explain why.

104. On 19 November, a nurse from the mental health team saw Mr Ware at the treatment hatch. She noted that he was not steady when he walked and appeared in pain. Mr Ware told her that this was due to his back problem. He was slightly tearful and described the pain as "unbearable". He explained that that his co-codamol had been stopped because he had taken illicit substances to ease the pain. He felt like he was in a "vicious circle" and said that taking illicit substances had helped him sleep better. The nurse noted that a GP appointment had been booked for Mr Ware.

105. On 21 November, Mr Ware went to work, collected his medication and ate food. Mr Ware phoned his mother at 2.10pm. She told him that she was not feeling well. She asked Mr Ware what he wanted and said that she had paid money into his prison account that morning. She said that she was exasperated with him because she continued to receive numerous texts, day and night, from prisoners asking for money to clear his debts. Mr Ware responded angrily and said that he knew the culprit and intended to "smash his head in". He said that he had had enough of Parc and would end up "down the block" (a term used by prisoners for the segregation unit). Mr Ware's mother said that she was fed up with him and told him not to call her anymore. Mr Ware asked his mother for £20. She refused and their call ended.

22 November

106. Staff completed ACCT checks on Mr Ware at 5.20am, 5.50am (when he asked for and was given a toilet roll) and 6.13am (when he was seen watching television) and raised no concerns.

107. CCTV footage shows that a PCO checked Mr Ware at 6.44am (as recorded in the ACCT record) and at 7.01am, a PCO completed a simultaneous roll check and ACCT check, recording no concerns. He did not record this in Mr Ware's ACCT record. A PCO recalled that when he checked on him, Mr Ware was standing up in his cell, with the light on. He said that this was normal for Ware who usually woke early because of his back pain.

108. At 7.20am, Mr Ware phoned his mother. Their conversation was brief, and Mr Ware apologised for what he had done in his life. He told his mother that he intended to hang himself and the call ended shortly afterwards. (After his death,

Mr Ware's mother told Parc that Mr Ware had had such conversations with her before.)

109. A PCO started duty at around 7.30am. At approximately 7.40am, he started the daily task of issuing milk bottles to prisoners. CCTV footage shows that the PCO arrived at Mr Ware's cell at 7.44am, unlocked and opened his cell door. Mr Ware was sitting on his bed, facing the wall under the window. The PCO thought that this was an unusual position for Mr Ware and he noted that the cell light was turned off (although it would usually be on at that time). The PCO said that he went into the cell while calling Mr Ware's name. Mr Ware did not respond or move. As the PCO got closer, he saw a piece of torn bedding from the back of Mr Ware's head which led to the window above. When he touched Mr Ware, he fell to one side. He said that he quickly supported Mr Ware's body and lifted him to take the weight off the ligature. While doing this, the PCO shouted for help from other staff.

Emergency response

110. CCTV footage shows three PCOs arrived at Mr Ware's cell within 18 seconds of responding to the PCO's shout. The PCO did not have his anti-ligature knife with him (and neither did the other responding officers). The PCO shouted to another PCO to get one from the office downstairs. A PCO immediately pressed his personal alarm button on his radio and ran to collect the anti-ligature knife. A PCO used his radio and called a code blue emergency alarm recorded on body-worn camera footage as occurring at 7.46am. Two PCOs assisted the PCO to support Mr Ware's body and tried to remove the ligature.

111. A PCO returned within ten seconds and gave the PCO the cut down tool, and he cut the ligature. The PCOs then laid Mr Ware on the floor and the PCO checked him for signs of life, but found none. While doing this, he heard a bleeping noise which was coming from the in-cell phone which was off the hook. A PCO immediately started cardiopulmonary resuscitation (CPR). Two PCOs assisted.

112. A nurse arrived at Mr Ware's cell at 7.47am with the medical emergency bag which included oxygen and airways. She asked the officers to continue CPR while she assessed Mr Ware for signs of life but found none. She noted that Mr Ware was grey and a deep ligature mark could be seen on his neck. Three nurses arrived at 7.50am and assisted with CPR until paramedics arrived.

113. The paramedics arrived at Mr Ware's cell at 7.59am but pronounced at 8.22am that he had died.

114. Staff found a letter written by Mr Ware in his cell. Mr Ware said that he had received unfair treatment on a daily basis which amounted to torture. He said that he was in daily physical pain to the point that suicide became a viable option. He said that he was completely exhausted and had begged for help but did not receive it, despite threatening to harm himself.

Contact with Mr Ware’s family

115. The Director and a PCO, who was appointed as the family liaison officer (FLO), visited Mr Ware’s mother at 12.45pm. They broke the news to her and offered support. Parc contributed to the cost of Mr Ware’s funeral in line with national instructions.

Support for prisoners and staff

116. On the same day, the Head of House blocks and a senior operational manager, debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The prison posted notices informing other prisoners of Mr Ware’s death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Ware’s death.

Information after Mr Ware’s death

117. After Mr Ware’s death, the security team listened to his telephone call to his mother on 5 October, in which he asked her to pay £150 into a bank account to settle his debts. The security team started an investigation to find out which prisoner(s) this was linked to.

118. On 23 November, a healthcare administrator noted the receipt of a message dated 21 November and timed at 4.57pm. The message was from the healthcare champion on Mr Ware’s wing. (A healthcare champion is a prisoner whose job is to support the healthcare team.) The healthcare champion said that the healthcare runner (an officer) should have collected Mr Ware on 21 November. The healthcare runner had said that he would return with a wheelchair but never did. The healthcare champion said that he would tell Mr Ware to book another appointment and asked the healthcare administrator if a wheelchair would be available.

Post-mortem report

119. At the time of issuing this initial report, the post-mortem report was still not available. However, the toxicology test results confirmed the presence of PS in Mr Ware’s system when he died.

Findings

ACCT management

120. Prison Service Instruction (PSI) 64/2011 on safer custody sets out the processes that should be followed when a prisoner is at risk of suicide and self-harm. Mr Ware had a number of risk factors, including a history of self-harm, substance misuse, depression, anxiety and anger issues. He also had chronic back pain, for which he was prescribed pain relief and antidepressants which were withdrawn because they would have been dangerous in combination with his PS use. He was in debt because of his PS use and feared for his safety.

121. After Mr Ware cut himself with a razor blade, he was monitored under ACCT procedures for two weeks from 7 November 2018 until his death. The underlying reason he cited for his self-harm and PS use was his ongoing back pain.

122. There were a number of deficiencies in the way that operated ACCT procedures. PSI 64/2011 states that the ACCT assessor and case manager should be different individuals. An operational manager completed Mr Ware's ACCT assessment and chaired his first case review as the ACCT case manager. The Safer Custody Team suggested that the operational manager acted as both the assessor and case manager because of staff shortages.

123. The PSI requires that ACCT caremaps reflect a prisoner's needs, level of risk and the triggers of their distress. They should aim to address issues identified in the ACCT assessment interview. They must be tailored to meet prisoners' individual needs and reduce risk. They must be time-bound and say who is responsible for completing the action.

124. After the first ACCT case review, the operational manager added a caremap action for Mr Ware to book an appointment with the prison GP, for staff to allow Mr Ware time out of his cell and that he should comply with the basic regime. While Mr Ware's prison and medical records indicate that these issues were ongoing, staff failed to note what progress had been made and whether they had been completed. If this had been done, staff might have become aware that Mr Ware failed to attend a GP appointment on 13 November and had not collected his medication on at least two occasions. We do not know if this was because Mr Ware's pain affected his mobility or because he feared for his safety because of his drug debts. Either way, these were important pieces of information that staff should have followed up to reduce his risk, particularly as Mr Ware's main stated issue was his back pain.

125. Mr Ware was known to be using PS and to be in debt but these issues were not considered or referred to in the caremap. His PS use meant that his prescription pain killers had been withheld because of the risk of taking them in combination. These were important risk factors for Mr Ware, even though he may have been reluctant to acknowledge them to staff, and we consider that they should have been taken into account in the ACCT. If they had been, staff might have had a better understanding of the risk Mr Ware posed to himself.

126. In line with PSI 64/2011, staff should record ACCT observations and conversations immediately or as soon as possible afterwards. Although CCTV

footage shows that a PCO checked on Mr Ware at 7.01am on the morning of Mr Ware's death, he did not speak to him and did not record his observation in Mr Ware's ACCT record.

127. Mr Ware was found hanged about 40 minutes later. Staff did not know that he had just told his mother that he was going to hang himself and we accept that they had no reason to believe he was at imminent risk of taking his life that morning.

128. We make the following recommendations:

The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that:

- **staff have a clear understanding of their responsibilities and roles when assessing a prisoner's risk;**
- **staff hold multidisciplinary ACCT reviews which involve staff who contribute to a prisoner's care;**
- **case managers complete ACCT caremap actions and chart the progress of each action and when it is completed; and**
- **all staff undertake ACCT observations as directed, actively engage with prisoners being monitored and promptly record their contact.**

Mr Ware's debt problems

129. PSI 64/2011 requires that all verbal and physical acts of violence must be challenged, appropriate sanctions for perpetrators applied robustly, fairly and consistently, and victims supported and protected. Being a victim of intimidation or violence is a recognised risk factor for suicide and self-harm. Parc has a policy and guidance in place for staff and prisoners on dealing with debts in prison, supported by drugs and violence reduction strategies.

130. Mr Ware reported three times (on 16 and 20 July and at the beginning of November 2018) that he feared for his safety due to his drug debts. Following their investigation in July, the prison's security team moved Mr Ware to a different wing and offered him advice on debt management. The investigation however did not find any evidence that staff recorded information on his prison records or submitted an intelligence report after Mr Ware disclosed his debt problem in November. By not recording and sharing information related to drug debt, staff were unable to comprehensively assess the degree that Mr Ware's problems may have affected his safety and risk of self-harm at the time. We make the following recommendation:

The Director should ensure that staff report and record all instances of drug debt, including submitting information to the security team, and take action, where appropriate.

Drug strategy at HMP Parc

131. The prison has a local drugs strategy policy, issued in 2017, which sets out a number of actions to reduce the demand and supply of illicit drugs. It is a concern

that, despite measures currently in place, Mr Ware was able to obtain drugs regularly and suggests that much more needs to be done to tackle the issue of drugs at Parc.

132. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works. We welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

133. In relation to reducing the supply of drugs, the new Prison Service strategy says:

"Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

134. We were told that Parc is now revising its drugs strategy and we recommend that:

The Director should ensure that the key drug issues at Parc are identified and that the prison's local drugs strategy is revised by September 2019 to address these issues.

Substance misuse

135. Mr Ware had a history of substance misuse and despite support and intervention, this did not change when he arrived at Parc. While Mr Ware was fully aware of the risks of PS to his physical and mental health, he continued to use it. Indeed, Mr Ware told staff that he would not stop taking illicit substances because he considered they helped with his back pain better than his prescribed medication. The post-mortem toxicology test results showed that he had taken PS at some time before his death and it is possible that this affected his mood and played a part in his decision to end his life.

136. Although we acknowledge that Mr Ware was unlikely to have stopped using PS, we note that on 27 July, he was allocated a substance misuse offender supervisor (SMOS), whose role included offering substance misuse support. Despite Mr Ware's substance misuse problems, drug debts, back pain and risk of suicide and self-harm, no one from the SMOS team saw him before he died, four months later. There is no evidence that the SMOS team was aware of the nature and extent of Mr Ware's continued substance misuse (including a code blue being called on 6 November after he was found under the influence of PS) and suicide and self-harm risk. This is unacceptable, and we make the following recommendations:

The Head of Healthcare should ensure that when primary healthcare staff attend a PS incident, they promptly notify the SMOS team.

The Head of Healthcare should ensure that healthcare staff record their interactions with prisoners identified as having a substance misuse problem on the SystmOne medical record, even when prisoners decline clinical intervention.

Anti-ligature knives

137. When Mr Ware was found hanged, staff responded promptly. PSI 64/2011 states that all uniformed staff on duty must be given and carry an anti-ligature knife. Despite anti-ligature knives being available in the wing office for staff to collect at the beginning of their duty, none of the first officers who responded to a PCO's shout for help staff had done so. We recognise that a PCO obtained an anti-ligature knife within ten seconds, but in other circumstances, this might have caused a longer delay in cutting a ligature. We make the following recommendation.

The Director should ensure that all staff carry an anti-ligature knife at all times when on duty.

Clinical care

138. The clinical reviewer concluded that, overall the care that Mr Ware received at Parc was equivalent to that which he could have expected to receive in the community. Mr Ware was able to access healthcare services, his health needs were assessed appropriately and effectively communicated between healthcare and prison staff.

139. The clinical reviewer concluded that Mr Ware was appropriately assessed and referred in relation to his mental health needs and was given advice about relevant interventions.

140. During his reception screening and throughout Mr Ware's stay at Parc, prison and healthcare staff recorded that he had a history of ongoing back pain and sciatica. The clinical reviewer concluded that overall, healthcare staff managed Mr Ware's pain appropriately and assessed his symptoms. Healthcare staff also appropriately assessed and balanced the need for prescribing pain relief to Mr Ware against the risks of mixing prescribed medication with illicit substances, which he refused to stop taking. Once his gabapentin was discontinued, Mr Ware continued to be prescribed a combination of naproxen and co-codamol, the latter of which was appropriately stopped when his use of PS was known. Mr Ware was offered regular and ad-hoc analgesia but there was evidence that he was not always compliant in taking his prescribed pain relief medication and missed a number of healthcare and GP appointments.

141. Mr Ware said that his pain reduced his mobility. On at least three occasions (5 and 21 September and 21 November), Mr Ware was unable to attend appointments due to his back pain. There is also evidence that Mr Ware failed to attend appointments and/or collect his medication on numerous occasions, and there are no records to explain why not. In the absence of evidence, it is difficult to assess the severity and frequency of his mobility problems and whether they

affected his ability to collect his medication or attend appointments or whether he did not do so because he feared for his safety.

142. Although Parc has a process in place to monitor non-attendance at planned appointments, we are concerned that for the majority of occasions that Mr Ware did not attend appointments, nothing reason was recorded and there is nothing to suggest that any action was taken to address the issue. On 24 October and 11 November, staff noted that a wheelchair would be available to escort Mr Ware to healthcare appointments, yet he still failed to attend appointments. This was in spite of healthcare runners apparently being available to escort prisoners who have difficulty attending appointments.

143. There is no evidence that the healthcare team or physiotherapist created a plan to support Mr Ware's mobility needs. There is no evidence that staff assessed Mr Ware's mobility, including whether he needed mobility aids to get to the treatment hatch or the healthcare unit. We are concerned that despite Mr Ware's known mobility issues, staff did not ensure that a wheelchair was available to escort him to the healthcare unit and there is no evidence that staff considered whether this increased his risk of self-harm or added an action to his ACCT caremap. We make the following recommendations:

The Director and the Head of Healthcare should ensure that prisoners' mobility needs are assessed promptly, risks identified and a plan formalised to address any needs.

The Head of Healthcare should ensure that healthcare staff provide a clear and accurate record of reasons for a prisoner's non-attendance at healthcare appointments in their medical records.

Liaison with Mr Ware's family

144. PSI 64/2011 on safer custody requires prison staff to communicate with the next of kin of prisoners who are seriously or terminally ill and following death. Mr Ware's mother was unhappy about Parc's contact with her about returning her son's property and funds held in his prison account. Despite writing to the prison to raise her concerns, the prison failed to respond or make any efforts to communicate with her from the end of January 2019.

145. In March, the Director of Parc wrote to Mr Ware's mother. She acknowledged and apologised for the prison's lack of contact, which had had happened because the allocated family liaison officer was on sick leave. While we are pleased to note that the Director has now taken responsibility for managing this failing, it is important that prisons have contingency plans in place to cover staff absences and that they maintain contact with the bereaved family. A deputy family liaison officer should have been appointed at the outset to ensure continuity of contact with Mr Ware's family. We make the following recommendation:

The Director should ensure that when a prisoner dies in custody, a trained deputy family liaison officer is promptly appointed to provide continuity of contact and support in the absence of the family liaison officer.

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