Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jonathan Jones, a prisoner at HMP Leicester, on 5 October 2019

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jonathan Jones was found hanged in his cell at HMP Leicester on 5 October 2019. He was 43 years old. I offer my condolences to his family and friends.

Mr Jones had only been at Leicester for five weeks when he died. He was there temporarily to attend a court hearing. I am satisfied that prison staff at Leicester could not reasonably have known that Mr Jones was at risk of suicide. He had no history of suicide or self-harm and gave staff no concerns about his wellbeing during their interactions with him, including in the days before his death.

Mr Jones had used psychoactive substances (PS) before his death. Although this was not found to have caused his death, PS is known to affect mental health adversely. I am concerned that Mr Jones was able to obtain PS with apparent ease at Leicester. The prison needs to continue in its efforts to reduce the supply of and demand for drugs.

There were also deficiencies in the emergency response and in allowing the PPO investigator access to Mr Jones's medical records.

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 **March 2021**

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Summary

Events

1. On 2 June 2015, Mr Jonathan Jones was remanded to HMP Leicester, charged with murder. It was not his first time in prison. He had a lengthy history of substance misuse, including heroin, cocaine, cannabis, psychoactive substances (PS) and alcohol use. On 10 December, Mr Jones received a life sentence. In October 2018, he was transferred to HMP Dovegate.

2. On 29 August 2019, he was escorted from Dovegate to Leicester Magistrates Court, charged with GBH against a fellow prisoner. Mr Jones was remanded to HMP Leicester to appear at Leicester Crown Court on 7 October.

3. When he arrived, staff at Leicester identified that Mr Jones had no significant health concerns, did not have a history of suicide and self-harm and was not prescribed any medication.

4. During his short time at Leicester, staff recorded very few concerns about Mr Jones. He was due to return to Dovegate and therefore told staff that he did not intend to engage with any services at Leicester.

5. At 5.57am on 5 October 2019, an officer found Mr Jones hanged from the window bars in his cell, with a ligature tied around his neck. Staff and paramedics responded promptly but pronounced Mr Jones dead at 6.37am.

Findings

Identifying risk of suicide and self-harm

6. We found no evidence that prison staff could reasonably have known that Mr Jones was at risk of suicide. He had no history of suicide or self-harm and gave staff no concerns about his wellbeing during their interactions with him. We do not therefore consider that they could reasonably have predicted his actions.

Psychoactive substance availability at Leicester

7. We are concerned about the continued availability of PS at Leicester.

Emergency response

8. Staff did not call an ambulance immediately after the medical emergency code was called and this resulted in a short delay. We cannot say whether this affected the outcome for Mr Jones.

Prison and Probation Ombudsman's access to medical records

9. Contrary to Prison Service Instruction 58/2010, the healthcare department failed to provide the PPO investigator with a copy of Mr Jones's relevant medical records, despite repeated requests.

Recommendations

- The Governor should ensure that the key drug issues at Leicester are identified and that the prison's local drugs strategy is appropriately revised to address them.
- The Governor should ensure that all prison staff working in the control room are fully briefed about emergency procedures and call for an ambulance as soon as a medical emergency code is radioed.
- The Head of Healthcare should ensure that the electronic medical records and all relevant hard copy medical records are made available to the PPO investigator as requested, in line with PSI 58/2010.
- The Governor should discuss the requirements of PSI 58/2010 with the Head of Healthcare.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Leicester informing them of the investigation and asking anyone with relevant information to contact him.

11. The investigator visited Leicester on 9 October 2019. He obtained copies of relevant extracts from Mr Jones's prison records. The Head of Healthcare refused to give him a copy of Mr Jones's medical records.

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

13. The investigator and clinical reviewer jointly interviewed five members of staff.

14. We informed HM Coroner for Leicester City and South District of the investigation. She provided us with a copy of Mr Jones's post-mortem report. We have sent the Coroner a copy of this report.

15. We contacted Mr Jones's mother about our investigation, but she did not respond.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). They found four factual inaccuracies in the report and these have been amended accordingly. HMPPS accepted all four recommendations.

Background Information

HMP Leicester

17. HMP Leicester is a local prison that holds 350 men. The prison serves the courts of Leicestershire.

HM Inspectorate of Prisons

18. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Leicester in January 2018. Inspectors found significant improvement across many areas since their last inspection in 2015. Inspectors reported that staff were more visible, confident and friendly and prisoners in crisis reported that they felt supported by staff. HMIP congratulated the Governor and prison staff about the progress achieved since their last inspection.

19. However, inspectors were concerned that PS remained a threat to stability. Although there were good initiatives to address this, efforts to reduce the supply of drugs were not effective enough. Inspectors made a recommendation about drug supply reduction.

20. Inspectors reported that healthcare services had improved, although clinical records did not always contain a mental health care plan or report regular nursing reviews.

Independent Monitoring Board

21. 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 ending January 2019, the IMB reported that the prison had some very challenging prisoners and although self-harm and violence rates had increased, both concerns were well managed. The report noted that prisoners are treated fairly and with respect.

Previous deaths at HMP Leicester

22. Mr Jones was the fourth prisoner to take his life at Leicester since October 2017. There was no similarity between the previous deaths and that of Mr Jones. Since Mr Jones's death, a further prisoner has taken his life and we are currently investigating the death.

Psychoactive substances (PS)

23. PS (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 many 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.

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

25. HM Prison and Probation Service (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

Background

26. Mr Jonathan Jones had served several previous sentences. He had a lengthy history of substance misuse, including heroin, cocaine, cannabis, psychoactive substances (PS) and alcohol.

27. In June 2015, Mr Jones was remanded to HMP Leicester, charged with murder. On 10 December, Mr Jones received a life sentence, with a minimum tariff of 21 years before he could be considered for release.

28. In October 2016, he was transferred to HMP Gartree. On 18 July 2018, Mr Jones seriously assaulted another prisoner at Gartree and was charged with grievous bodily harm with intent. On 3 October, Mr Jones was transferred to HMP Dovegate.

HMP Leicester

29. On 29 August 2019, Mr Jones was escorted from Dovegate to attend court for the July incident. He was remanded in custody to HMP Leicester as he was scheduled to attend Leicester Crown Court on 7 October. It was expected that Mr Jones would return to Dovegate after that.

30. Mr Jones's person escort record identified no significant health care problems and no history of suicide or self-harm but did say that he had seriously assaulted another prisoner and had substance misuse issues.

31. During Mr Jones's first night interview with an officer at Leicester, he told her that he had no thoughts of suicide or self-harm. The Head of Safer Custody noted that Mr Jones's cell-sharing risk assessment (CSRA) remained high because he had seriously assaulted a prisoner by throwing hot water on him.

32. A nurse completed Mr Jones's reception health screen. Mr Jones denied any physical, mental health or substance misuse issues. He had engaged with the substance misuse service at Dovegate from March 2019 but declined further support at Leicester.

33. The nurse offered Mr Jones a screen for blood-borne viruses, but he declined. Mr Jones did not tell her that he had hepatitis C, and his documentation from Dovegate did not refer to this. Mr Jones's medical records showed that he had been diagnosed with hepatitis C in 2015 and had subsequently and repeatedly refused treatment.

34. A substance misuse worker completed a substance misuse review for Mr Jones, but he declined support. She advised him how to minimise harm from substance misuse and about screening for blood-borne viral infections. Mr Jones again did not say that he had hepatitis C.

35. A nurse completed a secondary health screen for Mr Jones on 4 September. He again declined an offer to screen him for blood-borne viruses. He also declined smoking cessation support.

36. On 30 August, a member of the chaplaincy team saw Mr Jones as part of the induction process. Mr Jones said that he expected to return to Dovegate soon. His medical records indicated that he therefore did not want to engage with support services at Leicester.

37. On 3 September, a nurse saw Mr Jones after he complained of feeling unwell. She recorded in Mr Jones's medical record that he had abdominal pain and was concerned that he was having a relapse of a previous liver disorder. She examined Mr Jones and noted that he had no obvious tenderness or swelling of the abdomen. A urine sample indicated a possible infection, so several tests were taken to check Mr Jones's liver function. The nurse documented a National Early Warning Score (NEWS) of 0, which indicated that no immediate intervention was needed. A prison GP later reviewed the results of Mr Jones's blood and urine tests but found no evidence of any ongoing infection.

38. On 4 September, a nurse spoke to Mr Jones about his hepatitis C status. He said that he had declined treatment at Gartree and did not want treatment at Leicester.

39. On 10 September, Mr Jones again complained that he had a dull abdominal ache. A nurse saw him but was unable to find the cause of his pain. She advised him to make another appointment if he felt any worse.

40. On 17 September, an officer introduced himself to Mr Jones as his new key worker. Mr Jones raised no concerns. The officer met him again on 30 September but, again, Mr Jones had no concerns.

4 October

41. At 8.31am on 4 October, Mr Jones phoned his mother. He talked about returning to Dovegate in the next few weeks and his upcoming court hearing on 7 October and said that he would call his mother again when he returned from court.

42. An officer told us that she unlocked Mr Jones's cell door at around 4.30pm. She had not previously had any significant contact with him. She asked Mr Jones if he was okay and whether he intended to leave his cell to collect his evening meal. She said that Mr Jones replied that that he did not want anything to eat and was okay. She locked Mr Jones's cell door and continued her duties.

43. An officer checked on Mr Jones during the evening roll check at around 8.00pm but raised no concerns about him.

5 October

44. At 5.45am on 5 October, CCTV footage shows that two officers started the roll check of the wing. At 5.57am, an officer arrived at Mr Jones's cell and looked through his cell door observation panel to check on him. He saw Mr Jones hanging from a ligature of torn sheets attached to the window bars.

45. The officer immediately shouted to his colleague, who was nearby, for help. He told her to call a medical emergency code blue (to indicate a life-threatening emergency) and that he would go into the cell. His colleague did so, and the control room log indicates that this happened at 5.58am. He then broke his

sealed key pouch to go into the cell but was unable to do so because Mr Jones had barricaded the door with furniture.

46. The other officer arrived at Mr Jones's cell in approximately 30 seconds, followed shortly afterwards by a third officer. With strenuous effort, the officers managed to force Mr Jones's cell door slightly open at 5.59am, and an officer managed to squeeze in. He removed the barricade to allow his colleagues to enter the cell.

47. An officer cut the ligature from the window bar with an anti-ligature knife. The other officers and a Custodial Manager (CM), who had also arrived, supported Mr Jones's weight and lowered him to the floor.

48. A nurse told us that he responded to the code blue quickly and arrived at Mr Jones's cell just as the officers had managed to break through the barricade. He saw Mr Jones hanging at the back of the cell before he was cut down.

49. In her statement, the CM said that after staff lowered Mr Jones to the floor, she radioed the control room to confirm that an ambulance was needed. An officer recorded in the control room log that he called an ambulance at 6.02am.

50. In the meantime, an officer used his ligature knife and removed the ligature from around Mr Jones's neck. The nurse, who had already set up his medical emergency equipment, examined Mr Jones and found no signs of life and noted his jaw was stiff. He attached a defibrillator which found no shockable heart rhythm. An officer started cardiopulmonary resuscitation (CPR) by doing chest compressions. The CM and an officer alternated chest compressions with another officer while the nurse continued to monitor Mr Jones's condition.

51. At 6.10am, paramedics arrived and took over resuscitation efforts. Air ambulance support arrived shortly afterwards but the air ambulance doctor confirmed at 6.38am that Mr Jones had died.

Contact with Mr Jones's family

52. On 5 October, the Deputy Governor and an officer visited Mr Jones's mother, his next of kin, and broke the news of Mr Jones's death. Leicester contributed to the cost of his funeral in line with national instructions.

Information received after Mr Jones's death

53. Mr Jones made a number of phone calls to his mother, brother and sister throughout his time at Leicester. On a few occasions, Mr Jones asked family members to send him money. Mr Jones suggested more than once that he was not happy at Leicester and wanted to return to Dovegate.

54. Intelligence received from a prisoner on 4 October indicated that the day before he died, other prisoners had demanded that Mr Jones should pay £40 to settle his drug debts. Mr Jones had apparently told the prisoners that he would settle his debt the following day.

Support for prisoners and staff

55. The Governor 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.

56. The Governor issued notices to staff and prisoners informing them of Mr Jones's death. Staff reviewed prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Jones's death.

Post-mortem report

57. A post-mortem examination found that Mr Jones's cause of death was "hanging". The toxicological examination revealed the presence of synthetic cannabinoids (PS) and noted that its use has been reported to lead to suicidal ideation and self-harm.

Findings

Identifying risk of suicide and self-harm

58. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires that prison staff are aware of the risk factors and triggers that may increase prisoners' risk of suicide and self-harm, and that they take appropriate action, including starting ACCT procedures when a prisoner is identified as at risk of suicide or self-harm.

59. Mr Jones was at Leicester to attend court and was due to return to Dovegate afterwards. He did not have a history of attempted suicide or self-harm and none of the prison staff we interviewed considered that he was at risk. We are satisfied that staff could not reasonably have known that he was at imminent risk of suicide in the days before his death.

Drugs strategy at HMP Leicester

60. Although Mr Jones had a history of substance misuse, there was no intelligence to suggest that Mr Jones was using illicit substances at Leicester. However, his post-mortem report confirmed that he had used PS some time before his death. Staff were not aware that he was using drugs.

61. The prison has a substance misuse strategy which sets out a number of actions to reduce the demand for and supply of illicit substances. In their most recent inspection report, HMIP noted that PS remained a threat to stability at Leicester and although there were good initiatives to address this, efforts to reduce the supply of drugs were not sufficiently effective.

62. Drug taking and trading is a serious problem across much of the prison estate and Leicester is not alone in facing this problem. In April 2019, HMPPS published a National Drug Strategy setting out their plans to reduce substance misuse by sharing best practice and providing direction and detailed guidance for prisons.

> "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."

63. We therefore recommend that:

The Governor should ensure that the key drug issues at Leicester are identified and that the prison's local drugs strategy is appropriately revised to address them.

Emergency response

64. PSI 03/2013 requires that prison staff understand their responsibility to radio a medical emergency code so that an ambulance is called automatically in a life-threatening emergency. The PSI makes it clear that the control room should not wait for the instructions of a manager or member of healthcare staff at the scene before calling an ambulance. It notes that an ambulance can be cancelled if it is later assessed that it is not needed.

65. Leicester issued an instruction to staff about medical emergency response codes in July 2019 which included this requirement. According to the control room log, an officer called a code blue at 5.58am but the control room did not call an ambulance until four minutes later.

66. While we recognise that staff responded very promptly to the emergency code, we cannot say whether the short delay in calling an ambulance affected the outcome for Mr Jones. In another emergency, such a delay could be critical. We make the following recommendation:

The Governor should ensure that all prison staff working in the control room are fully briefed about emergency procedures and call for an ambulance as soon as a medical emergency code is radioed.

Prison and Probation Ombudsman's access to medical records

67. PSI 58/2010 is clear that the Prison and Probation Ombudsman should have "unfettered access to all relevant material held both in hard copy and electronically" for the purpose of our investigations and that this should include "classified material, physical and mental health information".

68. When the investigator visited Leicester on 9 October 2019, he was refused access to Mr Jones's SystmOne records. An Assistant Ombudsman wrote to the Head of Healthcare on 11 October to ask again for Mr Jones's SystmOne records to be given to the investigator. She did not reply.

69. Our investigations rely on access to all relevant information which helps us understand the circumstances of a prisoner's death. A delay in receiving such critical documents may delay and prevent an adequate conclusion to our investigations. We make the following recommendations:

The Head of Healthcare should ensure that the electronic medical records and all relevant hard copy medical paper records are made available to the PPO investigator as requested, in line with PSI 58/2010.

The Governor should discuss the requirements of PSI 58/2010 with the Head of Healthcare.

Clinical care

70. The clinical reviewer concluded that the care that Mr Jones received at Leicester was equivalent to that which he could have expected to receive in the community.

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