Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jalil Ayub, a prisoner at HMP Wealstun, on 31 May 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 Jalil Ayub died on 31 May 2019 from the effects of psychoactive substances (PS) at HMP Wealstun. He was 36 years old. I offer my condolences to Mr Ayub's family and friends.

I am concerned that Mr Ayub was able to obtain PS at Wealstun. The prison will need to strengthen its approach to reduce the availability of illicit drugs in line with the Prison Service's *Prison Drugs Strategy*.

The investigation found that there was a missed opportunity to refer Mr Ayub for substance misuse support when he arrived at Wealstun. However, I am satisfied that he received an appropriate level of support for his substance misuse issues from April 2019 onwards.

I am concerned that there was a delay in the emergency response when Mr Ayub was discovered unresponsive in his cell. It is unlikely that the delay affected the outcome for Mr Ayub, but it is important that staff follow the correct medical emergency procedures to minimise any delays in providing emergency treatment.

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 2020**

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Summary

Events

1. Mr Jalil Ayub was recalled to prison custody on 29 November 2018, after being arrested for theft and possession of a bladed article. He was sent to HMP Wealstun on 25 February 2019. He had been at Wealstun before.

2. Mr Ayub had a history of using illicit substances in prison, particularly psychoactive substances (PS). However, when he arrived at Wealstun and had his reception health screen, the nurse recorded that he told her he did not use illicit drugs or alcohol.

3. On 30 April, a substance misuse worker saw Mr Ayub after he asked for support with his substance misuse issues. Mr Ayub admitted that he used PS. The substance misuse worker discussed the risks of PS with him.

4. During a roll check at approximately 8.00pm on 31 May, an operational support grade (OSG) saw Mr Ayub bent over his bed with his head on the pillow. She could not see any movement so she kicked the door to try to get a response from Mr Ayub. According to her account, when he did not respond, she called a medical emergency code. Several officers joined her at the cell. The officers went into the cell and found Mr Ayub unresponsive. They asked the control room to call an ambulance and began cardiopulmonary resuscitation (CPR), which they continued until ambulance paramedics arrived. Paramedics declared Mr Ayub's death at 8.55pm.

5. The post-mortem report concluded that Mr Ayub died from the effects of psychoactive substances (PS).

Findings

6. We are concerned that Mr Ayub was able to obtain illicit drugs at Wealstun. The prison needs to identify and address the key weaknesses in reducing the supply of drugs.

7. Mr Ayub had a history of using PS in prison. However, when he arrived at Wealstun in February 2019 the reception nurse recorded that he had no substance misuse issues. She did not check his medical record for recent PS use. This was a missed opportunity to refer him for support.

8. However, Mr Ayub received appropriate support after he self-referred to the Substance Misuse Team in April.

9. Although the OSG who found Mr Ayub unresponsive said she called a medical emergency code, the control room said they heard a call for urgent assistance and not an emergency code and did not, therefore, call an ambulance. It was not until officers had entered the cell and requested an ambulance that one was called. It is unlikely that the delay affected the outcome for Mr Ayub, but it is important that staff follow the correct medical emergency procedures to minimise any delay in providing emergency treatment.

10. Managers did not hold a debrief for staff after Mr Ayub's death.

Recommendations

- The Governor should identify and address the key weaknesses in reducing the supply of drugs at Wealstun and revise its local Substance Misuse Strategy in light of the findings.
- The Head of Healthcare should ensure that staff who undertake reception screening check a prisoner's medical record for recent use of psychoactive substances (PS) and make a referral to substance misuse services where appropriate.
- The Governor should ensure that all staff understand and follow the medical emergency procedures, in line with PSI 03/2013.
- The Governor should ensure that a debrief for staff is held after a death in custody.

The Investigation Process

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

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

13. NHS England commissioned a clinical reviewer to review Mr Ayub's clinical care at the prison. The investigator interviewed eight members of staff and a prisoner on 9 and 10 July. They jointly interviewed four members of staff.

14. We informed HM Coroner for West Yorkshire (Western District) of the investigation. The coroner gave us the results of Mr Ayub's post-mortem examination and toxicology report. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Ayub's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked for details of when staff checked Mr Ayub during the night and whether he was given his medication. We have addressed their questions in this report.

16. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not raise any factual inaccuracies. They provided an action plan which is annexed to this report.

17. We provided Mr Ayub's family with a copy of our initial report. They identified no factual inaccuracies. They raised several issues which we have addressed in separate correspondence.

Background Information

HMP Wealstun

18. HMP Wealstun is a category C prison near Wetherby, West Yorkshire, which holds up to 832 men. Care UK provides health services.

19. In August 2018, Wealstun was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

20. The most recent published inspection of HMP Wealstun was in August 2015. (The most recent inspection took place in October 2019 but the report had not been published at the time of writing.) Inspectors reported that the availability of psychoactive substances (PS) was very high and its widespread use was posing a serious threat to the safety and health of prisoners. In the HMIP survey, far more prisoners than elsewhere (51% versus 36%) said it was very easy to get drugs at the prison and that they had developed a drug problem while there (17% versus 8%).

21. The prison was responding with a determined whole-prison approach and a well-informed supply reduction strategy and action plan. The 'zero-tolerance' review process was impressive and encouraged prisoners known to be using PS to change their behaviour. However, security intelligence was not well enough managed and there was a considerable backlog of intelligence reports waiting for a full analysis, which risked missing opportunities to detect and disrupt the supply of PS.

Independent Monitoring Board

22. 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 May 2019, the IMB reported that the volume of drugs had not reduced significantly during the year despite additional funding secured through the "10 Prisons Project". However, the positive mandatory drug testing rate fell by 50% in 2018-19 to 20.9%, a possible indicator that drug use was reducing.

Previous deaths at HMP Wealstun

23. Mr Ayub was the second prisoner to die at Wealstun since May 2017. The previous death was self-inflicted. The PPO also investigated the self-inflicted death of a prisoner shortly after his release from Wealstun. There were no similarities between the findings we have made in Mr Ayub's case and those made in the previous investigations.

Psychoactive substances (PS)

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

25. 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.

26. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

27. On 18 April 2016, Mr Jalil Ayub was sentenced to 22 months in prison for wounding. He was released on licence on 19 July 2016, but recalled to prison on 10 March 2017, for intimidating witnesses. Mr Ayub was released on licence again on 19 July 2018, but on 29 November, he was arrested for theft and possession of a bladed article. He was sent to HMP Leeds on 10 December and moved to HMP Wealstun on 25 February 2019.

28. A nurse carried out an initial health screen when Mr Ayub arrived at Wealstun. The nurse recorded that Mr Ayub told her he was not on any prescribed medication (which was not true) and did not use illicit drugs or alcohol, although had used cannabis in the past. (Mr Ayub had been suspected of being under the influence of drugs, including psychoactive substances (PS), on nine occasions while in prison, including four times during his time at Wealstun between December 2017 and July 2018.) Mr Ayub had previously been prescribed fluoxetine (antidepressant), propranolol (for anxiety) and Rivaroxaban (blood thinner) for a pulmonary embolism (blockage of a blood vessel in the lungs) which he continued to be prescribed at Wealstun.

29. Mr Ayub attended an induction presentation the next morning, when he was given information about work, healthcare, complaints, safer custody, drugs and alcohol advice and the support available.

30. On 27 February, Mr Ayub submitted a request to see a member of the mental health team. A nurse met with him on 6 March. They discussed how he felt some prisoners were “out to get him” and that he had been bullied in prison before. He said he did not use illicit substances, but had used cannabis and cocaine in the past. Mr Ayub said he had no thoughts of harming himself, agreed to do some in-cell work to try to manage anxiety, and said he would contact the mental health team if he needed to speak to someone.

31. A prison GP met with Mr Ayub on 12 March to discuss his anxiety and low mood. Mr Ayub said he had been threatened on the wing and at work and that he had reported this to staff. The prison GP changed Mr Ayub’s antidepressant medication from fluoxetine to citalopram.

32. On 30 April, a nurse met with Mr Ayub to discuss his substance misuse after Mr Ayub submitted a self-referral asking for support. Mr Ayub said that after his release in July 2018, he had abstained from drugs and alcohol, but as he encountered some old acquaintances and became stressed, he began to take cocaine, cannabis and drink a litre of vodka each night. Mr Ayub said he had previously used PS. He said he was aware of the risks of using illicit substances and mixing them with other drugs and alcohol and prescribed medication. They also discussed the risks of using PS.

33. Mr Ayub told the nurse that he had no emotional issues, said he was “in a good place”, was prescribed propranolol for anxiety and knew how to access the mental health team if he had any thoughts of self-harm. Mr Ayub said he had no concerns about his physical health, despite taking blood thinning medication for a pulmonary embolism.

Events of 31 May 2019

34. A prisoner and friend of Mr Ayub's, told the investigator that Mr Ayub had not wanted to take his medication on the morning of 31 May because he was fasting for Ramadan. He said he wanted to collect his medication to take in the evening, but prisoners must take their medication at the medication hatch, so this was not possible. Mr Ayub attended Muslim prayers that day, and he recalled nothing out of the ordinary.

35. An officer was working on D Wing on 31 May, and recalled seeing Mr Ayub at about 2.00pm, when he went to Muslim prayers. The officer last saw Mr Ayub at approximately 4.45pm, when he was locked in his cell, and said he seemed well. There was no staff interaction with Mr Ayub after that.

36. An operational support grade (OSG), was on an overnight shift on D Wing. She carried out a final roll check for all prisoners at approximately 8.00pm. When she arrived at Mr Ayub's cell, she saw him bent over his bed, with his head on his pillow, but could not detect any movement. She kicked the cell door to rouse Mr Ayub, but he remained unresponsive. She said that she radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Within minutes, three officers arrived at Mr Ayub's cell. The OSG unlocked the door and the officers went in.

37. An officer checked Mr Ayub for breathing and pulse, but could not detect either. She rolled him over on the bed and saw he had been sick and there was also blood. She could see Mr Ayub had blue lips and he felt cold. The officer radioed for an ambulance to be called, saying it was a code blue for a non-responsive prisoner. At 8.19pm, an operational support grade in the control room, called an ambulance.

38. Two officers started cardiopulmonary resuscitation (CPR) on Mr Ayub, while an officer went to get a defibrillator. The officers continued CPR and attached the defibrillator, which advised no shock and to continue with CPR.

39. Paramedics arrived at the prison at 8.35pm, and asked prison staff to continue CPR while they assessed Mr Ayub. They pronounced Mr Ayub's death at 8.55pm.

Contact with Mr Ayub's family

40. The Deputy Governor, and the prison Imam visited Mr Ayub's wife in the early hours of 1 June. Initially, they did not have the family's correct address on their system, which caused a delay. Once they had this, the Imam advised that as it was the last fasting night of Ramadam, they should wait until the last evening services had concluded before visiting the family. Wealstun subsequently appointed an officer as the family liaison officer (FLO). The prison contributed to Mr Ayub's funeral, in line with national guidelines.

Support for prisoners and staff

41. There was no hot debrief held after Mr Ayub's death.

42. The prison posted notices informing other prisoners of Mr Ayub's 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 Ayub's death.

Post-mortem report

43. The post-mortem report concluded that Mr Ayub's death was caused by synthetic cannabinoid (PS) toxicity.

Findings

Drug strategy

44. We are concerned that Mr Ayub was able to obtain PS at Wealstun. During their inspection of Wealstun in 2015, HMIP found that the availability of PS was very high and its widespread use was posing a serious threat to the safety and health of prisoners.

45. Wealstun's Substance Misuse Strategy, dated September 2018, notes that PS had been linked to a number of deaths in custody and there was an increasing number of prisoners requiring emergency treatment as a result of PS use. It refers to promoting a culture where individual users of PS are dealt with confidently and competently, and appropriate treatment is provided. It also refers to a PS Action Plan to reduce the negative effects of PS on prisoners, staff and the community.

46. We have been told that the funding given to Wealstun as part of the "10 Prisons Project" has been used to install equipment for scanning mail for PS, an airport-style body scanner for detecting drugs secreted internally, increased fencing and netting on exercise yards and increased use of drug detection dogs.

47. 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 and we welcome the fact that such guidance was issued in April 2019, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

48. In relation to reducing the supply of drugs, we note that 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."

49. We make the following recommendation:

The Governor should identify and address the key weaknesses in reducing the supply of drugs at Wealstun and revise the local Substance Misuse Strategy in line with the findings.

Clinical care

50. When he arrived at Wealstun, Mr Ayub told a nurse that he did not use illicit drugs or alcohol. The clinical reviewer noted that the reception nurse did not look

at Mr Ayub's medical record to check this information. This was a missed opportunity to refer Mr Ayub to the Substance Misuse Team. The clinical reviewer also noted that the reception nurse recorded information inaccurately. We make the following recommendation:

The Head of Healthcare should ensure that staff who undertake reception screening check a prisoner's medical record for recent use of psychoactive substances (PS) and make a referral to substance misuse services where appropriate.

51. The clinical reviewer was satisfied that following Mr Ayub's self-referral to the Substance Misuse Team, he received appropriate support. She was also satisfied that he received a reasonable standard of care for his mental health.

Emergency response

52. Wealstun does not have 24-hour healthcare cover. There were no healthcare staff on duty when Mr Ayub was discovered, and so the emergency was managed by prison staff.

53. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, says that all prisons must have a medical emergency response code protocol so that staff can clearly and concisely convey the nature of the medical emergency. It says that where a prisoner is found unresponsive, staff should call an emergency code blue and the control room should telephone for an ambulance immediately.

54. The OSG said she radioed a code blue call as soon as she discovered Mr Ayub. Two officers say they heard a code blue call. The OSG in the control room said she heard the OSG radio for urgent assistance, but it did not sound particularly urgent and there was no code called. She said she took no action and waited for further information once officers had gone into the cell. She told the investigator at interview that even if a code blue had been called, she would have waited for an instruction to call an ambulance before doing so. The investigator was not able to listen to the prison's radio traffic to confirm that a code was called.

55. The investigator listened to the call to the Ambulance Service and notes there were delays in relaying important information about Mr Ayub's condition. At the time of the call, the OSG in the control room could not say whether Mr Ayub was conscious or breathing and there were several exchanges before the necessary information was given.

56. The guidance that was in place at Wealstun at the time of Mr Ayub's death, dated January 2012, said that when a code blue was called, control room staff should wait for information from the scene before calling an ambulance. This was not in line with PSI 03/2013. A Governor's Notice, issued in October 2019, tells staff that an ambulance should be called in response to a code blue. The notice also says that staff on the scene must provide details of the prisoner's condition to the control room, who can then pass it promptly to the Ambulance Service.

57. Although a Governor's Notice has been issued since Mr Ayub's death, which specifically says that an ambulance should be called in response to a code blue,

we consider that the Governor still needs to ensure that all staff understand and follow the correct medical emergency procedures.

58. We make the following recommendation:

The Governor should ensure that all staff understand and follow the correct medical emergency procedures, in line with PSI 03/2013.

Hot debrief

59. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or, indeed, good practice). It also provides those directly involved with an opportunity to process events.

60. Managers did not carry out a debrief after Mr Ayub's death, due, we are told, to staff shortages. There should have been a debrief for all staff involved in the emergency response, as set out in PSI 09/2014, *Incident Management Manual*.

61. We make the following recommendation:

The Governor should ensure that a debrief for staff is held after a death in custody.

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