

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Imran Azad, a prisoner at HMP Wealstun, on 7 June 2019

A report by the Prisons and Probation Ombudsman

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mr Imran Azad died in hospital on 7 June 2019, while a prisoner at HMP Wealstun. The cause of his death was synthetic cannabinoid toxicity. He was 35 years old. I offer my condolences to Mr Azad's family and friends.

Mr Azad was a vulnerable prisoner who frequently used psychoactive substances. Several forms of support were put in place for him, but he struggled to fully engage. Staff appropriately addressed reports of bullying and assault and were proactive when they observed untoward behaviour. However, I am concerned that, due to resource problems, requests for drug testing were not actioned. I am also concerned that Mr Azad did not have key worker support for long periods at a time when he seemed to be particularly vulnerable.

The investigation found some weaknesses in the emergency response after Mr Azad was found unresponsive. These have been largely addressed following our recommendation in a previous report, but I believe that operational staff would benefit from a reminder of the need to begin resuscitation immediately when a prisoner is unresponsive.

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

October 2020

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Summary

Events

1. Mr Imran Azad was remanded to prison on 21 September 2017. He was later convicted of burglary and sentenced to three and a half years in prison. Mr Azad had a learning disability, as well as a history of self-harm and substance misuse. He continued to use psychoactive substances, (PS), in prison.
2. Mr Azad transferred from HMP Leeds to HMP Wealstun on 17 April 2018. At his initial health screen, he refused a referral to the drug and alcohol recovery service (DARS) and a mental health assessment concluded that he was not in crisis. The next day, Mr Azad was found under the influence of PS and staff referred him to DARS.
3. Prison staff referred Mr Azad to DARS several times, but he had limited engagement with the service and often denied drug use. Except for a couple of short periods of abstinence, he continued to use PS almost every day, funded by cleaning other prisoners' cells and selling food and other items. On numerous occasions, his use of PS led to code blue medical emergencies. Mr Azad was also subject to bullying by other prisoners. It was reported that they sometimes forced him to take PS so they could see the effects and for entertainment.
4. Mr Azad was allocated a dedicated learning disability nurse on 16 August. His vulnerability, drug use and self-harm were also managed under formal processes, including the suicide and self-harm prevention procedures known as ACCT; violence reduction provisions; weekly safer interventions meetings; complex case arrangements and other multidisciplinary meetings. He was moved around the prison several times, for his own protection.
5. Just after 11.00am on 7 June 2019, a prisoner asked an officer to go and see Mr Azad in his cell. The officer saw Mr Azad on the floor, unresponsive and radioed a code blue. The prison's paramedic and other healthcare staff tried to resuscitate him and a prison GP helped to insert an intravenous line.
6. An ambulance arrived at the cell at 11.39am and the paramedics continued treating Mr Azad. They then took him to hospital, where he died at 12.17pm.

Findings

7. The most recent inspection of Wealstun and previous PPO investigations found there was widespread use of PS, but no coherent substance misuse strategy. The prison has now developed a comprehensive Drug Strategy to reduce supply and demand, with specific guidance on handling PS use, and an awareness campaign was due to take place in late August 2020. As this addresses the concerns we raised earlier this year, we make no further recommendation.
8. Wing staff knew about Mr Azad's vulnerability and frequent drug use. We found that they managed him in line with agreed substance misuse policies. Each time he was found under the influence of PS, he was referred to DARS, but he was reluctant to engage. Punitive action was also taken.

9. We are satisfied that Mr Azad's clinical care was equivalent to that which he could have expected to receive in the community.
10. Security intelligence reports suggested 'on suspicion' drug tests for Mr Azad, but none were actioned and there was no evidence that he was ever tested. Prison managers attributed this to insufficient staff resources and limited space to conduct drug tests. Mandatory drug tests had been prioritised as they were linked to the prison's performance measures.
11. Although key worker entries were suitably detailed, Mr Azad did not have a key worker for several months in 2019. A new key worker was allocated in April, but several sessions were cancelled due to staffing problems and he did not have a meeting with her until 27 May, a week and a half before his death. While we do not know whether closer key work support would have helped Mr Azad, it is important that key work sessions are held at the required intervals.
12. Mr Azad was managed in line with the prison's safety policy. He was identified as one of the prison's top ten vulnerable prisoners and discussed at weekly safer interventions meetings. Wing staff put in place protective measures and monitored him under challenge, support and intervention plans (CSIPs). They moved him to different wings for his own safety and on his last wing, he was placed in a cell where it was easier to observe him.
13. There were weaknesses in the handling of the emergency response when Mr Azad was found on 7 June. The first officer at the incident radioed a code blue, but stated that no staff were required. She called a further code when she was unable to obtain a response from Mr Azad. Neither of the two officers who arrived first began attempted resuscitation. Several minutes passed before the control room called an ambulance. Since Mr Azad's death, the prison had taken substantive steps to re-educate staff about the correct emergency response procedures. However, we consider that staff should receive further guidance on the importance of starting resuscitation immediately when a prison is unresponsive.

Recommendations

- The Governor should review the prison's drug testing arrangements to ensure that prisoners suspected of using drugs are tested. This should include an auditable process to track and action requests for mandatory drug tests.
- The Governor should ensure that key workers are allocated to all prisoners and that sufficient time is allocated for regular contact to be maintained.
- The Governor should ensure that all prison staff receive sufficient guidance to understand the benefits of starting cardiopulmonary resuscitation immediately when a prisoner is unresponsive and that they should carry out chest compressions until medically trained staff arrive, unless there is clear evidence that it would be futile in the circumstances.

The Investigation Process

14. 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.
15. The investigator visited Wealstun on 17 June 2019. She met prison managers, viewed CCTV footage and obtained copies of relevant extracts from Mr Azad's prison and medical records.
16. The investigator also liaised with the West Yorkshire police team who were investigating Mr Azad's death and the supply of PS in Wealstun. The team shared information and statements from staff and prisoners.
17. NHS England commissioned an independent clinical reviewer to review Mr Azad's clinical care at the prison.
18. The investigator and clinical reviewer jointly interviewed eight members of staff at Wealstun on 15 July. The investigator had a telephone interview with another member of staff on 28 August.
19. We informed HM Coroner for West Yorkshire (Eastern) of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. One of the Ombudsman's family liaison officers contacted Mr Azad's father, his next of kin, to explain the investigation and to ask if he had any matters for the investigation to consider. Mr Azad's father had no specific questions, but wished to see a copy of the report.
21. Our investigation was suspended between 21 October 2019 and 15 July 2020, while waiting for the cause of death. This has delayed the initial report.
22. Mr Azad's father received a copy of our initial report. He made no comments.
23. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan is annexed to this report.

Background Information

HMP Wealstun

24. HMP Wealstun is a category C prison near Wetherby, West Yorkshire. It holds up to 833 men. Care UK provides physical and mental health services. Substance misuse and psychosocial services are provided by Midlands Partnership NHS Foundation Trust and Care UK.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Wealstun was in October 2019. Inspectors found that the ready availability of illicit drugs had undermined much of what the prison was trying to achieve and there was no clear overall strategy to deal with the supply of drugs. Sixty-nine per cent of prisoners said it was easy to obtain drugs, which was higher than other similar prisons and psychoactive substances (PS) were still a serious problem. The prison had recently introduced new technology and enhanced physical security to help detect and prevent drug dealing. However, the positive impact of this had been compromised by the lack of response to intelligence reports. Inspectors noted that far too little targeted searching or testing had been carried out, which was a missed opportunity given the good quality intelligence received.
26. Inspectors noted that levels of violence had increased in the previous year, most of it due to drug use and associated debts. Although there were positive staff-prisoner relationships, wing staff seemed to lack the confidence to challenge poor behaviour and some remained in offices during association when there were larger numbers of prisoners out on the wing.
27. The safer custody team had become more effective because of increased staff and there had been more targeted and effective use of challenge, support and intervention plans (CSIPs). Wing managers acted as case managers for the CSIPs, holding reviews and sharing information with wing staff, who were aware of each case on their wing. The plans in place at that time were of good quality and provided effective actions, but there were few formal interventions to support victims.
28. The monthly safety intervention meeting reviewed individual CSIPs, as well as discussing prisoners who were vulnerable or at risk. It provided good outcomes for individuals, but there were no focused actions or plans to reduce violence across the prison.
29. Inspectors were disturbed that the level of self-harm was high and had increased six-fold since the previous inspection. Prisoners who were subject to ACCT case management procedures generally felt well supported. However, inspectors found the quality of recording in ACCT documents was far too variable.

Independent Monitoring Board

30. 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 most recently published annual report for the year ending 31 May

2019, the Board noted that it had been an extremely difficult year for Wealstun, impacted by a significant level of violence and self-harm.

31. The Board found the volume of drugs entering the prison fluctuated, but had not significantly reduced. However, positive mandatory drug tests had fallen from 50% to 20.9%. The Board noted the volume of violence, bullying and self-harm remained high.
32. The Board identified that continued changes of role for senior staff hampered continuity of management and that the majority of wing staff had less than two years' experience. The Board considered the lack of support, staffing shortfalls and frequent changes of leadership roles resulted in the prison struggling to achieve satisfactory standards at times.

Previous deaths at HMP Wealstun

33. There have been five deaths at Wealstun since June 2017, as well as a death soon after release. Of those investigated, three were self-inflicted and two were drug-related. In previous investigations we have highlighted weaknesses in the emergency procedures.

Psychoactive Substances (PS)

34. 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.
35. 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.
36. 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. 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.

Assessment, Care in Custody and Teamwork (ACCT)

37. 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.

Key Events

38. Mr Imran Azad was remanded to HMP Leeds on 21 September 2017, charged with burglary. It was not his first time in prison. He was later convicted and sentenced to three and a half years imprisonment.
39. At reception health screens on 21 and 22 September, it was noted that Mr Azad was diabetic and had a learning disability, which appeared to affect his speech. He also had a long history of self-harm and had been under the care of prison mental health services during previous sentences. The reception nurse referred Mr Azad to the prison GP, long-term conditions nurse, mental health team and DARS.
40. Throughout his time at Leeds, Mr Azad was frequently found under the influence of psychoactive substances (PS), often resulting in code blue medical emergencies, and a PS care plan was created. (A code blue indicates that a prisoner is unresponsive, or has breathing difficulties.)
41. Mr Azad told a drug and alcohol recovery worker that he did not want one to one interventions, but felt he would benefit from group work. He said that he had been addicted to PS for years and struggled to say no when it was offered. He had used it daily in the community, but his use was limited in prison due to affordability and access. The drug and alcohol recovery worker gave him advice on minimising his risk of harm and explained how PS affected his mental and physical health. Mr Azad completed the substance misuse treatment programme and was told how to self-refer if he needed further support. He continued to use PS.
42. At mental health assessments, Mr Azad disclosed serious issues he had faced in his life, including learning difficulties, hearing problems, childhood rape, bullying in the community and in prison. He volunteered information about his use of PS. A prison GP was concerned about his vulnerability and noted a split lip and broken tooth, which Mr Azad had attributed to assaults.
43. Mr Azad attempted to hang himself in Leeds and he was managed under the ACCT procedures from November 2017. (ACCTs were opened nine times between November 2017 and his death in June 2019.)
44. After sentencing on 16 March 2018, Mr Azad requested a transfer to another prison.

HMP Wealstun

45. On 17 April, Mr Azad moved to HMP Wealstun, where he had friends and knew the prison and staff very well. During his initial health screen, he refused a referral to DARS. At the request of the reception nurse, a mental health nurse assessed Mr Azad during the screen and noted that he did not appear to be in crisis.
46. The next day, a medical emergency was called when Mr Azad was found under the influence of PS. He was closely monitored and staff referred him to DARS.

47. On 24 April and 29 June, a drug and alcohol recovery worker held substance misuse monitoring sessions with Mr Azad and reviewed his care plan. Mr Azad was keen to stop using PS and said that with the help of drug-free friends and the distraction of work and the gym, he was achieving this. He thought it would be beneficial to repeat the PS group course that he had completed in Leeds. The drug and alcohol recovery worker offered Mr Azad advice on relapse prevention and what to do if he had cravings, or was offered PS. At the second meeting, he thought that Mr Azad's attitude and appearance reflected his change in behaviour and he discharged him from the service. (Mr Azad later began the PS course and engaged well, but it ended due to low attendance.)
48. Mr Azad was subject to the ACCT process for lengthy periods during the latter half of 2018, to manage several issues - continued bullying by others; self-harm attempts when he felt upset or unsupported; and to express his emotions. Nurses, mental health staff and substance misuse workers attended case reviews.
49. Wing staff also managed Mr Azad under the Challenge Support Intervention Plan (CSIP) - a process primarily designed to address the behaviour of prisoners at risk of being violent, but also used to manage victims. They offered several options to help improve the situation, such as moving to a different wing, or the other side of his existing wing where he had other friends. Mr Azad refused, as he saw this as a weakness and "did not want to let them win".
50. On 16 August, the Senior Learning Disability Nurse assessed Mr Azad. His score suggested that he might be learning disabled, so the nurse referred him to the learning disability clinic and added him to her caseload. In subsequent sessions with the nurse, Mr Azad spoke of bullying, including racist abuse and comments about his functioning. He also felt that he had been bullied by staff. The nurse created communication and vulnerability care plans, which she shared with the safer custody team and custodial managers. She noted that Mr Azad might have been vulnerable to bullying due to his learning disability, or it could have been perceived bullying because of this condition. He was also likely to feel threatened by others, due to low self-esteem.
51. The nurse identified several strategies for operational staff to support Mr Azad, including giving him opportunities to disclose incidents of bullying; allowing him sufficient time to express himself; re-directing him back to topics; and checking that he understood information given to him. The nurse's sessions with Mr Azad were supposed to be fortnightly, or monthly, but she saw him more frequently in response to his needs and attended some ACCT reviews.
52. Towards the end of August, Mr Azad was moved from D to B wing, for his own safety, due to conflicts with other prisoners. Reports of bullying continued and he moved around the prison several times. The Senior Learning Disability Nurse planned for him to attend groups to socialise with others in a safe environment.
53. In October and November, Mr Azad was found under the influence of PS, and on 24 and 25 December, he was found unresponsive. During the latter incident, he was found lying in the recovery position, covered in washing up liquid and food. Staff demoted him to the 'basic' level of the Incentives and Earned Privileges

scheme (the former process to incentivise and reward good behaviour) and referred him to DARS.

54. On 31 December, prisoners either shaved or used hair removal cream on part of Mr Azad's head. (This is a way of indicating that someone is in debt.) Mr Azad was transferred to J wing for his own protection, but he did not understand this. He was frustrated and angry about the move and tried to hang himself within an hour.
55. The same day, a drug and alcohol recovery worker assessed Mr Azad. He denied using PS. She explained that they could only support those who admit their issues with PS, so she stopped the assessment and discharged him.
56. In the first week of January 2019, Mr Azad had emergency care for PS use three times. He was added to the list of prisoners to be discussed at the weekly, multidisciplinary Safer Interventions Meeting (SIM). SIM meetings discussed the top ten prisoners at high risk due to vulnerability, violence or PS use.
57. On 7 January, at a structured support session with a drug and alcohol recovery worker, Mr Azad denied any drug use or debt. He received advice on harm minimisation and a PS pack and was invited to attend the PS group. On 10 January, he told the Senior Learning Disability Nurse that he used PS to get the attention of officers. The following week, Mr Azad used PS several times and on one occasion toothpaste was found in his ear, again thought to have been the act of prisoners.
58. On 15 January, a multidisciplinary team meeting was held. Attendees included the mental health manager, a substance misuse worker, wing officer, mental health nurse, general nurse, prison psychologist and a member of the regional safer custody team. It was agreed that J wing staff should watch Mr Azad closely to quickly identify and deal with any perpetrators of bullying.
59. Episodes of PS use, bullying and self-harm continued. On 17 January, the Senior Learning Disability Nurse noted that he had twice been made to eat faeces in return for PS and there was a possibility that other prisoners had given him PS to test it. She added that staff should be aware of his vulnerability and risk of emotional and physical harm from others and follow his care plan. The same day, a drug and alcohol recovery worker noted that Mr Azad sometimes admitted using PS and had said that he could get anything he wanted, but at other times he denied such use. He moved to A wing that day.
60. On 18 January, Mr Azad told a drug and alcohol recovery worker that he smoked PS in paper form, because of bullying by officers and prisoners. She gave harm reduction advice and referred Mr Azad to the Multi-Professional Complex Case Conference (MPCCC), for review.
61. On 31 January, Mr Azad attended the Foundations to Recovery group meeting. After a discussion with the facilitators, it was decided that he was unsuitable to attend such groups, due to his vulnerabilities, including his learning disability and being a target for bullying.
62. A drug and alcohol recovery worker and the Senior Learning Disability Nurse therefore arranged a joint support session with Mr Azad on PS and bullying. The

session, held on 7 February, covered risk, health and debt. Mr Azad said that he had smoked PS only once on A wing, for a “head change” (the psychoactive and emotional effects of a high) and had asked others not to give him any if he asked. The positives had been using and enjoying the gym and he hoped to get a wing cleaning job. His substance misuse file was then closed, noting that he had achieved all his care plan objectives and was involved in other psychosocial treatment interventions. He knew how to access help, if needed.

63. Mr Azad appeared brighter in February. Two prisoners had bullied him, but he reported the incidents to staff each time and some of the other prisoners had protected him. Towards the end of February, it was noted that there had been a big improvement since Mr Azad stopped taking PS. He had a positive mindset and was no longer in crisis.
64. On 4 March, staff began the ACCT procedures as Mr Azad attempted to hang himself due to alleged staff bullying. (The allegation was investigated and ACCT monitoring remained in place until Mr Azad’s death.)
65. In the following days, Mr Azad relapsed into using PS, but refused to engage with DARS. He tried to harm himself with a ligature and was dismissed from his cleaning job, due to being out of bounds. The Senior Learning Disability Nurse recorded that he had moved to C wing. Although he was unhappy, he insisted he did not want to move to another prison. He had increased his use of PS and a lack of appropriate engagement meant that he was unable to get a job, or address his vulnerability, PS use and self-harm. She noted that officers, other prison staff and a large number of agencies had to be coordinated to achieve this and that Mr Azad struggled to accept support and engage positively with the work she offered.
66. On 26 March, a nurse wrote that Mr Azad was heavily supported by the Senior Learning Disability Nurse, who had implemented a comprehensive care and support plan which had been shared with staff.
67. On 9 April, an officer was allocated as Mr Azad’s new key worker. She noted in his records that she would meet him on 23 April. Further entries indicated that planned sessions had been cancelled due to changes in detailing staff.
68. In April and May, Mr Azad was found under the influence of PS several times, often leading to code blue emergency calls. He persistently denied such use, refused to engage with DARS and declined distraction packs for the evenings. He attempted to self-harm by cutting and ligaturing. For safety, staff omitted Mr Azad’s prescribed medication when he had taken illicit drugs. He was demoted to the ‘basic’ regime, but staff quickly reinstated him when, in response, he jumped on the wing netting with a ligature. Further referrals were made to the SIM, MPCCC and the healthcare multidisciplinary team meetings.
69. On 11 May, an officer noted an improvement in Mr Azad’s behaviour. They agreed he needed to be more mature in recognising and dealing with negative situations. The officer recommended that Mr Azad apply to attend Narcotics Anonymous (NA) meetings and he agreed this might help him.

70. Staff noted several incidents linking Mr Azad to Prisoner A. During association on 15 May, he was seen giving away portions of his Ramadan meal to him. Staff thought this might be in payment for PS and immediately searched Prisoner A's cell. They found PS, Subutex, a phone and charger. On 21 and 23 May, both men had code blue medical emergencies as a result of PS use. Mr Azad said he could not leave his cell due to being in debt. (On 23 and 26 May, further searches of Prisoner A's cell found PS and other drugs.)
71. On 27 May, Mr Azad's key worker had her first key work session with Mr Azad and discussed her concerns about his PS use. Mr Azad became agitated and replied, "If I don't smoke it they said they will batter me" meaning that he was being bullied to take it. He gave one name and said that staff on the wing knew about it. He had tried to stay in his cell. Mr Azad's key worker said she would open a CSIP.

Events of 7 June 2019

72. An officer told the investigator that she spoke to Mr Azad three or four times in the morning during ACCT monitoring and had also checked him through the observation panel. He was on his bed reading and had no concerns. At 10.45am, she unlocked prisoners on basic regime for meals and stood at the gate. Just after 11.00am, a prisoner asked the officer to go and see Mr Azad as he was, "in a bad way." When she arrived at the cell, Mr Azad was lying on the floor in the recovery position.
73. The officer said she thought Mr Azad was 'under the influence' as he had been many times before. She radioed a code blue emergency, stating no officers required. She checked his wrist and neck, found no pulse and realised he was not breathing. The officer then called another code blue at 11.09am. Two officers arrived. One saw Prisoner A nudging Mr Azad and saying, "Come on Bhooni" (Mr Azad's nickname). Several prisoners had gathered and several other officers arrived. They tried to get a response from Mr Azad and started to disperse the prisoners.
74. The prison's paramedic was dealing with two code blue emergencies on D wing. He heard the code blue called for C wing and went to Mr Azad's cell immediately with a nurse. He asked the officers to request an ambulance and get a defibrillator. He and the nurse then began cardiopulmonary resuscitation (CPR). Additional healthcare staff arrived and the prison GP assisted with inserting an intravenous tube.
75. An entry in the control room log recorded that healthcare had requested an ambulance at 11.14am. Yorkshire Ambulance Service records show the call was received at 11.17am. The ambulance arrived at the prison at 11.35am and reached the cell at 11.39am. Paramedics continued the resuscitation attempts and took Mr Azad to Harrogate District Hospital at 11.53am. He was pronounced dead at 12.17pm.

Information received after Mr Azad's death

76. CCTV footage showed that 12 prisoners had gone in and out of Mr Azad's cell before staff were alerted to his condition. The police interviewed these prisoners.

They said that Mr Azad used PS every day. He would offer to clean other prisoners' cells, or sell his food and other items in exchange for PS or money to buy it. Some prisoners also gave him PS to see how he reacted to it.

77. The prison's security department received several security intelligence reports, giving information on the source and suppliers of the PS used by Mr Azad that day and the type of PS they believed he had taken. It was alleged that Mr Azad had not taken the PS voluntarily that day, but had been forced to do so by two prisoners (with others watching) for entertainment.

Contact with Mr Azad's family

78. A Custodial Manager accompanied Mr Azad to hospital and acted as the family liaison officer (FLO). Meanwhile a prison manager telephoned Mr Azad's family to advise them to go to the hospital, as he was unwell.
79. The FLO met Mr Azad's family at the hospital and broke the news of his death. He telephoned them at home in the evening, to offer support. He later visited Mr Azad's family and kept in touch over the following weeks. The prison Imam also spoke to the family and attended Mr Azad's funeral on 10 June. The prison paid the full costs of the funeral expenses.

Support for prisoners and staff

80. After Mr Azad's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
81. The prison posted notices informing other staff and prisoners of Mr Azad'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 Azad's death. They also offered additional support to Prisoner A.

Post-mortem report

82. The post-mortem report established that the cause of Mr Azad's death was synthetic cannabinoid toxicity. The post-mortem examination also found that he had heart disease, with a build-up of fatty deposits in two of his three main arteries and that this had significantly contributed to, but did not cause his death.
83. The report concluded that the use of PS had caused a fatal abnormal heart rhythm, due to the unpredictability of taking PS with pre-existing heart disease.

Findings

Substance misuse strategy at HMP Wealstun

84. After an inspection in October 2019, HM Chief Inspector of Prisons criticised the ready availability of drugs at Wealstun and the level of associated violence. He noted that a high number of prisoners had been found under the influence of PS over the previous six months and almost all the 211 requests for an ambulance had arisen because of PS. While there were good examples of actions to address this, the Chief Inspector felt there was no clear overall strategy.
85. The Head of Drug Strategy at the time of Mr Azad's death, said the prison had focussed on improving physical security, rewarding prisoners and using drug/alcohol dogs. Prisoners identified as having a drug problem were referred to DARS, which had a flexible waiting list based on need, rather than a first come, first served basis, to ensure capacity to accept urgent referrals. After a first offence, a prisoner could have their punishment suspended if they attended a DARS course. Punitive action was taken on further offences.
86. Monthly security meetings and intelligence meetings are multidisciplinary. The former Head of Security and Intelligence said that security intelligence reports (between 900 and 1080 a month) are analysed by an external regional intelligence hub, then returned to managers for review and action. In discussion about the possibility of closer monitoring of Mr Azad's frequent drug-taking, the former Head of Security and Intelligence said that almost one in three men (at that time) tested positive in mandatory drug tests and a large number had similar levels of usage to Mr Azad.
87. The prison had set up an Incentivised Substance Free Living (ISFL) unit and operational staff had worked closely with DARS to identify suitable prisoners. Healthcare and operational management leads were working together to try to expand the unit.
88. The investigation found that Wealstun now has a comprehensive and recently updated Drug Strategy, which was due to be re-published in late August 2020, as part of an awareness campaign for staff. It is a 'live' document, which is regularly updated and includes a distinct PS policy, with specific procedural guidance and tools for staff. Wealstun regards an ineffective drug strategy as a significant risk to the prison, so the strategy sets out strong governance measures, including oversight by the Governor.
89. In January 2020, following another death caused by PS, we recommended that Wealstun addressed weaknesses in the substance misuse strategy and revise the policy accordingly. We are pleased to note that this has been done and therefore make no further comment on this issue.

Clinical care

Support for Mr Azad's substance misuse

90. By his own admission, Mr Azad did not go more than two days without using PS. He engaged with DARS sporadically and claimed to be abstinent from drugs for

short periods but, for the most part, he continued to use PS. Owing to his complex needs, some linked to his substance misuse, Mr Azad was allocated a learning disability nurse and was managed under several support mechanisms, including ACCT, SIM and MPCCC. Mr Azad did not have a mental health diagnosis, but the mental health team was actively involved in his management during the ACCT process and other multidisciplinary teams.

91. Staff took action in line with Wealstun's local policy, referring Mr Azad to DARS when they found him under the influence of PS. However, as an almost daily user and with only two regular staff to supervise a large wing, there were many times when his use went unnoticed. As well as interventions, staff also took punitive action.
92. The clinical reviewer is satisfied that healthcare staff were responsive to Mr Azad's physical and mental healthcare needs and that they contributed to protecting and supporting him. We agree with the clinical reviewer's conclusion that Mr Azad's clinical care was equivalent to that he could have expected to receive in the community.

Drug testing

93. Mr Azad's frequent drug use was known to staff, yet there is no record of him ever having a drug test at Wealstun. His personal records and security intelligence reports show that on-suspicion drug tests had been recommended a few times, but none appear to have been actioned.
94. At interview, the investigator asked about the large number of security intelligence reports relating to Mr Azad and why he had not been tested. The former Head of Security and Intelligence said that the volume of reports about Mr Azad was comparable to several other prisoners. He further explained that in the year before Mr Azad's death, there had been little suspicion or frequent testing due to a lack of staff resources. Also, the prison had only a small testing area, with one confinement space. As they could only accommodate one test at a time, priority was given to mandatory drug tests (MDTs) as they were performance-related.
95. Drug testing is a vital part of any strategy to reduce substance misuse, so it is important that there is adequate provision for this. We make the following recommendation:

The Governor should review the prison's drug testing arrangements to ensure that prisoners suspected of using drugs are tested. This should include an auditable process to track and action requests for mandatory drug tests.

Key worker sessions

96. All prisoners in closed prisons must have a key worker to engage with them, identify their needs and provide one-to-one support through their sentence. Key workers document meetings in prisoners' electronic case notes and management checks are made. The prison inspection in October 2019 found that the key worker scheme was developing well. All prisoners had been allocated a key worker and there had been an increase in staff contact.

97. Our investigation found that the key worker entries in Mr Azad's personal records were detailed and reflected the depth of discussions about a range of issues, including his use of PS. However, between January and April 2019, there were no entries.
98. A new key worker was allocated on 9 April. Owing to staffing changes beyond her control, several sessions were cancelled and she did not see him again until 27 May. She noted that Mr Azad had raised many issues that day, as he had been waiting to see her for a long time. They spoke about him being under the influence of drugs the day before and he implied that he had been forced to smoke PS. His key worker encouraged him to divulge names, so that she could record this and monitor him under CSIP, but he was reluctant to do so and only gave one name. This was his last key work session. When she raised the problem, in passing a few days later, he said it had been resolved.
99. The gap in Mr Azad's key work sessions coincided with a period of frequent PS use and episodes of self-harm (eight code blue calls between March and May). Although he was supported by other processes, including multidisciplinary teams, we are concerned that a man with complex needs and multiple enduring problems had an extended period without one-to-one support. We do not know whether such input would have helped him to remain drug-free, but key work sessions are bound to be more effective if they are regular and consistent. We therefore make the following recommendation:

The Governor should ensure that key workers are allocated to all prisoners and that sufficient time is allocated for regular contact to be maintained.

Violence and bullying

100. Mr Azad was managed under several formal processes, including ACCT and CSIP, as a victim. He was also discussed as part of safer interventions, a weekly multidisciplinary risk management meeting to manage, monitor and support around ten prisoners, "the critical few" who pose the highest level of risk to others, or themselves. Information was shared on vulnerability, the risk of violence and PS use.
101. Wing staff recognised that Mr Azad was at risk of bullying and coercion to try out PS. Prison managers told the investigator that they continually had concerns about him and had put in place protective measures, but other prisoners would often get around them. Despite his reluctance, Mr Azad was moved around the prison, but this did not seem to help. His final move was to C wing. Managers explained this was the biggest wing, so it was hard to spot if someone was struggling, but they had placed him in a cell close to the staff office to keep an eye on him.
102. We are satisfied that Mr Azad was managed in line with Wealstun's safety policy. Staff did their best to keep him safe and were responsive when he reported incidents, or they observed dubious behaviour between him and other prisoners.

Emergency response

103. PSI 03/2013, Medical Emergency Response Codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions on efficiently communicating the nature of a medical emergency and says that if an emergency code is called over the radio, an ambulance must be called immediately.
104. The investigation found shortcomings in the initial handling of the emergency response. When the officer radioed the first code blue, she said that officers were not required. She called a further code blue moments later. There was then a delay of between three to five minutes before the control room called an ambulance.
105. There were only two officers on the wing. Both were very new to the role and still on probation. Although an officer checked for a pulse and breathing, neither officer started CPR. At interview, the officer said that, with hindsight, she should have attempted resuscitation.
106. In this and previous investigations at Wealstun, we found that staff were confused about the emergency response procedures. However, in October 2019, the prison issued Notice to Staff (NTS) 373/2019, *Emergency Response in Custody (E.R.I.C) Protocol* and gave staff individual information cards, reiterating the correct procedures. Knowledge and awareness sessions were also held on residential units. On 30 January 2020, NTS 032/202, *Emergency Response Codes*, reminded staff to follow the national guidance in Prison Service Instruction (PSI) 03/2013. A full staff meeting dedicated to this issue was facilitated by the safer custody team, Care UK and a paramedic.
107. We are satisfied that Wealstun has taken appropriate steps to improve staff understanding of the emergency response policy, such as the correct use of emergency codes and the need to request an ambulance promptly, so we make no comment on these issues. However, we consider that staff should be reminded about the importance of immediate cardiopulmonary resuscitation. We make the following recommendation:

The Governor should ensure that all prison staff receive sufficient guidance to understand the benefits of starting cardiopulmonary resuscitation immediately when a prisoner is unresponsive and that they should carry out chest compressions until medically trained staff arrive, unless there is clear evidence that it would be futile in the circumstances.

**Prisons &
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