Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Ashley Dawe a prisoner at HMP Parc on 4 November 2017

**A report by the Prisons and Probation Ombudsman**

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## Our Vision

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

## Our Values

**We are:**

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

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

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

Mr Ashley Dawe died in hospital on 4 November 2017 after being found collapsed in his cell at HMP & YOI Parc on 2 November, on the eve of his 24th birthday. He died from severe and irreversible brain damage following a cardiac arrest, as a result of using psychoactive substances (PS). I offer my condolences to Mr Dawe's family and friends.

The investigation found that Mr Dawe's mental health care was not equivalent to that which he could have expected to receive in the community in that there was no detailed review of his mental health needs during the eight months he was at Parc. He did, however, continue to receive medication.

Mr Dawe was subject to Prison Service suicide and self-harm monitoring (known as ACCT) between 24 and 31 October. We found some deficiencies in the management of the ACCT process, although there is no suggestion that Mr Dawe's death was the result of deliberate self-harm.

We found that Mr Dawe's cellmate delayed calling for help for 25 to 30 minutes after Mr Dawe collapsed. It also appears that there was a further unnecessary delay before an ambulance was called. However, the clinical reviewer does consider that these delays affected the outcome for Mr Dawe.

Despite these deficiencies, we concluded that the key issue was Mr Dawe's use of PS. Staff at Parc gave Mr Dawe support with his substance misuse and warned him of the dangers of using PS, but he continued to use them.

I am concerned, along with HM Inspectorate of Prisons and the Independent Monitoring Board, that PS use among prisoners at Parc is rife. While the prison has taken measures to tackle the issue, more needs to be done and the investigation found some inconsistencies at the prison between policy and practice.

I am increasingly concerned by the number of deaths I investigate in which PS has played at least some part. Mr Dawe's death is another example of how dangerous PS is and how even prisons that we judge have effective measures in place to reduce PS use, are struggling.

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

It is clear that there are prisoners who, despite being advised of the risks of PS, are determined to continue to abuse them. I hope that the promised national strategy will include focus on effective education for prisoners in the dangers of PS, and that it will be clear on how to engage effectively with and protect prisoners with specific clinical or psychiatric needs from these dangerous drugs.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Elizabeth Moody**
**Deputy Prisons and Probation Ombudsman** **February 2019**

## Contents

# Summary

## Events

1. On 23 November 2016, Mr Ashley Dawe received a 14-year sentence for wounding with intent to cause grievous bodily harm. He spent time at HMP Cardiff and a secure psychiatric hospital before being moved to HMP & YOI Parc on 28 February 2017.

2. Mr Dawe had a history of drug abuse and had been diagnosed with a personality disorder, depression, schizophrenia and post-traumatic stress disorder (PTSD).

3. A senior substance misuse offender supervisor (SMOS) began to see Mr Dawe in March. The senior SMOS planned for Mr Dawe to attend psychosocial groups to discuss his drug use but there is no record that Mr Dawe attended. On 3 April, the senior SMOS moved Mr Dawe to the substance misuse support unit to engage with substance misuse interventions. He stayed there until 24 May.

4. On 13 July, Mr Dawe failed a mandatory drug test, as his urine tested positive for psychoactive substances (PS). An officer placed him on report but there is no record that Mr Dawe was referred to the substance misuse team.

5. On 15 and 22 September, the senior SMOS saw Mr Dawe, who admitted to occasionally using PS. The senior SMOS told Mr Dawe about the dangers of using illicit substances and how to minimise the risk.

6. On 24 October, staff started suicide and self-harm monitoring (known as ACCT) after Mr Dawe made cuts to his arm. During the first case review on 25 October, a manager set a caremap action for Mr Dawe to have an appointment with the mental health team. Although an appointment was made, Mr Dawe was not seen before he died. Staff closed the ACCT on 31 October.

7. At 11.03pm on 2 November, Mr Dawe's cellmate asked for help because Mr Dawe had collapsed after smoking PS. An officer attended and called an emergency radio code. Officers and healthcare staff responded and tried to resuscitate Mr Dawe. Control room staff called for an ambulance at 11.12pm.

8. Paramedics took over the resuscitation attempt and found that Mr Dawe's circulation had returned so they took him to hospital. While paramedics were treating Mr Dawe, his cellmate said that he had delayed calling for help because Mr Dawe had recovered after collapsing in the past. Once at hospital, Mr Dawe's condition continued to deteriorate and at 9.26pm on 4 November, hospital doctors declared that he had died.

## Findings

### Substance misuse

9. Mr Dawe died as a result of using PS.

10. Staff at Parc gave Mr Dawe support with his substance misuse and warned him of the dangers of using PS, but he continued to use them. However, there was a potential missed opportunity to help Mr Dawe address his PS use in July 2017.

We also agree with the clinical reviewer that the prison's PS interventions were not as structured as those for opiate users.

11. We are concerned at the availability of PS at Parc. Despite a comprehensive local drugs strategy, it is clear that more needs to be done to limit supply and demand. In our view there is now an urgent need for HMPPS to issue national guidance on this to prisons, rather than leaving individual establishments to develop their own local strategies on a piecemeal basis. We have made a recommendation to this effect to the Chief Executive of HMPPS in a previous investigation and raised our concerns with the prisons minister.

12. It is clear that there are prisoners who, despite being advised of the risks of PS, are determined to continue to abuse them. We hope that the promised national strategy will include focus on effective education for prisoners in the dangers of PS.

### Mental health

13. Parc did not carry out a detailed review of Mr Dawe's mental health or his treatment needs. We agree with the clinical reviewer that his mental health care was not equivalent to that which he could have expected to receive in the community.

### ACCT Management

14. We found several deficiencies with the ACCT process. The member of staff who completed the Concern and Keep Safe Form did not complete their details or the date and time, the first ACCT case review was not held within 24 hours, caremap actions were marked as complete when they were not and staff did not observe Mr Dawe twice an hour as they should have done.

15. There is, however, nothing to suggest that Mr Dawe used PS before his death in an attempt to self-harm. On the contrary, it appears that he did so to 'celebrate' his birthday.

### Emergency response

16. There was a delay of 25 to 30 minutes in Mr Dawe's cellmate seeking help after Mr Dawe collapsed. The clinical reviewer concluded that the delay is likely to have affected the outcome for Mr Dawe. Consequently, we consider that prisoners need further education about the importance of seeking urgent assistance when a fellow prisoner becomes unresponsive after taking drugs.

17. We are also concerned that there was a delay of seven minutes between the code blue call and the control room calling an ambulance.

### Family liaison

18. On 24 October, Mr Dawe changed his next of kin from his father to his grandmother. We are concerned that the prison disregarded Mr Dawe's choice of next of kin and contacted his father when he was taken to hospital.

## Recommendations

- The Director and Head of Healthcare should ensure that staff inform the substance misuse team when prisoners fail drug tests so that it can provide prompt substance misuse support.
- The Director and Head of Healthcare should take steps to develop a more integrated and bespoke substance misuse treatment service for prisoners who use psychoactive substances.
- The Director and Head of Healthcare should ensure that prisoners arriving with identified mental health problems are referred to the mental health team for assessment and treatment and that follow up mental health reviews are carried out as planned.
- The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:
    - fully complete the Concern and Keep Safe Form;
    - hold a multidisciplinary case review within 24 hours of an ACCT plan being opened;
    - record ACCT caremap actions as complete only when they have been fully completed; and
    - adhere to the frequency of observations set out in the ACCT document and undertake observations at unpredictable times.
- The Director and Head of Healthcare should ensure that prisoners understand that they should quickly seek help from prison or healthcare staff when other prisoners collapse after using illicit substances.
- The Director should ensure that all control room staff call an ambulance as soon as an emergency code is called.
- The Director should ensure that when a prisoner changes their next of kin, staff update the prisoner's NOMIS prison record promptly.

# The Investigation Process

19. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded but did not have any relevant information for the investigation.

20. The investigator visited HMP Parc on 10 November 2017. He obtained copies of relevant extracts from Mr Dawe's prison and medical records.

21. Healthcare Inspectorate Wales (HIW) commissioned a review of the clinical care Mr Dawe received at the prison.

22. The investigator interviewed eight members of staff at HMP Parc on 12 and 13 December 2017 and two members of staff by telephone on 8 and 19 February 2018. The clinical reviewer accompanied the investigator for the five interviews held on 13 December.

23. We informed HM Coroner for Bridgend and Glamorgan Valleys District of the investigation who gave us the results of the post-mortem examination. Our investigation was suspended for nearly six months until we received the post-mortem report from the coroner. We regret the consequent delay in issuing this report. We have sent the coroner a copy of this report.

24. One of the Ombudsman's family liaison officers contacted Mr Dawe's grandmother and father to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Dawe's father wanted to know what had happened on the evening that Mr Dawe collapsed and how his mental health issues were managed, including details of any medication he had been prescribed.

25. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies with the clinical review and this review has been amended accordingly. The action plan has been annexed to this report.

26. Mr Dawe's father received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

# Background Information

### HMP & YOI Parc

27. HMP & YOI Parc is a medium security private prison run by G4S, which holds around 1,800 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under 18.

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

### HM Inspectorate of Prisons

29. The most recent inspection of HMP & YOI Parc was in January 2016, although inspectors did inspect the Young Person's Unit in October 2017. Inspectors reported that the ready availability of psychoactive substances (PS) was having a severely negative influence. Over 50% of prisoners told inspectors that it was easy or very easy to get drugs in the prison, which was significantly higher than at comparator prisons. Inspectors found that the prison had made attempts to deal with the problem, but the problem remained and did not appear to be receding. Inspectors found substance misuse work was well managed and was a recovery-focused service.

30. Inspectors also found that health services were reasonably good, except for mental health provision that was inadequate. Despite this, prisoners remained overwhelmingly negative about access to and the quality of health services. Inspectors noted that three healthcare staff located in the prison at night ensured prompt access during emergencies and appropriate emergency equipment was located across the prison. They found that all operational staff were first aid trained, with most trained to use easily accessible automated defibrillators, and that ambulances were called promptly during medical emergencies.

### Independent Monitoring Board

31. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 28 February 2018, the IMB reported that it was concerned that the demand for mental health services remained high and that self-harm figures were very significant.

32. The IMB expressed concern that the level of substance abuse in the prison remained high and that the amount of drugs, particularly PS, entering the prison was presenting a continual challenge.

### Previous deaths at HMP & YOI Parc

33. Mr Dawe was the 16th prisoner to die at Parc since November 2014. Of the previous deaths, eleven were due to natural causes, three were self-inflicted and one was unascertained but suspected to be drugs related. There have been four subsequent deaths. One was due to natural causes and three are awaiting classification. We have made previous recommendations about ensuring ACCT

procedures are managed in line with national guidance and prisoners' next of kin details are kept up to date.

### 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.

### Assessment, Care in Custody and Teamwork

37. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and 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.

38. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

39. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm, to self, to others and from others (Safer Custody).

# Key Events

40. On 22 February 2016, Mr Ashley Dawe was remanded to custody on suspicion of attempted murder and was sent to HMP Cardiff. On 23 November, he received a 14-year sentence, which comprised a custodial sentence of nine years and an extension period of five years, for wounding with intent to cause grievous bodily harm.

41. At his initial health screen at Cardiff, Mr Dawe told the healthcare assistant he regularly used heroin, crack cocaine and cannabis. He also said he had been diagnosed with a personality disorder, depression, schizophrenia and post-traumatic stress disorder (PTSD). The healthcare assistant referred Mr Dawe to the mental health team, though there was no record that he was referred to the substance misuse team. On 24 February, a prison GP reviewed Mr Dawe and prescribed him quetiapine (an antipsychotic drug used in the treatment of schizophrenia and bipolar disorder).

42. On 26 February, a nurse saw Mr Dawe, who told him he had a history of drug misuse but that he wanted to stop using drugs. There is no record that the nurse referred him to the substance misuse team.

43. From February, healthcare staff at Cardiff regularly reviewed Mr Dawe's mental health and diagnosed him with psychosis, PTSD and a cluster B personality disorder (this includes antisocial, borderline, histrionic and narcissistic personality disorders). Healthcare staff treated these conditions with quetiapine, though there were occasions when he refused to take his medication. On 1 April, the forensic psychiatrist decided that he needed to be admitted to a secure psychiatric hospital. On 9 August, Mr Dawe was moved to a secure psychiatric hospital.

44. On 31 October, doctors discharged Mr Dawe from the secure psychiatric hospital as they felt that he had not presented with psychotic symptoms, and he was returned to Cardiff. From 1 November, healthcare staff at Cardiff, including a forensic psychiatrist, regularly reviewed Mr Dawe's mental health. They treated his conditions with propranolol (used to treat anxiety) and sertraline (used to treat depression), though in January 2017 Mr Dawe stopped taking his medication, as he said it was not working. Healthcare staff reviewed his medication and replaced it with quetiapine and venlafaxine (an antidepressant used to treat major depressive disorders and anxiety).

45. On 28 February, Mr Dawe was transferred from Cardiff to HMP & YOI Parc. During his induction, Mr Dawe said that he did not have any substance misuse issues and he named his father as his next of kin. An induction officer told Mr Dawe that he could access substance misuse support from a Substance Misuse Offender Supervisor (SMOS) and his personal officer and he could apply to attend the Building Skills for Recovery programme.

46. On the same day a prison GP prescribed Mr Dawe quetiapine and venlafaxine medication but did not see him.

47. On 1 March, an unidentified substance misuse worker recorded in Mr Dawe's Record of Induction that he did not have a history of substance misuse and that a

substance misuse referral had not been made. They also recorded that Mr Dawe had "no issues" with substance misuse.

48. In early March, a senior SMOS met with Mr Dawe, who said that he drank alcohol and used Valium, cannabis and amphetamines on a daily basis. He planned for Mr Dawe to attend psychosocial groups to discuss his usage and referred him to the Drug Interventions Programme and to Narcotics and Alcoholics Anonymous, although there is no record that Mr Dawe attended these groups. He decided that Mr Dawe did not require a detoxification programme.

49. On 15 March, a mental health team meeting discussed Mr Dawe's mental health after the lead clinician at Cardiff told them he suffered with a personality disorder rather than a psychotic illness. The lead clinician said that Mr Dawe was treated with medication and occasional input from a psychiatrist but that he had not accessed secondary care services.

50. On 21 March, a mental health nurse met Mr Dawe who said that his mood was "up and down". The mental health nurse referred Mr Dawe to the lead mental health nurse, although there is no record that they saw him.

51. On the same day, the senior SMOS met with Mr Dawe, who agreed to move to the substance misuse support unit, D wing, to engage with substance misuse interventions. Mr Dawe was moved on 3 April but left on 24 May, after telling him that he feared for his safety and had locked himself in his cell.

52. On 17 May, the senior SMOS received information from Cardiff that Mr Dawe had been discharged from the mental health team because he had been diagnosed with a personality disorder.

53. On 13 July, Mr Dawe failed a mandatory drug test, as his urine tested positive for PS, and an officer placed him on report. There is no record that Mr Dawe was referred to the substance misuse team. On 31 August, an Independent Adjudicator found Mr Dawe guilty of the offence and punished him with a further 18 days in custody.

54. On 15 September, the senior SMOS saw Mr Dawe for a one to one session and asked him whether he used PS. Mr Dawe said he did occasionally so he told him about the dangers of using illicit substances and how to minimise the risk.

55. A week later, the senior SMOS saw Mr Dawe, who said that he was trying to stay away from using PS. He again told Mr Dawe about the dangers of using illicit substances and how to minimise the risk.

56. On 26 September, the senior SMOS and Mr Dawe's offender manager met with Mr Dawe to discuss his sentence plan. Mr Dawe said he used PS but it was under control, and he was aware of the dangers and that it could affect his mental health. The attendees agreed that Mr Dawe needed to abstain from drugs and engage with the substance misuse team.

57. The following day, Mr Dawe's offender manager completed Mr Dawe's OASys Assessment (designed to assess the risks and needs of an offender) and recorded that he said he regularly used "mamba" (a form of PS) as it kept him calm. She noted that he had a limited desire to address his substance misuse.

58. On 23 October, a substance misuse nurse made an entry on Mr Dawe's electronic medical record that he had been referred to the prison's Integrated Drug Treatment Service.

59. The following morning, Mr Dawe made deep cuts to his left arm and said that he was hearing voices that had told him to hurt himself or others. An unidentified member of staff started Prison Service suicide and self-harm monitoring (known as ACCT), but they failed to complete some sections of the Concern and Keep Safe Form including their name, the date and time. The front page of the ACCT document noted it was opened at 10.10am. Mr Dawe listed his grandmother as his next of kin.

60. At 10.36am, a prison manager completed an Immediate Action Plan for Mr Dawe. Mr Dawe said that he was not on any medication, was not working with a mental health nurse and that he wanted a cellmate. He asked a nurse to refer Mr Dawe to the mental health team though there is no record that this happened. He decided that staff should observe Mr Dawe twice an hour. At approximately 1.00pm, Mr Dawe was moved into cell C1-56 and began sharing with another prisoner.

61. At 8.30am on 25 October, an officer completed Mr Dawe's ACCT assessment. Mr Dawe said that his mental health had deteriorated and that he had been unable to attend mental health appointments so wanted a mental health assessment. Mr Dawe said that he did not plan on taking his own life but that cutting himself gave him relief.

62. At 10.55am, a prison manager held the first ACCT case review with Mr Dawe and a substance misuse nurse. Mr Dawe said that he was struggling on the basic regime and that his mental health issues made him depressed. He said that he had not engaged with the mental health in-reach team because he felt anxious and rarely came out of his cell. He considered that Mr Dawe presented a low risk of suicide and self-harm (on a scale of low, raised and high) and kept the same level of observations. He scheduled the next ACCT case review for 31 October.

63. The prison manager also completed Mr Dawe's caremap (designed to identify the main areas of concern and the actions required to reduce risk). He noted that Mr Dawe needed an appointment with the mental health in-reach team and to be escorted to the appointment to help with his anxiety. He also decided that a senior prison manager needed to review Mr Dawe's IEP level.

64. On 30 October, Mr Dawe refused a mandatory drug test so an officer placed him on report. The matter was referred to the Independent Adjudicator but the hearing was not held before Mr Dawe's death.

65. At 9.10am on 31 October, the prison manager held the second ACCT case review with Mr Dawe and a substance misuse nurse. He recorded that Mr Dawe said that he did not have any thoughts of suicide or self-harm and that he was happy being off the basic regime. Mr Dawe also said that he had a good relationship with his cellmate so wanted the ACCT to be closed. He reviewed the caremap and recorded that all the actions had been completed, though Mr Dawe had not had his appointment with the mental health in-reach appointment (which

was arranged for 1 November). He closed the ACCT and scheduled a post closure review for 7 November.

### Events from 2 November 2017

66. During the morning of 2 November, a nurse from the substance misuse team saw Mr Dawe, who said that he felt distressed and anxious and had self-harmed recently in response to auditory hallucinations. The nurse planned for the lead mental health clinician to review Mr Dawe but this did not happen before his death.

67. Later that day, the nurse from the substance misuse team discussed Mr Dawe with a locum GP who did not consider that Mr Dawe demonstrated any imminent risk. He planned a GP review for Mr Dawe and to flag his issues to the mental health team, though these did not happen before his death.

68. The cell bell record for Mr Dawe's cell recorded that an officer visited at 8.26pm and 10.35pm. An officer who was working on the wing that evening, told the investigator that he did not remember checking on Mr Dawe that evening.

69. At 11.03pm, Mr Dawe's cellmate pressed his cell bell, which an officer answered on the cell intercom within 30 seconds. He said there was something wrong with Mr Dawe and that the officer needed to call a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing). The officer went to Mr Dawe's cell, saw Mr Dawe lying on the floor and asked whether he was breathing but his cellmate said he did not know. At 11.05pm, the officer called a code blue emergency but did not enter the cell because he considered it unsafe to do so as it was a shared cell.

70. At 11.08pm, another officer responded to the code blue and entered Mr Dawe's cell with the first officer. An officer started cardiopulmonary resuscitation (CPR) and was quickly joined by another officer, a nurse, a healthcare assistant and a healthcare administrator. The nurse, the healthcare assistant and an officer continued CPR, gave Mr Dawe oxygen and attached a defibrillator but it did not detect a shockable heart rhythm and advised to continue CPR.

71. The control room operator told the investigator that he had called for an ambulance almost immediately after an officer called the code blue. However, at 11.12pm, he recorded on the control room ledger "ambulance required – put through to C1 visit". The Welsh Ambulance Service log confirmed they received the call for an emergency ambulance at 11.12pm.

72. Paramedics reached Mr Dawe at 11.18pm and took over the resuscitation attempt. At 11.48pm, the paramedics found that Mr Dawe's circulation had returned so they took him to the Princess of Wales (POW) Hospital, Bridgend. Two officers accompanied Mr Dawe but did not restrain him.

73. While paramedics were treating Mr Dawe, his cellmate told the healthcare administrator that Mr Dawe had smoked a "fingertip" amount of PS using a pipe because it was his birthday on 3 November. He said that Mr Dawe inhaled once before collapsing and that he hit his head on a shelf as he collapsed. He said that he did not immediately call for help because Mr Dawe had collapsed in the past after using PS but always recovered. He also said that he did not want to

get Mr Dawe into trouble. He said that he left Mr Dawe for 25 to 30 minutes but called for help when he went grey. The cellmate refused an interview with the investigator after having obtained legal advice from his solicitor.

74. On arrival at hospital, doctors admitted Mr Dawe to the intensive care unit and put him on a life support machine. Mr Dawe's condition continued to deteriorate so hospital doctors performed two brain stem tests (used to determine whether a patient has permanently lost the potential for consciousness and the capacity to breathe). Mr Dawe did not respond to a variety of stimuli so at 9.26pm on 4 November, hospital doctors declared that he had died. However, hospital staff did not switch off the ventilator until 5 November to enable the donation of his organs.

### Contact with Mr Dawe's family

75. At 11.35pm on 2 November, the prison appointed a Chaplain as the family liaison officer. Prison staff attempted to contact Mr Dawe's father by telephone to tell him that his son was in hospital but could not get through. The prison asked South Wales Police to visit the home address of Mr Dawe's father to deliver the news, which they did in the early hours of 3 November.

76. At 3.05am on 3 November, the Chaplain went to the hospital and supported Mr Dawe's family. He continued to support Mr Dawe's family during discussions about switching off Mr Dawe's life support and following his death.

77. Mr Dawe's funeral took place on 13 December 2017 and the prison contributed to the funeral costs in line with national policy.

### Support for prisoners and staff

78. In the early hours of 3 November, a senior prisoner manager debriefed the prison and healthcare staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support from the staff care team. After Mr Dawe's death, a senior prison manager debriefed the escorting staff who were present when Mr Dawe's died to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

79. The prison posted notices informing other prisoners of Mr Dawe's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide and self-harm in case they had been adversely affected by Mr Dawe's death.

### Post-mortem report

80. The post-mortem report concluded that Mr Dawe died from hypoxic-ischaemic encephalopathy (when the brain does not receive enough oxygen to function correctly) following a cardiac arrest after taking PS.

81. The toxicology report said that Mr Dawe's blood contained PS and a therapeutic level of gabapentin (a prescription only drug used to treat epilepsy and nerve pain but which can also enhance the euphoric effects of other drugs and is subject to abuse).

# Findings

## Substance misuse

82. Mr Dawe had a history of drug abuse. When he arrived at Parc, he initially told two members of staff that he did not have any substance misuse needs, but later admitted that he drank alcohol and used Valium, cannabis and amphetamines on a daily basis. From March 2017, the prison appointed a senior SMOS to support Mr Dawe. He moved Mr Dawe to the substance misuse support unit in April, where he stayed for approximately six weeks, which allowed him to access substance misuse interventions. He also warned Mr Dawe about using illicit substances on 15 and 22 September.

83. While Mr Dawe received some appropriate substance misuse care, we are concerned there was a missed opportunity to help him address his use of PS. On 13 July, Mr Dawe failed a mandatory drug test, as his urine tested positive for PS, but there is no record that anyone spoke to him about this until the senior substance misuse offender supervisor did so on 15 September, over two months later. We make the following recommendation:

**The Director and Head of Healthcare should ensure that staff inform the substance misuse team when prisoners fail drug tests so that it can provide prompt substance misuse support.**

84. We also agree with the clinical reviewer that the prison's PS interventions were not as structured as those provided to opiate users. As HM Inspectorate of Prisons and the Independent Monitoring Board were both concerned about the prevalence of PS at Parc, we consider that more structured PS support services are required. We make the following recommendation:

**The Director and Head of Healthcare should take steps to develop a more integrated and bespoke substance misuse treatment service for prisoners who use psychoactive substances.**

85. During the investigation, the Head of Security explained the steps that Parc had taken to reduce the supply of drugs into the establishment. These included efforts to stop drones reaching the establishment, increased searching of staff and an increased security presence during family visits.

86. We are satisfied that Parc has taken steps to reduce the supply and demand for drugs. Nevertheless, the HMIP report indicated that drugs are easily accessible to prisoners and Mr Dawe died after taking PS. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for PS.

87. Parc is not alone in facing this problem: it 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, in the PPO's view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

88. In a recent investigation, we recommended that the Chief Executive of HMPPS should issue detailed national guidance on measures to reduce the supply and

demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of deaths she was investigating that were due, or linked, to the use of PS. The Chief Executive has told us that HMPPS plan to issue a national drug strategy in the autumn of 2018. We therefore make no recommendation.

### Mental health

89. Mr Dawe had been diagnosed with a personality disorder, depression, schizophrenia and post-traumatic stress disorder (PTSD). While at Cardiff, Mr Dawe received prompt mental health treatment from nurses, doctors and a forensic psychiatrist. Their input led to Mr Dawe spending nearly three months at the secure psychiatric hospital.

90. Despite his complex mental health issues, once at Parc, Mr Dawe was only seen by one mental health nurse and his mental health needs were discussed at a single multidisciplinary team meeting. We agree with the clinical reviewer that there was no detailed review of Mr Dawe's mental health or his treatment needs in the months between his admission to Parc and his death. We agree with the clinical reviewer that Mr Dawe's mental health care at Parc was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

**The Director and Head of Healthcare should ensure that prisoners arriving with identified mental health problems are referred to the mental health team for assessment and treatment and that follow up mental health reviews are carried out as planned.**

### ACCT management

91. Prison Service Instruction (PSI) 64/2011 'Safer Custody' sets out the processes that should be followed when an ACCT has been opened. This includes that the Concern and Keep Safe Form must be completed, that the first case review must be held within 24 hours of the ACCT being opened, that the caremap must aim to address the prisoner's issues identified during the ACCT process and that staff must follow the planned frequency of observations.

92. An unidentified member of staff opened Mr Dawe's ACCT because he made deep cuts to his left arm and was hearing voices. Despite adding this information to the Concern and Keep Safe Form, they did not complete the form as their name and the time and date is missing. We are especially concerned that the time and date is missing because many subsequent tasks are time dependent. We are also concerned that a prison manager completed a Quality Assurance Record following the first ACCT case review and incorrectly recorded that the Concern and Keep Safe Form had been signed and dated.

93. The front cover of the ACCT document says that it was opened at 10.10am on 24 October but the first ACCT case review was not held until 10.55am on the following day. While it was outside the 24-hour period allowed by only 45 minutes, we are concerned that such a crucial requirement of the ACCT process was overlooked and that there was an unnecessary delay in addressing Mr Dawe's needs.

94. Following the first ACCT case review, a prison manager added a caremap action for Mr Dawe to have an appointment with the mental health team. This action was marked as having been completed on 31 October, despite Mr Dawe not having been seen by the mental health team. We are concerned that this action was prematurely marked as complete and that Mr Dawe's mental health issues had not been addressed.

95. A prison manager set the level of observations at twice an hour but we are concerned there were over 30 instances when staff did not observe him within 30 minutes, with the longest gap being 78 minutes. We are also concerned that many observations took place exactly on the half hour after the last observation and not at unpredictable times. We make the following recommendations:

**The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:**

- **fully complete the Concern and Keep Safe Form;**
- **hold a multidisciplinary case review within 24 hours of an ACCT plan being opened;**
- **record ACCT caremap actions as complete only when they have been fully completed; and**
- **adhere to the frequency of observations set out in the ACCT document and undertake observations at unpredictable times.**

### Emergency response

96. Mr Dawe's cellmate said that he had not called for assistance for 25 to 30 minutes after Mr Dawe had collapsed. He said that Mr Dawe had collapsed in the past but had always recovered and he did not want to get him into trouble with prison staff.

97. The clinical reviewer concluded that they did "consider it likely that [Mr Dawe's] death would more likely have been prevented had [his cellmate] called for help sooner".

98. Whether or not the delay affected the outcome for Mr Dawe, we consider that a delay of 25 to 30 minutes could make a significant difference in other cases.

99. We note that during meetings with their offender supervisors, prisoners at Parc are given a Substance Misuse Harm Reduction Checklist. The checklist provides guidance on what to do if someone suffers physical effects after taking stimulants or depressants and includes calling for an ambulance and remaining with the person who has taken the illicit substance. However, the checklist does not include any guidance about immediately calling for help.

100. While prisoners are aware of the physical effects of certain drugs, we believe that prisoners need further education about the need for immediate emergency assistance when fellow prisoners have become unresponsive after taking drugs. Anecdotal evidence from other prisons suggests that this issue has arisen at other establishments and is not limited to Parc. We hope that the national drugs strategy, mentioned above, will include educational measures that can address this issue at all establishments. We make the following recommendation:

**The Director and Head of Healthcare should ensure that prisoners understand that they should quickly seek help from prison or healthcare staff when other prisoners collapse after using illicit substances.**

101. Prison Service Instruction (PSI) 03/2013 'Medical Emergency Response Codes', states that control room staff must automatically call an ambulance when a code blue or code red is called.

102. When an officer found that Mr Dawe was unconscious, he correctly and promptly called a code blue emergency. He called the code blue emergency at 11.05pm, yet the control room ledger and Welsh Ambulance Service log agree that the ambulance was not called until 11.12pm, a delay of seven minutes. Although he was adamant that he called for an ambulance immediately, we believe that the documentation shows there was an unnecessary delay. We are concerned that he did not follow PSI 03/2013 because he did not immediately call for an ambulance. We make the following recommendation:

**The Director should ensure that all control room staff call an ambulance as soon as an emergency code is called.**

### Family liaison

103. PSI 64/2011, 'Management of Prisoners at Risk of Harm to Self, to Others and from Others (Safer Custody)', sets out the guidance and mandatory actions for prison staff to follow for identifying a prisoner's next of kin. This includes that information about the next of kin must be kept up-to-date.

104. When Mr Dawe arrived at Parc in February 2017, he listed his father as his next of kin. However, when prison staff placed Mr Dawe on an ACCT on 24 October, he changed his next of kin to his grandmother. This change was ignored when Mr Dawe collapsed and was taken to hospital because prison staff and South Wales Police informed his father rather than his grandmother. We are concerned that the prison disregarded Mr Dawe's choice about his next of kin and did not follow the instructions in PSI 64/2011 on keeping information about his next of kin up-to-date. We make the following recommendation:

**The Director should ensure that when a prisoner changes their next of kin, staff update the prisoner's NOMIS prison record promptly.**

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