

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Nicholas Rose, a prisoner at HMP Guys Marsh, on 19 May 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 Nicholas Rose died on 19 May 2019 at HMP Guys Marsh from the effects of psychoactive substances (PS). He was 37 years old. I offer my condolences to Mr Rose's family and friends.

Mr Rose had a history of substance misuse in prison but appeared to have been abstinent for over a year before he died. He was regarded as a role model by staff and prisoners and supported other prisoners with substance misuse issues. His death was a great shock to all at Guys Marsh and is another sad example of the dangers of psychoactive substances.

We found there was no obvious indication that Mr Rose had resumed using drugs before he died. The problem of drugs in prison is a complex and multi-faceted one. Guys Marsh provided us with their current drug strategy and evidence of the measures they are taking to reduce supply and demand. We are satisfied that they are doing what they can in this regard, given the changing nature of drug culture and the scale of the problem across the prison estate. We make no recommendations.

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

August 2021

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Summary

Events

1. Mr Nicholas Rose was sentenced to imprisonment for life for murder in 2005. He was not known to use drugs in prison until October 2016, when he made superficial cuts to his arm to relieve stress about debts due to psychoactive substance (PS) misuse.
2. On 24 October 2017, Mr Rose transferred to HMP Guys Marsh. Mr Rose was found under the influence of PS on several occasions between October 2017 and January 2018.
3. In February 2018, Mr Rose set up a project ('Rock Bottom') to offer advice and support to other prisoners who used PS. He gained enhanced status under the Incentives and Earned Privileges (IEP) Scheme and, in July, he gained a place on a unit for enhanced prisoners.
4. In November 2018, Mr Rose found out that his tariff expiry date (TED - the earliest date that he would be considered for release by the Parole Board) was a year later than he had thought. He suffered a period of low mood after this and was seen by the prison's mental health team.
5. In March 2019, he moved back to a standard wing after losing enhanced status. Mr Rose appeared to have been abstinent from drugs since early 2018 and was considered a role model by staff and prisoners.
6. On 19 May, Mr Rose was found dead in bed in his cell.
7. A post-mortem and toxicology report showed that Mr Rose had died from airway obstruction due to using psychoactive substances.

Findings

8. There was no obvious indication that Mr Rose had resumed using drugs before he died. He was regarded as a role model by staff and prisoners and his death came as a great shock to everyone in the prison.
9. Guys Marsh has an up-to-date and dynamic drug strategy with multi-agency working and cross department sharing of information. We are satisfied that Guy Marsh are doing what they can to reduce drug supply and demand.
10. Mr Rose showed signs associated with death when he was found in his cell and the decision not to attempt resuscitation was the correct one.
11. The first officer on scene turned on his body-worn camera when he realised that Mr Rose had died. Prison service guidance is that staff turn on their camera when attending incidents, including when life-saving medical intervention is necessary. There was no intervention in this case and, while we do not criticise the officer, we consider there must be a balance between capturing direct evidence of what happened and sensitivity and respect towards the prisoner and their family.

Recommendations

12. We have made no recommendations.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Guys Marsh informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Rose's prison and medical records. She watched body-worn camera footage from 19 May 2019. Further information was obtained from South West Ambulance Service Trust.
15. NHS England commissioned a clinical reviewer to review Mr Rose's clinical care at the prison. The investigator and clinical reviewer interviewed three members of staff at Guys Marsh in July 2019. The investigator spoke to another three members of staff and one prisoner alone. She asked to speak to a second prisoner, but he declined to be interviewed.
16. We informed HM Coroner for Dorset of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. We are sorry that this report is very late. Interviews were completed within two months of Mr Rose's death and we suspended our investigation pending the toxicology report. We were not made aware of the results of this for almost a year after they were received. We are sorry for the added distress this will have caused to Mr Rose's family.
18. Our family liaison officer wrote to Mr Rose's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Rose's mother asked what time Mr Rose had been checked before he was found dead and when he had last been seen alive. We have sent her a copy of this report.
19. At initial report stage, Mr Rose's family said their primary concern was the adequacy of the welfare checks made on Mr Rose, the process underpinning welfare checks and the ability of prison officers to identify when a prisoner was in respiratory distress. They were concerned that the check carried out at 8.30am on 19 May was inadequate and that they did not know when Mr Rose was last seen alive.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Guys Marsh

21. Guys Marsh is a medium security prison that holds up to 579 men. Practice Plus Group (formerly Care UK) provides primary and secondary mental healthcare and has commissioned another agency, EDP, to provide integrated substance misuse services. Healthcare services are available on weekdays and at weekends from 8.30am to 6.00pm and there is a doctor on duty on Saturday mornings.

HM Inspectorate of Prisons (HMIP)

22. The most recent inspection of HMP Guys Marsh was in January 2019. Inspectors reported that some improvements had been made to reduce the supply of illicit drugs, but it remained high. Many good initiatives were relatively recent and were not yet sufficiently embedded. Suspicion drug testing was being carried out in a timely fashion but target searching in response to intelligence was often not taking place. Drugs were still too readily available in the prison. There had been a great deal of attention to reducing the supply of illicit drugs, with appropriate use of dogs and technology, but too many of these initiatives were less than a year old and not yet sufficiently embedded. There was a good range of psychosocial support with 50% of the population actively engaging with services.
23. HMIP carried out an independent review of progress at Guys Marsh in October 2019 to review progress against the key recommendations from their earlier investigation. They reported that, although their overall findings were disappointing, the prison had made good progress in developing effective responses to drug misuse and debt. They found that substance misuse was reducing, drug strategy work had developed well, and there was a good focus on educating prisoners on the dangers of using illicit drugs. Several other useful initiatives had been developed since the inspection, such as overdose awareness events, drug forums and roadshows. Work to help prisoners with avoiding and managing debt was developing reasonably well.

Independent Monitoring Board

24. 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 annual report, for the year to November 2019, the IMB reported that the use of psychoactive substances (PS) continued to drive high levels of debt, coercion and serious health alarms, despite the concerted efforts of a variety of teams dedicated to supporting prisoners out of addiction and into staying safe. The Board reported that the death of a prisoner who had been a leading light in the fight against the use of PS [Mr Rose] had shocked everyone and much effort was made to help all those who were close to the prisoner and those involved in the incident.

Previous deaths at Guys Marsh

25. Mr Rose was the sixth prisoner to die at Guys Marsh in the two year period since May 2017. Of the previous deaths, one was from natural causes, three were PS-related and one was a self-inflicted death in which PS played a part. There has been one death since Mr Rose's (in July 2020) also due to PS.

Psychoactive Substances (PS)

26. 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.
27. The effects of PS are unpredictable, and prisoners do not know what exactly they are using. In the course of our investigations, we see numerous examples of apparently fit young men dying as a result of the effects of PS.

Incentives and Earned Privileges (IEP) Scheme:

28. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Key Events

29. Mr Nicholas Rose was sentenced to imprisonment for life for murder in 2005. Apart from some episodes of low mood Mr Rose had no significant physical or mental health issues in prison. He was not known to use drugs in prison until October 2016, when he made superficial cuts to his arm to relieve stress about debts due to psychoactive substance (PS) misuse.
30. On 24 October 2017, Mr Rose transferred to HMP Guys Marsh. Mr Rose was found under the influence of psychoactive substances (PS) on several occasions between October 2017 and January 2018. He was referred to and assessed by the substance misuse team in October 2017 and January 2018 but did not complete any group work. He was referred to the team again in February 2018 but declined to work with them.
31. Mr Rose later told his offender supervisor (probation officer in prison) that he had been very low at the end of 2017 and the beginning of 2018 because he had learned that Inside Justice (a charity that investigates possible miscarriages of justice) were not going to pursue an appeal against his conviction. He said he had resorted to using PS to cope.
32. In February 2018, Mr Rose set up a project ('Rock Bottom') to offer advice and support to other prisoners who used PS. He said he was no longer using PS and wanted to help others to be abstinent. Mr Rose said he was doing this independently from the substance misuse team because of "past disagreements" with them.
33. In May 2018, Mr Rose was given enhanced status under the Incentives and Earned Privileges (IEP) Scheme in recognition of his good behaviour and his Rock Bottom project work. He worked on the prison's Growth Project (a project to develop a rehabilitation culture in Guys Marsh) as a representative. In June 2018, he began training to be a peer mentor and undertook the Level 2 peer mentoring course.
34. In July 2018, Mr Rose moved to Fontmell Unit, the wing for enhanced prisoners, and completed his peer mentoring course.
35. Also, in July 2018, Mr Rose took part in a two-day workshop in the prison as part of the education and learning in response to four PS-related deaths in Guys Marsh earlier in 2018. The Head of Healthcare told us that Mr Rose played a key role in talking about his experience and the challenges prisoners face in coming off drugs.
36. Intelligence gathered during a cell search of another prisoner in July 2018 showed Mr Rose's name on a list presumed to be of prisoners with drug debts. This was the only intelligence relating to Mr Rose and drugs after he claimed to have stopped using them.
37. In November 2018, Mr Rose found out that his tariff expiry date (TED - the earliest date that he would be considered for release by the Parole Board) was a year later than he had thought. His offender supervisor said that Mr Rose was very low about this.

38. On 15 January 2019, the offender supervisor made healthcare staff aware of Mr Rose's continued low mood. A psychotherapist spoke to him the same day. He said that Mr Rose was feeling low in response to bad news, and this was perfectly normal. He did not find any signs that Mr Rose was suffering from a mental illness.
39. On 25 January, Mr Rose told the Head of Healthcare that he was still feeling low and was finding it hard to get out of bed. She said that she would make him another appointment with the psychotherapist.
40. The psychotherapist saw Mr Rose the next day, but Mr Rose said he had changed his mind and did not need support. The psychotherapist said that he spoke to Mr Rose about the fact that he might need a bit of support because of the effects of PS and the work he was doing to support others. Mr Rose told him that he knew how to get support if he needed it. He thanked the psychotherapist and said he had found their discussion helpful.
41. On 4 March 2019, Mr Rose lost his place on Fontmell Unit following several incidents when he was argumentative and challenging to staff. His prison record showed he had also spent increasing amounts of time in bed. On 27 March, he moved to Jubilee Unit.
42. On 29 April, the offender supervisor received confirmation from the public protection casework section that Mr Rose's tariff expiry date (TED) was indeed a year later than he had thought. Mr Rose refused to accept that this was correct. On 2 May, he told her that he had obtained legal aid to challenge his TED. She said that Mr Rose was upbeat about this news.
43. An officer said Mr Rose had been very helpful since he moved to Jubilee Unit and he was a trusted prisoner. She had not seen him under the influence of illicit substances, and she knew him as someone who helped other prisoners with their substance misuse issues. She said Mr Rose was known to spend his time in bed when he was not at work.
44. An officer became Mr Rose's keyworker when he moved to Jubilee Unit. He said that Mr Rose appeared to spend a lot of time in his cell in bed. He asked a colleague on Fontmell Unit whether this was usual behaviour for Mr Rose, and they told him that Mr Rose had spent an increasing amount of time in bed during his last weeks on that unit.
45. The officer said that Mr Rose had not confided in him when he spoke to him on the wing. He had never seen Mr Rose under the influence of anything illicit and he had never suspected that Mr Rose might have relapsed.
46. The Head of Healthcare said she knew Mr Rose very well indeed. Before his death, she said she had no concerns that Mr Rose had resumed using PS or that he was at risk of suicide or self-harm. She said she wondered in hindsight whether the fact Mr Rose was very popular and was looked up to by prisoners and respected by staff, would have made it difficult for him to admit that he had started using PS again and needed help.

19 May 2019

47. Officer A said he unlocked the prisoners on Jubilee Unit at about 8.30am and made a welfare check. He was required to get a verbal response from each prisoner. He said he was not a Jubilee Unit officer, but he knew Mr Rose from his previous wing and that it was not unusual for Mr Rose to sleep late. When he checked Mr Rose's cell, he could see that Mr Rose was in bed. He said good morning to him, and he said Mr Rose grunted in response.
48. A prisoner said that he and another prisoner went into Mr Rose's cell at about 10.00am to return a DVD to him. He said Mr Rose was lying in bed on his left-hand side and the second prisoner told him he thought he was asleep. It was quite dark in the room and they did not want to wake Mr Rose, so they left the DVD on his table. The second prisoner declined to speak to the investigator.
49. Officer A said Mr Rose did not come down for his lunch but, as it was a weekend, he did not think it was unusual. He told us that if there was a meal left on the hotplate at the weekend, it was normally Mr Rose's because he would still be in bed.
50. At about 12.15pm, Officer A began the lunchtime roll count. He said he often used to pull Mr Rose's leg about the amount of time he spent in bed, so he looked into his cell and said, "Alright Rose? Why have you been a lazy git?" When he did not get a response, he touched Mr Rose's foot and discovered it was cold. He put the cell light on and saw Mr Rose was in an unnatural position with his arm sticking out of bed. He noticed the skin on Mr Rose's arm was blue.
51. Officer A turned on his body-worn camera and radioed a code blue emergency (indicating a prisoner is not breathing). He said he realised Mr Rose was dead and went into shock. He called a colleague to the cell. The colleague said she could see post-mortem pooling in Mr Rose's limbs and told Officer A to leave the cell. The prison paramedic attended and confirmed that Mr Rose showed signs unequivocally associated with death.
52. The prison incident log and records from South West Ambulance Service showed that the emergency call was received at 12.17pm and an ambulance was dispatched at 12.20pm, arriving at Guys Marsh six minutes later.

Contact with Mr Rose's family

53. Because of the distance between the prison and Mr Rose's family home and the concern that the family would hear of Mr Rose's death before they were able to visit in person, the then Governor rang Mr Rose's mother to inform her that her son had died and to offer a visit. The Governor and a Custodial Manager visited Mr Rose's family the next day.
54. The prison held a memorial service for Mr Rose which was attended by members of his family. The Governor and the Custodial Manager attended Mr Rose's funeral. The prison offered a financial contribution to the cost of Mr Rose's funeral in line with national guidance.

Support for prisoners and staff

55. After Mr Rose's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
56. The prison posted notices informing other prisoners of Mr Rose's death and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Rose's death.

Post-mortem report

57. The pathologist concluded Mr Rose died from airway obstruction due to aspiration of vomit as a result of PS intoxication.

Findings

Identification of Mr Rose's PS use

58. Mr Rose used PS regularly when he first arrived at Guys Marsh but from February 2018, he claimed to have been abstinent. There was no direct evidence to contradict this claim and the last security intelligence relating to him was in July 2018, when his name was found on a list presumed to be of prisoners with drug debts.
59. Mr Rose worked hard on his project to provide peer support to prisoners with drug issues and was seen as a role model by staff and prisoners. Although he clearly spent more time in his cell after he found that his TED was a year later than he had thought, he never appeared under the influence of drugs or showed any other sign of relapse. With hindsight, it is possible to see that Mr Rose's previous use of PS coincided with bad news about his conviction and sentence, and that the news about his TED should have been regarded as a trigger. However, Mr Rose was offered support from the mental health team at this point and had a good relationship with his offender supervisor and the head of healthcare and neither saw any indication that he had suffered a relapse.
60. In early May, Mr Rose appeared upbeat because he had been told he could have Legal Aid to challenge the decision about his TED. We do not consider that staff missed any obvious indication before his death that he had relapsed and was using drugs.
61. We make no recommendations.

Guys Marsh's drug strategy

62. Mr Rose's death is an example of the dangers of PS and illustrates why prisons must do all they can to eradicate its use. Our investigations into the PS-related deaths of four prisoners at Guys Marsh during 2018, found that the prison was taking a number of measures to tackle the problem of PS and that there was clear evidence of a desire from senior management to combat the PS problem. Mr Rose's death was the only PS-related death in 2019, and there was a single PS related death in the prison in 2020. While any death is one too many, the high numbers of 2018 have not been repeated.
63. The investigator obtained evidence from the prison including their Drug Strategy (published in November 2019 and updated most recently in April 2021), Drug Strategy Action Plan (most recently updated in March 2021) and copies of the monthly Drug Strategy Newsletters from 2021. All of these initiatives have been implemented since Mr Rose's death.
64. In addition, the prison has increased collaboration between the drug strategy, safety and security functions to improve information sharing. Target searches for drugs are supported by the dog team, random searches of staff have been introduced, and searches are supported with an x-ray machine, a high intensity pole, wands and an atomiser. All in-coming mail to prisoners, apart from legally privileged mail, is opened and given to prisoners in the form of photocopies, and information on the risks of supplying drugs to prisoners is provided to visitors.

The minutes of the prison's monthly drug strategy meetings are sent to the Prison Service's national drug task force to inform the bigger picture across the prison estate. The Governor reviews the Drug Strategy every three months.

65. We are satisfied that Guys Marsh are doing what they can to reduce supply and demand and we make no recommendation.

Morning welfare check

66. Officer A said Mr Rose grunted in response to his welfare check at 8.30am. Mr Rose had signs of rigor mortis when he was found dead nearly four hours later at about 12.15pm. Rigor mortis usually starts about two hours after death and so it is possible that Mr Rose was still alive at 8.30am. Mr Rose was known to sleep late at the weekends, and we do not think the officer should have found it unusual that he was still in bed at 8.30am on a Sunday morning. The officer knew he was required to get a response from each prisoner, and he was satisfied that Mr Rose had responded. There is no way of independently verifying that this was the case, but we have no reason to disbelieve him.
67. In a previous death at Guys Marsh in March 2018, we found that a culture had developed of officers unlocking cells and moving on without making proper checks. That was on a different unit and we do not think that this was the case here. A prisoner told the investigator that, although staff practice varied, the officers on duty on Jubilee Unit that morning were known to make welfare checks in accordance with the rules.
68. Mr Rose was almost certainly dead when the two prisoners returned his DVD at about 10.00am. The first prisoner said the room was dark and the second prisoner told him that Mr Rose was asleep. We were unable to corroborate what the second prisoner saw because he declined to be interviewed. If either prisoner had realised Mr Rose was dead and alerted staff, it is unlikely resuscitation would have been successful at this stage.

The emergency response

69. The European Resuscitation Council Guidelines for Resuscitation 2010 state that "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". Attempting resuscitation in these circumstances is distressing for staff and is not in accordance with the principle that the deceased be treated with respect and dignity. Mr Rose had signs that were unequivocally associated with death and we consider that the decision not to attempt resuscitation was appropriate.

Use of body-worn cameras in deaths in custody

70. PSI 04/2017 requires all staff attending any incident to turn on their body-worn camera. When a prisoner is receiving lifesaving medical intervention, the PSI requires staff to make a dynamic risk assessment and, if there is no threat to the security or safety of others, they should consider non-intrusive recording of the medical intervention such as directing the camera lens at the head and shoulders of the staff involved with occasional direct capture of the medical procedure.

71. We understand that Officer A was concerned to record a serious incident and turned on his camera as a matter of course in difficult and distressing circumstances. By his own account he went into shock when he realised Mr Rose was dead and we do not criticise him. However, in this case there was no medical intervention, and there is unnecessary footage of Mr Rose's corpse. We consider there must be a balance between capturing direct evidence of what happened and sensitivity and respect towards the prisoner and their family.
72. In our investigation into a death at Guys Marsh in March 2018, we made a recommendation that the Governor remind staff of the guidance in PSI 04/2017 about the unobtrusive use of body-worn cameras by staff attending deaths in custody. We have seen the resulting Notice to Staff and note that this was re-issued in August 2020, after the death of a prisoner in July 2020. We therefore make no recommendation.

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