

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Thomas, a prisoner at HMP Garth, on 2 February 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 Lee Thomas died on 2 February 2019 at HMP Garth. A cause of death has not yet been ascertained but a toxicology examination identified that Mr Thomas had used several illicit prescription medications and psychoactive substances (PS) before his death. He was 37 years old. I offer my condolences to his family and friends.

I am concerned about the ease with which Mr Thomas was seemingly able to obtain and use illicit alcohol and drugs on the day he died. His friend told us that Mr Thomas spent much of the day under the influence of substances. I am concerned that there is little evidence that prison staff spent time patrolling his spur and interacting with prisoners that day.

I am also concerned by a number of delays to the emergency response. Mr Thomas's cell was not opened quickly enough when he was found unconscious, and a medical emergency code should have been called earlier. Even when the radio call was made, the control room operator did not hear the message. These and other omissions meant that around 14 minutes passed from when Mr Thomas was found unconscious until an ambulance was called. This was unacceptable.

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

January 2020

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	12

Summary

Events

1. Mr Lee Thomas was remanded in custody to HMP Liverpool on 8 August 2017, and later sentenced to fourteen and a half years in prison. On 21 March 2018, he was transferred to HMP Garth.
2. At Liverpool and during his first weeks at Garth, prison staff often suspected that Mr Thomas had misused drugs, usually psychoactive substances (PS). They referred him to the prison substance misuse services, but Mr Thomas consistently declined to work with them.
3. In May 2018, Mr Thomas moved to B Wing, after which staff recorded no more suspicions that he had used drugs. Although there were occasional reports that he might be engaged in prohibited activity, B Wing staff told us that Mr Thomas was a trusted prisoner who worked well and raised few issues.
4. On 2 February 2019, prisoners on B Wing spent most of the morning and afternoon able to mix freely with each other. Mr Thomas's friend told us that he began to drink strong, illicitly brewed alcohol at around 9.30am, and quickly became drunk. His friend said that Mr Thomas spent the rest of the day trying to obtain illicit prescription medication, and that he saw Mr Thomas take some tablets. (The toxicology examination found that Mr Thomas had taken mirtazapine, olanzapine, carbamazepine and paracetamol, none of which he was prescribed. It also found that he had taken PS)
5. Prisoners were locked in their cells at around 5.00pm. At 7.53pm, the night patrol officer found Mr Thomas seemingly unconscious. She fetched a colleague who, after looking into the cell, radioed for assistance. When other staff arrived, they opened the cell and found that Mr Thomas was not breathing. They radioed a medical emergency code but the control room operator did not hear this and several minutes passed before an ambulance was called.
6. Prison staff began cardiopulmonary resuscitation but paramedics confirmed Mr Thomas's death at 8.47pm.

Findings

Substance misuse support offered to Mr Thomas

7. Substance misuse teams at both Liverpool and Garth tried several times to engage with Mr Thomas but, each time, he said that he did not want to work with them. We found that staff made appropriate and satisfactory efforts to engage with Mr Thomas.

Mr Thomas's alcohol and drug use on 2 February 2019

8. Mr Thomas's friend told us that he spent much of 2 February under the influence of illicitly brewed alcohol and illicit drugs. CCTV footage shows that only one member of staff spent time on his spur that afternoon, and then only briefly. We are concerned that this was a missed opportunity to recognise Mr Thomas's substance misuse and take action to help him.

Emergency response

9. We are concerned by several aspects of the emergency response. Prison staff did not enter Mr Thomas's cell or radio a medical emergency response code as quickly as they should have done. When they did try to radio the emergency, there was a technical issue with the radio which delayed the call. The control room operator did not then hear the radio message which led to a further delay. When paramedics arrived at the prison, there were additional delays in it reaching Mr Thomas.

Recommendations

- The Governor should ensure that officers undertake frequent patrols during association periods and are alert for signs of substance misuse.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
 - Staff go into cells as quickly as possible in a potentially life-threatening situation subject to a risk assessment.
 - Staff communicate a medical emergency without delay, using the appropriate medical emergency response code, to communicate the nature of the emergency quickly and effectively.
 - All radios are working effectively, and any network or handset issues that might affect this are investigated and addressed.
 - Control room staff request an ambulance as soon as an emergency code is called.
 - There are no delays in escorting ambulances to the relevant location.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Thomas's prison and medical records.
12. The investigator interviewed eight members of staff and two prisoners at Garth in March 2019.
13. NHS England commissioned a clinical reviewer to review Mr Thomas's clinical care at the prison.
14. We informed HM Coroner for Preston and West Lancashire of the investigation. We have sent the Coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Thomas's brother to explain the investigation and to ask if he had any matters that he wanted us to consider. Mr Thomas's brother did not ask any questions.
16. We shared the initial report with HM Prison and Probation Service (HMPPS). They highlighted some factual inaccuracies, and this report has been amended accordingly.
17. We also shared the initial report with Mr Thomas's brother. He did not make any comments.

Background Information

HMP Garth

18. HMP Garth holds up to 846 prisoners serving sentences of four years or longer or indeterminate sentences. Bridgewater NHS Foundation Trust provides health services.
19. B Wing is a residential support unit for prisoners who cannot be held with the general prison population due to fears for their safety, for reasons such as debt or gang-related threats.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Garth was in December 2018 and January 2019. Inspectors reported that the prison had a well-thought out approach to reducing the supply of drugs, but prisoners still found it far too easy to obtain illicit drugs. A survey conducted by inspectors found that 60 per cent of prisoners found it easy to obtain drugs, and over a quarter of prisoners had developed a drug problem at the prison.
21. Inspectors reported that interactions between prisoners and staff were respectful and courteous overall. However, some staff did not consistently enforce basic rules in residential units. The key worker system had been introduced between October 2018 and January 2019, and, although it was new, it was functioning well. Prisoners were allocated a key worker, who they met fortnightly to focus on their progression, set targets and discuss any concerns.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to November 2017, the IMB reported that there had been a dramatic increase in use of psychoactive substances (PS) at the prison. They reported that an increase in targeted searches had resulted in increasing finds of illicit items, including PS and illicitly brewed alcohol.

Previous deaths at HMP Garth

23. Mr Thomas is the eighth prisoner to die at Garth since February 2017, the first prisoner in that time to die seemingly as a result of drug toxicity.
24. In our investigation into the death of a man who took his own life at Garth in October 2018, we found evidence of widespread drug use in the prison. We recommended that the Governor should ensure that there were effective supply and demand reduction strategies, and that staff were vigilant for signs of drug use and knew how to respond when a prisoner appeared under the influence of such substances. Garth accepted our recommendations, and identified measures that they had taken, including the formation of a designated search team, increased interception of mail and increased searching of staff.

Psychoactive Substances (PS)

25. PS (formerly known as 'new psychoactive substances' (NPS) 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 PS to precipitate or exacerbate the deterioration of mental health, and they are linked to suicide or self-harm.
26. 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.
27. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

28. Mr Lee Thomas was first sent to prison in November 2015 and was taken to HMP Liverpool. In 2016, prison staff found him under the apparent influence of PS on several occasions. He was released in February 2017 and served two more short prison sentences in the following months.

HMP Liverpool

29. On 8 August 2017, Mr Thomas was remanded in custody to Liverpool, charged with robbery. A nurse assessed him on arrival and recorded that he was prescribed mirtazapine (an antidepressant medication) and that he said that he did not drink alcohol or use drugs. A prison doctor prescribed mirtazapine. The next day, Mr Thomas did not attend an introductory session with Liverpool's substance misuse service. Instead, a substance misuse worker left a pack in his cell that contained information, including about the services available and the effects of using PS.
30. On 22 August, a nurse assessed Mr Thomas. She recorded that he said that he had post-traumatic stress disorder (PTSD), anxiety and depression but did not want to engage with support services.
31. On 31 December, prison staff found Mr Thomas vomiting and under the apparent influence of PS. The next day, they started suicide and self-harm prevention procedures (known as ACCT) as Mr Thomas had told his cellmate that he did not care if he died as he was facing a long sentence and just wanted to obtain drugs.
32. On 3 January 2018, a substance misuse worker assessed Mr Thomas. He said that he had used PS three days earlier because he had run out of cannabis and had immediately regretted it. Mr Thomas said that he did not need to engage with the substance misuse service because he had made a "silly mistake" and would not use PS again. The substance misuse worker recorded that she had given Mr Thomas harm minimisation information.
33. That afternoon, prison staff found Mr Thomas under the influence of PS. (A drug test confirmed that he had used PS and cannabis.) The next day, he told staff that he had used PS because he was concerned about his trial, but now intended to stop.
34. Prison staff found Mr Thomas under the apparent influence of PS three times in the next month. He continued to decline all interventions offered by the substance misuse team.
35. On 16 February, Mr Thomas was sentenced to fourteen and a half years in prison.
36. On 18 February, an officer spoke to Mr Thomas about his sentence. Mr Thomas said that he was looking forward to moving to a training prison so that he could settle and get on with his future in custody. The officer asked Mr Thomas if he wanted to work with the substance misuse team now that he had been sentenced. Mr Thomas declined, saying "I need to do this on my own".

37. On 1 March, prison staff found Mr Thomas under the apparent influence of PS. The next day, they stopped ACCT procedures.

HMP Garth

38. On 21 March, Mr Thomas was transferred to HMP Garth. A nurse assessed him on arrival. She recorded a clinical history of PTSD, depression and asthma, and that Mr Thomas was currently prescribed mirtazapine. Mr Thomas said that he had previously used cannabis but said he had not used drugs in the last month. The nurse asked him if he would work with Garth's substance misuse service. Mr Thomas declined.
39. On 28 March, an offender supervisor met Mr Thomas and recorded that he told her that he had used cocaine in the past but had stopped. Mr Thomas said that he did not use PS in prison. She recorded that she later established that this was not correct and that substance misuse work would therefore form part of Mr Thomas's sentence plan.
40. On 3 April, a substance misuse worker recorded that she had met Mr Thomas. She gave him a drugs harm reduction leaflet.
41. Mr Thomas initially lived on C Wing, a standard residential unit. On three occasions in mid-April, prison staff found him under the apparent influence of PS. On 19 April, a substance misuse worker recorded that she had tried to see Mr Thomas three times in line with the local PS strategy. Mr Thomas declined to see the substance misuse worker and said that he did not want to work with the substance misuse service.
42. On 27 April, prison staff searched Mr Thomas's cell and found PS. The next day, he told prison staff that he feared for his safety because a large amount of money had been offered to a prisoner to assault him because of his involvement in a previous offence. Mr Thomas began to self-isolate in his cell, and completed an application for B Wing, the residential support unit.
43. On 30 April, Mr Thomas said that he no longer wished to self-isolate and that the effects of PS had made him exaggerate the risk he faced.
44. On 12 May, prison staff found Mr Thomas under the apparent influence of PS. Three days later, they again suspected that he had used drugs.
45. On 16 May, Mr Thomas said that he wanted to self-isolate in his cell again, for the same reasons as before. Prison staff told him that his application for B Wing had not yet been reviewed.
46. On 20 May, Mr Thomas moved to D Wing, a standard residential unit. Later that day, prison staff found him under the apparent influence of PS. They noted that his cell was subsequently listed for a search but there is no indication that this happened. This was the last time that staff recorded that Mr Thomas appeared to have used PS or any other illicit drug.
47. On 23 May, Mr Thomas told staff that the threats towards him had followed him to D Wing. His move to B Wing was approved.

48. Around this time, Mr Thomas stopped collecting mirtazapine. No reason for the omission is recorded and there is no record that his mental health was reviewed afterwards.

B Wing

49. On 25 May, Mr Thomas moved to B Wing. Mr Thomas said that he was glad to have moved. Three weeks later, Mr Thomas's personal officer recorded that he mixed well with his peers and had settled in well on the wing.
50. On 18 June, Mr Thomas's offender supervisor recorded that Mr Thomas was now employed in a prison workshop and said that he no longer used PS. She again noted that Mr Thomas's sentence plan required him to work with substance misuse services at Garth.
51. In July, prison staff dismissed Mr Thomas from his job in the workshop when he was heard threatening another prisoner. Prison staff recorded at other times in July and August that they suspected Mr Thomas of bullying or threatening other prisoners.
52. In late August, Mr Thomas was employed in the laundry on B Wing. In September, Mr Thomas's personal officer recorded that he did a good job and had no concerns.
53. On 8 October, a prisoner told officers that Mr Thomas was dealing PS on B Wing. They noted that his cell was listed for a search as a result but again, there is no indication that this happened. The Head of Security told us that they did not have a full complement of staff in their Dedicated Search Team at that time and they were not therefore able to complete all requested searches. He said that the team reached full complement in December 2018 and have introduced a new system for identifying priority searches.
54. On 1 November, his personal officer spoke to Mr Thomas. He recorded that Mr Thomas displayed good conduct and worked unsupervised in the laundry. He noted that Mr Thomas said that he had no issues he wished to raise.
55. On 7 December, a Custodial Manager (CM) recorded that he had received intelligence that Mr Thomas was 'taxing' other prisoners on B Wing. He recorded that he had spoken to Mr Thomas about this and warned him that he might lose his place on B Wing, should it continue.
56. On 13 December, an officer spoke to Mr Thomas as he had been appointed as Mr Thomas's new keyworker. (Key workers are each responsible for supporting five to six prisoners and should have dedicated time timetabled each week for the key worker role, which should include meaningful conversations with each prisoner.)
57. The new keyworker recorded that Mr Thomas worked diligently in the laundry and followed the wing regime. Mr Thomas said that he hoped to achieve enhanced status on the prison's Incentives and Earned Privileges (IEP) scheme (which aims to encourage and reward responsible behaviour in prisons).

58. There is no evidence that the new keyworker spoke to Mr Thomas again after 13 December.
59. Other B Wing staff also told us that Mr Thomas worked well and did not raise any issues or concerns. A Supervising Officer (SO) who was a B Wing manager, added that Mr Thomas's position in the laundry was a trusted job for which wing staff had selected him. He said that he had not heard any intelligence that Mr Thomas used drugs. The SO said there had been some intelligence when he first arrived on the wing that Mr Thomas was running a 'shop' from his cell, but they found no evidence to support this when they searched the cell.
60. On 6 January 2019, his offender supervisor spoke to Mr Thomas. She recorded that he was in good spirits and said that he was interested in transferring to the therapeutic community at HMP Dovegate. (Therapeutic communities provide group-based therapy to promote positive relationships, personal responsibility and social participation.) She recorded that she had given Mr Thomas an application pack for the therapeutic community.
61. On 1 February, B Wing staff upgraded Mr Thomas to the enhanced level of the Incentives and Earned Privileges (IEP) scheme.

2 February 2019

62. On 2 February, prisoners on B Wing spent much of the day able to mix freely with each other. Prisoners have keys to their own cells and can come and go as they please once prison staff have unlocked the cells. Cells were unlocked from around 9.00am to 12.00pm and from around 2.00pm until 5.00pm.
63. A prisoner told us that he was a close friend of Mr Thomas. He said that Mr Thomas had not used drugs during their time on B Wing but had once drunk alcohol before 2 February.
64. The prisoner said that Mr Thomas began drinking strong, illicitly brewed alcohol at around 9.30am on 2 February. He said that Mr Thomas drank until around 10.30am, by which time he was drunk. He said that Mr Thomas spent much of the rest of the day trying to obtain illicit medication and he saw him take "one or two" tablets in the afternoon. He said that by evening lock-up, Mr Thomas was slurring his words and his drunkenness was exaggerated.
65. At around 4.10pm, Mr Thomas telephoned his ex-partner. He spoke to her, and their children, for around four minutes.
66. Another prisoner who lived in the cell opposite, told us that he spent time with Mr Thomas shortly before evening lock-up. He said that Mr Thomas seemed well at the time and did not complain of any health problems.
67. At 5.02pm, an officer looked in Mr Thomas's cell and then locked it for the night. The officer told us that he could not remember what Mr Thomas was doing but that he did not see anything unusual.
68. An operational support grade (OSG), was the night patrol on B Wing. She began a count of prisoners at around 7.50pm and arrived at Mr Thomas's cell at 7.53pm. CCTV recordings show that the OSG spent around 20 seconds knocking on and

kicking the door before leaving the spur. The OSG told us that Mr Thomas was sitting on a chair, with his head slumped. She said that she thought that he might be unconscious after using PS. She said that she did not make a call for emergency medical assistance as in previous incidents, the prisoner had quickly regained consciousness. Instead, she fetched an officer who was working on the ground floor of B Wing, to ask his opinion. (The ground floor of B Wing is a separate unit for prisoners diagnosed with personality disorders.) She said that she did not consider opening Mr Thomas's cell as she had been told never to open a cell by herself before support arrived.

69. At 7.56pm, the OSG and the officer returned to the cell. The officer looked in the cell and kicked the door. He also told us that Mr Thomas was sitting slumped in his chair, and he did not respond to their attempts to rouse him. He said that he did not know what had happened to Mr Thomas. After 45 seconds (the time was now 7.57pm), the officer made a radio call for intervention staff (a response team of officers who attend incidents overnight) to attend B Wing, adding that a prisoner was unresponsive.
70. At 8.00pm, two other officers arrived. An officer opened the cell as they approached and all three went in. The officer told us that Mr Thomas was "obviously unconscious ... pretty cold", he could not detect a pulse and Mr Thomas was not breathing. An officer made a radio call for the response nurse, to attend. The nurse replied asking about the nature of the incident. An officer said that the radio "froze" for around a minute before he could reply that it was a medical emergency code blue (indicating a life-threatening situation).
71. An officer told us that Mr Thomas's mouth was full of sick, which instantly refilled when the officers tried to remove it. An officer began cardiopulmonary resuscitation, and an officer took over resuscitation efforts.
72. At 8.06pm, two nurses arrived at Mr Thomas's cell. A nurse recorded that there was excessive vomit present and evidence of cyanosis (a blue tinge) to the lips and finger. They attached a defibrillator, which advised one electric shock and to continue resuscitation.
73. The control room operator told us that he did not hear the code blue radio message because he was busy dealing with other calls at the time, as officers on each wing were telephoning to say that they had completed their counts of prisoners. At 8.07pm, one of the nurses radioed to ask when the ambulance would arrive. He telephoned the ambulance service immediately.
74. Paramedics arrived at Garth at 8.21pm, and at Mr Thomas's cell at 8.33pm. The OSG told us that, at night, each gate between the main entrance and the relevant wing is opened individually as the ambulance is escorted through the prison.
75. The paramedics continued cardiopulmonary resuscitation on their arrival. At 8.47pm, they confirmed that Mr Thomas had died.

Contact with Mr Thomas's family

76. Mr Thomas had named his brother as his next of kin, and it was noted that he lived at an address in in Leicester. The details of the address were not precise and it was not clear exactly where Mr Thomas's brother lived. Due to the time of

night, distance and the very bad weather conditions, the advice of the police who attended Garth following the death was to contact Leicestershire Police and ask them to locate Mr Thomas's brother. Leicestershire police visited later in the morning and found that Mr Thomas's brother did not live at the recorded address.

77. A prison family liaison officer (FLO), then telephoned Mr Thomas's brother. He did not answer, and she left a message, asking him to telephone the prison.
78. The FLO then found an address for Mr Thomas's ex-partner (to whom he had spoken by telephone shortly before his death) in his prison records. On the afternoon of 3 February, she visited Mr Thomas's ex-partner's house but found that no one was at home. The FLO then contacted Merseyside Police and asked them to visit Mr Thomas's ex-partner. They visited her that evening and told her of Mr Thomas's death.
79. Mr Thomas's ex-partner then contacted his brother and told him of the death. Mr Thomas's brother telephoned Garth later that evening and spoke to the FLO.
80. Garth contributed to the costs of the funeral in line with Prison Service instructions.

Support for prisoners and staff

81. After Mr Thomas's death, the Head of Safety debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
82. A prisoner told us that prison staff told him of his friend's death on the morning of 3 February. He said that the support that he and other prisoners received was "fantastic".

Post-mortem report

83. The cause of death was not available when we issued our report. The toxicology examination found evidence that Mr Thomas had used several medications that he was not prescribed: mirtazapine, olanzapine (an antipsychotic used to treat schizophrenia), carbamazepine (used to treat epilepsy, nerve pain and bi-polar disorder) and paracetamol. A second toxicology examination identified that Mr Thomas had used synthetic cannabinoids (PS) in the time before his death.

Findings

Substance misuse support offered to Mr Thomas

84. In Liverpool and in his first months at Garth, prison staff suspected Mr Thomas of being under the influence of drugs, usually PS, on several occasions. Substance misuse teams at both prisons approached him a number of times but he consistently said that he did not want to work with them. Following his move to B Wing, there were no reports or suspicions that Mr Thomas had used drugs or alcohol until he died.
85. The clinical reviewer found that appropriate and satisfactory efforts were made to engage with Mr Thomas. We agree.

Mr Thomas's alcohol and drug use on 2 February 2019

86. In their inspection of December 2018/January 2019, HMIP found nearly half of prisoners said that it was easy to obtain drugs at Garth. Staff and prisoners, we spoke to during our investigation said that drugs and alcohol were harder to obtain on B Wing than other wings, seemingly due to its population's isolation from other prisoners.
87. We do not know where Mr Thomas obtained the illicit medication, PS and alcohol he supposedly used on 2 February, but we are concerned that he was able to obtain and use it with apparent ease.
88. Mr Thomas's friend told us that he began drinking strong, illicitly brewed alcohol during the morning of 2 February, and was drunk by mid-morning. His friend said that Mr Thomas spent time trying to obtain illicit medication and he saw him take some tablets that afternoon.
89. CCTV footage of Mr Thomas's spur during the afternoon shows that in the three hours that prisoners were unlocked, only one member of staff spent time on the spur, and then only briefly. We appreciate that wing staff are busy but it is hard to understand how they might identify illicit behaviour if they spend so little time patrolling and interacting with prisoners. While more frequent patrolling would not necessarily have identified Mr Thomas's substance misuse, this was a missed opportunity to recognise it. We make the following recommendation:

The Governor should ensure that officers undertake frequent patrols during association periods and are alert for signs of substance misuse.

90. We are also concerned that there is no evidence that Mr Thomas's key worker spoke to him between 13 December and his death.

Emergency response

Entering the cell

91. At night, officers have a key in a sealed pouch for use in an emergency. Prison Service Instruction (PSI) 24/2011 on management and security at night says that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening

cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment. Local Instruction 2.77, issued in April 2014, incorporates this into local guidance at Garth.

92. The OSG said that she thought Mr Thomas was unconscious when she looked into his cell. She said that she did not consider opening the cell to check on his welfare as she had been told never to open a cell on her own. This contradicts the national instructions of PSI 24/2011.
93. Even when an officer arrived, he and the OSG still did not enter the cell, and a total of seven minutes passed from when the OSG identified that Mr Thomas appeared unconscious until the intervention team arrived and entered the cell.
94. We do not say that the OSG should necessarily have entered the cell on her own, but we are concerned that she did not know that she could have done. We are also concerned that she and an officer did not enter the cell together. In the circumstances described, we would normally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life.

Communicating the emergency

95. PSI 03/2013 on medical emergency response codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for Governors and Directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure that there are no delays in calling an ambulance and it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called.
96. Garth's Staff Information Notice 18/152, issued in August 2018, instructs the use of the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when the prisoner has difficulty breathing or is unconscious.
97. The OSG said that she did not radio a medical emergency code blue when she discovered Mr Thomas seemingly unconscious because in previous similar incidents, the prisoner in question had quickly regained consciousness. However, PSI 03/2013 also states that if staff are in any doubt about the nature of the injury or illness, they must call an ambulance, and it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required. She thought that Mr Thomas was unconscious and we consider that she should have called a code blue.
98. An officer told us that when he tried to make the code blue radio call, he was delayed by around a minute when his radio "froze". He explained that when this

happened, the light that indicated someone else was communicating a message had remained on and he could not transmit until it had switched off. The officer said this was an issue that he had experienced before.

99. Even when the officer was able to make the call, the control room operator, said that he did not hear it as he was busy dealing with other non-emergency communications at the time.
100. In total there was a delay of around 14 minutes from when Mr Thomas was first identified as unconscious until the ambulance service was contacted. While we cannot say whether an earlier call to the ambulance service would have made a difference to the final outcome, this was an unacceptable delay.

Escorting the ambulance to B Wing

101. When the ambulance arrived at Garth, it took around 12 minutes to reach B Wing. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **Staff go into cells as quickly as possible in a potentially life-threatening situation subject to a risk assessment.**
- **Staff communicate a medical emergency without delay, using the appropriate medical emergency response code, to quickly and effectively communicate the nature of the emergency.**
- **All radios are working effectively, and any network or handset issues that might affect this are investigated and addressed.**
- **Control room staff request an ambulance as soon as an emergency code is called.**
- **There are no delays in escorting ambulances to the relevant location.**

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