Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Avery, a prisoner at HMP Garth, on 11 August 2020

A report by the Prisons and Probation Ombudsman

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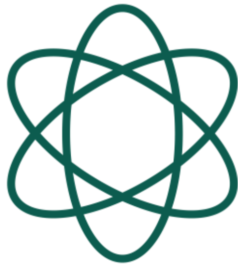
Our vision

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.

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 Mark Avery died on 11 August 2020 after taking psychoactive substances (PS) at HMP Garth. He was 54 years old. I offer my condolences to Mr Avery's family and friends.

Mr Avery had a history of substance misuse. In the month before his death, prison and healthcare staff suspected that Mr Avery had used drugs on several occasions. Healthcare staff treated Mr Avery appropriately, warned him about the risks of using PS and referred him to the prison's substance misuse service but he refused to accept their support.

I am concerned that Mr Avery was able to obtain PS with apparent ease at Garth. The prison needs to do more to reduce the availability of drugs. I am also concerned that staff failed to submit intelligence reports on two occasions when they thought Mr Avery was under the influence of PS.

It is possible that Mr Avery intended to end his life by using PS. He was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) for two weeks in July and August 2020. The ACCT was closed a week before Mr Avery's death. I am satisfied that closing the ACCT was a reasonable decision to have made.

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 **April 2021**

Contents

Summary 1

The Investigation Process..4

Background Information...5

Key Events...7

Findings 12

Summary

Events

1. On 12 December 2013, Mr Mark Avery was sentenced to 16 years imprisonment for murder. On 27 May 2014, he was moved to HMP Garth.

2. Mr Avery had a history of substance misuse and several long-term health conditions including asthma, epilepsy and chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases).

3. On 1, 2 and 9 July 2020, prison and healthcare staff suspected that Mr Avery had used psychoactive substances (PS). Healthcare staff treated Mr Avery appropriately, warned him about the risks of using PS and referred him to the prison's substance misuse service (known as DARS). After each incident, DARS recovery practitioners saw Mr Avery, but he refused to accept their support.

4. On 27 July, a DARS recovery practitioner began Prison Service suicide and self-harm monitoring (known as ACCT) after Mr Avery said that he did not see any point in being alive, that he had attempted to use PS to kill himself in the past and that he was very depressed. The ACCT was closed on 4 August when Mr Avery said he felt better as he had received help with his physical health problems.

5. At 5.39pm on 11 August, an officer unlocked Mr Avery's cell and said he was "hit with a wall of fumes" that made him feel unsteady and which he thought was PS. The officer saw that Mr Avery was unresponsive, so he called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing). After two minutes, another officer responded. The officers were unsure whether Mr Avery was breathing or had a pulse and put him in the recovery position.

6. Three nurses and other officers then responded. The nurses found that Mr Avery was not breathing so they started cardiopulmonary resuscitation, gave him rescue breaths and attached a defibrillator. The nurses noted that Mr Avery had "blood" and "fluid" pooling on his stomach and chest (signs that someone has been dead for some time).

7. At 5.43pm, the control room operator noted in the control room log that an ambulance was needed. Four minutes later, the Ambulance Service sent a rapid response vehicle, which reached Mr Avery at 6.10pm. A paramedic noted that Mr Avery showed pooling of blood and, at 6.12pm, declared that he had died.

8. Toxicological analysis showed that Mr Avery had used PS before he died.

Findings

Substance misuse care

9. The clinical reviewer was satisfied that the substance misuse care that Mr Avery received was equivalent to that which he could have expected to receive in the community. DARS repeatedly offered Mr Avery support but he refused to engage.

Physical and mental health care

10. The clinical reviewer was satisfied that the physical health care Mr Avery received was equivalent to that which he could have expected to receive in the community. She considered that his mental health care was of a reasonable standard and was responsive to his needs, though she noted three missed opportunities to discuss the negative impact that his physical health was having on his mental health and his PS use.

Reducing the supply and demand for illicit substances

11. We are concerned that Mr Avery was able to obtain PS at Garth in the months before his death, despite various methods that the prison used to disrupt supply. The prison needs to review its drugs strategy. We are also concerned that staff failed to submit intelligence reports about Mr Avery's substance misuse on 2 and 9 July.

Assessment of Mr Avery's risk

12. We cannot rule out the possibility that Mr Avery used PS with the deliberate intention of taking his life. Although we found some deficiencies with Prison Service suicide and self-harm monitoring, we are satisfied that it was not unreasonable for staff to have closed the ACCT a week before Mr Avery died.

Emergency response

13. There were delays in calling for an ambulance when Mr Avery was found. It made no difference to the outcome for Mr Avery as he had been dead for some time, but any delay could be critical in future cases.

14. We are concerned that the officers who found Mr Avery unresponsive did not start resuscitation attempts.

15. We are also concerned that healthcare staff tried to resuscitate Mr Avery, despite physical signs that he had died.

Recommendations

- The Head of Healthcare should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate and make a referral when indicated.

- The Head of Healthcare should develop joint care pathways to support prisoners with substance misuse and mental health conditions and use joint approaches to maximise prisoners' engagement.

- The Governor and Head of Healthcare should ensure that staff follow the prison's Substance Misuse Strategy by submitting intelligence reports when a prisoner is suspected of using illicit drugs.

- The Governor should identify and address the key weaknesses in reducing the supply of drugs at Garth and revise the drug strategy in light of the findings.

- The Head of Healthcare should ensure that healthcare staff are aware of their responsibility to start ACCT procedures whenever they are concerned about a prisoner's risk of suicide or self-harm and that they clearly document their decision making.

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

    - accurately record all information disclosed in an ACCT case review; and
    - set meaningful caremap actions, aimed at reducing the prisoner's risk to themselves.

- The Governor should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity when a prisoner is unresponsive.

- The Head of Healthcare should ensure that healthcare staff are given guidance about the circumstances in which resuscitation is inappropriate, in accordance with European Resuscitation Council Guidelines.

- The Governor should ensure that all staff are made aware of and understand PSI 03/2013, as well as local instructions, and their responsibilities during medical emergencies, including:

    - immediately calling an ambulance when a medical emergency code is called; and
    - promptly providing information about a prisoner's condition to the control room so that they have this information when requesting an ambulance.

The Investigation Process

16. 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. Two prisoners responded but only one agreed to be interviewed by the investigator.

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

18. NHS England commissioned a clinical reviewer to review Mr Avery's clinical care at the prison.

19. The investigator interviewed 15 members of staff and two prisoners at Garth between September and November 2020. The clinical reviewer joined the investigator for seven interviews.

20. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

21. One of the Ombudsman's family liaison officers contacted Mr Avery's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Avery's sister asked for a copy of the report but did not have any specific matters she wanted the investigation to consider.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

23. Mr Avery's sister received a copy of the initial report. She did not make any comments.

Background Information

HMP Garth

24. HMP Garth holds up to 845 prisoners serving sentences of four years or longer or indeterminate sentences. Greater Manchester Mental Health NHS Foundation Trust provides primary care, mental health and clinical substance misuse services and Delphi Medical provides non-clinical substance misuse services.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Garth was in December 2018/January 2019. Inspectors reported that 60% of prisoners said that it was easy to obtain drugs in the prison and that 25% of prisoners said they had developed a drug habit at Garth. However, inspectors found that intelligence gathering was generally managed adequately, with good collaboration between the security department and the rest of the prison. They found that substance misuse services worked well to address drug issues, though many initiatives to reduce drug use had not been fully embedded.

26. Inspectors also reported that staff had received 'Emergency Response in Custody' (ERIC) cards which described the emergency codes, and that ambulances were called promptly during emergencies.

Independent Monitoring Board

27. 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 2019, the IMB reported that the prison had a positive drug strategy, with good support from the drug strategy team, though drug use remained a major problem.

Previous deaths at HMP Garth

28. Mr Avery was the 11th prisoner to die at Garth since August 2018. Three of the previous deaths were self-inflicted, four were drug-related and three were from natural causes. We have previously made recommendations about reducing the supply of drugs, the need to submit intelligence reports about substance misuse, the need to call ambulances promptly during emergencies and the management of ACCT plans.

Psychoactive substances (PS)

29. Psychoactive substances, previously known as 'legal highs' are a 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.

30. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

Assessment, Care in Custody and Teamwork

31. 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.

32. 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.

33. 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

34. On 12 February 2013, Mr Mark Avery was remanded in prison custody and sent to HMP Hewell. On 13 December, Mr Avery was sentenced to life imprisonment, with a minimum 16-year tariff, for murder.

35. On 27 May 2014, after spending time at various prisons, Mr Avery was moved to HMP Garth.

36. Mr Avery had several long-term health conditions, including asthma, epilepsy and progressively worsening chronic obstructive pulmonary disease (COPD – a group of lung conditions that cause breathing difficulties). Mr Avery also had a history of depression and substance misuse, including abusing alcohol and cannabis.

37. In June 2017 and February 2018, prison and healthcare staff suspected Mr Avery was under the influence of drugs; and throughout 2018, 2019 and 2020, they suspected that he was sending money to members people outside prison to pay for drugs. Mr Avery also refused two mandatory drug tests in January 2018 and in March 2019. However, despite these concerns, Mr Avery refused to work with the prison's Drug and Alcohol Recovery Service (DARS).

2020

38. On 1 July 2020, an officer found that Mr Avery was struggling to breathe and noted that there was a strong smell of psychoactive substances (PS) in his cell. Mr Avery admitted having smoked PS. The officer called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) and a nurse responded. She took Mr Avery's basic observations, decided that Mr Avery did not need to go to hospital and told him that it was likely that he would die if he continued to use PS. Mr Avery said that he was "silly to use PS", that it took away his depression, that he had "nothing to lose anymore" and that he would not be bothered if he was dead, though he did not have thoughts about taking his life. She referred Mr Avery to DARS, a prison GP and the mental health team.

39. Following the code blue emergency, an officer submitted an intelligence report about Mr Avery's admission that he had used PS.

40. Later that day, a prison GP saw Mr Avery to review his prescription for oramorph (a liquid form of morphine which had been prescribed to alleviate his breathlessness). Mr Avery said that he could have died from using PS. The GP decided to withhold Mr Avery's oramorph prescription for 24 hours as no-one knew what PS he had used.

41. Later that day, a DARS recovery practitioner saw Mr Avery and gave him harm reduction advice, though Mr Avery denied having a problem and refused to accept support from DARS.

42. On 2 July, a prison GP spoke to a hospital respiratory consultant about Mr Avery's oramorph prescription and his illicit drug use. The consultant considered that the risks of using oramorph outweighed the benefits, so the GP stopped the prescription.

43. Later that day, an officer found that Mr Avery was struggling to breathe and noted that there was a strong smell of an unknown substance in his cell. The officer called a code blue emergency and two nurses responded. They took Mr Avery's basic observations and asked paramedics, who were already in the establishment, to assess him, but they decided not to take him to hospital. One nurse referred Mr Avery to DARS and asked other healthcare staff to review the medication he was allowed in his possession. The other nurse asked prison staff to check on him regularly.

44. On 3 July, a prison GP reviewed Mr Avery's prescribed medication. He decided that, due to Mr Avery's use of PS, he could not keep his amitriptyline and dihydrocodeine medication (used to treat Mr Avery's pain) in possession because of the dangers of taking these drugs at the same time as PS.

45. Later that day, a DARS recovery practitioner saw Mr Avery and gave him harm reduction advice, though he refused to discuss it or accept support from DARS.

46. On 5 July, an officer found that Mr Avery was struggling to breathe while using his nebuliser. The officer called a code blue emergency and a nurse responded. She took Mr Avery's basic observations and sent him to hospital as an emergency. While in hospital, doctors treated him for an exacerbation (worsening) of his COPD. He returned to the prison from hospital on the evening of 8 July.

47. On 9 July, a nurse reviewed Mr Avery and noted a very strong smell of illicit substances and that his cell was smoky. Mr Avery denied using illicit substances and said that it was the general smell on the wing. She noted that Mr Avery appeared to be alert and orientated. She explained to him that he could die from using PS, based on his age, weight and diagnosis of COPD. Mr Avery said he understood this and insisted that he had not used PS, though an officer agreed that the smell and smoke was coming from his cell. She referred Mr Avery to DARS. She also asked officers to monitor Mr Avery overnight and asked other healthcare staff to consider withholding his prescription.

48. Later that day, a nurse saw Mr Avery to attempt a mental health assessment. However, he could not see Mr Avery in private and Mr Avery was not prepared to discuss personal details in public.

49. Later that day, a healthcare administrator noted that Mr Avery refused to attend a post-PS review.

50. On 14 July, a prison GP saw Mr Avery, who said that he felt better after being seen in hospital. They also discussed the risks of using PS.

51. Three days later, a healthcare administrator contacted the prison GPs and asked them to ensure that Mr Avery was not allowed his prescription medications in his possession, as healthcare staff were concerned that they could be traded for illicit drugs. Later that day, a prison GP noted this concern.

52. On 24 July, a nurse saw Mr Avery for a short-term mental health intervention. Mr Avery said that he was unhappy being locked in his cell due to the COVID-19 restrictions, though the nurse did not note any evidence of depression. Mr Avery claimed to only have used PS two weeks ago, though prison officers considered

that he used it more often. The nurse advised him to stop using PS, due to the potential risks, but Mr Avery said he was dying anyway so it was his decision. The nurse referred him to DARS.

53. On the morning of 27 July, a DARS recovery practitioner saw Mr Avery, who refused to work with DARS. Mr Avery said that he did not see any point in being alive, that he had attempted to use PS to kill himself in the past and that he was very depressed. At 9.20am, she began Prison Service suicide and self-harm monitoring (known as ACCT).

54. Ten minutes later, a supervising officer (SO) completed an Immediate Action Plan, instructed staff to observe Mr Avery twice an hour and referred him to the mental health team for a review.

55. At 2.00pm, the SO held the first ACCT case review with Mr Avery and an officer. The SO noted that he had been unable to get any mental health staff to attend the review. Mr Avery said that he was frustrated about his declining physical health and that he “sometimes” thought about taking his own life, though he had no plans to do so. The attendees assessed that Mr Avery presented a raised risk of suicide and self-harm (on a scale of low, raised and high) and they kept the level of observations the same.

56. That same day, a prison GP reviewed Mr Avery’s medication in the light of his incidents of severe breathlessness and his deteriorating COPD, which was exacerbated by persistent use of PS. He decided that it was too unsafe for Mr Avery to keep his medication in possession, so he arranged for him to use a wheelchair to collect his medication.

57. At 9.00am on 28 July, the SO held the second ACCT case review with Mr Avery, another SO and a nurse. The SO noted that Mr Avery appeared in high spirits compared to the previous review. Mr Avery said that he did not feel suicidal but that could change at any time. The attendees assessed that Mr Avery presented a low risk of suicide and self-harm and they reduced the level of observations to one an hour.

58. The SO added two actions to Mr Avery’s caremap (designed to identify the main areas of concern and the actions required to reduce risk): that he needed a personal emergency evacuation plan and his own wheelchair.

59. The nurse recorded additional information in Mr Avery’s electronic medical record (known as SystmOne). Mr Avery said that he had stopped using PS, would not use it in the future and that he would work with the DARS team. The nurse noted that Mr Avery’s physical state dominated the review so there was no need for mental health to attend any future ACCT case reviews.

60. On 4 August, a SO held the third ACCT case review with Mr Avery and another SO. Mr Avery said that he felt a lot better as he had been given a wheelchair and a carer and was due to see a consultant about his COPD and angina. The attendees decided that the ACCT could be closed.

11 August 2020

61. At 11.09am on 11 August, a SO held an ACCT post-closure interview with Mr Avery, who said that he felt better than he had, despite his numerous health conditions. The SO decided that there was no need to re-open the ACCT or hold a second interview with Mr Avery.

62. At approximately 4.15pm, an officer visited Mr Avery's cell, gave him a toilet roll and pulled the door closed.

63. Around 15 minutes later, Officer A locked Mr Avery's cell. CCTV footage shows that he spent only seconds at Mr Avery's door and did not look into the cell.

64. At approximately 5.35pm, Officer A and Officer B started unlocking certain cells to let prisoners out to collect their evening medication. At about 5.37pm, Officer A unlocked the door to Mr Avery's cell and Officer B unlocked the neighbouring cell. Officer A said he was "hit with a wall of fumes" from Mr Avery's cell that he thought was PS. He described the fumes as smelling of "burning plastic" and said they made him feel unsteady on his feet. Officer B appeared not to be aware of this as CCTV footage shows that he walked away from his colleague and left the wing.

65. At 5.39pm, Officer A realised that Mr Avery was unresponsive, so he called a code blue medical emergency. Officer A and two prisoners briefly entered Mr Avery's cell. Two minutes after unlocking Mr Avery's cell, as Officer B walked along the corridor in response to the code blue emergency, Officer A entered and remained in the cell. Officer B then also entered the cell.

66. During his interview, Officer A told the investigator that he checked Mr Avery's pulse and breathing and thought that he felt both. However, during their interviews, Officer B and the two prisoners said that they thought that Mr Avery was not breathing and did not have a pulse. The two officers placed Mr Avery in the recovery position.

67. More staff then responded. The nurses found that Mr Avery was not breathing so they started cardiopulmonary resuscitation (CPR). The nurses also gave Mr Avery rescue breaths using an Ambu-bag and attached a defibrillator which did not detect a shockable heart rhythm and advised to continue CPR. On their SystmOne entries, the nurses noted, respectively, that Mr Avery had "blood" and "fluid" pooling on his stomach and chest.

68. At 5.43pm, as noted on the Control Room Daily Log, the control room operator noted that an ambulance was needed. According to the Log, the prison made the first of four telephone calls to the Ambulance Service at 5.47pm, although an operational support grade told the investigator that this would have been the time that the call finished. The North West Ambulance Service sent a rapid response vehicle and it reached Mr Avery at 6.10pm. A paramedic noted that Mr Avery showed hypostasis (pooling of blood) and, at 6.12pm, declared that he had died.

69. Following Mr Avery's death, Lancashire Police seized and examined two homemade smoking devices found in Mr Avery's cell. The forensic report noted they contained PS.

Contact with Mr Avery's family

70. Throughout Mr Avery's time in custody he had listed his sister as his next of kin, but on his electronic prison record (known as NOMIS) staff had recorded her address but not her telephone number.

71. Following Mr Avery's death, the prison appointed a SO as the prison's family liaison officer. In the absence of a telephone number for Mr Avery's next of kin, the Governing Governor decided that to avoid a delay searching his records for a telephone number, the police should be asked to visit her home address to break the news of his death. At approximately 1.00am on 12 August, West Midlands Police visited the home address of Mr Avery's next of kin and broke the news of his death.

72. At 11.50am, the SO telephoned Mr Avery's sister to introduce herself and to offer her condolences and support.

73. The SO continued to support Mr Avery's sister until his funeral, which was held on 2 September. The prison contributed towards the costs of the funeral in line with national instructions.

Support for prisoners and staff

74. After Mr Avery's death, a prison manager debriefed some of 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.

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

Post-mortem report

76. The post-mortem examination, completed before a toxicological analysis took place, considered that, if the analysis was inconclusive, then the cause of Mr Avery's death was coronary artery disease.

77. A toxicological analysis found that Mr Avery's blood and urine contained synthetic cannabinoids (PS). The toxicology report noted that the toxic effects of synthetic cannabinoids include abnormally fast heart rate, collapse, seizures, vomiting and mood disorders, and that the type of PS found in Mr Avery's blood and urine had subjectively stronger effects than other cannabinoids. The analysis also found the presence of medications prescribed to Mr Avery, though they were not at levels that could have caused his death.

Findings

Substance misuse care

78. Mr Avery had a long history of substance misuse and continued to use illicit substances at Garth. The clinical reviewer was satisfied that DARS repeatedly offered him support but, on each occasion, Mr Avery declined their support. The clinical reviewer was also satisfied that healthcare staff treated Mr Avery appropriately when he was found under the influence, made repeated attempts to remind him of the dangers of using PS and took steps to review and withhold his prescribed medications for safety reasons.

79. The clinical reviewer was satisfied that the substance misuse care that Mr Avery received was equivalent to that which he could have expected to receive in the community.

Physical health care

80. Mr Avery had a complex physical health history, which deteriorated significantly in the year before his death. However, despite the multiple conditions that Mr Avery had, the clinical reviewer was satisfied that there was nothing in SystmOne that indicated that he experienced chest pains or similar symptoms, and so there was nothing to alert healthcare staff to his coronary artery disease.

81. The clinical reviewer was satisfied that healthcare staff regularly reviewed Mr Avery's long-term conditions and gave him responsive care when unwell. The clinical reviewer was satisfied that the physical health care that Mr Avery received was equivalent to that which he could have expected to receive in the community.

Mental health care

82. Prior to his arrival in prison custody, Mr Avery had been diagnosed with depression and prison GPs had prescribed him antidepressant medication since 2013. Despite this diagnosis, Mr Avery had little contact with the mental health team until July 2020 when a nurse saw him for a short-term mental health intervention and during an ACCT case review.

83. While the clinical reviewer was satisfied that the mental health care that Mr Avery received was of a reasonable standard and had been responsive to his needs, she noted three missed opportunities to discuss the negative impact that his physical health had on his mental health and his PS use.

84. When the DARS recovery practitioner opened an ACCT for Mr Avery, she told the investigator that she did not refer him to the mental health team as they would attend the first ACCT case review. Although a nurse attended the second ACCT case review, we agree with the clinical reviewer that a case review should not be used as a substitute for a mental health review and that the DARS recovery practitioner should have referred him to the mental health team.

85. Throughout the ACCT process, Mr Avery focused on his physical health and the frustrations that his declining health caused him. For this reason, a nurse decided that mental health staff should not attend any subsequent ACCT case reviews. The clinical reviewer considered that this decision meant that there was a missed opportunity to explore the negative effect that Mr Avery's declining physical health might be having on his mental health.

86. Finally, from comparing Mr Avery's engagement with the nurse to his limited engagement with various DARS recovery practitioners, the clinical reviewer considered that there was a missed opportunity for joint working between the two teams to help him address his PS use.

87. We make the following recommendations:

The Head of Healthcare should ensure that all healthcare staff are aware of the circumstances in which a mental health referral is appropriate and make a referral when indicated.

The Head of Healthcare should develop joint care pathways to support prisoners with substance misuse and mental health conditions and use joint approaches to maximise that prisoner's engagement.

Reducing the supply and demand for illicit substances

88. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS use has a profoundly negative impact on the physical and mental health of prisoners. Mr Avery's death is an example of the dangers of PS and illustrates why prisons must do all they can to stop its use.

89. During their inspection of Garth in December 2018 and January 2019, HM Inspectorate of Prisons found that 60% of prisoners said that it was easy to obtain drugs. During interviews, staff and prisoners agreed that illicit substances, particularly PS, were commonplace in the prison.

90. In January 2020, Garth introduced a new Integrated Substance Misuse Strategy, which aims to reduce the supply and demand for illicit substances and to provide support and recovery opportunities for prisoners. To help reduce supply, the Strategy says that any member of staff should submit an intelligence report if they suspect a prisoner is involved in the supply, distribution or misuse of illicit substances. Security staff will analyse this information and make appropriate actions to address the issue, which could include a referral to DARS, a referral for a mandatory drug test or a restriction on visits.

91. During the PPO's interview with the Head of Security and Intelligence, he described the steps the prison have taken to reduce the supply of illicit substances, which includes the use of scanners to test incoming letters for PS, the introduction of counter-corruption training and additional checks on parcels. He also reiterated that any member of staff should submit an intelligence report if they suspect a prisoner is misusing illicit substances.

92. Between 1 and 9 July, prison and healthcare staff suspected that Mr Avery had used PS or another illicit substance on three occasions. However, an officer only

submitted an intelligence report about the incident on 1 July. We are concerned that this failure meant that the security department could not properly understand Mr Avery's substance misuse and the wider implications around the supply and distribution on his wing and around the prison.

93. We are also concerned that, despite the scanning of incoming mail and the fact that prison visits had been suspended due to the COVID-19 pandemic, Mr Avery managed to obtain PS in July and August 2020.

94. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff follow the prison's Substance Misuse Strategy by submitting intelligence reports when a prisoner is suspected of using illicit drugs.

The Governor should identify the key weaknesses in reducing the supply of drugs at Garth and revise the drug strategy in light of the findings.

Assessment of Mr Avery's risk/ ACCT management

95. In the weeks before his death, Mr Avery told a nurse and a DARS recovery practitioner that he saw no point in being alive. He also told the recovery practitioner that he had used PS in the past to try to kill himself. At interview, a friend of Mr Avery's said that Mr Avery told him to stop telling other prisoners to stop selling him "Spice" (a type of PS) because he wanted to die. In the light of Mr Avery's statements, we cannot rule out the possibility that he used PS with the deliberate intention of killing himself. We have therefore considered whether the management of Mr Avery's risk of harm was appropriate.

96. A nurse told the investigator that she could not remember whether she thought about opening an ACCT for Mr Avery on 1 July when he told her that he would not be bothered if he died. She said that opening an ACCT "tends to be something more that the prison would do". We are concerned that she assumed that prison staff should open an ACCT rather than healthcare staff.

97. We are also concerned that a SO's summary of the second ACCT case review on 28 July failed to mention that Mr Avery said he was willing to work with DARS or to add this as an action on his caremap. It is difficult to know how seriously to take Mr Avery's assertion about this as he had refused to work with DARS only the day before. Nevertheless, it may have been a missed opportunity to try to engage with him about his drug use.

98. We are, however, satisfied that it was not unreasonable to have closed the ACCT on 4 August as Mr Avery's mood had improved since he had received help with his physical health problems.

99. We make the following recommendations:

The Head of Healthcare should ensure that healthcare staff are aware of their responsibility to start ACCT procedures whenever they are concerned about a prisoner's risk of suicide or self-harm and that they clearly document their decision making.

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

- **accurately record all information disclosed at an ACCT case review; and**
- **set meaningful caremap actions, aimed at reducing the prisoner's risk to themselves.**

Emergency response

Finding Mr Avery

100. CCTV footage showed that although Officers A and B were close to each other, when Officer A opened Mr Avery's cell, Officer B appeared to be unaware, at that time, that there was any problem as he walked off the wing. After opening Mr Avery's cell, Officer A described, in both his Incident Report Form and during his interview, being hit with "a wall of fumes" that made him unsteady on his feet. As a result, he said that he felt unsafe entering Mr Avery's cell by himself.

101. During interviews with the prison staff that attended the emergency response, none of them noticed any smell or saw any visible fumes. However, during his interview, a prisoner recalled that Officer A said that Mr Avery's cell "stinks of fish [a slang term for PS]" and that he had started to feel dizzy. The prisoner also told the investigator that he entered Mr Avery's cell and switched on a fan to "waft the fish out of there".

102. We accept that there is evidence to support Officer A's assertion that he was affected by PS fumes and that it was therefore reasonable that he did not enter Mr Avery's cell by himself. We are satisfied that he called an emergency medical code when he realised that Mr Avery was unresponsive.

Resuscitation attempt

103. Prison Service resuscitation policy says, "Staff who are not able to recognise rigor mortis should start resuscitation until advised otherwise by a competent member of staff".

104. After finding Mr Avery, Officers A and B put him in the recovery position, but they did not start CPR. Officer A said he thought Mr Avery was breathing and had a pulse, while Officer B said he thought that Mr Avery was not breathing and did not have a pulse.

105. Both officers had attended an Emergency First Aid at Work course during their initial HMPPS training, which they completed, respectively, in January 2018 and March 2019. Officer A told the investigator that the course said that if you were unsure whether a person was breathing, you should check their airway and put them in the recovery position, while Officer B said that you should start CPR.

106. While we appreciate that there was a discrepancy between both officers as to whether Mr Avery was breathing or had a pulse, we consider that they were not competent to decide whether he was dead or not and that they should have started

CPR. While the delay in starting CPR will not have changed the outcome for Mr Avery, it could be critical in other cases. We make the following recommendation:

The Governor should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity when a prisoner is unresponsive.

107. The situation was, however, different for the nurses who responded to the medical emergency code. In March 2016, the National Offender Management Service (now HMPPS), the Royal College of Nursing and the Royal College of General Practitioners issued Guidance to support the decision-making process of when not to perform CPR. The guidance, which is based on the European Resuscitation Council Guidelines for Resuscitation, says resuscitation is inappropriate and should not be provided or continued when there is clear evidence that it will be futile. The guidelines say that resuscitation should not be attempted where hypostasis (blood pooling) is present.

108. After healthcare staff started CPR, they realised that Mr Avery had blood pooling on his chest and stomach. During the interviews with both nurses, they said they wanted to stop CPR, yet they considered that it had to continue once started. They also said they spoke to the Head of Healthcare for permission to stop the resuscitation, though she did not authorise this. The Head of Healthcare told the investigator that without full information about Mr Avery's condition, it was a hard decision to make remotely. She also considered that if resuscitation had been started, it needed to continue.

109. Healthcare staff need to understand that they should not start or continue CPR when a prisoner shows pooling of blood, rigor mortis or other clear signs of death. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff are given guidance about the circumstances in which resuscitation is inappropriate, in accordance with European Resuscitation Council Guidelines.

Ambulance call

110. PSI 03/2013, Medical Emergency Response Codes, contains mandatory instructions that on hearing a code blue emergency, control room staff must call an ambulance immediately.

111. Garth's local protocol reflects the PSI and refers to the ERIC process, which asks staff to quickly relay information required for the ambulance, including whether the patient is conscious and breathing. In June 2020, the prison issued a Staff Information Notice that highlighted significant parts of the local protocol.

112. Although Officer A called the code blue at 5.39pm, the control room operator did not call an ambulance until 5.43pm. Due to delays in passing information about Mr Avery's condition from the scene, it then took a further four minutes to inform the Ambulance Service that Mr Avery was not breathing and therefore required an emergency response.

113. We are concerned that there was a total delay of eight minutes in obtaining an emergency ambulance due to two unacceptable delays in making the initial call and providing information about Mr Avery's condition. We are particularly concerned that this occurred two months after the prison reminded staff about the local protocol. While this delay did not change the outcome for Mr Avery, it could be critical in other cases. We make the following recommendation:

The Governor should ensure that all staff are made aware of and understand PSI 03/2013, as well as local instructions, and their responsibilities during medical emergencies, including:

- **immediately calling an ambulance when a medical emergency code is called; and**
- **promptly providing information about a prisoner's condition to the control room so that they have this information when requesting an ambulance.**

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