

**Prisons &
Probation**

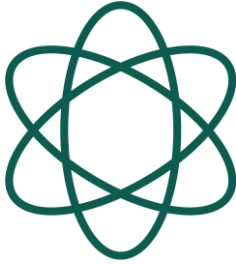
Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Ryan Jewell,
a prisoner at HMP Garth,
on 9 January 2021**



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

OGL

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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 Ryan Jewell was found hanged in his cell at HMP Garth on 9 January 2021. He was 28 years old. I offer my condolences to his family and friends.

Mr Jewell was not subject to suicide and self-harm monitoring at Garth and appears to have had a good relationship with prisoners and staff. In December 2020, following a Parole Board hearing, Mr Jewell was informed that he was not assessed as suitable for transfer to an open prison. Although he presented as disappointed with the outcome, he did not display any behaviour that might have indicated an increased risk. I am satisfied that there were no indications that Mr Jewell was at imminent risk of suicide or self-harm in the days leading to his death and that staff could not have predicted his actions. However, I am concerned that prison staff may have missed an opportunity to identify that Mr Jewell was giving away his possessions to other prisoners.

I am also concerned that the keywork process was not as effective as it should have been in offering Mr Jewell support, which the Governor will need to address.

There were also failings in the use of body-worn video cameras and the procedure for storing CCTV evidence, but I am satisfied that the prison acted promptly and addressed these issues.

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

February 2022

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Summary

Events

1. On 31 July 2008, Mr Ryan Jewell was remanded to HMP/YOI Stoke Heath, charged with grievous bodily harm. In May 2010, he received an imprisonment for public protection (IPP) sentence, with a minimum tariff of three years. Mr Jewell was released on licence in May 2014, but was recalled to prison in June 2015, charged with burglary. He was sentenced to eight years in prison in September and moved to HMP Garth on 18 March 2016.
2. Over the next four years, Mr Jewell progressed through his sentence and achieved Category C status. He had a prison job, abided by the rules and was never subject to suicide and self-harm prevention measures, known as ACCT.
3. On 8 December 2020, Mr Jewell attended a Parole Board hearing by video link. Six days later, his prison probation officer informed him that the Parole Board had concluded that he was not suitable for Category D status. She noted that Mr Jewell shrugged his shoulders and said, "I've dealt with knockbacks before".
4. On 7 January 2021, Mr Jewell's community probation officer asked his prison probation officer to arrange a joint meeting. She told us that Mr Jewell had called her the previous week and appeared to have difficulty accepting the Parole Board's decision. She also said that he felt that no one was helping him and that he could not see himself doing a further five years in prison.
5. A prisoner told the investigator that on 8 January, he spoke to Mr Jewell on the exercise yard, and he said, "I can't be bothered with this" and "Anyway, this is the last time I'm coming out here". Another prisoner told us that he spent time playing computer games with Mr Jewell and that he seemed fine.
6. At about 5.26am on 9 January, an officer looked through Mr Jewell's observation panel to conduct a roll check and found that it was covered from the inside. He could not get a response from Mr Jewell and radioed for assistance at 5.27am.
7. Around one minute later, other staff arrived. When they entered the cell, they found Mr Jewell hanging from a light fitting, with a ligature round his neck. They radioed a medical emergency code at 5.29am and an officer cut the ligature. Officers gave cardiopulmonary resuscitation (CPR) until a nurse associate told them to stop at 5.34am, as it was clear that Mr Jewell had died. At 6.07am, a paramedic confirmed that Mr Jewell was dead.

Findings

8. Mr Jewell gave no indication to staff that he was at risk of suicide and self-harm. Although he presented as disappointed about the outcome of his parole hearing, he did not display any unusual behaviour that might have indicated an increased risk. While we are satisfied that staff could not reasonably have predicted his actions, we are concerned that they may have missed an opportunity to notice that he was giving some of his possessions away to other prisoners.

9. Mr Jewell's keyworker had infrequent contact with him. Although the COVID-19 pandemic impacted on the delivery of keywork, we consider that the keyworker scheme could have been more effective in offering support to Mr Jewell.
10. Officers and healthcare staff responded promptly to the emergency, but it was evident that Mr Jewell had died.
11. Garth was unable to provide CCTV footage of the wing on 9 January due to a technical failure. They were also unable to provide body-worn video camera footage of the staff entering the cell as no one had drawn a camera. However, we are satisfied that this issue has been resolved and do not make a recommendation.
12. The clinical reviewer considered that the clinical care that Mr Jewell received at HMP Garth was equivalent to that which he could have expected in the community.

Recommendations

- The Governor should ensure that officers look for signs that prisoners may be giving their possessions away when patrolling the wings and conducting cell checks and take appropriate action.
- The Governor should ensure that:
 - the keyworker scheme provides meaningful and ongoing support to prisoners; and
 - keyworkers are assigned an appropriate number of hours to allow them to fulfil their role.

The Investigation Process

13. 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.
14. The investigator obtained copies of relevant extracts from Mr Jewell's prison and medical records.
15. The investigator interviewed two prisoners by telephone on 25 January 2021.
16. NHS England commissioned a clinical reviewer to review Mr Jewell's clinical care at the prison. The clinical reviewer jointly interviewed seven members of staff by telephone with the investigator on 22 and 23 February. The interviews were conducted by telephone because of the COVID-19 pandemic restrictions.
17. We informed HM Coroner for Preston and West Lancashire of the investigation. He gave us the results of the post-mortem examination and we have sent him a copy of this report.
18. The Ombudsman's family liaison officer contacted Mr Jewell's father to explain the investigation and to ask if he had any matters that he wanted us to consider. Mr Jewell's father did not raise any specific concerns.
19. Mr Jewell's father received a copy of the initial report. He did not raise any further issues or comment on the factual accuracy of the report.
20. The initial report was shared with HM prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Garth

21. HMP Garth holds up to 846 prisoners serving sentences of four years or longer or indeterminate sentences. Primary care services are provided by Bridgewater NHS Foundation Trust, mental health and clinical substance misuse services by Greater Manchester Mental Health NHS Foundation Trust and psychosocial substance misuse services are provided by Delphi Drug and Alcohol Recovery Service (DARS).

HM Inspectorate of Prisons

22. The most recent inspection of HMP Garth was in December 2018 and January 2019. Inspectors reported that levels of self-harm were significantly higher than at the last inspection and compared with other Category B training prisons. However, the standard of ACCT suicide and self-harm prevention measures was reasonably good.
23. Inspectors found that interactions between prisoners and staff were respectful and courteous overall. However, they noted that some staff did not consistently enforce basic rules in residential units. Inspectors found that the keyworker system had been introduced between October 2018 and January 2019, and, although it was new, it was functioning well. They found that prisoners were allocated a keyworker, who they met fortnightly to focus on their progression, set targets and discuss any concerns.

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 latest annual report for the year to November 2020, the IMB reported that prisoners were treated with respect and that the disruption caused by the COVID-19 pandemic had been made bearable with the adjustments the Governor had introduced, such as the provision of in-cell telephones.
25. The IMB reported that during December 2019 to February 2020, the keyworker scheme operated as normal. However, due to staff shortages, it was effectively put on hold during the COVID-19 pandemic. The Board continued to be concerned about the number of IPP prisoners in custody, but noted that an IPP progression board, led by probation staff, had been set up and was working well.

Previous deaths at HMP Garth

26. Mr Jewell was the twelfth prisoner to die at Garth since January 2019. Of the previous deaths, five were from natural causes, five were drug-related and one was self-inflicted. There have been two deaths since, one from natural causes and one self-inflicted. There were no similarities between the circumstances of Mr Jewell's death and those of the previous investigations.

Security categorisation

27. In England and Wales, male prisoners are divided into four security categories based on an assessment of risk, ranging from Category A (highest risk) to Category D (lowest risk). Prisoners who have more than four years of their sentence left to serve should have an annual re-categorisation review.

Parole Board

28. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to assess their suitability for transfer to open conditions and to decide whether they can safely be released into the community once they have served the minimum sentence imposed by the courts.

Key Events

29. On 14 May 2010, Mr Ryan Jewell received an imprisonment for public protection (IPP) sentence for grievous bodily harm, with a minimum tariff of three years. On 14 May 2014, Mr Jewell was released on licence from HMP Sudbury.
30. On 30 June 2015, Mr Jewell was recalled to HMP Leicester, charged with burglary. He was sentenced to eight years in prison on 2 September and moved to HMP Lincoln four weeks later.
31. In December, a psychiatrist assessed Mr Jewell and diagnosed that he had either severe anti-social personality disorder or a psychopathic disorder. She prescribed quetiapine (an antipsychotic).

HMP Garth

32. On 18 March 2016, Mr Jewell was moved to HMP Garth as part of his sentence progression. A locum GP prescribed quetiapine and the integrated mental health team added Mr Jewell to their caseload. In October, Mr Jewell decided to stop taking quetiapine as he felt it made no difference. In November, a mental health nurse reviewed Mr Jewell and noted that he refused to engage with the mental health team. She also noted that he did not display any symptoms of a thought disorder and that he agreed with her decision to discharge him.
33. Over the next three years, prison records show that Mr Jewell was well behaved, had a prison job and was categorised as a Category B prisoner. There is no evidence that Mr Jewell had any involvement with the mental health team, used illicit substances or reported any thoughts of suicide or self-harm to staff.
34. On 12 February 2020, a prison offender manager (POM) visited Mr Jewell to review his sentence plan and to set objectives to help him work towards a parole hearing later in the year. Mr Jewell said that he did not see the benefit in moving to a Category C prison and would prefer to move to a category D prison. She recorded that although Mr Jewell was well behaved, he had not completed any alcohol awareness courses or relationship work since 2017. She therefore referred him for a psychological risk assessment.
35. On 19 February, Mr Jewell's keyworker saw him for a short session. She noted that Mr Jewell did not have any concerns and said that he was hoping to obtain Category D status in the summer.
36. On 6 March, the POM recorded that a psychologist had reviewed Mr Jewell and agreed to conduct a psychological risk assessment. She also noted that she would not consider recommending Category D until it had taken place.
37. On 18 March, the keyworker tried to see Mr Jewell for a keywork session, but he refused to engage. She recorded that he continued to comply with the wing regime and the prison rules.
38. On 20 May, the POM wrote to Mr Jewell that it had not been possible to arrange a psychological risk assessment due to the COVID-19 pandemic, but that this would take place once restrictions eased.

39. On 11 June, the POM submitted a sentence planning and review report to the Parole Board. She concluded that she was not able to support a move to an open prison until the psychology department had completed a risk assessment. She told the investigator that the Parole Board decided to wait until the risk assessment had taken place and deferred Mr Jewell's hearing to December.
40. On 30 June, a forensic psychologist in training conducted Mr Jewell's psychological risk assessment and recorded that he engaged well.
41. On 5 August, a substance misuse recovery worker met Mr Jewell to complete a recovery plan. (Parole Board records show that Mr Jewell had contacted the substance misuse team after the POM raised his failure to complete alcohol awareness work as an issue.) However, Mr Jewell said that he no longer wanted to engage as he was free from drugs and alcohol.
42. On 2 October, Mr Jewell received Category C status following a positive review of his progression and prison behaviour. The POM told us that Mr Jewell did not particularly want Category C status, but agreed to it after she explained that if she was to recommend Category D, it might be helpful for the Parole Board to know that he had achieved Category C.
43. On 29 October, a substance misuse recovery worker visited Mr Jewell for a follow-up appointment. She recorded that Mr Jewell said he did not need any support and that he had a parole hearing in December. She subsequently discharged him from the substance misuse team.
44. On 8 November, the keyworker recorded that she was unable to see Mr Jewell for a keywork session due to the COVID-19 pandemic. However, she noted that she had spoken to him on the wing several times and that he had not reported any concerns.
45. On 8 December, Mr Jewell attended a Parole Board oral hearing by video link. The following day, the Parole Board sent an 'oral hearing decision letter' to the prison. It stated that although the POM and the forensic psychologist recommended that Mr Jewell be transferred to a Category D prison, the panel had concluded that he would have to demonstrate that he had learned from interventions before he could progress to open conditions.
46. On 14 December, the POM visited Mr Jewell and informed him of the Parole Board's decision. However, she did not document the details of her visit until after he had died. She recorded (on 11 January 2021) that she read the decision to Mr Jewell and that he shrugged his shoulders and said that he had "dealt with knockbacks before". She also noted that he declined to read the report in more detail later that day.
47. On 22 December, Mr Jewell was due to attend a sentence planning meeting with the POM and his community probation officer. However, Mr Jewell phoned his community probation officer that morning and told her that he did not want to attend the meeting as he was finding it difficult to focus and come to terms with the Parole Board's decision. She updated the POM and suggested they schedule another meeting in the New Year.

48. On 29 December, HM Prison and Probation Service (HMPPS)'s Public Protection Casework Section (PPCS) wrote to Mr Jewell to tell him that the target for his next Parole Board hearing was June 2022.
49. On 7 January 2021, the community probation officer sent an email to the POM. She said that Mr Jewell had phoned her the previous week. She said that Mr Jewell was having difficulty accepting the Parole Board's decision and asked her to schedule a meeting. The community probation officer told us that during the call, Mr Jewell said that no one was helping him, and that probation was useless. She also told us that he said he could not see himself doing another five years in prison, but he did not elaborate.

Events of 8 and 9 January

50. On 8 January, during afternoon association, a prisoner told the investigator that he spoke to Mr Jewell on several occasions and that he did not notice anything unusual about him. However, he said that when they were on the exercise yard, Mr Jewell said, "I can't be bothered with this" and went inside, saying, "Anyway, this is the last time I'm coming out here". Another prisoner told us that Mr Jewell spent the final hour and a half of association time in his cell playing computer games with him. He said that he seemed fine and that his last words to him as he left were, "Good fun".
51. At around 7.30pm, Officer A looked through Mr Jewell's cell observation panel to conduct a roll check and found that it was covered from the inside. He told us that he asked Mr Jewell to remove the covering and that Mr Jewell did so and that he did not report any issues or concerns and was smiling.
52. At around 5.26am on 9 January, Officer A looked through Mr Jewell's observation panel to conduct a roll check and found that he had covered it up again. He banged on the cell door and switched the light on, but Mr Jewell did not respond. At 5.27am, he radioed for assistance and waited outside the cell.
53. Around one minute later, an acting Custodial Manager (CM) and Officer B arrived. After failing to get a response from Mr Jewell, the CM decided to enter the cell. Officer A broke the security seal on his key pouch and unlocked the door. The CM led the officers into the cell, and they found Mr Jewell hanging from a light fitting, with a ligature made from a bed sheet around his neck. The CM radioed a medical emergency code blue at 5.29am, and supported Mr Jewell's weight, whilst Officer A cut the ligature.
54. Officer C arrived as the CM and Officer A were lowering Mr Jewell onto his bed and started cardiopulmonary resuscitation (CPR). At 5.34am, a nurse entered the cell and instructed Officer C to continue with CPR whilst he conducted an assessment. He found that Mr Jewell's body showed signs of rigor mortis and at 5.38am, he advised Officer C to stop CPR. Officer C went to obtain a body-worn video camera (BVWC) and returned just as the paramedics arrived. At 6.07am, a paramedic confirmed that Mr Jewell had died.
55. Mr Jewell had written 'FREE' in large letters on his stomach and left four notes: three addressed to family members and one to Leicester probation. In the letter to probation, Mr Jewell said, "Did you lot think I would be a dog on a leash being told how to live and what to do ... I blagged the first sentence easy ... second time

round, my chances of fooling you lot are low.” In another note Mr Jewell wrote, “Fuck the system. I play it easy first time. Second time the lies to hard to maintain, Parole see right through my act, I’m never getting out so I will go on my terms, whatever it takes to be happy.”

Contact with Mr Jewell’s family

56. At 10.00am, a prison chaplain telephoned Mr Jewell’s father, his named next of kin, and broke the news of Mr Jewell’s death. He passed the phone to the Supervising Officer (SO), who explained that she had been appointed as family liaison officer and offered her support.
57. The SO provided ongoing support to Mr Jewell’s father until the funeral, which took place on 19 February. The prison offered to contribute towards its cost in line with national instructions.

Support for prisoners and staff

58. After Mr Jewell’s death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
59. The prison posted notices informing other prisoners of Mr Jewell’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 Jewell’s death.

Post-mortem report

60. A post-mortem examination found that Mr Jewell died from asphyxiation by hanging. Toxicology analysis was not undertaken.

Events after Mr Jewell’s death

61. On 9 January, staff submitted an intelligence report which stated that three prisoners had been overheard saying that Mr Jewell had given them some of his personal items before his death. However, there is no record that staff were aware of this at the time.
62. On 25 January, a prisoner told the investigator that he had known Mr Jewell for several years and had spoken to him daily. He said that Mr Jewell was one of the most positive people that he had ever met but that his outlook changed following the Parole Board’s decision. He said that Mr Jewell went on a “bit of a bender” with drugs and started talking about killing himself on his birthday (27 February). He said that he spoke to him about it daily and that he would have told staff if he had sensed any urgency. He added that he felt Mr Jewell deliberately chose not to give him any of his possessions as he would have known what he was planning.

Findings

Assessment of Mr Jewell's risk of suicide and self-harm

63. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm, and to take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.
64. Mr Jewell was not subject to ACCT monitoring at Garth. Prison records show that he had a good relationship with staff, engaged well with other prisoners and abided by the rules.
65. The POM told us that Mr Jewell presented positively every time she saw him and that he never reported any concerns. She said that although he did not say too much when she informed him of the Parole Board's decision, she was not concerned about how he took the news. The community probation officer told us that Mr Jewell's behaviour in January was not unusual as he often expressed anger about his sentence, the victim of his offence and professional agencies. She said that there was no indication that he was feeling particularly low about having to remain in a closed prison or she would have notified the prison.
66. While Mr Jewell's response to the Parole Board's decision could have indicated his increased risk of suicide or self-harm, particularly with the benefit of hindsight, we accept that there was little other information at the time to suggest that this was the case. The comments he made to his community probation officer in January do stand out, but we consider that she was well placed to make an informed assessment of risk having worked with Mr Jewell for some time. We also recognise that Mr Jewell had managed similar disappointments in the past and did not report any thoughts of suicide or self-harm. In this context, we are satisfied that her actions were reasonable.
67. Although a prisoner said that Mr Jewell had told him that he intended to take his own life, there is no record that anyone else who had contact with Mr Jewell in the weeks before his death had reason to consider that he was at risk. He did not display any unusual behaviour, appear under the influence of illicit substances or report any thoughts of suicide or self-harm to staff. Another prisoner told us that he was completely "blindsided" by Mr Jewell's actions and that his death came as a "total shock". He said that he knew that Mr Jewell was annoyed about the Parole Board's decision but thought he had ultimately accepted it.
68. Mr Jewell had given his possessions away to other prisoners, which is a significant risk factor. There is no evidence that staff observed him doing so and a prisoner told us that he must have given his things away quietly, as he was not aware of it until after he died. He also said that one of the items that Mr Jewell gave away was an XBOX console, a device that is often cherished by prisoners. While it is possible that Mr Jewell's actions may have made it difficult for staff to notice him giving his possessions away, they are required to check cells daily and we would expect missing items, such as an XBOX, to be identified and explored.

69. We are satisfied that there was no reason for staff to consider ACCT monitoring in the weeks leading to Mr Jewell's death and we do not consider that staff could reasonably have predicted his actions. However, we are concerned that prison staff may have missed an opportunity to notice that Mr Jewell was giving away his possessions. We therefore make the following recommendation:

The Governor should ensure that officers look for signs that prisoners may be giving their possessions away when patrolling the wings and conducting cell checks and take appropriate action.

Keyworker support

70. His keyworker should have had a weekly meeting with Mr Jewell. While we recognise that the COVID-19 pandemic had a significant impact on the prison's ability to deliver keywork and that Mr Jewell did not meet the criteria for support under the Prison Service's exceptional delivery model, his keywork sessions were infrequent before March 2020. The keyworker told us that it was often difficult for staff to find time for keywork sessions and when they did, staff shortages often meant they were redeployed to other parts of the prison. Although we appreciate that operational pressures can lead to staff changes, the prison needs to ensure that officers have enough time to complete keyworker duties.
71. Prison records show that Mr Jewell had minimal contact with staff and a prisoner told us that he "kept a healthy distance from staff", only speaking to them when absolutely necessary. The keyworker said that Mr Jewell did not really like talking to staff and that made it difficult for her to find ways to engage him in meaningful conversations. While this may have been the case, more frequent contacts may have helped to break down barriers and make way for more meaningful conversations. We therefore consider that a keyworker should have had a more supportive role. We make the following recommendation:

The Governor should ensure that:

- **the keyworker scheme provides meaningful and ongoing support to prisoners; and**
- **keyworkers are assigned an appropriate number of hours to allow them to fulfil their role.**

Emergency response

72. Officer A responded quickly when he could not see or obtain a response from Mr Jewell. He requested assistance and told us that he decided not to enter the cell and to wait for staff to arrive as he thought Mr Jewell might have been on the toilet, ignoring him or intending to assault him. As he could not see into the cell and there was no evidence to indicate that Mr Jewell was at risk of suicide or self-harm, we are satisfied that his action was appropriate.
73. Additional staff arrived swiftly, and the CM appropriately decided to enter the cell. He used the correct emergency medical code, and the control room called an ambulance immediately, in line with Prison Service instructions. Healthcare staff arrived within minutes, but it was evident that Mr Jewell had died, and staff stopped

CPR following medical advice. The clinical reviewer was satisfied that the resuscitation attempt and the decision to stop were correct.

CCTV and body-worn video camera footage

74. Although a CCTV camera covered the outside of Mr Jewell's cell, the footage of the emergency response was not archived due to a faulty digital video recorder. We have therefore been unable to review the CCTV footage. A CM provided evidence to the investigator that the digital video recorder had been replaced.
75. PSI 04/2017 on body-worn video cameras states that it is mandatory for staff to use body-worn video cameras at any reportable incident (as outlined in PSI 11/2012 on the management and security of the incident reporting system) and that staff should start recording at the earliest opportunity.
76. Body-worn video cameras were available to staff at Garth, but no one involved in the emergency response drew one and it was not until paramedics arrived that a camera was activated. The CM told us that he did not draw a camera as he had an issue with his fob. Officer A said that the intervention officers, who responded to the incident during the night, were also required to draw a body-worn video camera, but no one had one. On 11 January, in response to Mr Jewell's death, a Governor's Order was issued, stating that all prison staff carrying out night duties (except operational support grades) must draw and wear a body-worn video camera at the start of their shift.
77. While we are concerned that CCTV footage was lost and that staff were not wearing body-worn video cameras, we are satisfied that the prison acted promptly and addressed these issues. We therefore we do not make a recommendation.

Clinical care

78. The clinical reviewer concluded that the clinical care that Mr Jewell received at Garth was equivalent to that which he could have expected in the community. Mental health staff completed appropriate reviews, and substance misuse staff assessed him when required. We are satisfied that the care Mr Jewell received was of a good standard.

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