

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Williams, a prisoner at HMP Guys Marsh, on 31 July 2020

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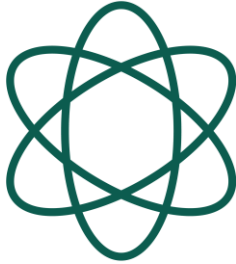
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Our vision

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

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 Jason Williams died on 31 July 2020 of the effects of psychoactive substances at HMP Guys Marsh. He was 39 years old. I offer my condolences to Mr Williams' family and friends.

Mr Williams had a history of abusing illicit substances and was homeless before going to prison. He was regularly offered support from the prison's mental health and substance misuse team but continued to use psychoactive substances until his death.

I am concerned that healthcare staff and the security department were not always notified when officers suspected Mr Williams was using drugs.

Despite being assessed as a vulnerable prisoner due to his behaviour and appearance, there is little evidence that Mr Williams received victim support or had meaningful interaction with officers during his time at Guys Marsh.

I am also concerned that an officer did not check Mr Williams' wellbeing when he opened his cell door on the afternoon that he died.

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

March 2022

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Summary

Events

1. Mr Jason Williams was remanded into custody in January 2019 for burglary. He was referred to the prison's substance misuse service and started on a drug detoxification programme. He was sentenced to three years and six months in July.
2. Mr Williams transferred to HMP Guys Marsh in August. He was referred to the mental health team and safer custody department because he was considered at risk from other prisoners due to his poor personal hygiene and odd behaviour.
3. In September, a mental health nurse reviewed Mr Williams and suggested that he might have drug induced brain damage rather than a mental health disorder. Mr Williams refused further investigations and the mental health team continued to support him.
4. Mr Williams was found under the influence of drugs on a number of occasions but refused to engage with the drug recovery worker. Officers recorded concerns that Mr Williams was being passed psychoactive substances (PS) for other prisoners' entertainment and that he might be the victim of bullying.
5. As a result of the referral to the safer custody team, Mr Williams was discussed at a complex offenders meeting in February 2020 but was removed from the complex offender list the same day as it was agreed that he had "no issues".
6. On 30 July, officers suspected that Mr Williams was under the influence of drugs. They started a monitoring log, but did not tell healthcare colleagues, who found out at a management meeting the next day. Healthcare staff did not assess Mr Williams, but a drugs recovery worker visited him on the morning of 31 July.
7. At 2.15pm that afternoon, an officer unlocked Mr Williams' cell door but did not look into the cell or speak to Mr Williams. At 3.16pm that afternoon, another officer found Mr Williams unresponsive in his cell and radioed a medical emergency. Staff attempted to resuscitate him. An ambulance arrived at 3.28pm and paramedics confirmed Mr Williams' death at 3.47pm.
8. Post-mortem examinations concluded that Mr Williams died from a mixture of two different types of synthetic cannabinoids (PS). The pathologist was unable to determine when or in what quantity Mr Williams took the PS that caused his death.

Findings

Clinical care

9. Mr Williams was offered regular support from mental health and the substance misuse team at Guys Marsh. The clinical reviewer considered that Mr Williams' clinical care was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.

Welfare logs

10. According to the prison's local policy, prisoners suspected of being under the influence of drugs should be reviewed by healthcare staff and officers should open a prison welfare log to monitor the prisoner's condition. Although we welcome the formalising of monitoring arrangements in these circumstances, we are concerned that healthcare staff were not always notified when officers suspected that Mr Williams had misused drugs. We are particularly concerned that healthcare staff were not told Mr Williams was suspected of using drugs on 30 July and did not assess him on that occasion. He died of drug misuse the next day.

Key worker scheme and support for vulnerable prisoners

11. We are concerned that Mr Williams' key worker contact fell far below the required frequency throughout his time at Guys Marsh. We are concerned that, although the prison identified that, exceptionally, he needed the ongoing support of key work during the pandemic due to his vulnerability on the wing, he had only one key work session between March 2020 and his death on 31 July.
12. Although we recognise the operational challenge of delivering key work in a restricted regime, we consider that the Governor should have facilitated contact for those considered in need of continued support during the COVID-19 lockdown, in line with the Exceptional Delivery Model.

Unlock procedures

13. The officer who unlocked Mr Williams' cell door on the afternoon of his death did not check on his welfare as he should have done. We cannot say whether this might have affected the outcome for Mr Williams', but it could be critical in other cases and it is important that prison staff carry out unlock procedures correctly so that any welfare needs are identified.

Prison intelligence

14. Mr Williams was regularly found under the influence of psychoactive substances. We are concerned that the prison's security department was not always notified of his suspected drug use.
15. After Mr Williams' death, the prison received intelligence that he might have used drugs the day he died. The source also identified who might have supplied the drugs. This information was referred to the prison's security department, but we are concerned that it was not referred to the police.

Recommendations

- The Governor should ensure that healthcare staff are notified all incidents of suspected drug use as soon as possible, in line with the prison's welfare log procedure.
- The Governor should ensure that:
 - prisoners identified as at risk of bullying are monitored and supported by staff; and
 - the key worker scheme provides meaningful and ongoing support to prisoners, in line with the Exceptional Delivery Model and subsequent guidance.
- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner, in line with PSI 75/2011.
- The Governor should ensure that:
 - all drug-related incidents are referred to the security department; and
 - intelligence received relating to a death in custody is referred to the police.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Guys Marsh informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
17. The investigator obtained copies of relevant extracts from Mr Williams' prison and medical records. She interviewed seven members of staff and three prisoners at Guys Marsh on 13 August, 30 September and 23 November 2020. NHS England commissioned a clinical reviewer to review Mr Williams' clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the COVID-19 restrictions.
18. We informed HM Coroner for the County of Dorset of the investigation. The Coroner gave us the results of the post-mortem examination and toxicology analysis. We have sent the coroner a copy of this report.
19. We are sorry that this report is very late. Most interviews were completed within two months of Mr Williams' death. We suspended our investigation pending the toxicology report and cause of death, which was delayed and was received on 21 January 2021, some six months after his death. The investigation was further delayed by the COVID-19 pandemic. We apologise for the added distress this will have caused to Mr Williams' family.
20. One of the Ombudsman's family liaison officers contacted Mr Williams' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Williams' mother did not have any specific questions but asked to see a copy of the report.
21. Mr William's family received a copy of the draft report and indicated that they were satisfied with the findings.
22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Guys Marsh

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

HM Inspectorate of Prisons (HMIP)

24. The most recent full inspection of HMP Guys Marsh was in January 2019. Inspectors reported that the prison had started to make progress after successive poor inspections. However, they remained concerned about safety and purposeful activity. Levels of violence, driven by drug use and debt, were higher than at similar prisons. and the prison had been slow to formulate improvement strategies. New measures to combat illicit drug use were untested, and several deaths had been related to the use of illegal psychoactive substances. Recommendations following Prisons and Probation Ombudsman investigations had been implemented but there remained a problem with increased self-harm among prisoners. There was a significant amount of work being done to try to improve the situation and support for those in crisis seemed good. Staff/prisoner relationships were mostly good, and the key worker scheme seemed to be helping greatly. Health service provision was very good overall.
25. In October 2019, HMIP carried out an Independent Review of Progress to look at progress against key recommendations from the earlier inspection. Inspectors reported that, overall, progress had been disappointing. There had been many incidents, and some deaths, relating to the use of illicit drugs, debt and intimidation arising from the trade in those drugs. Work to prevent drug use and debt prevention work was developing well, and the number of positive drug tests had dropped markedly. A wide range of security measures had been taken to cut the supply of drugs, but more work was needed in light of continuing poor outcomes. Inspectors found that the response to the drugs problem was undermined by the fact that intelligence was not always processed promptly or analysed systematically to identify trends and patterns, and target searching was often not taking place. They recommended that, coordinated action should be taken to make the prison safer, in particular developing effective responses to drug misuse and debt.

Independent Monitoring Board

26. 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, covering the year to November 2020, the IMB reported that illicit substances were still widely available among the prison population, most commonly psychoactive substances. Drugs were sold to prisoners who had little regard for, or knowledge of the chemical content. The easy availability of drugs, both before and during the COVID-19 lockdown, continued to make rehabilitation challenging. Accessibility of drugs also exacerbated anxiety

levels in some of the most vulnerable prisoners because of increased levels of debt, intimidation, bullying and violence.

Previous deaths at HMP Guys Marsh

27. Mr Williams was the second prisoner to die at Guys Marsh in the two-year period since July 2018. There was one previous death in May 2019, also from the effects of psychoactive substances (PS). Apart from the cause of death, there were no other similarities.

Psychoactive Substances (PS)

28. Psychoactive substances (formerly known as ‘new psychoactive substances’ or ‘legal highs’) are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
29. The effects of PS are unpredictable, and prisoners do not know what exactly they are using. In the course of our investigations, we see numerous examples of apparently fit young men dying as a result of the effects of PS.

Welfare Logs

30. As part of their drug strategy, Guys Marsh have introduced welfare logs for prisoners suspected to be under the influence of PS. If officers suspect that a prisoner has taken PS, they should start a welfare log to monitor the prisoner’s condition and offer them support. Officers are required to check prisoners every 15 minutes for the first three hours and record these observations. After that the frequency of observations reduces to hourly and checks should continue until 8.00am the next day, unless directed otherwise by healthcare staff.
31. The welfare log reminds officers to contact healthcare staff as soon as they suspect a prisoner has used drugs. It also prompts officers to contact the orderly officer, submit a security intelligence report, tell the substance misuse team, and record the prisoner’s suspected drug use in their prison record and the wing’s observation book.

Key worker scheme

32. HMPPS’s policy document, Managing the Custodial Sentence Policy Framework, sets out the minimum requirements needed to case manage those in custody from reception to the end of post-release supervision. This included the gradual introduction of the key worker role from September 2018, replacing the previous system of personal officers. Requirements of the scheme include:

- All prisoners in the male closed estate must be allocated to a key worker whose responsibility is to engage, motivate and support them throughout the custodial period.
- All prison officers who work on a residential unit will be allocated a maximum of six prisoners.
- Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Key workers will record meetings, discussions and any progress that has been made on NOMIS in a detailed manner. These notes will be regularly checked as part of on-going quality assurance, so it is important that they are sufficient.

33. Key work was suspended across the prison estate on 24 March 2020 due to the COVID-19 pandemic. On 12 May, the Prison Service introduced an Exceptional Delivery Model (EDM) for key work which provided a framework of principles within which establishments must operate but left it to local determination on how to deliver this safely. The EDM set out the expectations of contact and that all contacts and concerns should be recorded on a prisoner's record. The EDM identified priority prisoner groups for whom it was recommended that key work should continue, which included vulnerable prisoners.

Key Events

34. Mr Jason Williams was remanded to custody on 22 January 2019 on burglary charges and sent to HMP High Down. During an initial health screen, Mr Williams said that he was homeless before coming to prison. He tested positive for cocaine, so was referred to the prison's substance misuse service and started on a methadone detoxification programme.
35. On 1 March 2019, Mr Williams was transferred to HMP Winchester and on 23 July, he was sentenced to three years six months in prison. On 5 August, he was transferred to HMP Guys Marsh where he continued with his methadone detoxification programme.
36. On 9 August, Mr Williams attended a Drug Addiction Therapy session with a recovery worker and a nurse. He said he had used cocaine, heroin, cannabis and psychoactive substances (PS) in the past. The worker noted that Mr Williams had poor personal hygiene, was wearing multiple layers of clothing, and alternated between staring intently or giving no eye contact at all during their conversation. The worker contacted the safer custody department because he was concerned that Mr Williams could be vulnerable and at risk from other prisoners on the wing.
37. A nurse visited Mr Williams on 22 August. His cell was very untidy, and he had been sleeping on the floor. He was dressed inappropriately for the warm weather, wearing around 10 pairs of socks and a woolly hat. He avoided eye contact when spoken to, behaved strangely and seemed to have involuntary body spasms. She noted that his speech was slow and that he moved his eyes to the right when he spoke. Although she recorded that he seemed to be under the influence of illicit substances, officers told her that this was Mr Williams' usual presentation. She referred Mr Williams for a mental health assessment.
38. On 3 September, a mental health nurse reviewed Mr Williams' records and recorded that she thought he had amphetamine induced brain damage, rather than a mental health disorder, and recommended an MRI brain scan. A referral for an MRI was made but Mr Williams refused to attend.
39. On 6 September, officers contacted the mental health nurse because they were concerned that Mr Williams was being given PS for the entertainment of other prisoners. They had noticed a crowd of prisoners hanging around his door and on occasion observed Mr Williams under the influence while others laughed and joked. She assessed Mr Williams' mental health and vulnerability in his cell and wrote in his medical record that he was "clearly vulnerable and at risk" from others. He agreed to meet with her again for a further review. She sent an email to the prison's safer custody department. There is no corresponding entry in Mr Williams' prison record or any evidence that anyone contacted the security department about their concerns.
40. On 13 September, the drug recovery worker noticed that Mr Williams had a black eye while he was queuing for his medication. When he was asked about it, Mr Williams became defensive and said it was a burst spot and not a bruise. Eventually, Mr Williams became threatening and left the dispensary.

41. On 27 October, Mr Williams was found under the influence of drugs. He was on the floor, conscious but unresponsive. His fists were clenched to his chest and he had vomited. Healthcare staff attended but Mr Williams denied being under the influence and refused to speak to them. Officers opened a prison welfare log to document and monitor his condition throughout the day. Other than the welfare log, there is no record of this incident in Mr Williams' NOMIS (electronic prison record) or any record that the security department was notified.
42. On 3 November, Mr Williams collected his medication from the dispensary. He had tears in his eyes and did not engage with staff. A nurse spoke to him because she was concerned, but he said he was not being bullied and did not feel vulnerable on the wing.
43. The mental health nurse visited Mr Williams in his cell on 13 November and 4 December. He was dressed in lots of layers of clothes. Again, she tried to persuade him to go for a brain scan to explore possible brain damage related to drug use, but he was reluctant. The nurse said she was concerned that other prisoners were using him as a "guinea pig" to test drugs on the wing. Mr Williams said that he knew what he was doing and told her that he was not under threat or being bullied.
44. On 20 November, Mr Williams was referred to the Complex Offenders meeting and added to the complex list.

2020

45. Mr Williams completed his methadone detoxification programme on 26 January 2020 but continued to go to the medication hatch to collect methadone. The recovery worker spoke to the mental health team because he was concerned that Mr Williams might have some memory issues. The mental health nurse spoke to Mr Williams on 4 February. He told her that he was struggling and wanted to be re-prescribed methadone. He said he had struggled to express this to healthcare staff, so assumed that, if he kept going to the medication hatch, they would eventually give him methadone. She explained that he could not be re-prescribed methadone safely while he continued to use other illicit substances in prison.
46. On 8 and 9 February, an officer wrote in Mr Williams' prison record that he "spent most of the day under the influence but not bad enough to be seen by healthcare". The officer recorded that Mr Williams was unsteady on his feet with slurred speech. There were no corresponding entries in his medical record and no evidence that anyone contacted the security department about Mr Williams' continued drug use or that officers started a welfare log.
47. A code blue (an emergency response code requiring immediate healthcare assistance) was called on 10 February, when Mr Williams was found under the influence in another prisoner's cell. He was the only person in the cell at the time. He was taken back to his own cell, where healthcare staff assessed him, and the security department was informed. Officers started a welfare log to monitor his condition until the next morning. Mr Williams later denied being under the influence of illicit substances.
48. In response to concerns about Mr Williams' vulnerability, the safer custody department referred him to the complex needs support pathway to provide him with

additional support on the wing. In preparation for the Complex Prisoners meeting, a Supervising Officer (SO) spoke to Mr Williams on 25 February. He noted that Mr Williams was wearing all the clothes he owned, and his cell was in a disgusting state. The SO spoke to him about his mental wellbeing and his use of PS (also known as 'Spice'), and wrote in his prison records:

“Mr Williams states that he does use spice but only when he really wants to get his head down as he struggles sleeping in prison. He also states that mentally he feels sound of mind despite having bizarre living habits such as choosing to sleep on the hard floor as opposed to his bed.”

The SO noted that Mr Williams was keen to work and bored with spending so much time in his cell. The SO recorded that Mr Williams' behaviour was unusual, but normal for him. He noted, “Progress was definitely made with Mr Williams today but there is still a long way to go in understanding his lifestyle and behaviour”.

49. Mr Williams was removed from the complex list at the Complex Offenders meeting on 26 February. The meeting minutes recorded that Mr Williams was removed from the complex list as “no issues” were identified.
50. Mr Williams had a key worker session with an officer on 8 and 19 March. Mr Williams asked about education or employment to allow him to spend more time out of his cell, but the officer recorded no other concerns.
51. Due to the COVID-19 pandemic, a number of medical clinics were suspended. The mental health nurse assessed Mr Williams' risk as 'medium', as prisoners could no longer have face to face mental health appointments. He did not fully engage with the mental health team but had developed a therapeutic rapport allowing some staff to monitor him by visiting him on the wing, so they agreed the mental health team would continue to see him in his cell. A letter was sent to Mr Williams to inform him of the changes.
52. Mr Williams continued to use drugs and on 11 April refused to engage with a recovery worker after being found under the influence of drugs the day before.
53. Key worker sessions were heavily restricted due to the COVID-19 pandemic. In May, the Prison Service introduced an Exceptional Delivery Model for key work, requiring prisons to identify priority prisoners who would continue to receive key work support (although not necessarily from the same officer, as would have been the case pre-pandemic). It was agreed that Mr Williams' vulnerability meant he was a priority prisoner, and he should continue to have key worker sessions. On 7 June, an officer met Mr Williams for a key worker session. She recorded that he said he was near the end of his sentence and did not need her help with anything; that he was settled and happy on the wing; and that he was detoxing and that was going well. This was Mr Williams' last documented key work session.
54. Staff submitted security intelligence reports in May and June setting out concerns about Mr Williams' vulnerability on the wing. One of the reports suggested he was in debt to other prisoners and another that a prisoner had been seen taking personal possessions from Mr Williams' cell. There is no record that officers spoke to Mr Williams or that any other action was taken.

Thursday 30 and Friday 31 July 2020

55. On 30 July, officers suspected that Mr Williams and another prisoner were under the influence of illicit substances. A custodial manager asked officers to monitor Mr Williams' condition using a welfare log. The security department was informed. Officers checked Mr Williams overnight, in line with the requirements of the welfare log. The last recorded entry was at 7.40am on 31 July, when an officer recorded that he said, "Alright Miss".
56. Officers did not tell healthcare staff about Mr Williams' suspected drug use, and healthcare staff only discovered it at the daily briefing meeting the next morning, 31 July. The drugs recovery worker visited Mr Williams at 9.50am. Mr Williams confirmed he had been smoking drugs and said, "I smoke drugs all the time". The worker tried to discuss the dangers of taking drugs, but Mr Williams asked him to leave and not visit him again. The worker agreed but reminded Mr Williams he could ask for support whenever he needed it.
57. At 12.00pm, Mr Williams collected his lunch. Officer A locked Mr Williams in his cell at about 12.15pm and unlocked Mr Williams' cell again at about 2.15pm for association. The officer told the investigator that he remembered looking into Mr Williams' cell, but he could not remember if he spoke to Mr Williams. However, CCTV shows that he did not look into the cell
58. At 3.16pm, Officers A and B were checking cell accommodation. Officer B arrived at Mr Williams' cell, opened his door and found him sitting on the floor with his head resting on the bed. She asked Officer A (who was checking the cell next door) to help her. Officer A went into the cell first, followed by Officer B. Mr Williams did not respond, and Officer A could not find his pulse. Officer B immediately called a code blue, and an ambulance was called one minute later, at 3.17pm.
59. Another officer and a Custodial Manager arrived quickly and helped to move Mr Williams to the floor so staff could try to resuscitate him. Healthcare staff arrived and took over cardiopulmonary resuscitation. A defibrillator was used but no shock was advised. An ambulance arrived at 3.28pm. Paramedics continued resuscitation attempts but at 3.47pm, they confirmed that Mr Williams had died.

Contact with Mr Williams' family

60. Mr Williams' nominated next of kin was his father, but the prison could not reach him, so they asked Hampshire Police to find another family member. The police eventually informed Mr Williams' mother of his death on 12 August.
61. The prison's family liaison officer contacted Mr Williams' mother on 13 August to introduce herself and answer any questions she had. She arranged for Mr Williams' family to visit the prison on 26 August. The prison offered to contribute to funeral costs, in line with national instructions.

Support for prisoners and staff

62. After Mr Williams' death, the Head of Security 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.

63. The prison posted notices informing other prisoners of Mr Williams' 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 Williams' death.

Information received after Mr Williams' death

64. The police recorded that Mr Williams had been found in his cell holding a milk carton that appeared to have been made into a makeshift smoking device. Staff also found a razor handle adapted to make a pipe and a small metal pipe, possibly used for smoking, in Mr Williams' cell.
65. The police also recorded that there had been a 'throw over' (when a package of contraband items is thrown over the prison perimeter to be recovered later by prisoners) during the early hours of 25 July and that there had been numerous PS-related medical incidents in the days afterwards.

Post-mortem report

66. The post-mortem report gave Mr Williams' cause of death as synthetic cannabinoid intoxication.
67. The post-mortem examination found nothing to suggest that Mr Williams had been physically assaulted or restrained prior to his death and no evidence of significant natural disease that might have accounted for his death. The post-mortem toxicology tests found that Mr Williams had used two different types of synthetic cannabinoids (a form of PS), known as 'Spice', some time before his death. The pathologist found that this was the most likely explanation for Mr Williams' death, especially given the smoking device found in his hand. He could not determine when Mr Williams took the illicit substances or in what quantity.

Findings

Clinical Care

68. Mr Williams did not report any significant physical healthcare issues during his time at Guys Marsh. He said he was homeless before he came to prison. His long-term drug use exposed him to potential health risks, but he did not engage with healthcare staff's efforts to assess his physical health and offer preventative healthcare. The clinical reviewer was satisfied that Mr Williams was offered regular support from healthcare staff and the substance misuse team throughout his time at Guys Marsh.
69. Mr Williams had regular interventions with the mental health team, and the mental health nurse felt he remained vulnerable, so the intervention continued even during the restricted COVID-19 regime. The clinical reviewer concluded that the prison tried to address Mr Williams' mental health needs appropriately, given the restrictions in place at the time.
70. The clinical reviewer considered that Mr Williams' clinical care was reasonable and at least equivalent to that which he could have expected to receive in the wider community.

Welfare logs

71. Due to suspected PS use, Mr Williams was subject to monitoring through a welfare log three times at Guys Marsh: in October 2019, February 2020 and 30 July (the day before he died). Officers' last recorded entry was at 7.40am on 31 July. We are concerned that officers did not always follow the prompted actions on the log. We are particularly concerned that healthcare staff were not notified of Mr Williams' suspected PS use in February, and, notably, the day before he died.
72. The Head of Healthcare said that healthcare staff were not informed of Mr Williams' suspected drug use on 30 July. She said, "If we get called for someone being under the influence we would attend in person and assess the patient. We would record all contact with a patient on SystmOne." She said that officers do not routinely inform healthcare staff of all incidents of drug use on the wing, depending on whether they consider clinical intervention is required.
73. Guys Marsh's welfare log is a welcome local initiative to ensure that the wellbeing prisoners suspected of drug use on the wing are monitored. However, it should not replace the requirement for clinical assessment in such circumstances. Although it is not possible to know whether it would have affected the outcome in this case, Mr Williams was not clinically examined following suspected drug use the day before he died. He subsequently died of synthetic cannabinoid intoxication. It is at least possible that a clinical assessment could have identified urgent health needs in the hours before he died.
74. Prison staff are not medically trained, so are not qualified to decide if healthcare assistance is required. As set out in the welfare log document, officers should call healthcare staff immediately if they suspect a prisoner has misused drugs. We make the following recommendation:

The Governor should ensure that healthcare staff are notified all incidents of suspected drug use as soon as possible, in line with the prison's welfare log procedure.

Key worker scheme and support for vulnerable prisoners

75. Between 5 August 2019 and 19 March 2020, there are only five documented key worker sessions in Mr Williams' prison record. We are concerned that Mr Williams did not receive regular key worker sessions even before the pandemic.
76. After the EDM reintroduced key work for priority prisoners, Guys Marsh issued a Governor's Notice 68/2020 dated 14 May 2020, saying that "the expectation is that these men will receive at least a weekly key work session". (Although the expectation pre-pandemic was that the prisoner would see the same key worker consistently, key worker sessions during the pandemic were conducted by the staff who were available and could, therefore, change each time.)
77. Mr Williams was identified as being a priority prisoner. An officer said at interview that she was assigned a key worker session on 7 June and spoke to Mr Williams then, but had no further key worker shifts assigned before he died seven weeks later. She told the investigator that key worker sessions did not take place if there were not enough staff to facilitate them.
78. We are concerned that, despite well-documented concerns about Mr Williams' vulnerability and possible bullying, victim support measures were not put in place for him at any time. The drugs recovery worker and the mental health nurse referred their concerns to the safer custody department, which resulted in a referral to the complex needs support pathway. There is no clear record of the reason for the decision. An SO could not remember why Mr Williams was removed from the complex needs pathway, but thought it was because although Mr Williams' behaviour was unusual, it was not particularly unusual for him, so he was not considered in particular need of the additional support. There is no further evidence of any consideration of victim support measures or monitoring to protect Mr Williams from possible bullying on the wing.
79. Mr Williams' vulnerabilities and unusual behaviour were well-documented by staff, as was his continued substance misuse. He had been identified as at risk from other prisoners and intelligence seemed to support that this was the case. We are very concerned that, despite staff concerns, he was offered so little in the way of staff support during his time at the prison.
80. A key work recovery toolkit for prison staff and a leaflet for prisoners was issued by Her Majesty Prison and Probation Service (HMPPS) in May 2021 to reflect the fact that prison regimes are being relaxed as the number of COVID-19 cases reduces. The recovery toolkit says that key worker sessions should be held for 45 minutes at least every fortnight for all prisoners. Although we are pleased to see that Guys Marsh has taken steps to begin reintroducing key work, we make the following recommendation:

The Governor should ensure that:

- **prisoners identified as at risk of bullying are monitored and supported by staff; and**

- **the key worker scheme provides meaningful and ongoing support to prisoners in line with the Exceptional Delivery Model and subsequent guidance.**

Unlock procedures

81. Prison Service Instruction (PSI) 75/2011, *Residential Services*, says:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...

“[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”

82. Mr Williams was found dead at about 3.15pm. We do not know when Mr Williams died, but it is possible that he was already dead when Officer A unlocked his cell for association at 2.15pm. We are concerned that he could not recall getting a response from Mr Williams when he unlocked his cell that afternoon and that CCTV does not show that he looked into Mr Williams’ cell. He told the investigator that another prisoner remembered seeing Mr Williams outside his cell after this time, but CCTV footage does not support this. We cannot be sure whether a proper welfare check at that time would have made a difference in this case, but it could be crucial in future medical emergencies. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner, in line with PSI 75/2011.

Prison intelligence

83. Mr Williams was regularly found under the influence of psychoactive substances. It is unacceptable that not all of these incidents were reported to the security department, despite the clear prompt on the welfare log to submit an intelligence report. It is concerning that suspected substance misuse is not routinely referred to the security department to inform the drugs strategy.

84. On 3 August 2020 (after Mr Williams’ death), the security department received intelligence that he might have used drugs the day he died, identifying a possible supplier by name. This information was referred to the prison’s security department but was not referred to the police. The Head of Security told the investigator that the information was “analysed and developed at the time. The action deemed necessary for the information within it was to refer to the SWRDT (South West Regional Dog Team) and DST (Dedicated Search Team), therefore no referral to the police”.

85. Mr Williams died of synthetic cannabinoid intoxication. Although his cause of death was not known at the time, the prison knew of his extensive and very recent substance misuse. We consider that information of this nature, especially related to

a death in custody, should have been referred to the police. We make the following recommendation:

The Governor should ensure that:

- **all drug-related incidents are referred to the security department; and**
- **intelligence received relating to a death in custody is referred to the police.**

The local drug strategy

86. Mr Williams' death is an example of the dangers of PS and illustrates why prisons must do all they can to reduce its use. Guys Marsh has a local drug strategy published in November 2019 and updated most recently in April 2021, and a Drug Strategy Action Plan (most recently updated in March 2021).
87. The new drugs strategy includes increased collaboration between the drug strategy, safety and security functions to improve information sharing. Target searches for drugs are supported by the dog team, random searches of staff have been introduced, and searches are supported with an X-ray machine, a high intensity pole, wands and an atomiser. All in-coming mail to prisoners, apart from legally privileged mail, is opened and given to prisoners in the form of photocopies, and information on the risks of supplying drugs to prisoners is provided to visitors. The minutes of the prison's monthly drug strategy meetings are sent to the Prison Service's national drug task force to inform the bigger picture across the prison estate. The Governor reviews the drug strategy every three months.
88. Despite the serious concerns about the availability of drugs raised by HMIP and the IMB, we consider that Guys Marsh are now doing what they can to reduce supply and demand and we make no recommendation.

**Prisons &
Probation**

Ombudsman
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