Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John-Paul Pace, a prisoner at HMP Chelmsford, on 22 July 2020

A report by the Prisons and Probation Ombudsman

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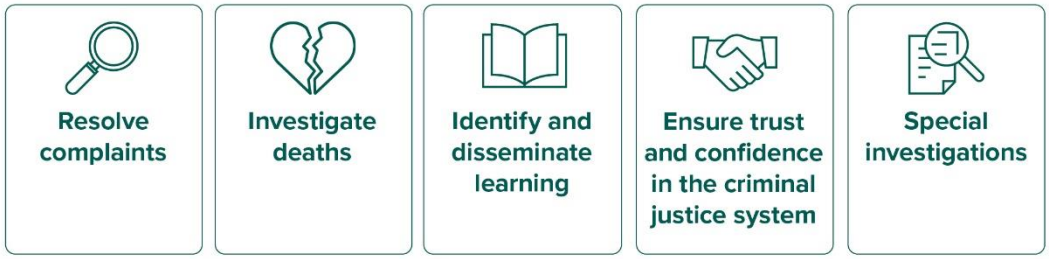
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 John-Paul Pace died on 22 July 2020, from the toxic effects of psychoactive substances (PS) at HMP Chelmsford. He was 41 years old. I offer my condolences to Mr Pace's family and friends.

Mr Pace had a history of drug misuse and was on a drug treatment programme for his heroin addiction until 28 May, when he came off it against medical advice. On 30 March, he had tested positive for PS, but there were no other known incidents of illicit drug use before his death. He was generally thought by staff to be doing well prior to being found unresponsive in his cell on 22 July.

The clinical review into Mr Pace's death concluded that his healthcare was equivalent to that which he could have expected in the community.

However, I am concerned that Mr Pace was able to obtain illicit drugs at Chelmsford with apparent ease. The prison needs to continue its efforts to prevent the supply of and demand for illicit substances. The prison has updated its drugs strategy with the aim of reducing supply and demand. The prison needs to ensure this is implemented fully, to reduce the serious harm caused by drug use, and ensure that staff are vigilant for signs of drug use.

I am also concerned that when an officer discovered Mr Pace unresponsive, there was a delay in calling a medical emergency code blue to alert healthcare staff. Although this made no difference to the outcome for Mr Pace as he had been dead for some time when he was found, it could be crucial in future cases. I have raised this issue in several recent cases at Chelmsford.

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**

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Summary

Events

1. In November 2019, Mr John-Paul Pace was recalled to prison after being arrested for drugs offences. He was sent to HMP Chelmsford. On 4 March 2020, he was sentenced to 27 months imprisonment.

2. Mr Pace had a history of misusing drugs in the community and was prescribed methadone (an opiate substitute) when he entered Chelmsford.

3. On 30 March, Mr Pace failed a drugs test when he tested positive for psychoactive substances (PS). There were no other instances of him testing positive for drugs or being suspected of using PS.

4. On 28 May, Mr Pace withdrew from the methadone programme against the advice of the drugs treatment staff and stopped taking methadone altogether.

5. Shortly before 8.00am on 22 July, an officer found Mr Pace unresponsive while unlocking his cell. She went to the office to get help from a Supervising Officer, who called a medical emergency code. Healthcare staff attended quickly. Mr Pace showed signs that he had been dead for some time, so they did not attempt resuscitation.

6. A post-mortem examination and toxicology tests showed that Mr Pace died from PS misuse.

Findings

7. We are concerned that Mr Pace was able to access PS. HM Inspectorate of Prisons has previously raised concerns about the availability of drugs at Chelmsford.

8. However, we are aware that in 2020, Chelmsford took active steps to reduce the supply of drugs including photocopying all prisoner mail, use of a Rapiscan machine (to detect drugs in mailed items), fitting of grilles to cell windows to prevent prisoners accessing drugs thrown over the prison walls, and the appointment of a dedicated Head of Drugs Strategy. As the prison is progressing appropriate steps to address the drug supply, we make no recommendation at this time, but urge the Governor to maintain the momentum, especially when normal regime returns.

9. There was a delay in calling a medical emergency code, as the officer who found Mr Pace did not call the code as she should have done but instead went to fetch a more senior officer. Although this did not affect the outcome for Mr Pace, as he had been dead for some time when he was found, it was a failing on the officer's part. The officer has now left Chelmsford, as she was seconded from another prison, and has since returned there.

10. The clinical reviewer concluded that the healthcare that Mr Pace received at Chelmsford was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that officers on detached duty understand the actions expected in emergency situations.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Pace's prison and medical records. These were provided very promptly by the Safer Custody Manager and her consistent assistance throughout the investigation is much appreciated.

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

14. The investigator interviewed five members of staff, one jointly with the clinical reviewer, in October 2020. The interviews were conducted by telephone because of the COVID-19 restrictions.

15. We informed HM Coroner for Essex and Thurrock of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. One of the PPO's family liaison officers contacted Mr Pace's mother to explain the investigation and ask if she had any matters she wanted us to consider. Mr Pace's mother asked about her son's health, his medication, and the details of the discovery of his body and the emergency response. We have addressed her questions in this report and the clinical review.

17. The initial report was shared with Mr Pace's family. They did not make any comments on the initial report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one factual inaccuracy, which has been corrected.

Background Information

HMP Chelmsford

19. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It holds nearly 730 men. The Castle Rock Group is commissioned to provide 24-hour healthcare, which includes a range of primary care and secondary mental health services. The prison has a 12-bed enhanced care unit.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Chelmsford in May 2018. Inspectors found that safety was poor and noted several areas of significant concern including the ready availability of drugs and a very high percentage of positive drug tests.

21. The Chief Inspector of Prisons considered invoking the Urgent Notification (UN) protocol (which alerts the Secretary of State that immediate action to rectify problems is required). However, he noted that the previous Governor had left, and a new acting Governor was in post. In addition, Chelmsford had already been put under special measures by HM Prison and Probation Service (HMPPS), which meant that HMPPS had identified Chelmsford as needing additional, specialist support to improve its performance. He therefore had some confidence in these measures being effective in improving the prison and did not issue a UN.

22. In April 2019, HMIP carried out an Independent Review of Progress (IRP). They said that since their last visit, the prison had taken some active steps to stem the flow of drugs and other illicit items into the prison, and this had resulted in fewer prisoners testing positive for drugs and a reduction in contraband thrown over the prison wall. However, inspectors found it inexcusable that the prison had still not been equipped with more up-to-date drug detection equipment. They said Chelmsford needed to make further reductions in the supply of drugs a priority to safeguard prisoners' health and well-being, as well as making the prison safer by reducing violence and debts.

Independent Monitoring Board

23. 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 31 August 2020, the IMB reported that the long-awaited work to erect screens to some windows to prevent prisoners accessing drugs thrown over the prison wall, had still not been carried out.

Previous deaths at HMP Chelmsford

24. Mr Pace was the tenth prisoner to die at Chelmsford since July 2018. Of the previous deaths, four were self-inflicted, three were from natural causes, and two were drug related. We have made recommendations in previous cases about delays in calling a medical emergency code.

Psychoactive substances (PS)

25. Psychoactive substances (formerly known as ‘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.

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

Key Events

27. On 29 November 2019, Mr John-Paul Pace was recalled to prison after being arrested for possession with intent to supply Class A drugs (heroin and crack cocaine). He was sent to HMP Chelmsford. His offender manager considered that he was supplying the drugs to fund his own addiction, and when he arrived at Chelmsford, Mr Pace tested positive for both opioids and cocaine. He was put on a drug detoxification programme and was prescribed methadone (an opiate substitute), which was progressively reduced over the following months.

28. On 7 January 2020, Mr Pace's previous sentence expired, and he was held on remand pending the outcome of the new drugs charges. On 4 March, he was sentenced to 27 months imprisonment.

29. On 30 March, Mr Pace failed a drugs test when he tested positive for psychoactive substances (PS). This is the only known incident of illicit drug use prior to his death.

30. On 28 May, Mr Pace stopped taking methadone altogether before he had completed the methadone reduction programme. This was against the advice of the Integrated Drug Treatment Services (IDTS) team, but he said this was his preference and how he had done it in the past. He was prescribed medication to help with the expected withdrawal symptoms.

31. Mr Pace had a kitchen job, which meant he had much more time out of his cell and contact with staff than most prisoners (who were subject to a very restricted regime during the COVID-19 pandemic). At interview, prison staff told the investigator that Mr Pace was a friendly and polite man who spoke to them regularly. They did not suspect he was taking drugs, particularly as he worked most of the day in the kitchen. At the time of his death they were under the impression that he was doing well and taking positive steps to address his problems.

32. On the night of 21-22 July, an Operational Support Grade (OSG) carried out the night patrol on Mr Pace's wing. CCTV shows that at around 5.30am, she looked into Mr Pace's cell for a sufficient time for an adequate check. (The investigator has viewed both the CCTV and the body-worn video camera footage when staff later entered the cell and can confirm that Mr Pace could have looked like someone who was sleeping in a slightly awkward position.) The OSG handed over to an officer, who began a roll count of the unit at around 7.00am. When he looked into Mr Pace's cell, he did not notice anything unusual.

22 July 2020

33. Shortly before 8.00am on 22 July, an officer unlocked Mr Pace's cell so he could start his job in the kitchen. She said at interview that when he did not respond to her calls to get up, she went and got one of his fellow kitchen workers from an adjoining cell, to enter Mr Pace's cell with her. She said this was out of concern for Mr Pace's modesty as he was wearing only a T-shirt and underpants.

34. When they found Mr Pace, he was unresponsive. The officer went to get the Supervising Officer (SO) from her office. The SO went to Mr Pace's cell and called a code blue (a medical emergency code used when a prisoner is unconscious or

having breathing difficulties) on her radio at 7.57am, very shortly after entering the cell.

35. Healthcare staff responding to the code blue were at Mr Pace's cell by 8.00am and an ambulance was at the prison gates by 8.05am, with paramedics at Mr Pace's cell soon afterwards. As Mr Pace had rigor mortis (stiffening of the body that occurs between two and six hours after death), staff did not attempt resuscitation. Mr Pace was certified dead at 8.15am.

36. The prisoner in the adjoining cell whom the officer had asked to help, said that Mr Pace did not mention any illness in the preceding days and seemed perfectly normal the night before. He said he did not hear any banging or calls for help from Mr Pace's cell during the night. No one else reported hearing anything from his cell. The electronic record for the emergency cell bell shows that it was not activated in the night.

37. When Mr Pace's cell was searched after his death, empty vape capsules were found which are often used by prisoners for smoking PS.

Contact with Mr Pace's family

38. A prison manager was appointed as family liaison officer (FLO), and he visited Mr Pace's mother very shortly after he died. The prison returned Mr Pace's property to his mother in the following days and she was given the opportunity to visit his cell.

39. Chelmsford contributed to the costs of Mr Pace's funeral in line with national instructions.

Support for prisoners and staff

40. After Mr Pace's death, notices were issued for staff and prisoners informing them where they could get support if they were affected by his death. Because the discovery of Mr Pace's death coincided with shift changes and the role of the duty governor was being covered by another person, the hot debrief (to consider any immediate lessons and to support those involved) did not take place straight after the incident. When this was discovered, a hot debrief was held in the afternoon and chaired by the Safer Custody Manager, assisted by the orderly officer. We are satisfied that Chelmsford acted promptly when the oversight was discovered, and that staff were adequately supported.

Post-mortem report

41. The post-mortem did not find anything significant that would have accounted for Mr Pace's death. Toxicology tests showed that Mr Pace had taken a synthetic cannabinoid (a type of PS, commonly known as 'Spice') before he died. This drug is known to have a number of effects, including a rapid heart rate, seizures, and collapse. In the absence of any other cause, the pathologist gave Mr Pace's cause of death as synthetic cannabinoid misuse.

Findings

Availability of illicit drugs at Chelmsford

42. In 2018, HMIP expressed concerns about the availability of drugs at Chelmsford and reported that 40% of prisoners said that it was easy to get illicit drugs at the prison. In their follow up in 2019, they said that although there had been some improvement, more needed to be done.

43. Chelmsford issued a substance misuse strategy in April 2018 and holds monthly drug strategy meetings. The strategy includes developing substance misuse interventions, reducing demand and targeting supply.

44. The investigator interviewed the Head of Security and the Head of Drugs Strategy.

45. The Head of Security said that prior to the COVID-19 pandemic, there had been recent improvements in the number of men testing positive in MDTs. Unfortunately, the testing programme had to be suspended because of the pandemic. The COVID-19 restrictions also impacted on cell searches which dropped from around 120 a month to about 40 to 50. However, he said staff had intercepted more drugs thrown over the prison wall, which he thought was indirect evidence that COVID-19 measures, such as restrictions on visiting, had reduced the drug supply by making it more difficult to smuggle drugs into the prison.

46. The Head of Drugs Strategy said that her role was newly created and that she took up position on 1 July 2020. She said the prison had taken several recent initiatives that could be expected to reduce the supply and use of drugs in the prison:

    - Work had begun to fit effective grilles to the windows with access to drug throw over areas (an issue flagged by the IMB in their annual report).
    - Prisoners' incoming mail was being photocopied (to prevent PS-impregnated paper being passed to prisoners).
    - A Rapiscan machine was now being used to detect drugs in incoming mail.
    - Following Mr Pace's death, a new process has been developed that will follow up people who have refused to continue with their methadone reduction programme. Two weeks after stopping their medication, prisoners will meet with staff from IDTS and Full Circle (which helps prisoners with addiction problems) to discuss their progress. After this the management and support of the individual will transfer to Full Circle.
    - Chelmsford were exploring reintroducing an incentivised drug-free wing. This would include drug testing outside the MDT programme and offer a clearer route for people intent on breaking drug habits.

47. Mr Pace did not have an obvious profile as a PS user prior to his death, and so was not being monitored for drug abuse. Although it is still concerning that he was able to obtain illicit drugs with apparent ease, it is encouraging to see focus on tackling the drugs problem with the dedicated role of Head of Drugs Strategy, the development of new procedures for prisoners turning their back on medical advice on their drug treatment, and the additional measures to restrict drug supply. We

make no recommendations but reiterate to the Governor the importance of following up recent efforts by the prison to tackle the availability of illicit drugs.

Emergency response

48. Chelmsford's local policy reflects Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, which sets out the policy for calling a medical emergency code over the radio network. The intention is to ensure a timely, appropriate and effective response to medical emergencies and so maximise the likelihood of a positive outcome for the prisoner. Prison officers should not make a clinical judgement in an emergency situation but should immediately radio for assistance to ensure that healthcare staff attend as soon as possible.

49. The PPO has investigated several recent deaths at Chelmsford where staff have failed to follow the correct emergency procedures and call a medical emergency code. In response to our recommendations, Chelmsford undertook a programme of training that involved an emergency scenario exercise to reinforce staff knowledge of what to do when faced with such a situation, including correct use of radios. This began in October 2019 and was scheduled to be an annual event.

50. In this case, the first officer on the scene did not call a code blue immediately as she should have done, but instead went to fetch the SO from her office. This involved her going down two flights of stairs and through two locked gates, a journey that the SO estimated would have taken a couple of minutes. The medical emergency code was not called until the SO arrived at the cell.

51. The officer was seconded from HMP Leeds in January 2020 to work at Chelmsford to cover staff shortages there and had not, therefore, attended the training at Chelmsford.

52. The delay before the emergency code was called did not affect the outcome for Mr Pace, because he had been dead for some time when he was found. However, in another medical emergency a delay in calling the code could be the difference between life and death. We therefore make the following recommendation:

The Governor should ensure that officers on detached duty understand the actions expected in emergency situations.

Clinical care

53. The clinical reviewer concluded that overall, the standard of healthcare Mr Pace received at Chelmsford was equivalent to that which he could have expected to receive in the community.

Inquest

54. An inquest was held on 18-25 October 2023. The Coroner concluded that the cause of death was drug related.

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