	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: National Offender Management**
1	**CORONER - I am Dr James Adeley, Senior Coroner for Lancashire & Blackburn with Darwen**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 3 March 2020 I commenced an investigation into the death of Andrew Patrick Jones aged 37 years at the time of his death. The investigation concluded at the end of the inquest on Thursday, 19 March 2020. The conclusion of the inquest was a narrative conclusion as set out on the attached document.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death were fully set out in following attached documents: • Summing up extending to 20 pages including questions to the jury • Jury conclusions • Report of [redacted], consultant psychiatrist However, a brief synopsis was that Andrew Jones was a 37 year old male located on a wing for vulnerable prisoners separated from the main prison wings. There was a total failure of the Personal Officer Scheme with no entries being made in the 11 months prior to the death. After an altercation on 21 November 2018 he was transferred off the wing when there was no regime in place to manage such transfers and the reason for the transfer off the wing was inadequate. There was a failure to discuss the case at the Population Management meeting to manage the risk before transfer, there was a failure to reassess the changing circumstances caused after he had come off an ACCT document from which nearly all the actions that are because the self-harm had not been addressed, was transferred to the main prison regime with no assessment of risk by the transferring Custody Manager, transferring Senior Officer or receiving Senior Officer. The prisoner was then unlawfully detained on segregation with the requirements of healthcare assessment removed and which did not take place for the 33 hours prior to his death including a lack of regime of

	exercise, showering and a phone call. The unlawful detention had pre-existed the date of death for approximately three years across almost every wing in the jail and may have been applied to 6-700 prisoners, the number being unable to be ascertained due to a lack of prison records. The adjudication that should have taken place the following day did not occur and there was a failure in prison communication to inform the prisoner of this occurrence. Due to differing medication regimes on the wings, with no adequate explanation for this difference, Andrew Patrick Jones had his mood stabilisation medication and tramadol for back pain suddenly withdrawn without healthcare involvement. The expert psychiatric evidence stated that the prison regime created "*the perfect storm*" and the jury concluded that this contributed to the death and also added the rider of Neglect to indicate the failure to provide basic care by the Prison Service.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows and all share a central theme that the risk averse nature of the prison service has been substantially reduced over the last 5-6 years to one in which risk is routinely ignored: – (1) **Assessment of risk** Andrew Jones self-harmed on 26 October 2018 and remained on an ACCT document until 12 November 2018. The principal reasons identified by Andrew Jones for self-harming were that he had long-standing back pain, which his tramadol (an opiate-based medication) was being reduced by the prison GP, with which Andrew Jones did not agree, the back pain was to be addressed by remedial gym and physiotherapy and Andrew Jones did not cope well in his cell on basic regime. In summary, the only factor that was identified to initiate the self-harm that was addressed was the re-instatement of the normal IEP regime. The Post Closure Review (PCR) was undertaken on 19 November 2018 by Senior Officer [redacted] who had read the ACCT document before the review, who was familiar with Andrew Jones and who was aware of the following: • continuing back pain with reduction in pain relief but without compensating medical treatment, which was either impossible to deliver either due to the absence of any physiotherapy in the jail or the failure by the prison GP to refer Andrew Jones for remedial gym; • that prisoners on the wing were located there due to their vulnerability in the main prison estate; • that the support of his brother and other prisoners on the wing was a protective factor [redacted] identified a protective factor that Andrew Jones would speak to prison staff if he felt like self-harming: Every officer who gave evidence indicated that

Andrew Jones rarely, if ever, spoke to prison officers as he had previously been accused of being a grass.

However, the Senior Officer who undertook the review did not make his entry into the prison record until after the altercation had occurred on the 21 November 2018, when Andrew Jones was now on basic regime, on a charge and had been transferred off the wing. The Senior Officer accepted that he would have read the entry relating to the altercation, noted the return to basic regime and transfer off the wing, which immediately preceded his entry. This can be easily determined by looking at the Cnomis entries. The Senior Officer accepted that he was the only person who would have been aware of the substantial alteration in risk of self-harm for Andrew Jones, that there was a substantial alteration in the risk profile, then made an entry in the prison record reflecting only those events that were pertinent two days earlier and prior to the altercation.

The Senior Officer, and the senior prison management accepted that there had been a substantial alteration in risk with every protective factor now being converted into a risk factor. Furthermore, it was accepted that there was a failure to warn the receiving wing of the alteration in risk and that there was a further failure to reassess the alteration in risk. The consistent evidence of the senior management was that an ACCT should have been opened, healthcare would have been involved and the first question that is always asked is "*what medication is this prisoner on and is he taking it*"? This would have identified the fact that Andrew Jones was not receiving his mood stabilising medication and, due to a lack of prescription of tramadol, would have been withdrawing from the effects of opiates which combined with his psychiatric condition of Emotionally Unstable Personality Disorder, produced a very significant and ongoing increase in his risk of self-harm (See below). In addition, had an ACCT been opened the approach to segregation would have been markedly different.

(2) **No written protocol or common understanding undertaken regarding deselection from the RSU relating to risk on transfer to a normal prison wing:** Custody Manager [redacted] said that transfer off the RSU was appropriate, which was factually incorrect. The evidence of every governor grade witness who dealt with the point was that the altercation was insufficient to require the urgent transfer of Andrew Jones of the wing. This action substantially raised the risk of Andrew Jones self-harming.

With regard to the protocol for deselection of a prisoner form the RSU, it was the evidence at the inquest that the Number One Governor had given an instruction that, as the RSU was the only discrete unit without wraparound guidance on deselection, there should be a written regime. This was neither followed up by the Governor [redacted] nor by [redacted] Manager responsible for the RSU, neither of whom could provide a reasonable explanation for the omission. At no time was there a written protocol for deselection. There was a form but it appeared form the evidence of [redacted] on whom [redacted] relied, that this had never been used for deselection of a prisoner from the RSU at the Population Management Committee (**PMC**). [redacted] denied any conversation in which he had said it was unnecessary to refer to the PMC.

[redacted] had discussed Andrew Jones deselection from the RSU in the week before the altercation with the two SOs on the wing and that there was no entry in any prison record to reflect the discussion or an assessment of risk. To exacerbate the risk, [redacted] was aware that [redacted], the SO on duty on 21 November 2018, was unfamiliar with the wing not having worked there, had no prior knowledge of Andrew Jones and this reallocation of SOs to specialist areas of the prison with no supervision was commonplace. The only handover that was given by SO [redacted] on the RSU to the receiving wing was that there were no non-associates and Andrew Jones was behind his door on basic regime pending adjudication. SO [redacted] was unaware that Andrew Jones had been on an ACCT until after he had been sent to C Wing.

Finally, although SO [redacted] the SO on C Wing would have liked more information, he neither asked the transferring wing SO for this nor interviewed Andrew Jones when he arrived on C Wing. No adequate interview was undertaken on C Wing of Andrew Jones before his death despite the fact he was segregated nor were any distraction materials provided.

(3) **Unlawful use of Segregation**: In this case, the relevant segregation legislation was Prison Rule 53 (4) which provides for segregation prior to an adjudication. The guidance that accompanies Rule 53 (4) provides for an initial 4 hour period of being placed behind the cell door after which the prisoner is de facto segregated.

There was no legitimate reason to segregate Andrew Jones at all under Rule 53(4)as he could not collude or intimidate anyone as no one else was involved in the altercation. In addtition, as soon as Andrew Jones was brought to his feet, he remained calm and controlled until his death. It was accepted by the senior prison staff that segregation was unavailable under this Prison Rule, was unlawful and Andrew Jones should have been returned to the normal wing regime at the end of four hours.

Unlawful use of segregation was routine practice since the introduction of the new rules some 3-4 years earlier. at a This is a substantial understatement of what was taking place at HMP Garth. Since the time of introduction, on a jail wide basis, prisoners were routinely segregated behind their cell doors for periods after the initial four hours had expired without any of the safety features of segregation including assessment by healthcare to determine if segregation would adversely affect the health of the prisoner, authorisation by a Governor, regular checks et cetera. As a basic calculation on figures provided by the prison, this would suggest that 6-700 prisoners were detained in their cells by this method. Even after concerns were raised regarding the application of Prison Rule 53 (4), an SO circulated emails to two wings suggesting that it was appropriate to place a prisoner behind a door for four hours by which time the end of the prison day had come and they could continue behind the door; this was a practice discouraged in evidence at the inquest. This use of segregation without healthcare involvement resulted in the removal of Andrew Jones' mood stabilising medication and the cessation

of his tramadol resulting in withdrawal symptoms occurring no later than the evening of 21 November 2018. Finally, Andrew Jones was segregated without even the benefits allowed to prisoners on the segregation unit of a shower, 30 minutes fresh air exercise and a telephone call each day.

The National Offender Management Service Specification for Prisoner Discipline and Segregation provides that the Key Outcome(s) for Service are a "*safe, ordered and decent prison*" and "*the use of segregation in prisons is lawful, safe and decent*". By reference to the NOM documentation the application of the rules was neither safe, lawful nor decent.

(4) **Personal Officer Scheme**: The Prison Service regime provides for a Personal Officer, who is usually an officer on the wing whether prison is located, to take a particular interest in the prisoner to achieve a greater knowledge of that prisoner through interaction than a regular prison officers would have. There is no indication in the prison records that any officer was appointed as Andrew Jones' Personal Officer and there is no indication in any of the prison records that any personal Officer interview or even time spent with Andrew Jones was either ever attempted or undertaken. In a prisoner who is failing to comply with the prison regime and attend work, possibly due, in Andrew Jones' case, to increasing paranoia or back pain, there was no attempted exploration of the prisoner's motivation for such behaviour and inconsistent threats of consequence as to what would happen if he continued his behaviour.

(5) **Different medication regimes operated by prison staff on the wings:** Andrew Jones was not allowed to hold medication in possession due to a previous overdose. Each morning and evening, he regularly collected his medication and was compliant with receiving and taking his mood stabilising medication (Quetiapine) and his analgesic (Tramadol). The system operated on the Residential Support Unit (B Wing) was that prison officers shouted out to the prisoners that medication was open and any prisoner that wanted to receive medication then pressed his cell bell and was released. On C Wing, where Andrew Jones was held in segregation, a list was delivered by Healthcare and the prison officers did not shout but unlocked those that were on the list. Consequently, because Andrew was transferred rapidly on the morning of 21 November 2018 he was not on the Healthcare list and was not unlocked: It is presumed that he would have waited to hear prison staff call out that medication was available. The first indication that Healthcare were aware that Andrew Jones had transferred to C Wing was midday on 22 November 2018 when he would already have been experiencing a reduction in mood stabilisation and significant symptoms from opiate withdrawal. There was no adequate explantion of why prison wings operate different system for prison staff to notify prisoners to collect their medication.

(6) **Adjudication hearing**: The altercation on 21 November 2018 should have resulted in an adjudication on 22 November 2018. On 22 November 2018 there was an overrun of the adjudications on the morning of 22 November 2018. As no one had informed Andrew Jones, he asked the prison officer who

attended him at midday on the 22 November 2018 what was happening. Andrew Jones was taken out of his cell and after the information had been obtained, informed that his adjudication was delayed. However, the message from the prison governor undertaking the adjudications that the adjudication would not occur that day and would be delayed to the following day did not reach the wing and was not conveyed to Andrew Jones. This is a breach of prison rules, did not detect that Andrew Jones was unlawfully segregated, failed to covey information to him and also failed to detect he did not even have the benefit of basic amenities such as a shower, a telephone call and fresh air.

(7) **Reliance upon medical reports that fail to address issues relevant to the the death**: The report by NHS England concludes that Andrew Jones' "*physical healthcare needs were appropriate and timely and his healthcare medications were prescribed appropriately*" and that Andrew Jones "*received healthcare equivalent to that which he could have expected to receive in the community*". This statement is almost entirely inaccurate and is based upon inadequate medical evidence.

The report of the consultant psychiatrist, [redacted] attached to this report provides an in-depth analysis of those matters affecting Andrew Jones around the time of his death. These include the following:

a. due to Andrew Jones Emotionally Unstable Personality Disorder and previous use of heroin, the reduction in his tramadol by the prison GP would have resulted in particular difficulties and should have been undertaken with Andrew Jones' agreement and in consultation with the psychiatrist;
b. the reduction in tramadol occurred when the GP did not undertake a referral for Remedial Gym and the prison had no physiotherapist to deliver any care. The result was a reduction in pain medication without the substitution of physical therapy;
c. that Andrew Jones did not receive his medication after 4pm on 20 November 2018 resulting in the sudden cessation of his mood stabilisation drug and the tramadol for his back pain. Andrew Jones' Emotionally Unstable Personality Disorder would have resulted in his experiencing increased levels of back pain above that of the normal person and enhanced withdrawal symptoms from a lack of opiates. This lack of prescribed medication was confirmed by toxicology at the time of his death which showed that Andrew Jones had no opiates or Quetiapine in his bloodstream;
d. Andrew Jones had been moved from the Residential Support Unit to the main prison estate where he still continued to believe that he was under threat;
e. that every positive factor identified on a recent ACCT review had been removed on his transfer to C Wing resulting in a substantial increase in risk;
f. that Andrew Jones was segregated and healthcare should have been summoned no later than 1:30pm on 21 November 2018 to undertake

a safety algorithm and provide an opinion to the prison governor as to whether or not continued segregation would have a detrimental effect on Andrew Jones. This would have also detected the lack of medication and would have led to an assessment of his mental state.

g. that the lack of a hearing would have given Andrew Jones an opportunity to have his side of the story heard; and
h. it was the conclusion of the consultant psychiatrist that the combination of deselection, removal of positive factors, removal of mood stabilisation drugs, segregation without access to a shower, telephone or exercise, sudden cessation of opiates resulting in opiate withdrawal symptoms, no adjudication hearing, lack of distraction activities created the "*perfect storm*" and contributed to Andrew Jones death.

This case demonstrates that there are cases that require a much more sophisticated approach to achieving a "*safe, ordered and decent prison*". A blanket approach to such a variety of cases is inappropriate and does not achieve this aim in complex cases. Noms tacit acceptance of this method of investigation indicates that it is missing important information in achieving a "*safe, ordered and decent prison*".

(8) **Independent Monitoring Board**: The Chair of the IMB gave evidence at the inquest where it became apparent that at times the membership of the IMB had constituted one person. It was variable as to whether or not there were IMB members able to attend segregation and there was no indication that there were sufficient numbers to make any visits for segregation on the wing. The evidence at the inquest suggested that the membership of the IMB was insufficient to properly conduct its functions, which include segregation, which was not considered by the PPO.

(9) **General approach to risk within the jail:** in this instance the jail removed almost every single safety feature to protect prisoners and prisoners at risk of self-harm summarised as follows:

a. Appreciation of risk by the Number One Governor that the RSU required a deselection protocol which was not completed;
b. Deselection of prisoners from the Residential Support Unit with no multidisciplinary assessment of past ACCT/self-harm, mental health, psychology input into the decision along with risk factors for an RSU prisoner in the wider jail
c. Misapplication by all senior officers and custody managers of wing segregation rules resulting in mass segregation of prisoners with no safety algorithm completion, enhanced checks, involvement of healthcare et cetera;
d. No risk assessment by the CM prior to transfer or the transferring wing Senior Officer prior to transfer;
e. No prison records of any discussions regarding transfer or the decision to transfer a prisoner between wings or of any checks undertaken prior to transfer

	f. No risk assessment by the receiving wing senior officer either on reception of the prisoner or at any time in the next 36 hours before his death; g. Inconsistent medication regimes without explanation; h. Closure of ACCT forms when either medical treatments were impossible to deliver or had not been undertaken although the reduction in analgesics had occurred; i. Records of post closure interviews been entered in the records when it was obvious that the risk profile had changed substantially since the post closure interview took place; j. No personal officer involvement to ascertain why a prisoner may be defaulting from the prison regime. Five years ago I rarely saw any deaths from HMP Garth and those that I undertook were normally well-managed. This demonstrates a substantial alteration as to how the jail approaches risk.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **22 June 2020**. I, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons. Andrew Jones Father. I have also sent it to Inquest, the Prison Reform Trust and HM Inspectorate of Prisons who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 20 April 2020 Signature for **Lanca**  **burn with Darwen**

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