

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Samuel Groves a prisoner at HMP Guys Marsh on 9 April 2018

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Samuel Groves died on 9 April 2018 after taking psychoactive substances (PS) at HMP Guys Marsh. He had undiagnosed heart disease and this, combined with his PS use, caused his death. Mr Groves was 29 years old. I offer my condolences to Mr Groves' family and friends.

Mr Groves used PS on a regular basis in prison. Although staff at Guys Marsh gave Mr Groves significant support for his PS use, he told staff he did not want to stop. The investigation found that the care provided to Mr Groves was equivalent to that which he could have expected to receive in the community.

I am, however, concerned that the emergency response by prison staff was not in line with national instructions.

Mr Groves' death was one of four that occurred at Guys Marsh between March and June 2018, and drugs played a part in all four. While the prison has taken measures to tackle the issue, more needs to be done. I am increasingly concerned by the number of deaths my office investigates in which PS has played at least some part. Mr Groves' death is another example of how dangerous PS is and how prisons are struggling to reduce PS use.

I am concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In my view there is now an urgent need for national guidance on the best measures to combat this serious problem. We have already made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service. We have also written to the Prisons Minister setting out our concerns at the number of drug-related deaths in custody.

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 2019**

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# Summary

## Events

1. On 9 February 2018, Mr Samuel Groves was sentenced to eight months imprisonment. He was moved to HMP Guys Marsh on 20 February.
2. Mr Groves had a history of using illicit substances, both in the community and during previous prison sentences. He was also known to try to hide and trade prescription medication in prison. Within two days of arriving at Guys Marsh, he was found under the influence of psychoactive substances (PS). This pattern of behaviour persisted and there are frequent entries in his prison record of him being under the influence and engaging in drug-seeking and trading behaviour.
3. The Integrated Substance Misuse Service (ISMS) team at Guys Marsh sought to engage with Mr Groves and a drugs support worker saw him weekly on a one to one basis, but he continued to use PS, saying that drugs were 'quite good fun'. Staff filed intelligence reports about Mr Groves' drug use and took measures including cell checks, random drug testing, putting Mr Groves on a basic regime and an intervention plan to manage his behaviour.
4. At around 8.45pm on 9 April, an officer saw Mr Groves unresponsive on his cell floor during the evening roll check. He fetched another officer and they both went into the cell. One of them radioed the control room who called an ambulance. Staff attempted to resuscitate Mr Groves and paramedics took over when they arrived. Their attempts were unsuccessful and the paramedics confirmed Mr Groves' death at 9.46pm.
5. The post-mortem examination found that Mr Groves had undiagnosed heart disease. PS was found in his body. The pathologist concluded that he died from the effects of PS, in combination with his heart disease.

## Findings

6. We are satisfied that the care Mr Groves received was equivalent to that which he could have expected to receive in the community. The clinical reviewer found there were no missed opportunities to diagnose Mr Groves' heart disease, and the support he received to address his substance misuse was good.
7. We found that information sharing about Mr Groves' substance misuse had much improved since a previous PPO investigation into a death at Guys Marsh and that intelligence was acted on. Guys Marsh are also developing a number of strategies targeting drug supply disruption, keeping offenders who have taken PS safe and working with them afterwards to address their behaviour
8. The emergency response, however, was not in line with national instructions and we repeat a previous recommendation made to Guys Marsh.

## Recommendations

- The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies including entering cells and using emergency codes.

## The Investigation Process

9. 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.
10. The investigator obtained copies of relevant extracts from Mr Groves' prison and medical records.
11. The investigator interviewed three members of staff at HMP Guys Marsh on 22 August 2018 and a further member of staff by telephone on 29 November.
12. NHS England commissioned a clinical reviewer to review Mr Groves' clinical care at the prison. He accompanied the investigator to Guys Marsh and led on the clinical interviews.
13. We informed HM Coroner for the County of Dorset of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The investigator contacted Mr Groves' family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended, where appropriate, accordingly. The action plan has been annexed to this report.

## Background Information

### HMP Guys Marsh

16. Guys Marsh is a category C training prison that holds up to 579 men. Care UK provides primary and secondary mental healthcare and has commissioned another agency, EDP, to provide integrated substance misuse services. Healthcare is open at weekdays and weekends from 7.30am to 6.00pm and there is a doctor on duty on Saturday mornings.

### HM Inspectorate of Prisons

17. The most recent inspection of HMP Guys Marsh was in December 2016. Inspectors were overall very disappointed with what they found and noted that Guys Marsh had not improved greatly since their last visit. As before, however, they found healthcare to be largely good, although they noted some problems with the supervision of the pharmacy hatch which created opportunities for diversion and violence.
18. Compared to a comparator prison where 43% of prisoners said it was easy to get drugs, 74% of prisoners at Guys Marsh said it was easy. Issues were identified with infrequent drug testing, an insecure perimeter fence, high levels of victimisation on the drug treatment wing, an increase in violence overall due to drugs debts, limited analysis of drug and security information and PPO recommendations not being addressed. Some useful actions had been taken to reduce supply but there was no strategic approach to coordinate them. Clinical reviews were considered to be good and psychological services improved.
19. After this report HM Prisons and Probation Service (HMPPS) placed Guys Marsh in 'special measures'. ('Special measures' means the prison needs additional, specialist support to improve performance.)

### Independent Monitoring Board

20. 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 30 November 2017, the IMB noted that there were staff shortages and the availability of psychoactive substances (and other illegal drugs) led to debt, which in turn impacted on safety, security and decency.

### Previous deaths at HMP Guys Marsh

21. Mr Groves was the ninth prisoner to die at Guys Marsh since April 2015. Of the previous deaths, two were drug-related, three were from natural causes and three were self-inflicted. Two months after Mr Groves died in April 2018, two further prisoners died and illicit substances were a contributory factor in those deaths too.
22. We have made recommendations about Guys Marsh's emergency response procedures before.

## Psychoactive Substances (PS)

23. 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.
24. 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.
25. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

## Key Events

26. On 9 February 2018, Mr Samuel Groves was sentenced to eight months imprisonment for tendering fake currency and sent to HMP Albany.
27. Mr Groves had previously served many relatively short term custodial sentences, seldom being out of prison for more than a few months after 2010. He had last been released from prison in November 2017, after serving a seven-month period in custody. During that sentence, he was recorded as taking illicit substances, attempting to trade prescription medication and being involved in fights. In August and September 2017, he had reported two incidents of chest pain on exertion at HMP Coldingley. On the second occasion, he was admitted to hospital for 24 hours where he was diagnosed with costochondritis (inflammation of the cartilages joining the ribs to the breast bone).
28. During his first night health screen at Albany on 9 February 2018, a nurse recorded that Mr Groves was overweight with a BMI of 28.2, that he declined a referral to the smoking cessation service and that his blood pressure was 133/83 (normal range is 90/60 to 120/80). He said he was prescribed diazepam (a sedative), mirtazapine (an antidepressant) and pregabalin (used for nerve pain, epilepsy and anxiety) in the community.
29. Mr Groves also saw a nurse and tested positive for cannabinoids and benzodiazepines (sedatives). He told her that he had been drinking on waking and taking cocaine regularly in the community. After a discussion with the GP, Mr Groves was admitted to healthcare for alcohol detoxification with a plan to phase his medication in slowly.
30. On 10 February, a nurse saw Mr Groves and noted his family history of cardiovascular disease which included a maternal history of high blood pressure and heart issues at age 40-50. Mr Groves' grandmother had also had heart issues at a similar age. His blood pressure was 138/80.
31. On 11 February, Mr Groves was caught smoking a substance in his cell in the early hours of the morning. In the evening, a nurse recorded that he had been found not taking the medication prescribed for his alcohol detoxification. On 14 February, Mr Groves was seen taking his medication out of his mouth and placing it in his pocket after collecting it from the medication hatch.
32. He was moved to HMP Winchester on 15 February. A nurse completed Mr Groves' first night screen at Winchester. She recorded that he denied any issues with bullying or trading medicines. Mr Groves' pulse rate was 39 bpm and his blood pressure 127/87. He also saw a second nurse, who noted that he had just been through an alcohol detoxification programme at Albany. His urine was not tested as they could not obtain a sample.
33. On 20 February, Mr Groves was moved to HMP Guys Marsh. A paramedic did his first night screen. Mr Groves said he had no drug problems and no issues with bullying or trading medication. He said he had not used drugs in the preceding month. Mr Groves said he was prescribed diazepam, pregabalin and mirtazapine. He said that he smoked and he saw a smoking cessation advisor the next day who gave him some nicotine patches.

34. An officer introduced Mr Groves to the wing staff and told him about the regime and healthcare timings. The officer told him his induction programme would start the next day and that staff were available for advice in the interim.
35. On 21 February, Mr Groves saw a Support, Time and Recovery Worker (providing practical support to people with mental health issues). He told her he had mental health issues including Post-Traumatic Stress Disorder (PTSD). He said he was happy to engage with the Integrated Substance Misuse Service (ISMS) and to look at working on his alcohol issues.
36. On 22 February, a GP prescribed Mr Groves diazepam, pregabalin and mirtazapine. Mr Groves attended the medicine hatch that evening but was unsteady on his feet, slurring his speech and his eyes were red. He was sent back to the wing without his medication. That evening, an officer recorded that Mr Groves was behaving in a confused and unsteady way.
37. On 23 February, wing staff asked a nurse to assess Mr Groves but he was aggressive when she arrived and she recorded that he was 'under the influence'. She observed that he was unable to coordinate his limbs or speech and was attempting to vomit. She attributed it to PS misuse. Later that day, an officer recorded that Mr Groves was found in possession of a quantity of PS, which officers seized.
38. On 24 February, Mr Groves was seen standing on his furniture 'spaced out'. He was put on report and the intelligence report submitted the next day suggested that a cell search was carried out.
39. On 25 February, a GP saw Mr Groves and recorded that he seemed to be under the influence of what he thought was 'probably Spice' (PS). An officer recorded on the NOMIS electronic records system that Mr Groves was 'bumping all over the place' and his speech was slurred.
40. On 26 February, a Support, Time and Recovery Worker, saw Mr Groves and discussed his alcohol consumption. She referred him for drug addiction therapy. Later that day, a nurse recorded that a member of wing staff had phoned to say Mr Groves had been put on a basic regime because of PS use.
41. On 28 February, a member of staff was unable to complete an assessment because she suspected Mr Groves was under the influence again. That day, an intelligence report was completed saying that Mr Groves had smoked an unknown substance in another prisoner's cell.
42. On 2 March, an ISMS worker tried to complete her assessment but was unable to do all of it as there were very few staff in the prison due to severe weather. She recorded that Mr Groves did not see his cannabis use as much of a problem and said he would like to work with the ISMS team to gain extra knowledge and because it would look good for probation. She produced a care plan which included a requirement for him to complete some in-cell packs covering alcohol, motivation to change, relapse prevention and stress management. He also agreed to attend some workshops.
43. In a further discussion with staff on 6 March, Mr Groves denied that he took PS, apart from on one occasion where he claimed someone else had given him a 'roll

up' which must have had some in it. He said he thought that his behaviour was due to the side effects of his prescribed medications.

44. On the same day, Mr Groves was overheard having a suspicious conversation with his partner which prompted a member of staff to create an intelligence report. Mr Groves asked his partner if she had received something and spoke to his brother who the member of staff believed was giving him money.
45. On 7 March, a prison GP stopped Mr Groves' pregabalin prescription because he had been caught 'palming' (hiding) his pregabalin the day before when he collected it from the medication hatch. (Pregabalin is misused by prisoners because it can enhance the euphoric effects of other drugs. It can be particularly harmful when combined with PS.) On the same day, an officer spoke to Mr Groves as she was concerned he might have been in debt – Mr Groves denied this.
46. On 14 March, it was recorded that Mr Groves had completed his 'Motivation and Change' pack which revealed some conflicted thinking: he said that he enjoyed using illicit substances but understood that the consequences outweighed the benefits. He requested a 'Thoughts and Feelings' work pack and one covering cocaine and crack, which was issued. The ISMS worker saw Mr Groves again on 23 March, and he told her he was worried about a potential adjudication for PS use, even though he said he had not used PS since he had moved to the wing. He said he was worried about completing the drugs pack in case it reflected badly on him. She told him it would not and also gave him an alcohol work pack.
47. On 26 March, Mr Groves was selected for a random drug test and tested positive for PS. (An officer recorded this on NOMIS, the prison's computer system, on 9 April.)
48. On 28 March, the Head of Healthcare recorded that Mr Groves had tested positive for PS. He did not attend an appointment with a prison GP the next day.

### Events of 9 April

49. On the morning of 9 April, Mr Groves attended an ISMS workshop on safer drinking.
50. An officer said that he saw Mr Groves on the morning of 9 April at 8.15am when he was going to work but did not recall anything unusual about him. Later that morning at approximately 11.40am, Mr Groves had an argument with another prisoner. He accused Mr Groves of making silly comments but neither prisoner would tell officers exactly what it was about. Later that day they were seen socialising together with no issues.
51. At 5.20pm, an officer who was on detached duty from HMP The Verne, locked Mr Groves in his cell. He could not recall anything unusual about that evening's lock up.
52. At approximately 7.20pm, an officer responded to Mr Groves' cell bell. Mr Groves asked the officer to pass him some bread which he had left on a table outside his cell. The officer checked the bread and gave it to Mr Groves who

thanked him. He said that Mr Groves did not seem to be under the influence of anything. The officer said he was aware that Mr Groves was a drug user and that he had recently failed a drug test. He said that, on a previous occasion when Mr Groves had misused illicit substances, he had had bloodshot eyes, seemed sleepy and slurred his speech. The officer said Mr Groves was not showing any of those symptoms.

53. Between 8.40pm and 8.45 pm, an OSG (operational support grade) started his shift on the wing and was briefed by an officer who told him there was 'Spice' in the prison. Afterwards, the OSG started the roll count. When he reached Mr Groves' cell he opened the observation hatch and saw him lying on his front on the floor. Mr Groves was not moving and the OSG thought some fluid had come out of his mouth. The OSG's statement said he was not particularly concerned initially and thought Mr Groves looked asleep. He turned the light on from outside, banged on the door and shouted Mr Groves' name, but when Mr Groves did not respond he pressed an 'orange button' (which has since been explained as a personal alarm) on his radio to summon assistance. His call was not answered and he told the investigator he thought by this point that Mr Groves was dead as he had not moved at all. The OSG then went to Gwent Wing, which was the closest, and asked an officer to accompany him to Mr Groves' cell.
54. When they reached the cell, the officer went in and said he turned the light on. He described Mr Groves as lying face down in vomit, fully clothed. The officer could not find a pulse and said Mr Groves was cold. He asked the OSG to call for assistance as Mr Groves was not breathing. The OSG said in his statement written shortly afterwards that he 'did the three shouts over the radio and specified the cell'. He told the investigator that by this he meant he said 'Assistance required. Assistance required. Assistance required' over the radio, and that he gave the cell number, wing and the fact a prisoner was unresponsive. The control room log confirms that this happened at 8.55pm and that an ambulance was also called by control room staff at this point.
55. The officer turned Mr Groves onto his back and started cardiopulmonary resuscitation (CPR). The OSG went to the main gate to direct the paramedics when they arrived. Another officer arrived and opened Mr Groves' airway and a third officer arrived and applied a defibrillator. The third officer had arrived for duty as the radio call for assistance was broadcast which is why he took a defibrillator with him. Several other officers had also arrived by the time the officer got there.
56. The defibrillator did not advise that the officers deliver a shock so they continued with rounds of CPR until the paramedics arrived at approximately 9.20pm. Paramedics were unable to resuscitate Mr Groves and confirmed his death at 9.46pm.

### **Contact with Mr Groves' family**

57. At 6.15am on 10 April, the morning after Mr Groves' death, the prison's family liaison officer (FLO) and the prison Governor went to the address held for Mr Groves' mother. This was the first opportunity they had to break the news in person because the address was on the Isle of Wight and the ferry had stopped running for the day the evening before.

58. The resident of the address had no knowledge of Mr Groves' mother and, after trying another similar address on the island, someone at the prison contacted Hampshire Police. The police provided a telephone number but there was no reply when the FLO called. The FLO and the governor decided to visit the address held for Mr Groves' partner instead and broke the news to her. They also visited Mr Groves' mother after being given her contact details by Mr Groves' partner.
59. The FLO explained the PPO investigation and continued to offer the family support. Mr Groves' funeral was held on 2 May and the FLO and the Governor attended. In line with national policy, the prison contributed to the funeral costs.

### **Support for prisoners and staff**

60. After Mr Groves' death, the Governor 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.
61. The prison posted notices informing other prisoners of Mr Groves' 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 Groves' death.

### **Post-mortem report**

62. The post-mortem report says that Mr Groves died as a result of synthetic cannabinoid (PS) intoxication against a backdrop of chronic myocardial hypertrophy (enlarged heart) and ischaemia (weakened blood supply to the heart). The post-mortem examination found that Mr Groves had significant undiagnosed heart disease and that any sudden rise in blood pressure would have been likely to trigger a defect in the heart's rhythm or pumping efficiency, with potentially fatal consequences. PS are known to increase blood pressure and therefore, it was likely that the taking of PS was the trigger for Mr Groves' death.
63. The report also says that a 'wrap of green grainy material' was found in Mr Groves' pocket, but there is no reference to this being tested.

# Findings

## Clinical issues

64. Mr Groves died due to PS use against a background of significant heart disease. Mr Groves' heart condition was unusual for a man of his age (29) and had not been diagnosed. The clinical reviewer examined all Mr Groves' custodial healthcare records back to January 2007 for any missed opportunities to do so but concluded there were none.
65. The clinical reviewer found that the care Mr Groves received at HMP Guys Marsh was equivalent to that which he could have expected to receive in the community.

## Substance misuse management

66. Mr Groves had a long history of persistent substance misuse both in the community and in prison. During his final prison sentence, Mr Groves was caught smoking illicit substances on his second day in custody and he continued to misuse PS throughout his time at Guys Marsh. However, the clinical reviewer concluded that the care Mr Groves received for his substance misuse problems was arguably better than that which he could have expected to receive in the community. The clinical reviewer considered that the continuity of care between Albany, Winchester and Guys Marsh was good and that at Guys Marsh his care - weekly input in his cell from an ISMS worker - was relatively intensive.
67. We agree with the clinical reviewer that the care Mr Groves received from ISMS and primary healthcare services was at least equivalent to that he could have expected to receive in the community.
68. The ISMS worker told the clinical reviewer that PS users are always regarded as at a high-risk of coming to harm because of the variable components of PS and their potentially dangerous interactions with prescribed medications. Additionally, PS users seem to be particularly poorly motivated to explore change. Mr Groves had told her that he found illicit substances 'quite good fun'.
69. Mr Groves 'palmed' medication at the medication hatch in March 2018. We are aware that the Coroner issued a Regulation 28 report in August 2018, following the inquest into another prisoner's death at Guys Marsh. This directed the prison to review its medication hatch logistics and how it might restrict the opportunities for prescribed drugs making their way onto the wings to be traded or taken illicitly. The review was ongoing at the time of this investigation and we have not, therefore, made a recommendation about this.

## Sharing and acting on intelligence

70. There were many instances where Mr Groves was either observed to have abused substances himself or to be involved in some way in the prison's drug culture. A previous PPO investigation into a death at Guys Marsh found that healthcare staff were less likely than other staff to complete intelligence reports and to formally log their observations with the custodial side of the prison. We recommended that healthcare staff should be trained to complete intelligence reports and the prison accepted this.

71. The investigator saw all the intelligence reports that were filed about Mr Groves when he was at Guys Marsh. Because of the way reports are completed, it is very difficult to tell if every single instance that we would expect to prompt an intelligence report did so and what the outcome was. Codes are used instead of staff names on the reports and the printed reports do not always show clearly what has happened next.
72. The Head of Healthcare said that the use of the prison's 'Mercury' (intelligence) system by healthcare staff to report relevant instances had increased from 45% to 70% in the past year. She said the reason it was not 100% was that not everyone could remember how to use the system when they needed to because there were often long gaps between needing to. On these occasions, staff would ask her to input the information and she readily did this.
73. Staff said that all ISMS staff were trained to use the Mercury system and routinely did so. The Head of Security confirmed that the Head of Healthcare and ISMS staff had filed intelligence reports on Mr Groves.
74. The investigator asked the Head of Security what actions had been taken in response to each intelligence report. He provided a 'round-up' of outcomes relating to 'earlier reports' only. They included a referral to the ISMS team, information about Mr Groves' drug use being shared among staff, Mr Groves being placed on a 'Challenge Support Intervention Plan' to manage his behaviour and regressing him to a basic regime and placing him on a 'suspicion list' for mandatory drug testing. There is also evidence in the prison file of at least one cell search.
75. The Head of Security said that he could not identify any further specific actions in response to 'later reports' but, as Mr Groves' substance related behaviour had already been identified, he thought the appropriate actions were already in place.
76. The investigator asked the Head of Security to summarise some of the issues facing Guys Marsh in trying to keep the establishment drug-free. He said that PS are always changing in terms of their make-up and how they come into the prison, and this made it difficult for drugs dogs and equipment to detect them. While the methods for trafficking drugs into the prison are getting more sophisticated, more rudimentary methods are also still employed. Drugs might be thrown over the perimeter fence or smuggled in by visitors.
77. Our investigation found evidence that Guys Marsh is currently undertaking many measures to tackle the problem of PS. We accept that Guys Marsh has a drug strategy in place and staff are working hard to implement it. Nevertheless, the HMIP report indicated that drugs are easily accessible to prisoners and following a cluster of deaths at the prison in a short space of time, it is clear that more needs to be done to reduce both the supply and the demand for PS.
78. Guys Marsh is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

79. In a recent investigation, we recommended that the Chief Executive of HMPPS should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of deaths she was investigating that were due, or linked, to the use of PS. The Chief Executive has told us that HMPPS plan to issue a national drug strategy in the autumn of 2018. We therefore make no recommendation.

### Emergency Response

80. Prison Service Instruction (PSI) 24/2011, which sets out the procedures for management and security in prisons at night, says that under normal circumstances prisoners' cells can only be opened on the authority of the Night Orderly Officer and with at least two staff present. However, it goes on to say that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer and an individual member of staff can enter the cell on their own.
81. PSI 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency is called. Its provisions are mirrored in local policies at Guys Marsh.
82. The OSG discovered Mr Groves on the floor of his cell when he was doing the evening roll count. He had started the roll check at approximately 8.45pm. Even though Mr Groves was on the floor, had fluid coming out of his mouth and did not respond to his calls, the OSG did not enter the cell or call an emergency code. Instead, he went to another wing and asked an officer to accompany him to Mr Groves' cell.
83. The investigator asked the OSG why he had not entered the cell when he first discovered Mr Groves. The OSG said that staff are not allowed to enter cells alone. He believed the correct procedure was to radio staff in the communications room who would respond and confirm assistance was on the way – only when assistance arrived could he enter a cell. The investigator asked the OSG if he thought anything different should be done where a prisoner's life was in danger, and he said that he was very much of the opinion that Mr Groves was dead. When pressed about what he would do if a prisoner's life was in danger he repeated the assertion that he thought Mr Groves was dead.
84. The OSG has since returned his unsigned note of the telephone interview to the investigator. He has deleted the line 'and the OSG said that although he had initially thought Mr Groves was asleep he soon suspected that he had in fact died'. He added a handwritten note saying 'Delete all. Not in the right context'. The prison liaison officer, told the investigator that the OSG would be emailing the PPO to explain this further. The investigator did not receive an email and she maintains that this is what the OSG said in his conversation with her.
85. The officer described Mr Groves as lying face down in vomit, fully clothed. He could not find a pulse and said Mr Groves was cold. He asked the OSG to call

for assistance as Mr Groves was not breathing. The OSG confirmed at interview that he did not call a code blue emergency code over the radio, but instead called 'Assistance required' three times, specified the cell and said that a prisoner was unresponsive. The control room log confirms that they were aware of an emergency at 8.55pm and that an ambulance was also called by control room staff at this point. Control room staff recorded a 'code blue' emergency situation on their log and they clearly treated it as such.

86. The investigator asked the OSG if he was aware of any other ways to raise an alarm in a medical emergency. He referred to codes red and blue, the differences between them and he knew that calling one meant staff would attend. He was not clear about the fact that using an emergency code would instruct staff to immediately call an ambulance but did say that he had described Mr Groves' condition to communication room staff as he knew that they would need this information. He also implied that it was for more senior staff to decide if an ambulance was required.
87. The investigator asked the OSG how the prison's code system had been cascaded to him, but he referred to his 'army training' and the 'three shouts' system. He said he had called for assistance rather than a code because he believed more staff would respond than they did to emergency codes where he said maybe a couple of staff would turn up. He said that he knew that at that time there would be a number of day staff congregating near the communications room leaving their shift. His amended note crosses out 'a couple of staff' and says 'Night patrol'.
88. There was a delay of several minutes between the OSG discovering Mr Groves and an ambulance being called, which is directly attributable to the OSG's failure to call an emergency code immediately. We cannot say whether the delay affected the outcome for Mr Groves, but it may make a critical difference in other cases.
89. We are concerned that the OSG did not know that he could enter a prisoner's cell alone at night if there is, or appears to be, an immediate risk to life, and that he did not think of doing so in this case, even though he told the investigator that he thought Mr Groves was dead. We are also concerned that he took the decision to go to another wing and fetch a colleague rather than calling an emergency code; that he did not call an emergency code when he and the colleague entered the cell; and that he did not know that the reason he should have called an emergency code rather than calling for assistance, is that calling a code automatically triggers the control room to call an ambulance.
90. This is not the first time we have identified failings in Guys Marsh's emergency response procedures. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies including entering cells and using emergency codes.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations