Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Emmett, a prisoner at HMP Aylesbury, on 25 May 2023

A report by the Prisons and Probation Ombudsman

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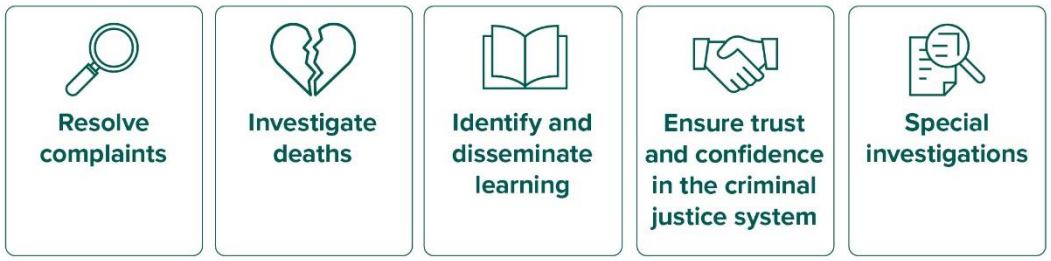
OUR VISION

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit, is appropriate, our recommendations should be focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr George Emmett was found collapsed in his cell at HMP Aylesbury on the evening of 25 May 2023, and was later pronounced dead by attending paramedics. The pathologist found that Mr Emmett had used psychoactive substances (PS) in the hours before he died and that this likely caused his death. Mr Emmett was 25 years old. I offer my condolences to his family and friends.

At the time of Mr Emmett's death, HMP Aylesbury had experienced an increase in the use of PS which was also likely to have caused the death of another prisoner ten days before Mr Emmett's death. The Governor has since taken steps to educate prisoners about the risks of taking drugs and reduce the supply and demand in the prison. I make no recommendations.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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Summary

Events

1. On 25 June 2022, Mr George Emmett was arrested for carrying a knife in public and handling stolen goods. He appeared in court, was remanded to custody and taken to HMP Thameside. Two days later, he was sentenced to 25 weeks imprisonment. He was also recalled to prison for breaching his licence from a previous sentence. In September 2022, he transferred to HMP Aylesbury. Mr Emmett had Attention Deficit Hyperactivity Disorder (ADHD - people with ADHD can seem restless, may have trouble concentrating and may act on impulse) and did not always take his medication.

2. Mr Emmett had a long history of cannabis misuse, and he seemed eager to deal with the problem and to work towards his release. Mr Emmett had no recorded history of using psychoactive substances (PS), but he was suspected to be under the influence of an illicit substance on 10 May 2023. After he died, his vape tested positive for PS.

3. During a standard check at 8.35pm on 25 May, an operational support grade (OSG) saw Mr Emmett lying face down on his cell floor. They called to him, but he did not respond so they telephoned for staff assistance. When other staff arrived twelve minutes after Mr Emmett had first been found, they went into the cell and found that Mr Emmett was not breathing. Staff radioed an emergency code and requested an ambulance. Staff and paramedics tried to resuscitate Mr Emmett, but at 9.40pm the paramedics pronounced that he had died.

4. The post-mortem examination found that Mr Emmett had most probably died from use of PS.

Findings

5. Mr Emmett had a long history of cannabis misuse which he wanted to address and for which he was receiving support. The only apparent previous time that Mr Emmett had misused PS was on 10 May. Aylesbury has since taken a proactive approach to addressing drug supply and demand.

6. When Mr Emmett was found unresponsive on the evening of 25 May, the OSG should have immediately radioed for an emergency response. However, we are satisfied that he has since sufficiently reflected on the incident and staff in general have been reminded what they should do in an emergency situation.

7. The clinical reviewer found that Mr Emmett’s clinical care at Aylesbury was only partially equivalent to what he could have expected to receive in the community. In particular, she found that the substance misuse care offered to him was insufficient when he was found under the influence. Aylesbury has since made improvements in this regard. She also found no evidence that the mental health team explored with him his failure to collect his prescribed medication after 15 May.

8. We make no recommendations.

The Investigation Process

9. HMPPS notified us of Mr Emmett's death on 25 May 2023. The investigator issued notices to staff and prisoners at HMP Aylesbury 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 Emmett's prison and medical records.

11. The investigator interviewed seven members of staff and two prisoners at Aylesbury on 13 and 26 July. She interviewed two other members of staff by video-link.

12. NHS England commissioned a clinical reviewer to review Mr Emmett's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with healthcare staff.

13. We informed HM Coroner for Buckinghamshire of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

14. The Ombudsman's office contacted Mr Emmett's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Emmett's mother's solicitors responded to us and asked:

    - When Mr Emmett was found under the influence of drugs on 10 May:
        - was he checked by healthcare staff?
        - what clinical concerns were noted?
        - what were the clinical findings?
        - did healthcare staff review him after this and if not, why not?

    - Was the vape that was discovered on 10 May tested?
    - What medication was Mr Emmett receiving at the time of his death?
    - When was Mr Emmett last seen alive and by whom?
    - How often should prisoners be checked in the evening?
    - Why did staff not open the cell immediately when they found Mr Emmett unresponsive?
    - On 25 May, where in the cell did staff find a vape and was the vape tested?

15. We have answered these questions in this report and additional questions in separate correspondence.

16. We shared the initial report with Mr Emmett's mother's solicitors and with HM Prison and Probation Service (HMPPS). HMPPS identified several inaccuracies in our report, which we have corrected.

Background Information

HMP Aylesbury

17. HMP Aylesbury holds category C prisoners. All cells are designed for single occupancy. Central and North West London NHS Foundation Trust provides physical and mental healthcare services. In October 2022, Forward Trust were contracted to provide substance misuse treatment, replacing the previous provider, Inclusion. Nurses are on duty from 7.30am to 6.30pm in the week and from 8.30am to 5.30pm at weekends.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Aylesbury was in November and December 2022. Inspectors noted that Aylesbury was then in a period of transition moving from a longstanding function of holding long-term and high-risk young adult prisoners into a new role as a category C training prison. Inspectors noted that they had been consistently critical of Aylesbury over many years and this inspection was no different. Inspectors found that there was poor provision of purposeful activity, that prisoners were not treated well enough, and their needs were not being met.

19. Inspectors noted that a contributory factor to Aylesbury's difficulties was a problem in recruiting staff. The prison was short of around 50 officers, and staffing shortages in healthcare were of such concern that the prison tried not to accept any prisoners over the age of 40. Prisoners time in the open air was limited to 30 minutes a day and unemployed prisoners spent up to 23 hours a day locked up.

20. Inspectors noted that only 14% of prisoners said it was easy to get drugs, which was half the reported level at other category C prisons. Random testing had showed that drug use had spiked in the late summer of 2022, but a co-ordinated approach and targeted actions had reduced supply. Inspectors considered this a successful area of work.

21. Inspectors found that the re-categorisation of the prison, along with the change in healthcare provider and staff shortages had affected delivery of pharmacy services. Approximately 70% of prisoners received their medicines in possession and the remainder received supervised administration. Medicines were administered twice a day from a treatment hatch on the main healthcare lobby, which was also a thoroughfare. Inspectors found that the location of the treatment hatch, combined with the variable quality of supervision by officers of the medicine queues, presented potential for diversion of medication.

Independent Monitoring Board

22. 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 March 2022, the IMB noted that overall, Aylesbury appeared a reasonably safe prison with no deaths occurring within the reporting year. The IMB noted that the substance misuse team used a variety of means to identify prisoners who needed drug or alcohol rehabilitation,

including when prisoners were found under the influence. They created individualised care plans based on a prisoner's needs.

Previous deaths at HMP Aylesbury

23. Mr Emmett was the fourth prisoner to die at HMP Aylesbury since May 2020. Of the previous deaths, one was most likely to be drug related, one was self-inflicted and the other was most likely to be natural causes, although the actual cause was unascertained.

24. The other death that was also believed to be drug related, occurred ten days before Mr Emmett's death. In that case we found that the prisoner was not referred to the substance misuse team when he was found under the influence of PS.

25. Up until the end of May 2024 there had been one further death at Aylesbury, the cause of which was still under investigation at the time of writing.

Psychoactive Substances (PS)

26. PS (formerly known as 'legal highs') continue to be a serious problem across the prison estate. They can be 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, the use of PS is associated with the deterioration of mental health and an increase in suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

HMPPS Substance Misuse Group

27. After the two apparent deaths from PS in May 2023, Aylesbury requested support from HMPPS' National Drug Strategy team. The Substance Misuse Group (SMG) visited Aylesbury on 14 June. We reflect their findings later in this report.

Key Events

28. Mr George Emmett was released on licence in December 2021 after serving over five years for offences of kidnapping, blackmail, assault, robbery, drug offences and possession of an offensive weapon. On 25 June 2022, Mr Emmett was arrested and charged with carrying a knife in public and handling stolen goods. He appeared in court, was remanded to custody, and also recalled due to being on licence. Mr Emmett was taken to HMP Thameside.

29. On arrival, Mr Emmett told a nurse that he had ADHD. He said that he had been prescribed medication for the condition but had stopped taking it due to the side effects. Mr Emmett said that he had no thoughts of suicide or self-harm. He also said that he did not have problems with drugs or alcohol.

30. On 27 June 2022, Mr Emmett was sentenced to 25 weeks imprisonment for his most recent offences and was later sentenced to a further seven days imprisonment for obstructing a police officer.

31. On 24 August, Mr Emmett asked staff for help for problems with cannabis use. The substance misuse team gave him an in-cell work pack which he completed the next day.

HMP Aylesbury

32. On 5 September, Mr Emmett transferred to HMP Aylesbury. At a reception health screen, Mr Emmett told a nurse that while at Thameside he had asked to restart medication for ADHD but was still waiting to see a psychiatrist. He said he had no thoughts of suicide or self-harm.

33. On 8 September, Mr Emmett saw a substance misuse worker. Mr Emmett said that he had used cannabis from the age of 14 and continued to use it up to the present time. He said that he wanted to learn more about the impact of cannabis including how it could affect his future. They agreed that he would complete a workbook on the drug.

34. Also on 8 September, Mr Emmett moved to G wing where he stayed for his remaining time in Aylesbury.

35. On 10 September, a prisoner told staff that Mr Emmett had been offering PS infused paper to prisoners on the wing. This allegation was recorded in Mr Emmett's security record, but it was not verified and there was no further investigation.

36. On 14 September, a psychiatrist assessed Mr Emmett. He spoke about his involvement in violence when he had been in Aylesbury in the past, but said he was keen to progress ahead of his next parole hearing so he was minimising his engagement with prisoners who he thought might goad him into violence. Mr Emmett said that he had no thoughts of suicide or self-harm and did not use PS. The psychiatrist prescribed Mr Emmett medication for ADHD.

37. On 18 September, an officer (the key worker) saw Mr Emmett for a key-worker session (each officer works as a key-worker to a small group of prisoners who they see regularly to discuss their needs, concerns and goals). Mr Emmett said that he had settled well and was mixing with other prisoners. He also said that he was keen to progress and to get a job on the wing.

38. On 22 September, another officer submitted a security information report about a strong smell of cannabis coming from four cells on G wing, including Mr Emmett's cell. There was no further investigation into this report.

39. On 5 October, Mr Emmett became an enhanced prisoner following a number of positive entries for helping to clean the landings and for his positive attitude and compliance with the rules. Enhanced prisoners are entitled to more benefits under the Prison Service's incentives and earned privileges (IEP) scheme and are able to apply for more trustworthy prison jobs.

40. On 29 October, the key worker saw Mr Emmett for another key-worker session. He noted that Mr Emmett wanted to complete offending behaviour courses before his next parole hearing as he wanted to be ready for release.

41. On 7 December, Mr Emmett completed his work with the substance misuse team and said that he had a better understanding of harm from cannabis use. Mr Emmett was discharged from the substance misuse team caseload.

42. On 6 February 2023, Mr Emmett started a course called Becoming New Me (BNM) to examine the motivation to his offending.

43. On 21 April, Mr Emmett saw a health and wellbeing coach and they spoke about his recent request to attend a substance misuse workshop. The health and wellbeing coach added Mr Emmett's name to the workshop waiting list. The investigator understood that this would be group work for relapse prevention and was due to start in June.

44. On 26 April, Mr Emmett saw a psychiatrist to discuss his ADHD medication. While at Aylesbury, Mr Emmett went through periods of not collecting his medication due to its side effects and he was also switched between different ADHD medications. Mr Emmett told the psychiatrist that his concentration and focus had improved since he had started taking Methylphenidate a week earlier and he asked for the dose to be increased. The psychiatrist agreed to increase the dose and he noted that Mr Emmett was calm and appropriate in demeanour.

45. On 1 May, the key worker saw Mr Emmett for another key-work session. The officer noted that Mr Emmett had been an enhanced prisoner for seven months and had recently progressed from wing cleaner to the more responsible position of servery worker. Mr Emmett said that he thought he would soon be suitable to move to a category D (open) prison and he wanted to discuss this with his offender manager. The key worker told Mr Emmett that he would email the offender manager to arrange a meeting.

46. On 5 May, Mr Emmett completed the BNM course. The tutor noted that Mr Emmett had worked very hard during the course and had said that he was focused on his goal of the Parole Board recommending his release.

47. On the morning of 10 May, an officer noted that they suspected that Mr Emmett was under the influence of an illicit substance in his cell and was holding a tampered vape containing an unknown substance. A nurse examined Mr Emmett and noted that his eyes were bloodshot, his speech was slurred, and he was unsteady on his feet. The nurse advised Mr Emmett to drink a lot of fluids and she told officers to observe him and to contact healthcare again if they had any concerns. An officer noted that Mr Emmett would remain in his cell for the rest of the day, but no record was made of checks made on him to ensure he was well and recovering appropriately.

48. Staff discussed Mr Emmett at the afternoon healthcare meeting. However, the substance misuse team's regional manager told us that her team was not at the meeting and were not told that Mr Emmett had been found under the influence. She said that had the team been told, Mr Emmett would have been offered support. She also said that she understood that substance misuse staff later offered Mr Emmett support, but he declined one-to-one work as he wanted to do the group work, which he was already on the waiting list for. This was not recorded in his medical record.

49. Staff sent Mr Emmett's vape for testing. (The result was not received until after Mr Emmett's death and was positive for PS). Staff submitted an intelligence report naming the prisoner who was thought to have supplied Mr Emmett with the substance and that the exchange had been made in the healthcare waiting area. (The source of this information is vague, but it seems to have come from a prisoner.) Staff noted that this was the first time the other prisoner had been implicated in the possible supply of drugs.

50. On 15 May, staff noted that Mr Emmett did not collect his ADHD medication and that he would need a medicines review before the prescription could be restarted.

51. On 24 May, an officer praised Mr Emmett for speaking to and helping another prisoner who was at high risk of suicide or self-harm.

52. The investigator spoke to two of Mr Emmett's prisoner friends. Both described Mr Emmett as a generally cheerful man who was focused on being recommended for release by the Parole Board. Neither believed that he was at risk of deliberately harming himself and both said that they were unaware that he used PS.

Events of 25 May

53. On the morning of 25 May, the Dispensary Manager saw Mr Emmett smoking a vape in the healthcare waiting area. He did not collect his medication that morning so there was no valid reason for him to be there. The Dispensary Manager said there were around ten prisoners, including Mr Emmett, in the waiting area that morning, a number of whom were using vapes which was against the rules. She said that an officer noted the names of all the prisoners who had been using vapes and they were given warnings.

54. The Dispensary Manager told the investigator that Aylesbury had an unusual system where all prisoners in receipt of not-in-possession medication went to the healthcare unit for their medication (in other prisons, not-in-possession medication is dispensed on the individual wings). She said that some prisoners were escorted to the healthcare unit by officers, but others went during free-flow (when prisoners

could walk unescorted). She said that she was surprised to see Mr Emmett that morning as several days had passed since he had last collected his medication.

55. The Dispensary Manager said that there was a general belief at Aylesbury that prisoners from across the prison used the healthcare waiting area as a place to trade drugs.

56. Also that morning, there were intelligence reports that G wing smelt strongly of PS, although these reports were not directly related to Mr Emmett.

57. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to prison radio transmissions for the afternoon of 25 May. The following account has been taken from all sources.

58. Prisoners collected their lunch between 11.30am and 12.00pm. CCTV shows that Mr Emmett returned to his cell with his lunch at 12.18pm and did not come out of his cell again after that.

59. At 4.50pm, an officer unlocked Mr Emmett's cell for him to collect his evening meal. The officer told the investigator that Mr Emmett was lying on his bed and said he was not feeling very well. He said that he did not want any food, he just wanted to sleep. The officer asked if he wanted a nurse or for her to collect some food for him, but he declined both offers. The officer said that Mr Emmett's speech was not slurred, and she did not notice any smell of drugs in the cell. She said that she had no particular concerns and just assumed that Mr Emmett had a slight headache.

60. At 6.17pm, an officer carried out a routine check. She said that when she looked through Mr Emmett's observation panel, she saw him sitting on his chair near the cell door.

61. At around 8.35pm, an OSG was making a routine count of all prisoners when he saw Mr Emmett lying chest down on his cell floor. He shouted Mr Emmett's name several times, but he did not respond. The OSG thought it was possible that Mr Emmett might be sleeping on the floor or was pretending to be ill or asleep as he had experienced before with other prisoners. He could not tell if he was breathing. The OSG completed his checks on other prisoners by visiting the remaining two cells and returned to Mr Emmett's cell one minute later. Mr Emmett was still unresponsive, so he radioed the control room, told them that Mr Emmett was not responding and asked for advice. The control room told the OSG to contact the officer in charge: a Custodial Manager (CM).

62. The OSG went downstairs to the wing office to use the telephone. He said he did not use the radio as he did not want other staff to panic, and he was unsure of the situation with Mr Emmett. The CM told the investigator that when the OSG telephoned her, he first reported the numbers from his count before then saying that there was a prisoner lying on his cell floor and he was not responding to him. From the tone of the OSG's voice, the CM thought the prisoner might be under the influence of an illicit substance. The OSG remained in the wing office waiting for staff to arrive for the next few minutes.

63. The CM went to G wing accompanied by three officers. CCTV shows that they did not appear to be hurrying. They reached Mr Emmett's cell at about 8.47pm, twelve

minutes after the OSG had first found him unresponsive. One officer wrote a statement to say that when he looked into the cell, Mr Emmett appeared asleep. He then unlocked the cell and when he shook Mr Emmett's arm, he was cold to the touch, and he saw that his lips were blue. The officer noted that Mr Emmett had no pulse and was not breathing. The CM radioed a code blue emergency (to indicate a prisoner is unconscious or having breathing difficulties). The officers attached a defibrillator and started cardiopulmonary resuscitation (CPR).

64. Control room staff called for an ambulance when the code blue call was made, and paramedics reached Mr Emmett at around 9.03pm. The paramedics moved Mr Emmett onto the landing and continued treating him there. At around 9.40pm, the paramedics pronounced that Mr Emmett had died.

Contact with Mr Emmett's family

65. The Head of Security was appointed as the family liaison officer. Mr Emmett's next of kin, his mother, lived in Kent. The family liaison officer was aware that Mr Emmett was a popular prisoner and he understood that some of the other prisoners knew Mr Emmett's family. He was concerned that other prisoners would contact the family about Mr Emmett's death, so he decided that the best option was for him to telephone the family. At 11.00pm, he rang both telephone numbers held for Mr Emmett's mother, but he received no response. After making a further unsuccessful attempt he telephoned the police force closest to her home and asked them to make a home visit.

66. At 6.15am the following morning, the police told the family liaison officer that they had not been able to get a response from the address. At 8.15am, he telephoned Mr Emmett's mother again and spoke to her to inform her of the news and offer his condolences. Aylesbury contributed to Mr Emmett's funeral costs in line with HMPPS policy.

Support for prisoners and staff

67. After Mr Emmett's death, the Head of Safety 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.

68. The prison posted notices informing other prisoners of Mr Emmett's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Emmett's death.

Post-mortem report

69. Toxicological investigation found that Mr Emmett had used a synthetic cannabinoid (also known as PS) in the hours prior to his death and had possibly used a vape to smoke the drug. Presence of codeine, paracetamol and quetiapine were found in Mr Emmett's urine, but the toxicologist noted that the absence of these compounds in Mr Emmett's blood suggested that he had not used these medicines in the hours before his death.

70. The pathologist noted that Mr Emmett had significant but isolated coronary artery atheroma (fatty deposits in the arteries around the heart) with pulmonary changes of acute left ventricular failure (when blood supply fails in the left side of the heart caused suddenly by an event). The pathologist concluded that it was likely that Mr Emmett's use of PS had probably caused his death, although he explained that a definitive diagnosis could not be made due to the limited information on the relationship between blood concentrations of PS and their toxic effects. The pathologist gave Mr Emmett's cause of death as unascertained.

Findings

Mr Emmett's substance misuse

71. Mr Emmett had a history of cannabis use and when he arrived at Aylesbury said that he wanted to learn more about how use of the drug might prevent him moving forward in his life. He completed a cannabis workbook and later asked to join a workshop to deal with relapse prevention (he was due to start this in June).

72. Mr Emmett denied a history of using PS, but when he was suspected to be under the influence on 10 May, tests on his vape were positive for PS (although this result was not received until after his death). The clinical reviewer noted that the response to Mr Emmett being under the influence on that date was not as robust as it should have been. The nurse did not do any clinical observations to assess Mr Emmett's physical health. (On 12 May, a healthcare monitoring and observation form was introduced but was withdrawn from use a week later. A revised version was reintroduced on 15 June 2023 along with new guidance: *suspected prisoner under the influence welfare pack,* for prison and healthcare staff.)

73. Forward Trust told us that they were not aware of Mr Emmett using PS that day. If they had been told, they said they would have checked on him and offered him immediate support. The clinical reviewer concluded that Mr Emmett's substance misuse care was not equivalent to that he could have expected in the community.

74. However, as outlined, Aylesbury has since taken steps to improve the substance misuse support provided to prisoners from a clinical and prison perspective. We make no further recommendation.

75. Mr Emmett also tested positive for codeine (a painkiller) and quetiapine (an anti-psychotic) after he died. It is not known how he obtained these medications. It may have been from other prisoners who were prescribed them, or from drugs illegally brought into the prison. There was no intelligence that Mr Emmett was taking medication not prescribed to him before he died. The steps that Aylesbury have taken to address the supply of illicit medication and other drugs are outlined later in the report.

Clinical care

76. Overall, the clinical reviewer found that Mr Emmett's care at Aylesbury was partially equivalent to that he could have expected to receive in the community. This was partly due to gaps in his substance misuse care as already noted.

77. The clinical reviewer also noted that when Mr Emmett ceased collecting his ADHD medication from 15 May onwards, there was no evidence that he was seen by the mental health team to explore his reasons. She considered that this was a missed opportunity and has made two associated recommendations which the Head of Healthcare will wish to consider.

Drug strategy at HMP Aylesbury

78. A substance misuse needs assessment was carried out at Aylesbury in June 2022. This was around the time that Aylesbury began the transition from being a young offender institution to a category C adult prison. At that time, cannabis was the most prevalent drug of choice for prisoners at Aylesbury, followed by alcohol and cocaine. The assessment found that there was low use of PS at the prison. The assessment noted that the ongoing change in the age group of the prisoner population had not yet affected the drugs of choice. However, the assessment noted that the prison's drug strategy needed to ensure that all services remained responsive to any development in the most prevalent drugs of choice.

79. In their last inspection of Aylesbury at the end of 2022, HMIP noted that prisoners reported that it was much more difficult to get drugs at Aylesbury compared to other category C prisons.

80. Aylesbury's drug strategy notes several measures aimed at reducing the supply of drugs in the prison, including:

- High quality searching of prisoners, staff and visitors.
- Rigorous screening of incoming and outgoing prisoner mail.
- Scanning of incoming property.
- Effective use of the dedicated search team and search dogs.
- Good intelligence gathering and active management of the intelligence.
- Identification of prisoners using illicit substances.
- Use of mandatory drug testing and use of the adjudication system for those identified to be misusing drugs.

81. Around the time of Mr Emmett's death, we understand that there had been an increase in PS use at Aylesbury, including a death ten days before that of Mr Emmett which was also likely to have been due to PS. On the morning of Mr Emmett's death, there were intelligence reports that G wing smelt strongly of PS although these reports were not directly related to Mr Emmett.

Specific measures taken shortly before Mr Emmett's death

82. On 25 April 2023, Aylesbury held a drugs amnesty, encouraging prisoners to hand in illicit items and there would be no consequences. This was supported by advice about the dangers of PS use.

83. To reduce trafficking of drugs into the prison through the post via drug impregnated paper, the prison photocopied all incoming post in the first two weeks of May 2023.

84. Aylesbury identified that drugs were being sent to prisoners in clothing parcels from individuals, so changed the policy so that clothing parcels were only allowed directly from named suppliers.

Actions taken after Mr Emmett's death

85. Following the death of Mr Emmett and another prisoner in May 2023, Aylesbury took the following steps:

- Education of prisoners and staff on the risks of PS use via information notices and education sessions with prisoners.

- Greater focus on intelligence led searching for drugs rather than random searching.

- The security department and safer prisons team met to consider knowledge gaps and prisoners who were believed to be involved in drug supply and distribution. Disruption tactics based on the intelligence were also discussed.

- Aylesbury moved away from having dedicated search teams and were supporting residential staff to pro-actively challenge and search individuals on residential units. HMPPS Standards Coaching team supported Aylesbury in the training of staff.

- On 13 July, the prison issued a community notice reminding prisoners that only approved delivery suppliers could deliver parcels.

86. As previously stated, Aylesbury also sought support from HMPPS' National Drug Strategy team and the Substance Misuse Group (SMG) visited Aylesbury on 14 June. The SMG found that:

- The medication dispensing area was identified as a known area for diversion of both illicit and prescribed medication due to the high number of prisoners passing through and poor control by officers.

- A significant percentage of staff were unaware of the prison's drug strategy and their individual roles within the strategy.

- Aylesbury had a number of challenges and the presence and demand for drugs continued to be a serious threat. The challenges and threats were potentially compounded by a sense of frustration from prisoners that staff had not been prepared in moving from working with young offenders to category C adults.

- Aylesbury did not offer Opiate Substitute Treatment (OST), so there might be prisoners with ongoing or hidden opiate addictions who were not receiving sufficient support and could therefore be at risk of self-medicating.

- Aylesbury needed to recognise substance misuse as a key driver for increased violence, self-harm, bullying and debt.

87. To specifically deal with the concern that the dispensary waiting area was a possible trading area for both illicit drugs and prescribed medication, Aylesbury introduced dedicated healthcare officers to supervise prisoners more robustly. In addition, movement officers now collect prisoners for medication and GP appointments which has led to fewer prisoner attending the healthcare department and fewer prisoners gathering there for extended periods of time. Supervising officers and orderly officers have also been instructed to visit the healthcare unit more often to ensure that prisoners are being appropriately supervised.

88. In view of the proactive steps taken by Aylesbury to address substance misuse at the prison, we make no recommendation.

Emergency response

89. When the OSG saw Mr Emmett unresponsive on his cell floor, he said that he made a dynamic risk assessment and did not go into the cell as he thought Mr Emmett might be pretending to be unresponsive. We are not critical of this. However, the OSG was clearly uncertain about what he should do next and asked the control room for advice.

90. The CM said that when the OSG then telephoned her, he first reported his numbers from his routine count before then telling her about an unresponsive prisoner. When we asked whether she considered advising him to radio an emergency code or radioing one herself, she said that she considered that the OSG would have done that already if he believed it to be an emergency.

91. There was a twelve-minute delay between the OSG finding Mr Emmett unresponsive and staff going into the cell. We do not know if this delay had an impact on the outcome for Mr Emmett. The OSG told the investigator that if he was ever in a similar situation again and was unsure whether a prisoner was genuinely unwell or not, he would radio an emergency medical code immediately.

92. The Head of Safety told the investigator that he has regularly sent notices to staff to remind them about the process for making emergency code blue and code red calls where a prisoner appears to have breathing difficulties or is bleeding. He said that where necessary, individual staff are spoken to, to remind them of the process. In view of this action, and the OSG's assurances about what he would do if ever in a similar situation in the future, we make no recommendation.

Governor to note

Family liaison

93. Prison Service Instruction (PSI) 64/2011 sets out the process that should be followed following a death in custody. This instructs that, where possible, the prison family liaison officer must visit the family to break the news of the death. The PSI notes that time is of the essence to try to ensure that the family do not find out about the death from another source. The PSI also instructs that when the family live a long distance from the prison, other options include requesting help from the nearest prison to the family or contacting the police force local to the family.

94. We acknowledge the family liaison officer's concern that Mr Emmett's mother might hear the news from another prisoner and that was why he chose to try to telephone her first. We also note that Mr Emmett's mother was apparently away from home at that time so any visit to her would have been unsuccessful. However, the Governor will wish to ensure that telephoning the next of kin to break the news of an unexpected death is a last resort saved for very limited circumstances.

Inquest

95. An inquest into Mr Emmett's death held from 23 to 27 June 2025 concluded that his cause of his death was toxic effects of synthetic cannabinoid.

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