Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ross Appleby, a prisoner at HMP Parc, on 18 January 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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, then our recommendations should be focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Ross Appleby died on 17 January 2023 at HMP Parc. The pathologist gave Mr Appleby's cause of death as a sudden unexpected death in a man exposed to synthetic cannabinoids, protonitazene (a synthetic opioid) and mirtazapine (an antidepressant). Mr Appleby was 29 years old. I offer my condolences to his family and friends.

Mr Appleby had no recorded history of drug misuse while at Parc, although his cellmate said that he had been using drugs when locked in his cell. I note that Mr Appleby's toxicology report shows that he also used two unprescribed medicines that he presumably obtained from other prisoners.

Mr Appleby was the second of two prisoners at Parc to die after using synthetic cannabinoids and a synthetic opioid in January 2023. There were two other deaths in the preceding three years following drug use and, alarmingly, four deaths possibly following drug use by prisoners in Parc in February and March 2024. HMPPS Substance Misuse Group visited Parc in January 2023 and again in April 2024. Their report evidenced significant amounts of psychoactive substances (PS) in Parc and found that many improvements were needed to reduce supply and demand. The prison has introduced new measures in response and work is ongoing. I acknowledge that this is an area with constantly evolving challenges and more can always be done. However, there are a number of factors that mean that PS are likely to be especially prevalent at Parc and I am extremely concerned that unless more is done to reduce drug availability at the prison, more prisoners will die there.

Nationally, there has been increasing awareness and concern about the high toxicity of synthetic opioids, known as nitazenes, including protonitazene, and which are often mixed with PS or other drugs. I am concerned about the grave consequences for Mr Appleby, as well as several other prisoners whose deaths we are also investigating. I note that Parc has established several methods of engaging with prisoners about substance misuse and I encourage staff to use those mechanisms to alert prisoners to the significant risks of using drugs potentially laced with these substances. I remain concerned that medication queues are not being adequately supervised.

Although it is unlikely that it affected the outcome for Mr Appleby, I am concerned about elements of the emergency response when he was found unresponsive.

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 **October 2024**

Contents

Summary 1

The Investigation Process.....2

Background Information.....3

Key Events.....5

Findings 8

Summary

Events

1. On 3 September 2022, Mr Ross Appleby was remanded to HMP Cardiff charged with possession of drugs with intent to supply. In early October, he was convicted and sentenced to three years in prison, and he transferred to HMP Parc on 13 October.

2. Mr Appleby said that he had used cannabis in the community, but that was the only drug he used. He was not assessed as needing any substance misuse support.

3. Mr Appleby's cellmate said that Mr Appleby had been using drugs in their cell including at around 9.00pm on 17 January 2023. At around 11.00pm that night, Mr Appleby's cellmate rang the cell bell when he saw that Mr Appleby's face was blue and his hand was cold to the touch.

4. Officers went into the cell and after finding he had no pulse, began cardiopulmonary resuscitation (CPR). Nurses arrived a minute later and took charge of Mr Appleby's care. Ambulance paramedics arrived at 11.19pm and continued efforts to try to resuscitate Mr Appleby. At 12.12am the paramedics ceased all efforts and pronounced that Mr Appleby was dead.

5. The pathologist gave a narrative cause of death for Mr Appleby which was the sudden death of a person with synthetic cannabinoids, protonitazine and mirtazapine in his system.

Findings

6. There were no recorded incidents of Mr Appleby using illicit substances while at Parc, although his cellmate said that he had been using drugs in their cell.

7. Mr Appleby's death was one of a number of other deaths at Parc following illicit drug use.

8. Officers were slow to start CPR when they realised that Mr Appleby did not have a pulse.

9. Following the death of the prisoner ten days before Mr Appleby, we made several recommendations which are also relevant to another prisoner's death. We do not repeat those recommendations here.

The Investigation Process

10. HMPPS notified us of Mr Appleby's death on 18 January 2023.

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

12. The investigator obtained copies of relevant extracts from Mr Appleby's prison and medical records. He interviewed five members of staff and one prisoner during March. The interviews were conducted by telephone and video-link. The investigation was subsequently reallocated to another investigator. He interviewed three additional staff at Parc in July and August 2023, and reinterviewed one of the staff previously interviewed by the previous investigator.

13. Health Inspectorate Wales commissioned a clinical reviewer to review Mr Appleby's clinical care at the prison. The clinical reviewer jointly interviewed clinical staff with both investigators.

14. We informed HM Coroner for South Wales Central of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's Office contacted Mr Appleby's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Her solicitor responded on her behalf and asked:

    - What were the circumstances surrounding Mr Appleby's death?
    - Were all policies and procedures followed in response to finding Mr Appleby unresponsive?
    - How long did it take for the ambulance and medical professionals to arrive following the code blue call?

    We have addressed these questions in this report.

16. Mr Appleby's mother also asked several further questions about her son's care and about events after her son's death, which we have answered in separate correspondence.

17. We shared our initial report with HM Prison and Probation Service (HMPPS) and with the solicitors acting for Mr Appleby's family.

18. HMPPS identified two minor factual inaccuracies which we have corrected in this report.

19. The solicitors acting for Mr Appleby's family did not inform us of any factual inaccuracies.

Background Information

HMP Parc

20. HMP Parc is a medium security private prison run by G4S. It holds adult and young adult remand and convicted men. It also has a unit for young offenders under the age of 18. Since 15 December 2022, healthcare services have been provided by Cwm Taf Morgannwg University Health Board. Nurses are on duty 24 hours a day. A local GP practice provides a daily clinic and out of hours cover.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Parc was in June and July 2022. Inspectors found that relationships between staff and prisoners were generally good, but the delivery of key-work to support and develop prisoners was limited to those deemed the highest risk. Inspectors reported that the availability of drugs continued to be a key concern and that 49% of prisoners said that it was easy to get drugs at Parc, compared to 32% at similar prisons. However, inspectors also noted that prison leaders understood the risks that illicit drugs posed and were proactive in their efforts to tackle the threat, which included the appointment of dedicated staff to analyse intelligence reports, dedicated staff for search operations and joint work with the police to target staff corruption.

22. Inspectors noted that Dyfodol, the substance misuse service, was well integrated at the prison and worked closely with the drug strategy manager to ensure that substance misuse was a consistent strategic priority. Inspectors noted that all new arrivals at Parc were screened in reception for drug and alcohol issues and saw clinical prescribers as necessary. All prisoners who were suspected of using psychoactive substances continued to be seen for support.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2022, the IMB noted that the reporting year coincided with the second year of the COVID-19 pandemic during which the Board was operating with just two full members which restricted active monitoring across the prison. Within that context, the IMB noted that the level of drug use across the prison was hard to monitor, although there continued to be the presence of drugs and other illicit items. The IMB noted that staff worked diligently to limit the supply of drugs, including use of a body scanner in reception, thorough searching of property, scanning of letters and use of drug dogs.

Previous deaths at HMP Parc

24. Mr Appleby was the 18th prisoner to die at Parc since 18 January 2020. Of the previous deaths, three were drug related and in a death from unknown causes, the prisoner had some drugs in his system that might have caused or contributed to his death. Of the other deaths, 12 were from natural causes and one was self-inflicted.

25. In our investigation into a death in April 2022 following use of a synthetic cannabinoid, we found that the prisoner had also obtained and used an unprescribed medicine that he presumably obtained from another prisoner. We had not issued our report into that investigation by the time of Mr Appleby's death.

26. In our investigation into a death at Parc ten days before Mr Appleby's death, we again found that the prisoner had used both synthetic cannabinoids and a synthetic opioid and had taken medication not prescribed to him.

27. Between February and May 2024, there were four further deaths at Parc where illicit substances might have played a part. The investigations into these deaths were still at an early stage in August 2024 when we drafted this report. In early June, the Director of Parc stood down from her role and a new Director was appointed.

Psychoactive substances (PS)

28. The term psychoactive substances is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazene) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

29. PS 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 these substances 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, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key worker scheme

30. The key worker scheme was introduced in the men's prison estate in 2018. It provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

31. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key-work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

32. On 3 September 2022, Mr Ross Appleby was remanded to HMP Cardiff charged with possession of class A and B drugs with intent to supply. This was not his first time in prison.

33. From reception, Mr Appleby was initially moved to the segregation unit as a body scan indicated the presence of a package in his bowel. He was warned of the dangers associated with internal secretion of drugs.

34. On 4 September, a further scan proved negative, and Mr Appleby was moved to the induction wing. A substance misuse nurse saw Mr Appleby and noted that he denied having any issues with drugs or alcohol and she noted that he was showing no signs of substance withdrawal.

35. On 3 October, Mr Appleby was found guilty of the offences with which he had been charged and was sentenced to three years in prison.

36. On 13 October, Mr Appleby transferred to HMP Parc, and a nurse saw him for a reception health screen. She noted that he appeared to be fit and well, that he had no history of self-harm and had no current thoughts of suicide or self-harm. He said that he was 'okay' about being at Parc as he had been there before.

37. At an assessment in Parc's reception wing, Mr Appleby said that he had used cannabis in the community but that was the only drug he used, and he said that he had never used drugs while in prison. Mr Appleby was given information about the local substance misuse service (Dyfodol), but no referral was needed for him at that time.

38. The investigator spoke to Mr Appleby's cellmate. He said that he shared a cell with Mr Appleby from 8 December and within a week, Mr Appleby started to use PS when in the cell. He would use PS several times a week and after using it, would go quiet and fall asleep.

39. In a telephone conversation with his mother on 15 January 2023, Mr Appleby spoke about the recent death of another prisoner at Parc, who was believed to have died after using PS. Mr Appleby said that he believed PS was worse than crack cocaine, although he had never used PS himself.

40. On 16 January, the cellmate made an application to healthcare to say that he had thoughts of hurting Mr Appleby. A member of staff spoke to him, and he asked to move to a single cell. He was not moved as there were no indications that he had mental health issues, but staff believed he was instead being manipulative.

41. The cellmate told the investigator that he did not, in fact, have thoughts of harming Mr Appleby, but made the comment to try to move to a single cell as he no longer wanted to be exposed to Mr Appleby's use of drugs.

Events of 17 January

42. The following account is taken from the body worn video camera (BWVC) footage, prison documents, staff reports and interviews with staff and prisoners. The investigator tried to watch CCTV footage at Parc, but the footage would not play.

43. The cellmate said that on the evening of 17 January, he had been watching television while making a matchstick model. At just after 9.00pm, Mr Appleby had smoked PS and fallen asleep. At around 11.00pm, he realised that Mr Appleby seemed quieter than usual, and he saw that his head was slumped down to his chest. He went to lift Mr Appleby's head and then saw that his face was blue, and his hand was very cold. He rang the cell bell and told Prison Custody Officer (PCO) A over the intercom that he thought that Mr Appleby was dead.

44. PCO A told the investigator that he was in the wing office when the cellmate told him over the intercom to come quickly to his cell. He said that the wing office was around 20 metres away from the cell, so he arrived very quickly. When he looked into the cell, Mr Appleby was in a sleeping position on his bed. He asked the cellmate to check him, and he said that Mr Appleby was unresponsive. He radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties).

45. PCO A said that as there were two prisoners in the cell and the situation was unclear, he had to wait for support before going into the cell. PCO B arrived around one minute later and they went into the cell. An Operational Manager (OM) also arrived, and he and PCO B checked Mr Appleby for signs of life. The OM and PCO B continued checking Mr Appleby for signs of life by checking his wrist and neck for a pulse and checking for signs that he was breathing. The OM said that he was unsure if Mr Appleby had a pulse or if it was his own pulse he was feeling and he feared he might harm Mr Appleby if he started cardio-pulmonary resuscitation (CPR) if he was in fact breathing and had a pulse. He also said that he had never previously needed to give CPR during his 26 years in service. At 11.06am, the OM decided that Mr Appleby had no pulse and he briefly started CPR while Mr Appleby was on his bed. He found that the bed was too springy for CPR, so he and PCO B moved Mr Appleby to the floor and resumed CPR.

46. A nurse arrived at 11.07am and another nurse arrived one minute later (she was delayed by around 90 seconds as she initially tried to go via the gym, but the officer accompanying her did not have the correct key for the gym gate). While the OM and PCO B took turns giving CPR, a nurse called for a defibrillator and checked Mr Appleby's airway. She said that Mr Appleby's airway was obstructed with vomit and his tongue was quite swollen. She said that there were suction units at most of the medication hatches at Parc but there was no unit on Mr Appleby's wing, so a healthcare worker collected a unit from healthcare. The defibrillator said that no shock could be given so they continued giving CPR.

47. The nurse confirmed that they had naloxone in the emergency bag (naloxone is a medicine that can reverse the effects of opioid overdose), but they did not give Mr Appleby naloxone. She could not explain at interview why she did not use naloxone.

48. Ambulance paramedics arrived at around 11.19pm and took charge of Mr Appleby's care. The paramedics gave adrenalin and naloxone. All efforts to try to resuscitate

Mr Appleby proved unsuccessful and paramedics pronounced him dead at 12.12am.

Contact with Mr Appleby's family

49. Parc appointed a family liaison officer. At just after 4.00am, she and Parc's then Director visited Mr Appleby's mother's home and broke the news of her son's death and offered their condolences.

50. Parc contributed to the cost of Mr Appleby's funeral in line with national instructions.

Support for prisoners and staff

51. The Head of Security debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

52. The prison posted notices informing other prisoners of Mr Appleby'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 Appleby's death.

Post-mortem report

53. Toxicological investigation found the presence of several synthetic cannabinoids and a synthetic opioid in Mr Appleby's system. Investigation also found the presence of three unprescribed medicines: low concentrations of buprenorphine (a synthetic opioid) and dihydrocodeine (a strong painkiller) and a high concentration of mirtazapine (an antidepressant). The toxicologist noted that the concentration of mirtazapine could indicate excessive use or overdose of the drug, although the amount detected could also be accounted for through normal changes in drug concentration after death.

54. The pathologist found no evidence of injury or significant natural disease and, in the absence of any other potential explanation for death gave Mr Appleby's cause of death as sudden unexpected death in a man exposed to synthetic cannabinoid receptor agonists, protonitazene and mirtazapine.

Findings

Mr Appleby's substance misuse

55. When Mr Appleby arrived at Parc in October 2022, he said that he had used cannabis in the community but did not use any other drugs and had not used drugs while in prison. There were no recorded instances of Mr Appleby being seen under the influence in his time at Parc, so there was no apparent reason for him to be offered support from Dyfodol. We note the cellmate's evidence that Mr Appleby had been using drugs in their cell, but there is no evidence to suggest that staff were aware of this. Indeed, the cellmate said that Mr Appleby generally took drugs and then went to sleep.

Drug strategy at Parc

56. Parc's drug strategy for 2022/2023 noted that PS continued to be an ongoing area of concern. The strategy document reports on a research project that identified three main reasons why people in custody used PS, which were to cope with thoughts and feelings, to manage boredom and to self-medicate psychological symptoms. The project highlighted the need to focus on improving how prisoners cope with being in prison, with particular focus on prisoners aged 31 to 40 as they were the dominant users. The strategy made clear that reducing the supply of and trafficking of illicit items, including substances, was critical. It noted that traditional methods of supply, such as throw-overs, staff corruption and visits, continued, but there had been increased use of drones in recent years and a significant increase in PS sprayed paper through internal mail. In response to these risks, Parc upgraded the CCTV coverage of the external perimeter, had invested in drone detection technology, had installed a Rapiscan device (which detects drugs) to check mail and were awaiting a body scanner. The strategy noted that in addition to preventing drugs getting into the prison, intelligence gathering was critical in limiting trafficking through targeted searching including use of drug detection dogs.

57. Parc's strategy for 2023/2024 was broadly similar to the previous year's strategy. It noted that there had been a worrying increase in PS incidents in early 2023, with concern that in addition to synthetic cannabinoids, synthetic opioids (such as protonitazene) were also coming into the prison. The strategy noted that the increase, together with two deaths from apparent substance misuse in January 2023 (including Mr Appleby's death), had resulted in the development of a PS action plan. Specific actions within the action plan included proactive provision of harm reduction advice, advertising of Dyfodol services, an amnesty for prisoners to hand in drugs and the issue of a notice to prisoners warning of the dangers of protonitazene.

Measures to reduce supply and demand for drugs in place at Parc before Mr Appleby's death

58. Newly arrived prisoners at Parc were subject to full searches, including through the X-ray body scanner and all prisoners were subject to lower level searching through the day.

59. Intelligence led searching of prisoners and their cells for illicit items were conducted daily.

60. From late 2022, Parc reviewed the process for prisoner visits from the point of entry up to the visits hall and had a dedicated search team with drug dog support focussing on social visits. As part of the review Parc submitted a business case for a second X-ray body scanner to be used on prisoners following a visit.

61. All prisoner mail was photocopied, and all legal mail was checked with the Rapiscan. Parc had also established links with the Regional Organised Crime Unit and, in partnership with them, conducted a number of joint operations targeting specific areas of drug supply including via social visits, via kitchen staff and via officers. The Regional Organised Crime Unit also provided specific intelligence to Parc to assist with specific targeted searches of prisoners' cells.

Advice to prisoners

62. In December 2022, Parc published a notice to prisoners about new forms of PS that were being found in prisons in South Wales that contained synthetic cannabinoids and synthetic opioids. The notice explained that these substances were up to 200 times stronger than morphine and their use had caused many deaths. The notice gave advice on how prisoners could keep safe and was published for prisoners to access on the self-service kiosks. Further notices were published in 2023 as other, even stronger, forms of PS became available. Following feedback from a prisoner council meeting, Parc moved to publication of information on PS developments through paper notices directly delivered to each prisoner. In addition, Parc engaged in television and radio interviews with local media on the dangers associated with the developing forms of PS and prisoners were told of the dates and times of the programmes.

Actions taken after Mr Appleby's death

63. Following Mr Appleby's death and another apparently drug related death 10 days later, Parc requested support from HMPPS' National Drug Strategy team. The Substance Misuse Group (SMG) visited Parc in January 2023. Key points noted by SMG included that:

- Parc's Head of Drug Strategy had a clear focus and was delivering positive work.
- Parc had a comprehensive drug strategy with links to the debt strategy.
- Parc's analysts produced good information on current risk on drugs based on evidence from security reporting systems.
- The substance misuse team supported prisoners found to have used drugs.
- PS was reported as the prominent drug of choice.
- The price of PS at Parc was considerably lower than the national average.
- The low price of PS at Parc suggested that a considerable supply was available.
- Parc did not have a specific PS strategy.
- Parc received a good service from local police, but there was potential for improvement in the working relationship.

- The main way PS was getting into the prison was likely to be via prisoner admissions, with supply via confidential legal correspondence (Rule 39 letters) and legal visit, together with staff corruption also being likely routes. Parc's intelligence collection did not focus on these areas.
- Intelligence gaps that needed to be explored were paper based PS (including PS on books) and PS on clothing.
- The number of parcels entering Parc was a particular concern.
- There was limited intelligence on PS coming in via the outer walls and fencing and it was likely that this would become an increased avenue for supply as security in other areas was tightened.
- Parc did not have an enhanced searching area for staff and visitors.
- There appeared to be a punitive approach to substance misuse at Parc and the prison would benefit from development of a rehabilitative approach.

64. SMG made 15 recommendations (some of the recommendations were for actions already being undertaken at Parc). Actions introduced at Parc following the SMG report included improvement to CCTV coverage of the perimeter wall, consideration of enhanced drone detection equipment, use of an X-ray body scanner to check prisoners following social visits, allowing prisoners to receive just one package of property within 28-days post-conviction and all clothing received from the community to be washed before being given to the prisoner.

65. In April 2024, SMG made a follow-up visit to Parc as part of the response offered following the series of deaths at the prison in early 2024, some of which were found to be drug related. SMG noted that it was evident that Parc had used the information from the 2023 visit to reflect on areas of illicit substance supply reduction. However, SMG found that since the previous visit, the price of PS had reportedly fallen considerably which suggested that a sizeable supply was available. SMG noted that the entrance gate had previously been identified as a vulnerability, and on this visit they considered that searching practices were poor with minimal attention paid to the contents of bags. SMG also noted a potential problem with the body scanner used to check newly arrived prisoners.

66. SMG noted that Parc's Drug Strategy Lead, together with other senior managers had been extremely proactive in trying to combat use of illicit substances, including the new threat from nitazenes.

67. SMG spoke to prisoners who consistently said that the main driver for drug seeking behaviour was boredom and constant changes in consistency of regime delivery. SMG understood that prisoners who were not employed and not in education only received a maximum of 90 minutes out of their cells each day. SMG also spoke to staff from Dyfodol and made physical observations across the prison. In their summary of findings, SMG found that Parc had many staff dedicated to roles involving drug strategy and security and who were clearly committed to delivering a safe, secure and stable environment. However, SMG also found that while there was a lot of good individual work being driven by the Drug Strategy Lead, Parc would benefit from closer strategic alignment between departments. SMG also found that staffing levels and associated regime changes were impeding drug strategy delivery and potentially increasing demand for illicit substances.

68. SMG made five recommendations, including the need for closer strategic alignment between security, safety and drug strategy; for promotion of the drug strategy in helping deliver key messages, and for a review of medication administration.

69. In response to SMG recommendations, Parc developed an action plan that included improved use of technology to identify and remove substances from circulation, improved management of intelligence to better understand supply routes of substances and how to reduce supply, to commence installing improved cell windows to reduce conveyance of substances via drones and throw-overs and to improve support and education of prisoners. Parc also developed a specific action plan aimed at improving recruitment and retention of staff.

70. We fully recognise the significant challenges inherent in preventing drugs entering Parc. PS is especially prevalent in category C prisons because their lower security measures and stable population allows for the maintenance of distribution networks. In addition, Parc has a large population, has a large perimeter and is situated in an open and accessible semi-rural area close to the M4 making it vulnerable to throw-overs and drones (although we understand that both throw-overs and use of drones at Parc has diminished in recent times). The illicit drugs market in prison is controlled by organised crime gangs and the scale of the problem requires a co-ordinated approach, which Parc fully recognises and has been doing. Although it is clear that some very good work is being done at Parc, including the analysis of intelligence and the system for checking the validity of legal mail, the threat from drugs is constantly evolving and more can always be done. We expect the Director to maintain focus on all actions needed reduce to supply and demand for drugs.

Diverted medication

71. Mr Appleby's toxicology report showed that he had used two unprescribed medicines before his death, mirtazapine and dihydrocodeine. Prisoners at Parc can be prescribed mirtazapine in-possession (to keep in their cell and take as prescribed), but dihydrocodeine is always prescribed not-in-possession (and must be collected daily from the medication hatch). We do not know how Mr Appleby obtained these medicines. However, if he obtained the dihydrocodeine from a prisoner being prescribed that medicine that would mean that the other prisoner would have concealed the tablet in his mouth without detection and which he subsequently gave or sold to Mr Appleby.

72. In our investigation into a death from PS in April 2022, we found that the prisoner had also obtained and used an unprescribed medicine that he had presumably obtained from another prisoner. In July 2023, Parc responded to our recommendation on diverted medication to say that training sessions had been delivered to staff focusing on supervision of medication queues and responding to medication diversion. It is disappointing to note that when SMG visited Parc in April 2024, they found that prisoners receiving medication on A and B wings were not being observed by officers. Instead, medical staff had to distribute medication alone, and to attempt to check that the medication had been taken correctly, which was made more difficult by the pharmacy security barrier.

73. In our investigation into a death at Parc ten days before Mr Appleby's death, the prisoner had also been able to obtain medication not prescribed to him. The Director will need to consider urgently our concerns and those made by SMG on the

lack of officer supervision of medication queues. The Director will be aware of the grave dangers associated with prisoners obtaining and using non-prescribed medication, and in particular when those medicines are combined with other medicines or illicit drugs. In our investigation into the death at Parc ten days before Mr Appleby's death, we recommended that the Director should ensure that officers supervise medication queues appropriately to limit opportunities for diversion of medication. We do not repeat the recommendation here.

Entrance gate

74. Among its findings SMG noted that Parc's entrance gate was vulnerable with poor searching practices of visitors and their bags. PPO investigators who have visited Parc would concur with this assessment. They were searched in what they considered was a narrow corridor and two of the investigators who visited on separate occasions did not consider that their bags had been searched thoroughly. Similarly, in our recommendation into the death at Parc just before Mr Appleby's death we recommended that G4S should pursue with HMPPS the provision of enhanced gate security at Parc including deployment of additional staff, use of X-ray scanners, more thorough searching of bags and use of drug detection dogs. Again, we do not repeat the recommendation here.

Key-worker scheme

75. Mr Appleby had no key-worker meetings in his three months at Parc. The Head of Rehabilitation told the investigator that Parc delivered the key-worker scheme on a priority group and non-priority group basis. Priority group prisoners were those who had been identified as being vulnerable and they received weekly key-worker sessions. With non-priority group prisoners, Parc aimed to deliver monthly key-worker sessions.

76. Mr Appleby would have been in the non-priority group so should have received monthly sessions. The Head of Rehabilitation acknowledged that Parc had not always been able to achieve their target for delivery of sessions due to operational reasons. He said that it was possible that key-worker sessions had been offered to Mr Appleby, but which he declined, although in that case staff should have made a record of the interaction. He provided data to show that in the first six months of 2024, Parc achieved 95% of the target for delivery of key-work sessions to priority group prisoners and we note that delivery remained consistent across the six-month period. For non-priority group prisoners Parc achieved 104% of the target delivery, although we note a significant drop in performance in June 2024, where Parc achieved 73% of target delivery. As Parc is now delivering key-work sessions at a reasonable level, we make no recommendation, however the Director will wish to ensure that the prison maintains performance in this important area of prisoner support.

Clinical care

77. The clinical reviewer found that Mr Appleby's care at Parc was equivalent to what he could have expected to receive in the community.

Head of Healthcare to note

78. The clinical reviewer found several issues of concern relating to the emergency response. The reviewer found that there was a delay in providing suction of Mr Appleby's airway as there was no suction unit on the wing, so a unit had to be collected from healthcare. The reviewer also found that nurses did not give Mr Appleby naloxone despite having the medicine in the emergency bag. The reviewer also noted the slight delay in attendance of healthcare staff due to the lack of access through the gym gate. The clinical reviewer noted, however, that Mr Appleby was likely to have been in a state of cardiac arrest for some time when he was found so it was unlikely that any of the issues he identified would have affected the outcome. The clinical reviewer has made recommendations to the Head of Healthcare on provision of suction units and on use by staff of naloxone where indicated which they will want to address.

Director to Note

Emergency response

79. The investigator viewed body worn video camera footage of the emergency response. He noted that after staff entered the cell they began checking Mr Appleby for signs of life at 11.03am, but they did not commence CPR until three minutes later. The OM said that he was up to date in first-aid training but had never previously needed to give CPR. While we acknowledge his comments about being uncertain whether he was feeling Mr Appleby's pulse or his own pulse, we consider that it took staff too long to commence CPR. The Director will wish to remind staff about the need to commence CPR with as little delay as possible.

Inquest

80. An inquest into Mr Appleby's death held from 29 September to 9 October 2025 concluded that his cause of his death was sudden unexpected death in a man exposed to synthetic cannabinoid receptor agonists and protonitazene.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100