Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Singh, a prisoner at HMP Berwyn, on 23 November 2019

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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

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

Mr Matthew Singh died on 23 November 2019, from the toxic effects of psychoactive substances (PS) at HMP Berwyn. He was 26 years old. I offer my condolences to Mr Singh's family and friends.

Mr Singh had a history of substance misuse and was a frequent user of PS in custody. He received support from Berwyn's substance misuse service and, although they told him of the dangers, he continued to use PS.

My investigation found that Mr Singh received good support from the substance misuse service and staff responded appropriately when Mr Singh was found under the influence of PS.

I am concerned, however, about delays in discovering Mr Singh and in the emergency response. Staff failed to respond appropriately when they realised Mr Singh had covered the observation panel in his cell door and could not get a response from him. This led to a delay in discovering he was lying unresponsive on his cell floor.

Officers then delayed going into the cell because they sought permission from a senior officer, which was unnecessary. They failed to start resuscitation attempts until a nurse arrived five minutes later.

We cannot say whether the delays affected the outcome for Mr Singh, but we know that in an emergency situation a delay of a few minutes may be critical.

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 **September 2020**

Contents

Summary

Events

1. Mr Matthew Singh was serving a six-year sentence for burglary, robbery and assault. He was moved to HMP Berwyn on 4 October 2017.

2. Mr Singh had a history of drug misuse in the community and in prison. During his time at Berwyn, there were 18 occasions when Mr Singh was suspected of using psychoactive substances (PS). He told a substance misuse worker at Berwyn that he wanted to stop using drugs but he struggled to stop.

3. On 20 November 2019, Mr Singh was moved to Berwyn's Glyndŵr unit where he hoped the regime would help him prepare for his release from prison early in the New Year.

4. On the evening of 23 November, while doing a roll check, an operational support grade (OSG) found that Mr Singh's observation panel was covered. The OSG knocked on the door and called out to Mr Singh but got no reply. He continued with his roll check and then returned to Mr Singh's cell around eight minutes later. He saw through a gap in the paper that Mr Singh was lying unresponsive on his cell floor. He radioed a medical emergency code and two officers responded. After obtaining permission to enter the cell from the Night Orderly Officer, they went in. They checked Mr Singh for a pulse, but could not find one. A nurse arrived five minutes later and started cardiopulmonary resuscitation (CPR).

5. Paramedics arrived at 9.05pm, and continued with resuscitation attempts. The paramedics took Mr Singh to hospital where he was pronounced dead at 9.59pm.

6. A post-mortem examination and toxicology tests showed that Mr Singh died from cardiac arrest caused by the toxic effects of PS.

Findings

7. We found that Mr Singh received good support with his substance misuse issues. However, he continued to use PS despite being made aware of the dangers.

8. When the OSG failed to get a response from Mr Singh after finding his observation panel covered, he should have contacted the Night Orderly Officer for assistance.

9. The OSG correctly called a medical emergency code when he saw Mr Singh lying on his cell floor. When officers arrived, they asked for permission from the Night Orderly Officer before entering the cell. We consider that the officers should have gone into the cell straightaway when they saw Mr Singh was unresponsive.

10. Staff should have started CPR straightaway and not waited for the nurse to arrive.

Recommendations

- The Governor should ensure that staff follow the correct procedures when they find a prisoner has covered their cell observation panel.
- The Governor should ensure that all staff understand their responsibilities during a medical emergency, and in particular that:
    - officers fully understand the expectation that preservation of life must take precedence when considering entering a locked cell whether at night or at any other time; and
    - officers administer basic life support as needed until healthcare staff arrive.
- The Governor should share this report with the Night Orderly Officer and discuss the Ombudsman's findings with him.
- The Governor should share this report with the two officers who responded when Mr Singh was found on his cell floor and with the OSG and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Berwyn informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

12. The investigator obtained copies of relevant extracts from Mr Singh's prison and medical records. He interviewed 15 members of staff and one prisoner at Berwyn between 23 January and 20 February 2020.

13. Health Inspectorate Wales commissioned an independent clinical reviewer to review Mr Singh's clinical care at the prison. They jointly interviewed staff.

14. We informed HM Coroner for North Wales (East and Central) of the investigation. The Coroner sent us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. We contacted Mr Singh's next of kin to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. The family asked for the investigation to examine the help Mr Singh received for his drug use, the care he received for his diagnosed condition of Marfan syndrome and the events surrounding his death. These issues have been covered in the report.

Background Information

HMP Berwyn

16. HMP Berwyn is a newly built category C training prison near Wrexham. It opened in 2017 and is designed to hold 2106 men. Berwyn is comprised of three house-blocks or units – Alwen, Bala and Ceiriog – each divided into eight communities. Healthcare services are provided by Betsi Cadwaladr University Health Board.

HM Inspectorate of Prisons

17. The most recent inspection of Berwyn was in March 2019. Inspectors noted that 23% of prisoners reported that they felt unsafe, which was similar to other category C prisons. Inspectors noted that drugs were too readily available with 48% of prisoners saying that drugs were easy to get. Inspectors found that a substantial number of health emergencies were related to psychoactive substances (PS), with one death at Berwyn attributed to their use. Inspectors noted that Berwyn had taken a wide range of actions to address drug supply and demand and there was evidence that drug availability was reducing. Inspectors also found, however, that the substance use strategy was weak and was not supported by a plan to coordinate, drive and measure the effectiveness of actions taken. Inspectors found that the Glyndŵr progressive community provided a good intervention for more challenging prisoners.

Independent Monitoring Board

18. 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 28 February 2019, the IMB reported that the ongoing availability of illicit substances continued to cause concern. The IMB pointed out that use of substances often led to prisoners building up substantial debts leading to violent and aggressive behaviour.

Previous deaths at HMP Berwyn

19. Mr Singh was the fifth prisoner to die at Berwyn since it opened. Of the previous deaths, one was from the effects of PS and three were from natural causes. In our investigation into the previous PS-related death, we found that the prisoner continued to use PS despite being made aware of the dangers and despite losing privileges.

Psychoactive Substances

20. Psychoactive substances or PS (formally known as ‘new psychoactive substance’ 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.

21. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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 NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

22. HM Prison and Probation Service (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

23. On 19 January 2017, Mr Matthew Singh was remanded in prison custody charged with several offences, including burglary, robbery and assaulting a police officer. He was sent to HMP Leeds. Mr Singh was later sentenced to six years in prison. This was not his first time in prison.

24. On 23 February, Mr Singh was moved to HMP Lindholme. At a review with a drug support worker at Lindholme, Mr Singh said that he had started smoking cannabis at the age of 15 and from the age of 19 he had started to use crack cocaine and then heroin. He said that since coming to prison, he had used psychoactive substances (PS).

25. On 4 October, Mr Singh was moved to HMP Berwyn. During his reception health screen, Mr Singh told the nurse that he had Marfan syndrome (a hereditary disorder of the body's connective tissues which can cause heart defects). He said that he had a history of drug abuse and a nurse referred him to the prison's substance misuse service.

26. During 2017, Mr Singh was found under the influence of illicit substances, suspected to be PS, on 12 occasions. Each time, staff put Mr Singh on the basic level of the Incentives and Earned Privileges (IEP) scheme for 14 days. (The IEP scheme is used to encourage good behaviour where prisoners at the higher levels receive more privileges than those at lower levels. There are three levels: enhanced, standard and basic.)

27. On two occasions, a prison GP wrote to Mr Singh warning him of the physical dangers of illicit drug use and asking him to speak to the substance misuse team for support.

28. A case worker in Berwyn's substance misuse team, started meeting with Mr Singh in October 2017.

29. On 16 January 2018, a prison GP wrote to the cardiology unit at a hospital to ask that they assess Mr Singh. The prison GP said that Mr Singh had Marfan syndrome and was under review by cardiologists at a hospital he was at Lindholme. The prison GP said that Mr Singh had some symptoms of chest pain and an echocardiogram indicated that he had reduced left ventricular function (indicating that his heart was not working as efficiently as it should). The hospital replied to say that Mr Singh had been placed on the cardiology waiting list. (Mr Singh's post-mortem report noted that he had an MRI scan in July 2018 which indicated that his heart function was mildly reduced.)

30. On 31 March, a prisoner and friend of Mr Singh's, died from the effects of PS.

31. On 4 April, the case worker met Mr Singh. He noted that Mr Singh was upset about the death of Mr Singh's friend. Mr Singh told him that he was struggling with PS use.

32. There were four occasions during 2018 when Mr Singh was suspected of being under the influence of drugs; the last was in December 2018. During 2018, Mr Singh had a total of ten consultations with the case worker. One of the regular

themes of their meetings was Mr Singh's past use of drugs and his desire to stop using drugs in the future. They also spoke about his hereditary heart condition.

33. Mr Singh started attending a PS awareness group towards the end of 2018 and he began training to become a 'recovery champion'. Following a training session on 12 December, staff noted that:

> "Matthew attended today's session and engaged well. [He] spoke about the help he has received from [case worker] and how this has helped him become a recovery champion. [He] stated that he wants to help people and make a difference."

34. On 28 February 2019, the case worker saw Mr Singh for another counselling session. Mr Singh said that he had been going through an unstable period after making friends with some prisoners from Liverpool. He said they had been giving him 'Spice' (PS) and then watched and ridiculed him while he was under the influence of PS. The case worker noted that Mr Singh had a tendency to make progress in his sentence followed by a period of instability leading to substance misuse.

35. At a counselling meeting with the case worker on 28 May, Mr Singh said that he had recently started using a new illicit substance but he was unsure what it was. He said though that he intended to stop using the drug. They spoke about Mr Singh moving to a residential drug rehabilitation unit on release from custody and Mr Singh said that he saw that as a positive step forward. After the consultation, the case worker sent an email to a unit in Bradford for information on the process for referral and whether funding would be available for Mr Singh.

36. On 2 June, Mr Singh was observed to be apparently under the influence of drugs. His eyes appeared glazed, he was sluggish and his speech was slurred. This was the first time that Mr Singh was observed in this condition since December 2018.

37. On 23 July, the case worker met Mr Singh for a counselling session. He noted that Mr Singh was in good spirits and was focused on his release and thinking about where he wanted to settle as he realised that returning to Bradford would be a negative move as his associates there would hinder his long-term recovery. Mr Singh said that he continued to struggle with 'Spice' use which he said was only sporadic but he realised he was taking risks and was very aware of his friend's death in March 2018.

38. On 8 August, an officer told Mr Singh that she was his new key worker. (Under the key worker scheme, officers should spend an average of 45 minutes every week on key worker duties for each of their allocated prisoners, including having meaningful conversations to build rapport and discuss any ongoing issues.) Mr Singh said that he had been on Bala Unit since January and that it was okay and he had no issues. He said that he did not have a lot of time left to serve and he was keen to rebuild family ties so was hoping to receive some extended family visits.

39. From 14 August, Mr Singh stopped attending PS mentor training. The case worker was unsure why Mr Singh stopped attending but said that the substance misuse team believed that he had the skills for the role.

40. At a review with Mr Singh on 21 August, the case worker told Mr Singh that on his release he was likely to be placed at an approved premises in Leeds and there was a unit in Leeds that could offer him activities during the day. Mr Singh said that he would prefer that option rather than attending a drug rehabilitation unit as it was his intention to remain drug free on release.

41. On 23 August, the key worker made a note in Mr Singh's records to say that he was locked in his cell and he would not speak to her. Unit staff told her Mr Singh and his cellmate had apparently smoked some 'Spice' that they had been asked to look after for other prisoners. The 'Spice' was allegedly worth "a couple of grand" and that was why they would not come out of the cell.

42. On 3 September, Mr Singh was moved to Alwen Unit.

43. On 10 September, Mr Singh had a meeting with his key worker. Mr Singh said that he was happier now that he was on Alwen Unit. He was hoping to get a unit based job so he would not have to go off Alwen and get into conflict with other prisoners.

44. On 19 October, Mr Singh was again found under the influence of drugs, believed to be PS. He was noted to have glazed and red eyes, slow speech and slow reactions. (His IEP level was reduced back to basic, as happened each time he was found under the influence.)

45. A healthcare support worker spoke to Mr Singh the following day. He denied using any substance but she advised him of the risk to life of using unknown substances and told him to contact the substance misuse team if he needed extra support.

46. On 25 October, the key worker noted that Mr Singh was isolating himself in his cell as he did not want to get into trouble. He said that he was unable to leave the unit in any case, due to debts to other prisoners. The key worker noted that Mr Singh was not especially concerned about his debts as he would soon be out of prison. Mr Singh asked about a possible transfer to the Glyndŵr community on Bala Unit as it had a more structured regime. The key worker told Mr Singh that she would speak to the head of the Glyndŵr Unit, a Custodial Manager (CM).

47. The Glyndŵr Unit CM told the investigator that the Glyndŵr community was a progressive environment used to help prisoners who have a history of behaviour which stops them from progressing through their sentence as they should. He said that Glyndŵr held around half the number of prisoners of a standard unit and had a greater ratio of officers compared to standard. In addition, Glyndŵr used peer mentors to guide the prisoners on the unit.

48. On 29 October, the case worker went to see Mr Singh on Alwen Unit. Mr Singh said that he was 'partially' self-isolating and wanted to move to Glyndŵr ahead of moving to another prison for local release. He said that he had worked out that he had only 80 days left to serve of his sentence.

49. On 8 November, the Glyndŵr Unit CM told the key worker that Mr Singh had been accepted for transfer to Glyndŵr but there were no spaces available at that time so his move would be dependent on a one for one swap between units. The key worker told Mr Singh the news a few days later and explained that some of the men on Glyndŵr had completed their courses so they were ready to move off as soon as

new cells were arranged for them. The key worker noted that Mr Singh seemed happy with the news.

50. Mr Singh's offender supervisor told the investigator that he was involved in trying to arrange for Mr Singh to transfer to HMP Leeds ahead of his release to an approved premises in the Leeds area. He said that Leeds agreed to accept Mr Singh, but they would only take him once they had a place available. He said that at times, Mr Singh became irritated with the delay.

51. On 20 November, the offender supervisor told Mr Singh that Leeds had accepted him for transfer ahead of local release but, due to bed space availability, Leeds could not say when the transfer would occur. He noted that Mr Singh was relieved and happy to hear the news. He reminded Mr Singh that he needed to be "on his best behaviour" to ensure that his release was not affected.

52. Later that day, Mr Singh was moved to Glyndŵr.

23 November

53. An officer unlocked Mr Singh at around 9.00am on 23 November, and he came out of his cell and was mingling with other prisoners. The officer told the investigator that a short while later, he introduced himself to Mr Singh and asked him about his move to Glyndŵr. Mr Singh said that he had got himself into trouble on his previous unit and he wanted to make a fresh start as he was due for release in January. The officer said that he opened the exercise yard at 9.15am but as it was raining, Mr Singh was the only prisoner who went out.

54. Another officer told the investigator that he spoke to Mr Singh after he was unlocked in the morning and asked him how he was. He said that Mr Singh seemed his usual happy self and said that he did not have long left until his release date. The officer said that after using the exercise yard, he spent the rest of the morning mixing with other prisoners.

55. A third officer told the investigator that he briefly spoke to Mr Singh between around 8.30am and 9.30am. He told Mr Singh about Glyndŵr and the courses that he would be doing and the help that was available. He asked him why he had moved to Glyndŵr and he said that he had used 'Spice' in the past and he wanted to stay clean ahead of his release. The officer said that Mr Singh was happy with the move.

56. The third officer said that Mr Singh spoke to him again soon afterwards when he was going to exercise. He said that he had not received his prison shop order as that had been left on his previous unit. The third officer told him that he would arrange for that to be sent over to him. In a written statement made soon after Mr Singh's death, the officer wrote that Mr Singh already seemed settled and gave him no cause for concern.

57. At around 11.00am, staff locked prisoners back into their cells while the servery was prepared for the midday meal. Once Mr Singh had collected his meal, he was then locked back into his cell for the afternoon (on Glyndŵr, half of the prisoners have their association time in the morning and the other half have their association in the afternoon).

58. At around 4.45pm, an officer unlocked Mr Singh so he could collect his evening meal. The officer said that when Mr Singh came out of his cell he made a joke about the fact that Liverpool had scored a late goal in their match that day. In a written statement just after Mr Singh's death, the officer wrote that Mr Singh showed no signs of being at risk of self-harm or of being under the influence of any substance.

59. Another officer said that while Mr Singh was returning to his cell, he said that he did not have a kettle and he asked if he could collect some hot water, which he did. The officer said that he locked Mr Singh back into his cell. Once all the prisoners were in their cells, the officer made a roll count at around 5.15pm. When he looked into Mr Singh's cell, he was standing up making a hot drink.

60. An operational support grade (OSG), carried out the evening roll check (count of prisoners) and the CCTV footage shows that he reached Mr Singh's cell at 8.34pm. The OSG told the investigator that Mr Singh had obscured the observation panel with toilet paper. He tried to look through a small gap in the paper but he could not see Mr Singh. He knocked on the door several times and called out to Mr Singh, but he did not respond. He continued with his roll check.

61. The OSG returned to Mr Singh's cell at 8.42pm, and when he looked through the gap this time, he saw Mr Singh's body slumped in the toilet area. He banged on the door and called Mr Singh's name, but got no response. He radioed a medical emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties).

62. Two officers were on the third floor of Bala Unit when they heard the code blue. They arrived at the cell at 8.44pm and saw Mr Singh slumped on the floor. One of the officers radioed the Night Orderly Officer, for permission to enter the cell. The Night Orderly Officer gave permission and the two officers went into the cell (the CCTV recording shows that they went in at 8.45pm). The officers moved Mr Singh from the corner of the toilet area to the middle of the cell and turned him onto his side into the recovery position. One of the officers noted that when they moved Mr Singh onto his side blood and vomit came out of his mouth. The officer also noted that Mr Singh was very cold to the touch. The officer checked Mr Singh's neck and wrist for a pulse but could not find one. He shook Mr Singh and called his name but got no response.

63. The Night Orderly Officer arrived at 8.48pm. He said that one of the officers told him that he could not feel a pulse and that Mr Singh was cold. The Night Orderly Officer did not consider it appropriate to tell the officers to resuscitate Mr Singh.

64. A nurse told the investigator that when she heard the code blue call she was on the adjoining wing dealing with a code red incident. The CCTV recording shows her momentarily near Mr Singh's door before going to the dispensary to collect an emergency bag. She returned to Mr Singh's cell just before 8.49pm (she arrived 50 seconds after the Night Orderly Officer). The nurse asked the officers to move Mr Singh onto the landing. She said that Mr Singh was not breathing and he did not appear to have any signs of life. She also noted that his skin was blue and mottled. She said that she told the officers to start giving chest compressions while she tried to insert an airway tube to give Mr Singh oxygen: she said she was

unable to insert an airway as Mr Singh's jaw was clenched shut. While officers continued to give chest compressions, the nurse checked Mr Singh with a defibrillator. At each check, the defibrillator found that there was no shockable rhythm.

65. One of the officers told the investigator that when she moved Mr Singh onto his back to start resuscitation she had to straighten his legs and there was a cracking sound as she did so. She also said that while her colleagues were giving chest compressions, Mr Singh's legs were rising so she rested her weight on his legs to keep them down.

66. Ambulance paramedics arrived at 9.05pm and they continued with efforts to resuscitate Mr Singh. At 9.49pm, the paramedics took Mr Singh to hospital, where he arrived at 9.57pm. Mr Singh was pronounced dead by hospital staff at 9.59pm.

Contact with Mr Singh's family

67. Mr Singh had named his uncle as his next of kin and one of the prison's family liaison officers (FLOs) made a routine call to the local police to check if the address was safe to attend. The FLO and a colleague left Berwyn at around 11.30pm to drive to Mr Singh's next of kin's address and while on their way, the police telephoned to say that there were concerns about the address and they agreed to meet the FLO there. When the FLO arrived, she found that the front door was badly damaged and the home was unoccupied. The FLO spoke to the police about what she had found and they provided an alternative address. The FLO drove to the new address but received no answer when she knocked on the door. She then telephoned Mr Singh's next of kin's mobile telephone but without success. The FLO then returned to Berwyn, where she arrived at 5.30am on 24 November.

68. On return to Berwyn, the FLO tried again to telephone Mr Singh's next of kin and also telephoned two other numbers listed for another family member. None of her calls were answered. The FLO tried other numbers listed on Mr Singh's list of social contacts but again without success. At about 8.00am, the FLO spoke to Mr Singh's cousin and she informed her of the news. Mr Singh's cousin has since taken responsibility as Mr Singh's next of kin.

69. Berwyn contributed to the cost of Mr Singh's funeral in line with national instructions.

Support for prisoners and staff

70. The Night Orderly Officer debriefed the staff who were involved in the response when Mr Singh was found. The staff care team also offered support.

71. The prison posted notices informing other prisoners of Mr Singh'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 Singh's death.

Events following Mr Singh's death

72. Following Mr Singh's death, the North Wales Prison Investigation Team reviewed the CCTV footage to establish whether any of the other prisoners passed any items

to Mr Singh in the hours leading up to his death. The police observed three prisoners going to Mr Singh's locked door at various times between 4.06pm and 4.38pm. None of the prisoners were seen passing anything to Mr Singh and all three denied passing PS to him.

Post-mortem report

73. Toxicology tests showed that Mr Singh had taken PS before he died. His postmortem report notes that the drugs he had taken have a number of effects, including causing a rapid heart rate. The pathologist noted that Mr Singh's prolonged and recent use of PS could have exacerbated his underlying heart problems leading to cardiac arrest. The pathologist gave Mr Singh's cause of death as cardiac arrest caused by PS use.

Findings

Availability of PS at Berwyn

74. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS was a source of increasing concern in prisons and that PS use had a profoundly negative impact on the physical and mental health of prisoners. Mr Singh's death is an example of the dangers of PS, and illustrates how prisons must do all they can to eradicate its use.

75. HMIP reported in March 2019 that 48% of prisoners at Berwyn said that it was easy to get illicit drugs at the prison. HMIP found that while Berwyn had taken a wide range of actions to address drug supply and demand with evidence that drug availability was reducing, it also found that the substance use strategy was weak and not supported by a plan to coordinate, drive and measure the effectiveness of actions taken.

76. Berwyn had a Substance Misuse Strategy issued in April 2018 that was designed to deal with PS use in a supportive manner, including educating prisoners about the dangers of PS, while also aiming to reduce supply through targeted and intelligence led initiatives.

77. In April 2019, HM Prison and Probation Service (HMPPS) published the National Drug Strategy. It set out plans to reduce substance misuse in prisons by providing direction to assist all stakeholders along with detailed guidance for prisons to help them identify issues and share best practice.

78. In relation to reducing the supply of drugs, the HMPPS strategy says: "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

79. In January 2020, Berwyn implemented a new Drug Strategy with an associated action plan to address the recommendations made by HMPPS. The revised policy was in consultation at the time of Mr Singh's death, but had not been formally published. The revised strategy and action plan are more clearly focused on reducing supply and demand for drugs and in building recovery for those who use illicit substances. Information from Berwyn's monthly intelligence meeting is used to help focus on emerging areas of risk. We consider that Berwyn has taken appropriate action in response to the HMPPS National Drug Strategy. We therefore make no recommendation.

OSG's response to covered observation panel

80. Mr Singh's observation panel was covered with toilet paper when the OSG carried out his roll check at 8.34pm. He looked through a gap in the paper, but could not see Mr Singh. He knocked several times and called out to Mr Singh but got no response. He carried on with his roll check and returned to Mr Singh's cell eight minutes later, which is when he saw him lying on the cell floor.

81. The prison's Local Security Strategy says, 'Any prisoners who are blocking an observation panel must be instructed to clear the obstacle immediately. If this instruction is not complied with the Night Orderly Officer should be informed accordingly.' We consider that the OSG did not comply with this instruction. He should have contacted the Night Orderly Officer when he failed to get a response from Mr Singh. We make the following recommendation:

The Governor should ensure that staff follow the correct procedures when they find a prisoner has covered their cell observation panel.

Delay in entering cell and starting CPR

82. When two officers responded to the code blue they saw Mr Singh lying unresponsive on his cell floor and they sought permission from the Night Orderly Officer to enter the cell.

83. Prison Service Instruction (PSI) 24/2011, Management and Security of Nights, says that under normal circumstances, the Night Orderly Officer must give permission for a cell to be unlocked and that night staff should not take action that they feel would put themselves and others in unnecessary danger. However, the PSI also states that preservation of life must take precedence and, where there appears to be immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer.

84. There were two trained officers at Mr Singh's door as well as the OSG and we consider that the staff should have gone into the cell immediately without seeking permission from the Night Orderly Officer.

85. When the officers entered the cell, they checked Mr Singh for signs of life but found none. Neither of the officers started cardiopulmonary resuscitation (CPR) and nor did the Night Orderly Officer when he arrived almost three minutes later. It was only when the nurse arrived a further 50 seconds later that she told staff to start CPR.

86. The investigator asked the officers why they did not start CPR before a nurse arrived. One of the officers said that he was new in service and was in shock and he did not think about starting CPR until instructed to do so. The other officer said that when the nurse instructed them to start CPR, they had only just completed their checks for signs of life.

87. It is possible, given the descriptions of Mr Singh's body, that the delay in starting CPR made no difference to the outcome. However, it is important that officers start CPR when they find a prisoner unresponsive. Healthcare staff may decide that CPR would be futile and that it should not continue, but this is a judgement that needs to be made by a trained healthcare professional and not by officers.

88. In this case, the nurse asked staff to start CPR, which ambulance paramedics continued. The officers should have started CPR straightaway, as soon as they realised that Mr Singh was unresponsive. We cannot say whether the delay affected the outcome for Mr Singh, but we know that in an emergency situation, a delay of a few minutes may be critical.

89. We make the following recommendation:

The Governor should ensure that all staff understand their responsibilities during a medical emergency, and in particular that:

- **officers fully understand the expectation that preservation of life must take precedence when considering entering a locked cell whether at night or at any other time; and**
- **officers administer basic life support as needed until healthcare staff arrive.**

Clinical care

90. The clinical reviewer found that Mr Singh's care at Berwyn was equivalent to that which he could have expected to receive in the community. The reviewer noted that on his transfer to Berwyn, Mr Singh received a thorough assessment of his drug use and contact with his substance misuse worker continued throughout his time at Berwyn. The reviewer found that Mr Singh's relationship with the case worker was positive. The reviewer noted that Mr Singh was given information on the health risks of using illicit drugs, including those associated with Marfan syndrome, and that his use of substances reduced significantly during this time. The reviewer also noted, however, that despite his best efforts and intentions, Mr Singh continued to use PS.

91. The clinical reviewer also noted that Mr Singh should have had a cardiovascular annual review in November 2019, but this had not taken place before his death. The reviewer also commented on the delay in starting efforts to resuscitate Mr Singh.

Learning from this report

92. We consider it important that staff should learn the lessons from this report. We therefore recommend:

The Governor should share this report with the Night Orderly Officer and discuss the Ombudsman's findings with him.

The Governor should share this report with the two officers who responded when Mr Singh was found on his cell floor and with the OSG and arrange for a senior manager to discuss the Ombudsman's findings with them.

Inquest

93. An inquest into Mr Singh's death held on 3 November 2025 concluded that his cause of his death was cardiac arrest following synthetic cannabinoid abuse.

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