Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Liam Turner, a prisoner at HMP Manchester, on 6 December 2021

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 Liam Turner died on 6 December 2021 from the toxic effects of psychoactive substances (PS), combined with prescription drugs at HMP Manchester. He was 31 years old. I offer my condolences to Mr Turner's family and friends.

Mr Turner had a long history of substance misuse. Despite the best efforts of the prison's Drug and Alcohol Recovery Service (DARS) to warn him of the dangers, he continued to use drugs. The clinical reviewer was satisfied that Mr Turner received appropriate support with his substance misuse and mental health issues.

However, I am concerned about delays in Mr Turner being seen by healthcare staff on the day he died. When an officer realised that Mr Turner was under the influence of drugs, he did not ask healthcare staff to check on him and it was another 30 minutes before they were contacted. Also, when Mr Turner became unresponsive, officers failed to call a medical emergency code immediately.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **December 2022**

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Summary

Events

1. In April 2014, Mr Liam Turner was sentenced to nine years in prison for attempted murder and grievous bodily harm. He was released on licence in November 2018 but was recalled to prison that month after taking drugs. He was moved to HMP Manchester on 20 September 2021.

2. Mr Turner had a long history of substance misuse. He engaged with the prison's Drug and Alcohol Recovery Service (DARS) but, despite their best efforts, he continued to use drugs, including psychoactive substances (PS).

3. At 10.30am on 6 December, an officer carried out a fabric check in Mr Turner's cell and thought she could smell burning. She searched the cell but found nothing. She saw Mr Turner on the wing, and he seemed fine.

4. At 2.00pm, an officer unlocked Mr Turner for exercise which he declined. The officer, who could also smell burning, thought that Mr Turner was under the influence of drugs. He was sitting on his bed but was slumped to one side. The officer went to collect Mr Turner's property from his previous wing as he knew he had been asking for it. He then returned to the wing office.

5. At 2.30pm, a supervising officer (SO) heard staff saying that Mr Turner was under the influence of drugs. The SO asked an officer to call healthcare staff. Healthcare staff were attending to another call but made their way to Mr Turner at approximately 2.50pm.

6. At around the same time, two officers went to check on Mr Turner. A third officer was already at the cell door and the three of them went in. Mr Turner was now lying on his bed and was unresponsive. The officers were not sure if he had a pulse. The one officer with a radio asked for healthcare staff to attend. At 2.54pm, an officer who was on her way to Mr Turner's cell called a medical emergency code blue when she heard over the radio that Mr Turner was not breathing. At 2.56pm, control room staff called for an ambulance.

7. Healthcare staff arrived and started cardiopulmonary resuscitation (CPR). Paramedics continued resuscitation attempts but at 3.49pm, they declared that Mr Turner had died.

8. The post-mortem concluded that Mr Turner died of PS toxicity combined with dihydrocodeine, mirtazapine and promethazine (medications he was prescribed).

Findings

9. We are concerned about the ready availability of PS at Manchester. However, we also acknowledge the challenges of tackling drug supply in a busy city centre prison. We note that Manchester has a comprehensive drug strategy in place and is taking steps to tackle PS supply and demand. We make no recommendation.

10. The clinical reviewer found that Manchester provided appropriate care to Mr Turner for his substance misuse and mental health issues. The clinical reviewer was also content that Mr Turner received appropriate prescribed medication.

11. We are concerned that the officer, who thought Mr Turner was under the influence of drugs, did not notify healthcare staff. Later, when Mr Turner became unresponsive, officers failed to use a medical emergency code and failed to start CPR until a nurse arrived. We are also concerned that control room staff did not call for an ambulance immediately in response to the code blue.

Recommendations

- The Governor should ensure that when staff suspect that a prisoner is under the influence of psychoactive substances, they contact healthcare staff and monitor the prisoner until healthcare staff arrive.
- The Governor should ensure that staff are aware of their responsibilities during medical emergencies including that:
    - staff who discover the emergency should call the appropriate medical emergency code immediately and start CPR if the prisoner is not breathing; and
    - control room staff should call for an ambulance immediately when a medical emergency code is called.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Turner's prison and medical records.

14. The investigator interviewed ten members of staff at HMP Manchester during March 2022.

15. NHS England commissioned a clinical reviewer to review Mr Turner's clinical care at the prison. He jointly interviewed the clinical staff with the investigator.

16. We informed HM Coroner for Manchester City of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent him a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Turner's next of kin, his foster parent, to explain the investigation and to ask if she had any matters, she wanted us to consider. She asked for a copy of our report but did not raise any issues.

18. Mr Turner's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

20. An inquest was held on 29 January 2024, and concluded Mr Turner's death was drug related.

Background Information

HMP Manchester

21. HMP Manchester is a Category B training prison. There is a Category A unit for prisoners posing greater security risks. The prison holds up to 727 prisoners spread across nine residential units, a segregation unit, specialist intervention unit and a healthcare unit. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing care.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Manchester was in September 2021. Inspectors reported that the security team remained well-resourced and was appropriately focused on addressing the supply of illicit items and associated violence, the prison's key risks.

23. A dedicated senior leader oversaw the local drug strategy. There were close working relationships with the health and substance misuse service providers, but the monthly drug strategy meeting was poorly supported by staff from other key departments such as the security and residential departments and the offender management unit. The Governor had held a drug summit during which staff and prisoners were consulted on how to reduce the supply of drugs and leaders had developed a promising action plan.

24. Drug testing had restarted in April 2021, appropriately focused on suspicion testing. Data from results from April to July, indicated a positive test rate of 23.4%, just under half of which related to the use of psychoactive substances (PS). However, testing staff were not scheduled enough time to follow up drug results, which meant that time limits for processing positive test results were sometimes exceeded, meaning no action was taken against the prisoner. For example, in August, disciplinary charges were not brought in 60% of positive test results because the results had not been processed on time, which undermined the use of testing as a deterrent.

Independent Monitoring Board

25. 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 February 2022, the IMB reported that Delphi Medical was the independent provider of drug and alcohol treatment, ensuring clinical and psychosocial provision as part of a recovery pathway. They also provide the DARS programme and ran a recovery unit located on G Wing. Wing staff attended weekly progress meetings to help develop positive relationships between DARS, wing staff and those who live on the unit.

Previous deaths at HMP Manchester

26. Mr Turner was the thirteenth prisoner to die at HMP Manchester since December 2019. Of the previous deaths, two were self-inflicted, seven were from natural

causes, two were unascertained and one was drug-related. We have previously made recommendations about delays in staff using medical emergency codes.

Psychoactive substances (PS)

27. PS, previously known as 'legal highs', are a 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 dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

29. In April 2014, Mr Liam Turner was sentenced to nine years in prison for attempted murder and grievous bodily harm. He was released on licence in November 2018 but was recalled to prison that month after taking drugs.

30. Mr Turner had a long history of self-harm by cutting and by tying ligatures around his neck. Staff supported him using suicide and self-harm procedures (known as ACCT) on multiple occasions. He also had a history of substance misuse and drug debts, which resulted in alleged threats from other prisoners. He was moved multiple times and also spent time isolating in his cell. He was a challenging prisoner to manage as he frequently threatened to harm himself, and to harm staff if they refused to agree to his requests.

HMP Manchester

31. Mr Turner was moved to HMP Manchester on 20 September 2021. The reception nurse noted his history of drug use and self-harm and referred him to the mental health and substance misuse teams. A mental health nurse saw Mr Turner and noted that he had no formal mental health diagnosis but had emotional unstable personality disorder.

32. On 21 September, a member of the substance misuse team contacted Mr Turner. He did not wish to engage with their services, but she explained how he could do so if he changed his mind.

33. That day, a prison GP prescribed Mr Turner's medication, which included dihydrocodeine (an opiate painkiller) and mirtazapine (an antidepressant).

34. On 24 September, Mr Turner referred himself to the substance misuse team and from there, he was referred to the prison's Drug and Alcohol Recovery Service (DARS).

35. Staff submitted several intelligence reports about Mr Turner during his time at Manchester, and some of these related to suspected drug use. On 25 September, Mr Turner questioned staff about exercise shifts and duties and was suspected of wanting to move or receive an illicit parcel. That day, he made superficial cuts to his arms and staff started ACCT monitoring.

36. On 26 September, staff moved Mr Turner to the Care and Separation Unit (CSU) after he started a dirty protest and tied a ligature. He was there for one night before returning to H Wing.

October 2021

37. On 5 October, a nurse carried out a comprehensive depression assessment and assessed that Mr Turner had mild depression. She referred him for a medication review and on 8 October, a GP increased Mr Turner's mirtazapine. He also prescribed zopiclone to help Mr Turner sleep. That day, staff stopped ACCT monitoring.

38. On 7 October, Mr Turner was moved to G Wing, the prison's drug recovery wing. The next day, a DARS worker carried out an introduction assessment with Mr Turner and made a further appointment for 12 October.

39. On 12 October, Mr Turner told the DARS worker that he was using drugs and Mr Carey gave him comprehensive harm minimisation advice. The advice included information about the dangers of using drugs in combination with medication. They met again two days later to focus on drug education and Mr Turner said he had been using subutex (a strong opioid painkiller) daily. The DARS worker told him it was risky and advised him of the treatment pathways available. He also decided to work closely with the mental health team to try and manage Mr Turner's risks.

40. On 18 October, a nurse saw Mr Turner and discussed the risks associated with subutex, including overdose.

41. On 21 October, Mr Turner was moved from G Wing to D Wing. It is unclear why, but Mr Turner's history suggests it was because of drug debts.

42. On 27 October, Mr Turner told staff that his grandmother had died, and he was having panic attacks, so staff restarted ACCT procedures. (It transpired that his grandmother had in fact died at least six months to a year before.) A prison GP reviewed Mr Turner's medication and replaced zopiclone with promethazine (a sedating antihistamine).

43. The next day, staff increased ACCT observations after Mr Turner threatened to make a ligature.

November 2021

44. On 1 November, Mr Turner was moved from D Wing to A Wing. He had previously said he was happy on D Wing, but then changed his mind and said he had felt there was no support when he needed it and that he was under threat.

45. The next day, Mr Turner asked the DARS worker if he could be prescribed morphine and be returned to G Wing. He was refused morphine and the DARS worker said he would discuss a wing move with him at his next appointment.

46. On 5 November, a prison GP agreed to prescribe zopiclone again for another short period. Mr Turner also made threats to kill himself and said he was in debt on the wing. He was put on a constant watch and moved from A Wing to a cell on B Wing, where staff could observe him.

47. The next day, at an ACCT review, Mr Turner said he had been using 'Spice' (a PS). He had got into debt on his previous wing and was concerned the debt could follow him. Staff decided he should be followed up by the DARS team, and he had an appointment with them the next day.

48. On 7 November, an officer submitted an intelligence report as a suspected drugs facilitator had 'made a beeline' for Mr Turner. That day, Mr Turner told the DARS worker he was using PS. Mr Carey warned him about the dangers and also that fentanyl (a strong opioid painkiller) was circulating in the prison which came with overdose risks.

49. On 8 November, a nurse dispensing medication noticed that Mr Turner seemed to be under the influence of drugs. She did not give him his prescribed medication and told the DARS team. She contacted Mr Turner and gave him advice about the dangers of using drugs and the pharmacy wrote to Mr Turner to tell him his mirtazapine would be stopped or reduced as a precaution if he continued to take drugs. The next day, after a medication review, the pharmacy sent Mr Turner a letter, warning him about the risk of using PS with mirtazapine.

50. On 12 November, the DARS worker gave Mr Turner harm reduction advice. He told him that if he was going to continue to use, he should do so in small amounts, spread out and never when sleepy or tired. They discussed Mr Turner connecting with peer support on the wing and Mr Turner was open to trying it. The DARS worker sent a referral.

51. On 13 November, Mr Turner said he had overheard a conversation suggesting he was in danger. Mr Turner told staff he did not feel in immediate danger but would like to move wings. An officer told Mr Turner this would be looked into and submitted an intelligence report the next day.

52. The intelligence assessment said that while it was realistic that Mr Turner could be in debt because of drug use, he had not given any names, so the information was not deemed credible. Wing staff told Mr Turner a move would be considered if he engaged with DARS. The assessor was confident from Mr Turner's record that he was doing okay on B Wing and would tell staff if he was under threat.

53. That day, Mr Turner made a phone call to his friend and talked about some hooch (illegally brewed alcohol) which had 'blown his head off'. Staff submitted an intelligence report and the assessor arranged for a wing search by dogs and for Mr Turner to be refused his medication.

54. Mr Turner also told his friend about an altercation with another prisoner which had almost ended in a fight, but which they resolved between them. Staff submitted an intelligence report and the assessor concluded that wing managers should be advised of the potential for violence involving Mr Turner.

55. On 15 November, Mr Turner said at an ACCT review that he was not using drugs and wanted to move to G Wing. Staff told him he would have to demonstrate commitment to recovery and connect with peer support on his current wing first.

56. On 17 November, Mr Turner said another prisoner was spreading rumours that he did not pay his debts in an effort to get him 'cut'. Staff submitted an intelligence report, but the assessor concluded it was not proved that the other prisoner was trying to get Mr Turner into trouble.

57. On 18 November, the DARS worker reminded Mr Turner that he would need to connect with peer support if he still wanted to move wings. Shortly after this appointment, Mr Carey was on leave for two weeks. While the DARS worker told the interviewer that he usually saw the men in his caseload every four to six weeks, he saw Mr Turner a little more frequently.

58. On 22 November, a clinical support worker discussed again with Mr Turner the dangers of mixing drugs. She recorded that he had had a good week. That day, staff stopped ACCT monitoring. Mr Turner had made friends on the wing, was engaging with his family, and generally doing well.

59. On 24 November, Mr Turner showed staff he had cut his arm and said he wanted another TV after his had been stolen. Staff thought he had sold it and said that until this was confirmed, he would not be getting another. He demanded to be taken to the healthcare unit and misused his cell bell. The officer submitted an intelligence report, noting that Mr Turner had just stopped being monitored under ACCT procedures and that he was manipulative when he wanted something. The intelligence report assessor concluded that CCTV footage should be watched to find out what happened to his TV and that the wing manager should be informed. Staff reopened Mr Turner's ACCT.

60. On 24 November, a prison GP increased Mr Turner's mirtazapine dose and recorded that Mr Turner said his mood was low. Mr Turner also wanted an increase of dihydrocodeine. The GP did not increase the dose and outlined the risks of drug intolerance while using an opioid painkiller. The GP increased Mr Turner's dose of etoricoxib (a non-opioid painkiller) instead. (Mr Turner was prescribed 90mg of dihydrocodeine twice a day. Prescribing guidance indicates that 60mg-120mg twice a day is an acceptable range.)

61. On 29 November, staff closed Mr Turner's ACCT as they considered he had settled again and planned for him to move back to G Wing to engage with the drug recovery service.

December 2021

62. On 1 December, Mr Turner told staff he had been accused of being an informer at HMP Parc. He said he wanted to move to another wing, even though he said he had not been threatened. When staff refused to move him, Mr Turner said he wanted to be monitored under ACCT procedures and would cut himself, which he later did. Staff reopened his ACCT and submitted an intelligence report. The assessor considered that no further action was necessary.

63. Between 29 November and 1 December, Mr Turner was moved to G Wing.

64. On 2 December, Mr Turner tied a ligature tightly around his neck and rang his cell bell. He told an officer he had done this because another prisoner was threatening him. Staff submitted an intelligence report, and the assessor concluded Mr Turner was being supported by the ACCT process and that there was no intelligence to suggest the named prisoner was threatening Mr Turner. The assessment also noted that the named prisoner was now on the same wing as Mr Turner.

65. That day, a Supervising Officer (SO) chaired a case review. Mr Turner said that he thought tying a ligature around his neck was the best way of getting a wing move. The SP told Mr Turner he could discuss a potential wing move at the next day's case review.

66. On 3 December, a SO chaired a case review. Mr Turner said he had made the ligature to secure a move from G Wing because he felt under threat (although he admitted that the person he felt intimidated by had not actually made any direct threats). Staff told him a wing move was not possible as they wanted to keep him in a safer cell and there were none available on other wings. Mr Turner said that if he was staying where he was, he wanted to be under constant watch (as part of ACCT monitoring) so someone was always outside his door. The SO noted this as manipulative behaviour.

67. A nurse, who was at the ACCT review, asked Mr Turner why he was repeatedly getting into drug debts and whether he thought counselling might help. Mr Turner agreed to counselling and a note was made to refer him although it was thought this could take some time. Mr Turner became aggressive at the end of the meeting and the decision was taken to keep him under constant watch in case his behaviour escalated. It was hoped a safer cell would be available on E Wing the next day. He was to stay in anti-rip clothing and bedding but be given his vape pen back.

68. On 4 December, a SO chaired another case review. Mr Turner was well and keen not to be monitored constantly and not to have to wear anti-ligature clothing. They told Mr Turner that the plan was to move him to a safer cell on E Wing but pointed out that with every move, he showed the same pattern of behaviour and got into debt. Mr Turner said he understood and that he would speak to staff if he had further problems but that he saw this as a fresh start. He would have a TV in the safer cell but was warned that as he was on the basic Incentives and Earned Privileges (IEP) level, the wing SO could remove it if his behaviour declined. Staff reduced observations to one an hour, with three quality conversations a day. Staff moved Mr Turner to a safer cell on E Wing.

Events of 6 December

69. Shortly after 8.20am on 6 December, Officer A unlocked Mr Turner for his medication. She had no concerns.

70. At 10.30am, Mr Turner rang his cell bell to ask if he was going to be unlocked. Officer A was on her way to unlock him. He said he wanted to speak to Nurse B, who was on the wing with another prisoner.

71. Nurse B spoke to Mr Turner for around ten minutes. She said he was chatty and engaged. He talked about wanting a fresh start and not wanting to take PS. They discussed the harm that drugs can cause and the future.

72. At around 11.55am, Officer A went to Mr Turner's cell to do a fabric check. He was not in the cell. She thought she could smell burning but there was nothing burning in sight and after checking the cell, she found nothing of concern. She found Mr Turner on the wing and asked him if he was okay. He said he was, and she had no concerns about him at that time.

73. At approximately 2.00pm, Office C began unlocking prisoners for exercise. He decided to unlock Mr Turner last because he did not know him and heard he had been violent recently. (Any altercation would delay the other prisoners getting out for their exercise.)

74. When Officer C asked Mr Turner if he wanted exercise, Mr Turner said no. The officer could smell smoke and thought Mr Turner was under the influence of drugs. He was sitting on his bed, with his feet on the floor but was slumped to one side.

75. Officer C went to G Wing to collect Mr Turner's property as he knew Mr Turner had been asking a colleague for it. At approximately 2.30pm, prisoners were returning from exercise and the officer mentioned to Officer D that he thought Mr Turner was under the influence of drugs.

76. A SO overheard the conversation and told Officer D to contact healthcare staff. When the officer called them, he was told they were not available. A message was passed to a nurse, who called back at around 2.50pm. The nurse said she was told Mr Turner was semi-conscious and she said she would make her way over.

77. Around 2.30pm, a worker from the Education Department went to tell Mr Turner that a tutor was going to visit him the next day. Mr Turner was on his bed, with his bottom partially exposed and was very still. She told two unnamed officers what she had seen. They told her that healthcare staff were coming within the next hour.

78. A short time later, Officer E from the safer custody team went to Mr Turner's cell to speak to him about an allegation that he had spat at an officer. Wing staff had told him that Mr Turner was under the influence of PS and that healthcare staff had been called. The officer said he could smell PS and Mr Turner was sitting on his bed, with his head to one side. He called to him but got no response.

79. Officers C and D then arrived at Mr Turner's cell to monitor him until healthcare staff arrived. Officer E unlocked the cell door when he heard his colleagues coming and they went in. Mr Turner was now lying on the bed.

80. Mr Turner had vomited a thin, brown substance onto the bed and smoking paraphernalia was next to him. Officer D checked for a pulse. What he thought he could feel was faint, so he asked Officer C and Officer E to check, but they were not certain either. Officer C was the only one of the three officers carrying a radio and he used it to call for healthcare staff to attend.

81. As the officers were not certain Mr Turner had a pulse, they moved him to the floor so they could start CPR. Then two nurses arrived. Officer D asked another Officer F, who had arrived at the cell, to call a code blue as he was not carrying a radio.

82. Officer F had already called a code blue at 2.54pm before she got to the cell because she had heard someone say that Mr Turner was not breathing, and she had not heard a code blue by that point. At 2.56pm, the control room called an ambulance.

83. Nurse Spirou started CPR and when officers took over, she inserted an i-gel and attached an ambu bag and oxygen. She said that Mr Turner was still warm. A nurse requested a defibrillator, a suction machine and oxygen cylinders. The defibrillator found no shockable rhythm.

84. Both nurses administered naloxone (a drug which can rapidly reverse opioid overdose impacts) twice in a five minute period, but it had no effect. The defibrillator continued to advise 'no shock'.

85. At 3.05pm, paramedics arrived at the prison and were escorted to Mr Turner's cell where they continued resuscitation efforts. (Two rapid response vehicles and another ambulance arrived shortly afterwards.) Resuscitation attempts were not successful and at 3.49pm, paramedics declared that Mr Turner had died.

Contact with Mr Turner's family

86. On 6 December, the prison appointed two family liaison officers.

87. Mr Turner's funeral was held on 19 January 2022. The prison contributed to the costs of the funeral in line with national policy.

Support for prisoners and staff

88. After Mr Turner's death, a Custodial Manager 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. Healthcare managers debriefed the nurses separately.

89. The prison posted notices informing other prisoners of Mr Turner'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 Turner's death.

Post-mortem report

90. The post-mortem report concluded that Mr Turner died of PS toxicity, combined with dihydrocodeine, mirtazapine and promethazine. It noted that the three medications can have a depressant effect on the central nervous system when combined and PS may also have depressant impacts.

91. Mr Turner was prescribed dihydrocodeine, mirtazapine and promethazine. Dihydrocodeine was found at a higher level than expected for therapeutic use but at the lower end of levels associated with fatality. (The toxicologist noted that there may have been a cumulative effect if Mr Turner had used dihydrocodeine regularly.) Mirtazapine was found at a higher level than therapeutic use but much lower than levels associated with fatality. Promethazine was at a level consistent with therapeutic use.

Findings

Drug supply at Manchester

92. Mr Turner died after taking psychoactive substances (PS). We are concerned about the ready availability of PS at Manchester. However, we acknowledge the difficulty of preventing drugs getting into a busy city centre prison.

93. We are aware that Manchester has a detailed substance misuse strategy which is regularly updated. As well as detailing a range of measures to detect and prevent drugs entering the prison, it also has a designated section on tackling PS use. This includes details of a PS awareness workshop which is aimed at educating users to deter further use.

94. At the last HMIP inspection in September 2021, inspectors reported that the Governor had held a consultation forum known as the 'drug summit' during which staff and prisoners were consulted on how to reduce the supply of drugs. Following this, managers had developed an effective action plan. In view of the steps that the prison is taking to tackle drug supply, we make no recommendation.

Response when Mr Turner was found under the influence of drugs

95. The prison's substance misuse strategy says that prisoners who are suspected of being under the influence of PS or other drugs should be reported to healthcare staff immediately. At interview, the wing SO confirmed that healthcare staff should be asked to check on prisoners who are suspected of being under the influence of drugs. He also said that he would expect staff to check on prisoners while they were waiting for healthcare staff to arrive.

96. Although we recognise that Mr Turner was responsive when Officer C spoke to him at around 2.00pm, he should have reported to healthcare staff that he suspected Mr Turner was under the influence of drugs. It was not until 2.30pm that an attempt was made to contact healthcare staff. Officers did not then go to check on Mr Turner until around 2.50pm. Staff should have monitored Mr Turner while they were waiting for healthcare staff to arrive. We recommend:

    The Governor should ensure that when staff suspect that a prisoner is under the influence of psychoactive substances, they contact healthcare staff and monitor the prisoner until healthcare staff arrive.

Emergency response

97. PSI 03/2013, Medical Emergency Response Codes, requires all prisons to have a medical emergency response code protocol in place, the purpose of which is to ensure a timely, appropriate and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff, including healthcare staff, are alerted, the correct equipment is brought, and an ambulance is called immediately.

98. There was a delay in calling an emergency code when staff discovered Mr Turner unresponsive. The only officer who had a radio, Officer C, called for healthcare

assistance rather than a medical emergency code blue. The code was not called until a few minutes later, by an officer on her way to the cell.

99. The three officers who found Mr Turner unresponsive said that they were unsure whether Mr Turner had a pulse. They said that once they realised that he had no pulse, they moved him to the floor so that they could start CPR. They said that at that point, nurses arrived.

100. A nurse said that when she arrived, Mr Turner was on the floor and no one was doing CPR. She said officers seemed unsure about what to do and so CPR was not started until she and her colleague arrived.

101. We recommend:

The Governor should ensure that staff are aware of their responsibilities during medical emergencies including that:

- **staff who discover the emergency should call the appropriate medical emergency code immediately and start CPR if the prisoner is not breathing; and**
- **control room staff should call for an ambulance immediately when a medical emergency code is called.**

Clinical care

Substance misuse care

102. Mr Turner was under the care of the DARS team at Manchester and also spent time on the drug recovery wing. There was evidence that DARS workers gave Mr Turner harm minimisation and education sessions and regularly warned him of the danger of using PS and other drugs. The clinical reviewer had no concerns about the substance misuse care Mr Turner received at Manchester.

Prescribed medication

103. The post-mortem report concluded that Mr Turner died from PS toxicity in combination with dihydrocodeine, mirtazapine and promethazine (all prescribed to him). The clinical reviewer was satisfied that medication reviews were thorough and there were no issues with the prescribing.

Mental healthcare

104. The clinical reviewer had no concerns about the mental healthcare Mr Turner received at Manchester. Although he did not have a formal mental health diagnosis, Mr Turner harmed himself when stressed and drug debts were the main cause of his stress. The mental health nurses worked alongside the DARS team and also attended Mr Turner's ACCT reviews, even though he was not officially on their caseload.

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Independent Investigations

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