Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marlin Burrows, a prisoner at HMP Garth, on 16 August 2022

A report by the Prisons and Probation Ombudsman

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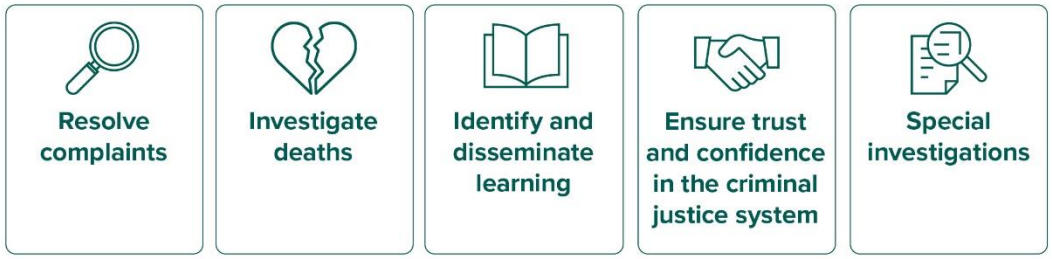
OUR VISION

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 Marlin Burrows died on 16 August 2022 while a prisoner at HMP Garth. The cause of his death has not yet been ascertained but post-mortem toxicology results identified that he had used amitriptyline (which he was not prescribed but is commonly used for depression and neuropathic pain) before his death. Other illicit prescription drugs were also found in his cell. Mr Burrows was 45 years old. I offer my condolences to his family and friends.

There is substantial evidence that Mr Burrows often used psychoactive substances (PS) in prison. I am concerned about the ease and frequency with which Mr Burrows was seemingly able to obtain PS and illicit prescription drugs.

Prison staff, under the instruction of healthcare colleagues, monitored Mr Burrows, whom they suspected was under the influence of psychoactive substances, for 15 hours before he was found unresponsive and subsequently died. I am deeply troubled that healthcare staff did not escalate concerns about his condition during this prolonged period of time and did not refer him to hospital sooner. While we cannot know whether or not Mr Burrows' death would have been prevented if he had been transferred to hospital earlier, the failure of healthcare staff to escalate his care promptly reflects a serious failure in care provision.

HM Inspectorate of Prisons was also concerned about the availability of illicit drugs at Garth. The prison has a drugs supply reduction strategy but there needs to be more focus not only on stopping the diversion and trading of prescription drugs but in ensuring that the care of prisoners under the influence of illicit substances is escalated promptly.

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 **April 2024**

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Summary

Events

1. Mr Marlin Burrows had been in prison since 21 March 2018. He was transferred to HMP Garth on 19 October of that year. He had a history of self-harm, substance misuse, anxiety and depression.

2. Prison staff found Mr Burrows under the influence of illicit substances, mainly believed to be psychoactive substances (PS), on multiple occasions during his time at Garth. At 11.19am on 15 August 2022, staff radioed a medical emergency code blue after they found him unconscious, lying on his cell floor. They considered that he was under the influence of PS. However, they also found illicit prescription drugs in his cell. They agreed with healthcare staff to monitor him by conducting welfare checks every ten minutes for an hour and then to review him again.

3. Welfare checks continued throughout the day and night for around 15 hours, during which time prison staff mostly checked on Mr Burrows by looking through his cell door observation panel and occasionally going into his cell. Healthcare staff attended at 2.00pm, 5.00pm, 8.14pm and 11.16pm to assess him. Most of the time, he remained lying on the floor and staff considered that he was still under the influence of PS. He was confused and his speech was incoherent. Staff continued to monitor him but took no further action.

4. At 2.03am on 16 August, prison staff found Mr Burrows unresponsive during a welfare check. A prison officer radioed a medical emergency code blue, and prison and healthcare staff began cardiopulmonary resuscitation (CPR). When paramedics arrived, they continued with CPR but confirmed at 3.29am that Mr Burrows had died. While Mr Burrows' cause of death has not yet been ascertained, post-mortem toxicology tests found amitriptyline in his system.

Findings

Availability of illicit drugs

5. We are concerned about the ease with which Mr Burrows was able to obtain PS and illicit prescription drugs at Garth.

Clinical care

6. The clinical reviewer noted that the healthcare that Mr Burrows received in prison was not equivalent to that which he could have expected to receive in the community. In particular, there was ineffective multidisciplinary decision-making in managing him when he was found under the influence of illicit substances.

Lack of escalation

7. We are troubled that Mr Burrows was monitored for an excessive period of time (nearly 15 hours) without his care being escalated by healthcare staff.

Clinical toxicology database and amitriptyline

8. We are concerned that staff significantly underestimated Mr Burrows' level of risk. They were so certain that he had taken PS that they did not sufficiently consider the additional risks if he had taken an overdose of the illicit prescription medication found in his cell, including amitriptyline. Healthcare staff failed to check TOXBASE, the online clinical toxicology database to which they have access, for toxicity information about amitriptyline and they did not review Mr Burrows' medications.

Record-keeping

9. Record-keeping was poor during the 15 hours that staff monitored Mr Burrows.

Recommendations

The Governor should ensure that the key drug issues at HMP Garth are identified, that the local drugs strategy is reviewed and revised, where appropriate, to address them and that staff are aware of its contents and their responsibilities.

The Head of Healthcare should ensure that healthcare staff follow a clear and robust process when they find prisoners with illicit prescription drugs, including that they record, communicate and address it appropriately.

The Head of Healthcare should ensure that healthcare staff know how to use TOXBASE and escalate cases of concern promptly.

The Head of Healthcare should ensure that:

- **the welfare check sheet used for monitoring prisoners suspected to be under the influence of a substance includes timescales for review, escalation and transfer to hospital; and that**
- **training is provided for healthcare staff on identifying when prisoners are under the influence and when and how to escalate their care.**

The Head of Healthcare and Greater Manchester Mental Health Services should consider what additional support can be put in place to address staffing shortages at Garth and consider how they can reasonably deliver a meaningful healthcare resource.

The Governor and Head of Healthcare should ensure that:

- **prison staff record key information about their contact with prisoners on NOMIS, the prison records database, accurately and in a timely manner; and that**
- **healthcare staff make contemporaneous records on SystmOne, the clinical records database, in line with the Nursing and Midwifery Council's Code.**

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners responded.

11. The investigator obtained copies of relevant extracts from Mr Burrows' prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Burrows' clinical care at the prison.

13. The investigator and clinical reviewer jointly interviewed 15 members of staff and three prisoners. Some interviews were completed in person and others by MS Teams.

14. We informed HM Coroner for Lancashire & Blackburn with Darwen of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent him a copy of this report.

15. The PPO's family liaison officer contacted Mr Burrows' family to explain the investigation and to ask if they had any matters they wanted us to consider. They asked about the circumstances that led to Mr Burrows' death.

16. Mr Burrow's family received a copy of the initial report. They did not make any comments.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS and Greater Manchester Mental Health NHS Foundation Trust pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Garth

18. HMP Garth is a category B training prison and holds long-term and life-sentenced prisoners. It is part of the Long-Term High Security Estate (LTHSE). Greater Manchester Mental Health NHS Foundation Trust provides physical health, mental health, social care and clinical substance misuse treatment at Garth, 24-hours a day and seven days a week, with Delphi subcontracted to provide psychosocial substance misuse services. There are seven residential wings and a segregation unit next to the prison's healthcare department. Prisoners live in single cells.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Garth was in November 2022. Inspectors noted that while the prison had worked to reduce drug supply, drugs remained easily available, the mandatory drug testing rate was high and searching procedures were insufficient. The dedicated search team were often not available to check property issued to prisoners, although most targeted searches were effective.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 30 November 2021, the IMB reported that they continued to be concerned about the number of illicit items brought into the prison, but this had been helped greatly by improved security at the gate. They noted that psychoactive substances (PS), commonly known as spice, was the most used drug in the prison and that there was evidence of PS production within the prison. They noted that hooch (alcoholic fermenting liquid often made from fruit and other food available to prisoners) also continued to be brewed at Garth. They also noted that searches of cells were conducted regularly.

Previous deaths at HMP Garth

21. Mr Burrows was the thirteenth prisoner to die at Garth since August 2020. His death was the second related to apparent drugs toxicity.

22. Our investigation into the death of a prisoner in August 2020 highlighted that drugs were readily available at Garth. We recommended that the prison should identify the key drug issues and amend their local drugs strategy accordingly. Garth accepted our recommendation and agreed to review their substance misuse strategy, with a view to identifying and addressing local issues.

Key Events

23. On 21 March 2018, Mr Martin Burrows was remanded into custody at HMP Altcourse, charged with grievous bodily harm with intent against his partner. He had been in prison a number of times before.

24. Mr Burrows had a history of attempted suicide and self-harm and substance misuse, including the use of psychoactive substances (PS) while in custody. He had a mixed anxiety and depressive disorder, for which he was prescribed an antidepressant.

25. On 12 September 2018, Mr Burrows was sentenced to ten years in prison.

HMP Garth

26. On 19 October 2018, Mr Burrows was transferred to HMP Garth. Prison staff interviewed him in Reception and recorded no concerns about him.

27. A nurse completed his reception health screen and noted Mr Burrows' history of substance misuse (amphetamines, cocaine and PS), anxiety and depression and that he was prescribed venlafaxine, an antidepressant. No concerns were raised about his mental health. Mr Burrows refused the support of the mental health and substance misuse teams.

28. In December, the prison GP changed Mr Burrows' prescribed antidepressant to mirtazapine. He was assessed as fit to keep and administer his medication himself.

29. Between 2018 and 2019, Mr Burrows was found under the influence of PS on multiple occasions when staff found him unconscious, sleepy, agitated, aggressive and/or his speech was slurred. They radioed a medical emergency code blue (used when a prisoner is unconscious or having breathing difficulties) a number of times. His Incentive and Earnings Privilege (IEP) level was reduced to basic (the lowest level and limiting aspects of prison life, including access to a television, visits and other things) many times for poor behaviour.

30. Mr Burrows worked with the psychosocial team from September 2019 and was referred to the adult drug services on 6 April 2020, following which he engaged with a substance misuse worker.

31. In November 2020, Mr Burrows told a member of the substance misuse team that his mood was generally good and that he had not used illicit substances since the COVID-19 restrictions began in March as they were not available. He said he did not need support from the substance misuse team and was discharged from their care.

32. From January 2021, the prison regime, movements and interactions at Garth were limited because of continuing COVID-19 restrictions. Staff noted that in the previous three months, Mr Burrows' behaviour had improved, and they upgraded his IEP level to enhanced.

33. From February, prison staff found Mr Burrows under the influence of illicit substances on more than one occasion. Mr Burrows told staff that he had "fallen off the wagon". A member of the substance misuse team discussed with him the risks of using illicit substances and harm reduction strategies, but he told them that he did not need their support.

34. In June, Mr Burrows had a seizure after taking PS and was hospitalised with breathing problems. He continued to decline the substance misuse team's support.

2022

35. Prison staff again found Mr Burrows under the influence of an illicit substance on 4 February 2022. He refused the substance misuse team's support.

36. In March, a security intelligence report noted that information had been received that Mr Burrows and another prisoner had been heard discussing plans for buying and selling PS.

37. In June, prison staff noted that Mr Burrows was doing well, had received no negative reports over the last few months and had maintained his enhanced IEP level. Mr Burrows also had a job in a workshop.

Events on 15 August

38. At around 8.30am, prison staff started to unlock some of the prisoners on D Wing, where Mr Burrows lived, for work, exercise and to collect medication.

39. CCTV footage shows that at around 9.00am, a Supervising Officer (SO) and an officer unlocked Mr Burrows' cell to conduct the daily cell check. At interview, the SO told us that while completing this, she talked to Mr Burrows and had no concerns about him. Mr Burrows' door remained unlocked, but he did not leave his cell after this.

40. CCTV footage shows that until 11.18am, a number of prisoners were seen on the D Wing landing. They went into and left Mr Burrows' cell many times.

41. Prisoner A told us that at around 11.15am, he saw that Mr Burrows' cell door was open and he looked inside. He said that Mr Burrows was lying on the floor, with his body half underneath his bed. Other prisoners on the landing had also noticed this. He said that he went into the cell and tried to talk to Mr Burrows. He described Mr Burrows' speech as incoherent and said that he was talking "nonsense". Prisoners on the landing considered that Mr Burrows was under the influence of PS. The prisoner said that he and two other prisoners tried to put Mr Burrows back onto his bed, but he was too heavy to move so they left him on the floor.

42. The cell was hot due to the weather. The prisoners tried to give Mr Burrows a cup of water, but Mr Burrows knocked the cup away, and water spilled on the floor. Another prisoner told us that Mr Burrows was regularly under the influence of illicit substances. A further prisoner told us that Mr Burrows had been under the influence since early that morning. However, he thought that Mr Burrows was under the influence of a substance other than PS as PS symptoms lasted for around an hour whereas Mr Burrows' symptoms were prolonged.

43. Prisoner A told prison staff that he was concerned about Mr Burrows. The SO and an officer attended Mr Burrows' cell and found him still on the cell floor. He was breathing but unconscious, and his eyes were moving slightly. Prison staff believed that he was under the influence of PS. The SO immediately radioed a medical emergency code blue (used when a prisoner is unconscious or has breathing difficulties) which was recorded in the control room log as occurring at 11.19am. An ambulance was called immediately. She said that Mr Burrows then started to make grunting noises.

44. Two nurses responded to the code blue. Mr Burrows was lying on the floor, with his head and top half of his body under the bed. A portable fan was pointed in his direction to try to keep him cool. The nurses asked prison officers to move Mr Burrows from under his bed so that they could examine him. The nurses tried to undertake a full set of physical observations of Mr Burrows' heart rate, temperature, blood pressure, respiratory rate, level of consciousness and oxygen saturation. Mr Burrows' heart rate was elevated. However, he became a little agitated, was resistant to being examined and appeared unable to understand what was happening. The officers helped Mr Burrows to sit up. Due to his presentation and elevated heart rate, they considered that he was under the influence of PS. The nurses examined him for around 15 minutes. From their medical observations, they noted that he had improved a little in their presence. The nurses stood down the ambulance. Mr Burrows was placed in the recovery position on the floor before staff left his cell.

45. In discussion with the nurses, it was agreed that prison staff would monitor Mr Burrows every ten minutes to assess him until he had recovered and that they would notify healthcare staff immediately if his health deteriorated. The SO started a welfare check sheet to record staff's observations of Mr Burrows while under the influence of a substance. At interview, the Head of Safer Prisons and Equalities and a nurse said that the monitoring of prisoners in such situations should be short-term and would normally last for around an hour, after which the effects of PS should have worn off. They said that after this period, prison staff should contact the healthcare team to review the prisoner.

46. While prison staff did not conduct a full search of Mr Burrows' cell, the SO looked around his cell for drug paraphernalia. She found a box containing ibuprofen (24 tablets), amitriptyline (17 tablets) and mirtazapine (8 tablets) which had not been prescribed to Mr Burrows. She removed the drugs and gave them to a nurse. The medication find is recorded in Mr Burrows' clinical records and the SO told us at interview that the medications were given to the pharmacy team for disposal. There are no clinical records to confirm this. No one from the healthcare department considered whether the medications found posed any risk of overdose or serious health concerns and they did not consult TOXBASE (the online clinical toxicology database to which healthcare staff have access for toxicity information about drugs).

47. At 11.40am and 11.50am, an officer recorded on the welfare check sheet that Mr Burrows was still on the floor in the recovery position, unresponsive but breathing. At 12.00pm, when she checked on Mr Burrows, she went into his cell and adjusted him on the floor for comfort. Mr Burrows did not respond but made eye contact. Another officer completed further checks on Mr Burrows over the next hour and

noted no change to his condition. At 1.30pm, an officer noted that Mr Burrows appeared still not to have recovered so she contacted the healthcare team.

48. At around 2.00pm, two nurses attended Mr Burrows' cell to review him. Wing staff told Nurse A that Mr Burrows had responded to them earlier but appeared to have deteriorated again. Mr Burrows was still on the floor, lying on his left-hand side. She told us that two vape cannisters were lying next to Mr Burrows' head, which prison staff removed, and questioned the possibility that Mr Burrows had not fully recovered because he had used an illicit substance again. Prison staff tried to move Mr Burrows into an aided sitting position, but he became agitated. Another prison officer helped Mr Burrows to keep on an emergency mask to deliver oxygen to him. Nurse A's assessment was therefore limited as she was unable to remain close to Mr Burrows for long periods of time because he became agitated. Mr Burrows' clinical records noted that although his oxygen saturation level was within normal ranges - 94% at first and then increasing to 98%, his heart rate was high at 130 beats per minute, he was disorientated and incoherent, with a small amount of blood on his lip and pillow. However, she was unable to take Mr Burrows' blood pressure. She relayed her findings to Nurse B, who was standing at the cell door. Mr Burrows appeared confused. Nurse A told prison staff to monitor him every ten minutes (for the next hour) for signs of deterioration and asked them to update her about his progress at around 3.30pm.

49. At 2.40pm and 3.00pm, staff recorded on the welfare check sheet that Mr Burrows remained in the same position, unresponsive. At 3.30pm, an officer went into Mr Burrows' cell and tried to obtain a response from him. Mr Burrows was a little more responsive but remained on the floor.

50. In interview, a SO said that wing staff had told him that Mr Burrows' condition had not really improved so he telephoned Nurse A at around 3.30pm to update her. She was unable to attend D Wing as she was dispensing medication. However, she told the SO that she would contact Nurse B (the duty nurse) and ask her to assess Mr Burrows. The SO said he would also update the duty governor. Nurse A said she told the SO that Mr Burrows may need to be transferred to hospital. She contacted Nurse B, who was attending an emergency, but agreed to go to D Wing as soon as possible. She said she passed this information to the SO and reminded him that he should call a medical emergency code if Mr Burrows' condition deteriorated.

51. Nurse A told us that she was extremely busy that afternoon and did not get an opportunity to record her conversation with the SO in Mr Burrows' medical record.

52. An officer noted at 4.30pm that Mr Burrows had moved onto his bed but by 5.00pm, he was lying on the floor again.

53. At 5.06pm, Nurse B and Nurse C examined Mr Burrows in his cell, following the SO's concern. Prison staff tried to help Mr Burrows onto his bed, but he became verbally and physically aggressive towards them (grabbing and kicking at their legs). Nurse C told us that due to Mr Burrows' behaviour, prison staff considered it unsafe to be in his cell at that time. The nurses were therefore unable to examine Mr Burrows fully. They noticed that while Mr Burrows' airway was clear and his speech and actions had improved, he had not "come around" properly and still presented as confused. Nurse B noted that Mr Burrows' long recovery time and the

fact that he was not currently known to be a regular PS user meant that it was likely that his drug intolerance might have delayed his recovery. She noted that wing staff should continue to monitor him every ten minutes and to notify healthcare staff immediately about any concerns. At interview, she told us that she had asked wing staff to search Mr Burrows' cell for any illicit substances as she suspected that he might have been 'topping up' on drugs (as he had not yet recovered) but she did not know if wing staff had done so. Healthcare staff on night duty added Mr Burrows to their list of prisoners to review that night. The prison staff and nurses left Mr Burrows' cell at around 5.10pm.

54. Officer A noted on the welfare check sheet that staff were to continue with observations every 10 minutes.

55. At 5.35pm, Officer A noted on the welfare check sheet that Mr Burrows was "still on floor moving about x 3 checks". He recorded similar comments at 6.02pm, "x 2 obs on floor moving". At 7.00pm, he noted, "All obs completed... still on floor, movement noted". (From around 6.00pm, it appeared that welfare observations were far less frequent than the agreed observation schedule of every 10 minutes. There is no evidence to determine why this changed.)

56. CCTV footage does not correlate with the timings of the checks recorded on the welfare check sheet. It shows that after healthcare staff left the wing, Officer A checked on Mr Burrows at 5.30pm, 5.49pm, 6.48pm and 7.33pm. This final check at 7.33pm was not recorded on the welfare check sheet. He finished his work shift at around this time and left a handover note for the night duty staff in the wing observation book to tell them that Mr Burrows was to be observed every 10 minutes.

57. A CM, an officer and a nurse started their night shifts at around 7.30pm. Day staff told them about Mr Burrows. CCTV footage shows that the officer checked on Mr Burrows at 7.43pm during the roll check, but this was not recorded on the welfare check sheet. He saw Mr Burrows lying on the floor and noted movement.

58. The CM and nurse checked on Mr Burrows again at 8.14pm. Other staff present included an officer who was part of the prison's intervention team. When he went into the cell, Mr Burrows moved but did not respond verbally. Mr Burrows appeared confused, a little aggressive and lashed out and swore at the officers while trying to stand up. The officer told us that Mr Burrows appeared to be under the influence of an illicit substance. The nurse told us that Mr Burrows was hostile towards staff, so she was unable to complete a full set of physical observations. Prison staff moved Mr Burrows onto his bed. They searched his cell but found no further evidence of illicit drug use. The nurse told staff to monitor him every 30 minutes and notify healthcare staff immediately if they were concerned about him.

59. At 9.00pm, an officer checked on Mr Burrows and noted on the welfare check sheet that he was on the cell floor, breathing. Although not noted on the welfare check sheet, CCTV footage shows that the officer looked through Mr Burrows' cell door observation panel at 9.29pm.

60. At 10.29pm, the prison incident log noted that Mr Burrows' cell door was to be opened for staff to complete a welfare check. CCTV footage shows that the officer and a nurse were outside his cell at 10.32pm. The officer had checked on Mr

Burrows by looking through the cell door observation panel. He checked on Mr Burrows again at 10.52pm.

61. Body-worn camera footage shows that a nurse and prison staff went into Mr Burrows' cell at 11.17pm. Mr Burrows was on the floor, his head and upper body partially under his bed. His condition appeared the same as earlier in the day. The CM noted that Mr Burrows was slurring his words and still appeared to be under the influence of an illicit substance. Since staff had last checked on him, he had turned on the fan and it was pointed at his head. The nurse examined him and recorded his physical observations which were considered acceptable. She noted that Mr Burrows still appeared a little confused but also spoke. He told staff to turn the cell night light off and to "fuck off". She told prison staff to continue to monitor him and they agreed that as Mr Burrows "appeared to be comfortable" on the floor, they would leave him where he was.

62. Shortly before midnight, an officer and an Operational Support Grade (OSG) checked on Mr Burrows. He was sitting on the floor, with his back towards the cell door.

16 August

63. Officer B noted on the welfare check sheet that he checked on Mr Burrows at 12.00am and 1.00am. He remained sitting on the floor, and at 1.00am, he was talking to himself.

64. At 1.57am, Officer B completed another welfare check on Mr Burrows. He was concerned about Mr Burrows' position. He was still sitting on the floor but in a strange position and so Officer B alerted the CM, who was in the wing office.

65. The CM and Officer C attended Mr Burrows' cell. The CM asked for additional staff to come and support them. At Mr Burrows' cell, Officer C looked through the cell door observation panel. He saw Mr Burrows kneeling down, with his head on the floor and facing the window. At 2.02am, the CM went into the cell as they were concerned. Mr Burrows then started waving his hands around, while his body doubled up. The CM and Officer C laid Mr Burrows on the floor and he then stopped moving. Staff placed Mr Burrows in the recovery position. He was not responsive and appeared not to be breathing.

66. Officer B immediately radioed a medical emergency code blue. The control room operator recorded the message at 2.03am and telephoned for an ambulance immediately. Body-worn camera footage shows that the CM and an officer checked Mr Burrows for signs of life at 2.04am but found none. Mr Burrows was placed on his back, and an officer started cardiopulmonary resuscitation (CPR).

67. In the meantime, an officer collected a defibrillator from the office. The CM applied it, and it advised that CPR should continue.

68. The control room operator's call for an ambulance was placed in a queue because the ambulance service was experiencing a high volume of calls. Other staff responded to the emergency call and while CPR continued, the control room staff made numerous attempts to get updates from the ambulance service.

69. At 2.07am, a nurse arrived with medical emergency equipment, including oxygen. Prison staff and the nurse continued CPR.

70. At 2.34am, paramedics arrived at the cell and took over Mr Burrows' care. Additional paramedics arrived afterwards and helped but at 3.29am, they pronounced that Mr Burrows had died. The paramedics recorded that Mr Burrows' temperature was dangerously high at 41.1 degrees Celsius.

Contact with Mr Burrows' family

71. The prison appointed an officer and a prison chaplain as the family liaison officers. At 7.50am on 16 August, they left the prison and tried to visited Mr Burrows' father who was his next of kin, but he no longer lived at that address. They telephoned Mr Burrows' father to confirm his new address and broke the news to him. They visited him at 10.10am and offered their condolences and support. Garth contributed to Mr Burrows' funeral costs in line with national instructions.

Support for prisoners and staff

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

73. After Mr Burrows' death, the staff involved in the incident were given the opportunity to discuss any issues arising and the staff care team also offered support.

Post-mortem report

74. The post-mortem and toxicology examinations did not establish Mr Burrows' cause of death and it will be determined by the coroner at the inquest. The post-mortem toxicology results showed the presence of amitriptyline but no other substances. Amitriptyline, mirtazapine and ibuprofen were found in Mr Burrows' cell after he died, none of which had been prescribed to him.

Findings

Availability of illicit drugs

75. While we cannot determine how Mr Burrows obtained amitriptyline, mirtazapine or ibuprofen which had not been prescribed to him, we are very concerned that he was able to obtain them illicitly. A prisoner who asked not to be named told us that another prisoner had given Mr Burrows 80 amitriptyline tablets. Following their inspection in November 2022, HM Inspectorate of Prisons also shared our concern that drugs remained easily available at Garth.

76. Prisoners told us that Mr Burrows was regularly under the influence of illicit substances. Prison records noted that he had last been suspected of being under the influence of drugs and involved in the supply of drugs on the wing in February/March 2022.

77. The prison has an Integrated Substance Misuse Strategy dated December 2021 which sets out the actions that Garth plans to take to eliminate the supply of drugs, reduce demand and promote user recovery. We consider that further work is needed to reduce the availability of illicit drugs and diverted medication, and we make the following recommendation:

    The Governor should ensure that the key drug issues at HMP Garth are identified, that the local drugs strategy is reviewed and revised, where appropriate, to address them and that staff are aware of its contents and their responsibilities.

Clinical care

78. The clinical reviewer noted that, overall, the healthcare that Mr Burrows received in prison was not equivalent to that which he could have expected to receive in the community. She found that there was ineffective multidisciplinary decision-making in managing Mr Burrows when staff found him under the influence.

Managing Mr Burrows while under the influence on 15 August

Amitriptyline

79. While Mr Burrows' cause of death is yet to be determined, the post-mortem toxicology results indicated the presence of amitriptyline. When Mr Burrows was initially found unconscious in his cell, healthcare staff considered that he was under the influence of PS. We cannot know whether or not he had also taken PS sometime before his death because post-mortem toxicology tests would likely not have identified PS in his system so many hours after he had potentially taken them.

80. While it might have been reasonable for healthcare staff to assume Mr Burrows had taken PS based on the high use of PS in custody and his history of using PS, illicit prescription drugs found in his cell, including amitriptyline, should have led healthcare staff to suspect that he might have used them. Their failure to do so meant that they did not explore whether Mr Burrows' presentation might have

resulted from polydrug use rather than PS specifically. Had healthcare staff checked TOXBASE, they would have learnt that amitriptyline is highly toxic, can result in life-threatening symptoms and fatal cardiac arrythmias and can remain in the body for a prolonged period. Healthcare staff should have considered whether Mr Burrows had taken an overdose of amitriptyline and used this possibility to manage his care effectively, including referring him to hospital promptly. We are concerned about the lack of professional curiosity about the medications found in Mr Burrows' cell, especially as he remained under the influence for a prolonged period. We make the following recommendations:

The Head of Healthcare should ensure that healthcare staff follow a clear and robust process when they find prisoners with illicit prescription drugs, including that they record, communicate and address it appropriately.

The Head of Healthcare should ensure that healthcare staff know how to use TOXBASE and escalate cases of concern promptly.

Lack of escalation of care

81. We consider that healthcare staff significantly underestimated Mr Burrows' level of risk. Having assessed Mr Burrows, they cancelled the ambulance that prison staff had requested at 11.15am. We are horrified that despite Mr Burrows' lack of improvement over the next 15 hours, healthcare staff did not escalate his care or call for an ambulance. Prison staff requested an ambulance when he was completely unresponsive, by which time it was too late, and Mr Burrows died.

82. While prison staff monitored Mr Burrows regularly after he was initially discovered, his condition had not changed after an hour. Therefore, they agreed to monitor him for a further hour. We consider that this was reasonable in the circumstances because his condition had not worsened but remained the same. At 1.30pm, prison staff notified healthcare staff that Mr Burrows' condition still had not changed. Healthcare staff were not able to attend until 2.00pm due to staff resourcing issues (which we discuss later in this report).

83. When healthcare staff checked on Mr Burrows at 2.00pm, they found him in a similar condition, but also found two vape cannisters near him. They suspected at that stage that he might have taken more drugs so decided to review him at 3.30pm. In the circumstances (of his condition remaining the same rather than worsening and the difficult staffing pressures), we consider that this decision was not unreasonable, particularly without the benefit of hindsight.

84. By the time healthcare staff reviewed Mr Burrows at approximately 5.00pm on 15 August, there remained no change in his presentation, and healthcare staff should unequivocally have transferred him to hospital as he continued to present as under the influence of a substance. From the body-worn camera footage, it is clear that even 12 hours after Mr Burrows was found under the suspected influence of PS, he remained incoherent, confused and in a similar state to when he was found. However, no meaningful action was taken to escalate his care, other than to continue monitoring him.

85. The clinical reviewer noted there was no collaborative multidisciplinary decision-making and assessment by prison or healthcare staff, and no healthcare escalation

of his care. She noted that Mr Burrows should have been assessed after a maximum of four hours. While his physical observations were considered acceptable, given that there was no change to his presentation, this should have caused enough concern for healthcare staff to transfer him to hospital. This did not happen.

86. In addition, there was no staff guidance on how to manage use of the welfare check sheet. Garth relied on a Governor's Order dated February 2022 which reminded staff about the "actions they must take when finding prisoners presenting as possibly under the influence of an unknown substance". However, the document contained no guidelines on how long to use the welfare check sheet to monitor prisoners before escalating their care, including transferring them to hospital. The order simply required prison and healthcare staff to agree the level of observations needed. While many staff told us that they had concerns about the length of time that Mr Burrows had been under the influence, no individual member healthcare staff took ownership or the initiative to escalate his care and Mr Burrows was never sent to hospital.

87. While we cannot know whether the outcome would have been different for Mr Burrows if he had been sent to hospital promptly, and even within four hours as the clinical reviewer considered should have happened, it is clear that healthcare staff missed opportunities to escalate his care, and this was a serious failure to provide an appropriate standard of care to Mr Burrows. We make the following recommendations:

The Head of Healthcare should ensure that:

- **the welfare check sheet used for monitoring prisoners suspected to be under the influence of a substance includes timescales for review, escalation and transfer to hospital; and that**
- **training is provided for healthcare staff on identifying when prisoners are under the influence and when and how to escalate their care.**

Staff resourcing issues

88. Without diluting the serious concerns we have about Mr Burrows' care on 15 August, we acknowledge that healthcare resources were extremely stretched that day. At interview, the Head of Healthcare told us that the day Mr Burrows was found under the influence was particularly difficult for healthcare staff due to staff shortages. (Three members of day staff were on annual leave, and another was on sick leave.) Healthcare staff had to assist with a number of other emergencies that day, including a fire breaking out on a prison wing and 16 other prisoners needing medical intervention. A code blue was also called for another prisoner who needed an ambulance, there was a self-harm incident and two general alarms.

89. The healthcare staffing provision for the night shift at Garth was just one qualified nurse to cover the potential needs of 800 prisoners. There was only one registered nurse on night duty on 15 August. Like the clinical reviewer, we are concerned that the responsibility of managing so many prisoners appropriately, including Mr Burrows, was an unmanageable, excessive and unrealistic workload for one qualified nurse.

90. We are concerned about the ongoing impact of healthcare staffing shortages at Garth on all prisoners. This directly affected Mr Burrows' care provision in the lead up to his death, and we make the following recommendation:

The Head of Healthcare and Greater Manchester Mental Health Services should consider what additional support can be put in place to address staffing shortages at Garth and consider how they can reasonably deliver a meaningful healthcare resource.

Record-keeping

91. Poor record-keeping might also have affected the care Mr Burrows received.

92. Staff had found two vape devices lying on the floor next to Mr Burrows two and a half hours after he was first found under the influence. We were told that prison staff had removed the vapes from the cell and given them to the pharmacy team to dispose of there are no prison or clinical records about this. We therefore cannot say whether they were tested for illicit substances. Interviews with healthcare and prison staff, the Head of Safer Custody and Head of Security did not clarify this.

93. Nurse A did not record her contact with the SO at around 3.30pm when he asked about the plan for Mr Burrows. She assigned another nurse to review Mr Burrows again and suggested that they were considering transferring him to hospital. At interview, she told us that lack of records was due to the chaos of the shift, staffing issues and not having a computer to document this information.

94. There were inconsistencies with entries in the welfare check sheet. Staff either failed to record entries after they checked on Mr Burrows or failed to check him at the prescribed times. We noted that from around 6.00pm on 15 August, staff conducted Mr Burrows' welfare checks far less frequently than at the agreed 10-minute intervals. However, there was no recorded reason for this change in approach. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **prison staff record key information about their contact with prisoners on NOMIS, the prison records database, accurately and in a timely manner; and that**
- **healthcare staff make contemporaneous records on SystmOne, the clinical records database, in line with the Nursing and Midwifery Council's Code.**

Inquest

95. The inquest into Mr Burrows' death concluded on 1 May 2024. The conclusion was that Mr Burrows' death was multiple organ failure caused serotonin syndrome and drug toxicity including amitriptyline toxicity. The inquest found that Mr Burrows' death was an accident. Failure to access and consult Tox Base, and failure to identify whether Mr Burrows was prescribed amitriptyline contributed to his death.

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