Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Delahunty, a prisoner at HMP Risley, on 29 March 2018

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 Kevin Delahunty died in hospital on 29 March 2018 after he was found on fire in his cell at HMP Risley on 25 March. He was 40 years old. I offer my condolences to his family and friends.

Mr Delahunty had a history of substance misuse and there is evidence that he regularly took drugs, including psychoactive substances (PS), at Risley. The evidence indicates that before he died, Mr Delahunty tried to smoke PS, which he ignited from the electrical socket in his cell, and that his clothes accidentally caught fire while he was under the influence of the PS.

The details of this investigation are truly shocking. It is clear that Mr Delahunty was determined to continue to use PS despite being fully sighted on the risks. It is extremely troubling that, although his drug use was very clear to the prison, he was able to obtain PS with ease.

Earlier this year, I raised my concerns about the availability of illicit drugs at Risley after a prisoner died in March 2017. It is hard to conclude that the prison's drug strategy is working and, while that is the case, deaths such as that of Mr Delahunty are almost inevitable.

This is a national problem and one which requires new and transformative action from the centre to help prisons which are clearly struggling with the resources and tools available to them to make the step change required. I understand that the Chief Executive of HM Prisons and Probation Service intends to publish national guidance to all prisons on how to tackle the availability and use of substances, including PS, this autumn. I welcome that.

I acknowledge the very significant steps which Risley has taken since Mr Delahunty's death to reduce drug supply and demand. In light of the factors identified above, I make limited recommendations to them in relation to PS but fear I will be returning to this topic before long if serious action is not taken by the Ministry of Justice. I hope that there will be learning from the prison's actions and that this tragic case will inform the promised strategy and the 10 priority prisons project which the Prisons Minister launched recently.

This investigation has also highlighted some of the fire safety risks since prisons became smoke-free environments, and from which other prisons might also learn.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **December 2018**

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Summary

Events

1. On 24 March 2016, Mr Kevin Delahunty was remanded into custody, charged with burglary. On 21 April, he was convicted and sentenced to five years in prison. After spending time in a number of prisons, he was transferred to HMP Risley on 5 May 2017.

2. Mr Delahunty had a long history of drug misuse in the community and in prison. Between May 2017 and March 2018, Mr Delahunty was found under the influence of psychoactive substances (PS) more than 13 times. Staff offered support and advised him of the dangers of his actions but he refused help.

3. At 5.01pm on 25 March, Mr Delahunty was locked in his cell. At 5.25pm, a support worker, who worked on the wing landing, smelt burning and found Mr Delahunty on fire in his cell. A general alarm was raised but no one called an emergency code. Prison staff responded to the incident, extinguished the fire and removed Mr Delahunty from his cell. They administered first aid treatment, assisted by healthcare staff and the fire service when they arrived. An ambulance was called but took over an hour to arrive. Paramedics then took over the emergency treatment. They took Mr Delahunty to hospital, where he died of his injuries on 29 March.

4. The plug socket in Mr Delahunty's cell had been used as an ignition source to light a flame. A pipe was also found in his cell. The evidence indicates that Mr Delahunty had been smoking an illicit substance and accidentally set fire to his clothing while he was under the influence.

Findings

Assessment of risk

5. We found no evidence to suggest that Mr Delahunty's death was deliberate or that he wanted to take his life.

6. Although staff at Risley monitored Mr Delahunty four times under suicide and self-harm prevention procedures, known as ACCT, there were some deficiencies in the way they did so. There was no evidence that anyone from the healthcare or mental health team attended the ACCT review on 14 July. Staff did not create an ACCT caremap after they started ACCT monitoring on 7 September, and Mr Delahunty was never referred for a mental health assessment, despite staff recognising that he was at risk of suicide and self-harm.

Psychoactive substances

7. Mr Delahunty had a significant history of misusing drugs, particularly PS. He was aware of the risks associated with PS but had access to and used illicit drugs at Risley. Although Risley had a drugs strategy in place, more needed to be done to eradicate the supply and demand of illicit drugs.

Clinical care

8. The clinical reviewer concluded that the care that Mr Delahunty received at Risley was not equivalent to that which he could have expected to receive in the community. Healthcare staff were unaware that Mr Delahunty had been discharged from hospital after serious self-harm and they did not therefore contribute to his care. Healthcare staff did not use recognised tools to assess Mr Delahunty after he had been identified as using illicit substances. There was a lack of integration and information sharing between primary healthcare, substance misuse and mental health services, particularly as Mr Delahunty had a long history of substance misuse.

Emergency response

9. Staff did not use a medical emergency code after Mr Delahunty was found on fire. There was also a three-minute delay in calling an ambulance. Although it is unlikely that this affected the outcome for Mr Delahunty, it could make a crucial difference in other cases.

Staff support

10. This was an extremely distressing incident for all staff involved and they continue to require support.

Notifying families of serious illness

11. There was a delay in Risley notifying Mr Delahunty's next of kin that he was seriously ill and had been taken to hospital.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
    - staff have a clear understanding of their responsibilities and the need to record relevant information about risk;
    - prison, healthcare and/or mental health staff work jointly to manage prisoners at risk of suicide and self-harm; and
    - case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.
- The Governor should ensure that prisoners are unlocked during the core day and are able to engage in full-time purposeful activity.
- The Governor should ensure that staff report and record all instances of illicit drug misuse and refer prisoners promptly to appropriate prison support services.

- The Governor and Head of Healthcare should formalise the way that PS incidents are assessed and the handover of care from healthcare to prison staff including:
    - The development and introduction of a PS assessment template for SystmOne, to include routine recording of National Early Warning Scores (NEWS).
    - The way that care and monitoring instructions are communicated to prison colleagues.
    - Notifying Change Grow Live (CGL) when primary healthcare staff are required to attend a PS incident.
- The Governor and Head of Healthcare should implement a process to ensure that healthcare staff are notified when prisoners return from hospital and that all discharge information is shared promptly to inform care planning.
- The Governor and Head of Healthcare should ensure that prison, healthcare and mental health teams share all relevant information to ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.
- The Governor and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and radio a medical emergency code in an emergency situation, including in the event of a fire.
- The Governor should ensure that when a prisoner is taken to hospital seriously ill, their next of kin is informed without delay, are provided with comprehensive and accurate information and are kept informed of progress.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact him. No one responded but one prisoner was interviewed at the investigator's instigation.

13. The investigator visited Risley on 4 April. He obtained copies of relevant extracts from Mr Delahunty's prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Delahunty's clinical care at the prison.

15. The investigator interviewed eleven members of staff and one prisoner at Risley in May, jointly with the clinical reviewer. In addition, he interviewed a mental health nurse by telephone and wrote to the nurse who attended to Mr Delahunty after the cell fire to ask about her recollection of what happened. Neither were available to be interviewed in person.

16. We informed HM Coroner for Greater Manchester West District of the investigation. He gave us the results of the post-mortem examination and we have sent the Coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Delahunty's family to explain the investigation and to ask whether the family had any questions or concerns. They wanted to know whether Mr Delahunty had been prescribed medication to help with his substance misuse at the time of his death and if he had raised concerns about being bullied or in debt.

18. Mr Delahunty's family received a copy of the initial report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Prison Risley

19. HMP Risley is a medium security training prison which holds over 1,000 convicted men. Bridgewater Community Healthcare NHS Trust provides healthcare services in the prison. There is 24-hour healthcare cover and substance misuse services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Risley was conducted in June 2016. Inspectors found that the daily regime was not being delivered. Inspectors were told that difficulties in industrial relations had led to significant regime cuts in recent months. Inspectors found that about a third of prisoners remained in their cells during the working day. They noted that Risley did not provide enough full-time activity to meet the needs of the population, and attendance and punctuality in learning and skills activities were poor.

21. There was evidence to suggest that the availability and threat of PS at Risley was undermining prisoner wellbeing and was a major challenge to the stability of the prison. 60% of prisoners told inspectors that it was easy to obtain drugs, including PS, at Risley. Inspectors found that health services were reasonable but the requirement to respond to PS-related incidents placed significant additional demands on the services. They noted that substance misuse services were good, with a range of excellent recovery-focused interventions delivered by a well-integrated and skilled drugs team. However, inspectors found that too many prisoners had been maintained on opiate substitution rather than having their doses reduced, as they should have done.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to March 2017, the IMB was greatly concerned with the use of illicit drugs in the prison and the additional problems caused by PS. They noted that the high levels of substance misuse were a challenge for staff and that there was a lack of drug dogs. The IMB noted that there were problems running the prison due to the reduction in staffing levels. They said that this had an adverse effect on the welfare of prisoners who were locked in their cells for unacceptable periods.

Psychoactive substances (PS)

23. PS (formerly known as ‘new psychoactive substances’ 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.

24. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) 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 PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

25. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Previous deaths at HMP Risley

26. Mr Delahunty was the eighth prisoner to die at Risley since January 2015. Of these, Mr Delahunty was the third drug-related death.

Key Events

27. On 24 March 2016, Mr Kevin Delahunty was charged with burglary and remanded to HMP Leeds. It was not his first time in prison. He had a long history of drug and alcohol misuse and was known to the community drug and alcohol services. He had been diagnosed with depression and post-traumatic stress disorder (PTSD) and was prescribed fluoxetine (for depression, anxiety and to manage his anger) and inhalers (for asthma).

28. On 21 April 2016, Mr Delahunty was sentenced to five years in prison for burglary. (His sentence was reduced to four years after he appealed.)

29. On 5 May, he was transferred to HMP Lindholme. During May and June, staff found Mr Delahunty under the influence of spice, a PS. Staff referred him to the substance misuse team. Intelligence reports noted his involvement in a number of incidents, including trading PS on the wing. Mr Delahunty told staff that he had accumulated debts and was being bullied but he did not name the perpetrators. Staff instigated a violence reduction investigation and moved Mr Delahunty to a different wing.

30. On 1 July 2016, Mr Delahunty was transferred to HMP Forest Bank after being involved in an incident of indiscipline at Lindholme.

31. On 1 August, staff at Forest Bank started ACCT procedures after Mr Delahunty cut his chest. He said that he had self-harmed to instigate a move to a different wing because “trouble had followed him” in relation to previous drugs debt and he feared for his safety. Staff submitted an intelligence report. The next day, after assessing and reviewing Mr Delahunty’s risk, staff stopped ACCT procedures.

32. On 26 April 2017, staff found Mr Delahunty under the influence of PS. They submitted an intelligence report and reduced his Incentives and Earned Privileges (IEP) level to basic. (The IEP scheme is designed to encourage good behaviour and challenge misbehaviour.) He was also sacked from his cleaning job. Staff offered to refer him to the substance misuse team but he declined.

Mr Delahunty’s transfer to HMP Risley

33. On 5 May 2017, Mr Delahunty was transferred to HMP Risley.

34. A registered general nurse completed Mr Delahunty’s initial health screen. She recorded that he was prescribed medication for depression, anxiety and asthma. Mr Delahunty said that he had no thoughts of suicide or self-harm and had not harmed himself in prison before (despite his previous self-harm at Forest Bank.) She also recorded that Mr Delahunty had said that he did not misuse drugs (despite his long history of substance misuse). She did not refer Mr Delahunty to the mental health or substance misuse teams. The prison GP subsequently continued Mr Delahunty’s medication prescriptions.

35. A substance misuse team leader for Change, Grow, Live (CGL), the substance misuse service provider at Risley, said that CGL saw Mr Delahunty as part of his reception screening. Mr Delahunty told him that he had completed an opiate

detoxification programme in prison in 2016, had not used illicit drugs since then and did not want any further interventions. Mr Delahunty said that he would attend Narcotics Anonymous after he was released from prison. The substance misuse team leader said that at the time, CGL used another database. They did not use SystmOne, the electronic medical record, until October 2017.

36. After completing his reception screening, Mr Delahunty was located on A Wing. At the time there was no specific induction wing. New receptions went on to any of the main wings and attended an induction centrally.

37. On 26 May, Mr Delahunty was moved to E Wing after his induction. That day, staff started ACCT procedures because Mr Delahunty made a ten-centimetre cut to his forearm. He was transferred to hospital for treatment and returned later that day. Healthcare staff recorded on SystmOne that they were informed by prison staff that Mr Delahunty would be staying in hospital overnight. When they tried to find out which ward he was on, the hospital told them that he had already returned to the prison. No one from the healthcare team recorded whether Mr Delahunty had a discharge letter from hospital.

38. The next day, a Custodial Manager (CM) chaired a multidisciplinary first ACCT review. A mental health nurse, attended. Mr Delahunty said he had inherited a PS debt from his cellmate. He said that he had self-harmed because other prisoners were harassing him to clear the debt. He apologised for his actions, and denied thoughts of suicide or self-harm. He admitted that he had used PS when he first arrived at Risley. The review panel judged that Mr Delahunty's risk of self-harm was low and stopped ACCT procedures. The CM noted that Mr Delahunty was willing to consider a move to C Wing, the drug recovery unit, but said that he was settled on E Wing and had no intention of using PS again. The mental health nurse recorded that Mr Delahunty did not need to be referred to the mental health team but she would refer him to CGL.

39. After he self-harmed, Mr Delahunty failed to attend a number of healthcare appointments in late May and early June 2017 to review his wound and remove his stitches. The records do not explain the reasons for his non-attendance.

40. On 14 July, an Officer started ACCT procedures after Mr Delahunty made a large cut to his head. A nurse treated Mr Delahunty's cut after responding to a medical emergency code red (which indicates blood loss). She recorded brief details on SystmOne which included his clinical observations of blood pressure, pulse and oxygen saturation levels (which were all in the normal range). Mr Delahunty said that he had no suicidal thoughts. Staff completed an ACCT multidisciplinary review which two members of the healthcare team attended. Mr Delahunty said that he had self-harmed to instigate a move to a different wing because of drug (PS) debts he had accumulated. He said that he feared for his and his family's safety as his personal address book had been taken from his cell and his family had been contacted. Mr Delahunty did not name the prisoner to whom he was in debt.

41. The review panel scheduled hourly ACCT observations and staff were required to have two conversations with him each day. They created a caremap in which they noted that Mr Delahunty was under threat because of debts he had accumulated and that a security relocation assessment (move to a different wing) should be completed. Staff completed a relocation risk assessment and sent it to the security

team. Mr Delahunty refused to be moved to another wing. Intelligence reports noted that Mr Delahunty had a history of involvement in the trade and misuse of drugs in the prison. There is no evidence that staff referred him to the mental health team for an assessment.

42. The prison GP saw Mr Delahunty on 19 July and continued to prescribe him fluoxetine. On 25 July, staff stopped ACCT procedures.

43. On 28 July, staff found Mr Delahunty under the influence of PS and radioed a code blue (indicating that a prisoner is unconscious and/or has breathing problems). A nurse examined Mr Delahunty and told staff to contact healthcare staff again if his condition deteriorated. She noted that she would advise the prison GP that Mr Delahunty's fluoxetine should be withheld for 24 hours because of the risk of taking it at the same time as PS. Staff placed Mr Delahunty on a disciplinary charge and submitted an intelligence report. The prison GP wrote to Mr Delahunty and reminded him of the dangers of using illicit drugs with prescribed medication, and the support available to him.

44. On 31 July, while escorting Mr Delahunty to his Thinking Skills Programme (which aimed to reduce his offending behaviour), staff realised that he was under the influence of PS. They returned Mr Delahunty to his cell, gave him another disciplinary charge and submitted an intelligence report. There is no evidence that the healthcare team was told.

45. On 3 August, staff again found Mr Delahunty under the influence of PS and called a code blue. When healthcare staff arrived, they found him on the floor, rigid and they noted that he had vomited. First aid was administered and wing staff were told to contact healthcare if Mr Delahunty's condition deteriorated. There is no evidence that staff referred Mr Delahunty to CGL.

46. Mr Delahunty was subsequently de-selected from the Thinking Skills Programme because he had missed two consecutive sessions due to being under the influence of PS. Intelligence noted that there was no evidence to indicate that Mr Delahunty had been bullied or forced to take illicit substances.

47. On 4 August, a Supervising Officer (SO), Mr Delahunty's offender supervisor, chaired an IEP review after Mr Delahunty's recent PS use. Mr Delahunty admitted that he had smoked something, which he believed was PS-sprayed paper. The review panel reduced Mr Delahunty's IEP level to basic.

48. On the same day, a manager chaired a disciplinary hearing. The manager recorded that although this was Mr Delahunty's first disciplinary hearing, staff had told him that Mr Delahunty had repeatedly been found under the influence of PS. Staff present said that having to manage a number of PS incidents impacted on resources, especially giving disciplinary charges. Staff said that when a prisoner was found under the influence of PS, they would call for healthcare assistance if the prisoner's condition looked bad. If a prisoner's condition appeared less serious, staff would monitor the prisoner in their cell until their health improved. The officer said that it usually took around 15 minutes for the effects of the drug to wane. The manager told every prison officer present that prisoners should be given disciplinary charges and every incident should be reported to the healthcare team. The manager referred Mr Delahunty to CGL.

49. On 11 August, staff reviewed Mr Delahunty's IEP level again and recorded that he would remain on basic. Mr Delahunty said that he was fully aware that his negative behaviour was not acceptable.

50. On 29 August, staff radioed a code blue when they found Mr Delahunty lying on his cell floor unresponsive. When Mr Delahunty eventually responded, his speech was slurred and he was unsteady on his feet. Staff noted that it was evident that he was under the influence of PS. Healthcare staff attended and deemed it unsafe to enter the cell to examine Mr Delahunty due to the thick haze and smell of an illicit substance. They instructed prison staff to contact healthcare staff again if his condition deteriorated. Staff placed Mr Delahunty on a disciplinary charge.

51. On 31 August, before he attended the disciplinary hearing in the segregation unit, Mr Delahunty complained that he had an open wound. He asked to see a nurse. The nurse treated his wound. Mr Delahunty told her that he had fallen asleep with something burning in his hand while he was under the influence of an illicit substance.

52. At the disciplinary hearing, the manager referred Mr Delahunty to the independent adjudicator because of his repeated use of PS.

53. Staff started ACCT procedures on 7 September because of Mr Delahunty's low mood. The Supervising Officer (SO) also Mr Delahunty's offender supervisor spoke to him about his PS use. Mr Delahunty said that his anti-depressant medication had stopped working, and he asked to see the mental health team.

54. The next day, a CM completed the first ACCT review, assisted by a mental health nurse. The CM described Mr Delahunty as "hyper" during the review. Mr Delahunty was angry and frustrated and admitted to using PS. He said his anti-depressant was not working and he wanted to be closer to his family in Yorkshire. He said he had had mood swings for the past six years and had previously seen a psychologist for PTSD. Mr Delahunty said that he was on basic IEP level. The nurse reviewed instances of Mr Delahunty's PS use and found that it coincided with his assertions that his medication did not work.

55. Mr Delahunty said that he had no thoughts of suicide or self-harm but had refused to eat or drink (since lunch time the previous day). The nurse noted that Mr Delahunty would be referred to the mental health team and discussed at the next weekly healthcare referral meeting. (There is no record of what was discussed at this meeting.) The CM noted that she would contact the Offender Management Unit (OMU) about the possibility of moving Mr Delahunty to a prison in Yorkshire. A SO agreed to discuss Mr Delahunty's sentence plan with him. Mr Delahunty promised that he would eat and drink over the weekend. The review panel agreed that scheduled ACCT observations would be set at three conversation each day and night. However, they did not create an ACCT caremap to record how they would address their concerns and reduce Mr Delahunty's risk.

56. On 11 September, the SO completed an ACCT review. A nurse and a member of the chaplaincy team attended. They noted that Mr Delahunty's IEP level had been restored to standard. Mr Delahunty said that the previous week had been "wobbly" for him but he had no thoughts of suicide or self-harm, was happy to remain on E

Wing and was aware of the available PS misuse support. ACCT monitoring was stopped.

57. Prison records for 12 September indicate that the independent adjudicator added 14 days to Mr Delahunty's sentence because of his continued use of PS.

58. On 29 September, staff offered Mr Delahunty a job for two weeks to keep him busy. He accepted the job and told staff that he would not let them down.

59. On 17 October, staff found Mr Delahunty on his cell floor, incoherent and being sick. Healthcare staff examined Mr Delahunty, confirmed he was under the influence of an illicit substance and told wing staff to contact them again if his condition deteriorated. (This incident was not recorded in Mr Delahunty's medical record.) Staff submitted an intelligence report which noted that there was no evidence to suggest that Mr Delahunty had been bullied or forced to take illicit substances.

60. On 19 October, staff observed Mr Delahunty retrieving an unauthorised item from his visitor in the visits hall. Staff searched Mr Delahunty, retrieved the item and the police were notified. Staff submitted an intelligence report and Mr Delahunty's IEP level was reduced to basic for four weeks. He was also placed on closed visits for three months.

61. Prison records on 25 October note that the independent adjudicator added a further 10 days to Mr Delahunty's sentence because of his continued use of PS.

62. On 5 November, Mr Delahunty refused to allow staff in his cell. When a CM went to see him, Mr Delahunty said that he had cut his forehead in protest that he was facing a disciplinary charge (for threatening to go onto prison netting in an unauthorised area) which he denied. He was also unhappy about the prison food. A nurse was unable to go into his cell because his mood was volatile. Mr Delahunty was conscious, orientated and there were no signs of blood on his head. He said that he might self-harm to teach the prison a lesson as he was not getting the food he ordered and felt that foreign national prisoners were treated better. The CM started ACCT monitoring and placed Mr Delahunty on hourly observations until the ACCT assessment and review were completed.

63. The next day the CM completed the ACCT assessment and another CM chaired the first ACCT review. The CM, a member of the chaplaincy team and a nurse attended. The other CM noted that Mr Delahunty's mood was good. Mr Delahunty apologised that he had overreacted the previous day. He said that he had no thoughts of suicide or self-harm and had stopped his hunger strike. The review panel noted that Mr Delahunty would remain on basic IEP level for his poor behaviour but assessed that his risk of self-harm was low and stopped ACCT procedures.

64. Staff reviewed Mr Delahunty's IEP level on 15 November and decided that he should remain on basic. His next IEP review was scheduled to take place in a week's time.

65. On 22 November, a SO reinstated Mr Delahunty's IEP level to standard and reminded him of the expected levels of behaviour required.

66. On 23 December, staff found Mr Delahunty under the influence of an illicit substance. A nurse attended E Wing and recorded that she examined Mr Delahunty. He was swaying from side to side, his eyes were glazed and his speech slurred. Mr Delahunty said that he had smoked a 'spliff' (which usually means a rolled cigarette containing cannabis). She told wing staff to monitor Mr Delahunty and to contact healthcare staff if his condition deteriorated. Although staff placed Mr Delahunty on a disciplinary charge, the investigator found no record of this incident on NOMIS or in intelligence reports.

67. At the subsequent disciplinary hearing on 27 December, the case was referred to the independent adjudicator.

Events from 4 January 2018

68. On 4 January 2018, staff found Mr Delahunty rolling around on his bed, unresponsive to verbal commands and foaming at the mouth. They radioed a medical emergency code blue. An improvised smoking pipe and drugs kit were found in his cell.

69. On 6 January, staff found Mr Delahunty and two other prisoners under the influence of an illicit substance. After both incidents, a nurse confirmed that Mr Delahunty had taken an illicit substance. Although no treatment was required, she told wing staff to contact healthcare staff if his conditioned deteriorated. Staff gave Mr Delahunty a disciplinary charge, submitted intelligence reports and reduced his IEP level to basic. Intelligence reports noted that there was no evidence to suggest that Mr Delahunty had been bullied or forced to take illicit substances. A prison GP wrote to Mr Delahunty after these incidents to remind him of the risks of using illicit drugs alongside prescribed medication.

70. On 9 January, Mr Delahunty attended a discipline hearing with an independent adjudicator and was found guilty of using PS in December 2017. He had extra days added to his prison sentence as a punishment. He also lost fourteen days of association.

71. A SO spoke to and reviewed Mr Delahunty's IEP level on 11 January. Mr Delahunty said that he was fully aware of the impact and risks of PS. A week later, Mr Delahunty asked to be referred to CGL for support. He told the SO that he wanted to stop using PS.

72. On 15 January, staff noted that Mr Delahunty had recently had a mandatory drug test and had tested positive for PS. On 18 January, the SO spoke to Mr Delahunty who said that he wanted to stop using PS and had referred himself to CGL. He said that he was looking forward to resuming open visits with his mother soon.

73. On 24 January, staff were told that a number of prisoners, including Mr Delahunty, were planning a fight in the exercise yard. They searched his cell and found a wooden table leg that he intended to use as weapon. Mr Delahunty told staff that there had been ongoing issues between the prisoners on the north and south side of E Wing. Staff gave him a disciplinary charge and submitted an intelligence report. Intelligence reports noted that the majority of incidents in which Mr Delahunty was involved related to the use of illicit substances. There was intelligence that he was part of the drug use network on E Wing.

74. On 27 January, staff recorded that Mr Delahunty had been involved in an altercation with another prisoner. He refused to return to his cell. He attended an IEP review where his IEP level was reduced to basic. Intelligence reports suggested that there had been a significant deterioration in Mr Delahunty's conduct.

75. On 31 January, prison records note that the independent adjudicator had added a further 14 days to Mr Delahunty's sentence because of his continued use of PS.

76. On 1 February, a SO had a long discussion with Mr Delahunty about his behaviour and reviewed his IEP. Mr Delahunty had failed to attend his education classes from 29 January to 1 February. The SO decided to restore his IEP level to standard. He explained to Mr Delahunty that he still had outstanding disciplinary charges which might result in further punishments. Mr Delahunty said that he was aware that staff were giving him another chance.

77. On 19 February, staff found Mr Delahunty under the influence of an illicit substance. Healthcare attended his cell, staff submitted an intelligence report, gave Mr Delahunty a disciplinary charge and reduced him to basic IEP.

78. On 27 February, 19 March and 20 March, staff again raised concerns about Mr Delahunty's poor behaviour after it was alleged that he had assaulted another prisoner. Staff gave him a disciplinary charge placed him on report and submitted intelligence reports.

79. On 23 March and 24 March, staff found Mr Delahunty under the influence of PS and contacted healthcare staff who attended both incidents. They recorded that Mr Delahunty was staggering around in his cell, which they were unable to enter because of thick smoke fumes. Staff submitted intelligence reports and gave Mr Delahunty a disciplinary charge.

Events on Sunday 25 March

80. At around 1.45pm, prisoners, including Mr Delahunty, were unlocked for the afternoon association period (where prisoners mix with other prisoners and spend time in the exercise yard).

81. CCTV shows Mr Delahunty leaving his cell at around 4.45pm and interacting with other prisoners before returning, and then leaving his cell a number of times. His demeanour appeared normal and there was no indication that he was under the influence of an illicit substance. At 5.00pm, Mr Delahunty returned to his cell for a final time.

82. CCTV shows that staff checked and locked all cell doors on Mr Delahunty's landing at 5.01pm. At 5.09pm, an Officer checked Mr Delahunty by looking through his observation panel. The Officer raised no concerns.

83. A prisoner lived two cells away from Mr Delahunty's cell. A care support worker was conducting an ACCT constant observation watch on the prisoner and so was outside his cell door. Both the care support worker and the prisoner told the investigator that at around 5.20pm, they heard Mr Delahunty shouting. They were not concerned as this was a frequent occurrence. The care support worker said that the shouting stopped and started repeatedly for a few seconds. A few minutes

later, the prisoner and the care support worker both realised that they could smell something burning.

84. The prisoner believed that Mr Delahunty had used PS and asked the care support worker to check on his wellbeing. He told the investigator that when you take PS, you become unaware of your surroundings and become physically frozen, with limited bodily movement. The prisoner said that he was therefore concerned for Mr Delahunty.

85. The care support worker looked through Mr Delahunty's cell door observation panel. She said that he was standing up, with his back facing the door, and was on fire with flames rising from the back of his t-shirt. He was not making any noise and there was no smoke in the cell. To raise the alarm quickly, she immediately pressed the emergency general alarm button outside Mr Delahunty's cell (recorded in the control room log at 5.25pm) and ran to the staff office at the end of the landing to raise the alarm.

86. Officer A and Officer B ran to the office cupboard to obtain the fire kit which included Respiratory Protection Equipment (RPE) - protective smoke hoods and the cell inundation key (a special key that opens a small porthole in the cell door to enable a fire hose to be put through to extinguish in-cell fires). Officer C and Officer D ran to Mr Delahunty's cell. They arrived within 21 seconds of the alarm being raised.

87. Officer D looked through Mr Delahunty's cell observation panel and saw Mr Delahunty sitting on his bed, on fire. Neither the cell nor its contents were on fire and there was minimal smoke. This meant that the domestic smoke detector, which was positioned on the ceiling of the landing outside the entrance of the cell door, was not automatically activated. Mr Delahunty was not making any noise, was completely still and did not try to extinguish the fire. Officer D immediately retrieved the water hose reel, which was at the end of landing almost opposite Mr Delahunty's cell door. While he did this, Officer C tried to break the observation panel with his baton to access the cell quickly to use the firehose. However, Officer A and Officer B arrived at 5.26pm in RPE and opened the fire access porthole with the inundation key.

88. A CM who had arrived instructed the staff to enter the cell as soon as it was deemed safe. At 5.27pm, Officer A and Officer B put smoke hoods on, placed the firehose through the inundation porthole and pointed it into Mr Delahunty's cell and extinguished the fire. Officer Braddock said that he had initially shouted verbal commands and instructions for Mr Delahunty to follow but he did not respond. He noted that Mr Delahunty's torso and trousers were on fire.

89. The CM radioed the control room and requested healthcare, an ambulance and the fire brigade, recorded in the control room log at 5.28pm. At the same time, Officer A and Officer B entered Mr Delahunty's cell.

90. The officers noted that Mr Delahunty had significant burns to his body and that his upper clothing was barely visible as a result of the fire. They noted that he was conscious but unresponsive and appeared unable to comply when he was given instructions and when the officers tried to move him. Officer A, Officer B and Officer D lifted Mr Delahunty out of his cell and placed him on the wing landing. The

officers continued to spray water into Mr Delahunty's cell after which they closed the cell door. Officer Mills placed wet blankets on Mr Delahunty and staff sprayed him with water.

91. A nurse arrived on the wing landing at 5.30pm. She was the only nurse available as there were two other ongoing emergencies at that time. She noted that Mr Delahunty had third degree burns to the right side of his face, groin area, both arms and the back and front of his upper torso. She gave him oxygen and monitored him. She noted that Mr Delahunty's temperature and heart rate were extremely high. The CM noted that as Mr Delahunty became more aware of what had happened he became distressed, started talking and pleading that he was in pain.

92. The fire brigade staff arrived at 5.46pm and took over care. Over a period of around 35 minutes, Mr Delahunty's temperature slowly reduced and staff stopped dousing him with water. The fire brigade and prison staff applied cling film to Mr Delahunty's burns and wrapped blankets around him. CCTV shows that a fire service officer opened Mr Delahunty's cell door at 5.49pm and a small amount of smoke came out of the cell, which activated the smoke detector.

93. Despite a number of calls to the emergency services for an ambulance, there was a significant delay in an ambulance arriving because of other emergencies in the community. Paramedics arrived at the prison at 6.26pm, and transferred Mr Delahunty to hospital at 6.43pm.

94. Staff found an improvised pipe in Mr Delahunty's cell and noted that he had used the cell sockets to create a flame to light a PS pipe.

95. As a result of his extensive burns, Mr Delahunty developed multi-organ failure. He failed to respond to intensive care treatment and his condition deteriorated. He died on 29 March.

Contact with Mr Delahunty's family.

96. On 25 March, prison records noted that between 6.30pm and 7.10pm, the prison control room received a total of three telephone calls from Mr Delahunty's sister and mother. They said that they had been told through social media that Mr Delahunty had been taken to hospital after an incident. The prison said that it was unable to provide any information to the callers for security reasons.

97. A CM started her duty as the officer in charge of the prison at around 7.30pm and received a handover from another CM. She was aware that it had been a busy evening with two concurrent emergencies, including Mr Delahunty, that required hospital admissions. She said that around 8.50pm she was contacted by the bedwatch prison officers who had escorted Mr Delahunty to hospital. They told her that Mr Delahunty's mother had phoned the hospital and wanted to visit her son. At this point, she said she did not know whether or not the prison had notified Mr Delahunty's family that he was hurt and in hospital. She told the bedwatch staff to tell Mr Delahunty's mother if she phoned again or tried to visit that she should contact her at the prison. She contacted the duty governor who said that he would speak to Mr Delahunty's mother in the morning after the hospital had updated him. She said that Mr Delahunty's mother phoned the prison at around 8.50pm, and she

told her that her son had been taken to hospital injured and that the duty governor would speak to her in the morning.

98. At 9.30am on 26 March, the hospital doctor updated a nurse about Mr Delahunty's condition. Mr Delahunty had been placed in a chemically-induced coma because he had 28% third degree burns. The doctor said that he was in a critical condition but might survive. The duty governor phoned Mr Delahunty's sister and updated her.

99. Two prison managers in the safer custody team were appointed as prison family liaison officers. At 10.30am, they called Mr Delahunty's sister who agreed to meet them at the hospital on 27 March. When they met, Mr Delahunty's sister told them that she had received phone calls and texts asking her to pay money into a bank account, details of which she was given. The family liaison officers submitted an intelligence report.

100. Risley maintained contact with Mr Delahunty's family, and in line with national instructions, they contributed to the costs of the funeral.

Support for prisoners and staff

101. A CM debriefed the staff who had been involved in the emergency response after Mr Delahunty was transferred to hospital on 25 March. He spoke separately to the care support worker and the prisoner. All staff and prisoners were offered the support of the prison's care team.

102. Risley posted notices informing other prisoners of Mr Delahunty's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Delahunty's death.

Post-mortem report

103. We are still awaiting the results of a post-mortem examination. The toxicology report confirmed that PS was found in Mr Delahunty's system. A makeshift pipe found in Mr Delahunty's cell at the time of his death was found to contain PS.

Inquest

104. An inquest was concluded in November 2024 which concluded that Mr Delahunty's death was due to misadventure. The coroner gave a verdict in which it was recorded that Mr Delahunty was found in his cell with his upper body in flames. The smoke alarm did not sound at this time. Prison officers extinguished the fire. Mr Delahunty was transported by ambulance to hospital where he died from his injuries. The use of spice was prevalent and unprecedented at the time of Mr Delahunty's death. There was inadequate communication about Mr Delahunty's drug misuse between healthcare, the prison and CGL which may have led to the questionable management of Mr Delahunty's substance abuse. Furthermore, the prison had knowledge of the unsafe ignition method.

Findings

Assessment of risk

105. Mr Delahunty had a number of risk factors, including a history of self-harm, substance misuse, depression, anxiety and anger issues. He was prescribed antidepressants. He was difficult to manage because his use of PS resulted in poor behaviour.

106. Mr Delahunty was monitored under ACCT procedures for brief periods four times between his arrival at Risley in May 2017 and his death.

107. PSI 64/2011 on safer custody requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm, and to take appropriate action. The PSI states that staff should decide at the first case review whether to refer someone for mental health or substance misuse support services and ensure that the referral(s) are made.

108. In Mr Delahunty's case, healthcare and mental healthcare team staff attended all four first ACCT reviews held. Although they identified his risk factors, they failed to refer him for a mental health assessment or to provide consistent information to CGL about his substance misuse.

109. The PSI requires that caremaps reflect a prisoner's needs, level of risk and the triggers of their distress. They should aim to address issues identified in the ACCT assessment interview. They must be tailored to meet prisoners' individual needs and reduce risk. They must be time-bound and say who is responsible for completing the action.

110. At the ACCT review on 18 July, the panel noted that Mr Delahunty had been referred to the mental health team. This was not recorded or updated on the caremap nor recorded on SystmOne. There was no evidence that Mr Delahunty saw a mental health nurse. Following Mr Delahunty's self-harm on 7 September, staff failed to update the caremap and to note a number of concerns discussed that affected his risk of self-harm, including being far from his family, his PS use and his sentence progression. The caremap also failed to note that they had referred Mr Delahunty to the mental health team's weekly referral meeting.

111. Although Mr Delahunty self-harmed at Risley, there is no evidence that he had thoughts of suicide at Risley or that his self-harm was an attempt to take his life. We found no evidence that Mr Delahunty intended to set fire to himself on 25 March. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

- **staff have a clear understanding of their responsibilities and the need to record relevant information about risk;**

- **prison, healthcare and/or mental health staff work jointly to manage prisoners at risk of suicide and self-harm; and**

- **case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.**

Allegations of violence and intimidation

112. PSI 64/2011 sets out how violent prisoners should be managed. It says that all verbal and physical acts of violence must be challenged, appropriate sanctions for perpetrators applied robustly, fairly and consistently, and victims supported and protected. Being a victim of intimidation or violence is a recognised risk factor for suicide and self-harm.

113. Mr Delahunty twice reported that he had been bullied by other prisoners at Risley due to debt that he had accumulated from his illicit drug use (27 May and 14 July 2017). However, there was no evidence before his death that he was being bullied, although intelligence reports submitted after his death indicated that he might have been in debt to other prisoners for drugs.

114. There is evidence that Mr Delahunty was heavily involved in the illicit drug trade in prison and in acts of violence. While there was no evidence that Mr Delahunty had been bullied into taking drugs, he was a victim of drug debt. However, this did not stop him taking PS. Staff at Risley told the investigator that Mr Delahunty was a likeable prisoner who was hooked on taking drugs, and this had an adverse effect on his behaviour.

115. We are satisfied that there was no evidence available before Mr Delahunty's death that would have given staff reason to monitor him as a victim under anti-bullying procedures. We make no recommendation.

Psychoactive substances at Risley

116. The investigator interviewed the Head of Healthcare, the Head of Security, the Head of Violence and the Head of Safer Custody. All recognised the significant challenge of PS use at Risley over the previous 12-18 months. They said that this had had an impact on prison and healthcare staff's morale, on resources and on the delivery of the regime. They said that there had sometimes been daily PS incidents, and on one occasion, there had been 18 recorded incidents in a day, coupled with violence and safer custody concerns. It was identified in 2017 that drones were one of the main ways that drugs were coming into Risley, which had the fourth highest reported drone activity in prisons in England and Wales.

117. We examined Risley's PS and substance misuse strategy, which was reviewed in January 2018, and concluded that there were reasonable measures in place to respond to the challenges of illicit substances, including PS. In the past twelve months, the Governor has adopted various measures to combat the supply, demand and management of prisoners suspected of taking illicit drugs, particularly PS. While these measures have not eradicated the supply and demand, they have

reduced the level of recorded PS incidents. Some of the measures implemented in the last twelve months include:

- A weekly multidisciplinary Safety Intervention Meeting (SIM) to discuss prisoners at risk, those who have any complex needs and the use of PS in the prison.
- Putting grills over all windows in D and E Wing, identified as the main areas of drone activity, to prevent prisoners accessing packages dropped by drones.
- A multi-agency security project at regional level to review drone activity.
- Photocopying prisoners' mail in response to an increase in PS sprayed on letters. Staff also telephone solicitors to confirm that all Rule 39 (legally privileged confidential mail) is legitimate.
- CGL-led initiatives, including a brief screening and awareness about the dangers of PS in the Welcome and Reception centre, trained peer mentors to work in the welcome centre, use of a weekly family group worker and psychoactive substances specialist, pop-up PS awareness sessions delivered on wings, wing observations, intelligence reports and PS information leaflets for prisoners.
- A handover form for rapid communication to the CGL team from healthcare staff if prisoners have been using PS.
- Introduction and use of a passive search dog which is based in the prison, works alongside regional dog and search teams.
- Improved links with the police for intelligence-led searches.
- Regular regional meetings of the Heads of Security to discuss trends and issues involving PS supply.
- A number of Safer Custody prisoner roadshows to deal with debt and reinforcing their violence reduction policy.

118. Although we consider that Risley have responded proactively to the evolving challenges of PS supply and demand, we recognise that this needs to continue. Mr Delahunty was apparently able to obtain and use PS without difficulty at Risley and continued to do so despite being made aware of the dangers, losing privileges and having additional days added to his sentence.

119. It is clear, however, that more needs to be done to reduce both the supply and the demand for PS at Risley. We note that there is evidence that prisoners are more likely to use PS when they are subject to a reduced regime and spend long periods in their cells. We therefore make the following recommendations:

The Governor should ensure that prisoners are unlocked during the core day and are able to engage in full-time purposeful activity.

The Governor should ensure that staff report and record all instances of illicit drug misuse and refer prisoners promptly to appropriate prison support services. Psychoactive substances across the prison estate

120. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS was then a source of increasing concern in prisons. Not only does PS use have a profoundly negative impact on physical and mental health, but trading in these substances can lead to debt, violence and intimidation. Mr Delahunty's death is a clear example of how dangerous PS is and illustrates why prisons must do all they can to eradicate its use.

121. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern about the ready availability of drugs at Risley and it is obviously a cause for concern that Mr Delahunty was apparently able to obtain and use illicit drugs so readily at Risley.

122. Risley is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

123. In a recent investigation, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of drug-related deaths she was investigating. The Chief Executive has told us that HMPPS plans to issue a national drug strategy in the autumn of 2018. We therefore make no further recommendation.

124. Nevertheless, the scale of the challenge facing prisons in addressing the risks of PS needs to be properly acknowledged. It is simply not acceptable that prisons are expected, at worst, tacitly to accept the kinds of behaviours which led to Mr Delahunty's horrific death, and, at best, to deploy interventions which will only ever achieve limited success. This is a national problem which needs national solutions and an open acknowledgement of the resources required to address it effectively.

Clinical care

125. The clinical reviewer, considered that the standard of care Mr Delahunty received in prison was not equivalent to that which he could have expected to receive in the community. She noted that there was a lack of integration and information sharing between primary healthcare, substance misuse and mental health services, particularly as Mr Delahunty had a long history of substance misuse.

Responding to prisoners under the influence of illicit substances

126. There is significant evidence that Mr Delahunty's illicit drug use on the day of his death was not an isolated incident, and that he regularly misused drugs at Risley in the period before his death. He made candid admissions to prison staff about his history of drug use. On occasion, he told staff that he would engage with substance misuse recovery groups at the prison but he did not do so and he continued using drugs.

127. Healthcare staff attended Mr Delahunty's cell a number of times after he was found under the influence of PS. Some of these were serious incidents and were recorded as code blue emergencies. The clinical reviewer noted that on most occasions, healthcare staff examined Mr Delahunty and recorded their clinical observations. However, the National Early Warning Score (NEWS) system (a tool to identify those whose health is deteriorating) was not used and the consistency and detail of recording Mr Delahunty's clinical observations was variable. When healthcare staff assessed Mr Delahunty after such incidents, they handed his care back to wing officers with instructions to monitor him, and to call healthcare again if his condition deteriorated. We are concerned that this could mean that care was handed back to non-clinical staff, with little specific direction about what signs of deterioration they should look out for.

128. We are also concerned that when Mr Delahunty was seen after using PS, there is no indication on SystmOne that healthcare staff had referred him to CGL, the substance misuse service. The CGL team leader, said that the first record of CGL being told of Mr Delahunty's PS use was in January 2018. Until then, CGL had not been aware of the nature and extent of Mr Delahunty's illicit drug use or how often the healthcare team had been called to see him. When CGL received a referral in January 2018, he said that Mr Delahunty declined support.

129. CGL's lack of involvement in Mr Delahunty's care is extremely disappointing, especially as wing and healthcare staff were fully aware of the extent of his illicit substance misuse (PS) at Risley. It is shocking that over an eight-month period (May – December 2017), Mr Delahunty's many instances of PS use failed to trigger CGL's support, and that existing systems for multi-disciplinary information sharing did not work. Given the safety risks associated with PS use, this is unacceptable and a robust information sharing system and process for joint risk assessment is urgently needed.

130. The CGL team leader told us that at the time of Mr Delahunty's death, CGL had only used SystmOne for a few months, and that this was beginning to improve information sharing and referrals to CGL. Nonetheless, it is clear that a formalised process for recording and sharing information about the care of prisoners found under the influence of illicit substances is required. We make the following recommendation:

The Governor and Head of Healthcare should formalise the way that PS incidents are assessed and the handover of care from healthcare to prison staff including:

- **The development and introduction of a PS assessment template for SystmOne, to include routine recording of National Early Warning Scores (NEWS).**
- **The way that care and monitoring instructions are communicated to prison colleagues.**
- **Notifying Change Grow Live (CGL) when primary healthcare staff are required to attend a PS incident.**

Mental health support

131. Mr Delahunty had a history of depression and anxiety, for which he took anti-depressants. He self-harmed seriously enough to require hospital admission in May 2017 but the healthcare team was unaware of his discharge from hospital and unable to follow up on any immediate care. It is essential that healthcare staff are aware of a prisoner's discharge from hospital, especially after serious self-harm so that hospital discharge advice or appropriate care plans can be implemented. The clinical reviewer noted that this was a missed opportunity for staff to have completed a mental health assessment after a period of crisis. Mr Delahunty then failed to attend several healthcare appointments to dress his wound and remove his stitches, and the healthcare and mental healthcare teams missed a further opportunity to contribute to his wellbeing.

132. While Mr Delahunty did not consistently show signs of mental ill health at Risley, he self-harmed, was monitored under ACCT procedures a number of times and showed signs of frustration, anxiety and anger, all of which should have prompted staff to refer him for a mental health assessment. While we acknowledge that a member of the mental and healthcare team saw Mr Delahunty at the first ACCT reviews, none completed a mental health assessment despite his clear risks. Early mental health intervention might have supported Mr Delahunty through periods of crisis. We make the following recommendations:

    The Governor and Head of Healthcare should implement a process to ensure that healthcare staff are notified when prisoners return from hospital and that all discharge information is shared promptly to inform care planning.

    The Governor and Head of Healthcare should ensure that prison, healthcare and mental health teams share all relevant information to ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.

Detection and extinguishing of cell fires

133. The Crown Premises' Fire Inspector, HMPPS (Health, Safety, Fire & Litigation Cluster for the North-West Region) and the fire service also investigated the circumstances of Mr Delahunty's death. The fire service report noted the ignition source of the fire in Mr Delahunty's cell as "smoking materials" and the main cause of fire as "Careless handling - due to sleep or unconsciousness".

134. The HMPPS Health, Safety and Fire report noted that the staff acted swiftly and in the best interest of Mr Delahunty's safety to remove him from his cell. It described the fire as unusual as no items other than the Mr Delahunty's clothing was alight. It noted that the domestic smoke detectors did not activate at the time of the fire. However, when they were tested immediately after the incident, they operated effectively and were noted to have been installed in the correct position in line with fire safety instructions.

135. There was evidence of the use of illicit smoking paraphernalia in the cell, including two metal foil strips in the electrical socket, a plastic spoon with a gel-type substance and an improvised pipe. The report noted the use of metal foil strips in electrical sockets, placed in a gel to heat up to a temperature sufficient to cause a

synthesis in the gel to provide an ignition source. It noted that this technique had been seen in a number of cell fire incidents across the prison estate and this was the most likely ignition source in this incident.

136. The report recommended that the Governor should investigate the use of PS in the prison. It also recommended that prison bedding should be urgently reviewed as, if Mr Delahunty's bedding had not been issued by the prison in line with fire safety standards, the fire might have "been more significant".

137. E Wing has not yet been upgraded with in-cell Automatic Fire Detection. The report noted that smoke detectors were outside cells and were domestic smoke alarms approved by the National Fire Safety Team. They are visually checked daily and a functional check is carried out on a monthly basis.

138. Before Mr Delahunty's door was opened, no smoke had escaped onto the landing area which explained why the smoke detector was not activated during the incident. The fire report noted that Risley might want to seek guidance from the National Fire Safety Section about the siting of smoke detectors.

139. We make no recommendations on fire safety as we are aware that the Governor will need to address the recommendations in all the fire investigation reports.

Emergency response

140. Staff attended Mr Delahunty's cell promptly and assessed the situation appropriately and in line with their safety policy and training. They ensured that the fire was extinguished before opening the cell door. They removed Mr Delahunty to a place of safety in less than four minutes of the alarm being sounded and administered first aid immediately.

141. In line with Prison Service Instruction 03/2013, staff should have used a medical emergency code when they found Mr Delahunty. This would have triggered the control room to call an ambulance immediately. Instead, a support worker pressed the general alarm button after she discovered Mr Delahunty on fire, which meant that an ambulance and the fire service were only called after a CM radioed the control room.

142. We are concerned that the support worker and the first responding officers did not radio an emergency code, even though staff had seen Mr Delahunty on fire and knew that this was not a false alarm. Mr Delahunty received prompt emergency first aid and it is unlikely that the three-minute delay in calling an ambulance would have changed the outcome for him. However, such a delay could be critical in other life-threatening situations. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and radio a medical emergency code in an emergency situation, including in the event of a fire.

Staff support

143. This was an extremely distressing incident for all staff involved and the competent handling of it is testament to their training and skills. Without exception, all of the staff interviewed agreed that they had been very well supported by colleagues and managers after the incident. It was clear that some of the interviewees were still coming to terms with the events of 25 March and had been significantly affected by them. A post-incident group support session was also arranged.

144. However, a number of staff said that they found it uncomfortable to speak in a group situation. Individual support and counselling had also been offered to staff. Staff involved have undoubtedly found peer support very useful, but it was apparent from the investigation interviews that some staff are still very traumatised by the incident. While Risley has acted in line national instructions to support staff and we do not make a recommendation, we draw this issue to the Governor's attention as he might exceptionally wish to make further support available to staff.

Notifying families of serious illness

145. Prison Rule 22(1) requires the Governor to tell a prisoner's next of kin or spouse if the prisoner dies, becomes seriously ill or sustains any severe injury. In this case, Mr Delahunty's family should have been told when he was taken to hospital seriously injured. This did not happen.

146. Instead his family learnt from other sources – presumably via a prisoner or prisoners using illicit mobile phones - that he had been involved in a serious incident and subsequently that he had been transferred to hospital. They tried a number of times to find out what happened by contacting the prison and hospital. Yet, Risley did not speak to his family until 8.50pm, over three and a half hours after the incident.

147. While it is important that the prison maintain strict security procedures in such circumstances, it is equally important that they contact a prisoner's next of kin promptly to avoid them hearing distressing news from another source. We make the following recommendation:

The Governor should ensure that when a prisoner is taken to hospital seriously ill, their next of kin is informed without delay, are provided with comprehensive and accurate information and are kept informed of progress.

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