Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Liam Elston, a prisoner at HMP Swaleside, on 11 February 2025

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

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

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Liam Elston died on 11 February 2025, from the toxic effects of psychoactive substances (PS) at HMP Swaleside. He was 36 years old. I offer my condolences to Mr Elston's family and friends.

Mr Elston had a long history of illicit drug use and was frequently suspected of being under the influence of PS while at Swaleside. I am satisfied that staff at Swaleside offered him appropriate support with his substance use issues, though he often declined help.

I make no recommendations.

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

Adrian Usher
Prisons and Probation Ombudsman **November 2025**

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Summary

Events

1. Mr Liam Elston was remanded in prison, charged with aggravated burglary, on 4 December 2023. He was subsequently sentenced to four years imprisonment and was moved to HMP Swaleside on 10 July 2024.

2. Mr Elston had a long history of illicit drug use and was frequently suspected of being under the influence of drugs while in prison. During his time at Swaleside, he was suspected of being under the influence of psychoactive substances (PS) on 11 occasions.

3. The prison's substance misuse service frequently offered support to Mr Elston but he often refused to engage. They discussed the dangers of illicit drug use with him and gave him harm minimisation advice.

4. During the routine early morning check shortly before 8.00am on 11 February 2025, staff discovered Mr Elston unresponsive on the floor of his cell. They radioed a medical emergency code and healthcare staff responded. A prison paramedic assessed that Mr Elston was dead and declared life extinct at 8.05am.

5. The post-mortem report concluded that Mr Elston died from the toxic effects of PS.

Findings

6. The clinical reviewer found that there was frequent contact between Mr Elston and substance misuse services at Swaleside and appropriate clinical management when Mr Elston was found under the influence of drugs. She concluded that these aspects of Mr Elston's care were equivalent to that which he could have expected to receive in the community.

7. Both HM Inspectorate of Prisons and the Independent Monitoring Board reported that the availability of illicit drugs was a major issue at Swaleside and that sophisticated drones were now being used to deliver packages. The prison told us that they are taking steps to address this, including working closely with local police.

8. We make no recommendations.

The Investigation Process

9. HMPPS notified us of Mr Elston's death on 11 February 2025.

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

11. The investigator visited Swaleside on 14 February. She obtained copies of relevant extracts from Mr Elston's prison and medical records.

12. The investigator interviewed five members of staff at Swaleside on 9 and 10 April.

13. NHS England commissioned an independent clinical reviewer to review Mr Elston's clinical care at the prison. She conducted joint interviews with the investigator at the prison on 9 April and over video call on 10 April.

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

15. The Ombudsman's office contacted Mr Elston's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Elston's mother wanted to know why Mr Elston had not been found earlier. This has been addressed in the report.

16. We shared our initial report with HMPPS and the prison's healthcare provider, Oxleas NHS Foundation Trust. They found no factual inaccuracies.

17. We sent a copy of our initial report to Mr Elston's mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Swaleside

18. HMP Swaleside, on the Isle of Sheppey, is part of the long-term high security estate, predominantly holding prisoners judged to be high risk and those serving long sentences. Oxleas NHS Foundation Trust provides physical and mental healthcare services, including 24-hour nursing cover. Change Grow Live (CGL) provides substance misuse services.

19. Swaleside has a specialist drug recovery wing (E Wing). The criteria for acceptance onto this wing is that prisoners must be ready to engage with CGL, be abstinent from substances and agree to be subject to security checks.

HM Inspectorate of Prisons

20. The last full inspection of Swaleside was in October 2021. Inspectors reported that while good progress had previously been made towards reducing the supply of illicit drugs, some of the work, for example suspicion drug testing, had stopped during COVID-19 restrictions. The mandatory drug testing positive rate was high, at 25%, but work to reduce the supply of drugs was having some success. In HMIP's survey, 37% of respondents said that it was easy to get illicit drugs in the prison. Inspectors also reported that staff shortages resulted in limited time out of cell for most prisoners.

21. Following an independent review of progress in July 2022, inspectors reported that the staffing problems had become worse leading to very limited time out of cell.

22. Another independent review of progress was carried out in August 2024. Inspectors noted that illicit drugs were now even more readily available than they had been during the previous full inspection. This was demonstrated by the higher positive drug testing rate. The average rate was around 32% over the last year, but in June 2024 it had peaked at over 56%. Inspectors also noted that there had been a substantial change in the way drugs and other illicit items were being supplied and sophisticated drones were now used to deliver packages. This was undermining safety and stability in the prison and the use of drugs underpinned the lack of progress in many of the concerns set out in their report.

23. Inspectors said they were impressed that the acute shortage of officers which they noted in their last report, had now been addressed through proactive recruitment. However, at the time of the follow up inspection, just over half the officer group had less than a year in service and this would increase over the next two months as newly trained officers were due to take up post. This level of inexperience inevitably led to a continuing lack of confidence and assertiveness in the management of prisoners.

Independent Monitoring Board

24. 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 April 2024, the IMB reported that there was an unprecedented staff shortage.

25. The Board noted that despite increased security measures, illicit items were a major issue. There were targeted cell searches to find the illicit items. However, the increased number of drones being used to drop illicit substances into the prison were increasing.

26. The Board noted that drug and alcohol rehabilitation was offered through CGL specialist caseworkers. However, they noted that the caseworkers had an unmanageable caseload as over 250 prisoners were receiving assistance from five caseworkers.

Previous deaths at HMP Swaleside

27. Mr Elston was the 23rd prisoner to die at Swaleside since February 2022. Of the previous deaths, eight were self-inflicted, 11 were due to natural causes, two were drug related and one was unascertained. Up to the end of August 2025, there have been three further deaths, all from natural causes.

Psychoactive substances

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

29. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key Events

30. On 4 December 2023, Mr Liam Elston was remanded in prison charged with aggravated burglary. He was subsequently sentenced to four years imprisonment and was moved to HMP Swaleside on 10 July 2024.

31. Mr Elston had a long history of illicit drug use and was frequently found under the influence of drugs throughout his time in prison. Staff suspected he was using psychoactive substances (PS).

32. A few days after his arrival at Swaleside, on 13 and 14 July, staff suspected that Mr Elston was under the influence of PS as he was unable to stand or speak. On 17 July, a substance misuse worker from Change Grow Live (CGL – the prison's substance misuse service) saw Mr Elston to offer support. Mr Elston said he would like to engage and the CGL worker discussed harm reduction and tolerance levels with him. She also gave him a harm reduction leaflet.

33. Staff suspected Mr Elston was under the influence again on 18 and 23 July. On 25 July, a CGL worker tried to carry out an assessment with Mr Elston, but he said he had changed his mind and no longer wished to engage with CGL.

34. On 13 August, Mr Elston passed a letter to prison staff. It said he could not leave his cell as he would be stabbed as he was in debt for £1,000. Staff agreed he could isolate in his cell on the wing.

35. On 20 August, staff started suicide and self-harm prevention procedures (known as ACCT) as Mr Elston said he was in debt, under threat from prisoners and felt suicidal. The next day, he was suspected of being under the influence of PS. Staff stopped ACCT monitoring on 6 September, after Mr Elston was moved to the vulnerable prisoners' (VP) wing and said he was fine and no longer needed any support.

36. On 4 October, Mr Elston was moved to Delta Wing, a standard wing. A week later, Mr Elston was suspected of being under the influence of PS.

37. On 14 October, staff started ACCT monitoring again after Mr Elston slid a note under his door saying he was going to kill himself. He told staff that his in-cell telephone did not work, he had not received an evening meal and his cell was cold, which had left him feeling low in mood, anxious, paranoid and with negative thoughts.

38. The next day, staff moved Mr Elston to another cell. On 21 October, a CGL worker tried to complete an assessment with Mr Elston at his cell door. Mr Elston would not complete the assessment and the CGL worker recorded that he would be seen again in a week's time.

39. Staff stopped ACCT monitoring on 25 October.

40. On 30 October, Mr Elston refused to leave his cell when other prisoners were allowed out because he was in debt. He said he wanted to detox from drugs and asked to move to the drug recovery unit. He said he would also like to engage with the mental health team so prison staff completed a mental health referral.

41. On 1 November, a CGL worker tried to complete an assessment with Mr Elston. Mr Elston said that he did not want anything and told the CGL worker to go away.

42. On 20 November, prison staff found Mr Elson lying on his cell floor unresponsive and radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). The duty nurse attended. Mr Elston regained consciousness and was agitated. He refused to let anyone take his physical observations. Staff concluded he was under the influence and they sent a referral to CGL.

43. On 29 November, a CGL worker completed an assessment with Mr Elston. The CGL worker recorded that they discussed tolerance, impulsivity, not sharing equipment, not using alone and the dangers of using illicit substances. They read the harm reduction statement, which Mr Elston signed. However, Mr Elston later refused to engage and signed the declined to engage form.

44. On 2 December, Mr Elston declined to engage with a CGL worker. The CGL worker gave harm minimisation advice and told Mr Elston how he could re-engage with the service if he changed his mind.

45. On 20 December, a mental health nurse assessed Mr Elston. The nurse recorded that Mr Elston said his mental health felt okay but his sleep was poor. He was still isolating for his own safety. The nurse noted that he was neat and clean, and he was calm and coherent. The nurse planned to see him again in 28 days.

2025

46. On 6 January 2025, Mr Elston was moved to the drug recovery wing (Echo Wing).

47. On 10 January, a CGL worker carried out an assessment with Mr Elston. He disclosed that he had been using PS daily in prison and had last used five days ago. He asked for help with his mental health and the CGL worker made a mental health referral. The mental health team discussed the referral six days later and booked a routine mental health assessment.

48. On 15 January, prison staff suspected Mr Elston was under the influence. However, healthcare staff did not confirm this.

49. On 23 January, a mental health nurse saw Mr Elston. He told her that he was fine and had no mental health problems. The referral was closed.

50. On 30 January, prison staff found Mr Elston unresponsive in his cell and radioed a code blue. Healthcare staff attended and assessed that Mr Elston was under the influence.

51. Mr Elston telephoned his grandmother on 6 February and said that he was stressed about his upcoming court case and his ex-partner and that he was smoking a lot [of drugs].

52. On 7 February, Mr Elston was found in another prisoner's cell and healthcare staff assessed he was under the influence. The next morning (at approximately 11.45am), healthcare staff assessed he was again under the influence.

53. Mr Elston made further calls to his mother and grandmother over the next few days. During these calls he asked his mother for money, if anyone had sent her their bank details, and for his mother to pay money into other bank accounts.

54. The last telephone call Mr Elston made to his mother was on 10 February. He asked his mother to transfer money to an account belonging to a prisoner because he wanted to buy vapes. During this call, Mr Elston was heard asking a prisoner, "Have you got a joint for me?"

55. CCTV shows that Mr Elston entered his cell at 4.49pm and was locked in for the night shortly after. Staff checked on him at 4.55pm, 5.06pm and 9.09pm. Nothing untoward was noted. Mr Elston did not ring his emergency cell bell during the night and staff were not otherwise expected to check him until the first routine check the following morning.

Events of 11 February 2025

56. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 11 February.

57. At interview Officer A said he was allocated duty as the early start officer, required to complete the first routine roll and welfare check of all cells. He arrived at Mr Elston's cell at 7.50am and he looked through the observation panel. The light was on but the observation panel was blocked by a tissue. Officer A knocked on the cell door. There was no response, so he said that he tried looking through the cracks of the door. He said he could not hear or see any movement within the cell. He finished checking the two remaining cells and then went to the office to collect a key to the inundation port (an opening in the cell door that enables a fire hose to be directed into the cell). He returned to the cell at 7.52am. He said he was able to dislodge the blockage and saw Mr Elston lying on his back on the floor. He ran downstairs to get staff, and they returned to the cell and went in.

58. Officer A radioed a code blue at 7.54am. He said he saw that Mr Elston's arm was purple. Other officers and healthcare staff entered the cell. Control room staff telephoned for an ambulance at 7.56am.

59. A prison paramedic checked for signs of life and noted that Mr Elston had no pulse, his pupils were dilated, he had rigid limbs and hypostasis (pooling of the blood due to a lack of circulation). At 8.05am, after discussions with other healthcare staff, he declared life extinct. Ambulance paramedics arrived at 8.20am and agreed with the prison paramedic's assessment.

60. Later that morning, police attended the cell and noted that there was drug paraphernalia in the cell. Tampered vape capsules and smoked/burnt paper were found in the cell. Intelligence reports submitted after Mr Elston's death said that on the night of 10 February, he had been shouting to the prisoner next door that he was going "to get on it" which was believed to mean that he was going to take PS.

Contact with Mr Elston's family

61. On 11 February, the prison appointed a supervising officer as the family liaison officer and a prison chaplain as the deputy family liaison officer. They and a member of the Care Team visited Mr Elston's next of kin and informed them of Mr Elston's death and provided support.

62. In line with national policy, the prison contributed to the costs of Mr Elston's funeral.

Support for prisoners and staff

63. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

64. After Mr Elston's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

65. The prison posted notices informing other prisoners of Mr Elston's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Elston's death. Listeners were deployed to wing to offer support.

Post-mortem report

66. The post-mortem report concluded that Mr Elston died from 5F-MDMB-PINACA (a synthetic cannabinoid, PS) toxicity.

Findings

Availability of drugs at Swaleside

67. Mr Elston was frequently suspected of being under the influence of PS at Swaleside, which suggests that drugs were readily available. In the months leading up to Mr Elston's death, there were high numbers of prisoners found under the influence: 26 in November 2024, 29 in December 2024, 18 in January 2025 and 48 in February 2025.

68. Both HM Inspectorate of Prisons and the IMB reported that the availability of illicit drugs was a major issue at Swaleside. In fact, inspectors found that illicit drugs were even more readily available when they inspected the prison in August 2024 compared to their previous inspection in September 2023. They reported that there had been a substantial change in the way illicit drugs were being supplied and that sophisticated drones were now being used to deliver packages.

69. One of the priority aims within Swaleside's 2024-25 Security Strategy is to improve safety by reducing ingress of illicit items. It lists a number of measures including searches, perimeter security, intelligence gathering and analysis, and working with the Serious Organised Crime Unit and local police to tackle ingress by drone.

70. The prison also has measures in place to inform prisoners about the risks of illicit drug use. We were told that CGL met with every new person on reception and offered the opportunity to work with them and if they declined, they offered harm minimisation and safety advice, including information on the dangers of new drugs such as synthetic opioids. There were also PS groups and wing drop ins for information, support and advice. We are satisfied that the prison is taking steps to tackle the supply and demand for drugs and make no recommendation.

Clinical care

71. The clinical reviewer found evidence of regular contact with the substance misuse team at Swaleside and many occasions where they engaged with Mr Elston and offered support and signposting. She also found evidence of appropriate clinical management when Mr Elston was found under the influence. She concluded that these aspects of his care were of a good standard and equivalent to that which he could have expected to receive in the community.

72. The clinical reviewer found that aspects of Mr Elston's care relating to his isolation, his refusal of medication and involvement of healthcare staff in ACCT procedures were not of the required standard. She made five recommendations. We do not repeat them here as the issues were not directly relevant to Mr Elston's death but the Head of Healthcare will wish to address them.

Inquest

73. At the inquest, held on 27 July 2026, the Coroner concluded that Mr Elston's death was drug related.

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