Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Deville, a prisoner at HMP Manchester, on 7 July 2024

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.

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 Paul Deville died from acute myocardial insufficiency (acute heart failure) on 7 July 2024, while a prisoner at HMP Manchester. This was caused by coronary artery atheroma (blocked arteries) and synthetic cannabinoid (psychoactive substances) use. Mr Deville was 53 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that Mr Deville's clinical care was equivalent to that which he could have expected to receive in the community.

Mr Deville had a history of substance misuse in the community and in prison. While at Manchester, the drug and alcohol recovery service tried to engage with him and warned him of the risks associated with drug use. However, he told staff he would not stop taking them.

Substance misuse in prison is one of the biggest challenges that HMPPS faces and it is a complex, multi-faceted problem with no simple answer. In October 2024, following an inspection of Manchester, HM Chief Inspector of Prisons issued an urgent notification to the Secretary of State for Justice as they had noted a significant deterioration since their previous inspection. They were particularly concerned about the use of drones in delivering drugs and other illicit items into the prison and the proportion of prisoners testing positive for drugs.

We do not underestimate the significant challenges Manchester faces in tackling organised crime and the supply of drugs into the prison which will require the support of HMPPS, the police and other security services.

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 **August 2025**

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Summary

Events

1. In September 2010, Mr Paul Deville was sentenced to 11 years in prison for aggravated burglary and malicious wounding.

2. On 3 July 2023, Mr Deville was transferred to HMP Manchester.

3. Mr Deville had a history of using illicit substances in the community and in prison, and he also had significant problems with alcohol. When he arrived at Manchester, Mr Deville refused any involvement from substance misuse services.

4. On 7 July 2024, staff found Mr Deville unresponsive in his cell. A medical emergency code blue was called (used when a prisoner has difficulty or has stopped breathing) and staff started cardiopulmonary resuscitation (CPR). Paramedics arrived and continued resuscitation efforts but they were unable to revive Mr Deville and pronounced life extinct at 4.55pm.

Findings

5. Mr Deville had a history of substance misuse. The prison's drug and alcohol recovery service tried to engage with Mr Deville but he made it clear he did not want their support.

6. The supply of and demand for drugs is a significant issue at Manchester.

7. When staff found Mr Deville, they should have immediately radioed a medical emergency. This is an issue that we have highlighted to Manchester in previous investigations.

Recommendations

- The Governor should ensure that the new drug strategy precisely diagnoses the issues to be tackled, sets out the specific and measurable actions, with timescales to address them, and includes a robust assurance process, including metrics against which the prison can monitor the progress of actions.

- The PGD for the LTHSE should continue to monitor the actions being taken by HMP Manchester to address the long-standing issues around emergency responses.

The Investigation Process

8. HMPPS notified us of Mr Paul Deville's death on 7 July 2024.

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

10. The investigator obtained copies of relevant extracts from Mr Deville's prison and medical records, including intelligence reports. He watched CCTV and body-worn video camera (BWVC) footage of the emergency response. Mr Cameron also obtained information from the Northwest Ambulance Service.

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

12. The investigator and clinical reviewer interviewed three members of staff on 28 and 29 August 2024. The investigator interviewed a further officer in October.

13. Another PPO investigator interviewed the Head of Safer Custody, the Acting Head of Healthcare and the Drug Trial Lead on 11 September.

14. Another investigator took over the investigation in February 2025.

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

16. The Ombudsman's office contacted Mr Deville's parents to explain the investigation and to ask if they had any matters, they wanted him to consider. Mr Deville's parents gave the investigator some information, but they did not have any specific questions.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS who pointed a factual inaccuracy, and this report has been amended accordingly.

18. Mr Deville's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Manchester

19. HMP Manchester is a high security category B training prison, which accepts long-term prisoners. There is a category A unit for prisoners who pose a greater security risk. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour primary care and mental health care at the prison. Drug and alcohol recovery services are delivered by Delphy Medical seven days a week.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Manchester took place in September 2024. Following this, HMIP issued an urgent notification to alert the Lord Chancellor and Secretary of State directly of their significant concerns about Manchester's performance.

21. Inspectors reported that they found a very unstable environment due to organised criminal activity, serious violence and widespread drug use and an officer group that lacked confidence and capability. They recorded that the proportion of prisoners testing positive for drug use was very high at 39%. They identified examples of poor physical security and a failure to replace damaged netting which hampered the prison's efforts to fight the supply of illicit items, including drugs. They noted that in the last year, there had been over 220 drone sightings which was by far the highest across all prisons in England and Wales.

22. In respect of the support and treatment for prisoners with addictions, inspectors reported that the substance misuse support was a seven day a week service which was well embedded within the prison and the staff worked closely with healthcare and prison staff.

23. Since the inspection HMPPS and the Ministry of Justice have submitted an action plan which seeks to address HMIP's priorities and key concerns.

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. The latest annual report covered the year to February 2022, and reported on the ongoing impact of the pandemic. The main concerns were about a lack of staff and a lack of progress in relation to the installation of secure windows.

Previous deaths at HMP Manchester

25. Mr Deville was the sixteenth prisoner to die at Manchester since July 2021. Of the previous deaths, seven were self-inflicted, six were from natural causes, one was drug-related and the cause of one has yet to be determined. Up to the end of May 2025, there have been three self-inflicted deaths and one the cause of which has yet to be ascertained.

26. Our reports into three deaths at Manchester found delays in calling medical emergency response codes.

Psychoactive substances (PS)

27. PS refer to drugs or other substances that affect mental process. Synthetic cannabinoids and synthetic opioids (including nitazenes) 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.

28. 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

29. On 10 September 2010, Mr Paul Deville was sentenced to 11 years imprisonment for aggravated burglary. Mr Deville was released on licence in November 2015 but recalled to prison in February 2016.

30. Mr Deville had a history of alcohol and substance misuse in the community and prison. There are a number of entries in his prison record where Mr Deville had been found under the influence of illicit substances.

HMP Manchester

31. On 3 July 2023, Mr Deville was transferred from HMP Long Lartin to HMP Manchester. Officers recorded no concerns about his risk of suicide or self-harm. It was noted that he had last been managed under suicide and self-harm monitoring, known as ACCT, in 2021. Mr Deville's risk to others was considered high and he was given a single cell on A Wing (the prison's induction unit).

32. At Mr Deville's initial health screen, staff noted his history of substance misuse, anxiety and depression. Mr Deville declined to be referred to the substance misuse team.

33. On 4 July, a recovery worker, spoke to Mr Deville to introduce the drug and alcohol recovery service (DARS). Mr Deville did not want to engage. She told him how to access the service if he changed his mind.

34. On 9 September, an officer noted that Mr Deville had been found under the influence of an illicit substance and healthcare staff saw him.

35. On 10 September, a recovery worker, saw Mr Deville. She recorded that Mr Deville had said that he had been using drugs and would continue to do so. She gave him harm reduction advice and offered to sign him up to DARS support. She recorded that Mr Deville declined and said, *"Everyone has a time to go and if mine is here, then so be it."*

36. On 24 October, Mr Deville told staff that he had burnt himself after falling asleep on the pipes in his cell following an anaphylactic episode. A GP operating in Manchester, saw Mr Deville and sent him to hospital for treatment.

37. On 14 December, during a search of Mr Deville's cell, staff found two five litre tubs of liquid. Staff noted that Mr Deville brewed hooch (an illicitly distilled alcoholic drink).

38. On 17 January 2024, an entry in Mr Deville's security file noted that he had been seen under the influence of an unknown substance in the exercise yard.

39. On 9 March, during a routine search of Mr Deville's cell, staff found five litres of hooch under his bed. Mr Deville admitted that it belonged to him and he was subsequently placed on report.

40. On 5 April, a DARS worker saw Mr Deville as part of a wellbeing check following the death of another prisoner from suspected illicit substance use. He was given harm reduction advice.

41. On 5 May, an officer noted that staff had found a bottle of fermenting liquid in Mr Deville's cell. He was given a behaviour warning.

42. On 15 May, Mr Deville was taken to the segregation unit because he had climbed on to the wing's safety netting in protest at not being moved to another wing. (Mr Deville thought he was under threat due to an incident that had happened at another prison. We did not find any particular evidence to support this.)

43. On 2 July, Mr Deville left the segregation unit and moved to G Wing.

44. At approximately 5.00pm on 5 July, a Healthcare Assistant was called to Mr Deville's cell as officers were concerned that he was under the influence of drugs. She recorded that Mr Deville was lying on the floor, appeared uncoordinated and needed help from officers to move and sit up. It was agreed that officers would monitor him throughout the night.

45. At around 6.00pm, a nurse reviewed Mr Deville in his cell. She noted that he was conscious, coherent and denied illicit drug use.

46. At 12.46pm on 6 July, a recovery worker, visited Mr Deville in his cell. She recorded that he was standing in his cell, holding his hand against the wall to support himself. She said she believed he was under the influence and notified the officers on the wing. She recorded that he would be seen the following day about harm reduction.

47. A short while later, a nurse went to check on Mr Deville in his cell. She noted that he was swaying backwards and forwards and was conscious. She noted that no further intervention was needed.

Events of 7 July 2024

48. At 9.25am on 7 July, an officer unlocked Mr Deville's cell. CCTV footage shows that Mr Deville then left his cell and for the rest of the morning, he was seen moving freely around the wing, in and out of other prisoners' cells.

49. At 11.37am, a recovery worker, arrived at Mr Deville's cell. She recorded that they discussed harm reduction advice thoroughly.

50. At 12.09am, an officer went to Mr Deville's cell to lock it for lunchtime. She said that another prisoner was in the cell with Mr Deville and neither appeared under the influence.

51. At 12.10pm, a Supervising Officer (SO) arrived at Mr Deville's cell. He said that he told the other prisoner to leave the cell and once he had left, he locked Mr Deville's cell door. The SO told the investigator that at the time, Mr Deville looked reasonable and alert. However, he had been concerned that the other prisoner might have taken something as he was a bit sluggish and unsteady on his feet.

52. At 3.59pm, an officer unlocked Mr Deville's cell door. In his statement to the police, the officer said that he found Mr Deville slumped in the corner of his cell, with his head between his legs. He said he tried to get a response by calling Mr Deville's name and shaking his shoulders, but he did not respond. He also tried to find a pulse but could not feel one. Approximately 30 seconds later, the officer left the cell and called for a second officer to help him.

53. At 4.01pm, a second officer arrived at Mr Deville's cell. The first officer told her that he could not find a pulse. The first officer told the investigator that she also tried to find a pulse but could not. She said she then shouted for the SO to help and radioed healthcare staff to attend.

54. At approximately 4.02pm, the SO arrived at the cell. He told the investigator that Mr Deville was slumped in the corner of his cell so he instructed the first officer to help move him and they laid him on his side. The SO said he then radioed a code blue (which indicates a prisoner is not breathing or having breathing difficulties, triggers the control room to call an emergency ambulance and healthcare staff to attend). The SO checked for a pulse and as he was not sure he found one, they moved Mr Deville on to his back and began cardiopulmonary resuscitation (CPR).

55. At 4.02pm, the prison called for an ambulance.

56. At approximately 4.03pm, healthcare staff arrived at the cell. The SO told the investigator that he and the first officer continued with CPR while healthcare staff set up their equipment. The SO said that while doing CPR, he had noticed part of an asthma inhaler on the floor. Once he was no longer needed for CPR, he took a closer look. He said that the asthma inhaler had been modified and looked as though it had been used to smoke illicit substances. He said that he wrapped up the inhaler and gave it to a colleague to place in an evidence bag.

57. According to the ambulance records, the ambulance arrived at the prison at 4.14pm. The paramedics were with Mr Deville at 4.19pm and continued treating him. At 4.55pm, paramedics pronounced life extinct.

Contact with Mr Deville's family

58. The prison appointed the chaplain, as the family liaison officer (FLO). Following a check of his prison records the liaison officer identified Mr Deville's parents as the next of kin and she sought to verify their contact details. However, she was unsure of their house number.

59. The prison contacted HMP Doncaster to see if they were able to deploy an officer, as the address was closer to them, but they were unable to assist. Following a conversation with the prison Governor, the decision was made to contact the family by phone.

60. At 6.55pm, the FLO informed the next of kin that Mr Deville had died and after a conversation she arranged to visit them the next day.

61. The prison contributed to the cost of Mr Deville's funeral in line with national instructions.

Support for prisoners and staff

62. Later that day, a senior prison manager debriefed and offered support to staff involved in the emergency. However, the prison could not confirm that postvention procedures (actions to reduce the risk of suicide and to provide support to people following a sudden death) were followed.

Post-mortem report

63. A post-mortem examination found that Mr Deville died from acute myocardial insufficiency caused by coronary artery atheroma and synthetic cannabinoid receptor agonists.

64. The pathologist recorded that Mr Deville's coronary artery disease was so severe that it could have caused his sudden cardiac death at any time, even at rest or during sleep. He noted that the toxicological assessment of the blood revealed the presence of three synthetic cannabinoid drugs although the toxicologist did not formally confirm their presence.

Inquest into Mr Deville's Death

65. The inquest into Mr Deville's death was held on 28 January 2026. The coroner concluded that it was a drug related death. and a verdict of natural causes was recorded.

    The coroner recorded that Mr Deville's death was due to acute myocardial insufficiency caused by coronary artery atheroma and synthetic cannabinoid receptor agonists.

Findings

Mr Deville's substance misuse

66. Mr Deville declined to be referred to DARS when he arrived at Manchester. However, recovery workers encouraged him to engage with the service and gave him harm reduction advice on a number of occasions. Following an incident in early September when Mr Deville had been found under the influence, a recovery worker recorded that Mr Deville had confirmed that he had taken drugs and would continue to do so. Given that Mr Deville did not want to engage, the support DARS could offer was limited.

Drug misuse at Manchester

67. In their inspection report, HMIP identified that the prison had a serious problem with drugs which was exacerbated by weaknesses in physical and procedural security.

68. In response to HMIP's urgent notification, the Ministry of Justice and HMPPS produced an action plan to address the priorities and key concerns identified. This plan includes actions to address the weaknesses in physical and procedural security which was allowing large quantities of drugs to enter the prison.

    The prison also requested support from HMPPS's National Drug Strategy Team. The Drug and Alcohol Support (Custody) Team visited the prison in February 2025 and later produced a report in which they identified a number of key areas for improvement and some recommendations. They concluded that while there had been real progress in security and harm reduction strategies, there were still challenges in demand reduction, regime stability and staff-prisoner engagement. They identified that to reduce drug use and improve overall prison safety and rehabilitation outcomes, the prison needed to enhance their security measures, improve their rehabilitation policies and adopt strategic intelligence sharing.

69. The prison's substance misuse strategy (which was updated in August 2023) is thorough, detailed and ambitious, setting out many initiatives and actions to tackle drugs. However, it was not always clear which actions were being taken forward and how they would be tracked or measured. The prison did not have a set of metrics in place to measure outcomes, but told us that they were looking at how they could record their data more effectively.

70. The prison said that their review of their drug strategy, scheduled for August 2024, had been delayed as their focus had been on rolling out nasal naloxone (which can reverse the effects of an opioid overdose) among prison staff (this was completed in April 2025). They confirmed that they would start their review in May 2025 and the areas for improvement and associated recommendations that the Drug and Alcohol Support (Custody) Team had identified would be included in the new strategy.

71. Given the significant issues that Manchester faces and the impact of drugs on the safety and stability of the prison, we make the following recommendation:

    The Governor should ensure that the new drug strategy precisely diagnoses the issues to be tackled, sets out the specific and measurable actions, with

timescales to address them, and includes a robust assurance process, including metrics against which the prison can monitor the progress of actions.

Emergency response

72. PSI 03/21013 on medical emergency response codes sets out the actions staff should take in a medical emergency, including calling a medical emergency code if they find a prisoner unconscious.

73. When an officer found Mr Deville in his cell, slumped, unresponsive and with no pulse, he should immediately have radioed an emergency code. Instead, the officer left the cell to call for help from a colleague.

74. A second officer who responded also failed to call an emergency code. Instead, she checked for a pulse and when she could not find one, she called for the SO to help and radioed for healthcare staff to attend. It was not until the SO arrived that a code blue medical emergency was called. This led to a delay of two to three minutes before an ambulance was called.

75. Following a previous death at Manchester, the Executive Director for the Long Term and High Security Estate accepted our recommendation that he should take steps to satisfy himself that all staff at Manchester understood their responsibilities during medical emergencies. We were told that this would be done through regular discussions with the Governor and performance and assurance meetings. We were also told that the Executive Director had tasked his Group Safety Team to undertake periodic dip tests to provide continued assurance, with deficiencies reported to the Executive Director for oversight. We were also told that the prison had completed comprehensive work to raise staff awareness. Despite these actions, we have identified the same issue in this investigation and therefore make the following recommendation:

The PGD for the LTHSE should continue to monitor the actions being taken by HMP Manchester to address the long-standing issues around emergency responses.

Clinical findings

76. The clinical reviewer found that the clinical care Mr Deville received was of a good standard and was at least equivalent to that which he could have expected to receive in the community.

77. She identified good practice in the healthcare team continuing to visit Mr Deville when he was found under the influence of substances and giving him harm reduction advice despite him not engaging with them.

Governor to note

78. There was no evidence to confirm that prison staff had checked on prisoners who were subject to suicide and self-harm prevention procedures following Mr Deville's death.

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