Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of John William Smith a prisoner at HMP Liverpool on 9 May 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 I oversee can improve their work in the future.

Mr John Smith died on 9 May 2018 from cardiac failure at HMP Liverpool. Mr Smith was 47 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith had underlying chronic respiratory problems and a history of opiate addiction. He had used psychoactive substances before he died and this may have contributed directly to his death.

I find that the prison failed to appropriately manage and monitor Mr Smith's opiate withdrawal and health concerns and that his healthcare fell below the standard he could have expected in the community.

I am concerned that staff failed to monitor or record suspicions they had about Mr Smith's illicit substance misuse on the wing.

I am also concerned that Mr Smith's family were not informed of his death until nearly nine hours after he died.

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

Sue McAllister CB
Prisons and Probation Ombudsman **April 2019**

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Summary

Events

1. On 22 March 2018, Mr John Smith was sentenced to 13 years imprisonment for robbery and other offences. He was sent to HMP Liverpool.

2. On his arrival at Liverpool, it was noted at Mr Smith's reception health screen that he had a history of opiate dependency and was on a daily dose of 50ml methadone for this. He also had chronic respiratory disease for which he received medication. Mr Smith had no recorded involvement with mental health services.

3. The drug dependency team monitored Mr Smith's opiate withdrawal. Over the next few months, Mr Smith sought an increase in his methadone dose but staff noted that his withdrawal symptoms did not support this and declined.

4. Mr Smith was kept under review by the chronic health team. He had no significant concerns until April when a nurse noted that he was short of breath and showed signs of oxygen deficiency. A prison GP reviewed him and gave him a nebuliser to deliver his medication more efficiently. After a week's course on the nebuliser, Mr Smith's health returned to normal.

5. When a nurse was administering the nebuliser to Mr Smith, he noticed a strong smell of smoke in the cell. Over the course of a few hours, he noted this smell on a couple of occasions, and also that Mr Smith appeared to be under the influence of something. The nurse suspected illicit drug use, as did several officers and other healthcare staff, and he raised his concerns with officers on the wing. Two officers made entries in the wing log and in Mr Smith's prison record but they did not open an intelligence report.

6. On 9 May, at approximately 12.20am, Mr Smith's cell mate discovered him unresponsive in their cell. He alerted prison officers who called an emergency code. An ambulance was requested immediately and healthcare staff attended promptly. They performed cardiopulmonary resuscitation while awaiting the ambulance.

7. At 12.30am, the ambulance crew arrived and took over Mr Smith's care. At 12.38am, paramedics pronounced Mr Smith dead.

8. Toxicology investigations found that Mr Smith had used psychoactive substances (PS) before he died.

Findings

Clinical care

9. We agree with the clinical reviewer that the care Mr Smith received at Liverpool fell below the standard he could have expected in the community. Healthcare staff failed to use appropriate diagnostic tools consistently, and failed to increase their clinical observations and interventions when his condition deteriorated.

Management of Mr Smith's drug addiction and illicit drug use

10. We agree with the clinical reviewer that the care Mr Smith received for his opiate dependency fell short of what he could have expected in the community. His withdrawal was not consistently monitored or managed.

11. We are also concerned that despite the prison's drug strategy and policy, officers failed to appropriately monitor or record suspicions they had about Mr Smith's illicit substance misuse on the wing.

Emergency response

12. We consider that the emergency response was appropriate when prison staff discovered Mr Smith unresponsive.

Liaison with Mr Smith's family

13. We are concerned that the prison delayed appointing a family liaison officer, which meant that Mr Smith's family were not informed promptly about his death. We are satisfied that the prison's contact with his family was appropriate after this.

Recommendations

- The Head of Healthcare should ensure that staff appropriately manage prisoners with chronic health complaints and that staff use clinical tools to monitor prisoners experiencing a deterioration in their condition.
- The Governor and Head of Healthcare should ensure that prisoners addicted to drugs are appropriately monitored and managed according to the relevant tools and guidelines.
- The Governor should ensure that staff proactively manage incidents of suspected drug use and log intelligence reports for any suspicious incidents.
- The Governor should ensure that a family liaison officer is appointed promptly when a prisoner dies so that he or she can inform the prisoner's family or next of kin of his death in person as soon as possible, in line with national guidance.

The Investigation Process

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

15. The investigator visited HMP Liverpool on 6 August 2018. He obtained copies of relevant extracts from Mr Smith's prison and medical records. He interviewed seven members of staff and one prisoner during August.

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

17. We informed HM Coroner for Liverpool and Wirral of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

18. The investigator wrote to Mr Smith's partner to explain the investigation and to ask whether she had any matters she wanted the investigator to consider. She did not respond to our letter.

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

Background Information

HMP Liverpool

20. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 994 men. Lancashire Care NHS Foundation Trust provided all healthcare services until 1 April 2018, when Spectrum Community Health and Mersey Care Trust took over. All staff were transferred to the new providers. There is a 24-hour inpatient unit.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Liverpool was conducted in September 2017. Inspectors reported an abject failure of the prison to offer a safe, decent and purposeful environment. The inspection team could not recall having seen worse living conditions, which they described as squalid. Many cells were not fit to be used. Some had emergency cell bells that were not working but were still occupied, presenting a danger to prisoners. There were hundreds of unrepaired broken windows, with jagged glass left in the frames. Many toilets were filthy, blocked or leaking. There were infestations of cockroaches in some areas, broken furniture, graffiti, damp and dirt.

22. While primary health care had improved, staff shortages had a negative impact on all aspects of health services, especially mental healthcare. Inpatients had a very poor regime and were offered little therapeutic activity. The integrated mental health and substance misuse team did not have capacity to meet the needs of a complex population.

23. Inspectors found that there did not appear to be effective leadership or sufficiently rigorous oversight to drive the prison forward in a meaningful way.

24. While the investigator was visiting Liverpool, it was clear that substantial work was being undertaken to upgrade many of the wings and cells at Liverpool. The prison was operating far below capacity while this work was being undertaken.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to December 2017, the IMB was concerned about the increased use of psychoactive substances within the prison, which it noted was the drug of choice there.

26. The Board said that the healthcare team generally enjoyed good morale despite difficulties within the environment at Liverpool. However, they were concerned about long waiting lists for treatment. They were also concerned about the heavy workload experienced by mental health teams.

Previous deaths at HMP Liverpool

27. Mr Smith was the third prisoner to die of natural causes at Liverpool since the start of 2017. There were no similarities between his death and these others.

Psychoactive Substances (PS)

28. Psychoactive substances (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.

29. 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.

30. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

31. On 28 February 2018, Mr John Smith was convicted of robbery and other offences. He was remanded in custody and sent to HMP Altcourse.

32. A nurse reviewed Mr Smith at a health screen on his reception at Altcourse. He noted that Mr Smith had chronic obstructive pulmonary disease (COPD) and was prescribed medication for this. Mr Smith told him that he was on buprenorphine (an opioid used to treat opiate addiction). He observed that he seemed fit and well and did not appear to be withdrawing, but he referred him to the GP for both his physical health and substance use. At a drug screen that day, Mr Smith tested positive for buprenorphine and cocaine.

33. The following day, a prison GP recorded that Mr Smith had asthma and COPD. He prescribed montelukast (to relieve his asthma), salbutamol (to reduce coughing, wheezing and breathlessness), seritide (to dilate his lungs and reduce swelling), and tiotropium bromide (to manage his COPD).

34. The same day, a substance misuse nurse assessed Mr Smith. She noted that he had a COWS score of eight. (The Clinical Opiate Withdrawal Scale, or COWS, is an 11-item scale used by clinicians to determine the severity of opiate withdrawal. Eight indicates mild withdrawal.) A prison GP reviewed Mr Smith and noted that he was prescribed buprenorphine in the community. Mr Smith said that he last used heroin many years earlier but had never used crack cocaine, although he admitted snorting cocaine a week earlier. He prescribed him a daily 40ml dose of methadone (an opioid used for opioid maintenance therapy).

35. The substance misuse team monitored Mr Smith regularly. On 8 March, he had a COWS score of four. A prison GP noted that Mr Smith was no longer showing signs of withdrawal and declined to increase his methadone dose. He advised staff to refer to Mr Smith's COWS score if he claimed he was withdrawing. The following day, a nurse recorded Mr Smith's COWS score as 14, which indicated moderate withdrawal, and referred him to the GP. He reviewed Mr Smith, and increased his daily methadone dose to 50ml.

Transfer to HMP Liverpool

36. On 22 March, Mr Smith was sentenced to 13 years imprisonment. He was sent directly to HMP Liverpool. He was immediately located on H Wing, which is reserved for prisoners with drink or drug dependency concerns.

37. A nurse reviewed Mr Smith at a health screen on his reception at Liverpool. He performed Mr Smith's observations and recorded that his NEWS score was 0. (The National Early Warning Score, or NEWS, is a predictive tool used to gauge the medical condition of a patient – 0 equates to no risk). He recorded Mr Smith's medication. He also referred him to the COPD community nursing team and to the drug dependency unit (DDU).

38. The next day, a prison GP reviewed Mr Smith's drug dependency. He observed that Mr Smith was lucid and orientated, and did not appear sedated, confused or have slurred speech. He continued him on the same daily 50ml dose of

methadone, and noted that Mr Smith should remain on methadone maintenance therapy with DDU staff to monitor him. The same day, a member of staff recorded that Mr Smith failed to attend his Drug and Alcohol Recovery (DARS) induction. She noted that he was given a referral form for the service, along with an information pack, including advice on harm reduction and information about PS.

39. On 26 March, a member of staff from DARS saw Mr Smith. She discussed the potential harm from smoking drugs and tobacco while suffering with COPD. She also advised him about PS and the risks associated with illicit substances. The next day, a member of staff from the drug harm reduction programme advised Mr Smith about harm reduction when using illicit substances. Mr Smith told her that he was currently on 50ml of methadone daily, but that this was "not holding him". A nurse reviewed Mr Smith after this session, and tasked the GP for advice about his methadone dose. He noted that Mr Smith was stable throughout the day but was finding it difficult to sleep.

40. On 29 March, a prison GP reviewed Mr Smith's sleep problems. He prescribed zopiclone (a sleeping pill) to help him sleep, but did not discuss Mr Smith's methadone dosage.

41. On 4 April, Mr Smith approached a prison GP on the wing. He said that he was struggling with his current dose of methadone and wanted it increased. The prison GP told him that he should be under a five-day nurse review but Mr Smith said he had not seen anyone. The prison GP later noted that he had been seen on 27 March and had requested advice from substance misuse doctors. The prison GP sent an electronic notification to the DARS team to see Mr Smith.

42. On 10 April, a clinical administrator from DARS reviewed Mr Smith for his methadone detoxification. She observed that he was cooperative and presented well but wanted an increase in his methadone dose. She noted that Mr Smith was on subutex in the community but that he had been taken off this after testing positive for cocaine on admission to prison. Mr Smith insisted that he was struggling on his 50ml dose so she referred him to the substance misuse doctors.

43. The next day, a nurse noted that Mr Smith's COWS score was two and that he was not clinically eligible for an increased methadone dose. Later, Mr Smith told a nurse on a clinical administrator the wing that he was struggling to sleep and tempted to use illicit drugs. The nurse did not perform a COWS assessment but observed that he was visibly sweaty.

44. A nurse later reviewed Mr Smith and recorded that he was unlikely to be still experiencing withdrawal. She noted that Mr Smith's COWS score was four but that this was purely subjective as he had no measurable symptoms. The nurse also noted that he had tested positive for benzodiazepines and opiate, but was not prescribed either. (Benzodiazepines are prescription only sedatives which can be highly addictive.) Mr Smith admitted that he got these on the wing. The nurse recorded that Mr Smith's oxygen saturations were 92% but that he had COPD and had a long walk to healthcare. (Oxygen saturation, or Sats, relates to the ratio of oxygen in the blood – 95%-100% is considered normal.)

45. On 12 April, a nurse reviewed Mr Smith's long-term health complaints. She noted that he had run out of inhalers three days earlier but that these had been reordered from the pharmacy. The nurse noted that Mr Smith was wheezing and clearly short of breath when walking. She also noted that his lips were cyanosed (blue) but that he had no cyanosis at his extremities. She recorded that his Sats were 91% but did not record his NEWS score. The next day, a prison GP reviewed Mr Smith and noted that he had been without his inhalers and had had a chesty cough for the last couple of days. He examined him and recorded that his Sats were 91% but that he had no central cyanosis and spoke in full sentences. He tasked a nurse to facilitate repeat observations for Mr Smith. He explained 'red flags' to Mr Smith, and noted that he understood this. (Red-flags are medical symptoms which may indicate the need for further clinical investigation.)

46. Over the next few days, healthcare staff monitored Mr Smith. On 13 April, a nurse recorded that his Sats had improved to 95% but that he would be reviewed over the weekend. On 14 April, a nurse noted that Mr Smith's Sats were 91%. She recorded that he said he felt a little better but that his breathing had not really improved. The nurse documented that he had been given his tiotropium bromide inhaler that morning so she would review him the next day. The following morning, a nurse noted that Mr Smith said he felt better but that he was still visibly short of breath. She did not record his Sats.

The events of 17 April

47. On 17 April, a nurse was covering H Wing because the usual nurse was on long term leave. He said in interview that a pharmacy technician asked him to see Mr Smith after noticing that his Sats were quite low. At about 12.15pm, the nurse observed Mr Smith from his cell door, and recorded that he was pale in colour but alert and orientated. He recorded that Mr Smith's Sats were 86%, which he said in interview were very low even for someone with COPD. He discussed his condition with a prison GP, who advised him to give Mr Smith a nebuliser and list him for a GP review the next day. The prison GP backed this up with his own entry in Mr Smith's medical notes.

48. At approximately 2.50pm, a nurse nebulised Mr Smith in his cell and noted that his Sats had improved slightly to 90%. He observed that Mr Smith was cyanosed at his peripheries and discussed this with a prison GP who said he would review him in the healthcare unit. The nurse did not think Mr Smith could manage to make it to the healthcare unit so he called the GP again. About half an hour later, a prison GP reviewed Mr Smith in his cell. He increased his nebuliser dose, and recorded that Mr Smith's Sats had improved considerably to 96%.

49. At 5.20pm, an officer unlocked Mr Smith's cell to enable a nurse to check him. The nurse recorded that there was a strong smell of smoke, which was also visible in the air. He noted that Mr Smith's cellmate, who was on the bottom bunk, hid something quickly but that Mr Smith was sitting on a chair at the cell table and appeared alert. In interview, the nurse said that the officer should have seen this because he entered the cell first. The nurse refused to enter the cell because of the smoke and noted that he had developed a headache from inhaling it. The officer recorded in the wing observation book that there was a

smell of smoke in Mr Smith's cell, and that it had come from an unknown substance. In interview, the officer said that he made this entry and discussed it with someone but did not start an intelligence report or record this on Mr Smith's electronic prison record. He acknowledged that this was an error.

50. At about 6.40pm, a nurse checked on Mr Smith while he was on the wing. He recorded that Mr Smith and his cellmate appeared to be under the influence of something. The nurse asked wing officers to assist and noted that an officer joined him. The nurse noted that both he and wing staff suspected both prisoners of having taken something illicit. When challenged, both prisoners denied taking drugs and said that they had acute toothache. The nurse discussed the incident with a prison GP who advised that Mr Smith was kept under observation and ideally moved to a hospital bed if possible to avoid any overdose risk. The nurse explained to Mr Smith about the risks of taking illicit substances, especially given his medical condition, and noted that he seemed to understand this. There was no intelligence report made for this incident, and no entry in the wing observation book or prison record.

51. The nurse then discussed his concerns with the senior officer on duty on H Wing. He accepted that there was no space in the healthcare unit, so suggested moving one prisoner to another cell. The nurse also asked whether officers could search the cell for illicit substances, but noted that the officer said this was impossible that night. In interview, the nurse said that he then returned to Mr Smith's cell with an officer, where they met a prison GP. The prison GP examined Mr Smith and advised that he could be nebulised up to eight times per day but that he should be reviewed by a GP if necessary. He was satisfied that Mr Smith could remain in his cell. An officer noted in the wing observation book and Mr Smith's electronic record about the suspicions of illicit drug use. In interview, the officer said that she would normally open an intelligence report but because she did not usually work on this wing she expected someone else to have done one.

52. At 8.30pm, a nurse returned to Mr Smith's cell to administer a further nebuliser dose. He noted that Mr Smith appeared sedated and was difficult to rouse when an officer tried. He said in interview that there was still a strong smell of smoke, which the officers also noticed. The nurse gave Mr Smith his nebuliser dose, and handed him over to the care of night staff.

53. At 10.21pm, a nurse saw Mr Smith in his cell. Mr Smith declined a physical examination and said that he no longer felt breathless. He recorded that both Mr Smith and his cellmate appeared intoxicated.

54. On 18 April, a prison GP reviewed Mr Smith. She noted that he presented with red eyes and a very slight slurring of his speech. The prison GP recorded that she refused to give Mr Smith his regular methadone dose due to fears over intoxication, because Mr Smith was suspected of having used illicit substances. She also noted that he could cope without methadone for 24 hours but could be given this in the afternoon if there was no further evidence or concern about intoxication or sedation. She also documented that if healthcare staff experienced any threats or intimidation from Mr Smith, they should escalate the matter to security staff. Later that morning, a prison GP reviewed Mr Smith and

advised him against smoking, given his health concerns. He noted that Mr Smith's Sats were 93% and observed that his chest was better.

55. That afternoon, a nurse reviewed Mr Smith and noted that after a review by the DDU, he would not be receiving methadone that day. She noted that Mr Smith was not happy about this and claimed that the anxiety this would cause would make his breathing worse. Mr Smith did not request a nebuliser for the rest of the day. The following day, Mr Smith told her that his breathing was much better. She recorded his Sats at 93%.

56. On 20 April, a prison GP resumed Mr Smith's 50ml daily dose of methadone. Substance misuse staff monitored Mr Smith and his COWS score. On 24 April, he told a clinical administrator, that it was unfair having his COWS score measured two hours after receiving his methadone. She referred this query to the substance misuse GPs but there is no record of any subsequent review. On 2 May, an electronic notification was sent by the GP to repeat Mr Smith's COWS score. The following day, a nurse saw Mr Smith and recorded that his COWS was 10.

57. Healthcare staff continued to review Mr Smith's health and long-term condition. On 24 April, a multidisciplinary meeting noted that his Sats were now 96%, which was a positive increase. His nebuliser prescription was due to finish and they planned for a further review on the wing. The next day, a prison GP reviewed Mr Smith's clinical observations and noted that there was no reason for a further review. On 27 April, a nurse reviewed Mr Smith and noted that his Sats were 94%-96% and that he did not appear short of breath.

The emergency response on 9 May

58. On the evening of 8 May, Mr Smith was locked in his cell with his cellmate. At about 12.20am on 9 May, his cellmate discovered Mr Smith unresponsive in their cell and raised the alarm by kicking on the cell door and shouting. An officer responded to this and saw Mr Smith lying on the floor of his cell, so made a code blue emergency call. (A code blue is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.)

59. An officer and a Custodial Manager (CM) attended and unlocked Mr Smith's cell. The officer recorded in Mr Smith's prison notes that an ambulance was called at 12.32am, and that Hotel 1 attended. (Hotel 1 is the radio call sign given to the healthcare staff assigned to deal with emergency responses.)

60. Two nurses attended as Hotel 1. One of them recorded that they heard the code blue call at 12.20am. On arrival they saw Mr Smith on the floor unconscious and unresponsive. The nurse noted that an ambulance was called at 12.21am, and that at 12.23am, additional healthcare staff were asked to attend. The nurse recorded that Mr Smith was rolled onto his back, and that staff started cardiopulmonary resuscitation (CPR) and attached a defibrillator to him. She noted that they completed four cycles of CPR, but the defibrillator did not advise them to shock at any time.

61. The nurse recorded that the ambulance crew arrived at approximately 12.30am, and took over Mr Smith's care. At 12.38am, paramedics pronounced Mr Smith dead.

Contact with Smith's family

62. At approximately 7.30am, a prison manager started her shift and offered to perform the family liaison role. The prison duly appointed her as Mr Smith's family liaison officer (FLO).

63. Mr Smith's next of kin was his partner. At approximately 9.30am, the FLO and an officer visited Mr Smith's partner at her home to inform her of his death and to offer support. Mr Smith's son and daughter were also present.

64. Mr Smith's funeral was held on 30 May. The prison contributed to the cost in line with national guidance.

Support for prisoners and staff

65. After Mr Smith'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.

66. The prison posted notices informing other prisoners of Mr Smith'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 Smith's death.

Post-mortem report

67. Toxicological investigations found that Mr Smith had a number of drugs in his system when he died, including methadone at levels consistent with his methadone maintenance programme, and a synthetic cannabinoid (PS). The pathologist noted that there was evidence that Mr Smith had used PS before he died and that he may have been experiencing some of the effects associated with PS, such as increased heart rate, breathlessness, agitation, convulsions and hallucinations. The pathologist also noted that a number of cases of sudden cardiac death have been attributed to synthetic cannabinoid use.

68. The post-mortem found that Mr Smith died from cardiac failure caused by severe chronic COPD, which was in turn exacerbated by opioid and synthetic cannabinoid use. The post-mortem report also gave a secondary cause as advanced liver cirrhosis.

69. The pathologist commented that the use of opioid drugs can be lethal in someone with COPD. He added that the consumption of PS may have had a direct harmful cardiac effect on Mr Smith, due to his already weakened and overstressed heart.

Findings

Clinical care

70. The clinical reviewer concluded that the care Mr Smith received was not equivalent to that he could have expected in the community. We agree with her that Mr Smith was not managed appropriately for his chronic health conditions, and not adequately monitored when his health deteriorated. Staff neglected to use the NEWS scoring tool consistently to assess his condition, and did not appropriately monitor him when his condition took a turn for the worse.

71. There were several occasions when the NEWS score was used to assess Mr Smith's condition but staff failed to follow the guidelines from the National Institute for Clinical Excellence (NICE) on the frequency of observations. There were other occasions where the NEWS tool was not used at all, and when the clinical reviewer retrospectively applied the NEWS formula this indicated that Mr Smith should have received more clinical intervention or monitoring at the time.

The Head of Healthcare should ensure that staff appropriately manage prisoners with chronic health complaints and that staff use clinical tools to monitor prisoners experiencing a deterioration in their condition.

Management of Mr Smith's drug addiction and illicit drug use

72. On his admission to Liverpool, Mr Smith was appropriately located on H Wing, which is specifically reserved for prisoners with drug or alcohol addiction. He was also appropriately assessed for his drug addiction, and placed under the supervision of various teams to monitor his substance misuse history.

73. We nevertheless agree with the clinical reviewer that the care Mr Smith received at Liverpool for his substance withdrawal fell short of that which he could have expected in the community. The clinical reviewer concluded that healthcare staff did not consistently use the COWS tool to monitor Mr Smith's withdrawal symptoms, and did not increase his methadone dose when they should have done. She noted that the '*Drug misuse and dependence: UK guidelines on clinical management*' recommends not under-dosing patients, and that greater benefits can be achieved with a daily methadone dose of between 60ml and 120ml. She concluded that an increase in Mr Smith's methadone dose from 50ml to 60ml would have been appropriate given his circumstances and presentation. Clearly Mr Smith felt that he was not given an adequate dose of methadone to keep him comfortable, and may have sought illicit substances to make up this shortfall.

The Governor and Head of Healthcare should ensure that prisoners addicted to drugs are appropriately monitored and managed according to the relevant tools and guidelines

74. At the time of Mr Smith's death, Liverpool had a drug strategy and policy in place to tackle illicit drug use. Among the measures employed at the time was the mandatory testing of prisoners where suspicions of drug use had been aroused. Liverpool also had a policy of searching prisoners, visitors and staff, and of monitoring the perimeter walls with cameras and dogs. Liverpool also relied on

intelligence reports, and there was an expectation that these would be submitted to security staff if there were any suspicions of drug use. The Head of Security and Intelligence at Liverpool has since informed us that the prison is in the process of increasing CCTV coverage around the prison and increasing checks in the visits complex. He also said that the prison is improving its intelligence and mandatory drug testing procedures as well as scheduling a monthly meeting to discuss prisoners involved in using or distributing drugs in the prison. Staff and managers said in interview that they were aware of the need to open intelligence reports where suspicions of drug use have been raised.

75. We cannot say whether Mr Smith had taken drugs at any other time but on 17 April, it was clear that suspicions had been aroused that he had taken illicit substances. This suspicion was acknowledged by healthcare staff and prison officers, with two separate officers making entries in the wing observation book. One of those officers also recorded this in Mr Smith's electronic prison notes. However, nobody opened an intelligence report despite this incident occurring over a sustained period. Indeed, there were no intelligence reports opened for Mr Smith at all during his time at Liverpool. We recognise that an officer acknowledged his error in not opening an intelligence report and that an officer said she would have done so if she had been on her own wing.

76. We commend the efforts made by a nurse to bring this to the attention of officers, and in escalating the incident to senior officers, but are concerned that this did not trigger any action by prison staff. We also note that the toxicology report recorded that Mr Smith had psychoactive substances in his system at the time of his death, which suggests that his suspected drug use on 17 April was not an isolated incident. This begs the question as to whether any earlier incidents went undetected, and how often this had happened.

The Governor should ensure that staff proactively manage incidents of suspected drug use and log intelligence reports for any suspicious incidents

Emergency response

77. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two code medical emergency response system in place. A code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.

78. When Mr Smith was discovered as unresponsive, an officer immediately called a code blue emergency. This ensured that an ambulance was called immediately, and other officers and healthcare staff attended promptly. Emergency first aid was given and the ambulance crew arrived with Mr Smith promptly. We are satisfied that the emergency response was conducted appropriately.

Liaison with Mr Smith's family

79. Prison Rule 22(1) states: "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the

governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

80. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* requires that "prisons must ensure that an appropriate member of staff engages with the next of kin of prisoners who are seriously ill", and that "time will be of the essence in order to try to ensure that the family do not find out about the death from another source".

81. Although Mr Smith's death was confirmed at 12.38am, it was a further seven hours before a family liaison officer was appointed. This meant that his family were not informed of his death until nearly nine hours after he died. We are concerned about this delay and make the following recommendation:

The Governor should ensure that a family liaison officer is appointed promptly when a prisoner dies so that he or she can inform the prisoner's family or next of kin of his death in person as soon as possible, in line with national guidance

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