

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Grant Alam, a prisoner at HMP Garth, on 22 February 2019

**A report by the Prisons and Probation Ombudsman**

## 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*



© Crown copyright 2018

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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.

Our 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 Grant Alam died from electrocution on 22 February 2019, while trying to smoke psychoactive substances (PS) in his cell at HMP Garth. He was 28 years old. I offer my condolences to Mr Alam's family and friends.

Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern about the prevalence of PS at Garth. Since Mr Alam's death, the prison has updated its drugs strategy with the aim of reducing supply and demand for PS. The prison needs to ensure this is implemented fully, to reduce the serious harm caused by PS use.

Mr Alam was suspected of using PS on several occasions at Garth. The investigation found that staff did not always respond in line with the local policy on dealing with prisoners suspected of being under the influence of drugs.

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**

**May 2020**

**Contents**

Summary ..... 1

The Investigation Process ..... 2

Background Information ..... 3

Key Events ..... 5

Findings ..... 9

# Summary

## Events

1. Mr Grant Alam was recalled to prison custody on 11 September 2014 and was moved to HMP Garth on 30 March 2015.
2. Mr Alam was found under the influence of illicit substances on several occasions at Garth. He was also found to be brewing illicit alcohol (“hooch”) and there was a suspicion that he was selling it to pay for drugs.
3. On 23 February 2019 at 5.00am, an officer began the morning roll check. When he arrived at Mr Alam’s cell, he noticed music was playing and the cell light was on, which was unusual. He saw Mr Alam sitting in an odd position on his chair and could not get a response from him so he radioed for staff assistance.
4. Staff arrived and went into Mr Alam’s cell. It was clear that Mr Alam had been dead for some time as rigor mortis was present. Staff called for healthcare staff who agreed that Mr Alam was dead and that cardiopulmonary resuscitation (CPR) was inappropriate. Ambulance paramedics confirmed Mr Alam’s death at 5.50am.
5. The post-mortem report concluded that Mr Alam died from electrocution. Toxicology tests showed that he had psychoactive substances (PS) in his system. After Mr Alam’s death, a prisoner told the investigator that prisoners would create a flame to smoke PS by attaching an adapted vape to a wire in a plug socket.

## Findings

6. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern at the easy availability of drugs at Garth. Since Mr Alam’s death, Garth has updated its drugs strategy with the aim of reducing the supply and demand for PS.
7. The local policy in place at the time of Mr Alam’s death said that whenever staff suspected a prisoner of using illicit drugs, they should submit an intelligence report and refer the prisoner for support with their substance misuse. This did not always happen in the case of Mr Alam.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff follow the prison’s Substance Misuse Strategy by submitting intelligence reports when a prisoner is suspected of using illicit drugs, and referring them to the Integrated Mental Health and Substance Misuse Service.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited Garth on 5 March 2019. She obtained copies of relevant extracts from Mr Alam's prison and medical records.
10. NHS England commissioned an independent clinical reviewer to review Mr Alam's clinical care at the prison. The investigator interviewed eight members of staff and a prisoner at Garth on 10 and 11 April. They jointly interviewed healthcare staff.
11. We informed HM Coroner for Preston and West Lancashire of the investigation. The coroner gave us the results of the post-mortem and toxicology reports. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Alam's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They raised no issues.
13. We shared our initial report with HM Prison and Probation Service (HMPPS). They raised no factual inaccuracies.
14. We provided Mr Alam's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

# Background Information

## HMP Garth

15. HMP Garth holds up to 846 men, the majority of whom are serving sentences of more than ten years. Bridgewater NHS Foundation Trust provides health services, while NHS Greater Manchester Mental Health Trust deliver the mental health team, which provides an integrated clinical substance misuse and mental health service.

## HM Inspectorate of Prisons

16. The most recent inspection of HMP Garth was in December 2018 and January 2019. Inspectors reported that there had been significant improvements in the two years since the previous inspection, which had found that drugs and violence dominated the prisoner experience. However, inspectors still found drugs, particularly psychoactive substances (PS), were a problem at Garth, with 60% of prisoners saying that drugs were easy to obtain, 30% testing positive for drugs and over a quarter saying they had developed a drug habit since being at the prison. Illicit alcohol (hooch) was also a problem with 45% of prisoners saying it was easy to get alcohol. Security and substance misuse services worked well together to address alcohol and drug issues and although very new, drug reduction strategies were in place.

## Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 November 2018, the IMB said that despite a good drugs strategy being in place, drug use remained high.

## Previous deaths at HMP Garth

18. Mr Alam was the ninth prisoner to die at Garth since February 2017. Of the previous deaths, three were self-inflicted, one was drug-related and four were from natural causes. We have previously made recommendations to Garth about reducing illicit drug use.

## Psychoactive Substances (PS)

19. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are an increasing 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.
20. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the 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.

21. 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

22. On 20 July 2012, Mr Grant Alam was sentenced to over 13 years in prison for aggravated burglary and theft. He was released from prison on licence on 10 July 2014, but was recalled on 6 August for breaching his licence conditions. Mr Alam was released on licence again on 3 September, but was recalled again for breaching his licence on 11 September. He was moved to HMP Garth on 30 March 2015.
23. At his reception screening at Garth, Mr Alam said he was not a drug user.
24. On 19 January 2017, Mr Alam was told his father had died. That night, staff suspected he had taken psychoactive substances (PS). He was checked over by paramedics (who were already in the prison for another incident) and told to rest.
25. On 15 May 2018, staff started suicide and self-harm monitoring (known as ACCT) after Mr Alam complained of low mood and expressed suicidal thoughts. He told staff his mother had died two years earlier, a brother had died unexpectedly, and his aunt, uncle and a close friend had also died. Mr Alam said he found it difficult to come to terms with these deaths and, although he did not like to ask for help, he thought it best he spoke to someone about his feelings. Staff referred Mr Alam to the mental health team for assessment, for a doctor's appointment to discuss antidepressant medication and knee pain, and bereavement counselling, to join health and wellbeing groups and one to one sessions. Staff reminded Mr Alam about the support available to him in the prison. Mr Alam said he did not use illicit substances and told staff that the "hooch" (illicit alcohol) he had brewed previously in April 2018, had been a one off. Staff stopped ACCT monitoring on 20 June.
26. A healthcare support worker met with Mr Alam on 20 June, at a one to one well-being meeting. Mr Alam spoke of his sadness and loneliness and she discussed coping strategies. Mr Alam said he was worried that his ACCT monitoring had stopped, but she reminded him that he would still be supported and he could speak to a member of the mental health team if he was struggling. She was scheduled to meet Mr Alam on 4 July, but was unable to as he had to attend a disciplinary hearing after being found with several litres of illicit alcohol in his cell that morning. She referred Mr Alam to the mental health team.
27. The mental health team discussed Mr Alam during a meeting on 20 July. They spoke about his increased alcohol consumption and that he had been selling illicit alcohol. They decided to refer Mr Alam to primary care and the substance misuse team, and to suspend his well-being sessions for the time being. A nurse saw Mr Alam on 5 August, when he denied increased alcohol use. He said he only drank it two to three times a month.
28. On 27 December, staff found ten litres of fermenting liquid in Mr Alam's cell. He was put on a disciplinary charge and onto the basic regime. The same day, staff submitted an intelligence report (IR) which linked Mr Alam to illicit drugs, mobile telephones and suspicious cash transactions. A further IR suggested Mr Alam brewed alcohol to pay for his drug use.

29. On 31 December, Mr Alam was in another prisoner's cell when staff smelt cannabis. Mr Alam looked as if he was under the influence and staff submitted an IR.
30. A mental health nurse met with Mr Alam on 7 February 2019, as he had requested bereavement counselling. She told him the prison did not have a bereavement counsellor, but a member of the chaplaincy could visit him.
31. There is a note in prison records that the electrics in Mr Alam's cell were tripped on 5 and 11 February. On 11 February, Mr Alam had put metal blades in the plug socket, which were removed. An electrician reset the electrics in the cell both times.
32. Mr Alam's key worker, an officer, met with him on 13 February. Mr Alam said he had no problems, but had recently been socialising with prisoners who caused issues on the wing. The key worker advised him to try to socialise with different people. They spoke about Mr Alam's bereavements and how he struggled with his grief. Mr Alam was concerned that he was not sure where he would live when he was released on 8 June 2020. The key worker said he would liaise with the Offender Management Unit (OMU) about this.
33. An officer put Mr Alam onto the basic regime on 15 February, as he had received many warnings for poor behaviour. Mr Alam then refused to return to his cell and became aggressive. Staff restrained Mr Alam and took him to his cell, where they discovered four litres of fermenting liquid and a distillery kit, which they removed. Mr Alam was placed on a disciplinary charge.
34. Mr Alam's key worker met with him again on 20 February. Mr Alam was still on basic regime for breaking prison rules. Mr Alam said he was struggling to follow the wing's regime and his key worker advised that he should look at the other prisoners he associated with. Mr Alam said he would like to transfer to another prison for a fresh start. Mr Alam said he had been attending Motivational and Engagement sessions, which he enjoyed.
35. Mr Alam was due to attend his seventh Motivational and Engagement session on 21 February, but could not as he appeared to be 'under the influence'. Records do not say whether this was suspected alcohol or drugs. Mr Alam denied that he had taken illicit substances, and said he felt unwell. The session was rescheduled for the next day.
36. Mr Alam was on several medications before he died, including migraine tablets and zopiclone to help him to sleep. Mr Alam had also been prescribed citalopram, an antidepressant, but he did not take it because he said it made him feel sick.
37. CCTV on C Wing on 21 February, shows Mr Alam on the landing just before he was locked in his cell for the evening. He appeared to be laughing with other prisoners, in high spirits and was one of the last prisoners to be locked up at 7.15pm. He did not appear to be under the influence of alcohol or drugs.
38. An officer began night duty on C Wing and started a roll check at approximately 8.00pm. The officer told the investigator that Mr Alam, who was in a single cell, had seemed fine and did not press his cell bell at any time that night.

39. At approximately 5.00am, the officer started the morning roll check on C Wing. He arrived at Mr Alam's cell at around 5.13am. He heard music playing from the cell. He opened the observation panel and saw the light was on and that Mr Alam was sitting in a "weird position". He knocked on the cell door and shouted for Mr Alam but got no response. He could not see Mr Alam's face and thought he might be under the influence of alcohol or drugs, so he radioed for staff assistance and for healthcare staff. He continued to try to get a response until an officer and a Custodial Manager (CM) arrived within one to two minutes. The CM went into Mr Alam's cell, followed by the officer. They saw Mr Alam leaning back on his chair, with his arms spread out and his legs arched. The CM checked Mr Alam for signs of breathing or a pulse, but found none. There were signs that Mr Alam had died some hours earlier, as rigor mortis was present, so staff did not attempt cardiopulmonary resuscitation (CPR).
40. A nurse arrived at the cell at approximately 5.16am, with an emergency bag, followed by an officer who had also heard the call for assistance. The nurse agreed that Mr Alam had died some hours earlier and CPR was not appropriate. She asked for an ambulance to be called, which the control room officer did at 5.20am. Staff sealed the cell until paramedics arrived at 5.35pm. They confirmed Mr Alam's death at 5.50am.
41. An electrician inspected Mr Alam's cell. There were no signs of burning or overheating, and the lighting circuit was still working.
42. The investigator spoke to a prisoner who had previously shared a cell with Mr Alam. He said that illicit drugs were easy to obtain at Garth, that Mr Alam had been smoking PS for years, and would usually do so once he was locked in his cell for the night (to avoid drawing the attention of staff during the day). He said that since the prison's smoking ban, prisoners would adapt part of a vape machine, attached to a wire in a plug socket, to create a flame which enabled them to smoke PS. He said that prisoners sometimes received a mild electric shock or burn by doing this, but nothing worse. He said that when Mr Alam was under the influence of illicit drugs he became "zombie like" and would slump in his chair.

### **Contact with Mr Alam's family**

43. Two of the prison's family liaison officers broke the news of Mr Alam's death to his next of kin.
44. The prison contributed to the cost of Mr Alam's funeral, in line with national guidelines.

### **Support for prisoners and staff**

45. After Mr Alam's death, a prison manager 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.
46. The prison posted notices informing other prisoners of Mr Alam'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 Alam's death.

## Post-mortem report

47. Mr Alam's post-mortem report concluded he had died from electrocution. Toxicology results showed that he had taken PS before he died.

# Findings

## Availability of drugs at Garth

48. Mr Alam died while smoking psychoactive substances (PS). During their inspection of Garth in December 2018 and January 2019, HM Inspectorate of Prisons found nearly half of prisoners said that it was easy to obtain drugs.
49. In response to a national instruction from HMPPS in April 2019 that all prisons should review their drug strategy, Garth issued their Integrated Substance Misuse Strategy in January 2020. This strategy sets out the aim of addressing supply reduction, demand reduction, mitigation of risk and states that monthly substance misuse management meetings will be held, attended by all relevant functional heads, including healthcare providers, to:
- Co-ordinate all aspects of substance misuse and drug strategy.
  - Monitor and identify emerging trends.
  - Ensure staff, men and visitors are aware of the strategy through implementing an effective communication plan.
  - Devise and implement an effective Debt Management Tool.
  - To review: MDT, Supply Reduction, Demand Reduction, Recovery/Through-care and impact on Safety and Violence.
  - Monitor and evaluate the effectiveness of HMP Garth Drug Strategy and identify areas of need and intervention.
  - To ensure the implementation of evidence based policies and procedures in line with national drugs strategy and partner agency and stakeholder requirements.
50. As Garth has taken steps to address the availability of drugs, we make no recommendation.

## Integrated Substance Misuse Strategy

51. Mr Alam was suspected of using PS on several occasions during his time at Garth.
52. At the time of Mr Alam's death, Garth had an Integrated Substance Misuse Strategy in place, published in January 2018. The strategy said that staff must submit intelligence reports whenever they suspected a prisoner to be involved in the supply, distribution or misuse of illicit drugs. However, this did not always happen. The strategy also said that staff should refer the prisoner to the Integrated Mental Health and Substance Misuse Service. Again, this was not always done.
53. In January 2020, Garth completed a revised Integrated Substance Misuse Strategy. It reinforces the need for staff to submit intelligence reports if they suspect a prisoner is involved in the supply, distribution or use of illicit substances. It also sets out how staff can refer a prisoner to the Substance Misuse Service (SMS) or to the Integrated Drug Strategy Team (IDTS). Security staff will identify specific prisoners linked to the supply and distribution of drugs and make recommendations on how to best to disrupt the networks, using a

number of measures such as searching, mail and telephone monitoring, and the use of adjudications and earned privileges.

54. It is important that staff follow guidance in the Integrated Substance Misuse Strategy whenever they suspect that a prisoner has taken illicit drugs and we make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff follow the prison's Substance Misuse Strategy by submitting intelligence reports when a prisoner is suspected of using illicit drugs, and referring them to the Integrated Mental Health and Substance Misuse Service.**

#### **Clinical care**

55. The clinical reviewer found that the care Mr Alam received for his mental health and substance misuse was equivalent to that he could have expected to receive in the community.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations