

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Foat, a prisoner at HMP Wymott, on 1 August 2020

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*



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michael Foat was found dead in his cell at HMP Wymott on 1 August 2020. Toxicology tests showed that he had taken psychoactive substances (PS) before he died. He was 40 years old. I offer my condolences to Mr Foat's family and friends.

Mr Foat was frequently found under the influence of PS at Wymott. I am satisfied that staff offered appropriate support to Mr Foat to address his substance misuse issues. I am concerned, however, that despite Wymott producing a revised drug strategy in 2019, PS appears to still be readily available at the prison. The prison needs to do more to address the supply of PS.

Around 20 minutes after an officer unlocked Mr Foat's cell on the morning of 1 August, prisoners alerted staff that Mr Foat was lying on the floor of his cell and when staff attended, they realised he was dead. I am extremely concerned that the officer who unlocked Mr Foat's cell did not notice that he was lying on his cell floor and failed to carry out a welfare check. This was unacceptable. This is not the first time that we have had to make a recommendation to Wymott on this issue.

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 2021

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Summary

Events

1. Mr Michael Foat was recalled to prison on 5 June 2018, after committing further offences. He was moved to HMP Wymott on 24 August 2018.
2. Mr Foat was frequently found under the influence of psychoactive substances (PS) at Wymott. Despite being offered support by the prison's drug services team and other staff, Mr Foat continued to use drugs.
3. At 8.36am on 1 August 2020, an officer unlocked Mr Foat's cell. Around 20 minutes later, a prisoner shouted to staff to come quickly, as Mr Foat was lying on the floor of his cell. When staff attended, they found that Mr Foat was cold and stiff. When healthcare staff arrived, they confirmed that Mr Foat had died.
4. The post-mortem examination could not establish Mr Foat's cause of death and concluded that a drug overdose was the most likely cause. Toxicology tests showed that Mr Foat had taken PS before he died.

Findings

5. We are concerned that despite the prison's revised drug strategy, issued in August 2019, PS appears to still be readily available at Wymott. The prison needs to review whether it is doing all it can to tackle PS supply.
6. The prison offered appropriate support to Mr Foat to address his substance misuse, but his engagement was patchy. We consider that the prison did all it could to support him.
7. Mr Foat had been dead for several hours when he was found. We are very concerned that the officer who unlocked Mr Foat's cell failed to notice that he was lying on his cell floor and failed to check on his welfare. We have made a recommendation to Wymott on this previously. It is disappointing that this remains an issue.

Recommendations

- The Governor should ensure that the key drug issues at Wymott are identified and that the prison's local drugs strategy is reviewed to ensure that these key issues are being addressed.
- The Governor should ensure that staff check on prisoners' welfare when unlocking cells.
- The Governor should share this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her.
9. The investigator obtained copies of relevant extracts from Mr Foat's prison and medical records.
10. The investigator interviewed six members of staff at Wymott on 12 and 18 August, and 9 September, and received statements from four prisoners. NHS England commissioned a clinical reviewer to review Mr Foat's clinical care at the prison.
11. We informed HM Coroner for Preston and West Lancashire of the investigation. The coroner provided us with 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 Foat's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Foat's brother raised no issues but asked for a copy of our report.
13. We shared our initial report with HM Prison and Probation Service (HMPPS). They noted a factual inaccuracy which has been amended for the final report.
14. We provided Mr Foat's next of kin's solicitor 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 Wymott

15. HMP Wymott is a medium secure prison holding over 1,100 adult men. Greater Manchester Mental Health NHS Foundation Trust provides the majority of healthcare services at the prison. Indigo Primary Care Services provides GP services and GTD Healthcare provides out of hours GP services. Delphi provides non-clinical substance misuse services.

HM Inspectorate of Prisons

16. The most recent full inspection of HMP Wymott was in October 2016. Prisoners told inspectors that drugs were freely available and in the inspection survey, 63% of respondents said that it was easy to obtain illicit drugs, which was higher than at comparable prisons (43%). Prisoners and staff were aware of the dangers of PS and had said that it was available on the wings.
17. Inspectors found that the substance misuse strategy had improved, with effective communication and links between the safer prisons, security, offender management and drug strategy teams. This included a specific action plan to reduce the use of PS. Security and drug strategy meetings were well attended, and detailed information-sharing took place between relevant departments.
18. In respect of processes, inspectors noted that all new arrivals were screened for substance misuse problems and about two thirds of prisoners had received support for drug and alcohol problems. Details in security information reports, prisoners' records and police reports were used to inform interventions. Drug testing after suspected use was too low, as testing staff were unavailable, but this had increased in line with requests from prison staff. Inspectors also noted that there was a broad mix of individual and group support activities, as well as good peer support. Dedicated nurses and visiting specialist substance misuse consultants assisted the drug services team; treatment regimes were flexible and reviewed regularly; and relationships between the psychosocial and clinical teams were excellent.

Independent Monitoring Board

19. 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 ending 31 May 2020, the IMB reported that the prevalence of illicit substances within the prison remained a concern, primarily PS, although there had been no significant increase since 2018-2019.
20. The Board considered that the prison had become better at dealing with the effects of PS; there had been fewer ambulance call outs and strategies had been implemented to help prisoners who wanted to recover, through the Robust Recovery programme. The prison now had a mail scanner for use on suspicious items of mail, which had had a positive effect.

Previous deaths at HMP Wymott

21. Mr Foat was the 13th prisoner to die at Wymott since August 2018. Of the previous deaths, 11 were from natural causes and one was drug related. We have previously made a recommendation about ensuring staff undertake a welfare check when unlocking prisoners.

Psychoactive Substances (PS)

22. Psychoactive substances (PS), previously known as '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.
23. In July 2015, we published a Learning Lessons Bulletin about the use of 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 NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

Key Events

24. Mr Michael Foat was sentenced to 51 months imprisonment for burglary on 21 December 2015. He was released on licence on 19 April 2018 but was recalled to prison on 5 June 2018 after committing further offences for which he received a new sentence of 57 months. He was subsequently given 28 additional days in prison following adjudications while serving this sentence.
25. Mr Foat was moved to HMP Wymott on 24 August 2018. During his initial health screen in reception, Mr Foat said he had no mental health, drug or alcohol issues, although said he had used cocaine in the past. His medical records showed he had used psychoactive substances (PS) and cannabis while in prison previously.
26. Mr Foat started work in the aluminium windows workshop. On 11 September, he appeared to be under the influence of drugs and asked to leave the workshop. Healthcare staff examined him in his cell on C Wing and assessed he had taken illicit drugs. Subsequently, Mr Foat was referred to Phoenix Futures (the non-clinical substance misuse provider up to 31 March 2020). Mr Foat was also considered for a place in the prison's Therapeutic Community (TC, a form of treatment for substance misuse involving group therapy and requiring abstinence from taking or seeking drugs). Mr Foat attended a PS Awareness Group and started a Thinking Skills Programme, but his attendance was sporadic, and he was not accepted to live on the TC.
27. During 2019, Mr Foat was reported for appearing under the influence of illicit drugs on ten separate occasions. This was managed through the prison's Incentive and Earned Privileges scheme (IEP) and adjudication process. Mr Foat was again invited to attend a PS Awareness Group, but he declined. He also lost his new job in the engineering workshop for non-attendance. In July, drugs and a mobile telephone were discovered in his cell during a routine cell search. Mr Foat admitted to staff that he had used PS. He was referred again to a PS Support Group, but again his attendance was sporadic.
28. The prison's intelligence reports show that Mr Foat was suspected of supplying drugs in February, was suspected of bullying another prisoner because of a drug debt (for 'Spice', a type of PS) in March, and staff found five litres of illicitly brewed alcohol in Mr Foat's cell on 1 April.
29. An officer was Mr Foat's allocated key worker from April 2020, having previously been his Offender Supervisor. She said she would occasionally discuss Mr Foat's PS use with him. He would then abstain for a period before resuming drug use.
30. On 12 May 2020, Mr Foat was identified by the prison's new non-clinical substance issue provider, Delphi, to attend a group to address PS use and Peer Pressure. Due to COVID-19 restrictions, the prison was unable to run these groups in person but, instead, gave Mr Foat an in-cell booklet to read and complete. There was an accompanying letter offering Mr Foat the opportunity to contact his key worker if he needed further support. Two months later, on 9 July, he told a drug worker that he had received this documentation and was keen to work with Delphi. She gave Mr Foat a self-assessment to complete and return to her. (This was still outstanding at the time of his death.)

31. On 14 May, Mr Foat's key worker sent a letter to all the prisoners she worked with to tell them about how COVID-19 would affect her key worker role and how she would support them remotely. On 3 June, Mr Foat received notification that his application to recategorize to a lower category to enable him to transfer to an open prison, had been unsuccessful. This was because of his continuing drug use.
32. On the evening of 31 July, an operational support grade (OSG) was working a night shift on C Wing. He would routinely get a handover from wing day staff, check the existing roll on the wing and during the night would answer cell bells as well as work through a checklist of tasks, for example checking fire doors. He would carry out another roll check the next morning.
33. CCTV shows the OSG at Mr Foat's cell door at 9.11pm. He told the investigator he was sure there was nothing untoward in any of the cells, although he could not remember Mr Foat's specifically and had there been, he would have reported it immediately. He said that he did not see any prisoners lying on their cell floor that night.

1 August 2020

34. CCTV shows the OSG checking Mr Foat's cell again at 5.06am on 1 August. He said he saw nothing out of the ordinary in any of the cells and did not see any prisoners on their cell floor. He added that at no time did he see any blood or vomit in any of the cells on the wing.
35. Later that morning, staff began to unlock prisoners on C Wing. Due to COVID-19 restrictions, prisoners were only allowed out of their cells for 45 minutes.
36. Officer A was detailed to work on C Wing that morning, which was not his usual place of work. CCTV footage shows that he was unlocking cells and that he reached Mr Foat's cell at 8.36am. CCTV shows him opening the observation panel on the cell door and looking inside before unlocking the door and opening it. He told the investigator he believed he had satisfied himself that he had seen that every prisoner was in their cell and noted their movement. He said he thought he had seen Mr Foat move on his bed, although he recalled a couple of the cells seemed quite dark.
37. At around 8.55am, a prisoner shouted to staff that they needed to come quickly as Mr Foat was lying on his cell floor and there was blood. Three officers responded as the prisoner shouted to them to hurry. On the way, one officer, sensing the panic in the prisoner's voice, radioed both an emergency code red and code blue. This was at 8.56am.
38. Two officers went into Mr Foat's cell. They saw Mr Foat lying face down on the cell floor, next to some blood and near vomit, and he was unresponsive. Officer A put his hand on Mr Foat's back and noted it felt cold and hard, and Mr Foat appeared to have rigor mortis (stiffening of the body that occurs from around two to six hours after death). Officer A said to a colleague, "I think he's dead". They did not check for a pulse or start CPR.
39. A nurse was the first responder to any medical emergencies (call sign Hotel 2) that morning. She was close to C Wing when she heard the emergency call and

arrived at Mr Foat's cell in less than a minute. Another nurse responded to the call with the emergency bag. The first nurse noted that there was a lot of blood around Mr Foat's head, vomit on a chair, and his hands and feet appeared mottled. She was unable to get any response from him. She noted his body felt cold and rigid and was sure rigor mortis had set in. She decided CPR would not be appropriate as Mr Foat showed no signs of life. Two minutes later paramedics arrived at Mr Foat's cell. They declared his death at 9.18am. The nurse told the investigator there was an empty vape cartridge near Mr Foat, as well as a weighted bottle tied to knotted bed sheets coming through the cell window.

Contact with Mr Foat's family

40. Mr Foat's next of kin was his brother, who was a prisoner at HMP Hindley. Wymott's family liaison officer telephoned the Governor at Hindley, who asked Hindley's prison chaplain to break the news of Mr Foat's death to his brother.
41. Mr Foat's sister-in-law telephoned the prison on 3 August. She told the family liaison officer that she had received a Facebook message from Mr Foat between 3.00am and 4.00am on the morning he died, asking for contact numbers for family members. This showed he had a mobile telephone in his possession and had been alive after the evening roll check.
42. The prison contributed to the cost of Mr Foat's funeral, in line with national guidelines.

Support for prisoners and staff

43. After Mr Foat'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.
44. The prison posted notices informing other prisoners of Mr Foat'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 Foat's death.

Post-mortem report

45. Mr Foat's post-mortem could not determine a cause of death, but said it was most likely he died from a drugs overdose. A toxicology report noted the presence of synthetic cannabinoids (PS).

Findings

Wymott's drug strategy

46. The PPO's Learning Lessons Bulletin on psychoactive substances (PS), issued in July 2015, highlighted that PS use has a profoundly negative impact on the physical and mental health of prisoners. Mr Foat's death is an example of the dangers of PS and illustrates why prisons must do all they can to eradicate its use.
47. Following an inspection in October 2016, HM Chief Inspector of Prisons was concerned that drugs were freely available at Wymott. The prison revised and reissued their substance misuse strategy in August 2018, setting out a number of actions to reduce the demand and supply of illicit drugs. The strategy includes a protocol for the management of prisoners suspected of misusing PS and a "Robust Recovery Package" with a flowchart for staff, setting out the actions to be taken.
48. In April 2019, HM Prison and Probation Service (HMPPS) published the National Drug Strategy. It set out plans to reduce substance misuse in prisons by providing detailed guidance for prisons to help them identify issues and share best practice. Wymott produced an updated drugs strategy in August 2019. It sets out its plan to restrict the supply, reduce demand and build recovery. However, we are concerned that PS continues to be available at Wymott and note that the IMB noted in its latest report that the prevalence of illicit substances within the prison, particularly PS, remained a concern. We recommend:

The Governor should ensure that the key drug issues at Wymott are identified and that the prison's local drugs strategy is reviewed to ensure that these key issues are being addressed.

Management of Mr Foat's substance misuse

49. We are satisfied that Mr Foat was managed appropriately when he appeared to be under the influence of illicit drugs. Staff submitted intelligence reports, shared information about him, managed him through the IEP scheme and staff from the Delphi team tried to interact with him.
50. The COVID-19 pandemic meant that after May 2020, Delphi staff were unable to hold groups for men with substance misuse issues, and instead worked with them remotely providing in-cell work. However, prior to the restricted regime, Mr Foat had attended groups about PS use and been supported by Delphi staff and his key worker, but he continued to take illicit drugs. We conclude that Wymott could not have done more to support Mr Foat to address his substance misuse.

Failure to carry out welfare check at unlock

51. At around 8.55am on 1 August, prisoners alerted staff that Mr Foat was lying on the floor of his cell. When staff got to the cell, they realised that Mr Foat was dead.
52. It is difficult to establish exactly when Mr Foat died, but given he had rigor mortis when he was found by staff at 8.56am, he must have died at least two hours

earlier. This means that Mr Foat may not have been dead during the OSG's morning roll check at 5.06am (Mr Foat sent a Facebook message to his sister-in-law between 3.00am and 4.00am that morning, so was alive then), but he was almost certainly dead on the floor of his cell when Officer A unlocked his cell at 8.36am.

53. CCTV shows Officer A looking through Mr Foat's cell's observation panel and then unlocking the door. He said he had not seen Mr Foat, or any prisoner that morning, lying on the cell floor, although he said some cells were quite dark.
54. The evidence indicates that Mr Foat was lying dead on the floor of his cell when Officer A unlocked his cell at 8.36am. Although CCTV shows that Officer A looked through the cell's observation panel before unlocking the door, the evidence indicates that he did not look properly. Staff are also supposed to carry out a welfare check at unlock, which requires them to get a response from the prisoner, either physical or verbal. Officer A clearly did not do this. Officer A's failure to check Mr Foat properly was unacceptable and caused unnecessary distress for the prisoners who discovered him.
55. The PPO has raised concerns previously about prison staff at Wymott failing to carry out a welfare check at unlock. In response to a previous PPO recommendation made in May 2019, the prison reissued the Notice to Staff on unlocking of cell doors (which says that staff should satisfy themselves of the wellbeing of the prisoner by obtaining some kind of response from them) and delivered training consisting of a physical demonstration of how a welfare check should be carried out. (The prison told us that training did not start until November 2020 due to the COVID-19 pandemic and that 44% of staff had received the training as at March 2021. Officer A received training in January 2021.)
56. We accept that Wymott was operating a restricted regime at the time of Mr Foat's death, and prisoners only had a short time out of their cells, so it was important that staff worked quickly, however, it remains important that staff check on the welfare of prisoners when unlocking them in the morning. It is unacceptable that Officer A did not notice that Mr Foat was lying dead in his cell or carry out a welfare check, and that other prisoners were left to discover him. We recommend:

The Governor should ensure that staff check on prisoners' welfare when unlocking cells.

The Governor should share this report with Officer A and arrange for a senior manager to discuss the Ombudsman's findings with him.

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