Prisons & Probation
Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Paddy Ward, a prisoner at HMP Manchester, on 18 August 2020

**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*

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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 Paddy Ward died on 18 August 2020 from the toxic effects of psychoactive substances (PS) at HMP Manchester. He was 28 years old. I offer my condolences to Mr Ward's family and friends.

Mr Ward had a history of substance misuse. In the months before his death, prison and healthcare staff suspected that Mr Ward had used drugs on several occasions. Healthcare staff treated Mr Ward appropriately and regularly warned him about the risks of using PS.

I am concerned that Mr Ward was able to obtain PS with apparent ease at Manchester. The prison needs to do more to reduce the availability of drugs. I am also concerned that staff failed to submit intelligence reports on eight occasions when they thought Mr Ward was under the influence of PS.

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** **August 2021**

## Contents

Summary ... 1

The Investigation Process ... 4

Background Information ... 5

Key Events ... 7

Findings ... 12

# Summary

## Events

1. In December 2018, Mr Paddy Ward was remanded in prison custody, charged with robbery and driving offences, and sent to HMP Forest Bank. In March 2019, he was moved to HMP Manchester. On 13 May 2020, Mr Ward was sentenced to four years in prison.

2. Mr Ward had a history of substance misuse and he regularly misused alcohol, cannabis and cocaine. He also had a history of mental health issues, including depression and psychosis.

3. Between 1 February and 21 March, prison and healthcare staff noted that Mr Ward appeared to be "under the influence" of an illicit substance on seven occasions. During this period, a community psychiatric nurse and a DARS recovery practitioner warned Mr Ward about the risks of using psychoactive substances (PS) and the negative impact that it would have on his mental health.

4. On 9 July, a supervising officer (SO) noted that he thought Mr Ward was trying to obtain PS from other prisoners.

5. On 29 July staff gave Mr Ward a warning for appearing under the influence of PS, and on 5 August an officer noted that Mr Ward had 'blown' the electricity in his cell every night that week, suggesting he was smoking drugs.

6. On 13 August, a nurse noted that Mr Ward appeared to be "under the influence" of an illicit substance and refused to give him his evening medication because of the risk of mixing it with illicit drugs.

7. The following day, two DARS recovery practitioners saw Mr Ward and warned him about the risks of using PS.

8. At 4.45pm, an officer unlocked Mr Ward's cell and found him unresponsive, so he called for staff assistance from nearby officers. Other officers quickly responded and started cardiopulmonary resuscitation (CPR) and called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing). Two nurses also responded to the code blue emergency. They assessed that Mr Ward had died and decided to stop CPR.

9. Paramedics reached Mr Ward at 4.59pm. They noted that Mr Ward had drug smoking paraphernalia in his hand. At 5.05pm, they declared that Mr Ward had died.

10. The post-mortem examination found that Mr Ward died from the toxic effects of PS and cardiomegaly (enlarged heart) and coronary artery atheroma (a build-up of fatty deposits on the walls of the arteries around the heart).

## Findings

### Substance misuse care

11. The clinical reviewer was satisfied that the substance misuse care that Mr Ward received was equivalent to that which he could have expected to receive in the community, though his care appeared to be disjointed due to several changes in his recovery worker, and there had been significant delays in arranging joint assessments between the substance misuse and mental health services.

### Physical and mental health care

12. Mr Ward had limited contact with primary care healthcare staff and the clinical reviewer was satisfied that there was no evidence during this limited contact that he had cardiomegaly or coronary artery atheroma. The clinical reviewer considered that Mr Ward's mental health care was of a particularly good standard, as he was under the care of a consultant psychiatrist and his named community psychiatric nurse regularly visited and reviewed him.

### Reducing the supply and demand for illicit substances

13. We are concerned that Mr Ward was able to obtain PS at Manchester in the months before his death, despite various methods that the prison used to disrupt supply. The prison needs to review its drugs strategy. We are also concerned that staff failed to submit any intelligence reports about Mr Ward's substance misuse after 1 February 2020.

### Emergency response

14. There were delays in calling a code blue emergency and in calling for an ambulance when Mr Ward was found. It made no difference to the outcome for Mr Ward as he had been dead for some time, but any delay could be critical in future cases.

### Consideration of Mr Ward's literacy issues

15. Mr Ward was unable to read and write. While his community psychiatric nurse and his recovery practitioner took this into account when working with him, we are concerned that Mr Ward's literacy issues were not widely understood, particularly during the COVID-19 pandemic.

## Recommendations

- The Head of Healthcare should develop a pathway between substance misuse and mental health services for complex prisoners who require joint assessment and management.
- 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.
- The Governor should identify the key weaknesses in reducing the supply of drugs at Manchester and revise the drug strategy in light of the findings.

- The Governor should ensure that all staff are made aware of and understand PSI 03/2013, as well as local instructions, and their responsibilities during medical emergencies, including:
    - immediately calling an ambulance in an emergency; and
    - promptly providing information about a prisoner's condition to the control room so that they have this information when requesting an ambulance.
- The Head of Healthcare should ensure that healthcare staff know of any prisoners with literacy issues and tailor any communication so as not to disadvantage them.

# The Investigation Process

16. 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.

17. The investigator obtained copies of relevant extracts from Mr Ward's prison and medical records.

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

19. The investigator interviewed 17 members of staff at Manchester in October 2020. The clinical reviewer joined the investigator for five interviews. All the interviews were conducted by video-link or telephone because of the COVID-19 restrictions.

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

21. The investigator contacted Mr Ward's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Ward's brother wanted to know:

    - When and why Mr Ward had used his cell bell on the day of his death?
    - What mental health care Mr Ward had received and whether it was appropriate?

22. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

23. We sent a copy of our initial report to Mr Ward's brother. He identified no factual inaccuracies.

# Background Information

### HMP Manchester

24. HMP Manchester operates as a high security prison and a training establishment and holds up to 750 men. Greater Manchester Mental Health NHS Foundation Trust provides primary care and mental health services and Delphi Medical provides clinical and non-clinical substance misuse services.

### HM Inspectorate of Prisons

25. The most recent full inspection of HMP Manchester was carried out in June and July 2018. Inspectors found that 53% of prisoners said it was easy to obtain drugs. They reported that the drug strategy lacked a whole-prison approach to supply reduction. They found that substance misuse services were well managed and their staff had the required competencies.

26. The Inspectorate conducted a review of progress in June 2019, to assess progress on twelve of the key recommendations. The review found that reasonable progress had been made on reducing the supply of drugs, as mandatory drug test results were relatively low compared with other prisons. Inspectors found that the prison had appointed a manager with responsibility for the drug strategy and a comprehensive drug strategy had been produced.

### Independent Monitoring Board

27. 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 28 February 2020, the IMB reported that prisoners' access to drugs remained an issue, though the number of prisoners testing positive for drugs had reduced. They felt this was due to several measures, including intelligence led cell searches, interception of packages thrown into the prison, the introduction of a new reception scanner and improved security measures relating to incoming mail.

### Previous deaths at HMP Manchester

28. Mr Ward was the 14th prisoner to die at Manchester since August 2018. Three of the previous deaths were self-inflicted, two were drug-related and eight were from natural causes. We have previously made recommendations about reducing the supply of drugs and staff responsibilities during medical emergencies.

### Psychoactive Substances (PS)

29. Psychoactive substances, 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.

30. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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.

## Key Events

31. On 26 December 2018, Mr Paddy Ward was remanded in prison custody, charged with robbery and driving offences, and sent to HMP Forest Bank. On 5 March 2019, he was moved to HMP Manchester.

32. Mr Ward had a history of substance misuse and he regularly misused alcohol, cannabis and cocaine. He also had a history of mental health issues, including depression and psychosis, and had been detained in a psychiatric hospital. Mr Ward's substance misuse and mental health issues were treated at Manchester with regular reviews with the same nurse and various recovery practitioners, the creation of care plans and prescribed medication. Mr Ward was also unable to read and write.

33. During his time at Manchester, prison and healthcare staff regularly suspected Mr Ward of being under the influence of illicit substances and of attempting to divert his prescribed medication. In July 2019, Mr Ward told a community psychiatric nurse that he used psychoactive substances (PS) weekly, as a way of "blocking things out".

34. On 16 December, the community psychiatric nurse reviewed Mr Ward, who said that he had not used PS for two weeks. Mr Ward said that he would take his antipsychotic and antidepressant medication, though the nurse noted that his compliance was sporadic. She contacted the Drug and Alcohol Recovery Service (DARS) and suggested a joint meeting to support Mr Ward with his mental health and PS use, having first done so on 29 July.

35. On 14 January 2020, a DARS recovery practitioner reviewed Mr Ward, who said that he had not used PS for "a while now". She gave Mr Ward harm reduction advice and agreed to complete his in-cell workbook together, as he was unable to read or write.

36. On 31 January, the community psychiatric nurse reviewed Mr Ward, as he was not taking his antipsychotic medication. She noted that Mr Ward appeared to be under the influence of an illicit substance, though he denied it. She told DARS about his suspected drug use.

37. On 1 February, an officer found Mr Ward on the wing landing and noted that he appeared to be "under the influence". The officer submitted an intelligence report. The following day, a nurse saw Mr Ward, who denied being under the influence of an illicit substance. The nurse noted that Mr Ward did not show any signs of sedation or intoxication.

38. On 5 February, the DARS care coordinator saw Mr Ward and gave him harm reduction advice about using PS. She decided to complete the PS workbook with Mr Ward, due to his recent, suspected usage.

39. On 9 February, the community psychiatric nurse reviewed Mr Ward and noted that he appeared to be sedated. She asked whether he had used PS and Mr Ward denied this. She warned Mr Ward about the risks of using PS and the negative impact that it would have on his mental health. She arranged a joint meeting with the DARS care coordinator.

40. On 14 February, the community psychiatric nurse and the DARS care coordinator reviewed Mr Ward, who said that he had only been using PS at night and would smoke pipes while standing up. The DARS care coordinator advised Mr Ward to sit while using PS, due to the risk of falling, and the nurse warned him of the risks of using PS together with his prescribed antipsychotic medication.

41. On 25 February, 5 March and 10 March, officers noted in Mr Ward's electronic prison record (known as NOMIS) that he had been removed from the prison workshop because he was behaving in a strange manner and was thought to be "under the influence".

42. On 6 March, the community psychiatric nurse reviewed Mr Ward and noted that he appeared to be under the influence of PS. She passed the information onto DARS.

43. On 21 March, the community psychiatric nurse reviewed Mr Ward and noted that he appeared slightly sedated. Mr Ward denied using PS though he laughed when she challenged this. She reminded Mr Ward about the risks of using PS and the negative effect that it would have on his mental health.

44. On 1 April, the community psychiatric nurse reviewed Mr Ward and noted that he appeared alert, with no evidence of any substance misuse. Mr Ward denied any recent use of PS, despite contrary entries on his electronic medical record (known as SystmOne). Mr Ward could not explain why he had not been taking his antipsychotic medication, but she explained the importance of taking it.

45. A week later, the DARS care coordinator reviewed Mr Ward and noted that there was no evidence of any substance misuse. Mr Ward said that he had not used any illicit substances though she gave him advice on the risks from using PS.

46. On 13 May, Mr Ward was sentenced to four years in prison.

47. Six days later, the community psychiatric nurse reviewed Mr Ward, as he had been sentenced, and noted that there was no evidence of current PS use.

48. On 9 June, the DARS care coordinator reviewed Mr Ward and agreed to restart his substance misuse work, as his literacy issues meant that he could not complete workbooks.

49. On 19 June, a restraining order was put in place, preventing Mr Ward from contacting his former partner (the mother of his children).

50. Also that day, the DARS care coordinator reviewed Mr Ward, who said that he had not used PS for two weeks. She reminded Mr Ward that his tolerance levels would have decreased and reminded him about the risks of using PS. She also told him that he would be shortly be allocated to another DARS worker.

51. The same day, Mr Ward asked an officer to collect a vape for him from another prisoner. When the officer refused, he said he had chest pain. The officer arranged to take Mr Ward to the healthcare unit, but he refused to go after another officer passed him a vape from another prisoner.

52. On 22 June, a nurse tasked a prison GP to review Mr Ward as he had attempted to hide his medication under his upper lip instead of swallowing it when it was dispensed. There is no record on SystmOne about Mr Ward diverting his medication. The task was eventually assigned to community psychiatric nurse.

53. The following day, the community psychiatric nurse reviewed Mr Ward and noted that he did not appear sedated. Mr Ward denied diverting his medication and explained that he had decided to start taking it normally. She planned to monitor Mr Ward's compliance with his medication over the coming weeks.

54. On 26 June, a nurse saw Mr Ward, as he said that he had experienced chest pain. The nurse took Mr Ward's basic observations, which were normal, and carried out an electrocardiogram (ECG – a test to check the heart's rhythm and electrical activity), which was normal. Mr Ward said that he had just eaten five cans of tuna so the nurse said that it was likely to be indigestion. She told him to use his cell bell if the pain worsened.

55. On 9 July, a Supervising Officer (SO) noted on Mr Ward's NOMIS record that he was constantly going to other prisoners' cells asking for vapes and considered that he was trying to collect PS from these cells.

56. On 14 July, the community psychiatric nurse reviewed Mr Ward and noted that he was "euthymic" (a normal, tranquil mental state or mood). Mr Ward denied using PS.

57. On 29 July and 5 August, the SO and other officers gave Mr Ward four Incentive and Earned Privilege (IEP) warnings: one for appearing under the influence of PS and three for misusing his cell bell. The SO also referred Mr Ward for a mandatory drug test. An officer noted on 5 August that Mr Ward had 'blown' the electricity in his cell every night that week (suggesting he was using exposed wires to produce a spark to smoke drugs).

58. On 7 August, the SO saw Mr Ward for an IEP review and decided to downgrade him to the basic regime level based on the number of negative entries that he had received. The SO set Mr Ward three timed, behavioural targets, which included engaging with DARS, to return to the standard regime level.

59. On 13 August, the DARS care coordinator and a DARS recovery practitioner, reviewed Mr Ward, who said that he had not used any PS since their last meeting. Mr Ward also said that he had been taking his mental health medication and that he was feeling better. The DARS care coordinator told Mr Ward that he was being reallocated to the DARS recovery practitioner, who planned to see him on 2 September.

60. Later that day, Mr Ward went to the wing's medication hatch to collect his evening medication. A nurse refused to give it to him for safety reasons, as she thought that he was "under the influence" of an illicit substance as he could not walk straight or talk properly.

61. On 14 August, the DARS recovery practitioner and another DARS recovery practitioner, saw Mr Ward, who said that he used PS to block out some of his thoughts. The DARS recovery practitioner told Mr Ward not to use PS by himself, to test out every new batch by using a very small amount first and to ask for help

if he had difficulties. Mr Ward said that, when using PS in the past, he had to be revived after losing consciousness and he agreed that he could not know what was in each batch of PS.

62. Later that day, the SO saw Mr Ward for an IEP review and noted that he had not received any negative comments in the last week, which was a big improvement. The SO told the investigator that he did not know that a nurse considered Mr Ward was under the influence of an illicit substance on 13 August.

### 18 August 2020

63. At approximately 11.30am, the community psychiatric nurse reviewed Mr Ward and noted that he was "euthymic". She warned Mr Ward about the risks of using PS together with antipsychotic medication, though he said that he had "not used for weeks". She challenged him on this, following the events of 13 August, and Mr Ward admitted that he used PS to "get away". She planned to see Mr Ward on 18 September.

64. At 1.32pm, Mr Ward pressed his cell bell. CCTV footage shows that an officer responded within a minute and spoke to Mr Ward for a few seconds.

65. At 2.54pm, an officer unlocked Mr Ward's cell, for him to exercise and use the shower, and Mr Ward immediately left his cell.

66. At 3.26pm, Mr Ward returned to his cell and an officer locked the door. In his witness statement, the officer wrote that Mr Ward appeared to be "perfectly fine", though they did not speak.

67. At 4.45pm, an officer unlocked Mr Ward's cell to allow him to collect his afternoon medication. The officer noted that Mr Ward was unresponsive, so he called for staff assistance from nearby officers. Two officers quickly responded. An officer checked Mr Ward's neck for a pulse but could not find it so started cardiopulmonary resuscitation (CPR). Meanwhile, an officer called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing).

68. Two nurses quickly responded to the code blue emergency. They assessed Mr Ward and noted that he had extreme cyanosis (a blueish discoloration of the skin caused by an increase in deoxygenated blood) on his face, hands and feet, and lividity (pooling of blood) on his abdomen, both signs that someone has been dead for a while. The nurses decided to stop CPR.

69. At 4.48pm, the prison called for an ambulance and the North West Ambulance Service sent an ambulance, which reached Mr Ward at 4.59pm. The paramedics noted that Mr Ward had lividity and that there was evidence of smoking paraphernalia in his right hand. At 5.05pm, they declared that Mr Ward had died.

### Contact with Mr Ward's family

70. Following Mr Ward's death, the prison appointed the managing chaplain as the prison's family liaison officer (FLO). At 7.00pm, the FLO telephoned Mr Ward's named next of kin, his ex-partner, but she did not answer the call. The FLO then

tried to telephone eight other members of Mr Ward's family but either the numbers had been disconnected or they did not answer the calls.

71. At 8.00pm, the Head of Residence suggested that a secure hospital, where Mr Ward's brother had recently been, may have a telephone number for a family member. The hospital provided a telephone number for another of Mr Ward's brothers, but the number had been disconnected.

72. At 8.45pm, the Safer Custody department provided a telephone number for Mr Ward's brother's next of kin. The FLO telephoned her and explained that Mr Ward had died. She offered to contact Mr Ward's family and ask them to contact the prison.

73. At 8.10am on 19 August, one of Mr Ward's brothers telephoned the prison and spoke to a prison manager. Mr Ward's brother said that he was upset and angry to have heard about his brother's death through social media. The prison manager apologised for this and answered some of Mr Ward's brother's questions.

74. At 9.30am, the FLO telephoned Mr Ward's aunt, who had telephoned the prison the previous evening. Mr Ward's aunt gave the FLO a telephone number for another of Mr Ward's brothers, who would act as the family's contact. The FLO then telephoned Mr Ward's brother and offered his condolences and support.

75. At 12.45pm on 20 August, Mr Ward's ex-partner telephoned the prison and spoke to the FLO. The FLO offered his condolences and support.

76. The FLO continued to support Mr Ward's family until his funeral, which was held on 4 September. The prison contributed towards the costs of the funeral in line with national instructions.

### Support for prisoners and staff

77. At approximately 7.00pm on 18 August, the Head of Residence debriefed the prison staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. She debriefed healthcare staff at 9.30am on 19 August. The staff care team also offered support.

78. The prison posted notices informing other prisoners of Mr Ward'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 Ward's death.

### Post-mortem report

79. The post-mortem examination found that the cause of Mr Ward's death was synthetic cannabinoids (PS) toxicity with cardiomegaly (an abnormal enlargement of the heart) and coronary artery atheroma (a build-up of fatty deposits on the walls of the arteries around the heart).

80. The pathologist commented that it was possible that Mr Ward's enlarged heart and moderate coronary artery narrowing made him more susceptible to sudden death as a result of PS use.

# Findings

### Substance misuse care

81. Mr Ward had a long history of substance misuse and continued to use illicit substances at Manchester. The clinical reviewer noted that Mr Ward did so despite receiving support and harm reduction advice from substance misuse and mental health services.

82. Overall, the clinical reviewer was satisfied that the substance misuse care that Mr Ward received was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer noted that Mr Ward's substance misuse care appeared to be disjointed, particularly after he arrived at Manchester, due to several changes in his recovery worker. She also noted that there had been significant delays, between 29 July 2019 and 14 February 2020, in arranging joint assessments between substance misuse and mental health, despite the community psychiatric nurse repeated requests. We make the following recommendation:

    **The Head of Healthcare should develop a pathway between substance misuse and mental health services for complex prisoners who require joint assessment and management.**

### Physical health care

83. Mr Ward's contacts with the healthcare team were predominantly with the mental health and substance misuse teams. Where Mr Ward was seen by primary care healthcare staff, the clinical reviewer was satisfied that he was able to access appropriate appointments and that there was no evidence during this limited contact that he had cardiomegaly or coronary artery atheroma.

### Mental health care

84. Mr Ward had a complex mental health history, but the clinical reviewer considered that his mental health care was of a particularly good standard. The clinical reviewer noted that Mr Ward was under the care of a consultant psychiatrist, his care was regularly discussed at mental health multidisciplinary team meetings and the community psychiatric nurse, his named nurse, regularly visited and reviewed him.

85. We agree with the clinical reviewer that the community psychiatric nurse provided consistent, responsive and patient centred care. The clinical reviewer considered that the community psychiatric nurses care often exceeded routine expectations, as she visited Mr Ward to remind him of appointments or to read medical letters to him, and she supported him during blood tests, knowing that he was scared of needles.

### Reducing the supply and demand for illicit substances

86. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS use has a profoundly negative impact on the physical and mental health of prisoners. Mr Ward's death is an example of the dangers of PS and illustrates why prisons must do all they can to stop its use.

87. During our investigation, staff told the investigator that illicit substances, particularly PS, were commonplace in the prison, though the COVID-19 pandemic appeared to have had some impact on their availability.

88. In April 2019, Manchester introduced a new Integrated Substance Misuse Strategy, which aimed to reduce the supply and demand for illicit substances and to treat the clinical, social and behavioural effects of drug misuse within the prison. To help reduce supply, the Strategy says that all staff should submit intelligence reports about all drug matters to help the Security Department collate and gather key information. Security staff will analyse this information and take appropriate actions to address the issue, which could include a referral for a mandatory drug test or a restriction on visits.

89. During the PPO's interview with the acting Head of Security and the previous acting Head of Security, they described the steps the prison has taken to reduce the supply of illicit substances. These included the use of scanners to test incoming letters for PS, the use of passive drug dogs, the use of staff to check all prisoner routes for throw overs, and joint operations with the police. The previous acting Head of Security also reiterated that any member of staff should submit an intelligence report if they suspect a prisoner is misusing illicit substances.

90. Between 9 February and 13 August, prison and healthcare staff suspected that Mr Ward had used PS or another illicit substance on eight occasions. However, none of the staff submitted intelligence reports about these incidents. We are concerned that this failure meant that the security department could not properly understand Mr Ward's substance misuse and the wider implications around the supply and distribution on his wing and around the prison.

91. We are also concerned that, despite the scanning of incoming mail and the fact that prison visits had been suspended due to the COVID-19 pandemic, Mr Ward managed to obtain PS in July and August 2020.

92. We make the following 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.**

**The Governor should identify the key weaknesses in reducing the supply of drugs at Manchester and revise the drug strategy in light of the findings.**

### Emergency response

93. PSI 03/2013, *Medical Emergency Response Codes*, contains mandatory instructions that staff must use emergency codes to clearly convey the nature of the medical situation and that on hearing a code blue, control room staff must call an ambulance immediately.

94. Manchester's local protocol reflects the content of the PSI. In July 2020, the prison issued a Governor's Order that reissued the local protocol.

95. When an officer initially found Mr Ward unresponsive in his cell, he shouted for staff assistance rather than immediately calling a code blue emergency. Although the officer called the code blue at 4.45pm, within a minute of finding Mr Ward, we are concerned that this was an avoidable delay.

96. We are also concerned that, despite the officer having called a code blue, a control room operator did not call for an emergency ambulance until 4.48pm, a delay of three minutes. We are particularly concerned that this came less than two months after the prison reminded staff about the local protocol. While this delay will not have changed the outcome for Mr Ward, it could be critical in other cases. We make the following recommendation:

**The Governor should ensure that all staff are made aware of and understand PSI 03/2013, as well as local instructions, and their responsibilities during medical emergencies, including:**

- **immediately calling an ambulance in an emergency; and**
- **promptly providing information about a prisoner's condition to the control room so that they have this information when requesting an ambulance.**

### Consideration of Mr Ward's literacy issues

97. Mr Ward was unable to read and write and the community psychiatric nurse and the DARS care coordinator took this into account when working with him. We are pleased that the community psychiatric nurse visited Mr Ward to read him certain letters and drug information notices, and the DARS care coordinator spent time with him so that he could complete his DARS workbooks.

98. Although we commend their actions, we are concerned that Mr Ward's literacy issues were not widely understood, particularly during the COVID-19 pandemic. As a result, Mr Ward's SystmOne record shows that, on 19 March, 20 and 21 April, 29 May and 29 July, various healthcare staff sent him letters about changes to their working practices, the cancellation of appointments and other matters. There is no evidence that anyone checked that he had understood these letters. We make the following recommendation:

**The Head of Healthcare should ensure that healthcare staff know of any prisoners with literacy issues and tailor any communication so as not to disadvantage them.**

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