Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Al-Yasa Hamza Abdussalaam, a prisoner at HMP Liverpool, on 1 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*

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 Abdussalaam was found dead in his cell at HMP Liverpool on 1 August 2020. The cause of death was congenital heart disease with synthetic cannabinoid toxicity. He was 26 years old. I offer my condolences to Mr Abdussalaam's family and friends.

Mr Abdussalaam had been in prison since August 2015 and had been at Liverpool for just over five weeks when he died. He had never reported any symptoms of heart disease and there was nothing to suggest that he was a regular user of illicit substances. The clinical reviewer is satisfied that his healthcare was equivalent to that he could have expected in the community, and we do not consider that staff could have foreseen or prevented his death.

Mr Abdussalaam was found dead in his cell at about 10.00am. We have been unable to establish why he was not unlocked at 8.00am that day to collect his medication and we cannot say whether the outcome might have been different if he had been found earlier. However, we consider that welfare checks should be conducted before 10.00am on prisoners who are not being unlocked.

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 **October 2021**

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Summary

Events

1. Mr Al-Yasa Hamza Abdussalaam was sentenced to two years in custody in August 2015. In August 2017, he received a further nine-year sentence for an attack on another prisoner. He spent time at a number of prisons.

2. Mr Abdussalaam was reported to be under the influence of illicit substances on two occasions in 2015 and tested positive for psychoactive substances (PS) in June 2019. However, he told staff he had no issues with substance misuse, and they had no concerns that he was a regular user.

3. Mr Abdussalaam's medical records showed that he had been born with ventriculo-septal defect (VSD, known as a 'hole in the heart'). He never reported any symptoms of heart disease but, in December 2019, a prison GP referred him for a routine cardiology appointment. This did not take place as the hospital said they had not received the referral.

4. On 25 June 2020, Mr Abdussalaam was transferred to HMP Liverpool. At his initial health screen, he reported no health concerns and said he had no substance misuse concerns. He was seen by a member of the substance misuse team who told him how to access support if he needed it. In line with COVID-19 requirements, he spent his first 14 days in isolation and then moved to a normal residential wing.

5. On 28 July, Mr Abdussalaam saw a prison GP and was prescribed a five-day course of antibiotics for an ingrowing toenail. He received his medication each morning at approximately 8.00am, and collected this on 29, 30 and 31 July. However, for reasons that are unclear, he was not unlocked to collect his medication on 1 August.

6. At about 10.10am that morning, officers went to Mr Abdussalaam's cell to deliver items he had purchased from the prison shop. They found him unresponsive, lying face down on the floor. They called a medical emergency code and nurses arrived quickly. They did not attempt resuscitation as rigor mortis was present.

7. Paramedics arrived at 10.27am and pronounced Mr Abdussalaam dead at 10.29am.

Findings

Clinical care

8. The clinical reviewer was satisfied that the care that Mr Abdussalaam received at Liverpool was equivalent to that which he could have expected to receive in the community. He had never reported any symptoms associated with his VSD and staff had no reason to suppose he was a regular user of illicit substances.

9. We do not consider that staff could have foreseen or prevented his death.

Emergency response

10. Mr Abdussalaam should have been unlocked at 8.00am to collect his medication on the day of his death and we have been unable to establish why this did not happen. He had been dead for some time when he was found at around 10.00am and we cannot say whether the outcome might have been different if he had been unlocked earlier.

11. We are, however, concerned that a 10.00am unlock does not meet the requirement in Prison Service Instruction (PSI) 75/2011 to conduct a welfare check in the morning to ensure that prisoners have not been taken ill during the night.

Recommendations

- The Governor and the Head of Healthcare should ensure that there is a robust system in place for calling prisoners to the medication hatch to receive prescribed medication, and that any discrepancies are followed up.

- The Governor should ensure that a morning welfare check is conducted in line with PSI 75/2011.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Abdussalaam's prison and medical records. She interviewed seven members of staff at Liverpool In September 2020.

14. NHS England commissioned a clinical reviewer to review Mr Abdussalaam's clinical care at the prison. The clinical reviewer was present for the interviews carried out by the investigator. All the interviews were conducted by telephone because of the restrictions in place during the COVID-19 pandemic.

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

16. The PPO's family liaison officer wrote to Mr Abdussalaam's next of kin to explain the investigation and to ask if they had anything that they wanted the investigation to consider. They did not respond.

Background Information

HMP Liverpool

17. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 750 adult men. Spectrum Healthcare UK Trust provide healthcare services. There is a 24-hour inpatient unit.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Liverpool was in September 2019. Inspectors noted significant improvements since the last inspection that took place in 2017. They found that more than half the population said that drugs were readily available and, while there had been a reduction since 2017, positive mandatory drug testing rates remained too high. However, they noted that the prison's drug strategy focused on rehabilitation and support, and there was evidence of some early success in reducing the use of illicit substances.

19. Inspectors reported that there had been significant improvements in health provision. Prisoners had prompt access to a wide range of daily nurse-led clinics and there was better care for patients with long-term conditions. They noted that there were good arrangements to ensure a rapid response to medical emergencies and trained nursing staff were present 24 hours a day. Appropriate medical equipment was readily accessible and regularly checked and maintained.

Independent Monitoring Board

20. 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 31 December 2019, the IMB reported that there had been major improvements in the physical conditions in which prisoners were held at Liverpool, and that the condition of cells and the external environment was significantly better.

Previous deaths at HMP Liverpool

21. Mr Abdussalaam was the 11th prisoner to die at Liverpool since August 2018. Of the previous deaths, six were due to natural causes and four were self-inflicted. There were no other drug-related deaths. There are no similarities between the previous deaths and the findings of this investigation.

Psychoactive Substances (PS)

22. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a problem across the prison estate. They are difficult to detect and can affect people in several 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, a potential for violence and sudden death. 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.

Key Events

23. Mr Al-Yasa Hamza Abdussalaam (who was previously known as Mr Ashley Beacham) had spent most of his life since the age of 17 in custody. In March 2015, he was remanded into custody on a charge of affray and threats to kill and was subsequently sentenced to two years in custody with extended licence conditions. In August 2017, he was sentenced to a further nine years in custody for an assault on another prisoner.

24. He spent time in a number of establishments. His behaviour fluctuated: he was sometimes described as having a good relationship with staff and at other times he refused to engage with staff at all. He was briefly managed under suicide and self-harm monitoring procedures (known as ACCT) in 2018 and 2019 after superficial self-harm but told staff he was not suicidal and had just wanted to go on an ACCT because he knew he would be able to speak to a manager.

25. Mr Abdussalaam's medical records indicate that he had been born with ventriculo-septal defect (VSD, known as a 'hole in the heart') which had required no surgery, and at the time was recorded as 'of no clinical significance'. During his time in custody, Mr Abdussalaam reported no issues relating to this diagnosis, although in December 2019, he told a prison GP at HMP Parc that he had attended bi-annual cardiovascular follow up appointments, and she requested a routine cardiology appointment for him. However, the appointment did not take place because the hospital said they had not received the request.

26. In addition to the diagnosis of VSD, Mr Abdussalaam is also recorded as having mild anxiety disorder, although he did not receive any medication for this.

27. In 2015, Mr Abdussalaam was twice suspected of being under the influence of illicit substances. He regularly denied using illicit drugs after that. However, in June 2019, he failed a mandatory drug test and was found to have used a psychoactive substance (PS). He told staff he had used PS as he was having a bad day and needed a release, but that he did not intend to take drugs again.

HMP Liverpool

28. On 25 June 2020, Mr Abdussalaam was transferred to HMP Liverpool. On his arrival at Liverpool, a reception health screen was completed, and his medical history was again noted. Mr Abdussalaam said that he had no thoughts of self-harm and had no concerns about being at Liverpool.

29. He denied any issues with substance abuse, but the nurse noted that this was contradicted by his notes and referred him to the substance misuse team. He was seen later that day by a recovery worker, who recorded that "structured misuse counselling" took place, and that Mr Abdussalaam was given an induction pack informing him of the substance misuse service and how to access support.

30. Due to the coronavirus pandemic, Mr Abdussalaam was required to spend a period of 14 days in isolation after he arrived at Liverpool. This meant that all but essential contact was avoided. He then moved to I wing, a standard residential wing.

31. On 28 July, Mr Abdussalaam was seen by a prison GP, after reporting pain from a recurring in-growing toenail. The GP prescribed a five-day course of antibiotics, along with co-codamol for pain relief. Mr Abdussalaam would be expected to collect his medication each morning from the medication hatch on the wing.

32. No other issues or concerns were raised by or about Mr Abdussalaam at Liverpool.

Saturday 1 August

33. An officer completed a roll check (count) of prisoners on Mr Abdussalaam's wing at around 5.00am on 1 August. He said that Mr Abdussalaam was asleep in bed.

34. Officer A said in a statement that he had been tasked with unlocking prisoners to take them to collect their medication that morning from about 8.30am to 9.30am. He said that Mr Abdussalaam was not on the list for medication and he therefore had no reason to go to his cell.

35. Later that morning, staff began to deliver items bought from the prison shop (canteen) to prisoners on the wing. Officers B and C were delivering canteen to prisoners on Mr Abdussalaam's landing. Officer B told the investigator that they began by placing bags outside each cell, before unlocking each cell and getting prisoners to check and sign for their items.

36. Officer B said that they arrived at Mr Abdussalaam's cell at approximately 10.10am. He said that he looked initially into the cell via the observation panel, before unlocking the door and shouting 'canteen'. When he got no response, he stepped into the cell as he thought Mr Abdussalaam might have been in the toilet area and not heard him. He called out again, but when he still received no response, he stepped fully into the cell and then saw Mr Abdussalaam lying face down on the floor.

37. Officer B said that he initially saw blood on the floor so shouted a medical emergency code red (indicating severe blood loss). Neither he nor Officer C were carrying radios, as their roles that day did not have radios allocated to them, so Officer C shouted 'code red' down the landing and other staff radioed it. (The expectation is that when a medical emergency code is used, healthcare and prison staff will respond immediately, and an emergency ambulance will be called.)

38. Officer B told the investigator that as he moved closer to Mr Abdussalaam, he could see that his face was blue, and he immediately told Officer C to inform other staff that it was in fact a code blue (meaning a prisoner is unconscious or struggling to breathe). Officer B said that Mr Abdussalaam was cold to the touch and was 'lying in an unnatural position'.

39. A nurse was on I wing administering medications when he heard the 'code red' and immediately made his way to Mr Abdussalaam's cell, taking with him an emergency response bag containing emergency equipment. He was quickly followed by a colleague. Both nurses told the investigator that when they saw Mr Abdussalaam it was clear to them that rigor mortis was present, and they therefore made no attempts to resuscitate him.

40. Paramedics arrived at the prison at 10.15am and were at Mr Abdussalaam's cell at 10.27am. After carrying out their own observations, they pronounced Mr Abdussalaam dead at 10.29am.

Contact with Mr Abdussalaam's family

41. Following Mr Abdussalaam's death, the prison appointed an officer as the family liaison officer (FLO.) Mr Abdussalaam had listed his grandparents as his next of kin. Due to the distance to their home address and the restrictions imposed by the coronavirus pandemic, the FLO told them of Mr Abdussalaam's death by telephone.

42. The FLO contacted the next of kin again on 2 August and confirmed with them that they wanted Mr Abdussalaam to have a Muslim funeral. He told them that the prison would help in any way that they could. The prison contributed towards the cost of the funeral, in line with national guidance.

Support for prisoners and staff

43. The duty 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 Abdussalaam'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 the death.

Post-mortem report

45. The post-mortem concluded that the cause of Mr Abdussalaam's death was Grown-up Congenital Heart Disease with synthetic cannabinoid (PS) toxicity.

46. Toxicology tests showed that Mr Abdussalaam had used at least two types of PS prior to his death. The pathologist commented that PS "have the propensity to induce fatal cardiac arrhythmias and to increase the likelihood of sudden death occurring in the context of the grown-up congenital heart disease".

Findings

Clinical care

47. The clinical reviewer concluded that the care that Mr Abdussalaam received at Liverpool was satisfactory, and equivalent to that which he could have expected to receive in the community.

48. She noted that although he had been born with a VSD 'hole in the heart', it was described as "clinically insignificant", and that there are no entries in his medical records to indicate that he exhibited any symptoms at any time throughout his time in custody or that he expressed any concerns about it. When he did mention the VSD to the GP at Parc, the GP referred him for a routine cardiology appointment (although the appointment never took place).

49. The clinical reviewer also noted that Mr Abdussalaam had reported no concerns about substance misuse and that his prison record only shows three drug-related incidents: two in 2015 where he was believed to be under the influence of an illicit substance and one in June 2019 when he failed a mandatory drug test. Nevertheless, he was referred to the substance misuse services when he arrived at Liverpool and was offered some individual support and in-cell workbooks.

Emergency response

50. We are satisfied that when Mr Abdussalaam was found unresponsive in his cell on 1 August staff called a medical emergency code promptly, healthcare staff responded quickly, and an ambulance was called. Rigor mortis (stiffening of the muscles which normally occurs between two and six hours after death) was present and the clinical reviewer is, therefore, satisfied that the nurses' decision not to try to resuscitate Mr Abdussalaam was appropriate and was in line with Resuscitation Council guidelines.

51. However, we have considered whether Mr Abdussalaam should have been found earlier.

52. Prison Service Instruction (PSI) 75/2011, Residential Services, says:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight, apparently from natural causes, but staff unlocking them have not noticed that the prisoner had died. This is not acceptable … The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock. For example, if a prisoner is expected to leave their cell for an activity shortly after being unlocked, then it will be sufficient for there to be a check on any prisoner who does not do so. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.

53. Mr Abdussalaam had been prescribed a five-day course of antibiotics on 28 July. The first dose of the medication was given on the evening of 28 July. He was

then issued with medication at approximately 8.00am on the mornings of 29, 30 and 31 July, recorded on his medical record. We would, therefore, have expected that he would have been unlocked to receive his final dose of antibiotics at 8.00am on 1 August. However, this did not happen.

54. We were told that a list of those prisoners who are due medication is generated by nursing staff on a daily basis and passed to prison officers whose role it is to unlock those on the list. Healthcare staff told us that as Mr Abdussalaam was on regular prescribed medication, he would have been on the printed list. However, officers who were responsible for unlocking on 1 August said in interview that if Mr Abdussalaam had been on the list, he would have been unlocked, and the fact that he was not unlocked meant that he was not on the list. Despite requests by the investigator and clinical reviewer, the prison was unable to provide a copy of the list generated on 1 August.

55. It is therefore not possible to say whether Mr Abdussalaam was on the medication list and should have been unlocked at 8.00am on 1 August.

56. We are also unable to say whether the outcome might have been any different for Mr Abdussalaam if he had been unlocked and discovered at 8.00am instead of 10.00am. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that there is a robust system in place for calling prisoners to the medication hatch to receive prescribed medication, and that any discrepancies are followed up.

57. We note that the prison was operating a restricted regime during the pandemic and that, at the time of Mr Abdussalaam's death, prisoners were not being unlocked in the morning as they would normally have been. This meant that the majority of prisoners would not have been unlocked until around 10.00am when their canteen orders were delivered. We are concerned that this does not meet the requirement under PSI 75/2011 to conduct a welfare check in the morning to ensure that prisoners have not been taken ill during the night. We recommend:

The Governor should ensure that a morning welfare check is conducted in line with PSI 75/2011.

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