Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marc Maguire, a prisoner at HMP Manchester, on 9 June 2019

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 Marc Maguire died on 9 June 2019 from synthetic cannabinoid toxicity at HMP Manchester. He was 39 years old. I offer my condolences to Mr Maguire's family and friends.

I am satisfied that Mr Maguire's physical and mental healthcare was equivalent to that he could have expected to receive in the community, and that he was well supported by the drug and alcohol recovery service to help address his substance misuse problems.

However, I am concerned that Manchester's substance misuse strategy has not been effectively disseminated or embedded across the prison. This means that drugs are still freely available and some actions, such as requests for mandatory drug tests, were not followed up.

Mr Maguire was subject to monitoring under suicide and self-harm prevention procedures (known as ACCT). As he could not be seen properly in his cell on the night he was found, it was impossible for staff to tell if he was breathing. Given his risk of self-harm and previous instances of being found unresponsive after using psychoactive substances, I have grave concerns that the wing officer on duty did not take immediate action to satisfy himself of Mr Maguire's wellbeing and that an hour and a half elapsed before he initiated a closer check. This was a serious lapse of judgement and it is important that staff learn from this.

Despite proactive measures by Manchester's safer custody team, some staff had a poor knowledge of the use of emergency codes and the policy on opening cells at night. There were also some disappointing attitudes about the importance of these procedures. Although this did not impact on the outcome for Mr Maguire, this lack of awareness and poor regard for handling such incidents casts doubt on the professionalism of staff and could have serious consequences in the future.

Finally, I am also concerned that it was over 14 hours before Mr Maguire's mother was notified of his unexpected death; a further day before anyone from Manchester contacted her directly to offer support; and several days before she received a visit. The prison has a number of trained family liaison officers and several managers and this should have been given higher priority.

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 **July 2021**

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Summary

Events

1. Mr Marc Maguire was remanded to prison on 29 January 2010. He was later convicted of burglary and sentenced to Imprisonment for Public Protection (IPP), with a minimum period to serve of four and a half years. Mr Maguire had a history of substance misuse and frequently used psychoactive substances (PS).

2. Mr Maguire moved to HMP Manchester on 12 July 2018. He engaged with the drug and alcohol recovery service sporadically and stopped taking PS for short periods but relapsed each time. He was managed under suicide and self-harm procedures, known as ACCT, several times, including the period leading up to his death.

3. Just after 5.00pm on 9 June 2019, Mr Maguire was locked in his cell for the night. Between 6.30pm and 8.02pm, wing staff checked him nine or ten times. Each time, he was lying on the floor in the same position, with only his legs visible and most of his body out of sight.

4. At 8.02pm, an officer asked the night manager to help him to have a closer look at Mr Maguire. They went into his cell and found him unresponsive. Resuscitation attempts by officers, nurses and paramedics were unsuccessful, and one of the paramedics confirmed Mr Maguire's death at 8.25pm.

5. Staff from HMP Haverigg informed Mr Maguire's mother of his death at around 10.20am on 10 June. Manchester's family liaison officer contacted her on 11 June and provided additional support over the following days.

Findings

6. Despite an up to date substance misuse strategy, Mr Maguire appeared to have easy access to PS at Manchester. We are not satisfied that the strategy has been effectively disseminated, or that all managers and staff across the prison have fully taken ownership of it.

7. Staff and prisoners knew that Mr Maguire used PS and he was often found under the influence. We are satisfied that the drug and alcohol recovery service supported him well when he chose to engage positively with the staff.

8. Wing staff made several requests for mandatory drug tests, but none were actioned and there is no record that Mr Maguire was tested at Manchester.

9. At the time of his death, Mr Maguire was subject to ACCT monitoring. Although he was seen lying on the floor, with only his legs visible, it was around an hour and a half before staff took the appropriate steps to go into the cell to check if he was alive and well. This delay was a serious error of judgement on the part of the wing officer.

10. We are not critical of the officer's decision to seek permission before going into the cell. However, the investigation found that some staff were not fully aware of the policy on entering cells at night and said they would not go into a cell alone under any circumstances.

11. In spite of proactive measures by the safer custody team to raise awareness of the emergency response procedures, some staff were unclear about the distinction between the emergency codes and displayed an offhand attitude to using them.

12. Mr Maguire received a good standard of physical and mental healthcare, equivalent to that he could have expected in the community.

13. There was a lengthy and unjustifiable delay in notifying Mr Maguire's mother of his death and subsequent contact by Manchester's family liaison officer should have taken place sooner.

14. We believe it would be beneficial to share the findings of this report with staff who were involved in Mr Maguire's care, or the emergency response, to help learn lessons from the investigation.

Recommendations

- The Governor should identify and address the key weaknesses in reducing the supply of drugs at Manchester and revise the substance misuse strategy in light of the findings. The strategy should be shared with all managers across the prison and the key issues disseminated to wing staff.

- The Governor should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local substance misuse strategy and that there is an auditable process to track and action requests for mandatory drug tests and the results.

- The Governor should ensure that staff conducting ACCT wellbeing checks establish that the prisoner is alive and well and does not need urgent medical attention. They should take immediate action if a prisoner is not visible or fails to respond to attempts to rouse them.

- The Governor should:

    - initiate an investigation into Officer B's failure to take action when Mr Maguire could be seen lying on the floor of the cell;
    - consider whether further action should be taken as a result; and
    - inform the Ombudsman of the outcome.

- The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency, subject to a personal risk assessment, when there is potentially a risk to life.

- The Governor should ensure that within one month of receipt of this report, all operational staff are reminded of the requirements of Prison Service Instruction 03/2013 and the expected actions during medical emergencies, including the distinction between the emergency codes and the reasons why it is important to use the correct one.

- The Governor should ensure that staff comply with the national instructions on contacting families, including:
    - in the event of a death, the prisoner's family, or next of kin are informed quickly, in line with national instructions; and
    - where it has not been possible for the prison to inform the next of kin personally, contact and a visit should be arranged as soon as possible afterwards to offer support and information.
- The Governor should arrange for a senior manager to share this report with Officer A, Officer C, the CM and the duty governor, and discuss its findings with them.

The Investigation Process

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

16. The investigator obtained copies of relevant extracts from Mr Maguire's prison and medical records. She also contacted Greater Manchester Police to discuss their enquiries and emerging findings and to obtain copies of the statements taken by the police.

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

18. The investigator and clinical reviewer visited Manchester on 20 June 2019. They spoke to the Governor, prison managers, staff and prisoners and viewed CCTV footage.

19. The investigator and clinical reviewer interviewed nine members of staff and two prisoners at Manchester on 5 August and 10 September. On behalf of the investigator, the clinical reviewer interviewed another prisoner at HMP Buckley Hall, on 10 October, and later re-examined the CCTV footage. The investigator interviewed two staff by telephone on 22 October and 26 November.

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. Our investigation was suspended while waiting for the cause of death. This has delayed the initial report.

22. One of the Ombudsman's family liaison officers contacted Mr Maguire's mother, his next of kin, to explain the investigation and to ask if she had any matters for the investigation to consider. Mr Maguire's mother had several concerns, including:

    - She thought that Mr Maguire had deteriorated after serving four years of his tariff.
    - In the weeks before his death, Mr Maguire had had a lot of trouble and had self-isolated due to debt.
    - Mr Maguire had been assaulted several times due to debt and she asked if he had received help for mental health and substance misuse problems.
    - There had been rumours about the circumstances of Mr Maguire's death, specifically that staff had left him on the floor for some time before alerting anyone and he was unresponsive when they eventually checked. She was concerned that he had been let down.
    - She was very unhappy that no one had contacted her on the night of her son's death and said she would have preferred the police to inform her if they could have told her sooner than prison staff.

23. We shared our initial report with HM Prison and Probation Service (HMPPS). They found some minor factual inaccuracies which have been amended in this report.

24. We sent a copy of our initial report to Mr Maguire's mother. She found no factual inaccuracies.

Background Information

HMP Manchester

25. HMP Manchester operates as both a high security prison and as a local prison serving the courts of the Greater Manchester area. It can hold more than 1,200 men. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing.

HM Inspectorate of Prisons

26. The most recent full inspection of HMP Manchester was carried out in June and July 2018. Inspectors reported that, compared to their last inspection in 2014, where the prison achieved reasonably good outcomes against their healthy prison tests, at this inspection there had been a deterioration in most outcomes. Drugs were readily accessible and positive mandatory drug test (MDT) rates were 18%.

27. 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. The prison had appointed a manager with responsibility for the drug strategy and a comprehensive drug strategy had been produced. Positive drug test rates were 15%, lower than the average at other local prisons. A monthly multidisciplinary meeting was held. However, attendance by managers from the residential and activities functions was poor, which reduced the effectiveness of actions on causative factors of drug-taking, such as poor living conditions, time out of cell and the opportunity for purposeful activities.

Independent Monitoring Board

28. 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. There is no recent IMB report for Manchester. However, the report for the year to February 2018, noted that in spite of drone activity and drugs frequently thrown over the wall, positive MDTs had reduced by about 8% during the reporting year. The Board also noted concern about prisoners' access to PS and poor behaviour on one of the wings.

Previous deaths at HMP Manchester

29. Mr Maguire was the 15th prisoner to die at Manchester since June 2017. Of the previous deaths, seven were self-inflicted, six were from natural causes and in one the cause of death was unascertained. There have been two further deaths from natural causes. We have previously made recommendations on the management of the ACCT process and use of emergency response codes.

Assessment, Care in Custody and Teamwork (ACCT)

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction

(PSI) 64/2011, *Managing prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Psychoactive Substances (PS)

31. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

32. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

33. 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

34. On 29 January 2010, Mr Marc Maguire was remanded to HMP Durham. On 24 June, he was sentenced to Imprisonment for Public Protection (IPP) for aggravated burglary, with a minimum term of four and a half years.

35. Mr Maguire had been diagnosed with asthma, hepatitis C and recurrent pain due to a jaw injury. He had a history of substance misuse, including use of heroin, cocaine, cannabis, amphetamines and LSD, with specific references to psychoactive substances (PS) use from 2015.

36. Mr Maguire's tariff had expired in August 2014, but he was not released as he had made insufficient progress and his behaviour was poor. This included aggression, possession of weapons and mobile phones, and damage to cells and property. Records show that he was both a perpetrator and a victim of violence. Mr Maguire was subject to over 150 adjudications (disciplinary hearings) and moved between prisons 21 times. He was managed under the ACCT procedures 17 times, following acts of self-harm.

Transfer from HMP Garth to HMP Manchester

37. On 12 July 2018, Mr Maguire was transferred from the segregation unit of HMP Garth to that of HMP Manchester, for security reasons. (He had been in Garth's segregation unit for seven months.)

38. Mr Maguire had a meeting with his offender supervisor on 24 July. He told her that he felt very 'bitter and twisted' and frustrated about the IPP sentence and system. He said he had been referred for counselling, following a segregation review the previous day, and he thought this would be beneficial. It was noted that some of his issues were due to unresolved childhood trauma and this had been problematic in prison. Mr Maguire had meetings with her throughout his time at Manchester.

39. In July and August, wing staff recorded that Mr Maguire had used PS several times. On 22 August, Mr Maguire was found unresponsive. Healthcare staff and paramedics treated him, but he refused to go to hospital when he regained consciousness. Mr Maguire was referred to the drug and alcohol service and for a mandatory drug test (MDT). (MDTs were requested several times over the next eight months, but there is no evidence that these were actioned.)

40. On 24 August, a healthcare support worker with the drug and alcohol recovery service completed a drug and alcohol assessment. He advised Mr Maguire to see the GP for a referral to the mental health team. On the same day, a prison GP issued a medication diversion warning that Mr Maguire's medication might be stopped, because he was suspected of diverting of tramadol and amitriptyline (which he had been taking for chronic pain) in order to sell or trade it with other prisoners. Later, Mr Maguire appeared to have taken illicit drugs.

41. During September, Mr Maguire had further severe reactions to PS, and was found to have concealed dihydrocodeine (an opioid painkiller he was prescribed). Mr Maguire repeated his resentment about his IPP sentence and considered it

the root of all his troubles. He wanted to transfer closer to home to receive family visits and he felt that Manchester could offer no constructive activities.

42. On 1 October, Mr Maguire had a structured psychosocial intervention meeting with a drug and alcohol recovery manager who had been allocated as his keyworker. She gave Mr Maguire information on the dangers of PS use and an in-cell workbook. She created a care plan and agreed to contact his offender manager (community-based probation officer) about a transfer. Mr Maguire said that he did not want to do any of the work and that he used PS as he had been refused parole a few weeks before.

43. In a conversation the next day, Mr Maguire's offender manager told the drug and alcohol recovery manager about Mr Maguire's history of transfer between prisons and his poor behaviour at all of them. Nevertheless, a request for transfer was made to Frankland. Mr Maguire continued to use PS and lost his job due to non-attendance. He received support from the manager, as well as other drug and alcohol recovery workers.

44. On 22 October, Mr Maguire made superficial cuts to his arm. (Staff managed him under the ACCT procedures until 3 December.)

45. On 24 October, a mental health nurse carried out a detailed mental health assessment. Mr Maguire subsequently had one to one sessions with the mental health team and the substance misuse service. He was also keen to receive counselling but did not want to use the prison's psychology service because of previous poor experiences.

46. There were numerous intelligence reports about Mr Maguire. An entry in October noted that he had repeatedly asked for wing moves due to drug debts and used self-harm to manipulate the situation. Staff had asked him to give more information about his debts and perpetrators so his problems could be better investigated, but there is no evidence that he gave this information.

47. During the latter half of November, Mr Maguire was settled, compliant and positive. He said that he had not taken PS. Staff commended his progress and encouraged him to sustain it, with a view to his next Parole Board hearing.

48. On 30 November, a psychiatrist assessed Mr Maguire, who repeated that he was unable to cope with the injustice and uncertainty over his sentence. Mr Maguire said that he used to make 'hooch' (illicitly brewed alcohol) or hold phones and chargers for other prisoners in return for PS, but he was not using it at that time. The psychiatrist planned to explore antidepressants for Mr Maguire's anxiety symptoms. (Mr Maguire remained under the care of psychiatrists, but he was discharged from the psychiatric nurse.)

49. On 2 January 2019, a psychiatrist assessed Mr Maguire. He confirmed a diagnosis of emotionally unstable personality disorder, after consulting colleagues. Later in the month, Mr Maguire had further sessions with the mental health nurse.

50. On 3 and 5 January, Mr Maguire was found under the influence of PS.

51. On 12 February 2019, Mr Maguire moved to HMP Frankland. During the reception procedures, he said that he feared for his safety and refused to stay. He returned to Manchester the next day.

52. Staff at Manchester immediately opened the ACCT procedures. On 14 February, the ACCT review team was unable to assess Mr Maguire's mental state, or risks, as he seemed to be under the influence of PS. Subsequent review meetings were postponed for the same reason. (Mr Maguire was suspected of being under the influence of PS on 15, 16, 18, 20, 24 and 28 February.)

53. A sessional prison GP wrote to Mr Maguire on 19 February. The GP informed him that due to his repeated drug use and the risks of adverse interactions with prescribed medication, his dihydrocodeine prescription would be stopped, and if he appeared to be under the influence at the medication hatch, nurses would not dispense his prescribed medication.

54. After episodes of PS use, staff referred Mr Maguire to the drug and alcohol service and a recovery worker would see him. On 22 February, he declined to engage with the service, but was still given advice on risks and issues, such as harm reduction, PS awareness and relapse prevention. It was later noted in his personal record that he had admitted taking PS most days and said he would never stop.

55. At a meeting with his offender supervisor on 6 March, Mr Maguire was dismissive of the drug and alcohol service and spoke about having little hope left. When they discussed his needs, he wanted a release date, but knew this was not possible because of the parole process for IPP.

56. There were further serious incidents of PS use in March. On 22 March, the nurse manager discussed stopping Mr Maguire's medication with a doctor. The doctor was of the view that the risks of withdrawing the medication could be greater than continuing to take illicit and prescribed drugs. He felt that it could significantly affect Mr Maguire's mental health and increase his use, so he should be supported to reduce his use. After the discussion, the nurse manager made a further referral to the drug and alcohol recovery service. The healthcare support worker saw Mr Maguire briefly the same day and Mr Maguire agreed to work with him.

57. The healthcare support worker carried out a detailed assessment on 29 March and created a care plan. Three days later, Mr Maguire was found under the influence. On 3 April, a healthcare assistant and recovery practitioner was assigned as Mr Maguire's substance misuse keyworker and he conducted a five-day review.

58. An entry in Mr Maguire's personal record on 6 April noted that he had asked for help and seemed to have a genuine wish to stop using PS. After consultation with the detoxification team, it was decided that Mr Maguire would clear out his cell and be left with a television, a kettle and one set of clothing. He would then detoxify "the old fashion (sic) way" and would not be unlocked with anyone else until the PS was "fully out of his system". The drug and alcohol recovery team had advised that it would take around a week. Two screens were placed outside

his cell, asking other prisoners not to bother him. (There is no record of this process or the discussions around it in Mr Maguire's medical record.)

59. The next day, wing staff asked the healthcare support worker and a detoxification nurse to speak to Mr Maguire. He said he wanted to stop using PS, although he seemed to be under the influence at that time.

60. Mr Maguire continued to have one to one sessions with his substance misuse keyworker to discuss progress and set goals. He initially said that he had stopped using PS. However, wing staff noted that this was not the case. On 25 April, Mr Maguire admitted that he had relapsed. He told his keyworker that he was reluctant to use drugs as he did not want to damage important family relationships or have time added to his sentence. However, he had given up hope that he would ever progress, so there was no reason not to use and it gave him some relief. Mr Maguire later agreed to go through the PS workbook with a recovery peer.

61. At lunchtime on 30 April, a psychiatrist reviewed Mr Maguire. She noted:

> "…Finding it a challenge psychologically to deal with indefinite imprisonment on IPP sentence, torn between wanting to comply, but feeling frustrated and disillusioned by the unknown. Has resorted to Spice [PS] use to prevent negative thoughts, ruminations and anger..."

Mr Maguire used books and a radio for distraction, as he was on the basic level of the privileges system so was not entitled to a television. He asked to be moved to the segregation unit, to help reduce the temptation of spice, but this was inappropriate. She noted that Mr Maguire was calm and composed, with open body language, but felt low and hopeless due to his circumstances and lack of progress. He also felt isolated from his family (who found it difficult to visit due to the distance). However, he denied abnormal thoughts and knew how to access the crisis support pathways if he needed it. She identified no risk to Mr Maguire, or others.

62. That evening, Mr Maguire cut his arms. He did not present as low, but again complained of frustration at the lack of progression and being in Manchester, due to difficulties with other prisoners. He asked staff to explore a transfer nearer to his family home. Staff began the ACCT procedures and moved him temporarily to the inpatient unit. (The ACCT was closed on 9 May.)

63. On 6 and 7 May, medical emergencies were called for Mr Maguire because he had used PS. A prison GP immediately warned Mr Maguire that his medication could not be safely continued if he used illicit substances and any further reports might lead to some of his medicines being reduced or stopped.

64. On 8 and 9 May, Mr Maguire was discovered unresponsive in his cell. On the latter occasion, an officer had gone into the cell because of a burning smell. He saw a kettle on the floor with the wires pulled out and an improvised weapon in Mr Maguire's hand. There were further instances of PS use on 10 and 14 May.

65. At his ACCT post-closure review on 16 May, it was noted that Mr Maguire could not work, or leave the wing due to "… having trouble all around the prison…" and struggling with PS misuse.

66. On the same day, a prison GP asked a mental health nurse to carry out a welfare check, as treatment nurses were concerned that Mr Maguire persistently took illicit substances after his prescribed medication. The nurse described Mr Maguire as brittle and frustrated, waiting for a transfer to a prison where he could have active rehabilitation and activities.

67. Mr Maguire said that he used PS to escape from his current reality and would not mind if his medication was stopped. He was reluctant to accept any responsibility for his progress but identified that it would help if he had goals to achieve through sentence planning. The mental health nurse noted that wing staff had tried to contact Mr Maguire's offender supervisor. It was agreed that Mr Maguire would continue with the drug and alcohol recovery service and contact his offender supervisor. The prison GP was advised of the outcome and an appointment was scheduled for 27 June.

68. On 16 and 17 May, Mr Maguire declined to speak to his substance misuse keyworker. On both days, the keyworker told Mr Maguire that he would be unavailable for a few weeks. He planned to see him again during the week of 10 June and reminded him of how to seek support during his absence. Mr Maguire said that the recovery peer had introduced himself.

69. On the night of 17 May, Mr Maguire deliberately cut his arm. His cited his previous concerns and said that he used self-harm to relieve his frustration and not to end his life. Staff opened the ACCT procedures. One of the issues identified was Mr Maguire's use of PS and he was re-referred to the drug and alcohol recovery service. He was also given a television to distract his thoughts. However, it was confiscated after PS use on 20 and 23 May.

70. On 27 May, Mr Maguire told wing staff that 'trouble would come his way' when he was unlocked to receive his canteen (goods bought from the prison shop) as he was in a lot of debt and had only ordered a packet of vapes. He asked for a move to I wing to get away from this threat and threatened to jump on the wing netting and slash himself if he was not transferred from Manchester by the end of the week.

71. At an ACCT review the next day, it was noted that Mr Maguire had been referred to an IPP progression panel and the psychology department. However, despite numerous attempts to engage with Mr Maguire they had struggled to achieve progress. It was also noted that he could not be transferred to HMP Durham, as it only served the courts, nor to HMP Holme House, as it was for category C prisoners (Mr Maguire was category B).

72. On 30 May, the offender supervisor and Mr Maguire discussed the refusal to re-categorise him to category C and he received a copy of the review form and security report setting out the reasons and why a move to the prisons he had suggested was not feasible. She agreed to apply on Mr Maguire's behalf for a temporary transfer to HMP Durham to receive accumulated visits (where a prisoner can save up visits to be taken in a block nearer home). Mr Maguire said he had not taken any PS that week, he had continued to see his recovery worker and had received counselling.

73. Mr Maguire began self-isolating by staying in his cell, as he felt threatened by other prisoners. On 2 June, he was found unresponsive. A nurse treated a head wound, but was unable to complete clinical observations, as Mr Maguire was still suffering the effects of PS when he regained consciousness and was thrashing around the cell.

74. On 4 June, Mr Maguire again used PS. As a result, a prison GP stopped his amitriptyline prescription and informed Mr Maguire and another doctor of the decision. The same day, the other doctor began to wean Mr Maguire off valproic acid (used to treat bipolar disorder), due to potential harmful interactions with PS.

75. In the afternoon, Mr Maguire had a multidisciplinary ACCT review with two Supervising Officers (SOs), his offender supervisor, a recovery worker and a prison chaplain. The offender supervisor told Mr Maguire that he had been referred to an IPP review for progression and he was due to be considered for parole. Mr Maguire asked for this to be deferred, as he thought it would preclude him from consideration for a transfer nearer home. He also said that the news about possible parole had triggered thoughts of self-harm.

76. At 9.30am on 9 June, Mr Maguire was unlocked for association and told staff he was coming out of his cell and ending his self-isolation. He later collected his lunch. In the afternoon, an officer noted that Mr Maguire was writing a card for a friend and said that he was all right.

Events on the evening of 9 June

77. At 5.02pm, an officer gave Mr Maguire a cup of hot water and locked him in his cell. He said words to the effect, “See you tomorrow”.

78. At 6.30pm, Officer A handed over to Officer B and told him that he had not completed Mr Maguire’s ACCT check. Officer A then checked Mr Maguire’s door and left the wing a few minutes later.

79. At 6.35pm, Officer B checked the cell door. At 6.40pm, he recorded in Mr Maguire’s ACCT document, “Seen in cell at roll check lay on floor”. At 6.48pm, he looked into Mr Maguire’s cell for eight seconds.

80. Having returned to the wing at 6.53pm, Officer A checked Mr Maguire’s cell for nine seconds at 6.54pm and left the wing at 6.58pm.

81. At 7.11pm, a nurse and Officer B walked along the wing and appeared to glance into either Mr Maguire’s, or the neighbouring cell. Officer B checked Mr Maguire’s cell again less than a minute later.

82. At 7.36pm, 7.42pm and 8.00pm, Officer B looked into Mr Maguire’s cell for 40, 30 and 35 seconds, respectively. After returning to the cell at 8.02pm, he telephoned the Custodial Manager (CM) and asked him to have a look at Mr Maguire as there was “something not right”. When the CM arrived at 8.03pm, the officer said that he could not tell if Mr Maguire was breathing.

83. The CM looked through the observation panel of the cell and radioed to inform the control room that he intended to open the cell. An officer then arrived. The CM and the officers went into the cell, where they found Mr Maguire

unresponsive. The CM radioed a medical emergency code red at 8.04pm and the control room called an ambulance immediately. (Code red indicates severe loss of blood, burns or fracture.) The CM and Officer B then left the cell and the other officer remained inside. Around a minute later, Officer B returned with a defibrillator and the CM with a body-worn camera, followed by Officer C.

84. Officer C began cardiopulmonary resuscitation (CPR), rotating with other officers. They attached the defibrillator, but no shocks were advised. Two nurses arrived at 8.08pm with the emergency bag and helped with the resuscitation attempts.

85. Paramedics arrived at the cell at 8.15pm and continued CPR. At 8.25pm, they confirmed Mr Maguire's death.

Contact with Mr Maguire's family

86. Just after midnight on 10 June, the duty governor contacted the night manager at HMP Haverigg (the nearest prison to Mr Maguire's family home). He asked if they could send a family liaison officer (FLO) to inform Mr Maguire's mother of his death, as it would take over two hours to get there from Manchester. The night manager at Haverigg agreed to hand it over to the day staff and he left a message for the chaplaincy at Manchester to deal with it first thing in the morning.

87. At 8.50am, a manager at Haverigg contacted Manchester to get further details of the circumstances of Mr Maguire's death. Shortly afterwards, he and the managing chaplain visited Mr Maguire's mother, arriving at around 10.20am. They broke the news of Mr Maguire's death and offered condolences. Mr Maguire's two brothers later joined them.

88. After the visit, the manager at Haverigg tried to report back to Manchester but was told that the FLO was unavailable. At around 3.00pm, Mr Maguire's mother contacted Haverigg to provide details of the funeral director and to ask if she could visit her son. The manager telephoned again to get further details and to ask staff at Manchester to contact her, as no-one from the prison had done so.

89. Manchester assigned a prison manager as family liaison officer. On 11 June, she telephoned Mr Maguire's mother to provide information and support and she kept in touch over the following days. She visited the family home on 20 June, the day of Mr Maguire's funeral, and returned his property. In line with national policy, Manchester contributed to the funeral expenses.

Support for prisoners and staff

90. After Mr Maguire's death, the duty governor debriefed the staff involved in the emergency response, including the nurses, to ensure they had the opportunity to discuss any issues arising and to offer support. A representative from the staff care team attended and spoke to staff individually.

91. The prison posted notices informing other staff and prisoners of Mr Maguire's death.

Post-mortem report

92. The post-mortem report recorded that the cause of Mr Maguire's death was 5F-MDMB-PICA and 4F-MDMB-BINACA ("Spice") toxicity.

93. The pathologist could not determine when Mr Maguire had taken the PS or collapsed. However, he found evidence that Mr Maguire had been dead for some time, rather than having collapsed shortly before staff found him. The pathologist considered it likely that Mr Maguire had experienced the effects of PS and possibly amitriptyline at the time of his death. He added, "There is currently limited information available on synthetic cannabinoids. However, there may be an interaction between the sedative effects from these drugs and those from amitriptyline and their toxic effects may be enhanced when used at or around the same time."

Findings

Drug strategy at HMP Manchester

94. After an inspection at Manchester in 2018, HM Chief Inspector of Prisons was concerned that illicit drugs were easily accessible in the prison. A subsequent review of progress in June 2019, found that the prison had made reasonable progress on reducing the supply of drugs and that positive drug test rates had reduced from 18% to 15%.

95. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO called for national guidance to prisons from HMPPS providing evidence-based advice on what works and we welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

96. In relation to reducing the supply of drugs, we note that the Prison Service strategy says:

> "Every prison is different and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

97. Manchester has an up to date *Substance Misuse Strategy*, which sets out several measures to reduce the demand and supply of illicit drugs. It includes a section on PS, outlining the aims and processes to be followed. The prison manager responsible for the drug strategy said that PS enters the prison in many ways, is easily hidden and is difficult to detect. One avenue is through bogus legal mail. He said it had been impossible to continue a trial of photocopying all social mail because of the large prison population and insufficient staff resources. Photocopying is now targeted on a risk basis. The drug dog is used on all mail and there is also spot testing.

98. In response to the Chief Inspector's criticisms of attendance at the monthly substance misuse strategy meetings, the prison manager said that the prison had relaunched and reinvigorated the meeting and the core group of departments are always represented.

99. Manchester's strategy clearly states that it applies to all areas of the prison yet, during the investigation, the custodial manager of a residential wing said that it was outside his area of responsibility and had not been disseminated to him or wing staff. Although he was not familiar with the strategy, he knew the expected process in the event of finding a prisoner under the influence of drugs.

100. It is a concern that despite improvements to Manchester's substance misuse strategy and processes to stem the flow of illicit drugs, Mr Maguire was frequently able to obtain PS. This suggests that much more needs to be done. The strategy will be more effective if managers and staff across the prison fully understand it, see it as an integral part of their role and are committed to taking forward the principles and actions. We make the following recommendation:

The Governor should identify and address the key weaknesses in reducing the supply of drugs at Manchester and revise the substance misuse strategy in light of the findings. The strategy should be shared with all managers across the prison and the key issues disseminated to wing staff.

Support for Mr Maguire's substance misuse

Engagement with the drug and alcohol recovery service

101. Mr Maguire had a history of substance misuse in the community which continued in prison. He attributed his use of PS to his frustration with the IPP sentence and his wish to be nearer home to receive visits from his family. Between February and June 2019, healthcare staff were called to see Mr Maguire numerous times, as he often had severe reactions to smoking PS. In line with the prison's policy, wing staff referred him to the drug and alcohol recovery service, who gave repeated verbal and written advice on the risks of taking illicit drugs and harm minimisation. Care plans were in place and named staff were allocated to support Mr Maguire.

102. Mr Maguire's engagement with the service was inconsistent. Sometimes he engaged positively, but at other times he refused to participate and continued to use PS. In April 2019, Mr Maguire attempted to stop, but he relapsed shortly afterwards.

103. We are satisfied that the drug and alcohol recovery service provided a good level of support, although Mr Maguire's did not always choose to engage with the service.

Drug testing

104. Mr Maguire's personal records show that wing staff requested on-suspicion mandatory drug tests at least eight times. None of these appear to have been actioned. A prison manager said that a prisoner should be tested every time staff suspect they have taken illicit substances, or if they are proven to have done so at a disciplinary hearing. There is no limit on the number of times they can be tested.

105. Mr Maguire's frequent drug use was known to staff and prisoners, yet there is no record of him ever having a drug test at Manchester. We make the following recommendation:

The Governor should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local substance misuse strategy and that there is an auditable process to track and action requests for mandatory drug tests and the results.

Notifying healthcare staff of substance misuse

106. Manchester's substance misuse strategy states, "All suspected use of PS or any other substances should be reported to healthcare immediately". The strategy also states that all staff would receive awareness training.

107. Although officers often asked healthcare staff to examine Mr Maguire when he appeared to have taken drugs, they did not do so every time. Some of the officers interviewed said they had received no specific training or guidance on managing prisoners who use PS. They also said that informing healthcare when a prisoner is suspected of being under the influence of PS used to be at the discretion of individual officers, but since Mr Maguire's death they were expected to notify healthcare in every case.

108. Manchester issued Staff Information Notice 137/19, *Prisoner Under the Influence* on 5 December 2019. It sets out the signs and symptoms of possible drug use and gives step-by-step instructions on the actions to be taken by wing staff who suspect that a prisoner is under the influence of illicit substances. This includes seeking medical advice each time.

109. We consider that the recent instruction is a positive step to increase staff awareness of identifying and safely managing prisoners under the influence of drugs. It addresses the confusion about when to engage healthcare staff and we therefore make no recommendation on this issue.

Dedicated supervision and support

110. At the time of his death, Mr Maguire did not have a key worker, a requirement of the HMPPS Offender Management in Custody model. However, a prison manager told us that the prison has since rolled out the scheme and a key worker is allocated to each prisoner within 72 hours of their arrival. The prison has also introduced peer mentors on most wings, who engaged with men struggling with substance misuse.

ACCT checks during the evening of 9 September

111. The ACCT procedures were opened after Mr Maguire self-harmed on 17 May. Staff were expected to check him three times during the night. CCTV footage shows that, between them, Officer A and Officer B looked into Mr Maguire's cell around nine or ten times between 6.30pm and 8.03pm. Each time, he was lying in the same position – on his right side on the floor, between the foot of the bed and the toilet. Only his legs were visible.

112. At interview, Officer A said that Mr Maguire did not usually lie on the floor, so he had shouted his name and kicked his cell door several times. He thought that he might be under the influence of drugs and sometimes these actions prompted prisoners to "come around". (The CCTV footage did not show kicking of the door.) There was no response and Officer B told Officer A to "leave it". He said that he complied, as Officer B was an experienced officer. Officer A checked that Officer B knew that Mr Maguire was on the floor and finished his shift feeling reassured that the situation would be dealt with immediately. He was surprised when he later found out that no-one had gone into the cell until after 8.00pm.

113. Officer B told the investigator that C wing was a fairly settled wing, where most prisoners worked full-time and there was relatively little drug use. Mr Maguire was the main user of PS. He said that because C wing was calm, staff were often redeployed elsewhere. So, there was little scope to develop intelligence on how prisoners, such as Mr Maguire, obtained illicit substances.

114. Officer B said he had stopped Officer A shouting Mr Maguire's name as:

> "…my concern was it was half-six, quarter-to-seven on a Sunday night. It was my last night. The wing was settled. They'd been locked up since five o'clock. There wasn't any noise. There was no music on. I didn't want everyone waking up."

He thought Mr Maguire was asleep and returned to the cell several times to see if he had moved or got into bed. He said it was not unusual for Mr Maguire to lie on the floor, but he had not done so during that week. He did not try to obtain a verbal response, to avoid disturbing the settled wing. After several checks, he became more concerned and thought Mr Maguire might have ligatured but could see no signs of this. He did not think that he had taken PS, or that a code blue was warranted at that point. He said that, with hindsight, he should have asked Officer A to open the cell during the roll check at lock up, as he had the keys.

115. The purpose of ACCT observation checks is to ensure that prisoners assessed as at risk of suicide and self-harm are alive and have not harmed themselves. As Mr Maguire's head and most of his body were obscured, the officers could not have known whether he was alive and breathing at the first check just after 6.30pm, or the subsequent checks and therefore did not properly discharge their responsibilities.

116. We consider that Mr Maguire's position on the floor; lack of movement over a period of time; ongoing risk of self-harm; frequent PS use; and previous episodes of unconsciousness should have alerted the officers to the possibility that he might have come to harm. At the very least, Officer B should have contacted the night manager sooner to go into the cell to check Mr Maguire more closely. There seems to have been a degree of complacency, as well as a serious error of judgement.

117. Mr Maguire was last seen alive at 5.02pm. Officer B first recorded that he was lying on the floor of his cell at 6.35pm. The cell door was opened at 8.03pm. We do not know exactly when Mr Maguire collapsed, and it is therefore impossible to say whether the outcome might have been different for him if he had received medical help earlier. However, any situation in which a prisoner on an ACCT cannot be seen requires an urgent response.

118. We make the following recommendations:

The Governor should ensure that staff conducting ACCT wellbeing checks establish that the prisoner is alive and well and does not need urgent medical attention. They should take immediate action if a prisoner is not visible or fails to respond to attempts to rouse them.

The Governor should:

- **initiate an investigation into Officer B's failure to take action when Mr Maguire could be seen lying on the floor of the cell;**
- **consider whether further action should be taken as a result; and**
- **inform the Ombudsman of the outcome.**

Unlocking cells at night

119. Prison Service Instruction (PSI) 24/2011, *Management and Security of Nights,* requires that all prisoners are locked in their cells during night state. Under normal circumstances, the night orderly officer must give authority to unlock a cell during night state, and no cell should be opened unless at least two or three members of staff are present, one of whom should be the night orderly officer. However, there is provision for prison staff to open cells at night without the authority of the night manager where there appears to be danger to life, subject to a dynamic risk assessment to ensure their safety. Manchester's local policy is consistent with this.

120. The CM told the investigator:

> "Staff are routinely taught not to go into cells on their own, in case there is a safety issue and it's something more sinister, it's not what it appears to be. So, staff are routinely told to wait until there're at least two, three staff and then go into the cell, for safety reasons."

121. Officer B said that wing staff had a cell key in a sealed pouch which could be used in "extreme circumstances", but there had to be at least three staff present. He knew that after assessing risk staff could go into a cell, but said, "It's not something I would ever do." When pressed on this, he said he would wait for other staff, but if it was likely to be five or ten minutes before their arrival, he would consider it.

122. At interview, Officer C insisted that officers were not permitted to enter a cell on their own after prisoners are locked up for the night and should wait for the night manager, even if a prisoner was hanging. When asked why officers were given an emergency key if they were not allowed to use it, he simply reiterated that they had to have assistance and the night officer had to be present.

123. We acknowledge that it was prudent for Officer B to wait for a colleague and permission before going into Mr Maguire's cell as he was uncertain that it was a medical emergency, and we do not criticise his decision to do so. However, we are concerned that he and Officer C, as experienced officers (with 24 and 31 years' service, respectively) did not have an accurate understanding of the Prison Service policy on opening cells at night in an emergency and had rather intransigent views on whether it would be appropriate to do so in a life-threatening situation. We make the following recommendation:

The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency, subject to a personal risk assessment, when there is potentially a risk to life.

Emergency response

124. PSI 03/2013 on Medical Emergency Response Codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident according to the nature of the emergency, and that there are no delays in calling an ambulance.

125. The CM said that he knew the distinction between the codes but had absentmindedly called a code red in error. We accept that this was a genuine mistake and it did not adversely affect the emergency response. We are also satisfied that the staff attended the emergency quickly and tried their utmost to try to resuscitate Mr Maguire.

126. The investigation found that the safer custody team at Manchester had proactively tried to increase awareness of the emergency response procedures, with measures such as issuing a pocket-sized card to all staff, outlining the key points and placing posters in shared areas such as staff toilets. In spite of this, most of the officers interviewed (with lengths of service ranging from 4 to 31 years) were either confused about the emergency code system, or unaware of the differences between code red and code blue. A nurse agreed that operational staff were sometimes unclear about the use of codes.

127. Additionally, during the interviews, a couple of the most experienced officers displayed a rather casual attitude to the use of emergency codes, with comments such as, “I don’t have time to run to my coat, get my little card out and decide…”, “I’m not into these codes at the moment…”, “…trying to remember your code red and code blue, while you’re in that situation and you’ve got 30 cons around you, it’s very – it’s all very nice…”, “I haven’t got a clue...”

128. This is unprofessional and such attitudes, together with their poor knowledge of the emergency response codes, could affect the chances of a prisoner’s survival in an emergency. We make the following recommendation:

The Governor should ensure that within one month of receipt of this report, all operational staff are reminded of the requirements of Prison Service Instruction 03/2013 and the expected actions during medical emergencies, including the distinction between the emergency codes and the reasons why it is important to use the correct one.

Clinical care

129. Mr Maguire had longstanding mental health problems. Relevant assessments were completed, he was under the care of a psychiatrist and his case was discussed at mental health-led multidisciplinary meetings. When Mr Maguire was managed under the ACCT procedures, mental health nurses usually attended his case reviews.

130. The clinical reviewer was satisfied that Mr Maguire’s physical and mental healthcare was managed well, with appropriate use of care plans. Medication risk assessments concluded that due to his history of substance misuse, he was not suitable to keep his medication in his cell.

131. We agree with the clinical reviewer that Mr Maguire's clinical care was of a reasonable standard, equivalent to that he could have expected to receive in the community.

Informing Mr Maguire's mother of his death

132. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner dies.

133. Prison Service Instruction (PSI) 64/2011, *Safer Custody,* sets out the actions to be taken after a death in custody. It states:

> "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source."

The PSI also says that if a prisoner was located a long distance from their next of kin, prisons must consider requesting a FLO from the nearest prison should break the news. In the event of another prison's FLO notifying the family, the expectation is that the prison where the death occurred will make a follow up visit as soon as practicable.

134. The travel time between Manchester and Mr Maguire's family home is around two and a half hours. Mr Maguire died at 8.25pm, but his mother was not informed until 10.20am the next morning. There are conflicting accounts of the request to notify Mr Maguire's family.

135. The duty governor said that the police security checks for the visit were not completed until around 2.00am and he considered the safety of staff travelling the long distance on difficult roads in the early hours of the morning. Having consulted the Governor, he decided to ask Haverigg to inform Mr Maguire's mother, as her home was around an hour from that prison and they believed this would be the quickest method.

136. The manager at Haverigg said that he started duty at 8.15am. He then telephoned the safer custody team at Manchester and offered to visit Mr Maguire's mother. He was told that they would contact him if they needed his help. He was concerned that it was over 12 hours since Mr Maguire's death and his family had not been told. He spoke to a member of his safer custody team and the managing chaplain and they decided that the decent thing to do would be to visit Mr Maguire's family. He obtained the address and other details from NOMIS (the database of offenders). He then informed Manchester that given the time lapse, he and the managing chaplain intended to go and break the news, and they agreed. He emphasised that at no point did Manchester specifically ask them to visit on that day and they would have facilitated a request sooner if they had been asked.

137. At that time, Manchester had eight or nine trained FLOs. A FLO at Manchester said that the arrangements for notifying families out of hours were the same as those for deaths during the core day.

138. The purpose of asking another prison to deliver the news of a death is to ensure that the next of kin is notified quickly. Given the distance involved, it was not unreasonable to ask Haverigg for help if the intention was to tell Mr Maguire's mother that night. However, it is clear that at the outset Manchester knew the notification would take place the following day, as Haverigg had said it would be handed over to day staff. While we accept that the police had to check that it was safe for staff to visit the address given, we consider that Manchester could have arranged for Mr Maguire's mother to be told sooner, either by sending their own staff, or asking the police to notify her on their behalf.

139. There was an unacceptable delay in notifying Mr Maguire's mother of his death and although there might have been a misunderstanding between the prisons, we consider that the responsibility for the delay rested with Manchester. We are also concerned that staff at Manchester made no direct contact with Mr Maguire's mother for over 36 hours and did not visit her until 11 days after his death. If family liaison officers were unavailable, a manager should have taken on this task. We make the following recommendation:

The Governor should ensure that staff comply with the national instructions on contacting families, including:

- **in the event of a death, the prisoner's family, or next of kin are informed quickly, in line with national instructions; and**
- **where it has not been possible for the prison to inform the next of kin personally, contact and a visit should be arranged as soon as possible afterwards to offer support and information.**

Sharing our report

140. We consider it important for the staff involved in the emergency response to see this report to help learn lessons from our findings. We make the following recommendation:

The Governor should arrange for a senior manager to share this report with Officer A, Officer C, the CM and the duty governor, and discuss its findings with them.

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