Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jamie Tate, a prisoner at HMP Manchester, on 14 March 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Jamie Tate died on 14 March 2021, having been found unresponsive in his cell at HMP Manchester. Post-mortem examinations were unable to ascertain the cause of Mr Tate's death, although a seizure, medication or illicit drugs were possible causes. Mr Tate was 33 years old. I offer my condolences to Mr Tate's family and friends.

Mr Tate suffered from seizures and psychosis and had a history of substance misuse. The clinical reviewer found that, overall, the healthcare he received in prison was appropriate. However, I am concerned that appointments were not always organised as they should have been, and that mental health and substance misuse services did not always work together effectively, a matter we have raised in previous investigations at Manchester.

I am also concerned that Mr Tate appears to have been able to access illicit drugs with apparent ease while at Manchester, although I note the proactive steps that the prison is taking to tackle and reduce their supply.

In addition, while I fully appreciate the difficulties of maintaining meaningful contact with prisoners during the COVID-19 pandemic, I consider that more should have been done to engage with Mr Tate in the months before his death.

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 **February 2022**

Contents

Summary

Events

1. In May 2014, Mr Jamie Tate was remanded to custody for aggravated burglary, assault and false imprisonment. In November, he was sentenced to 11 years imprisonment. He was later sentenced to another four and a half years imprisonment for offences he committed in prison.

2. Mr Tate suffered from seizures and psychotic hallucinations and had a history of substance misuse both in the community and in prison.

3. In July 2019, Mr Tate transferred to HMP Manchester. A psychiatrist assessed him, concluded his current anti-psychotic medication was not effective and applied for him to be transferred to a medium secure psychiatric unit where he could be more closely monitored while he was prescribed different medication. Between July and December, Mr Tate was admitted to the Humber Centre under the Mental Health Act.

4. In December 2020, Mr Tate returned to Manchester. He said his hallucinations had improved and he was reviewed regularly by the mental health team. In January 2021, staff suspected he was under the influence of illicit drugs on several occasions. After this, his behaviour seemed to improve, although staff and prisoners noted that he appeared sedated.

5. On 14 March, staff locked Mr Tate in his cell around 5.00pm. At 7.00pm, staff found him lying on the floor of his cell unresponsive, with a vape under his face. They went into the cell and started CPR. At 7.59pm, paramedics confirmed that Mr Tate had died. Police found a homemade pipe and burnt remnants of a substance in his cell. Intelligence reports submitted after Mr Tate had died indicated that he may have been supplied with socks soaked in psychoactive substances (PS) or fentanyl (an opiate painkiller).

Findings

6. Mr Tate's death could have been caused by seizures, medication or illicit drugs.

Clinical care

7. The clinical reviewer concluded that, overall, Mr Tate's healthcare was equivalent to that which he could have expected to have received in the community.

8. However, she was concerned that Mr Tate had missed two psychiatric appointments two months before he died, without any explanation noted on his medical record. In addition, once Mr Tate had been reviewed by the psychiatrist, a follow-up appointment was not booked as it should have been.

9. We are also concerned that communication between the teams responsible for Mr Tate's mental health and substance misuse care was inadequate.

Substance misuse

10. Although no psychoactive substances were detected in Mr Tate's system after he died, it remains possible that they may have impacted on his death, given the intelligence from prisoners, his history of drug misuse and the vape found under his face when he was discovered unresponsive.

11. We are concerned that Mr Tate was able to access drugs in the prison with apparent ease, although we note the proactive steps the prison is taking to try to address this problem.

Meaningful interaction

12. Although key working was suspended during the COVID-19 pandemic, we are concerned that it was not taking place in line with policy before this, and that welfare checks were not being done on Mr Tate during the pandemic, contrary to national policy.

Recommendations

- The Head of Healthcare should ensure that prisoners with a self-reported condition such as epilepsy, which requires treatment in the form of medication, should be started on a schedule of observations, with joint working between healthcare and prison staff, to establish if the condition is present and the patient's reported symptoms are accurate.
- The Head of Healthcare should ensure that there is a system in place that ensures follow up appointments are organised, confirmed and communicated to prisoners.
- The Governor should ensure that:
  - staff have regular, meaningful interaction with the prisoners in their care;
  - key working sessions take place regularly in line with Prison Service policy; and
  - if the key worker scheme has to be suspended in response to the COVID-19 pandemic, weekly welfare checks are conducted instead on all prisoners.

The Investigation Process

13. 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.

14. Due to the COVID-19 pandemic, the investigator was unable to visit the prison. She obtained copies of relevant extracts from Mr Tate's prison and medical records via post and email. She could not watch CCTV footage, as it was not compatible with PPO hardware.

15. The investigator interviewed seven members of staff and two prisoners. We have removed the names of prisoners from this report in order to safeguard individuals. NHS England commissioned a clinical reviewer to review Mr Tate's clinical care at the prison. The clinical reviewer and investigator jointly interviewed healthcare staff.

16. 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.

17. One of the Ombudsman's family liaison officers contacted Mr Tate's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. (The next of kin had fostered Mr Tate when he was young and then became his supported living provider when he was older. She said that the term 'carer' best described their relationship and we have used that term in this report.) She said that the emotional and psychological care Mr Tate received at HMP Manchester was "fantastic" and he was very positive about the staff at Manchester. Mr Tate's carer also asked the following questions:

    - Did Mr Tate take drugs? If so, where did he get them from and how regularly was he using them?
    - What COVID vaccination did Mr Tate have and when? Did he report any side effects to the vaccination?
    - Did staff try to resuscitate Mr Tate? If so, did they follow the correct procedure for resuscitation and calling an ambulance?
    - Was Mr Tate in a good state of mind?
    - Were Mr Tate's clozapine levels carefully monitored?

18. These questions are answered in this report and the annexed clinical review.

19. Mr Tate's carer received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Manchester

21. HMP Manchester is a high security category B prison. HMP Manchester is a training prison and accepts long term prisoners. There is a category A unit for prisoners posing greater security risks. The prison holds up to 744 prisoners. This is spread across nine residential units, a segregation unit, specialist intervention unit and a healthcare unit. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing care.

HM Inspectorate of Prisons (HMIP)

22. The most recent full inspection of HMP Manchester was in September 2021. The findings of this inspection were not available at the time of writing our initial report. Prior to this, a full inspection took place in June and July 2018. Inspectors reported that they observed many positive interactions between staff and prisoners although they also noted that a small but influential number of operational staff were disengaged and distant. Inspectors noted that there was a wide range of primary and secondary care services, with improved waiting times and some good practices in systematic assessment of patients.

23. In June 2019, HMIP carried out an Independent Review of Progress to assess progress against the key recommendations from the 2018 inspection. Inspectors reported that promising work had recently begun to support prisoners in crisis but was too new to be assessed, and that this was very concerning given that there had been three further self-inflicted deaths since the full inspection. They commented that it was bewildering to find that actions to prevent deaths in custody simply had not been reviewed until shortly before their visit. Similarly, the introduction of key work and wing peer support had been so slow that they could not yet see sufficient progress in this area.

24. HMIP also conducted a Short Scrutiny Visit at Manchester in June 2021 to look at the care of prisoners during the COVID-19 pandemic. They reported that the key worker scheme had been suspended but that the safer custody team was proactive, and they were pleased to see the use of trained counsellors to support individual prisoners at risk of self-harm or in crisis. The counsellors could be directly involved in the management of each case and provide additional support, such as promoting coping skills, to those in crisis. However, they were concerned that routine mental health referrals were not being assessed and no monitoring of those waiting was taking place.

Independent Monitoring Board

25. 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 February 2020, the IMB reported a number of positive developments during the year, including progression of the key worker scheme showing evidence of closer engagement between officers and

prisoners and the provision of in-cell telephones which was a major enhancement for prisoners allowing contact with friends and family throughout the day.

Previous deaths at HMP Manchester

26. Mr Tate was the 13th prisoner to die at Manchester since March 2019. Of the previous deaths one was self-inflicted, eight were from natural causes, two were drug-related and in one case the cause of death was unascertained. There have been three further deaths since that of Mr Tate, two of which were self-inflicted, and one was due to natural causes.

27. We have previously made recommendations about reducing the supply of drugs at the prison and improving care for prisoners with joint diagnoses of mental health and substance misuse issues. (The prison's response to these recommendations is discussed later in this report.)

Assessment, Care in Custody and Teamwork

28. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

29. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Psychoactive Substances (PS)

30. Psychoactive substances, previously known as 'legal highs', are a 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 dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

The key worker system

31. The key worker system is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

May 2014 – July 2019

32. On 11 May 2014, Mr Jamie Tate committed offences of aggravated burglary, assault and false imprisonment. The next day he appeared at court, was remanded to custody and taken to HMP Leeds. In November, he was sentenced to 11 years imprisonment.

33. During his time in prison, Mr Tate was sometimes subject to Prison Service suicide and self-harm support measures, known as ACCT, after cutting himself. He had a history of drug misuse, including PS, heroin, diazepam (a sedative), cannabis and subutex (an opioid painkiller).

34. Mr Tate had experienced seizures since he was 12 years old and was prescribed various medications to try to manage these seizures. In March 2019, a neurologist diagnosed Mr Tate with non-epileptic attack disorder. This meant that his seizures were not caused by abnormal electrical activity in the brain but by other factors such as overwhelming stress, mental health issues or physical health issues, such as low blood sugar. The attacks that Mr Tate reported as seizures were never witnessed by staff or prisoners.

35. Mr Tate also suffered from visual and auditory hallucinations in the form of an imaginary friend who made derogatory comments about him. He was prescribed various anti-psychotic medications to try to reduce these hallucinations. Mr Tate was also diagnosed with depression and prescribed antidepressants, as well as methadone (a heroin substitute) due to his substance misuse.

36. Mr Tate's behaviour in prison was variable. He was sometimes disruptive, fought with other prisoners, was involved in drug taking and spent time in the segregation unit. He was sentenced to a further four and a half years imprisonment for taking staff hostage and assaulting them. However, Mr Tate also had periods when he caused no issues and complied with the regime.

HMP Manchester: 23 July 2019 – 27 July 2020

37. On 23 July 2019, Mr Tate transferred to HMP Manchester. He engaged with the prison's Drug and Alcohol Recovery Service (DARS) and mental health teams regularly. On 5 August, a psychiatrist assessed Mr Tate and concluded that he was suffering from psychotic symptoms, complicated by seizures, which were not responding to the medication he was currently prescribed. The psychiatrist wanted to prescribe Mr Tate clozapine (an anti-psychotic medication), but was concerned about the potential side effects, including the possible impact on Mr Tate's seizures. He therefore referred Mr Tate for transfer to the Humber Centre, a medium secure psychiatric unit, for them to start the medication while closely monitoring Mr Tate.

38. Between July and January 2020, Mr Tate had monthly sessions with a key worker at Manchester. These were with different prison officers each time. In January 2020, he had two sessions with the same key worker.

39. On 5 February 2020, the psychiatrist reviewed Mr Tate. He said that the voices he could hear were getting more intense and that self-harming by cutting himself was a

way of stopping the voices. Mr Tate said he was still having difficulty sleeping and had seizures around twice a week during his sleep. The psychiatrist increased Mr Tate's prescription of mirtazapine (an antidepressant).

40. On 11 February, Humber Forensic Services refused to admit Mr Tate to monitor the change in his medication. The psychiatrist appealed against this decision. He and the mental health team at Manchester continued to review Mr Tate over the following months. Mr Tate said he continued to have seizures twice a week and that his hallucinations continued. He engaged with DARS but there continued to be some intelligence that he was using illicit drugs.

41. On 30 March, a prison GP assessed Mr Tate's seizures. Mr Tate said he was still having around two seizures a week. The GP increased his prescription of levetiracetam (to control Mr Tate's seizures) and noted that he would chase Mr Tate's neurology referral.

42. In April, Mr Tate was accepted for assessment at the Humber Centre to start his prescription of clozapine. Mr Tate was positive about this.

Humber Centre: 27 July 2020 – 8 December 2020

43. On 27 July, Mr Tate was admitted to the Humber Centre under Section 47 of the Mental Health Act (which allows sentenced prisoners to be transferred from prison to hospital for treatment by mental health professionals). A psychiatrist noted that Mr Tate settled well and was prescribed clozapine. The psychiatrist noted that sometimes Mr Tate appeared anxious but concluded that he had no symptoms of psychosis.

HMP Manchester: 8 December 2020 onwards

44. On 8 December, Mr Tate transferred back to Manchester. He told staff he had no thoughts of suicide or self-harm and he was happy to be back at Manchester. He also told mental health staff that his auditory hallucinations had decreased, and he was able to ignore his visual hallucinations. Mr Tate was added to the mental health team's caseload. A nurse from the substance misuse team assessed him and agreed that he would be regularly reviewed. Mr Tate also said that his seizures had reduced, and he felt well. He was referred to DARS.

45. Staff from the mental health team continued to review Mr Tate regularly. He said that his medication was effective but that he felt tired, and healthcare staff noted that he appeared sedated.

46. On 17 December, a Custodial Manager (CM) did a management check of Mr Tate's key worker entries. He noted that sessions had not taken place at the required frequency, no targets had been set and no meaningful interaction had been recorded. The CM noted that he spoke to Mr Tate's key worker that day.

47. On 22 December, Mr Tate moved to I Wing from H Wing. He was happy to move and knew staff and prisoners there as he had previously been located on the wing. He was also sentenced to a further six months' imprisonment for the assault of a prison officer (committed in January 2019).

48. On 30 December and 7 January 2021, Mr Tate was due to have an appointment with the psychiatrist but did not attend. On both occasions he was told in advance and knew about the appointments. The reason for his non-attendance was not recorded.

49. On 18 January, the psychiatrist reviewed Mr Tate, who said that he was still having fewer auditory hallucinations. Mr Tate said he had ongoing thoughts of suicide but that they had reduced, and he could easily distract himself from them. He said that his black eye was the result of a seizure, which he said he continued to have once a week. The psychiatrist prescribed Mr Tate clonazepam (to assist with his mental health and seizures) as a replacement for the lorazepam (a sedative used to treat anxiety) that he had been receiving in hospital, but which was not available in prison. He planned to review Mr Tate again two weeks later to see how the new medication was working. He told the investigator that Mr Tate was more positive about the future and his mental health seemed to be improving.

50. The same day, a nurse facilitated a telephone appointment for Mr Tate with a consultant from the hospital neurology department. The psychiatrist received an update from Mr Tate's neurologist after his appointment indicating that they also thought Mr Tate might have non-epilepsy attack disorder and they wanted to do some further investigations.

51. On 19 January, Mr Tate was found under the influence of drugs twice by staff. Healthcare staff were informed, staff submitted an intelligence report, a local incident report, wrote in the wing observation book, warned Mr Tate about his behaviour and referred him to DARS (with whom he was already engaged but were offering a minimal service due to COVID restrictions).

52. A GP wrote to Mr Tate explaining the dangers of taking illicit drugs with the medication he was prescribed and said that if he continued to do so his medication may be reduced or stopped. The next day a substance misuse worker spoke to Mr Tate who said he had used drugs as he was bored. They outlined the risk this presented to Mr Tate and gave him a distraction pack and some library books.

53. A mental health nurse and a senior support worker also reviewed Mr Tate. He admitted using illicit drugs. Officers had told healthcare staff that his black eye was as a result of a drug debt, but Mr Tate denied this. He said he had no thoughts of suicide or self-harm and his hallucinations were still much better.

54. On 21 January, staff found Mr Tate heavily under the influence of drugs. They removed smoking paraphernalia from his room, including a vape which smelt strongly of PS. They submitted an intelligence report and a local incident report and made a note in the observation book. He was reduced to the basic level of the Incentives and Earned Privileges (IEP) scheme. Healthcare staff spoke to him about the dangers of taking illicit drugs as well as his prescribed medication. Intelligence suggested that prisoners on I Wing were having clothes sent into them by friends and family that had been soaked in PS, and then smoking the ripped-up fabric.

55. During February, Mr Tate's behaviour improved. He told staff he had stopped taking PS and he was upgraded to the standard level of the IEP scheme. Staff from the mental health and substance misuse teams continued to review him.

56. On 22 February, a nurse completed an ECG on Mr Tate. She sent the recording to a clinician for analysis. The result was normal, but they recommended a medication review and a further blood test.

57. Mr A, a prisoner, said that when Mr Tate first returned to prison from the Humber Centre, he had seemed much healthier and had been determined to be drug-free. However, he said that Mr Tate then returned to using drugs, using his belongings as payment. Mr A said that Mr Tate seemed to be sedated by his prescribed medication, was lethargic and spent a lot of his time in bed. He said Mr Tate tended to just sit on the stairs when he came out of his cell. Mr A said he tried to encourage Mr Tate to come out of his cell and clean it. He said that he spoke to staff about Mr Tate's lack of self-care.

58. On 3 March, a DARS recovery practitioner introduced herself to Mr Tate as his new substance misuse worker. She said that she would contact him the following week on his in-cell telephone. He said he was not using any illicit drugs and had no thoughts of suicide or self-harm. He did not raise any concerns. She told the clinical reviewer that she had woken Mr Tate up when she went to see him, but he did not seem sedated or under the influence of illicit drugs.

59. On 9 March, the senior support worker reviewed Mr Tate. She noted that he appeared settled, said he had no hallucinations and did not report any issues. He asked when he would next see the psychiatrist, as he had said he would see him two weeks after their last appointment in January. She noted she would request an appointment with the psychiatrist and did so after their meeting. This was booked for 29 March.

60. That evening Mr Tate spoke to his carer. He was positive about his mental health worker, and said his medication was working and everything was going well.

61. On 10 March, an officer introduced himself as Mr Tate's key worker. He noted that Mr Tate had recently progressed well and there were no reports that Mr Tate had been under the influence of drugs for several weeks. He wrote that Mr Tate was a complex person but that he said he felt comfortable on the wing, supported by staff and other prisoners, and that he had no concerns. The officer spoke to Mr Tate about his personal hygiene, and he said he preferred to shower alone due to his scars. The officer said that he would see him again within the next few weeks. He arranged individual showers for Mr Tate after their session.

62. The officer told the investigator that he assumed Mr Tate was on strong medication for his mental health as he seemed sedated and "zoned out" during the day. He said he came out of his cell for association and had a lot of friends on the wing. He said that Mr Tate slept quite a lot during the day and would never go out for exercise in the morning. He never witnessed Mr Tate having any seizures or obviously hallucinating.

63. On 11 March, the substance misuse worker tried to call Mr Tate twice on his in-cell phone, but it was engaged. She sent Mr Tate a letter to say that she would be out of the prison until 22 March but would contact him on her return. She noted that he could contact other DARS staff in her absence and gave instructions how to do this. She also included harm reduction advice in the letter.

64. Mr B, a prisoner, said he had known Mr Tate since 2018. He told the investigator that he had never seen him having a seizure or hallucinating. Mr B said that Mr Tate smoked PS throughout the time that he knew him and would take whatever PS he could get. He said that Mr Tate always paid his debts with his canteen [purchases from the prison shop] and was never bullied, and that he was a big prisoner who could "handle himself". Mr B said that Mr Tate seemed his "usual self" in the days leading up to his death.

Events of Sunday 14 March 2021

65. The investigator listened to Mr Tate's telephone calls from 4 March onwards. He was in regular contact with friends and family, was looking forward to his release and reported that "things were going well for a change". On 14 March at 10.15am, Mr Tate rang his carer. They had a general conversation for around 20 minutes. Mr Tate's carer told the PPO's family liaison officer that he "seemed to be in the best place he had ever been psychologically".

66. Mr A said that he saw Mr Tate when they were unlocked that morning. He was sitting on the stairs and he seemed lethargic, as he had done for a few weeks, and it was hard to have a conversation with him.

67. Around 4.30pm, Officer A spoke to Mr Tate when he unlocked his cell for dinner and medication. The officer said he asked Mr Tate if he was alright, and Mr Tate confirmed that he was. Mr B and Mr Tate's key worker saw Mr Tate when he collected his dinner and medication. They had no concerns and said that Mr Tate seemed his usual self. Mr Tate was locked back in his cell by 5.00pm.

68. At 7.00pm, Officer B started doing a roll check. When he got to Mr Tate's cell, he looked in through the observation panel and saw Mr Tate lying face down on the floor. He kicked the door several times to attract his attention, but Mr Tate did not respond. He thought that Mr Tate might have been under the influence of illicit drugs. He shouted to Officer A on the landing below that a prisoner was unresponsive.

69. Officer A ran to the cell, looked through the observation panel and saw Mr Tate lying face down on the floor. He unlocked the door and went into the cell. He shouted to Mr Tate, who did not respond, checked for signs of life and turned him over. When he did so, he found a vape under his face. Another officer, who had also responded, radioed a code blue (a medical emergency code which indicates a prisoner is unresponsive or having difficulty breathing). Staff in the control room immediately telephoned to request an ambulance. Officers began chest compressions.

70. Prison staff estimated that two nurses arrived at Mr Tate's cell with the emergency equipment around four minutes after they had first got there. (The investigator has been unable to watch the CCTV footage.) One of the nurses noted that Mr Tate was on his back and had blood on his face. She shouted Mr Tate's name, but he did not respond. The nurse detected a weak carotid pulse but noted Mr Tate was not breathing. She observed that Mr Tate's limbs were blue and mottled with signs of blood pooling but that he felt warm. She attached the defibrillator and began chest compressions. Nurses inserted an airway and administered oxygen. Another nurse administered naloxone (an opiate antidote) to Mr Tate.

71. Paramedics arrived and took over Mr Tate's care, helped by prison officers and nurses. They attached their defibrillator, continued CPR and administered adrenaline. At 7.59pm, the paramedics pronounced Mr Tate had died.

72. After Mr Tate had died, the police seized some vaping equipment from his cell, along with a homemade pipe and burnt remnants of a substance.

Intelligence after Mr Tate had died

73. Mr B told the investigator that he beckoned an officer over to his cell after Mr Tate had died and gave him a note saying that Mr Tate had got drugs from Mr A in a parcel of socks. (The investigator has not seen this note as the prison could not produce it.)

74. Mr B told the investigator that Mr A had told him that he had asked his mother to dissolve 50mg fentanyl (an opiate painkiller) tablets in water and soak some socks in them and send them to him. Mr B said that Mr A said that he had received them on 14 March. Mr B said that Mr A had done this a few months previously with 30mg fentanyl tablets and had distributed it on the wing and it had led to prisoners collapsing. Mr B said that Mr A continued to sell pieces of these socks on 15 March. Mr B said that he told the officers that Mr A had sold a piece of sock to another prisoner.

75. An intelligence report noted that at 2.30pm on 14 March an officer had given Mr Tate some socks and boxer shorts which had been received through the post. These items had been searched and X-rayed and checked by search dogs. No concerns were noted about the contents.

76. Another intelligence report noted that on 15 March, Mr B handed a note to an officer, which said that Mr Tate had got PS from Mr A, who had had a parcel of socks delivered to him that afternoon which were all impregnated with PS. Staff searched Mr A's cell and an officer found a pair of socks which had some material cut from them. He seized them and they tested positive for opiates. Police seized the socks as evidence, but they were not tested further. The officer submitted an intelligence report and spoke to his manager.

77. When asked about the socks, Mr A told the investigator that he had bought the socks from another prisoner as he was told that they had PS on them. He denied supplying them to Mr Tate but said that the person he bought them from supplied them to Mr Tate. He was not willing to name the prisoner. Mr A said he had never been involved in supplying drugs in the prison. He said he tried to buy more socks soaked in drugs after he had them confiscated but the other prisoner was unwilling to supply him with any after Mr Tate had died.

Contact with Mr Tate's family

78. A prison chaplain was appointed as family liaison officer. Due to restrictions on face to face contact during the COVID-19 pandemic, he informed Mr Tate's next of kin of Mr Tate's death by telephone and passed on his condolences. He remained in contact with Mr Tate's next of kin and offered a contribution to funeral expenses in line with Prison Service policy.

Support for prisoners and staff

79. After Mr Tate's death, a senior 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.

80. The prison posted notices informing other prisoners of Mr Tate'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 Tate's death.

81. Mr B said he had not felt adequately supported by the prison after Mr Tate died. He said he was not offered support or asked how he was apart from by a member of the chaplaincy. A nurse said that she had had good support from her colleagues but would have liked more support from the prison.

Post-mortem report

82. The post-mortem report concluded that the cause of Mr Tate's death was unascertained. Methadone, levetiracetam and clozapine (all of which he was prescribed) were detected in Mr Tate's system. The pathologist noted that the levels of methadone and clozapine were quite high, but fell within the range of therapeutic levels, although this also overlapped with levels associated with toxicity. However, the pathologist said that given Mr Tate's longstanding prescriptions for these drugs, it was unlikely that he had overdosed on either of these medications.

83. The level of levetiracetam was also at a therapeutic level but the toxicologist noted that this would not necessarily mean that Mr Tate's seizures were adequately controlled. The pathologist said that she was not aware of the cause of Mr Tate's seizures but that the way he was found could be consistent with him having had a seizure.

84. The pathologist also noted that Mr Tate had previously used PS. She noted that PS covers a large number of compounds with variable and unpredictable effects. As there are over 400 possible PS variants, they are not all tested for and identification can be very difficult. Therefore, although no PS was detected in Mr Tate's system, it is not possible to rule out the possibility that he had taken PS before he died or that it contributed to his death.

85. Another prisoner alleged Mr Tate had been supplied with fentanyl (an opiate) before he died. No opiates were detected in Mr Tate's system.

Findings

86. The pathologist concluded that the cause of Mr Tate's death was unascertained and could have been caused by seizures, medication or illicit drugs.

Clinical care

Physical healthcare

87. The clinical reviewer noted that Mr Tate's seizures were never witnessed by staff or prisoners and there was no apparent monitoring of them. She considered that Mr Tate should have been monitored to establish if he had seizures. The clinical reviewer also noted that there were no care plans in place for Mr Tate's non-witnessed seizures.

88. The clinical reviewer also concluded that an appropriate referral was made to the neurology department for a specialist review of Mr Tate's condition, but that this should have taken place earlier.

89. We recommend:

The Head of Healthcare should ensure that prisoners with a self-reported condition such as epilepsy, which requires treatment in the form of medication, should be started on a schedule of observations, with joint working between healthcare and prison staff, to establish if the condition is present and the patient's reported symptoms are accurate.

Mental healthcare

90. The clinical reviewer concluded that there was evidence that Mr Tate received a good standard of mental health care at Manchester. However, she was concerned that Mr Tate had missed two appointments with the psychiatrist following his return from the psychiatric unit, and there was no record to explain why.

91. The prison has since put into place a new process under which the mental health team contact all prisoners on the day of their psychiatric appointment to ask them to attend. If they do not attend, the mental health team will try to find out why and if prisoners repeatedly do not attend, the psychiatrist will visit the prisoner to assess them in their cell. All of this must be documented on their medical record. As the prison has already taken action to address this, we have not made a recommendation about it.

92. When the psychiatrist reviewed Mr Tate on 18 January 2021, he noted that he would review him in two weeks. However, no appointment was made, and the mistake was only rectified on 9 March when Mr Tate asked when his next appointment was. It was booked for 29 March, after Mr Tate died.

93. The Healthcare and Drug Strategy Lead said that the psychiatrist should have told administrative staff to book an appointment with him. It was not possible to determine whether the psychiatrist had not communicated this or administrative

staff had failed to book it. It could have been a vital missed opportunity to assess Mr Tate. We make the following recommendation:

The Head of Healthcare should ensure that there is a system in place that ensures follow up appointments are organised, confirmed and communicated to prisoners.

94. The clinical reviewer noted that the psychiatrist took appropriate action when he arranged for Mr Tate to be transferred to a medium secure psychiatric unit to be prescribed clozapine. When Mr Tate returned to Manchester, he was required to have regular blood tests to monitor his blood in line with mandatory prescribing requirements for clozapine. The clinical reviewer concluded that Mr Tate had appropriate blood tests and was appropriately monitored when he returned from the Humber Centre.

Substance misuse

95. Mr Tate had a long history of substance misuse. There was intelligence both before and after Mr Tate died about his use of drugs. However, there had been no drug related intelligence submitted during the last six weeks of Mr Tate's life. Despite this, when Mr Tate was found, there was a vape under his face. Police also found further vaping equipment, a homemade pipe and burnt remnants of a substance in his cell.

96. Mr Tate was under the care of the DARS and engaged with them during the last months of his life, despite their service being limited due to COVID restrictions. We are satisfied that when Mr Tate was considered to be under the influence, staff took appropriate steps to support him, educate him about the dangers of drug use and issue appropriate sanctions for his behaviour. The clinical reviewer concluded that Mr Tate's substance misuse clinical care was equivalent to that he could have expected to receive in the community.

Dual diagnosis healthcare

97. The clinical reviewer was concerned that the substance misuse and mental health services were not working together effectively. The Healthcare and Drug Strategy Lead told the investigator that he was concerned that there did not seem to be adequate communication between the two teams about how they were going to plan and manage Mr Tate's care.

98. Following a previous drug-related death at the prison in August 2020, we recommended that the prison develop a pathway between substance misuse and mental health services for complex prisoners who require joint assessment and management. The prison accepted this recommendation and said that they were developing such a pathway and would also discuss such prisoners at the weekly safety intervention meeting. They were due to complete these actions in October 2021, several months after Mr Tate's death.

99. The Healthcare and Drug Strategy Lead said that since Mr Tate's death, he had asked the services to develop a pathway to manage prisoners with complex mental health and substance misuse needs. He said joint team meetings have now started to discuss such prisoners and how they will be managed from a multi-disciplinary

perspective. He also expects that a prisoner's physical healthcare would be considered as part of this joint working.

100. We therefore make no further recommendation but are concerned to note that integrated dual diagnosis care has once again been a concern at the prison.

Availability of drugs

101. Although post-mortem toxicology tests detected no PS in Mr Tate's system, it remains possible that he had taken PS before he died or that it contributed to his death. A vape was under Mr Tate's face when he was found unresponsive, along with other drug paraphernalia in his cell, including burnt remnants of a substance. There was also intelligence both before and after Mr Tate died that he took PS.

102. Although Manchester has a comprehensive drug strategy, we are very concerned that Mr Tate appears to have had no difficulty in obtaining and using PS. More needs to be done to reduce both the supply of, and demand for, PS.

103. Following deaths due to PS toxicity at the prison in 2019 and 2020, we made recommendations about reducing the supply of drugs. In response, Manchester said in August 2021 that the Head of Drug Strategy had been in contact with other prisons to share learning and methods used to tackle and reduce the supply of drugs. They had also sought prisoners' views through surveys and forums and fed the learning from these into a drug summit chaired by the Governor on how to tackle weaknesses in reducing the supply of drugs.

104. The Healthcare and Drug Strategy Lead said that it is difficult to prevent drugs being thrown over the walls in a city centre prison, but they are taking proactive measures to reduce drugs coming into the prison in other ways. They had been aware before Mr Tate's death that drugs were potentially coming in soaked in clothing and they had started testing clothing coming into the prison for drugs. He said that they had also started photocopying all mail (aside from legal mail, which is privileged) in case the paper had been soaked in drugs. They have also started using a specific registered service for legal mail.

105. 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. In April 2019, the Prison Service introduced a national drug strategy. This says that:

> "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."

106. Manchester has a strategy to address both the supply of, and demand for, illicit drugs. A revised version is due to be published imminently. It includes numerous actions intended to reduce the supply of drugs into the prison and movement of drugs around the prison. There are also measures to educate prisoners about the dangers of PS and support those known to use drugs, plus disciplinary measures to deter drug use.

107. Given the proactive steps the prison has taken both before and after Mr Tate's death in addressing the issue of drug misuse at Manchester, we make no further recommendation.

Meaningful contact with prisoners

108. The key worker scheme provides for a dedicated member of staff to establish a relationship with a prisoner and should therefore provide opportunities to identify any concerns a prisoner may have and help to put support in place. Key workers are allocated 45 minutes per week per prisoner for this work.

109. Between July 2019 and January 2020, Mr Tate had monthly meetings with a key worker. This was not in line with Prison Service policy as it was not sufficiently regular and involved different members of staff on each occasion.

110. Mr Tate then met the same key worker twice in January 2020 but had no further meetings before he transferred to a psychiatric unit in July 2020. After he returned to Manchester in December 2020, he had no key working sessions until 10 March 2021. He died four days later.

111. In December 2020, a manager reviewed Mr Tate's key worker entries. He noted that sessions had not taken place at the required frequency, no targets had been set and no meaningful interaction recorded. The manager noted that he spoke to the key worker that day.

112. Key working was suspended across the prison estate in response to the COVID-19 pandemic, although prisons were expected to maintain key working for particularly vulnerable prisoners and to conduct weekly welfare checks on all other prisoners.

113. In June 2020, Manchester restricted key working to priority groups. We are surprised that Mr Tate was not considered to be in a priority group. Manchester was categorised as a COVID outbreak site on four occasions over the following 18 months and they only managed to progress to another stage of regime delivery twice (in November – December 2020 and April 2021). The prison told us that due to high levels of staff sickness, they struggled to deliver monthly key working sessions throughout this period, so they continued to focus on the most vulnerable prisoners.

114. There are no welfare checks recorded for Mr Tate. We appreciate the difficulties that COVID-19 has presented in terms of maintaining meaningful interaction between staff and prisoners, but we are concerned that in Mr Tate's case key working sessions were not taking place as they should have before the COVID-19 pandemic. In addition, the manager checking Mr Tate's key worker entries in December 2020 was not satisfied they were sufficient at that time.

115. We are concerned that the lack of regular welfare checks on Mr Tate was a missed opportunity to identify his needs. We therefore make the following recommendation:

The Governor should ensure that:

- **staff have regular, meaningful interaction with the prisoners in their care;**

- **key working sessions take place regularly in line with Prison Service policy; and**
- **if the key worker scheme has to be suspended in response to the COVID-19 pandemic, weekly welfare checks are conducted instead on all prisoners.**

Entering Mr Tate's cell

116. Officer B said that when he found Mr Tate unresponsive in his cell, he initially thought that Mr Tate might have been under the influence of drugs, and that is why he had called to another officer before going into the cell. We are satisfied that he made a dynamic risk assessment, and we are not critical of this decision.

117. However, Officer B also said that he would never enter a cell on his own even if there was a clear risk to life. This is not in line with Prison Service policy. Since it was not relevant to the death of Mr Tate, we have not made a recommendation, but we have flagged our concerns to the Head of Safer Custody.

Inquest

118. The inquest into Mr Tate's death concluded in April 2024. The Coroner found that although the medical cause of Mr Tate's death was unascertained, there was a possibility that the use of an illicit substance and/or an unwanted side effect of medication (clozapine) were contributory factors.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100