

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Duffey a prisoner at HMP Liverpool on 16 July 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr John Duffey was found hanged in his cell at HMP Liverpool on 16 July 2016. He was 44 years old. I offer my condolences to Mr Duffey's family and friends.

Mr Duffey was a military veteran with a diagnosis of post-traumatic stress disorder and depression. He had a long history of illicit drug use and alcohol abuse. The investigation found deficiencies in the operation of suicide and self-harm prevention procedures at the prison. I am concerned that this is not the first time that I have found suicide and self-harm prevention procedures to be inadequate at Liverpool. However, I do not consider that staff at Liverpool could have predicted that Mr Duffey intended to take his own life when he did and, therefore, could not have prevented his actions.

Fellow prisoners said that Mr Duffey was a regular user of 'Spice', a new psychoactive substance, that he was being bullied and was in debt for drugs, but the investigation found no evidence to corroborate these claims. Nevertheless, I note the ease with which Mr Duffey appeared to have been able to acquire illicit drugs at Liverpool and the prison needs to increase its efforts to combat the risks posed to prison safety particularly by new psychoactive substances.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2017

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Summary

Events

1. Mr John Duffey was a military veteran who had been diagnosed with post traumatic stress disorder (PTSD) and depression. He also had a long history of alcohol and drug abuse. Mr Duffey had served custodial sentences dating back to 2004. He was released on licence on 5 November 2014.
2. On 27 February 2015, Mr Duffey was recalled into custody at HMP Liverpool and charged with assault and theft. He was convicted on 4 August 2015 and had to serve the remainder of his original 56-month sentence.
3. On 7 November, Mr Duffey self-harmed and said he wanted to die. Staff monitored Mr Duffey under Prison Service suicide and self-harm prevention procedures (known as ACCT) until 13 November.
4. From November 2015 to July 2016, Mr Duffey lived on J Wing. He was a trusted prisoner, worked as a wing cleaner and successfully completed the substance misuse programme.
5. On 16 July 2016, a prisoner found Mr Duffey hanged in his cell. Staff were called and immediately began resuscitation until paramedics arrived. Mr Duffey was transferred to hospital and treated in intensive care. Hospital doctors pronounced Mr Duffey dead later the same day.

Findings

Management of risk of suicide and self harm

6. We found that ACCT procedures at Liverpool were not conducted in line with mandatory national instructions. The first case review was not conducted on the same day as the assessment and the post-closure review was held nearly two months after it should have occurred.
7. Mr Duffey had a long history of alcohol and drug abuse which he shared with staff. He made further admissions of drug use within Liverpool several times but these were seemingly not taken seriously or appropriately addressed by staff members.

New Psychoactive Substances

8. After Mr Duffey's death, we were told that he regularly used NPS, or 'Spice', and was being bullied for drug debts. Although we could find no evidence to corroborate this, it cannot be ruled out. We are concerned at the ready availability of illicit drugs at Liverpool.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
 - Assessing the level of risk and recording the reasons for decisions;

- Setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;
 - Conducting ACCT reviews as specified in the national instructions;
 - Conducting ACCT post-closure interviews as specified in the national instructions.
- The Governor should ensure there are effective supply and demand reduction strategies to help eradicate the availability of new psychoactive substances, and that staff are vigilant to signs of their use and know how to respond when a prisoner appears to be under the influence of such substances.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Liverpool on 26 July. He obtained copies of relevant extracts from Mr Duffey's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Duffey's clinical care at the prison.
12. The investigator interviewed nine members of staff and six prisoners at Liverpool in September.
13. We informed HM Coroner for Liverpool of the investigation. He gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Duffey's sister to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Through her legal representative, Mr Duffey's sister asked whether Mr Duffey was being monitored, because he was thought to be at risk of suicide at the time of his death, and what plans were in place for his resettlement upon release. Mr Duffey's family received a copy of the initial report. The solicitor representing Mr Duffey's family wrote to us pointing out a factual inaccuracy and asked for details of Mr Duffey's suicide note to be included in the report. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Liverpool

15. HMP Liverpool is a local prison, holding over 1,200 men and serving the Merseyside, Wigan and Blackburn courts catchment area. Lancashire Care NHS Foundation Trust provides health services at the prison. Lifeline Project provides the substance misuse services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Liverpool was carried out in May 2015. Inspectors found that the quality of suicide and self-harm prevention procedures was variable. Some were very good but too many lacked consistency of case management, had inadequately-completed care plans and too many reviews that were neither timely nor multidisciplinary. Support for victims of violence and antisocial behaviour was underdeveloped. There were no management plans to address issues of vulnerability, to promote a prisoner's return to normal location on a general population wing, or ensure progression to other prisons. Staff were not sufficiently proactive in dealing with prisoners' issues. Relationships were further undermined by a lack of continuity of staff on the wings. Health provision had deteriorated sharply. Prisoners waited too long for routine GP appointments and they did not always have timely access to the full range of primary care services such as chronic disease management, clinics and screening programmes, which put their health at risk. Inspectors commented that three prisoners had taken their lives within the previous 14 months.

Independent Monitoring Board

17. 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 annual report to December 2015, the IMB noted its concern about the level of bullying, use of mobile phones, and the use of drugs at Liverpool. The IMB was also concerned about the lack of sufficient staff to run the prison safely. It reported there was still a large gap in services for personality disorders and serious mental health issues and the number of prisoners suffering from these issues has escalated in the previous 12 months.

Previous deaths at HMP Liverpool

18. Mr Duffey's was the seventh self-inflicted death at Liverpool since 2014. We are very concerned to have to raise the quality of the prison's assessment of the risk of suicide and self-harm again.

Assessment, Care in Custody and Teamwork (ACCT)

19. 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. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner

anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

New Psychoactive Substances

20. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS 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
21. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
22. NOMS 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. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

23. On 27 February 2015, Mr John Duffey was recalled into custody at HMP Liverpool charged with assault and theft. Mr Duffey had served custodial sentences dating back to 2004 for offences which included violence, fraud, theft, drugs, firearms and possession of offensive weapons. He had been convicted in 2012, and given a 56 months sentence from which he was released on licence from HMP Wymott in November 2014. Mr Duffey was a military veteran and had been diagnosed with post-traumatic stress disorder (PTSD) and depression in 2002. He also had a long history of alcohol and illicit drug abuse.
24. When he arrived at Liverpool, Mr Duffey saw a nurse. She recorded in Mr Duffey's medical records that he suffered from PTSD and depression and that his doctor in the community prescribed citalopram (an anti-depressant). Mr Duffey said he had no current thoughts of self-harm or suicide but said he had tried to hang himself in 2010, when he was in low mood due to alcohol misuse. He said he had abused alcohol since the age of 14 and used heroin and crack cocaine daily since his thirties. She referred Mr Duffey to the substance misuse team and requested his records from his doctor in the community.
25. A member of the substance misuse team also saw Mr Duffey. Mr Duffey said that he drank over 12 cans of strong lager a day, as well as cider. He said that he had last drunk alcohol the previous day. Mr Duffey also said he used heroin and crack cocaine daily. He said he last smoked crack cocaine three days earlier. Mr Duffey told her he had suffered a seizure within the previous seven days. She recorded that Mr Duffey was sweating, felt nauseous and had a tremor, which were all signs and symptoms of withdrawal. Mr Duffey's urine was tested giving a positive result for opiates. She referred Mr Duffey to a prison GP, who saw him immediately.
26. The prison GP recorded that Mr Duffey suffered from PTSD and depression, for which he was prescribed citalopram. Mr Duffey said he had no current thoughts of self-harm or suicide. The GP prescribed 10mls of methadone (an opiate substitute) and 30mg of chlordiazepoxide (for alcohol withdrawal) and citalopram.
27. On 2 March, Liverpool received Mr Duffey's community medical records, which confirmed that he had been diagnosed with PTSD and depression and was prescribed citalopram.
28. On 5 March, a prison GP saw Mr Duffey on the wing after he told staff that he had apparently had a fit in his cell, had fallen and banged his head. The GP requested an ambulance and Mr Duffey was taken to hospital. He remained in hospital for 12 days where doctors treated him for alcohol withdrawal.
29. On 17 March, Mr Duffey was discharged and saw a prison GP on return to Liverpool. The GP recorded that Mr Duffey was no longer withdrawing and required no further detoxification medication. He repeated the prescription of citalopram.
30. On 18 March, a member of the mental health team saw Mr Duffey for a mental health assessment. She recorded that Mr Duffey had been diagnosed with PTSD in 2002, following trauma while serving in the armed forces. She also

noted that Mr Duffey had an alcohol dependency and had been discharged from hospital. Mr Duffey said that he did not want any input from the mental health team as he was prescribed citalopram and was able to manage his symptoms.

31. On 5 November, Mr Duffey saw a member of the substance misuse team. Mr Duffey said that he had been using heroin while in prison and, as a result, was in debt on the wing. He said he wanted to move to J wing where he could join the 'Journey to Recovery' programme, known as J2R. This was a programme run by Lifeline, a charitable organisation providing addiction therapies. The nurse recorded that Mr Duffey would be considered for J2R and he would see him again as soon as possible.
32. On 7 November, Mr Duffey cut both his arms with a razor blade. A Supervising Officer (SO) opened an ACCT document and recorded that Mr Duffey said he had wanted to kill himself but had thought better of it once he made the cuts. A nurse examined Mr Duffey and recorded that he had made superficial wounds to his arms, which she cleaned and dressed. The SO completed an ACCT immediate action plan. He recorded that Mr Duffey was at a raised risk of suicide and self-harm, and that he should be moved to the care suite until he could transfer to another wing. The SO noted that officers should check Mr Duffey every hour until the first case review was held.
33. At 2.15pm, an officer assessed Mr Duffey as part of ACCT procedures. Mr Duffey said he had got into debt on the wing and struggled with his PTSD. He said that he had attempted to hang himself in 2010, when he was in Spain, because of heavy drinking. He said his family had turned its back on him due to his alcoholism and drug use. He said he had three children and wanted to rebuild relationships with them. Mr Duffey said he wanted to move to J wing for J2R. He said that despite cutting himself he had no more thoughts of self-harm or suicide.
34. That evening, a member of the mental health team saw Mr Duffey to review his mental health because he had self-harmed. Mr Duffey said he was struggling to cope with his PTSD as it was affecting his sleep and appetite. He said he had been prescribed citalopram for many years, and had received counselling in the past. She referred Mr Duffey to be seen by a counsellor and a doctor.
35. On 8 November, a SO held the first ACCT case review with a member of the mental health team and Mr Duffey present. Mr Duffey said that everything had "come to a head". He said he felt embarrassed that he had self-harmed. He said he did not want to die and had no further thoughts of self-harm. Mr Duffey said he wanted to move to J Wing which would alleviate his debt issues. The SO and the nurse assessed Mr Duffey as being at a low risk of suicide and self-harm, and reduced the level of observations from once hourly to four over the course of the day and four over the course of the night. The SO completed the ACCT caremap which contained two actions: for Mr Duffey to engage with mental health, and to move to J wing for J2R. The following day, a member of the substance misuse team told Mr Duffey that he had been accepted onto J2R, and Mr Duffey moved to J Wing that day.
36. On 13 November, a SO and a nurse held an ACCT case review with Mr Duffey on J Wing. The SO recorded that Mr Duffey was relaxed and engaged with the

review. Mr Duffey said that he felt much better and that being on the J2R programme had been a positive move for him. The SO and nurse agreed that his risk of suicide and self-harm was low and agreed to close the ACCT. The SO updated the caremap as all the actions had been completed. They set a post-closure review for 20 November. However, the post-closure interview was not held on that date.

37. On 31 December, a prison GP saw Mr Duffey to review his medication. Mr Duffey said that he had undergone a period of crisis in November which had led him to self-harm. He said he was now settled, participated in the courses on J2R, was positive about the future and looking forward to the possibility of getting parole. Mr Duffey said he had no current thoughts of self-harm or suicide. The GP recorded that he discussed with Mr Duffey the option of increasing the dose of citalopram, but had said that in his opinion it did not seem necessary. Mr Duffey agreed and said he felt well and was settled but would ask to see the doctor if he had any concerns.
38. On 18 January 2016, a SO conducted the ACCT post closure interview with Mr Duffey. This interview should have been conducted eight weeks earlier on 20 November 2015. Mr Duffey said he was no longer stressed and enjoyed being on the J2R programme. He said he got good support from staff and the other prisoners. The SO told the investigator that due to the prioritisation of workloads, tasks such as post closure interviews were not always completed.
39. On 10 March, Mr Duffey saw a qualified counsellor and member of the mental health team. Mr Duffey said he had completed the J2R programme and had done a lot of work in therapy over the previous six months. He said that this had really helped him, his anxiety had significantly reduced and his self-confidence had improved. Mr Duffey said he would not benefit from any counselling due to the work he had already done but that he would seek help for his PTSD when he was released. Mr Duffey said he had no thoughts of self-harm or suicide. The counsellor recorded that Mr Duffey suffered from PTSD, had a history of substance misuse, and had previously attempted suicide in 2010.
40. Over the rest of March until the end of June, Mr Duffey was seen regularly by a member of the substance misuse team and his offender supervisor. He also received support from the substance misuse team. Mr Duffey had completed the J2R programme but remained on J Wing as a cleaner and was considered by staff as a role model for other prisoners. Plans were made for him to have a place at Tom Harrison House, a hostel for former military veterans, which specialised in addiction problems, on his release.
41. On 6 July, a member of the substance misuse team saw Mr Duffey for a substance misuse review. Mr Duffey said he had a parole hearing on 9 August, and was confident that he would be released. He said plans were in place for him to have a place at Tom Harrison House. Mr Duffey said he enjoyed his role as a cleaner on J Wing.
42. On 14 July, a worker from Tom Harrison House visited Mr Duffey and told him that everything was in place for him to live at Tom Harrison House on his release. A Parole Board hearing was scheduled for 9 August and his offender supervisor recommended that Mr Duffey should be released. This was supported by Mr

Duffey's probation offender manager in the community and Tom Harrison House. The offender supervisor said although Mr Duffey was frustrated at the length of time the release process took, he was very positive about his future and looking forward to going to Tom Harrison House.

43. Mr Duffey's prison phone records show he last called his sister on 27 November 2015. From 1 April 2016, he made three calls: one to his solicitor on 3 June; one to a friend on 10 July; and one to probation on 13 July. The investigator listened to Mr Duffey's call to his friend: he left a voicemail message thanking her for her letter and saying he would write.
44. On 16 July, at 11.53am, a prisoner found Mr Duffey hanging from the frame of the bunk bed in his cell by a ligature made from cord. He shouted to staff for assistance. Two officers responded. When they arrived at the cell, an officer radioed an emergency code blue, which indicates a prisoner is unable, or having difficulty breathing. The control room log shows the code blue was called over the radio at 11.54am and an emergency ambulance was called immediately. Both officers immediately cut the ligature, lowered Mr Duffey to the floor and began cardiopulmonary resuscitation (CPR).
45. Healthcare staff responded to the code blue call. The nurses continued with the resuscitation and used an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. The defibrillator found no shockable rhythm, so the nurses continued with CPR. Paramedics arrived at 12.00pm and took over Mr Duffey's care. At 12.28pm, the paramedics transferred Mr Duffey to hospital where he was treated in intensive care. Mr Duffey did not respond to treatment and doctors withdrew life-support, he was pronounced dead at 8.20pm.

Contact with Mr Duffey's family

46. The Head of Offender Management tried to contact Mr Duffey's nominated next of kin, his sister, at 1.30pm, to inform her that Mr Duffey had been taken to hospital following a serious incident. Despite numerous attempts, Liverpool was unable to contact Mr Duffey's sister. The Head asked the police to trace Mr Duffey's sister and ask her to contact the prison.
47. Mr Duffey's sister contacted the prison at 6.30pm. The Head collected her from her home, took her to the hospital and remained with her. Following Mr Duffey's death, the Head offered his condolences and support and took Mr Duffey's sister home.
48. The prison appointed the Head of Residence as family liaison officer. He maintained contact with Mr Duffey's sister in the days after the death and the prison contributed to the costs of Mr Duffey's funeral in line with national policy. A note addressed to a female was found in Mr Duffey's cell, in which Mr Duffey had written: "everyone, so sorry, loved you all, John"

Support for prisoners and staff

49. After Mr Duffey had been taken to hospital, the Head held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they

had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

50. The prison posted notices informing staff and prisoners of Mr Duffey'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 Duffey's death.

Information received after Mr Duffey's death

51. Mr Duffey's cellmate told the investigator that Mr Duffey used NPS three to four times a week, and had smoked it the night before he died.
52. On 22 July, a prisoner on J Wing, told staff that Mr Duffey had been bullied by other prisoners on the wing. He said that Mr Duffey was in debt and was put under pressure to collect packages and bring them back to the wing. He named four prisoners who he claimed were the individuals who had bullied Mr Duffey.
53. Both officers told the investigator that Mr Duffey had never given any indication that he was in debt or was being bullied. The officers said that they had no evidence or intelligence to indicate that Mr Duffey was a victim of bullying.
54. The SO told the investigator that in his role as wing manager he had not been given any information, nor was there any indication that Mr Duffey was the victim of bullying. He also told the investigator that Mr Duffey had never disclosed that he was being bullied or pressurised to collect packages.
55. The investigator interviewed three of the named alleged bullies (the other had been released from custody and was not interviewed). All three denied that Mr Duffey was being bullied. The investigator has found no evidence or intelligence to corroborate the prisoner's allegation.

Post-mortem report

56. A post-mortem examination, conducted by a Home Office Forensic Pathologist, confirmed that the cause of Mr Duffey's death was hypoxic brain injury and cardiac arrest caused by hanging. He noted that the toxicology results confirmed the presence of citalopram but found no evidence of illicit drugs or NPS. However, given more than one account of his regular use of NPS (including in the days immediately before he died), together with the toxicological challenges in identifying new forms of NPS, we cannot conclusively state that the use of NPS was not a factor in Mr Duffey's death.

Findings

Management of risk of suicide and self harm

57. Staff correctly opened an ACCT on 7 November after Mr Duffey self-harmed and handed staff a noose. A SO completed an immediate action plan and assessed Mr Duffey as being at a raised risk of suicide and self-harm and moved him to the care suite. He set the level of observations at one per hour. We consider that the initial level of observations appears relatively low for someone considered as being at a raised risk of suicide and who had just committed an act of self-harm and indicated suicidal intent. The ACCT assessment interview was conducted at 2.15pm, on 7 November.
58. The first case review did not take place until 11.00am on 8 November. PSI 64/2011, which sets out the Prison Service's framework for delivering safer custody procedures, states that the first case review must be held within 24 hours of the ACCT being opened and ideally immediately after the assessment interview. We consider that the first case review should have been conducted on 7 November.
59. This ACCT was closed on 13 November, with a post-closure interview scheduled for 20 November. PSI 64/2011, states that post-closure interviews must be conducted within seven days of an ACCT being closed. The post-closure interview was held eight weeks later on 18 January 2016. The SO explained that the delay was caused because of the prioritisation of workloads. We consider this unacceptable. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Assessing the level of risk and recording the reasons for decisions;**
 - **Setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;**
 - **Conducting ACCT reviews as specified in the national instructions;**
 - **Conducting ACCT post-closure interviews as specified in the national instructions.**
60. Mr Duffey gave no indication to anyone that he had any suicidal thoughts in the days immediately before the 16 July. Two officers told the investigator that Mr Duffey was a trusted prisoner, he had a good relationship with staff, was looking forward to his release and had a place arranged at a hostel for former military veterans. Both officers said that they had spoken to Mr Duffey on the morning of 16 July. He appeared his usual self and had given no indication that he had any thoughts of self-harm.
61. We do not consider that staff at Liverpool could have predicted that he intended to take his own life and therefore could have done anything to prevent his actions.

New Psychoactive Substances

62. Mr Duffey made candid admissions to both prison and nursing staff about his history of drug use. He agreed to work with substance misuse recovery groups at the prison but, in November 2015, said he had used heroin and was in debt. His move to J wing and participation in the J2R programme appears to have been successful, yet Mr Duffey's cellmate said that Mr Duffey used NPS three to four times a week, and another prisoner said Mr Duffey was in debt for drugs and being bullied as a result. However, wing staff and Mr Duffey's offender supervisor said Mr Duffey had not given them any indication that he was using drugs, in debt or being bullied.
63. There are concerns that use of NPS can produce a range of bizarre behaviours or paranoia, but in the weeks leading up to his death, Mr Duffey had not given any indication that he was using NPS and there was no record that his behaviour was out of the ordinary. The post mortem did not indicate any use of NPS. Although we can find no evidence of debt or bullying, it is not possible to say whether Mr Duffey's actions were influenced either directly by drug use or by a fear of violence resulting from drug-related debt.
64. However, in July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. We make the following recommendation:

The Governor should ensure there are effective supply and demand reduction strategies to help eradicate the availability of new psychoactive substances, and that staff are vigilant to signs of its use and know how to respond when a prisoner appears to be under the influence of such substances.

Clinical Care

65. The clinical reviewer considered that, overall, the care that Mr Duffey received from healthcare staff at HMP Liverpool was equivalent to the care he would have received in the community. He comments that Mr Duffey was diagnosed with PTSD in 2002 after he left the British Army. He said PTSD is an anxiety disorder produced as a result of experiencing traumatic and frightening events. It is characterised by nightmares and flashbacks to the trauma resulting in feelings of isolation, irritability and guilt. PTSD is a common condition with military veterans.
66. The clinical reviewer was satisfied that Mr Duffey received appropriate treatment, intervention and medication for PTSD and depression.
67. The clinical reviewer commented that staff were not aware of the issues relating to Mr Duffey's alleged ongoing use of NPS, and that Mr Duffey's death could not have been predicted or prevented.

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