Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shehu Balogun, a prisoner at HMP Liverpool, on 12 July 2022

A report by the Prisons and Probation Ombudsman

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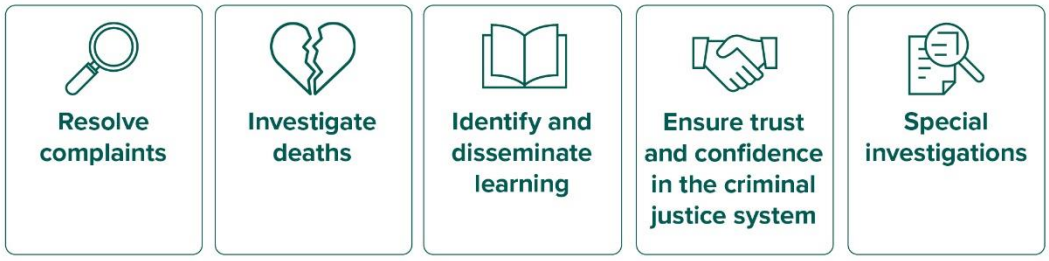
OUR VISION

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Shehu Balogun was found unresponsive in his shared cell at HMP Liverpool on 12 July 2022. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 29 years old. I offer my condolences to Mr Balogun's family and friends.

The post-mortem examination was unable to establish Mr Balogun's cause of death. The pathologist considered that Mr Balogun could have died from a heart condition or from mechanical asphyxiation (when an object or physical force stops a person from breathing) but he was unable to say which was the likely explanation based on the evidence available. The police investigated but no charges were brought in relation to Mr Balogun's death.

The clinical reviewer found that the care Mr Balogun received was equivalent to that which he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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Summary

Events

1. Mr Shehu Balogun was remanded in prison, charged with burglary, on 7 May 2022. He was sent to HMP Altcourse.

2. Mr Balogun received a monthly depot injection for schizophrenia and psychosis and had a history of substance misuse.

3. On 31 May, a psychiatrist noted that Mr Balogun's recent electrocardiogram (ECG, a test to check the heart's rhythm, carried out for individuals on antipsychotic medication) had showed an abnormality. At a multidisciplinary review the following day, a GP agreed to review Mr Balogun's ECG results and his medication. Healthcare staff subsequently agreed that the ECG result was borderline so would be managed by regular monitoring and that Mr Balogun could continue with his depot medication.

4. On 6 June, Mr Balogun was moved to HMP Liverpool.

5. On 16 June, staff offered Mr Balogun an ECG as part of his ongoing health monitoring. Mr Balogun declined, saying that he had had one recently and did not see why he needed another so soon.

6. Around 10.45am on 12 July, an officer was delivering mail to prisoners when Mr Balogun's cellmate told him that Mr Balogun was unresponsive. The officer tried to rouse Mr Balogun, but he did not respond. The officer left the cell to get help from his colleagues as he did not have a radio. When his colleague arrived and realised that Mr Balogun was unresponsive, he radioed a medical emergency code. The officers put Mr Balogun into the recovery position and healthcare staff arrived shortly afterwards. Staff began CPR which was continued by ambulance paramedics when they arrived at 10.57am. However, they were unable to resuscitate Mr Balogun and at 11.22am, pronounced his death.

7. The post-mortem report was unable to ascertain the cause of Mr Balogun's death. The pathologist considered that he had died either from a heart condition or from mechanical asphyxiation caused, for example, by an arm/neck lock. The police investigated whether Mr Balogun's cellmate was involved in his death, but no charges were brought against him.

Findings

8. Staff did not carry out a welfare check on Mr Balogun on the morning of 12 July. The prison carried out an internal investigation, and issued a written warning to the officer who should have carried out the check.

9. The officer who found Mr Balogun unresponsive did not have a radio, so he was unable to radio a medical emergency code straightaway. He had to leave the cell to call a manager, resulting in a delay of around two minutes before the code was called and an ambulance was requested. We consider that the delay is unlikely to

have made a difference to the eventual outcome for Mr Balogun but bring the issue to the Governor's attention.

10. The clinical reviewer found that the healthcare provided to Mr Balogun was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer noted that the discussion with Mr Balogun about a further ECG, which Mr Balogun declined, was not fully documented in his medical record and so it was unclear whether the risks of not having the test were explained to him.

Recommendation

- The Head of Healthcare should remind staff to ensure that patients understand the risks of refusing medical tests and clearly document this in medical records.

The Investigation Process

11. 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.

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

13. NHS England commissioned an independent clinical reviewer to review Mr Balogun's clinical care at the prison.

14. The investigator and clinical reviewer interviewed seven members of staff in September and October 2022. They were unable to interview Mr Balogun's cellmate due to him having a severe learning disability. When the police wanted to speak to Mr Balogun's cellmate, he was deemed not to have the capacity to be interviewed. He was later interviewed by police on 15 March 2024, but provided no additional information on the circumstances of Mr Balogun's death.

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

16. The Ombudsman's office contacted Mr Balogun's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She asked a number of questions, mainly relating to her son's healthcare. We have addressed these issues in this report and the clinical review.

17. We suspended our investigation for 17 months between October 2022 and April 2024, while we awaited the post-mortem report and the outcome of the police investigation.

18. We shared our initial report with the legal representatives of Mr Balogun's mother. They did not raise any factual inaccuracies.

19. We shared our initial report with the Prison Service. The Prison Service did not raise any factual inaccuracies with our report.

Background Information

HMP Liverpool

20. HMP Liverpool is a local prison serving the courts of Merseyside. Spectrum Community Care CIC provides physical healthcare services, Mersey Care NHS Trust provides mental healthcare, and Change, Grow, Live (CGL) provides substance misuse treatment.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Liverpool was in July 2022. Inspectors noted a significant improvement since their last visits in 2017 and 2019. They reported that levels of violence and self-harm had fallen and that the prison was calm and well-ordered, with most prisoners saying they felt safe.

22. Staff-prisoner relationships remained a strength. The culture was positive, most staff were caring and non-judgemental and inspectors noted many good examples of positive interactions.

23. Long-term conditions were managed very well. An identified lead screened the medical records of all new arrivals and arranged onward referrals and appropriate reviews for their condition. Two senior nurse prescribers led on the management of these prisoners and records indicated that all patients with a long-term condition had an up-to-date care plan which was regularly reviewed.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 December 2022, the IMB reported that the prison was a generally safe environment for prisoners.

25. The Board noted that healthcare services were maintained to an appropriate level although staffing was a major challenge for healthcare managers. It found nurses helpful and open in resolving issues and reported that managers were transparent about errors, continually looking to improve systems, procedures and training.

Previous deaths at HMP Liverpool

26. Mr Balogun was the 15th prisoner to die at HMP Liverpool since July 2019. Of the previous deaths, two were self-inflicted, two were drug related and ten were due to natural causes.

Key Events

27. Mr Shehu Balogun was remanded in prison, charged with burglary, on 7 May 2022. He was sent to HMP Altcourse. Mr Balogun had been in prison many times before, often short sentences for breaching a restraining order preventing contact with his mother. He had last been released from Altcourse only two weeks before. Mr Balogun had a history of self-harm but told reception staff that he had no thoughts of harming himself at that time. He said that he did not drink alcohol or use drugs, though his record showed a history of drug and alcohol misuse.

28. In the community, Mr Balogun was being treated under the Care Programme Approach. (CPA, a package used to plan a patient's mental health care.) He was on prescribed medication for his mental health. This included a regular depot injection of aripiprazole (an antipsychotic) for psychosis and schizophrenia. (A depot injection releases the medication into the bloodstream slowly over time, to allow less frequent administration.) Mr Balogun declined a COVID-19 vaccination.

29. On 19 May, Mr Balogun had a health check, which included an electrocardiogram (ECG, a test to check the heart's rhythm), which is standard for those prescribed antipsychotic medication.

30. On 31 May, Mr Balogun saw a psychiatrist. Mr Balogun said that since he had been receiving depot injections, he had not heard voices as often. He said that he had no concerns at present. The psychiatrist discussed with Mr Balogun that his ECG results had identified a borderline abnormality which the GP would consider further. Healthcare staff subsequently assessed that the ECG result was not too concerning and that a cardiology referral was not needed, but they would monitor and review regularly.

HMP Liverpool

31. On 6 June, Mr Balogun attended court and was transferred to HMP Liverpool.

32. Mr Balogun asked for vulnerable prisoner status and was allocated to a shared cell on K Wing, the vulnerable prisoner unit.

33. On 16 June, staff offered Mr Balogun an ECG as part of his ongoing health monitoring. Mr Balogun declined, saying that he had had one recently and did not see why he needed another so soon.

34. On 27 June, Mr Balogun tested positive for COVID-19. He was asymptomatic and said he did not feel affected by it. He and his cellmate were kept in their cell for a period of isolation.

35. On 7 July, a healthcare assistant gave Mr Balogun a vaccination screening review. Mr Balogun said that his father had suffered from heart problems.

36. On 8 July, Mr Balogun told his allocated key worker that testing positive for COVID-19 was restricting his day-to-day activities and he was looking forward to being able to mix with others again. Otherwise, he had no issues to raise.

37. On 11 July, Mr Balogun saw a consultant psychiatrist and a nurse for a psychiatric assessment. The doctor had no concerns about Mr Balogun. He assessed that no changes were required to his medication.

38. At around 7.00pm that evening, an officer carried out a routine check of all prisoners on the wing and noted no concerns.

12 July

39. No checks were scheduled for Mr Balogun or his cellmate during the night, and at no point did they operate their emergency cell bell. An officer made a morning routine check at approximately 4.40am on 12 July. She found no issues of concern.

40. Another officer came on duty at around 7.30am. He said that he unlocked prisoners who were getting medication or going to work, and this took place between 7.50am and 9.00am. Mr Balogun's cell was not unlocked.

41. During the morning, another prisoner went to Mr Balogun's cell to see him. The cell was locked so Mr Balogun's cellmate spoke to him through the door. He said that Mr Balogun was asleep, and he did not want to wake him. The other prisoner described seeing Mr Balogun lying in bed under a blanket with his eyes closed and his hands in a 'prayer pose'. Another prisoner also went to the cell to speak to Mr Balogun. Again, Mr Balogun's cellmate said that he did not wish to wake Mr Balogun. The prisoner said he could see Mr Balogun in bed, apparently asleep, so he left.

42. An officer was delivering mail when he arrived at Mr Balogun's cell at 10.46am. He opened the door and Mr Balogun's cellmate said that Mr Balogun was unresponsive. The officer tried to get a response from him but was unable to do so. He said that Mr Balogun was lying on his side with his hands crossed across his chest. He said that he felt that something sinister may have occurred.

43. The officer did not have a radio, so he locked the cell and went to find a Custodial Manager (CM) to report that he had an unresponsive prisoner. As they returned to the cell, the CM used his radio to ask the emergency response nurse to attend. When they got to the cell, the CM looked through the observation panel and then radioed a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately). The officer and CM went into the cell and tried to rouse Mr Balogun, without success. The officer felt for a pulse but was unable to find one, so they put Mr Balogun into the recovery position.

44. Other staff had responded to the emergency call, including healthcare staff. CCTV footage shows that the emergency response nurse arrived at 10.49am. She assessed Mr Balogun and found he was not breathing and had no pulse. She started CPR, assisted by officers and nurses. Staff applied a defibrillator (a machine used to give an electric shock to restart a person's heart if they are in cardiac arrest), but it recommended continuing with CPR. Staff did so until ambulance paramedics arrived at 10.57am and took over. At 11.22am, paramedics declared that Mr Balogun had died.

Information received after Mr Balogun's death

45. After Mr Balogun's death, other prisoners told the police that they often heard Mr Balogun arguing with his cellmate and they had heard them arguing in the early hours of 12 July. Mr Balogun's cellmate was deemed not fit for interview due to learning disabilities and complex needs. He was interviewed by police in March 2024, when he provided a prepared statement and gave a "no comment" interview. The police closed their investigation.

46. There were no entries in Mr Balogun's prison record to indicate either that he had raised any concerns about his relationship with his cellmate, or that staff had heard them arguing or had any concerns.

Contact with Mr Balogun's family

47. On 12 July 2022 at around 2.30pm, the Governor and the prison's family liaison officer visited Mr Balogun's mother at home to tell her that her son had died. The Prison Service offered a contribution to the funeral expenses in line with national instructions.

Support for prisoners and staff

48. A prison 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.

49. The prison posted notices informing other prisoners of Mr Balogun's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Balogun's death.

Post-mortem report

50. The post-mortem examination was unable to ascertain the cause of Mr Balogun's death. Toxicology tests found no traces of alcohol or drugs. The pathologist noted that the post-mortem identified findings to support the possibility of two types of death. Firstly, possible hypertrophic cardiomyopathy, an inherited heart condition which can cause sudden cardiac death. Secondly, possible mechanical asphyxia such as if someone is held in a head lock. The pathologist concluded that there was insufficient pathological evidence to confirm the cause of death and recorded that it was unascertained.

Findings

Cause of death

51. It is unclear how Mr Balogun died. The pathologist provided two alternatives, a sudden cardiac event or asphyxiation, but he could not offer an opinion on which was the likely cause based on the evidence available. The police investigated and interviewed Mr Balogun's cellmate, but no charges were brought in relation to Mr Balogun's death.

Clinical care

52. The clinical reviewer concluded that the healthcare Mr Balogun received was of a good standard and equivalent to that which he could have expected in the community.

53. Mr Balogun had an ECG on 19 May while at HMP Altcourse, which showed a borderline abnormality. He was offered a further ECG at Liverpool on 16 June, which he declined. The clinical reviewer noted that the medical records do not document any discussion with Mr Balogun about this and the potential risks in not taking the test. We make the following recommendation:

    The Head of Healthcare should remind staff to ensure that patients understand the risks of refusing medical tests and clearly document this in medical records.

Welfare checks at unlock

54. Prison Service Instruction (PSI) 75/2011 on Residential Services says that when prisoners are unlocked in the morning there must be "positive engagement between staff and prisoners ... The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock".

55. In April 2020, during the COVID-19 pandemic when prisons were not operating a standard regime and prisoners were locked in their cells for longer periods, the acting COVID lead at Liverpool sent an email to all residential custodial managers, advising that prisoners should not be left unchecked for a lengthy period of time. Wing managers were asked to decide "who and how" welfare checks were made on prisoners not being let out of their cells in the morning. The email said that the checks would need to be recorded in either the wing observation book or a line in the daily management book. In August 2020, the Head of Residence sent an email to all managers reminding them that prisoner welfare checks must be made after morning staff briefings and must be signed for in the wing roll book. He added that "good practice is to also put a time as to when these checks have been completed".

56. In July 2022, Liverpool's regime was adapting from restrictions that had been imposed during the COVID-19 pandemic. Prisoners on K Wing who were undertaking employment or education would be unlocked to attend their work. Other prisoners, which included Mr Balogun and his cellmate, would remain in their cells

apart from a period of 45 minutes a day. Prisoners were given breakfast packs the previous evening, so did not need to be unlocked for breakfast. The CM said he encouraged staff on his wing to do welfare checks by 9.00am.

57. The officer who discovered Mr Balogun did not conduct a welfare check on him or his cellmate until 10.46am. During the prison's internal investigation, he said that he had not had guidance, either in writing or verbally, on what a welfare check entailed until after Mr Balogun had died. While managers had been emailed as above, Liverpool had not issued a formal instruction to staff telling them when to make welfare checks or where to record them.

58. As a result of the prison's internal investigation, the officer received a written warning. On 22 July 2022, the Governor issued a Notice to Staff reminding them of their responsibilities around making welfare checks on prisoners, including signing the daily management book to confirm that they had made the checks. We therefore do not make a recommendation.

Emergency response

59. When the officer found Mr Balogun unresponsive, he did not have a radio and had to leave the cell to alert the CM, who then radioed the code. This resulted in a two-minute delay between Mr Balogun being found and the code being called, which meant there was a delay in healthcare staff being alerted and the ambulance being requested.

60. The prison told us that not all officers on the landings had radios, though there would always be some designated roles on the landing who would carry radios. We accept that it is not a requirement that every member of wing staff has a radio. However, staff need to be clear on the process to follow if they are not carrying a radio and encounter a medical emergency, so that any delays in calling a code over the radio network are avoided. We bring this to the Governor's attention.

Inquest

61. At the inquest, heard from 6 to 15 October 2025, the jury recorded an open conclusion. They were unable to establish Mr Balogun's cause of death on the evidence provided.

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