Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Malcolm MacDougal, a prisoner at HMP Full Sutton, on 30 September 2024

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 Malcolm MacDougal died on 30 September 2024, of a brain haemorrhage caused by use of a synthetic cannabinoid and high blood pressure, while a prisoner at HMP Full Sutton. He was 74 years old. I offer my condolences to Mr MacDougal's family and friends.

The investigation found that staff were responsive to instances of suspected substance misuse, as well as Mr MacDougal's persistent refusal to cooperate with drug tests. However, there is no documented evidence that he was referred to the substance misuse service.

There was a delay in calling a medical emergency when Mr MacDougal was found to be unresponsive and a further delay in requesting an ambulance. While there is no evidence that this affected the outcome, delays of this kind must be minimised to allow the best opportunity of effective treatment and recovery.

As we have found previously at Full Sutton, staff did not comply with the key requirements of assessing risk in the use of restraints. Namely, full account should be taken of the prisoner's medical condition at the time of the risk assessment and restraints should not be used during invasive treatment. The use of restraints while Mr MacDougal was in a coma calls into question staff attitudes to affording dignity to those in a critical condition and reflects poorly on the prison.

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 **December 2025**

Contents

Summary

Events

1. Mr Malcolm MacDougal was sentenced to life imprisonment in 1982, for wounding with intent. He had been at Full Sutton since 8 December 2007.

2. Mr MacDougal's health conditions included high blood pressure and mental health disorders. He also had a history of drug and alcohol misuse. Staff suspected that he used illicit drugs and security intelligence reports suggested that he might be involved in other activity linked to drug dealing. In June 2024, Mr MacDougal lost consciousness after suspected drug use, but recovered without going to hospital. He persistently refused to take drug tests.

3. At around 4.45pm on 30 September 2024, a prison officer conducting a welfare check was concerned that he did not get a clear response from Mr MacDougal, although he was noticeably breathing. A senior officer radioed a medical emergency code blue at 5.01pm and an ambulance was requested at 5.09pm. Healthcare staff attended but Mr MacDougal's breathing worsened and he remained unconscious.

4. Paramedics took Mr MacDougal to hospital and tests confirmed an intracerebral haemorrhage. Doctors withdrew his ventilation and confirmed life extinct at 9.36pm.

Findings

5. Full Sutton has a wide-ranging drug strategy and staff have implemented initiatives to reduce the demand for and supply of illicit drugs, which are monitored at a monthly multidisciplinary meeting. However, the overarching drug strategy document needs to be current and visibly updated.

6. There was clear guidance on handling prisoners under the influence of illicit substances. Staff generally complied with the process by documenting events, sharing information, considering risk and taking disciplinary action. However, we are concerned that there was no evidence of referrals to the substance misuse service, particularly after incidents of apparent drug use.

7. The clinical reviewer concluded that Mr MacDougal's clinical care was partially equivalent to that which he could have expected to receive in the community. His conclusion was based partly on the lack of referrals to the substance misuse service, but he also found weaknesses in other areas of Mr MacDougal's clinical management that were not related to his cause of death.

8. We are concerned that it took around 16 minutes to establish that Mr MacDougal was unconscious and call a medical emergency code. There was then a significant and inexplicable delay in requesting an ambulance after the medical emergency was notified.

9. Although Mr MacDougal was unconscious, restraints were used for the journey to hospital and were in place after he was sedated in the critical care unit. The issue of inappropriate use of restraints has been raised with the prison before. We remain concerned that staff either do not understand or are resistant to taking account of

factors such as mobility and state of health when completing security risk assessments.

Recommendations

- The Governor and Head of Healthcare should ensure that there is a robust and auditable process to refer prisoners suspected of using illicit substances to the substance misuse service.
- The Governor and Head of Healthcare should implement further measures to ensure that staff are appropriately skilled to complete and authorise escort risk assessments; decisions are based on a prisoner's medical condition and the actual risk they present at the time; and restraints are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.
- The Governor should ensure that staff call a medical emergency code without delay if a prisoner remains unresponsive after attempts to rouse them and that an ambulance is requested immediately after the code is called.

The Investigation Process

10. HMPPS notified us of Mr MacDougal's death on 1 October 2024.

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

12. The initial investigator obtained copies of relevant extracts from Mr MacDougal's prison and medical records, as well as detailed staff statements.

13. NHS England commissioned a clinical reviewer to review Mr MacDougal's clinical care at the prison. The initial investigator and the clinical reviewer interviewed a member of the healthcare staff on 4 November 2024. In addition, The clinical reviewer had informal discussions and email exchanges with additional healthcare staff.

14. The final investigator completed the latter stages of the investigation. She obtained additional documents and local policies relevant to the cause of death and had a meeting with the prison's drug strategy lead on 9 April 2025.

15. We informed HM Coroner for Hull and East Riding 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 MacDougal's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not reply.

17. The initial report was shared with HMPPS. They found no factual inaccuracies and their action plan has been annexed to this report.

Background Information

HMP Full Sutton

18. HMP Full Sutton is a high security prison that holds adult male prisoners. Spectrum Community Health CIC provides health services, and healthcare staff are on duty 24 hours a day.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Full Sutton was in March 2024. Inspectors reported that the prison was stable and mostly safe, with a good Governor and leadership team. The prison scored 'reasonably good' on most of the healthy prison tests including safety and respect, but purposeful activity had deteriorated.

20. Inspectors found that the drug strategy had been recently reviewed and the monthly drug strategy meeting was well attended, but there were delays in completing identified actions. They noted that 41% of prisoners surveyed said it was easy to get drugs. The positive rate for mandatory drug tests (MDTs) in the previous 12 months was 5.4%, lower than in other similar prisons. Suspicion tests were not always completed. For example, in the month before the inspection, only six of 34 requested suspicion tests were carried out, despite a full staff complement.

21. The substance misuse and mental health services (known as the recovery team) worked closely together, and the prison shared positive MDT results. Referrals to the team were accepted from all sources, including self-referrals by patients. They were discussed in a daily meeting and subsequent assessments were timely.

Independent Monitoring Board

22. 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 2024, the IMB reported that the prison was generally calm. Although staffing was at the target level, daily shortages through sickness and other absences had adversely impacted on aspects of the regime, such as drug testing, safety and key work sessions. The capacity for drug testing had reduced and there had been an increase in positive results.

Previous deaths at HMP Full Sutton

23. Mr MacDougal was the 10th prisoner to die at Full Sutton since September 2021. Of the previous deaths, nine were from natural causes and one was self-inflicted. As of mid-July 2025, there had been seven further deaths, five due to natural causes and two self-inflicted. We have previously raised concerns about poor risk assessments and the inappropriate use of restraints.

Psychoactive substances (PS)

24. The term psychoactive substances is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazene) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

25. PS 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 these substances 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, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for synthetic cannabinoids is in place in prisons as part of existing mandatory drug testing arrangements.

Key Events

Background

26. On 12 July 1982, Mr Malcolm MacDougal was sentenced to life imprisonment, with a tariff of 10 years, for wounding with intent to cause grievous bodily harm. He spent time in several prisons and moved to HMP Full Sutton on 8 December 2007.

27. Mr MacDougal's health conditions included hypertension (high blood pressure), irregular heartbeat, musculoskeletal disorders (neuralgia, neck and spine degeneration), depression and personality disorder. A care plan was in place to manage his blood pressure. He received daily medication for his mental health conditions, but was not under the care of the mental health team.

28. Mr MacDougal had a longstanding history of cannabis and alcohol misuse. For many years, he received strong painkillers, such as tramadol, gabapentin and pregabalin, for his musculoskeletal conditions. However, in March 2018, the GP at the prison stopped prescribing pregabalin as Mr MacDougal was suspected of using illicit drugs. No painkillers were prescribed during the year before his death.

29. Mr MacDougal had a consistent prison key worker, who regularly offered meetings. He often declined, but when he agreed, he would not discuss anything in depth.

2022 and 2023

30. There were many intelligence reports linking Mr MacDougal to drugs as a user, debtor, debt collector for other prisoners' debts and other illegal activity. He often refused to take mandatory drug tests (MDTs) and penalties included periods of cellular confinement in the segregation unit. It was noted that Mr MacDougal had a pattern of accruing debt and then asking to move wings. Staff twice opened a Challenge, Support and Intervention Plan (CSIP) to consider providing formal support as a potential victim of violence but concluded that it was not required.

31. Mr MacDougal had a very large sum of private cash. Following an altercation with another prisoner in March 2022, he told a custodial manager and wing officers that he owed hundreds of pounds, which he did not intend to pay back. The information was passed to the prison's dedicated search team, safer custody team and the wing manager. Mr MacDougal self-isolated for a period, for his own safety.

32. In June and September 2023, it was recorded that all or part of Mr MacDougal's weekly purchases from the prison shop, including vapes, were immediately given to another (named) prisoner.

33. On 12 October, Mr MacDougal refused to undertake a suspicion mandatory drug test (MDT). It was noted that he had refused 14 out of 24 tests at Full Sutton. He was placed on report and charged with refusing a lawful order. (The charge was later proven, and the penalty was 14 days cellular confinement.) On 19 October, the dedicated security team conducted a full search of his cell and nothing was found.

2024

34. From time to time, over many years, staff at Full Sutton suspected Mr MacDougal of being under the influence of drugs or demonstrating behaviour linked to illicit activity. In January 2024, the healthcare department wrote to offer him support from the substance misuse service and he declined.

35. A security intelligence report indicated that on 5 January 2024, Mr MacDougal went into another prisoner's cell empty handed and left with a handful of tablets which he put in the medication bag in his own cell. The other prisoner left the cell with some vape capsules. They were suspected of trading medication, with vapes as payment. In response to this, referrals were submitted for MDTs; the healthcare department was asked to check if Mr MacDougal's prescribed medication was tradeable and of interest to other prisoners; and the wing manager was asked to consider a medication check on Mr MacDougal, as well as an intelligence-led cell search for both prisoners. (A few weeks later, Mr MacDougal appeared to give away the items he had ordered from the prison shop.)

36. Mr MacDougal had an annual hypertension review on 25 January. Although his blood pressure reading was outside of the normal range, he reported no symptoms and said he continued to take his medication as prescribed.

37. On 27 January, Mr MacDougal claimed he had run out of prescribed medication, despite having recently received a months' supply. Mr MacDougal appeared to be under the influence of drugs as he could not maintain his balance or walk properly. He was referred for a mandatory drug test. Wing and healthcare staff were briefed and the Drug Strategy Lead was informed via the monthly report submitted to the drug strategy meeting. On 30 January, Mr MacDougal refused to attend the MDT test suite and was placed on report for disobeying an order. He was later given 14 days cellular confinement.

38. After reporting mild tightness of his chest on 28 February, tests were taken which showed that Mr MacDougal might have had a heart attack. On 21 May, he declined to go to hospital for urgent assessment and did not attend a follow up appointment with healthcare staff the next day. Dr A, GP, referred him to the rapid access pain clinic at a local hospital. (Owing to a miscommunication by the hospital, Mr MacDougal did not attend an appointment scheduled for 6 August and he died before this could be rearranged.)

39. On 15 June, two prisoners told staff that Mr MacDougal was unwell. Officer A found him slumped in his chair, breathing but verbally unresponsive, apparently under the influence of drugs. The officer called a code blue medical emergency (which indicates that a prisoner is either unresponsive or has difficulty breathing). An ambulance was requested and later stood down.

40. While Matron A and Nurse A were examining Mr MacDougal, his condition improved. He denied using drugs, but staff found a tampered vape with a suspicious substance, which was sent away for analysis. Mr MacDougal repeatedly refused to go the healthcare centre, so he was monitored in his cell. The Drug Strategy Lead was informed and the information was submitted to the drug strategy meeting. The dedicated search team later searched his cell but nothing further was found.

41. In July, there were further intelligence reports about Mr MacDougal using drugs and being one of several prisoners whose purchases from the shop were redistributed on the unit. At a key worker session on 12 July, Mr MacDougal said that he had not been called for an MDT as expected but, "if I was under the influence, it's too late now anyway".

42. On 3 August, wing staff saw several people (including Mr MacDougal) going into another prisoner's cell with their lunch and leaving with different items such as cereal bags and containers. On 15 August, the search team conducted a full search of Mr MacDougal's cell, but no contraband was found.

43. A nurse was due to review Mr MacDougal's heart condition on 24 September, but due to a medical emergency, he was placed on the waiting list for the next clinic.

Events of 30 September

44. At approximately 4.45pm, while counting and checking the wellbeing of prisoners, Officer B looked through the observation panel of Mr MacDougal's cell and saw that he was lying on the floor in an unusual position. Officer B went into the cell and shouted his name. He described Mr MacDougal as responding sleepily and audibly breathing, with consistent rise and fall of his chest. He checked for bruising or blood around his head. Officer B sought advice from Officer C, who went back to the cell with him to check again. They did not get a response when they called out to Mr MacDougal, but both believed he was in a deep sleep as he was visibly breathing.

45. As Officer B was uncomfortable with locking the cell without getting a clear response, he decided to phone healthcare staff for advice. On the way to the office, he met Supervising Officer (SO) A, who also went to the cell and saw that Mr MacDougal was breathing. However, as he could not get a response, SO A called a code blue emergency at 5.01pm.

46. Additional staff arrived and there was discussion as to whether Mr MacDougal might be under the influence of PS. Officer D noticed that Mr MacDougal's breathing worsened and appeared to be intermittent, so he placed him in the recovery position.

47. Custodial Manager (CM) A, the operational manager in charge of the prison, arrived at the cell at 5.06pm. The communications room requested an ambulance at 5.09pm.

48. Nurse B was the first of the healthcare team to arrive and saw that Mr MacDougal was breathing but unresponsive. Nurse B gave him oxygen and a shot of naloxone (an emergency antidote to opioid overdoses). He also set up the defibrillator and placed the pads on Mr MacDougal, as a precaution, but it was not used as he was still breathing independently. Nurse A and Healthcare Support Worker A arrived shortly afterwards.

49. At 5.19pm, Mr MacDougal stopped breathing and a further call was made to the ambulance service. The first ambulance arrived at the prison at 5.35pm and two others followed within five minutes.

50. The paramedics suspected that Mr MacDougal had had a brain haemorrhage and took him to hospital, leaving the prison at 6.36pm. Two prison officers escorted him, using an escort chain (a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer).

51. The hospital placed Mr MacDougal in an induced coma at around 7.30pm. With the permission of Mr A, the prison's duty governor, the escort chain was temporarily removed for a CT scan at 8.10pm and reapplied at 8.25pm. The scan detected an intracerebral haemorrhage and the restraints were permanently removed at 8.45pm.

52. At 9.15pm, the hospital withdrew Mr MacDougal's ventilation and a doctor pronounced life extinct at 9.36pm.

Contact with Mr MacDougal's family

53. When it became clear that Mr MacDougal was likely to die, the hospital asked for the contact details for his next of kin. Both the hospital consultant and the prison tried to telephone a landline number noted in his personal records and thought to be that of his mother, to inform her of Mr MacDougal's critical condition before his life support was withdrawn. There was no answer.

54. Mr MacDougal's brother was listed as next of kin in his personal records, with no telephone number or address. Another brother was identified from Mr MacDougal's telephone records and several attempts were made to call him. Mr MacDougal's probation officer had no additional details.

55. On 2 October, the prison's family liaison officer emailed the police, asking for help to contact Mr MacDougal's brother. On 3 October, he contacted a third brother, who agreed to help with contacting the brother listed in the telephone records and he eventually made contact on 8 October.

56. With the agreement of family members, the family liaison officer arranged Mr MacDougal's funeral and the prison paid the full costs.

Support for prisoners and staff

57. After Mr MacDougal's death, Mr A debriefed the escort officers at the hospital. He offered support and reminded them of the other avenues of support, such as the staff care team.

58. The prison posted notices informing other staff and prisoners of Mr MacDougal's death and offering support.

Information received shortly after Mr MacDougal's death

59. The day after Mr MacDougal died, a prisoner told wing staff that he expected the wing to be locked down and searched due to the amount of drugs and that it was "really bad." The information was recorded in the wing observation book. It was also shared with the dedicated search team, healthcare department and functional heads.

Post-mortem report

60. A post-mortem examination was held. The report concluded that the cause of Mr MacDougal's death was intracerebral haemorrhage (bleeding in the brain) due to synthetic cannabinoid ingestion and hypertension.

61. The toxicologist explained that the use of synthetic cannabinoids can cause an increase in blood pressure and this, in turn, increases the risk of intracerebral haemorrhage. Mr MacDougal was at particular risk due to his medical history of hypertension.

Findings

Drug strategy at Full Sutton

62. Full Sutton has a comprehensive drug strategy document, including a discrete section with mandatory actions to be taken when a prisoner is suspected of being under the influence of psychoactive substances. Elements of the strategy are actively and transparently addressed at monthly multidisciplinary drug strategy meetings.

63. Mr B, Head of Reducing Reoffending and Drug Strategy Lead said the key substance misuse issue at Full Sutton is the use of synthetic cannabinoids. Previously, PS was predominantly trafficked on paper and used in vape pens. Since January 2025, the prison has addressed this by photocopying all mail and encouraging the use of an email system bespoke to prisons, which also has the benefit of being cheaper for families. The drug strategy minutes indicated that the introduction of in-cell phones has also reduced the flow of mail.

64. It became evident that some mail had been falsified to be represented as legal correspondence as a route of supplying drugs. In response to this, the prison had launched a bar code system. Apart from a couple of instances some time ago, there had been no problem with drones as a source of trafficking, largely due to the remote location. However, the prison was alert to the possibility of increased drone activity following the opening of HMP Millsike, a new prison neighbouring Full Sutton.

65. Mr B said there was a low level of diverted prescription medication. He added that the prison had a good pharmacist who reduced medication or changed to an alternative if a prisoner's medicine became ineffective because of extended use. Those found under the influence had their prescription reviewed to ensure no clinical contraindications.

66. The prison is required to complete MDTs on 5% of prisoners (29-30 of a population of 594) per month. The positive rate is around 8%. They also conduct some suspicion testing but, owing to staff resource issues, MDTs are prioritised. For prisoners such as Mr MacDougal who repeatedly refuse to take MDTs, the penalties are increased at each subsequent adjudication.

67. Before recent changes to the national discipline policy and adjudication process, the prison gave first time drug offenders a suspended award, with the proviso that they engage with the drug treatment services. They have continued to do so for first time offenders and those with a long gap since they were previously found under the influence of drugs. The aim of the process is to ensure the men were supported to become drug-free, rather than taking punitive awards which might lead to them borrowing and getting into debt.

68. Mr B felt there were good relationships and communication channels across the prison's departments. A process was in place for sharing information, such as intelligence reports, with the SMS team via the drug strategy custodial manager. The dedicated search team shares information about finds at the drug strategy meeting, which should lead to referrals or visits to the prisoners concerned. As to

communication with prisoners, drug alerts are issued in the prison's community newsletter to inform prisoners of dangerous batches of drugs found in the community. This includes information on the composition of the drugs, effects and fatalities.

69. Relationships with the police were also said to be good. In the previous six months, there had been at least two joint operations with the local police on site in the car park and the use of active dogs. The drug strategy minutes reflected that the pharmacist is part of the Local Drugs Intelligence Service (LDIS) which provides information about substances in the community and drug supply lines.

70. The prison was alert to the possibility of staff corruption. Full searches of staff are conducted at different times of the day and in various areas of the prison.

71. We are satisfied that Full Sutton has a wide ranging and coherent drug strategy, with formal structures and processes to address substance misuse issues.

Support for substance misuse

72. Full Sutton's Staff Information Notice 35/2024 *Procedures for Suspected Substance Misuse* provides information on substances in the community which have led to fatalities. It also gives clear and detailed guidance on several steps to be taken when staff suspect a prisoner is under the influence of an illicit substance. These include notifying the healthcare department and monitoring the prisoner; informing the Recovery and Drug Strategy Team; completing a referral for a mandatory drug test; consideration of disciplinary procedures; and reviewing the prisoner under the incentives scheme. It also specifies that incident and intelligence reports should be completed, as well as an entry in the prisoner's personal records.

73. Mr B knew Mr MacDougal well and had asked him several times why he took drugs. He gave no particular reason, but replied along the lines of, "I do it because I do it". As Mr MacDougal was not classified as a prolific user and had not been known to use drugs frequently, Mr B did not think a frequent testing programme would have been particularly helpful to Mr MacDougal.

74. For the most part, prison staff actively addressed suspicious behaviour by Mr MacDougal in line with expected practice. Information was shared with relevant departments and key staff such as Mr MacDougal's key worker; and intelligence reports were triaged, with well documented consideration of risk and whether it was relevant to other security information gathered. However, we share the clinical reviewer's concern that there was no documented evidence that Mr MacDougal was referred to the substance misuse service, particularly after incidents of suspected substance misuse in 2024. We recommend:

The Governor and Head of Healthcare should ensure that there is a robust and auditable process to refer prisoners suspected of using illicit substances to the substance misuse service.

Clinical findings

75. The clinical reviewer concluded that Mr MacDougal's clinical care was satisfactory and partially equivalent to that which he could have expected to receive in the community. He identified several weaknesses, including concerns that there had been no mental health care plan in place since 2010, nor a substance misuse care plan. The reasons given by the Head of Healthcare were that Mr MacDougal had been discharged from the mental health team and had declined to engage with the substance misuse service in recent years. The clinical reviewer noted that his mental health condition had remained stable due to his medication.

76. We have reflected the clinical reviewer's concerns about Mr MacDougal's substance misuse care in the recommendation above. The Head of Healthcare will wish to consider the other recommendations by the clinical reviewer, which are not directly related to the cause of Mr MacDougal's death.

Restraints, security and escorts

77. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

78. A judgment in the High Court in 2007 (known as the Graham Judgement) made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

79. The medical section of the risk assessment form was ticked to indicate that Mr MacDougal had impaired mobility; life-saving treatment was required; his condition did not restrict his ability to escape unaided; there were no medical objections to the use of restraints and they did not need to be removed for treatment or consultation.

80. At interview, Nurse B said that he had completed the form in a hurry and had ticked "no" to the question of whether Mr MacDougal's condition restricted his ability to escape, as he thought the question was simply whether he had the ability to escape unaided. Nurse B was clear that, despite the indication on the form, Mr MacDougal's was unable to escape unaided as he was unconscious. He attributed the error on the form to his misinterpretation of the question and voluntarily suggested he might benefit from further guidance.

81. It was recorded on the risk assessment that Mr MacDougal had been on the Escape List (E-list) between 1998 and 2014. (The incidents linked to this had occurred between 1966 and 2010 and related to his skill in replicating prison keys.) His risk of escape and risk to the public were assessed as medium, due to his index offence and previous E-list status. All the other specific factors of concern were low risk. The form explicitly stated that Mr MacDougal was not thought to have the resources to fund an escape and described him as "an old man with mobility issues

and a registered PEEP" who had attended hospital previously with no incident. (Personal Emergency Evacuation Plan (PEEP) is a tailored plan to help people with mobility issues leave a building in the event of an emergency.)

82. Although Mr MacDougal was unconscious, he was restrained on the way to hospital and the escort chain remained in place while he was under sedation in the resuscitation and critical care units. It is unclear why the restraints were reapplied after the CT scan.

83. The reason recorded for recommending use of an escort chain was, "Cat B prisoner in HSE" and it was noted that the restraints could only be removed with the permission of the duty governor in the event of a life-threatening emergency. In a statement, Mr A said that he had authorised the escort chain as he knew that Mr MacDougal had struggled with drugs and alcohol, and prisoners can quickly recover from the use of synthetic cannabinoids and become violent.

84. We identified similar concerns about assessing risk and the inappropriate use of restraints in two investigations a few months before Mr MacDougal's death and the prison undertook to implement a robust process for varying the level of restraints, including regularly reviewed risk assessments compliant with the guidance on medical considerations and risks. We remain concerned that staff at Full Sutton do not fully understand the rationale for completing risk assessments. In particular, risk should not be assessed solely on a prisoner's index offence but should take account of the prisoner's state of health and mobility. Restraining a comatose man reflects poorly on the prison's attitude to dignity and decency. We recommend:

The Governor and Head of Healthcare should implement further measures to ensure that staff are appropriately skilled to complete and authorise escort risk assessments; decisions are based on a prisoner's medical condition and the actual risk they present at the time; and restraints are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.

Emergency response

85. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes* and Governor's Order 2/2020 *Emergency Response Codes in Custody* set out the actions staff should take in a medical emergency. They contain mandatory instructions on efficiently communicating the nature of a medical emergency and stipulate that if an emergency code is called, an ambulance must be called immediately.

86. It is concerning that it took around 16 minutes for staff to determine that Mr MacDougal was unconscious and not sleeping. We acknowledge that the officer who conducted the welfare check thought he initially heard a faint response and conscientiously sought advice from others due to a nagging uncertainty. However, several other staff also checked within that time and the consensus seemed to have been that he might be in a deep sleep. Given the prevalence of illicit drugs, staff need to be alert to the possibility that a prisoner might be unconscious even if their breathing pattern appears normal. This is particularly the case if they cannot be roused. We believe that a code blue should have been called sooner. It is worrying that staff and a manager did not adhere to a longstanding and important process,

which is in place to help achieve the best outcome for prisoners who are seriously ill. We recommend:

The Governor should ensure that staff call a medical emergency code without delay if a prisoner remains unresponsive after attempts to rouse them.

87. There was a significant delay of eight minutes between the code blue call and the request for an ambulance. The handwritten incident log notes that the operational manager was informed of the code blue at 5.02pm, arrived on the wing at 5.06pm and the ambulance was called at 5.09pm. While the reasons are not entirely clear, we were told that there was delay in getting basic information from the wing to pass to the emergency services. The prison has since conducted a review and further guidance has been issued to all staff, including those who work in the communications room. There is no evidence that the delay impacted adversely on the outcome for Mr MacDougal and we are satisfied that Full Sutton has taken steps to address this.

Governor to note

Notifying Mr MacDougal's next of kin

88. The security risk assessment form had two options for informing a prisoner's next of kin that they had been taken to hospital - within 48 hours, or immediately. Although it seemed clear at the outset that Mr MacDougal was in a grave condition, it was ticked to indicate the former. Staff may need to be reminded of the requirement under Prison Rule 22 to inform next of kin immediately if a prisoner is seriously ill.

89. Prison staff were responsive to the hospital's request for information, but Mr MacDougal's next of kin details were not up to date. It is inevitable that next of kin contact details might change over the course of time, particularly for older, long-term prisoners such as Mr MacDougal. There should be a clear process for updating such details, so that staff can contact families quickly, in line with national instructions.

Drug strategy document

90. The copy of the drug strategy document provided for the investigation was completed in January 2021, with a review date of October 2023. It is unclear whether that review took place. A visibly up-to-date document would give greater confidence that the strategy fully underpins Full Sutton's approach to tackling substance misuse and takes account of changes over time, such as changes in demand and supply routes.

Inquest

91. At an inquest held on 8 December 2025, the coroner concluded that Mr MacDougal died from an intracerebral haemorrhage caused by the combination of synthetic cannabinoid ingestion in a background of hypertension.

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Independent Investigations

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