Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Giles a prisoner at HMP Moorland on 6 April 2016

A report by the Prisons and Probation Ombudsman
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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 Giles was found hanged in his cell at HMP Moorland on 6 April 2016. He was 25 years old. I offer my condolences to Mr Giles' family and friends.

While Mr Giles had some risk factors for suicide and self-harm, I am satisfied that there was little to indicate that he was at heightened risk in the period before his death. Despite this, I am concerned that staff did not operate suicide and self-harm prevention procedures effectively some months before his death. There were also deficiencies on the morning of Mr Giles' death, including a delay of several minutes before anyone opened his cell.

More generally, the investigation has found evidence that Mr Giles had been taking new psychoactive substances (NPS) at Moorland and, at the time of his death, may have been in debt as a result. I share the concerns of the Chief Inspector and the Independent Monitoring Board that the prison needs to do more to reduce both supply and demand for NPS.

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 **November 2016**

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Summary

Events

1. Mr James Giles was remanded in custody in November 2012 and, in March 2013, sentenced to seven and a half years in prison. He was transferred to HMP Moorland in April 2013. Mr Giles had been in prison before, in Jersey, where he had reportedly tried to take his life earlier in 2012.

2. On 29 October 2015, Mr Giles tried to hang himself. Prison staff began suicide and self-harm prevention procedures (known as ACCT). Mr Giles said he could not remember trying to take his life, and prison and healthcare staff suspected he had taken a new psychoactive substance. No one referred him to the substance misuse team. Prison staff ended ACCT monitoring on 2 November.

3. In January 2016, Mr Giles began treatment for post-traumatic stress disorder. The cognitive behaviour therapist who treated him said that Mr Giles did well in the programme and she was happy for him to finish treatment on 31 March.

4. On 29 February, Mr Giles stole tobacco from his place of work. A friend of Mr Giles' said he did so to pay off a debt he had accumulated for drugs. Another prisoner told workshop staff that other prisoners might assault Mr Giles as his theft meant they would not receive a bonus payment. A safer custody officer investigated the threat, but did not interview Mr Giles.

5. Mr Giles' friends said he accumulated more debts for drugs in the time leading up to his death. At around 5.54am on 6 April, the night patrol officer found Mr Giles hanging from a ligature in his cell. He telephoned a medical emergency code, but did not open the cell. When the night orderly officer arrived, at around 5.57am, he removed the ligature and found that rigor mortis appeared to be established. The night orderly officer began cardiopulmonary resuscitation, but left the cell at 5.59am. Paramedics arrived at 6.15am and recorded that Mr Giles had died.

Findings

6. Although Mr Giles had some risk factors for suicide and self-harm, we found there was little to indicate to prison staff that he was at heightened or imminent risk in the period before his death. We consider that it would have been difficult for staff at Moorland to have foreseen or prevented his actions on 6 April. However, when he was managed under ACCT suicide and self-harm prevention procedures in October 2015, we are concerned that prison staff did not consider all of the issues that led to procedures being started, and the document was closed before those issues that had been identified were fully addressed.

7. Although there was evidence that Mr Giles used new psychoactive substances, no one referred him to the substance misuse team. Prison staff missed opportunities to identify that Mr Giles might be in debt to other prisoners - and therefore to support him – most notably, when he stole tobacco from his workshop.

8. We found that the night patrol officer took too long to go into Mr Giles' cell and, when he found him hanging, did not call for help through the most effective means. Staff unnecessarily tried to resuscitate Mr Giles when it was clearly too late.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with national guidance, including that:
    - ACCT caremap actions are specific and meaningful, identify all of the issues identified during the assessment interview and case reviews and that ACCT monitoring does not stop until all caremap actions have been completed.
    - Case managers have relevant training.
- The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.
- The Governor should ensure that prisoners who use new psychoactive substances are referred to drug treatment services and warned about the dangers and risks to health.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
    - Night staff use their radio to communicate the nature of a medical emergency quickly and effectively.
    - Night staff enter cells as quickly as possible in a life-threatening situation.
- The Governor should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

The Investigation Process

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

10. The investigator and a colleague visited Moorland on 11 April. They obtained copies of relevant extracts from Mr Giles' prison and medical records and interviewed six prisoners who knew Mr Giles.

11. The investigator interviewed ten members of staff and one prisoner at Moorland in May.

12. NHS England commissioned a clinical reviewer to review Mr Giles' clinical care at the prison. She joined the investigator for interviews with some prison and healthcare staff.

13. We informed HM Coroner for South Yorkshire East District of the investigation. We have given the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Giles' mother to explain the investigation. Mr Giles' mother had no specific matters she wanted the investigation to consider.

15. Mr Giles' mother received a copy of the initial report. She did not make any comments.

Background Information

HMP Moorland

16. HMP Moorland holds up to 1,000 sentenced men across six houseblocks. Houseblock 4, which has three separate spurs, is for prisoners who have been convicted of sex offences. Nottinghamshire Healthcare NHS Trust provides primary care, mental health and substance misuse services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Moorland was in February 2016. Nearly half of prisoners surveyed told inspectors that it was easy to obtain drugs in the prison, and staff and prisoners thought the prison was becoming increasingly unsafe due to the use of new psychoactive substances and corresponding debt and violence. Inspectors found that investigations into incidents of violence and bullying were not always thorough.

18. Inspectors found that care for prisoners managed under ACCT procedures was generally good, although appropriate staff did not often attend case reviews and it was not always possible to know if caremap actions had been completed before the document was closed.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to February 2016, the IMB reported that they had serious concerns about the availability of drugs in the prison, particularly new psychoactive substances. They highlighted the impact this had on violence, debt and the overall safety of the prison.

Previous deaths at HMP Moorland

20. Mr Giles was the seventh prisoner to die at Moorland since January 2014, and the third to take his own life. In our investigation into the self-inflicted death of a man in February 2014, we found that he received good supportive care although not all ACCT case reviews were multidisciplinary.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances

22. New psychoactive substances are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many new psychoactive substances contain synthetic cannabinoids, which can produce experiences similar to cannabis. They are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.

23. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances in prison can lead to debt, violence and intimidation.

24. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of new psychoactive substances. 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 new psychoactive substances; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between new psychoactive substances and debt and bullying.

Key Events

25. On 12 November 2012, Mr James Giles was remanded to HMP Leeds, charged with sexual assault on a child. He had previously served several short prison sentences in Jersey. When he arrived in prison, Mr Giles did not declare any physical or mental health issues, or a history of harming himself. Later that month, staff at HMP La Moye, Jersey, reported that Mr Giles had tried to take his life earlier in the year. Mr Giles denied this, and no one began ACCT procedures.

26. In March 2013, Mr Giles was convicted and sentenced to seven and a half years in prison. He was transferred to HMP Moorland in April. Mr Giles spent three months in HMP Hull in 2014 to complete an offending behaviour course. He returned to Moorland in September as he said he no longer wanted to take the course.

27. On 17 July 2015, Mr Giles passed a note to the night officer in which he said that he needed help from the mental health inreach team and that he might take his life. Prison staff began ACCT procedures. At an assessment the next morning, Mr Giles said his family had a history of mental illness and he was worried about his own mental health. A Supervising Officer (SO) held the first case review later that day. Mr Giles said that prison staff had taken his note out of context and he did not intend to harm himself. The SO concluded that it was appropriate to end ACCT monitoring. He referred Mr Giles to the mental health inreach team.

28. On 1 August, prison staff found Mr Giles unresponsive in his cell. An officer noted that he appeared to be under the influence of drugs. Mr Giles later denied this when questioned.

29. A mental health nurse assessed Mr Giles on 3 August. Mr Giles said he had experienced post-traumatic stress disorder after an assault several years earlier that had left him blind in his left eye. The nurse referred Mr Giles to the prison's Improving Access to Psychological Therapies team (IAPT, a group that treats depression and anxiety-based disorders) for assessment.

30. On 5 October, an IAPT practitioner assessed Mr Giles. He said he had cut his arms three to six months earlier and had made a ligature 18 months earlier. (There is no contemporaneous reference to either of these events in his prison records.) Mr Giles said his children and family were protective factors that prevented him doing further harm to himself. He said he had nightmares, reliving the attack that had left him partially blind.

31. The IAPT practitioner assessed him further on 19 October. Mr Giles said he had had more nightmares since their last meeting. He explained how he adjusted his behaviour to reduce the risk of attack (such as walking with a wall to his left side so as not to compromise his sight). The IAPT practitioner noted that she would discuss Mr Giles' assessment with a cognitive behaviour therapist. Around a week later, they agreed to place Mr Giles on the waiting list for therapy.

32. On 29 October, Mr Giles tried to hang himself. A mental health nurse began ACCT procedures. Mr Giles told her and a modern matron (lead nurse) that he had no memory of his actions when he tried to take his life. He denied taking

drugs. The modern matron noted that Mr Giles' presentation, particularly his confusion and lack of memory, was consistent with the use of new psychoactive substances.

33. On 30 October, an officer assessed Mr Giles as part of ACCT procedures. Mr Giles said he still could not remember the events of the previous day, but he thought it was a spur of the moment thing and he was glad he had not taken his life. He said that he was a long way from his family in Jersey and they struggled to visit. Mr Giles said that the workshop he worked in had been temporarily shut and this meant he had a lot of time on his hands to think. He did not mention drugs and said he had no other issues inside the prison.

34. The mental health nurse and the IAPT practitioner spoke to Mr Giles after the assessment. Mr Giles said that he had been thinking a lot recently about his situation in prison, the distance from his family and said he felt he had nothing to look forward to in life. Mr Giles agreed to have another mental health assessment and said he was happy to remain on the waiting list for IAPT.

35. Later that afternoon, a custodial manager held the first ACCT case review. Mr Giles and several staff also attended. The custodial manager recorded that the mental health nurse and the IAPT practitioner had spoken to Mr Giles and that he was happy with the plan they had made. He recorded that Mr Giles was at a raised risk of suicide and self-harm. He entered three actions on the ACCT caremap: for Mr Giles to speak to his offender supervisor about a possible transfer to Jersey, to apply for education or employment, and to continue intervention with IAPT. There is no record of a discussion about Mr Giles' possible use of new psychoactive substances.

36. On 2 November, an SO and a mental health nurse held an ACCT case review. Mr Giles said that before he tied the ligature, he read a letter which upset him and smoked a cigarette someone gave him which may have contained 'Spice' (a new psychoactive substance). Mr Giles said he did not want to harm himself and was receiving support from IAPT and the mental health inreach team. The SO said that Mr Giles presented well, was chatty and had resolved the issues that led to him harming himself. The SO stopped ACCT monitoring. No one referred Mr Giles to the substance misuse team.

37. The mental health nurse saw Mr Giles on 5 November, for a mental health review. Mr Giles now admitted he had smoked Spice when he tried to take his life and said his actions were due to a combination of the drug and the letter he had received. Mr Giles said he had no intention of smoking Spice again and felt much better than he did. The nurse recorded that there was no evidence of low mood or symptoms of psychosis and concluded that Mr Giles did not need further support from the mental health inreach team.

38. On 6 November, Mr Giles attended a voluntary group offered to all prisoners that aimed to raise awareness of the dangers of new psychoactive substances. The teacher who led the group said that Mr Giles was quiet during the session and did not say anything that indicated he had been using such drugs.

39. On 7 November, prison officers found Mr Giles dazed and having experienced "some kind of fit". A prison nurse assessed him and he quickly recovered. An officer asked Mr Giles if he had taken drugs, which he denied.

40. At an ACCT post closure review on 9 November, Mr Giles said his previous issues had now been resolved and he had no new issues to discuss. The SO who led the review noted that Mr Giles now worked in the DHL workshop (preparing items ordered by other prisoners from the prison shop).

41. On 17 December, the cognitive behaviour therapist began an assessment of Mr Giles' post-traumatic stress disorder. She completed the assessment on 8 January 2016, and met Mr Giles to discuss the results on 21 January. During the assessment period, Mr Giles said he continued to experience nightmares because of the attack that left him blind in his left eye. She and Mr Giles agreed to begin eye movement desensitisation and reprocessing therapy (a psychological technique used to treat trauma, anxiety and post-traumatic stress disorder). On 28 January, Mr Giles began weekly sessions with the cognitive behaviour therapist.

42. In January 2016, the Cross Border Transfer Section of the National Offender Management Service (NOMS) sent Mr Giles an application for him to complete to ask for a transfer to Jersey. (On an unknown date, Mr Giles had written to them to ask for a transfer.) A case administrator in the Offender Management Unit at Moorland also sent Mr Giles an application pack, on 22 January, and explained that he should return the form to her, with evidence that he had ties to Jersey. She told us that Mr Giles did not return the completed form to her or to NOMS and she heard nothing further from him.

43. On 29 February, an officer charged Mr Giles with a disciplinary offence when CCTV footage showed him stealing tobacco from the DHL workshop he attended. Mr Giles admitted to the officer that he had stolen the tobacco and said that he had also taken some the week before. Mr Giles lost his job in the workshop as a result. A prisoner who knew Mr Giles said that he stole the tobacco to pay off debts he had accumulated through drug use. He said that Mr Giles smoked Spice and also used illicitly obtained prescription drugs.

44. On the same day, another prisoner who worked in the DHL workshop told an officer that other prisoners were going to assault Mr Giles because his theft meant that they might not receive a bonus payment. The officer completed a violent incident reporting form.

45. An officer investigated the alleged threat of assault. She did not speak to either prisoner as she said that workshop staff had already spoken to him about this. (No one had spoken to Mr Giles about the threat.) She recorded that it was difficult to establish whether the prisoner's comment was a threat directly from him or if he was making a general comment about other prisoners. She concluded that the risk to Mr Giles had greatly reduced because he was now unemployed. She noted that staff should monitor the situation but that no further action was needed.

46. The Head of Corporate Services was the adjudicator at Mr Giles' disciplinary hearing on 9 March. (The hearing had been suspended for a week as Mr Giles

initially said he wanted to speak to his solicitor. He later said he had not received any advice.) Mr Giles pleaded guilty to stealing tobacco, and said that his actions were due to stupidity and naivety. The adjudicator punished him by not allowing him to buy items from the prison shop and reducing his income by 50 per cent for two weeks, and by taking away his association time for three days.

47. On 24 March, an officer spoke to Mr Giles in her capacity as his personal officer. She noted that Mr Giles had started a new job as a wing cleaner and had said he was happy in this role.

48. On 31 March, the cognitive behaviour therapist saw Mr Giles for a therapy session. Mr Giles said he was well and no longer had anxiety or nightmares. He said he felt better than when he started treatment. They agreed that Mr Giles had made enough progress to be discharged from therapy once he had a follow-up session four weeks later.

49. A prisoner, who was friends with Mr Giles, told us that Mr Giles used drugs frequently, especially Spice. As a result, Mr Giles accumulated debts in prison. He said that he twice helped Mr Giles pay off debts. On 3 April, Mr Giles approached the prisoner for help to pay off another debt. He told Mr Giles that he could not afford to help him this time. He said that Mr Giles appeared worried at the time, but seemed his normal self afterwards.

50. Another prisoner said that Mr Giles approached him on 4 April, and asked if he knew anyone who could lend him tobacco to use to pay off debts he had accumulated for Spice. Mr Giles told him that he was under pressure to pay off his debts.

51. Another prisoner recalled seeing Mr Giles on the afternoon of 5 April. He said that Mr Giles was always in debt and was keen to move to Jersey to be nearer his family, but seemed okay at the time.

52. Another prisoner said that Mr Giles spent around 25 minutes with him in his cell that evening. Mr Giles spoke about his father's death, and said the anniversary had passed the day before. He said Mr Giles seemed a little down, but not so much as to cause him concern.

53. Another prisoner saw Mr Giles around five minutes before the prisoners were locked in their cells for the night (at around 6.10pm). He said he knew that Mr Giles was in debt to several prisoners, including himself, but he did not appear to have any problems as a result of this. He said Mr Giles asked him for a cigarette paper and seemed to be all right at the time.

54. At around 5.50am on 6 April, an operational support grade (OSG), who was the night patrol officer, began a count of prisoners in their cells. He arrived at Mr Giles' cell at 5.54am and found him hanging from a scarf that he had tied to a cupboard. The OSG said that Mr Giles appeared to be dead. He said that he did not make an emergency radio call for assistance, as local policy requires, because he had been in shock. Instead, he went to the staff office and telephoned the communications room, where he reported a code blue medical emergency, indicating a life-threatening situation. The communications officer recorded the call at 5.55am, and called an ambulance. The OSG briefly returned

to the cell but did not open it. He said this was because he knew Mr Giles was dead and there was nothing more he could do.

55. At 5.57am, the night manager and two officers arrived on Houseblock 4 and opened Mr Giles' cell. One officer cut the ligature and the night manager checked Mr Giles for signs of life. He said he could not find a pulse and that Mr Giles was hard and cold. He said he thought that Mr Giles was dead. He said he began cardiopulmonary resuscitation, but was not clear how long he continued. Closed circuit television (CCTV) footage shows that all of the staff left Mr Giles' cell and closed the door at 5.59am. The night manager returned to the cell at 6.11am, with a defibrillator that he did not apply. He left the cell after 40 seconds. Paramedics arrived at 6.15am and recorded that Mr Giles had died.

56. Mr Giles left eight notes in his cell for family and friends, in which he indicated that he had made a clear decision to take his life as he could not see any future for himself.

Contact with Mr Giles' family

57. Mr Giles had listed his mother as his next of kin. As his family lives in Jersey, prison staff asked States of Jersey Police to inform them of Mr Giles' death. Police officers visited Mr Giles' mother's home and place of work on the morning of 6 April, but were unable to locate her. They visited Mr Giles' mother's house again at around 1.00pm, and broke the news of his death. The prison's family liaison officer spoke to Mr Giles' sister on the telephone later that afternoon. Mr Giles' funeral was held on 20 April and Moorland contributed to the costs in line with national instructions.

Support for prisoners and staff

58. After Mr Giles' death an operational 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.

59. The prison posted notices informing other prisoners of Mr Giles' death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Giles' death.

Post-mortem report

60. A post-mortem provisionally established the cause of death as hanging.

Findings

Assessment of risk of suicide and self-harm

61. Prison Service Instruction (PSI) 64/2011 says that all staff in contact with prisoners must be aware of the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm, and take appropriate action. Prison staff twice managed Mr Giles under ACCT suicide and self-harm prevention procedures, most recently around five months before he died. We have considered whether staff at Moorland should have recognised Mr Giles as at risk of suicide and self-harm at the time of his death in April 2016.

62. Mr Giles had a number of risk factors for suicide and self-harm. He had seemingly tried to take his life in October 2015, and had reportedly tried to do so earlier in his life. There was evidence that he used new psychoactive substances, which can produce a range of reactions and might increase the risk of suicide and self-harm. Mr Giles was being treated for post-traumatic stress disorder. He had also spoken of feeling isolated in prison, as he received few visits from family or friends, and had spoken of a desire to transfer to a prison closer to home.

63. Mr Giles completed his last eye movement desensitisation and reprocessing therapy session on 31 March. The cognitive behaviour therapist said he had done well in the programme, shown improvement and said he had no more problems with anxiety. Prisoners who knew Mr Giles said he was in debt for drugs, and one said that he appeared down due to the recent anniversary of his father's death. Prison staff did not know of these issues. Mr Giles left notes for family and friends indicating that he had made a clear decision to take his life. We consider that there was little to indicate that Mr Giles was at imminent and heightened risk of suicide at the time of his death.

64. While Mr Giles had several risk factors and was, therefore, always at long-term risk of suicide, ACCT procedures are designed to support and manage prisoners during short periods of crisis. Although we have some concerns about the management of Mr Giles' drug use and of previous ACCT procedures, we are satisfied, despite his underlying risk factors, that there was little reason for staff to consider beginning ACCT procedures in the weeks before his death. It is very difficult to prevent someone determined on suicide from carrying out that plan without making living conditions extremely restrictive. Had prison staff managed Mr Giles under ACCT procedures at the time of his death, it is unlikely that monitoring levels would have been sufficiently frequent to prevent his suicide, if he had planned it. We consider it would have been difficult for staff at Moorland to have predicted or prevented his actions.

ACCT procedures

65. Although we do not consider that Moorland's management of ACCT suicide and self-harm prevention procedures in October and November 2015 was connected with Mr Giles' death, we are concerned that the case reviews and caremap did not fully address his issues.

66. PSI 64/2011 says that the caremap must reflect the prisoner's needs, level of risk, and the triggers of their distress. Each action on the caremap must be tailored to meet the individual needs of the prisoner and must be time bound. The circumstances of Mr Giles' attempt on his life indicated that he was under the influence of new psychoactive substances, yet there is no evidence that staff discussed this at the assessment interview or first case review, and there was no action to address Mr Giles' drug use on the caremap. This might also have helped staff identify any issues associated with the use of new psychoactive substances, such as debt or bullying. It is concerning that staff did not identify this issue which, if addressed, might have helped reduce Mr Giles' risk.

67. The caremap actions set by a manager, who had not been trained in ACCT case management, amounted to no more than referrals to services or individuals. None of the actions had been resolved when a SO closed the document at the next case review two days later. We make the following recommendation:

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

- **ACCT caremap actions are specific and meaningful, identify all of the issues identified during the assessment interview and case reviews and that ACCT monitoring does not stop until all caremap actions have been completed.**
- **Case managers have relevant training.**

Mr Giles' safety at Moorland

68. Prisoners who knew Mr Giles told us that he frequently used drugs in prison, particularly Spice. Mr Giles appeared to be under the influence of new psychoactive substances when he tried to take his life on 29 October 2015. Most prison and healthcare staff we spoke to who dealt with him at this time agreed it was likely Mr Giles had misused drugs. Mr Giles confirmed this was the case at the ACCT case review on 2 November and at a mental health review on 5 November. Despite this, no one referred him to the substance misuse team.

69. Mr Giles' friends said he was often in debt for Spice, and had accumulated further debts shortly before his death. One friend said that Mr Giles' stole tobacco from the workshop in February 2016 in order to pay off an earlier debt. Although prison staff broadly investigated the threat made against Mr Giles after this incident in line with local policy, they did not interview Mr Giles about the incident. They did not therefore give themselves the opportunity to identify the reasons behind Mr Giles' actions or that he might be at risk. As such, they were unable to provide supportive measures to help Mr Giles.

70. HM Inspectorate of Prisons, in their inspection of February 2016, found that Moorland was becoming increasingly unsafe due to the use of new psychoactive substances and the corresponding debt and violence. In its most recent annual report, Moorland's IMB also highlighted this as a significant concern.

71. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of new psychoactive substances. 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 new psychoactive substances; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. We make the following recommendations:

The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.

The Governor should ensure that prisoners who use new psychoactive substances are referred to drug treatment services and warned about the dangers and risks to health.

Emergency response

72. We have a number of concerns about the emergency response on 6 April. Moorland's local instruction on medical emergency response codes (Notice to Staff 255/15) instructs that staff raising the alarm in a medical emergency should do so by radio, using the appropriate emergency code. The OSG used the telephone in the staff office rather than his radio. When staff carry radios, they should use them to communicate an emergency, as this is the quickest and most effective means.

73. PSI 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment. This is reflected in Moorland's Local Instruction 8.1.10 on opening cells at night.

74. The OSG found Mr Giles hanging and said he thought he had died. He did not open the cell as he said he did not think there was anything he could do. While we appreciate that it can be difficult in such situations, we would normally expect prison staff to go into a cell as soon as possible to check for signs of life and to determine whether it is appropriate to begin cardiopulmonary resuscitation.

75. While these issues do not appear to have had an impact on the outcome for Mr Giles, it is important that prison staff understand their roles in a medical emergency, as early intervention when someone is found hanging can save their life. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **Night staff use their radio to communicate the nature of a medical emergency quickly and effectively.**

- **Night staff enter cells as quickly as possible in a life-threatening situation.**

Resuscitation

76. The night manager said that he could not find a pulse when he examined Mr Giles, and that he felt hard and cold. He said that he tried to resuscitate Mr Giles for a short time.

77. European Resuscitation Council Guidelines 2010 say that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. The clinical reviewer, comments that the decision to commence cardiopulmonary resuscitation was not in line with these guidelines. We make the following recommendation:

The Governor should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

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