Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher McHugh a prisoner at HMP Humber on 22 March 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 McHugh was found hanged in his cell at HMP Humber on 22 March 2016. He was 29 years old. Toxicology tests showed that he had taken a new psychoactive substance before his death. I offer my condolences to Mr McHugh's family and friends.

I am concerned that too little was done to support Mr McHugh when he spoke of his fears for his safety at Humber in the two weeks before his death. There is little evidence that prison staff adequately considered the potential impact of Mr McHugh's concerns on his risk of suicide and self-harm. There were also deficiencies in the emergency response, including a delay of several minutes before anyone opened his cell or called an ambulance after he was found hanged.

I am concerned that this investigation identifies issues that I have raised previously over HMP Humber's identification and management of risk to prisoner safety and timely responses to incidents. I expect the Governor to address these as a matter of urgency.

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 Christopher McHugh was remanded to HMP Hull in May 2015. He was later sentenced to four years in prison. Prison staff found Mr McHugh under the apparent influence of drugs on several occasions at Hull. He moved to HMP Humber on 4 March 2016.

2. On 9 March, Mr McHugh tried to run from a prison officer towards an escort vehicle near the prison entrance. At a disciplinary hearing on 12 March, Mr McHugh said he did not want to be at Humber because he feared that a group of prisoners from Leeds would target him after a previous offence against one of their associates.

3. On 14 March, Mr McHugh told a safer custody officer that he was worried that the prisoners from Leeds would threaten him but he did not say why. He said he was concerned about reprisals from prison staff because he had burgled the house of a member of staff at another prison. Mr McHugh said he wanted to move to another prison, and the safer custody officer referred him to the unit that manages transfers. Although she told wing staff of Mr McHugh's concerns, they did not monitor or support him, and did not investigate his concerns.

4. On 18 March, Mr McHugh wrote to the safer custody officer. He apologised for any trouble he had caused and said he hoped to have a better life in future. Mr McHugh again asked to be moved because of problems he had with prisoners from Leeds. No one in the safer custody team saw Mr McHugh's letter before he died.

5. Prisoners who knew Mr McHugh said he told them that he was worried that prisoners from Leeds intended to assault him. They said that they spoke to this group of prisoners, who told them that it was not true. Mr McHugh's friends said they tried to reassure him of this. One prisoner told us that, on 21 March, Mr McHugh had asked him why he was going to assault him. The prisoner said that he did not know Mr McHugh, had no intention of harming him, and that Mr McHugh appeared scared and paranoid.

6. A prisoner said that he saw Mr McHugh prepare a joint of 'Spice' (a new psychoactive substance), shortly before they were locked in their cells on the evening of 21 March. At around 5.35am on 22 March, the night patrol officer found Mr McHugh hanging from a ligature in his cell. She radioed a medical emergency code, but did not open the cell. When the night orderly officer and response nurse arrived, they could not enter the wing immediately as the officer with the relevant 'doubles' keys was on the far side of the prison. When they went into Mr McHugh's cell at around 5.42am, they removed the ligature and found that rigor mortis was present. They began cardiopulmonary resuscitation and the nurse asked the control room to call an ambulance. Paramedics arrived and recorded that Mr McHugh had died.

Findings

7. Mr McHugh was anxious during his time at Humber, and told staff and prisoners that he was afraid of other prisoners on his wing. We are not satisfied that his concerns were properly addressed and investigated, or that he was appropriately supported. We found little evidence that prison staff considered the impact this had on his risk of suicide and self-harm, or that his behaviour might have been influenced by drug use.

8. We found that staff took too long to go into Mr McHugh's cell and to call an emergency ambulance when they discovered him hanging. Staff unnecessarily tried to resuscitate Mr McHugh, when it was clearly too late.

Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.
- The Governor should ensure that all information about bullying is fully coordinated and investigated, that staff consider whether victims are at increased risk of suicide or self-harm, and that apparent victims are effectively supported and protected with meaningful long term solutions which address their individual situations.
- The Governor should ensure that officers have meaningful contact with every prisoner through an effective personal officer scheme, which allows officers to get to know prisoners, identify their needs and make regular case history notes.
- The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances, and that staff are vigilant for signs of its use and are briefed about how to respond when a prisoner appears to be under the influence of such substances.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
    - Night staff enter cells as quickly as possible in a life threatening situation.
    - Control room staff call an ambulance as soon as an emergency code is broadcast.
    - The doubles keys are located centrally during morning roll check and doubles locks are removed in line with local guidelines.
- The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.
- The Governor should ensure that families are notified about the death of a prisoner without undue delay.

The Investigation Process

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

10. The investigator visited Humber on 29 March 2016. He obtained copies of relevant extracts from Mr McHugh's prison and medical records, and interviewed four prisoners.

11. The investigator interviewed ten members of staff and two prisoners at Humber on 9-10 May. He interviewed another member of staff at HMP Askham Grange in June.

12. NHS England commissioned a clinical reviewer to review Mr McHugh's clinical care at the prison. She joined the investigator for interviews with clinical staff on 10 May.

13. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr McHugh's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr McHugh's father asked the following questions:

    - Whether prison staff had considered placing Mr McHugh on suicide and self-harm monitoring procedures.
    - Whether there was any indication that Mr McHugh was scared for his safety, bullied, in debt or had been involved in any altercations.
    - Why Mr McHugh had moved from a shared cell to a single cell and whether prison staff considered his potential vulnerability at the time.
    - Whether anyone had assessed Mr McHugh's mental health.
    - When Mr McHugh was last seen before his death, what happened when he was found, and whether rigor mortis was present.

15. Mr McHugh's family received a copy of the initial report. They pointed out some factual inaccuracies. We have amended this report accordingly. They also raised some additional questions that we have addressed through separate correspondence.

Background Information

HMP Humber

16. HMP Humber is made up of two former prisons, HMP Wolds and HMP Everthorpe, and holds up to 1,062 prisoners. The two prisons formally merged in April 2014. B Wing, where Mr McHugh lived, is on the former Wolds site.

17. City Health Care Partnership provides healthcare services. There are healthcare staff on duty at all times.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Humber was in July 2015. Inspectors reported that the use of new psychoactive substances, and the resulting debt, was a significant issue and that the availability of drugs was high. Inspectors also found that procedures to keep prisoners safe were seriously underdeveloped, although prisoners harmed themselves less often than at comparable prisons.

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 2015, the IMB reported that there had been impressive initiatives introduced at Humber to counter the use of new psychoactive substances, including speaking individually to each prisoner and running workshops about new psychoactive substances. The IMB found that this had led to a significantly fewer reported incidents of prisoners using new psychoactive substances.

Previous deaths at HMP Humber

20. Mr McHugh was the seventh prisoner to die at HMP Humber since January 2014, and the fourth to take his own life. Our investigation into a death in November 2014 found that prison staff did not fully consider the effects of bullying and intimidation on the man's risk of suicide and self-harm. Our investigation into a death in August 2014 found that control room staff did not call an ambulance when they received an emergency radio call.

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 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 new psychoactive substances have 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 using 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, debt and bullying.

Key Events

25. Mr Christopher McHugh was released from HMP Wolds on 22 May 2015, but was arrested the next day, charged with burglary. He had been to prison a number of times but had never been managed under ACCT suicide and self-harm prevention procedures.

26. Mr McHugh was remanded to HMP Hull on 25 May 2015. At an initial health screen, Mr McHugh said he had no physical or mental health problems and had never harmed himself. He said he occasionally used 'Spice' (a new psychoactive substance). At a secondary health screen on 26 May, Mr McHugh said he felt stressed and depressed about coming back to prison, but did not intend to harm himself.

27. On 2 September, Mr McHugh was convicted of burglary and sentenced to four years in prison.

28. On 15 October, an operational manager segregated Mr McHugh for seven days after he tested positive for subutex (a prescription medication used as a substitute for heroin) at a mandatory drugs test. Mr McHugh chose not to see the prison's drug and alcohol recovery service afterwards, and signed a service withdrawal form.

29. On 16 November, prison staff found Mr McHugh seemingly under the influence of drugs. A nurse recorded that his voice was slurred and his pupils large and sluggish. Mr McHugh said he had taken a tablet that was not his.

30. On 4 December, prison staff again suspected that Mr McHugh had taken drugs. A nurse recorded that he vomited several times and appeared to have a seizure. She told us that Mr McHugh behaved bizarrely, and his speech was slurred and incoherent. She called an ambulance but when the paramedics arrived, Mr McHugh said he did not want to be treated.

31. On 19 January 2016, prison officers found items that could be used to prepare and take drugs in Mr McHugh's cell. Prison staff charged him with a disciplinary offence and an operational manager imposed various suspended punishments, including being segregated for two weeks.

32. A substance misuse recovery worker reviewed Mr McHugh on 29 January. Mr McHugh said he now wanted to work with the substance misuse recovery groups at Hull. She added Mr McHugh to the waiting list. He was still on the waiting list when he was transferred to HMP Humber on 4 March.

33. At an initial health screen at Humber with a nurse (who worked at both prisons), Mr McHugh said he had no concerns about his physical or mental health. She said that Mr McHugh did not give the impression that he did not want to be at the prison, and she saw him laughing and joking with other prisoners. She noted that he had misused drugs in the past, but did not ask for any further details.

34. An officer assessed Mr McHugh later that day. He recorded that there was no evidence of any risk factors for suicide and self-harm and concluded that he did

not need to begin ACCT procedures. Mr McHugh lived on B Wing, the induction unit, at Humber.

35. On 7 March, a recovery support worker assessed Mr McHugh. The drug and alcohol recovery service see all new prisoners as part of their induction to explain the services they provide and offer prisoners the opportunity to sign up for these services. She said she knew that Mr McHugh had been on a waiting list for substance misuse groups at Hull. She asked him if he wanted to continue working with the team at Humber, but Mr McHugh said he no longer felt he needed to use the service.

36. On 9 March, an officer found Mr McHugh in the Everthorpe site of the prison, an area in which he did not have permission to be. As he escorted him back to B Wing, Mr McHugh ran towards a gate that was open to allow a prisoner escort vehicle to enter the site. He stopped Mr McHugh and charged him with the disciplinary offence of disobeying a lawful order.

37. The then Head of Security (now Head of Safer Prisons) was the adjudicator at Mr McHugh's disciplinary hearing on 12 March. He told us that prison staff had initially considered whether Mr McHugh's actions constituted an attempt to escape. They concluded that there was no realistic possibility of escape at the time and that Mr McHugh's actions were more likely a "show of disobedience". He said that Mr McHugh was on "good form" during the disciplinary hearing. While Mr McHugh described his actions as an attempt to escape, he recalled that he said this in a very "tongue in cheek" manner and his demeanour indicated that he was not serious. Mr McHugh went on to say that he had trouble in the prison with a group of men from Leeds, as he had previously burgled the house of one of their associates. Mr McHugh then said that, while he had not intended to escape, he wanted to get out of Humber. Mr McHugh pleaded guilty to the charge, and he decided that he should lose three weeks' of association (time spent out of his cell with other prisoners) and a 50 per cent reduction in his earnings. (Mr McHugh had not yet got a job at Humber and so earned basic prison unemployment pay.) He contacted the safer custody team and asked them to speak to Mr McHugh about his concerns about other prisoners.

38. On 14 March, a safer custody officer spoke to Mr McHugh in his cell. Mr McHugh said he was worried about being threatened by prisoners from Leeds, but he would not explain why. He said that he had burgled the house of a member of prison staff at another prison, and was worried that he might face reprisals from staff at Humber because of this. She remembered that Mr McHugh did not have the courtesy lock on his cell door (which would prevent other prisoners on the wing, who were out of their cells at the time, from entering). She said that he appeared relaxed rather than frightened. Mr McHugh said he wanted to move to another prison. She said she told B Wing staff about her conversation with Mr McHugh. She did not advise that they monitor him more closely, as she did not think that Mr McHugh's presentation indicated that he was vulnerable or at risk. She referred Mr McHugh to the Observation, Classification and Allocations Unit, which manages prisoner transfers.

39. Later on 14 March, Mr McHugh spoke to his father by telephone. Prisoners' telephone calls are recorded and we listened to recordings of Mr McHugh's calls.

(Unless there are security grounds to target calls, prison staff listen to a random sample of telephone calls, but they had not listened to Mr McHugh's.) Mr McHugh told his father that he was on the verge of "smashing up" and might move prisons soon as he had too much trouble at Humber.

40. On 16 March, a prison chaplain visited Mr McHugh at his cell as he had asked to speak to a chaplain. Mr McHugh said that he did not want to speak to her as he wanted to go to the prison chapel before he would talk to a chaplain. There is no evidence that prison staff spoke to Mr McHugh to find out why he would only see a chaplain in the chapel.

41. On 17 March, Mr McHugh's cellmate moved to a different wing, after which Mr McHugh moved into a single cell. No one recorded why Mr McHugh moved cells. His cellmate told us that Mr McHugh said there was someone on the wing who was going to assault him because of a burglary he had committed in 2012. He said he thought Mr McHugh was scared because of this, but he did not think that anyone had directly threatened him. He also said that Mr McHugh did not use drugs during the time that they shared a cell.

42. Later that day, Mr McHugh spoke to his father. He said that he had not yet applied for a transfer, but had "too much beef" at Humber. Mr McHugh said he had smoked 'Spice' for a long time but had now stopped and felt his head was clear.

43. On 18 March, Mr McHugh wrote a letter to the safer custody team. On the front of the envelope, he wrote "Apologies to Governors and Staff, SAFER CUSTODY". He addressed the content of the letter to "miss in safer custody" (presumably the safer custody officer) and all of the Governors and staff of the prison. He apologised for causing trouble in this and other prisons, said that he wanted to change his life and that staff at Humber had helped him realise he could have a better life outside prison. Mr McHugh also wrote that he no longer used drugs. He asked to move to G Wing or to a prison in another part of the country. Mr McHugh was on the middle tier of the incentives and earned privileges scheme, (designed to encourage and reward good behaviour in prisons). G Wing however was for prisoners on the highest tier of the incentives and earned privileges scheme. Mr McHugh wrote that he needed to move because there was less chance of prisoners from Leeds seeing him, and prisons in the Yorkshire area were riddled with people who were after him. Safer custody staff found Mr McHugh's letter in their in-tray after his death, having arrived from B Wing via the prison's internal mail.

44. A prisoner on B Wing who had known Mr McHugh for a number of years and previously shared a cell with him at Hull, told us that Mr McHugh appeared paranoid when he arrived at Humber. Mr McHugh told him that prisoners from Leeds intended to assault him. However, he told us that he spoke to this group of prisoners who said that they had no argument with Mr McHugh. He said that these prisoners had told Mr McHugh this. On around 19 March, he found a note in Mr McHugh's cell addressed to him and the Leeds prisoners, in which he wrote that he was sorry for what he had done. He said he destroyed the note and reiterated to Mr McHugh that there was no problem and nothing would happen to him.

45. Another friend of Mr McHugh said that Mr McHugh told him he was "getting a lot of shit" on the wing because of a burglary he had previously committed. He said he spoke to the prisoners who Mr McHugh said had threatened him, but they said this was not true. He said he told Mr McHugh that his fears were unfounded. He said that Mr McHugh smoked Spice on B Wing.

46. Another prisoner said that Mr McHugh approached him on 21 March and asked him, 'Why are you going to batter me?' He said that he did not know Mr McHugh and told him that he had no problem with him and was not going to touch him. He told us that Mr McHugh appeared scared and paranoid. He said he did not know of anyone who intended to harm Mr McHugh and that he appeared to have many friends in the prison.

47. On the evening of 21 March, Mr McHugh came out of his cell for a shower and haircut. A prisoner thought he appeared much brighter afterwards. He saw Mr McHugh in his cell at 5.55pm, shortly before the prisoners were locked in their cells for the night. He said that Mr McHugh seemed depressed and was rolling a joint of Spice at the time.

48. At around 5.30am on 22 March, an operational support grade and the night patrol officer began a count of prisoners in their cells. She arrived at Mr McHugh's cell at around 5.35am, and found him hanging from a bed sheet that he had tied to the window bars. She said that her impression was that Mr McHugh had died. She radioed a medical emergency code blue, indicating a life threatening situation. She then left the cell and waited for her colleagues to arrive.

49. The night manager, an officer and a nurse responded. The night manager said that they had to wait to enter B Wing because the officer who carried the 'doubles' keys (at night, each wing is secured with a secondary lock for which there is only one key on site) was on the Everthorpe site removing the 'doubles' locks from wings there. They arrived at Mr McHugh's cell at around 5.42am, and opened the cell immediately. He removed the ligature and the nurse began cardiopulmonary resuscitation, assisted by two officers. The nurse asked the control room operator to call an ambulance, which she did immediately. The nurse said that rigor mortis was established but her view was that she should always administer cardiopulmonary resuscitation. She continued until paramedics arrived at around 6.05am and recorded that Mr McHugh had died.

Contact with Mr McHugh's family

50. Mr McHugh had listed his father as his next of kin. His family live in western Scotland, so prison staff asked Police Scotland to inform them of Mr McHugh's death. Police officers visited Mr McHugh's family home at around 3.30pm, and broke the news of his death to his mother. The prison's family liaison officer spoke to Mr McHugh's father and sister by telephone later that afternoon. Mr McHugh's funeral was held on 4 April and Humber contributed to the costs in line with national instructions.

Support for prisoners and staff

51. After Mr McHugh's death, the Head of Security 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.

52. The prison posted notices informing other prisoners of Mr McHugh's 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 McHugh's death.

Post-mortem report

53. Toxicology tests identified that Mr McHugh had used a synthetic cannabinoid. The post-mortem examination established the cause of death as hanging, with use of a synthetic cannabinoid a secondary factor.

Findings

Identifying risk of suicide and self-harm

54. Mr McHugh told staff and prisoners at Humber that he did not feel safe in the prison and was under threat from a group of prisoners. He told both a senior manager and the safer custody officer that he wanted to move to another prison because of fears for his safety.

55. Humber's local violence reduction strategy says that any incidents of violence or threats should be reported to wing managers, who will take appropriate action to thoroughly investigate, challenge perpetrators and support victims. Supportive measures listed include the prisoner speaking to their personal officer to discuss further support and to ascertain their underlying concerns for their safety.

56. While a safer custody officer interviewed Mr McHugh, little was done to help support him afterwards and there was no monitoring or investigation to establish whether his fears were genuine or whether there were other underlying issues. Mr McHugh was not assigned a personal officer at Humber and wing staff missed several opportunities to speak to him and give themselves the full opportunity to identify his concerns – when he tried to run through a gate to an escort van; after the safer custody officer's visit; and after the aborted chaplaincy visit. Although friends of Mr McHugh told us they thought his fears were unfounded, it appears that he believed them to be true.

57. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, highlights recognised risk factors that raise the risk of suicide and self-harm. Being a victim of violence or intimidation, or being in fear of such, is one of these risk factors. There was evidence that Mr McHugh used new psychoactive substances in prison, and there are concerns that use of these substances might increase the risk of suicide and self-harm. None of the staff we spoke to had considered Mr McHugh as at risk of suicide or self-harm, and there is no evidence that anyone identified his fear of other prisoners as increasing his risk or indicating that there might be other underlying issues.

58. A PPO publication of June 2011 found there was some evidence of bullying and intimidation in 20 per cent of self-inflicted deaths we investigated. In a PPO thematic report into self-inflicted deaths in 2013-14, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and robustly addressed. We also found that staff too rarely considered that bullying issues made prisoners more vulnerable and could increase their risk of suicide. While we recognise that staff would not automatically have started ACCT monitoring, we consider that staff at Humber should have been more alert to Mr McHugh's risk factors for suicide and self-harm. We make the following recommendations:

The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

The Governor should ensure that all information about bullying is fully coordinated and investigated, that staff consider whether victims are at increased risk of suicide or self-harm, and that apparent victims are effectively supported and protected with meaningful, long term solutions which address their individual situations.

The Governor should ensure that officers have meaningful contact with every prisoner through an effective personal officer scheme, which allows officers to get to know prisoners, identify their needs and make regular case history notes.

New psychoactive substances

59. There were indications that Mr McHugh misused new psychoactive substances at HMP Hull, and he agreed to work with substance misuse recovery groups at the prison. He changed his mind on arrival at Humber, and said he no longer needed to use such these services. A prisoner who knew Mr McHugh said he smoked Spice at Humber.

60. Although there was no immediate evidence to staff that Mr McHugh misused drugs at Humber, there are concerns that use of new psychoactive substances can produce a range of bizarre behaviour or paranoia. No one considered whether Mr McHugh's actions might have been influenced either directly by drug use or by a fear of violence resulting from drug related debt.

61. HM Inspectorate of Prisons, in their inspection of July 2015, found that use of new psychoactive substances and resultant debt was a significant issue, and the availability of drugs was high.

62. 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 recommendation:

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

Emergency response

63. We have a number of concerns about the emergency response on 22 March. At night, officers have a key in a sealed pouch for use in an emergency. Prison Service Instruction 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.

64. An operational support grade found Mr McHugh hanging and said she thought he had died. She did not open the cell and said she did not consider doing this. We appreciate that it can be difficult for staff in such situations to make instant decisions but when there is a potentially life threatening situation, it is essential to act quickly. We would normally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life.

65. The operational support grade appropriately radioed a medical emergency code blue when she found Mr McHugh hanging. However, there was a delay of several minutes before the control room called an ambulance. The officer in the control room said that local practice is to wait for prison or healthcare staff to ask for an ambulance.

66. PSI 03/2013 says that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly says that control room staff should automatically call an ambulance whenever there is an emergency code and a member of the prison healthcare team or a duty manager need not attend the scene before emergency services are called.

67. The night manager said that he and the response nurse had to wait to enter B Wing (at around 5.40am) because the officer carrying the doubles keys was removing locks on the Everthorpe site. (Night staff cannot enter a wing when the doubles locks are in place, and there is only one key.) Humber's local security strategy says that night staff should remove the doubles locks after 6.00am. We think that the doubles keys should be available during the early morning roll check, when there is more likelihood of identifying an emergency.

68. While these issues do not appear to have had an impact on the outcome for Mr McHugh, 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 enter cells as quickly as possible in a life-threatening situation.**
- **Control room staff call an ambulance as soon as an emergency code is broadcast.**
- **The doubles keys are located centrally during morning roll check and doubles locks are removed in line with local guidelines.**

Resuscitation

69. Several members of prison and healthcare staff tried to resuscitate Mr McHugh. However, the nurse said that rigor mortis was established and the night manager said that Mr McHugh had obviously been dead for some time.

70. The clinical reviewer said that it would have been justifiable not to attempt cardiopulmonary resuscitation. European Resuscitation Council Guidelines 2010 state, "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. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

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

Family liaison

71. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies or is seriously ill. It was appropriate to ask Police Scotland to contact Mr McHugh's family, given the distance they live from the prison. However, we are concerned that they did not break the news to Mr McHugh's family until more than nine hours after his death. The family liaison officer said he was asked to contact Police Scotland in the afternoon to check their progress. We think that prison staff should have been more proactive in ensuring that Police Scotland promptly contacted Mr McHugh's family. We make the following recommendation:

The Governor should ensure that families are notified about the death of a prisoner without undue delay.

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