Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark McGill, a prisoner at HMP Lancaster Farms, on 12 July 2015

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 Mark McGill died at HMP Lancaster Farms on 12 July 2015; a post-mortem could not determine the cause of his death. Mr McGill was 49 years old. I offer my condolences to Mr McGill's family and friends.

This is a perplexing and complex case, with no identified cause of death. As a result, we have had to explore a range of issues affecting Mr McGill, including concerns over his healthcare, his use of new psychoactive substances (NPS), allegations of bullying, how his risk of suicide and self-harm was managed, and the prison's emergency response.

The investigation was unable to draw firm conclusions in a number of areas, but did find that healthcare professionals at a number of prisons should have better investigated the serious symptoms presented by Mr McGill, particularly his apparent seizures. While Mr McGill was not always a compliant patient, I am concerned that his failure to attend appointments was not always followed up. There were also weaknesses in the emergency response.

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 **April 2016**

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Summary

Events

1. Mr Mark McGill was sentenced to life in prison for murder in 1994 and spent time in several prisons. When he arrived at HMP Kirkham in March 2015, his medical records show that he had a history of reported seizures. The seizures were not witnessed and their cause had not been diagnosed. A doctor had previously recorded that they may have been due to his nefopam (anti-inflammatory) medication, which a GP first prescribed in 2002 for jaw and back pain. Mr McGill denied using illicit drugs, although his prison and medical records show that he had a history of suspected use of new psychoactive substances (NPS). Mr McGill also suffered from allergies for which he was prescribed medication.

2. A week after arriving at Kirkham, Mr McGill was found after having had an apparent seizure. Staff called an ambulance but Mr McGill refused all treatment. Two days later, he told a prison officer that the seizures were due to epilepsy, although he later denied this to healthcare staff. The officer asked Mr McGill why he refused medical advice and he replied that he did not care whether he lived or died. Later that day, a nurse assessed Mr McGill, who complained of breathing problems after someone had given him 'something'. The nurse was satisfied that his breathing was okay, but noted he was agitated and arranged for him to see a GP the next day.

3. However, the next day, staff suspected Mr McGill had taken NPS and moved him to the segregation until before transferring him to HMP Lancaster Farms the day after. A doctor at Lancaster Farms renewed Mr McGill's prescription for nefopam but he later told a nurse he stopped taking it as it caused him to have seizures.

4. Once at Lancaster Farms, the prison substance misuse team offered Mr McGill support, which he refused. In April 2015, a nurse found that Mr McGill was under the influence of NPS. As a result, he was placed on report but the adjudication was not completed before he died. His incentive and earned privilege (IEP) level was also reduced to basic.

5. In April, staff twice opened monitoring plans under the Prison Service's suicide and self-harm monitoring procedures (known as ACCT), after they suspected Mr McGill was at risk of harming himself. They closed the plans when they believed he was no longer at risk.

6. Mr McGill wrote a letter and submitted two applications requesting a move because he said he did not feel safe at Lancaster Farms over six weeks leading up to the death.

7. Just after lunch on 12 July, a prison officer checked on Mr McGill, who had not come out of his cell for lunch. He found Mr McGill unresponsive and called for help. Mr McGill had no pulse and was not breathing; the officers called for immediate medical assistance and began cardiopulmonary resuscitation (CPR). When a senior officer arrived around five minutes later, he called an emergency code and the control room called an ambulance. Nurses arrived and took over CPR. Paramedics also arrived and an ambulance took Mr McGill to hospital. Doctors confirmed he had died shortly after arriving at hospital.

Findings

8. Healthcare staff at a number of prisons did not adequately investigate Mr McGill's symptoms. There was also insufficient evidence that staff, particularly at Lancaster Farms, encouraged Mr McGill to attend healthcare appointments or followed up failures to attend.

9. Mr McGill was heavily involved with the use of NPS, but the investigation was unable to find any direct link to his death and we also note the steps by Lancaster Farms to address the issue. Mr McGill was also subject to bullying and, on occasions, was managed under suicide and self-arm prevention procedures. While we identify some weaknesses in the prison's response to these issues, we can make no direct links to his death.

10. We are concerned that staff did not follow the correct emergency procedures, which led to a slight delay in calling an ambulance. While this was unlikely to have affected the outcome for Mr McGill, it could be crucial in other circumstances.

Recommendations

- The Head of Healthcare at HMP Guys Marsh, HMP Erlestoke, HMP Kirkham and HMP Lancaster Farms should ensure that clinicians consider all likely causes of a prisoner's symptoms, including the side effects of medication, and investigate accordingly.
- The Head of Healthcare at HMP Lancaster Farms should ensure that when a prisoner persistently does not attend healthcare appointments, healthcare staff follow up this up and where possible establish the reasons for non-attendance.
- The Governor and Head of Healthcare at HMP Lancaster Farms should ensure that all staff are clear about their responsibilities under PSI 03/2013. In particular, all staff must understand the need to use emergency medical codes in line with the national instruction and there are no delays in summoning an ambulance.

The Investigation Process

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

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

13. NHS England commissioned a clinical reviewer to review Mr McGill's clinical care at the prison.

14. The investigator and clinical reviewer interviewed five members of staff at Lancaster Farms on 13 and 14 August.

15. We informed HM Coroner for Preston and West Lancashire district of the investigation who gave us the results of the post-mortem examination. We suspended our investigation for one and a half months while waiting for completion of the post-mortem, toxicology and neurological examination, and regret the consequent delay in issuing this report. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr McGill's sister to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She asked for the following to be considered:

    - Did Mr McGill have epilepsy and, if so, how did the prison manage and treat it?
    - Was there any evidence that Mr McGill had used NPS?
    - Whether Mr McGill asked to move off his wing or to another prison and, if so, what action was taken?

17. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

18. Mr McGill's sister received a copy of the initial report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Lancaster Farms

19. HMP Lancaster Farms has four main residential units housing a maximum of 549 convicted adults. In 2014, it was re-rolled to a category C adult resettlement prison. There is a small population of indeterminate sentence for public protection (IPP is where the court sets a minimum term of imprisonment, after which the offender will be released once they can satisfy the Parole Board that their risk of reoffending has sufficiently reduced) and lifer prisoners.

20. Health services are provided by Lancashire NHS Foundation Trust. Nurses are on duty between 7.30am and 7.30pm on weekdays and GP's provide am sessions. Inspire North Lancashire provides an integrated drug and alcohol assessment, treatment and rehabilitation service.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Lancaster Farms was in May 2015. Inspectors reported that the availability of drugs was high and many prisoners commented that new psychoactive substances (NPS) were readily available. Prisoners told the inspectorate that NPS was the main cause of conflict between prisoners. They noted that robust measures had been taken in response to this. They found that those at risk of self-harm had good support; however, the management of prisoners who had got into debt or felt threatened by others needed closer attention to ensure they were located in the right part of the prison. Healthcare services were reasonably good with an appropriate range of primary care services. However, waiting times for most services, including the GP, were too long.

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 January 2015, the IMB reported that there had been many changes to healthcare provision since the re-role in 2014. This included providing services for prisoners of all ages and for men with longstanding chronic conditions and mental health conditions.

Previous deaths at HMP Lancaster Farms

23. The most recent death at Lancaster Farms was in January 2014. There are no evident similarities with the death of Mr McGill.

Assessment, Care in Custody and Teamwork

24. Assessment, Care in Custody and Teamwork (ACCT) is the 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 (NPS)

25. NPS are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS 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.

26. 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, while in prison can lead to debt, violence and intimidation.

27. In July 2015, we published a Learning Lesson Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

28. Mr Mark McGill was serving a life sentence for murder, with a minimum tariff of 14 years, imposed on 28 November 1994. He spent time in a number of prisons including HMP Guys Marsh, HMP Erlestoke and HMP Kirkham before moving to HMP Lancaster Farms in March 2015.

29. Records show that, from 2002, doctors prescribed Mr McGill nefopam (anti-inflammatory medication) for jaw and back pain, although he did not always take it. On 6 November 2013, a GP at HMP Guys Marsh recorded that Mr McGill reported fainting, and noted this could be a side effect of nefopam. However, the GP continued to prescribe it.

30. Mr McGill was at Erlestoke from February 2014 until March 2015. On 23 March 2014, Mr McGill stopped eating as he had been refused more tobacco and staff opened an ACCT. Staff closed this on 25 April after Mr McGill began eating again and had calmed down. On 7 October, Mr McGill was sent to hospital after an apparent seizure but refused treatment and discharged himself. Then, on 17 October, Mr McGill wrote a letter saying he did not want any further treatment if he had another seizure. Staff opened an ACCT the next day and closed this two days later after staff considered his mood had improved.

HMP Kirkham

31. Mr McGill was moved from Erlestoke to HMP Kirkham, a low security, open prison, on 18 March 2015. At his initial health screen, Mr McGill told a nurse that he had not used illicit drugs since 1985, though his prison records showed evidence that he had used NPS as recently as February 2015. There was no evidence that anyone discussed Mr McGill's history of fainting or seizures with him and doctors continued to prescribe nefopam for his back pain. Mr McGill also suffered from allergies and was prescribed cetirizine (allergy relief) for this.

32. On 22 March, an officer recorded that Mr McGill was found in his cell after having an apparent seizure. Staff called an ambulance; however, Mr McGill refused to go to hospital or have any treatment. The next day, a nurse spoke to Mr McGill about this incident and noted that he said he had a history of seizures, including three in February 2015. Mr McGill was agitated during this meeting and told the nurse that the seizures would not happen again. The nurse explained that it was important he was kept safe at Kirkham, especially as he had reported seizures in the past. Mr McGill was adamant they would not happen again and walked out. The nurse spoke to a prison manager about Mr McGill's seizures and prison staff monitored him. However, there was no record that the nurse referred Mr McGill to a GP.

33. On 24 March, Mr McGill saw his offender supervisor as part of his induction at Kirkham. He told her that he was "epileptic" but refused to take any medication (there was no record that he was ever diagnosed with epilepsy or prescribed any medication for the condition). She advised him of the importance of taking prescribed medication, but Mr McGill said he did not care if he lived or died. Staff did not open an ACCT in response to this. That evening, a nurse saw Mr McGill after he told an officer that he was having breathing problems. She recorded that Mr McGill was agitated and had told her that someone had given him

'something', but he did not know what. She assessed Mr McGill, who appeared to be breathing and talking normally. She booked an appointment for him to see a GP the next day.

34. The next day, the prison held a risk management meeting, attended by prison and healthcare staff. They discussed Mr McGill's reported seizures and staff reported that Mr McGill had bruising on his body which he could not explain. Staff considered the bruises may have been caused during seizures. Staff decided that Mr McGill was a risk to himself and could not be managed safely at Kirkham and should move to a more secure prison environment, where he could be monitored more closely.

35. Later that day, prison staff suspected Mr McGill of using NPS so they moved him to the segregation unit, where he stayed overnight. On 26 March, Mr McGill was transferred to HMP Lancaster Farms.

HMP Lancaster Farms

36. At an initial health screen with a nurse, Mr McGill denied having seizures. He refused to engage with her or allow her to carry out basic medical observations. A prison GP renewed Mr McGill's prescription for nefopam. On 28 March, he told a nurse he was not going to take nefopam anymore as it caused him to have seizures.

37. On 30 March, the prison referred Mr McGill to the substance misuse team after he was found to be using NPS, but Mr McGill declined their support.

38. On 31 March, an officer opened an ACCT plan after Mr McGill told her he planned to overdose on sleeping tablets (he was not prescribed these). He told her he was upset at not being allowed to order more tobacco from the prison canteen. He refused to engage with staff carrying out the ACCT and was put on half hourly observations. These were reduced to every hour once his risk of self harm was considered to have reduced. On 1 April, a nurse recorded that she had received an application from Mr McGill stating that he did not want to be resuscitated in an emergency. She booked an appointment for Mr McGill to see a GP about this. Staff closed the ACCT on 2 April and recorded that were satisfied that Mr McGill was no longer having thoughts of self harm.

39. On 7 April, a GP saw Mr McGill and spoke to him about his reported seizures or faints. He told her that the fainting was because of nefopam and denied ever taking drugs. She considered he was competent to make a decision about resuscitation and that his wishes should be respected, but there was no evidence that an order to this effect was completed.

40. On 9 April, staff suspected Mr McGill of being under the influence of drugs. He told a nurse that another prisoner had given him a 'smoke' and she recorded he had used NPS. The prison began an adjudication later that day for endangering health and safety, but suspended this (the adjudication was not concluded before Mr McGill died). The next day the prison reduced Mr McGill's IEP level to basic due to suspected drug use. (IEP is Incentive and Earned Privileges a scheme to reward good behaviour in prison. The scheme has three levels, basic being the lowest.)

41. On 11 April, an officer opened an ACCT plan for Mr McGill after she suspected that he was at risk of harming himself as he was upset at the outcome of the disciplinary hearing. On 12 April, Mr McGill told a mental health nurse that he felt he had been unjustly accused of using "spice" (NPS) when he had had a seizure. He said the stress was making him more likely to have another seizure. There was no record that she referred him to a GP about his reported seizures. On 14 April, a Senior Officer (SO), a mental health nurse and Mr McGill attended an ACCT review. After consulting with those present, the SO decided to close the ACCT because Mr McGill was no longer at risk of self-harm.

42. On 22 April, a GP saw Mr McGill and he said he did not want nefopam anymore but still had back pain, so she prescribed diclofenac (an anti-inflammatory) patches instead.

43. On 28 May, the GP saw Mr McGill again. He told her that he had not had any more seizures or faints. She recorded that Mr McGill "wasn't quite with it" and diagnosed Mr McGill with stress. She referred Mr McGill for a blood test to determine the cause of the problem but he did not attend six appointments for this and consequently never had the blood test. He also failed to attend two other appointments (one with a dentist and one with a GP).

44. On 29 May 2015, Mr McGill passed a letter through his door to an officer. The officer recorded in Mr McGill's prison record that Mr McGill alleged that he had been threatened on at least five occasions and that he had been attacked because he had reported spice usage and delivery to the prison. He asked for staff not to unlock his cell as he did not feel safe.

45. On 3 June, Mr McGill told an activity co-ordinator that he was refusing to work because he felt under threat for his life. The co-ordinator recorded in Mr McGill's prison record that he contacted a member of safer custody about this and asked Mr McGill to provide names of the perpetrators of the threats. Three days later, an officer recorded that she had received an application from Mr McGill asking to move from the wing as he did not feel safe. She also recorded that she had seen a number of prisoners going into Mr McGill's cell and that he had given them items from his canteen. The prison did not provide evidence that any further action was taken in response to these requests.

46. On 17 June, a nurse saw Mr McGill in his cell. She noted that he was unable to keep still and had a green substance on his table, next to some tobacco. When she examined him, she noted he was confused and agitated and suspected that he had used NPS. The nurse asked wing staff to observe him. Later that day, Mr McGill told a prisoner that he had smoked a substance (likely to be NPS), which had been given to him by another prisoner as a 'tester'.

47. On 3 July, an entry in Mr McGill's intelligence record stated that he had made an application requesting a move, complaining that he did not feel safe. On 8 July, he handed in an application form repeating the same requests. The receipt was signed by an officer, although the signature is not dated. At interview, he did not recall this request.

48. On 10 July, Mr McGill handed a partially completed transfer form to an officer, saying he did not feel safe at the prison but did not give any more information.

The officer advised him to stay locked in his cell if he felt in danger and provide more information. Later that day, Mr McGill completed a safety questionnaire saying that he was concerned for his safety as he had alerted staff to a 'Spice' (NPS) delivery. He sent the request and safety questionnaire to the safety custody team through the internal post, but it was not received until Monday 13 July, a day after Mr McGill's death.

12 July 2015

49. At 11.38am on 12 July, an officer responded to Mr McGill's cell bell. He saw Mr McGill was lying on his bed and asked if he was okay; Mr McGill nodded in response.

50. At around 12.10pm, an officer went to Mr McGill's cell, as he had not come out of his cell for lunch. The officer found Mr McGill unresponsive and face down on the bed. He called for assistance and a colleague joined him at 12.12pm. Mr McGill had no pulse and was not breathing, so the officers called for immediate medical assistance and began cardiopulmonary resuscitation (CPR). A senior officer arrived at around 12.14pm and called a code blue (an emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties). At 12.15pm, a control room operator called an ambulance.

51. At 12.16pm, two nurses arrived with an emergency bag and took over CPR. They also attached a defibrillator to Mr McGill which indicated no shockable rhythm.

52. Paramedics arrived at 12.37pm and took over resuscitation efforts. The ambulance left the prison at 1.12pm and took Mr McGill to hospital. Shortly after arrival, doctors at the hospital confirmed that Mr McGill had died.

Contact with Mr McGill's family

53. Mr McGill's nominated next of kin was his sister who lived some distance from Lancaster Farms. Shortly after Mr McGill died, a senior prison manager telephoned HMP Winchester, the nearest prison to Mr McGill's sister, to ask if they would inform her of his death. A prison manager from Winchester visited Mr McGill's sister to tell her that her brother had died.

54. The prison appointed a prison chaplain and a custodial manager as the prison's family liaison officers. The chaplain telephoned Mr McGill's sister and offered his condolences. On 15 July, the chaplain and the prison Governor visited Mr McGill's sister and her husband to provide further support and guidance.

55. Mr McGill's funeral was on 21 December and the prison contributed towards the costs in line with national policy.

Support for prisoners and staff

56. After Mr McGill's death a custodial 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.

57. The prison posted notices informing staff and prisoners of Mr McGill'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 McGill's death.

Post-mortem report

58. A post-mortem examination could not ascertain the cause of Mr McGill's death. The post-mortem report concluded that epilepsy could not be considered the cause of death because of the lack of a formal diagnosis or witnessed seizures. It reported no physical evidence that could account for the cause of death, including no indication that the death was self-inflicted. An additional examination of both Mr McGill's heart and brain did not find any evidence which would account for the death. Toxicology tests found no drugs or alcohol in Mr McGill's blood when he died. However, the test report also notes the difficulty of detecting synthetic compounds and that there was the theoretical possibility that Mr McGill may have used synthetic cannabinoids (NPS) before he died.

59. The police and our investigator found nothing in Mr McGill's cell to suggest that he may have taken his own life. The police found no evidence of any third party involvement or crime and treated Mr McGill's death as likely to be due to natural causes.

Findings

Clinical care

60. From March 2013, while at HMP Guys March, HMP Erlestoke and HMP Kirkham, records show Mr McGill reported having seizures or fainting a number of times. However, when asked about this, he sometimes denied it and records show he did not always engage well with healthcare staff. Records also show that Mr McGill often did not attend healthcare appointments, but this non-attendance was not followed up, particularly while at HMP Lancaster Farms. There was no record that anyone investigated Mr McGill's seizures or faints sufficiently, exploring all likely causes of the reported symptoms. As a result, the clinical reviewer commented that prison staff missed opportunities to assess his physical and mental health effectively.

61. From March 2015, Mr McGill was at Lancaster Farms. Healthcare staff were aware of his history of reported seizures/faints. A GP saw him three times in April 2015 and they discussed his seizures, but the doctor did not refer him for further investigation, apart from blood tests. The National Institute for Health and Care Excellence (NICE) guidance for the diagnosis and management of epilepsy, states that 'all adults with a recent onset suspected seizure should be seen urgently by a specialist (defined as a medical practitioner with training and expertise in epilepsy) to ensure precise and early diagnosis and initiation of therapy as appropriate to need'.

62. After seeing the GP in April 2015, Mr McGill did not attend for six blood test appointments (and consequently did not have the blood tests) and a further two healthcare appointments, but there was no record that anyone followed this up in an effort to find out why.

63. Doctors continued to prescribe nefopam for Mr McGill until April 2015, despite one of the known side effects of this medication being fainting and/or seizures. Apart from one reference in November 2013, there was no record that any clinician considered this as a possible reason for Mr McGill's symptoms or investigated it further.

64. The post-mortem report stated that, because of a lack of a formal diagnosis of epilepsy, this could not be considered as the cause of death. Since we do not know what caused Mr McGill's death, it is not possible to say whether further investigation of Mr McGill's report seizures/faints would have affected the outcome. However, we consider there should have been a more proactive attempt to establish their cause. As a result, the clinical reviewer concluded that overall Mr McGill's clinical care in prison was not equivalent to that he could have expected to receive in the community. We agree with the clinical reviewer's assessment and make the following recommendations:

The Head of Healthcare at HMP Guys Marsh, HMP Erlestoke, HMP Kirkham and HMP Lancaster Farms should ensure that clinicians consider all likely causes of a prisoner's symptoms, including the side effects of medication, and investigate accordingly.

The Head of Healthcare at HMP Lancaster Farms should ensure that when a prisoner persistently does not attend healthcare appointments, healthcare staff follow up this up and where possible establish the reasons for non-attendance.

65. The clinical reviewer also made a number of other recommendations which we do not repeat but which the Head of Healthcare of the relevant establishment will need to address.

Use of new psychoactive substances at Lancaster Farms

66. Evidence from Mr McGill's medical and prison records show that he used NPS, and that various staff were aware of this. It is also clear from interviews with staff at Lancaster Farms that NPS was commonly found in the prison.

67. It is not possible to say whether the use of NPS contributed to Mr McGill's death. Toxicology results did not show the presence of a synthetic cannabinoid. However, the report said there was a theoretical possibility that synthetic cannaboids may have been used prior to death but had not been detected.

68. Shortly after Mr McGill arrived at Lancaster Farms, staff referred him to the substance misuse team at the prison. Mr McGill declined this offer of support.

69. We note that HM Inspectorate of Prisons was concerned about the prevalence of NPS at Lancaster Farms when they inspected the prison in May 2015, just two months after Mr McGill's death. Inspectors noted that robust measures had been taken in response. We too are concerned about the prevalence of NPS at Lancaster Farms and the effect it can have on the behaviour and health of those taking it. However, we are satisfied that the prison has a specific strategy for dealing with the issue of NPS, which includes education for prisoners about the risks involved and a clear protocol for dealing with those suspected of taking these substances.

70. Without a cause of death and with no positive toxicology results indicating the use of NPS, it is impossible to say whether Mr McGill's evident use of these substances was in any way related to his death.

Identification of risk of suicide and self-harm

71. Mr McGill had a number of risk factors for suicide and self-harm and, in the year leading up to his death, he had been on suicide prevention procedures (known as ACCT) on 4 occasions. On two occasions, in March and April 2015, staff at Lancaster Farms recognised that Mr McGill had expressed suicidal thoughts and, appropriately, opened an ACCT. Staff closed the ACCTs once they were satisfied that he no longer had such thoughts.

72. With hindsight, we would have liked to have seen more evident consideration of Mr McGill's wider risk factors for suicide and self-harm, particularly his use of NPS, his fears over his personal safety and his bizarre request that he should not be resuscitated. However, we note that Mr McGill had no diagnosis for mental illness and do not consider that staff had any reason to consider him at immediate risk of suicide and self-harm in the 3 months leading up to his death.

73. Ultimately, the post-mortem, the police investigation and our own investigation have not found any evidence that Mr McGill's death was self-inflicted.

Bullying

74. We were told that Mr McGill was an unpopular prisoner, and there are records that he informed officers of NPS deliveries in the year before he died. As a result of this and possible drug debts, Mr McGill, frequently claimed that other prisoners were bullying or threatening him. There was even one report that he claimed to have been a 'tester' for Spice (this is where a prisoner is coerced or agrees to try out new batches of spice often to repay a debt). Mr McGill made at least three requests to move away from his wing in the six weeks leading up to his death. After Mr McGill's death, a prisoner came forward and said another prisoner had visited Mr McGill in his cell on the day of his death, demanding repayment of an NPS debt. We were unable to substantiate this claim

75. Again with hindsight, we would have liked to have seen more evident consideration by staff of ways to address Mr McGill's fears and concerns, for example by opening monitoring under Lancaster Farms' Tackling Antisocial Behaviour (TAB) policy. However, we have found no evidence to link bullying or intimidation to Mr McGill's death. The police investigation concluded that there was no third party involvement in his death.

Emergency response

76. Prison Service Instruction (PSI) 03/2013 requires Governors to have a local emergency protocol in place. An appropriate code should be used in an emergency, such as 'code blue' to identify a prisoner who has chest pain, has difficulty breathing or is unconscious, which ensures staff bring the correct equipment and control room staff call an ambulance immediately. This is clearly set out in Lancaster Farm's local emergency policy.

77. However, on this occasion a 'code blue' was not called until a senior officer arrived at Mr McGill's cell, despite two officers having found him unconscious and without a pulse. This meant that the control room did not call an ambulance for several minutes after Mr McGill was found. While there was no evidence the delay affected the outcome for Mr McGill, in other circumstances this could be crucial. We make the following recommendation:

The Governor and Head of Healthcare at HMP Lancaster Farms should ensure that all staff are clear about their responsibilities under PSI 03/2013. In particular, all staff must understand the need to use emergency medical codes in line with the national instruction and there are no delays in summoning an ambulance.

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Independent Investigations

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