Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marc Curtis a prisoner at HMP Humber on 14 July 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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Our Vision

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

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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*

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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 Marc Curtis was found hanging in his cell at HMP Humber on 14 July 2016. He was 39 years old. I offer my condolences to Mr Curtis' family and friends.

The investigation found that despite Mr Curtis telling staff he had suicidal thoughts, he was not provided with appropriate support under suicide and self-harm prevention procedures. Staff also discounted the threats Mr Curtis said he faced on L wing when they moved him there the day before he hanged himself. The emergency response was inadequate.

I am concerned that this investigation identifies issues which we have previously raised with HMP Humber regarding both the identification and management of the risk of suicide, and the prison's response to emergencies. The Governor needs to address these issues 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 **February 2017**

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Summary

Events

1. On 14 May 2007, Mr Marc Curtis was remanded into custody at HMP Leeds charged with attempted murder. He had served several custodial sentences since 1990. On 2 October 2007, Mr Curtis was convicted and given an indeterminate life sentence for public protection. Mr Curtis spent time at a number of prisons before he transferred to HMP Humber on 29 July 2014.

2. Mr Curtis had not harmed himself in prison and no one had ever considered he was at risk of suicide. He had a history of illicit drug use and openly acknowledged using New Psychoactive Substances (NPS) at Humber. He said he faced threats over debt and bullying in connection with illicit items in the prison.

3. Mr Curtis was diagnosed with a personality disorder but not prescribed any medication. He said he had had thoughts of suicide on two separate occasions in the weeks leading up to his death but he was not monitored under the Prison Service's suicide and self-harm prevention procedures (known as ACCT).

4. At 6.06am on 14 July 2016, staff found Mr Curtis hanging in his cell and raised the alarm. The staff entered Mr Curtis' cell at 6.13am, and began cardiopulmonary resuscitation (CPR). An emergency ambulance was called at 6.16am and paramedics arrived at 6.45am. They pronounced Mr Curtis dead at 6.47am.

Findings

Assessment of risk

5. Mr Curtis told a member of the mental health team that he had thoughts of suicide in the weeks before his death on two occasions. No consideration was given to support Mr Curtis by opening ACCT procedures. We note that action has been taken to address this specific failing so make no recommendation in relation to the individual.

6. The prison faced challenges in finding an appropriate location for Mr Curtis given his own behaviour on D Wing and concerns about threats he had previously reported on L wing relating to debt and bullying. He was returned to L wing the day before his death.

New Psychoactive Substances

7. We are concerned at the evident availability of illicit drugs at Humber, particularly new psychoactive substances (NPS). Although post-mortem tests suggested that Mr Curtis had not used NPS or other illicit drugs at the time of his death, other prisoners clearly stated, as did Mr Curtis himself, that he had used them during his time at Humber and we note his exposure to bullying, debt and the trafficking of illicit items.

Emergency response

8. We found that staff took too long to go into Mr Curtis' cell and to call an emergency ambulance after they discovered him hanging. While this did not affect the outcome for Mr Curtis it certainly could in other emergencies. We are also concerned that staff tried to resuscitate Mr Curtis despite there being clear signs that he had been dead for some time. This is undignified for the deceased and unnecessarily distressing for staff.

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. In particular, they need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.
- The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk from other prisoners, the need to record, share and consider all relevant information about risk, and make appropriate decisions based on that information.
- The Governor should ensure there are effective demand and supply reduction strategies to help eradicate the availability of new psychoactive substances, and that staff are vigilant to signs of their use and know 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;
    - Staff radio an appropriate emergency code;
    - Control room staff call an ambulance as soon as an emergency code is broadcast;
    - There is no unnecessary delay in escorting ambulances and paramedics.
- The Governor and Head of Healthcare 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 Humber informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners responded.

10. The investigator visited Humber on 21 July. He obtained copies of relevant extracts from Mr Curtis' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Curtis' clinical care at the prison.

12. The investigator interviewed nine members of staff and three prisoners at Humber in September.

13. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Curtis' family to explain the investigation and to ask whether the family had any matters which members wanted the investigation to consider. Mr Curtis' family's legal representative contacted the family liaison officer to inform her that the family wished to know whether Mr Curtis' concerns about moving wings were recorded and acted upon, whether there was any evidence to suggest a female member of staff had a dislike for Mr Curtis and whether Mr Curtis' concerns about a transfer to HMP Frankland were recorded and what steps were taken. Mr Curtis' family received a copy of the initial report. The solicitor representing Mr Curtis' family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Humber

15. HMP Humber comprises two former prisons, HMP Wolds and HMP Everthorpe, and holds up to 1,062 prisoners. The two prisons formally merged in April 2014. L Wing, where Mr Curtis lived at the time of his death, is on the former Everthorpe site. City Health Care Partnership provides healthcare services. There are healthcare staff on duty at all times.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Humber was conducted in July 2015. Inspectors reported that the use of new psychoactive substances (NPS), and the resulting debt, was a significant issue and that the drugs were widely available. 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

17. 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 most recently published report for the year to December 2015, the IMB reported that there had been impressive initiatives introduced at Humber to counter the use of NPS, including speaking individually to each prisoner and running workshops. The IMB found that this had led to significantly fewer reported incidents of prisoners using new psychoactive substances.

Assessment, Care in Custody and Teamwork

18. 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, *Management of prisons at risk of harm to self, to others and from others (Safer Custody).*

New Psychoactive Substances (NPS)

19. New psychoactive substances, previously known as ‘legal highs’ are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for

precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

20. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. 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.

21. National Offender Management Service (NOMS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Previous deaths at HMP Humber

22. Mr Curtis was the third prisoner to take his own life at HMP Humber in 2016. Our investigation into a self-inflicted death in March 2016, found that prison staff did not fully consider the man's risk of suicide and self-harm, and staff took too long to enter the cell and to call an emergency ambulance. Staff also started attempts resuscitation when it was clearly futile to do so. These issues were repeated in Mr Curtis' death. A further self-inflicted death occurred four weeks after that of Mr Curtis.

Key Events

23. On 14 May 2007, Mr Marc Curtis was remanded to HMP Leeds charged with attempted murder. On 2 October that year, he was convicted and given an indeterminate life sentence for public protection. Mr Curtis had a custodial history dating back to 1990. The cell sharing risk assessment (CSRA) assessed Mr Curtis as representing a high risk to others so he ought not to share a cell. Mr Curtis did not nominate anyone as his next of kin.

24. Following his conviction, Mr Curtis transferred to several prisons including HMP Garth, HMP Everthorpe, HMP Ranby and finally to HMP Humber on 25 July 2014. Throughout his time in custody, Mr Curtis never self-harmed and was not assessed as being at risk of suicide. Mr Curtis' security record details several incidents of inappropriate behaviour, including physical contact and inappropriate comments towards female staff, and threats towards other prisoners.

25. Mr Curtis' medical records show that he had been diagnosed with a personality disorder but was not prescribed any medication. He had a history of drug abuse, including "Spice" (an NPS). At Humber, Mr Curtis was offered interventions with the mental health team on 18 July 2014, 6 April 2015, and 13 August 2015, but he declined on each occasion.

26. On 27 October 2015, Mr Curtis saw a member of the mental health team because he said he felt stressed. The nurse recorded that he saw Mr Curtis in his cell on L Wing and that Mr Curtis' eyes were reddened and his speech was very rapid. He asked Mr Curtis whether he had taken anything. Mr Curtis said he had taken NPS ("Spice") about 30 minutes earlier. Mr Curtis said that he wanted support from the mental health team as he felt trapped with his thoughts. He told Mr Curtis that as he was under the influence of NPS it would not be appropriate for him to conduct an assessment at that time. He told him that he would arrange to see him on a future occasion.

27. On 9 November, the nurse conducted a mental health assessment on Mr Curtis. Mr Curtis said that he felt he could easily harm other prisoners or staff. He said he knew that he had no reason to harm anyone and that there was something wrong inside him. Mr Curtis said that he heard voices and when he looked at other prisoners he saw the faces of family members who had abused him as a child. He said he felt short tempered, agitated and paranoid. Mr Curtis said he wanted mental health support in a mental health unit rather than in prison. He denied having any thoughts of self-harm or suicide. The nurse recorded that Mr Curtis said he had not used NPS or any other illicit substance since 27 October. However, he was agitated but not psychotic. Mr Curtis was referred to the substance misuse team and allocated to be seen by a qualified mental health counsellor.

28. On 24 November, Mr Curtis saw a substance misuse counsellor. Mr Curtis declined any assistance from the substance misuse team. Mr Curtis signed a disclaimer which stated that he understood that healthcare and his offender manager would be informed that he had declined assistance.

29. Between 28 October and 11 February 2016, Mr Curtis had 14 separate therapeutic counselling sessions with the mental health counsellor. Each time he denied having any thoughts of self-harm or suicide.

30. On 12 February, a visiting psychiatrist, accompanied by the mental health counsellor, saw Mr Curtis for a mental health review. He recorded that he had read a previous psychiatric report which concluded that Mr Curtis suffered from a personality disorder of a paranoid and dissocial type. Mr Curtis said that he was always paranoid when anyone approached him and always considered going on the offensive. He said staff told lies about him. Mr Curtis said that he was capable of attacking anyone when he felt unsafe. He said he argued with everyone, even if they were trying to help him, but could not remember doing so afterwards. He said he wanted to stop having aggressive thoughts. Mr Curtis also disclosed that he had been physically abused by his parents.

31. The psychiatrist recorded that Mr Curtis had a personality disorder, was paranoid and emotionally unstable. He told Mr Curtis that personality disorders could not be treated with medication and suggested that therapeutic work in a specialised personality disorder unit would help him manage his condition. Mr Curtis agreed to be considered for a referral to a specialist unit. These are called Psychologically Informed Planned Environments (known as PIPE) and are located in seven prisons across England and Wales. They offer dedicated treatment pathways for prisoners with personality disorders.

32. On 14 March, the mental health counsellor saw Mr Curtis for a therapeutic session. Mr Curtis said that he was in debt, being bullied on the wing and coerced to hold illicit items for other prisoners. He wanted to move to a different wing. Mr Curtis would not say who he was bullied by or what the items were. She completed an Incident Report with this information and informed the safer custody team.

33. On 26 March, Mr Curtis was moved from L wing to D wing because of debt and bullying. Mr Curtis' half-brother was also a prisoner on D Wing. A custodial manager told the investigator that, in his role as the wing manager, he was aware that Mr Curtis had mental health issues. He said that Mr Curtis was an enhanced prisoner and worked as a wing cleaner. There was no intelligence to suggest that Mr Curtis was the victim of bullying while he was on D Wing.

34. Between 27 March and 8 June, Mr Curtis had six separate mental health therapeutic counselling sessions with the mental health counsellor. Each time Mr Curtis denied having any thoughts of self-harm or suicide. He was referred to the substance misuse team on 11 April, after he again admitted using NPS. Mr Curtis saw the substance misuse counsellor on 11 May, and told him he only wanted to work with women. When he told Mr Curtis that he was unable to choose his counsellor, Mr Curtis declined any further assistance and signed another disclaimer.

35. On 9 June, Mr Curtis participated in a telephone conference with his community probation offender manager, along with his prison offender supervisor and the mental health counsellor. They discussed with Mr Curtis the options and benefits of him applying to transfer to a PIPE unit. Mr Curtis agreed to liaise with the prison offender supervisor and decide which PIPE unit he would prefer.

36. On 17 June, the mental health counsellor saw Mr Curtis for a further therapeutic session. She recorded in Mr Curtis' medical record that he said that he had had thoughts of suicide during the previous week. Despite this, she recorded that Mr Curtis had no suicidal thoughts at that time and did not consider opening an ACCT.

37. On 23 June, the prison offender supervisor recorded in Mr Curtis' prison computer record that he had discussed PIPE units with Mr Curtis on several occasions since 9 June, and Mr Curtis wished to be considered for the PIPE unit at either HMP Wymott or HMP Frankland. He recorded that this information had been given to the community probation offender manager. He told the investigator that once an application was submitted it could take some time before a prisoner was granted a transfer to a PIPE unit, as applicants must wait until a place becomes available.

38. On 1 July, the mental health counsellor saw Mr Curtis for a further therapeutic session. She recorded in Mr Curtis' medical record that he again said that he had felt suicidal during the previous week. Despite this, she again recorded that Mr Curtis had no suicidal thoughts at that time and did not consider opening an ACCT. Mr Curtis said he was unable to choose a PIPE unit himself and was happy for staff to advise him which one to go to.

39. The mental health counsellor told the investigator that she saw Mr Curtis for a further therapeutic session on 8 July, but had not recorded this in his medical records. She accepted that this was a professional error. She said that she told Mr Curtis that she was due to go on annual leave and would see him as soon as she returned. She said that Mr Curtis denied having any thoughts of self-harm or suicide.

40. On 11 July, an officer completed an Incident Report as Mr Curtis had been abusive, had threatened her and made physical contact with her. Mr Curtis said that he wanted be "treated differently" as he had a life sentence. She told Mr Curtis that all prisoners on the wing were treated in the same way.

41. A custodial manager told the investigator that he knew that Mr Curtis was waiting for a transfer to a PIPE unit, either at HMP Wymott or HMP Frankland. He said that Mr Curtis' inappropriate behaviour towards the officer meant he would have to leave D Wing.

42. On 12 July, a member of the mental health team was stopped by Mr Curtis as she walked through D wing. Mr Curtis said that he felt ignored by the mental health counsellor, as he had been unable to speak to her the previous day. She reminded Mr Curtis that the counsellor had other patients to see and was on annual leave. Mr Curtis asked to see her the following day and she agreed.

43. On 13 July, the nurse went to see Mr Curtis on D wing as arranged. Mr Curtis initially declined to see the nurse as he was extremely angry that the mental health counsellor was on holiday. He said he felt let down by her and his "head was going". He said he felt messed around as he had not been given a definitive answer as to which PIPE he would transfer to. Mr Curtis said he liked things in "black and white" and did not want to be told anything until everything had been

decided. She recorded that Mr Curtis' mood fluctuated from being hostile to pleasant. She noted that Mr Curtis was not at risk of harm to himself or others.

44. Later that afternoon, Mr Curtis should have been moved to I wing as a result of the threats he had made to the officer. Mr Curtis' security record confirms that it had been arranged for him to move to I Wing, as a move to L Wing was not appropriate due to the issues of debt and bullying. The I wing manager refused to accept him as there were no single cells available on that wing and Mr Curtis, having received a high risk CSRA assessment, required a single cell. As a result Mr Curtis moved to L wing where a single cell was available.

Events of 14 July

45. At 6.06am, an operational support grade (OSG) was conducting the early morning roll check when he arrived at Mr Curtis' cell. He looked through the observation panel and saw Mr Curtis hanging from the window bars by a ligature made from bedding. He left the scene and went to the wing office and called the custodial manager and the night orderly officer (the person in charge of the prison during the night). He told her he had seen Mr Curtis hanging in his cell.

46. The OSG told the investigator that he had a radio and a key to enter cells in an emergency but he did not use them. He said he understood the emergency radio codes that staff should use including code blue, which alerts staff that a prisoner is unconscious or has difficulty breathing, and code red for blood loss. However, he confirmed that he went to the office to use the phone to contact the custodial manager instead. She used her radio to summon staff assistance on L Wing. No emergency code was used.

47. At 6.11am, an officer arrived at the cell. He told the investigator that he looked through the observation panel and could see Mr Curtis hanging from the window bars by a ligature. He was in a sitting position and was fully dressed. He explained that in emergencies staff have the discretion whether to enter a cell alone or wait for assistance.

48. At 6.12am, a nurse arrived at the cell. She told the investigator that no emergency code had been radioed and she had no idea what the nature of the emergency was. Once she arrived at Mr Curtis' cell, she looked through the observation panel, saw him hanging and immediately ran to get the emergency bag.

49. At 6.13am, the custodial manager arrived at Mr Curtis' cell, opened the cell door and she and the officer went into to the cell. They cut the ligature and noted that Mr Curtis' body was rigid and remained in the sitting position, indicating rigor mortis. However, they started cardiopulmonary resuscitation (CPR).

50. At 6.16am, the nurse returned to the cell with the emergency bag. She told the investigator that she had 24 years nursing experience, including accident and emergency and trauma units. She said that based on her experience it was evident that Mr Curtis had been dead for quite some time. She said she felt very uncomfortable carrying out CPR, as it would have been more dignified to not have carried out such procedures. However she believed she was obliged to perform CPR until the paramedics arrived and took over Mr Curtis' care. She

said she did not use an automatic defibrillator as she recognised that this would have been futile.

51. Yorkshire Ambulance Service records confirm that the emergency call was made at 6.16am. Paramedics arrived at the prison at 6.35am, and arrived at Mr Curtis' cell at 6.45am. The paramedics pronounced Mr Curtis dead at 6.47am.

Contact with Mr Curtis' family.

52. A member of the prison's chaplaincy saw Mr Curtis' half-brother to break the news of Mr Curtis' death and offer support. Although Mr Curtis had not given any details of his next of kin, he was allowed to call his mother and inform her of his half-brother's death.

53. The managing chaplain and family liaison officer, and the bereavement counsellor visited Mr Curtis' mother at home at 11.05am. They confirmed the news that Mr Curtis had died and offered their condolences and support. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

54. The Deputy Governor debriefed the staff who had been involved in the emergency response. Staff members were offered the support of the prison's care team.

55. The prison posted notices informing other prisoners of Mr Curtis' 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 Curtis' death.

Post-mortem report

56. A post-mortem examination, conducted by a Home Office Forensic Pathologist confirmed that the cause of Mr Curtis' death was hanging. Commenting on the toxicology results he found that no illicit substances or medicines were detected. However, a small quantity of alcohol was detected, although he stated that this may be due to naturally occurring microbial activity following death.

57. However, given the existence of more than one account of Mr Curtis being an NPS user, together with the toxicological challenges in identifying new forms of NPS, we cannot conclusively state that the use of NPS was not a factor in Mr Curtis' death.

Findings

Assessment of risk

58. The Prison Service Instruction covering safer custody, Prison Service Instruction (PSI) 64/2011, lists a number of risk factors and potential triggers for self-harm and suicide. These include recall to custody, previous self-harm, mental health issues and drug abuse. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

59. In a thematic report about risk factors in self-inflicted deaths published in April 2014, we identified that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. Mr Curtis had factors known to increase the risk of suicide and self-harm which are identified in our thematic report and in Prison Service instructions. He had mental health issues and had a history of drug abuse. We note that he was conscious of his lifer status and that progression to a PIPE was being discussed as a way of helping him progress.

60. On the two occasions Mr Curtis told the mental health counsellor that he had suicidal thoughts, she did not appropriately assess his risk of suicide and self-harm and did not take any action to support him despite her knowledge of Mr Curtis' mental health issues. This was a significant failing. We note that this issue has been investigated further by City Health Care Partnership. She was suspended from duty on 10 September, the day after she was interviewed by our investigator, while an internal investigation took place. She returned to duty on 12 December, on a supervised back to work plan which included addressing training needs and restrictions on her level of practice, until City Health Care Partnership is satisfied she is competent to practise on her own.

61. We consider that an ACCT should have been opened to support Mr Curtis when he said he had thoughts of suicide. Although we do not know whether this would have affected the outcome for Mr Curtis, the failure to open an ACCT meant that he did not receive structured, ongoing support. We make the following recommendation:

    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. In particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

62. Although we accept that there were good reasons for Mr Curtis to be moved from D Wing, we are concerned that he was moved to L wing against security advice. Mr Curtis had been moved from L Wing only three months earlier because of debt issues and bullying and there is no indication that this risk had reduced.

63. Mr Curtis' security record confirms that he was to be moved from D Wing to I Wing. We understand that there was an issue over the availability of single cells on I Wing, but the investigation has not been able to identify the number of

available single cells in the prison, other than on L Wing, on the day Mr Curtis was moved.

64. We consider that Mr Curtis should not have been moved to L Wing. It meant that Mr Curtis was moved to a wing where he was known to be at risk from others. We make the following recommendation:

The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk from other prisoners, the need to record, share and consider all relevant information about risk, and make appropriate decisions based on that information.

Clinical Care

65. The clinical reviewer commented that Mr Curtis was diagnosed with a personality disorder and with antisocial and paranoid traits. He was very difficult to engage fully in any mental health treatment due to his diagnosis. He noted that Mr Curtis appeared to have become over-dependent on his therapeutic relationship with the mental health counselor and that his medical record showed this had happened in the past with other health professional and prison staff. He said this is not uncommon with individuals with a personality disorder.

66. The clinical reviewer was concerned that the mental health counselor had failed to update Mr Curtis' medical record with the detail of all her interventions with Mr Curtis. He was also concerned that there was a missed opportunity to open an ACCT when Mr Curtis told her that he felt suicidal. Also that this information was not shared with the prison staff. He believed that, although this may not have prevented Mr Curtis from taking his own life, additional support outside the therapeutic relationship with her should have been put in place.

New Psychoactive Substances

67. Mr Curtis had made candid admissions to staff that he had used NPS while at Humber but he declined to work with substance misuse recovery groups at the prison. Although the post-mortem toxicology results indicate Mr Curtis had not used illicit drugs immediately prior to his death, he had told staff he had used NPS while at Humber. There are concerns that use of NPS can produce a range of bizarre behaviours or paranoia. We also note that Mr Curtis' use of NPS appears to have taken place on a wing where he was exposed to and involved in the traffic of illicit items and associated problems of debt and bullying. He was returned to that wing the day before he died.

68. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. 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 NPS; 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 are effective supply and demand reduction strategies to help eradicate the availability of new psychoactive substances, and that staff are vigilant to signs of its use and know how to

respond when a prisoner appears to be under the influence of such substances.

Emergency response

69. We have a number of concerns about the emergency response on 14 July. 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, states 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.

70. The OSG found Mr Curtis hanging, did not open the cell and told us that he 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.

71. The OSG did not radio a medical emergency code blue when he found Mr Curtis hanging as he should have done. Instead, he went to the wing office and telephoned the custodial manager. She radioed for staff to attend but also did not use an appropriate emergency code. This meant that when the nurse attended she did not know the nature of the emergency and had to leave to collect the emergency bag.

72. From the time that Mr Curtis was found hanging there was a delay of seven minutes before staff entered the cell and a further three minute delay before an ambulance was called.

73. PSI 03/2013, *Medical emergency response codes,* 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 states that control room staff should automatically call an ambulance whenever an emergency code is called and that it is not necessary for a member of the prison healthcare team or a duty manager to attend the scene before emergency services are called.

74. Ambulance Service records show that the paramedics arrived at the prison at 6.35am, and reached the patient at 6.45am. PSI03/2013 also says that governors should ensure there is no unnecessary delay in escorting ambulances and paramedics to the patient and this must include procedures for admitting ambulances during the night.

75. While these issues did not impact on the outcome for Mr Curtis, 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;**
- **Staff radio an appropriate emergency code;**
- **Control room staff call an ambulance as soon as an emergency code is broadcast;**
- **There is no unnecessary delay in escorting ambulances and paramedics.**

Resuscitation

76. Staff and the nurse started CPR when they entered Mr Curtis' cell and cut the ligature. However, she said that rigor mortis was clearly evident and Mr Curtis had obviously been dead for some time. The clinical reviewer commented that the emergency response provided by her was delivered to the best of her ability and knowledge. However, he was concerned that she felt compelled to carry out CPR even though she was clear that Mr Curtis was dead.

77. Attempting CPR when someone is clearly dead is distressing for staff and undignified for the deceased. European Resuscitation Council (ERC) Guidelines for Resuscitation 2015, Section 11 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.

78. Since Mr Curtis' death, the National Offender Management Service, the Royal College of Nursing and the Royal College of General Practitioners jointly issued guidance on when not to perform resuscitation (September 2016). The guidance states that resuscitation must be started on all patients who are found not breathing and/or pulseless unless certain conditions exist, in particular rigor mortis.

79. In prisons the primary judgment to be made is whether rigor mortis is present. The answer to this will inform the decision about commencing CPR. The ERC guidelines state that in such cases, a non-clinician might be making a diagnosis of death but is not verifying or certifying death. CPR should not be commenced when it has no chance of success in terms of survival and may violate the right for dignity in death.

80. Staff who are not able to recognise rigor mortis should start resuscitation until advised otherwise by a competent member of staff. When the decision not to resuscitate a prisoner has been made by a competent, qualified nurse or other healthcare professional, it is inappropriate for them to be overruled by prison staff.

81. It was inappropriate for staff to commence CPR on Mr Curtis as rigor mortis was clearly evident and he had been dead for some time. 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.

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