Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William McGeough, a prisoner at HMP Grendon, on 21 December 2019

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 William McGeough was found hanging in a toilet block at HMP Grendon on 21 December 2019. He was 47 years old. I offer my condolences to Mr McGeough's family and friends.

Mr McGeough arrived at Grendon on 19 December. He had spent just over a year at HMP Long Lartin, and then one night at HMP Bullingdon, before he was moved to Grendon.

Shortly after he arrived at Long Lartin in November 2018, Mr McGeough told staff that he felt under threat. He self-isolated in his cell for almost the entire time he was there. His sister died in late November 2019 and he told staff that he had had a "wasted life".

I am concerned that these pieces of information were not shared appropriately, which resulted in numerous missed opportunities to recognise that Mr McGeough's risk of suicide had increased and to put appropriate support in place.

I am also concerned that there were delays in prison staff finding Mr McGeough at Grendon. Despite the sanitation system alerting staff that Mr McGeough had not returned to his cell after being let out to use the toilet, there was a delay of at least seven minutes before he was found hanging. There were also delays in calling for an emergency ambulance. I cannot say whether the delays affected the outcome for Mr McGeough but, we know that in an emergency situation, a delay of a few minutes may be critical.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **November 2020**

Contents

Summary

Events

1. On 16 June 2014, Mr William McGeough was sentenced to 20 years imprisonment for violent offences. On 1 November 2018, he was moved to HMP Long Lartin.

2. Shortly after arriving at Long Lartin, Mr McGeough told staff that he did not feel safe as he and his family had received threats on social media. From 18 December, he self-isolated in his cell. Staff were concerned that his self-isolation was affecting his mental health and he was monitored by the Inclusion team (integrated mental health and substance misuse treatment services). Mr McGeough asked for a transfer out of Long Lartin.

3. On 29 November 2019, a chaplaincy volunteer told Mr McGeough that his sister had died and offered Mr McGeough support. A week later, the chaplaincy volunteer checked on Mr McGeough, who told him that he had had a violent childhood and a "wasted life".

4. On 17 December, Mr McGeough was moved to HMP Bullingdon, where he spent one night, before being moved to HMP Grendon.

5. At 12.35pm on 21 December, while all prisoners were locked in their cells, Mr McGeough was let out of his cell so he could use the toilet. (There is no in-cell sanitation at Grendon so prisoners must use the toilet block on the wing. When a prisoner is locked in their cell, they have to press a button to request access to the toilet block and then their cell is unlocked remotely.) Eight minutes later, the sanitation system recognised that Mr McGeough had not returned to his cell and an alarm rang in the control room.

6. A control room operator used the intercom to ask Mr McGeough to return to his cell but he did not respond. Then an officer went to the landing gate and called out to Mr McGeough but got no response. The control room operator called for a custodial manager to attend and when he arrived, they entered the toilet block and found Mr McGeough hanging from a ligature. The custodial manager called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing). Healthcare staff and other officers quickly responded. They started cardiopulmonary resuscitation, gave Mr McGeough rescue breaths using an Ambu-bag and attached a defibrillator.

7. The control room called for an ambulance at 12.58pm and again at 1.03pm. Paramedics reached Mr McGeough at 1.24pm but they were unable to resuscitate him and, at 1.52pm, an air ambulance doctor declared that he had died.

Findings

Assessment of Mr McGeough's risk of suicide and self-harm

8. Information about Mr McGeough's bereavement and his statement that he had had a "wasted life" was not shared with Long Lartin's Inclusion team or noted by

staff at Bullingdon or Grendon. Staff missed opportunities to recognise that Mr McGeough's risk of suicide had increased and put appropriate support in place.

9. Mr McGeough had been isolating for over a year before he was moved to Grendon and he recognised that reintegration would be his biggest challenge. Despite this, staff did not offer him specific support either before or after he transferred.

10. Grendon's chaplaincy team did not check on Mr McGeough or discuss his bereavement, despite Long Lartin's chaplaincy team having contacted them to suggest that he might need support.

Mental health

11. The clinical reviewer concluded that, overall, the clinical care that Mr McGeough received was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer considered that when Mr McGeough said he heard talking coming from the water on 20 May, Inclusion should have reviewed him further to rule out emerging psychosis.

Emergency response

12. Although the sanitation system alerted staff at 12.43pm that Mr McGeough had not returned to his cell, staff did not find him until at least seven minutes later. The prison did not call for an ambulance until 12.58pm and the call gave insufficient information for the Ambulance Service to treat it as an emergency, which delayed paramedics for a further five minutes.

13. During the resuscitation attempt, a nurse did not insert an airway because she thought that Mr McGeough's neck was blocked. The clinical reviewer considered that the airway's user guide does not record swelling of the neck as a reason for not inserting an airway and so considered that the nurse should have tried to insert an airway.

Recommendations

- The Governor, the Head of Healthcare and the Head of Chaplaincy of HMP Long Lartin should ensure that all staff have a clear understanding of the need to record and promptly share information about a prisoner's possible risk.

- The Governor and the Head of Chaplaincy of HMP Long Lartin should ensure all chaplaincy staff have access to NOMIS and that they record their own contacts with prisoners as soon as practicable.

- The Director General of Prisons should amend Prison Service Instruction 05/2016 to say that chaplaincy staff should pass on information to healthcare staff after breaking the news of a relative or friend's death to a prisoner.

- The Governors and the Heads of Healthcare of HMP Long Lartin and HMP Grendon should ensure that staff offer support to prisoners who self-isolate prior to and following a transfer.

- The Governors and the Heads of Healthcare of HMP Bullingdon and HMP Grendon should ensure that staff manage newly arrived prisoners in line with national guidelines, including ensuring that they:
  - examine all available documentation on the prisoner and consider and record all known risk factors for suicide and self-harm; and
  - interview the prisoner after examining all available documentation.
- The Governor and the Head of Chaplaincy of HMP Grendon should ensure that the chaplaincy team offers support to all prisoners who have recently suffered the death of a relative or friend.
- The Head of Healthcare of HMP Long Lartin should ensure that staff complete in-depth assessments when a prisoner makes statements that could suggest emerging psychosis.
- The Governor of HMP Grendon should review the processes when a prisoner has failed to return to their cell after using the sanitation system to ensure that control room staff immediately alert staff on the relevant wing and to minimise any delays finding the prisoner.
- The Governor of HMP Grendon should ensure that control room staff call an ambulance as soon as an emergency code is called and that information about the prisoner's condition is obtained and promptly passed to the ambulance service.
- The Head of Healthcare at HMP Grendon should ensure that staff know when it is appropriate not to attempt to insert an I-gel airway.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Grendon, HMP Bullingdon and HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

15. He visited Grendon on 30 December 2019. He obtained copies of relevant extracts from Mr McGeough's prison and medical records.

16. NHS England commissioned an independent clinical reviewer to review Mr McGeough's clinical care at the prison.

17. The investigator interviewed five members of staff and one prisoner at Grendon on 17 February, seven members of staff at HMP Long Lartin on 18 and 19 February and 2 March, and three members of staff at HMP Bullingdon on 21 February. He also interviewed two members of staff from Grendon by telephone on 12 March and 1 April. The clinical reviewer accompanied him for the interviews on 17, 18 and 21 February, and 2 March.

18. We informed HM Coroner for Buckinghamshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr McGeough's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr McGeough's next of kin asked for all future correspondence to be made through a Police Community Support Officer (PCSO). The PCSO passed on our contact details to another member of Mr McGeough's family who contacted another of the Ombudsman's family liaison officers and raised his concerns. Mr McGeough's other family member wanted to know:

    - Why Mr McGeough was moved to HMP Long Lartin and HMP Grendon.
    - What Long Lartin and Grendon knew about Mr McGeough's mental health and how they treated him.
    - Whether anyone picked up on the deterioration in Mr McGeough's mental health, which was clear from letters that he sent to his family from 12 to 18 months before his death.
    - Why Mr McGeough was moved to the segregation unit at Long Lartin.

    We have answered these questions in this report.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

21. The initial report was shared with Care UK, the healthcare provider at Grendon, by NHS England. Care UK pointed out some factual inaccuracies and this report has been amended accordingly.

22. The initial report was shared with the clinical reviewer, who pointed out some factual inaccuracies and this report has been amended accordingly.

23. Mr McGeough's other family member received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Grendon

24. HMP Grendon holds around 230 men and is one of only two prisons that undertake accredited therapy in democratic therapeutic communities. Care UK provides healthcare services and there is no inpatient unit.

25. The cells at Grendon do not have in-cell sanitation. Instead, they have communal toilet and washroom blocks. An automated unlocking system allows prisoners to access the toilets during lock-up periods. A prisoner must press the sanitation button and his door will be unlocked automatically, provided that no other prisoner is out of his cell. The prisoner has eight minutes to complete his visit and, on return to his cell, must enter a code to confirm his return. The system automatically locks his door and the next prisoner waiting can be let out. If the prisoner does not return to his cell, an alarm rings in the control room and the control room operator will take steps to check on that prisoner's wellbeing, including using the intercom system to ask the prisoner to return to their cell and contacting a wing officer to check on them.

HMP Bullingdon

26. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds approximately 1,100 prisoners. Care UK provides healthcare services and there is an inpatient unit, with 24-hour nursing care.

HMP Long Lartin

27. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners live in single cells. Care UK provides primary healthcare services and Inclusion provides integrated mental health and substance misuse services.

HM Inspectorate of Prisons

28. The most recent inspection of HMP Grendon was in May 2017. Inspectors reported that reception staff were welcoming, and support during a prisoner's early days in the prison was good. They also found that staff provided very good support to prisoners through the therapeutic process. Inspectors noted that the automated sanitation system was outdated and presented real challenges to prisoners.

29. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors reported that the strategic management of suicide and self-harm prevention was impressive and potential triggers were shared. They also found that Inclusion services were good and that the chaplaincy team played a full part in prison life.

30. The most recent inspection of HMP Bullingdon was in July 2019. Inspectors reported that most prisoners said that they were treated well in reception and that the initial welcome was good. However, inspectors were not confident that reception and first night staff adequately understood the risk factors that needed to be considered for all newly arrived prisoners.

Independent Monitoring Board

31. 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.

32. In its latest annual report for HMP Grendon, for the year to 31 December 2019, the IMB reported that there had been an increase in the number of intelligence reports submitted that related to the risk of suicide compared to the previous year and that the sanitation system was due to be upgraded.

33. In its latest annual report for HMP Bullingdon, for the year to 30 June 2018, the IMB reported that the turnover at the prison was high and that approximately 15,000 prisoners had passed through the reception during the reporting year.

34. In its latest annual report for HMP Long Lartin, for the year to 31 January 2019, the IMB reported that the prisoners who died in the prison had not been flagged by the monthly distribution of "trigger points". They also reported that a recent NHS Quality Inspection report found that healthcare services were good overall and that the work of the chaplaincy team had extended far beyond its statutory obligations, including supporting prisoners who had faced a new bereavement.

Previous deaths at HMP Grendon

35. Mr McGeough was the second prisoner to die at Grendon since December 2017. The first death was from natural causes. There were no similarities with the previous death.

Previous deaths at HMP Bullingdon

36. There have been 12 deaths at Bullingdon since December 2017. Five of the previous deaths were self-inflicted, one was drug-related and six were from natural causes. We have previously made recommendations about the management of newly arrived prisoners.

Previous deaths at HMP Long Lartin

37. There have been ten deaths at Long Lartin since December 2017. Six of the previous deaths were self-inflicted, two were drug-related and two were from natural causes. We have previously made recommendations about sharing information that increases a prisoner's risk of suicide or self-harm.

Key Events

38. On 8 January 2014, Mr William McGeough was remanded in prison custody and sent to HMP Exeter.

39. On 16 June, Mr McGeough was sentenced to 15 years imprisonment, with an extension period of five years, for serious, violent offences.

40. On 1 November 2018, after spending time at various prisons, Mr McGeough was moved to HMP Long Lartin.

41. On 9 November, Mr McGeough refused to return to his cell on C Wing because he was "under threat", though he refused to give further details. An officer placed Mr McGeough on a disciplinary charge and staff moved him to the segregation unit.

42. On 23 November, Mr McGeough told a healthcare administrator that he did not feel safe on standard wings due to threats that he and his family had received on social media. He also said that information about his offence had been broadcast on Channel 4's "Dispatches" programme. (Neither Mr McGeough nor any footage from Long Lartin appeared on this programme.)

43. On 4 December, an Inclusion recovery practitioner (Inclusion provide integrated mental health and substance misuse treatment services) saw Mr McGeough, who said that he had a history of depression that started when his aunt died from cancer. She noted that she did not have any concerns about Mr McGeough and that there was no evidence that he was suffering from a thought disorder. She planned for him to undertake some structured psychosocial intervention.

44. On 8 December, a supervising officer (SO) recorded in Mr McGeough's electronic prison record (NOMIS) that intelligence suggested there was a threat against him and that the prison was considering whether it was credible.

45. On 16 December, the Head of Residential Services completed a Situational Vulnerable Prisoner Assessment and authorised Mr McGeough to be classed as a vulnerable prisoner. Later that day, Mr McGeough was moved from the segregation unit to B Wing.

46. The next day, Mr McGeough told an SO that he was under threat from someone on B Wing and that he had heard someone shouting that they would "pay to have him done in". The SO opened a Violence Reduction (VR) document, which instructed staff to monitor Mr McGeough for a minimum of seven days, and applied to put Mr McGeough on a Challenge, Support and Intervention Plan (CSIP).

47. The same day, Mr McGeough refused to move from B Wing to A Wing because he said he was under threat from someone on A Wing. He said that he was prepared to accept a disciplinary charge but wanted to return to the segregation unit. The SO placed him on a disciplinary charge but Mr McGeough stayed on B Wing.

48. From 18 December, Mr McGeough chose not to leave his cell for association, exercise or to collect his food. Prison staff took meals to Mr McGeough's cell and offered him access to showers, exercise and association.

49. On 24 December, Mr McGeough said that he did not want to leave his cell to attend a VR review. An SO saw Mr McGeough in his cell, who said that he did not need anything from the staff. A week later, an SO closed Mr McGeough's VR document due to his unwillingness to engage with the process.

50. On 3 January 2019, a custodial manager (CM) rejected the CSIP application as he considered the prison could support Mr McGeough outside of that process.

51. The next day, an SO spoke to Mr McGeough about his self-isolation and the impact it was having. Mr McGeough repeated that he was under threat because a prisoner on F Wing had revealed something about him on social media. He also said that he did not want to engage with staff or the wing regime and that he would use the prison's sanitation system to use the showers. Later that day, the SO completed an Isolated Prisoner Form and Wing Management Plan, which instructed staff to offer Mr McGeough a shower, telephone call, time outside, a chance to clean his cell and food on a daily basis.

52. The same day, the SO completed a mental health referral and recorded that he was concerned about Mr McGeough's coping skills, mood changes, self-neglect, change of character, withdrawal and unusual behaviour.

53. On 9 January, the Inclusion recovery practitioner saw Mr McGeough, due to concerns about him self-isolating. Mr McGeough repeated that he was under threat from a prisoner who was friends with his victim. She explained that self-isolating would not help his mental health and that Mr McGeough needed to interact with other people. She decided to see Mr McGeough weekly, due to his self-isolation.

54. That same day, a trainee forensic psychologist saw Mr McGeough to discuss his sentence progression. Mr McGeough said he wanted a transfer from Long Lartin.

55. On 16 January, the Inclusion recovery practitioner saw Mr McGeough, who recognised that his mood had deteriorated. She agreed he had deteriorated since her previous visit so she gave Mr McGeough some activity sheets to occupy him when in his cell.

56. On 25 January, the trainee forensic psychologist saw Mr McGeough for a programme needs assessment. Mr McGeough said that he was considering a move to a therapeutic community prison, as part of his sentence progression.

57. On 6 February, the Inclusion recovery practitioner saw Mr McGeough, who said that he had become less motivated to complete any task and that he was spending more time sleeping.

58. Six days later, she saw Mr McGeough and noted that he seemed brighter than on her previous visits. He spoke about the experiences that shaped his behaviour and recognised that he had issues around rejection and abandonment.

59. That same day, an officer told Mr McGeough that the prison's offender management unit was looking to transfer him. Mr McGeough said that he wanted to go to HMP Dovegate, HMP Lowdham Grange or HMP Wakefield, as they ran the Kaizen offender behaviour programme (a programme for prisoners who have been convicted of violent or sexual offences).

60. On 12 March, an officer spoke to Mr McGeough and suggested that he could complete the Kaizen programme at HMP Frankland, but he said that he did not want to go back there.

61. The following day the trainee forensic psychologist told Mr McGeough that if he remained as a vulnerable prisoner then he could only complete the Kaizen in Frankland. She also gave Mr McGeough information about therapeutic community prisons.

62. On 14 March, the Inclusion recovery practitioner saw Mr McGeough, who was in a positive mood and was speaking about his future in prison. Mr McGeough reiterated that he was considering a transfer to a therapeutic community prison.

63. On 17 May, Mr McGeough told the trainee forensic psychologist that he wanted to defer the Kaizen programme so that he could transfer out of Long Lartin.

64. Three days later, the Inclusion recovery practitioner saw Mr McGeough and she apologised for not seeing him for a few weeks. Mr McGeough recognised that self-isolation had impacted his mental wellbeing and said he often slept during the day and was up at night. He said that, on occasions, he heard talking coming from the water when using the toilets at night though he recognised that this was not real. She agreed to see Mr McGeough in a few weeks but did not investigate his statement further.

65. On 12 June, the Inclusion recovery practitioner, a CM and an SO met with Mr McGeough to discuss his prolonged self-isolation. The Inclusion recovery practitioner considered that Mr McGeough's mental health had deteriorated and that she had not seen him so low in mood. Mr McGeough agreed his mental health had declined but said that he would not hurt himself. He also said that he would not reintegrate and repeated that he wanted to leave Long Lartin. She gave him more distraction material.

66. On 16 July, Mr McGeough completed an application for a transfer to the therapeutic community at HMP Grendon. Mr McGeough wanted to explore the issues that caused his offending behaviour, though he accepted that the therapeutic process could be difficult for him. Mr McGeough said that he was the oldest of five siblings and that one of his sisters had died unexpectedly.

67. On 18 July, the Inclusion recovery practitioner saw Mr McGeough, who said that his mental wellbeing was okay though he had days when he was lower in mood. Mr McGeough said that he had no thoughts of suicide or self-harm and that he had recently applied to Grendon, and hoped to transfer there before Christmas.

68. On 16 September, the Inclusion recovery practitioner saw Mr McGeough, who said that the transfer to Grendon was the "light at the end of his tunnel" and that it helped to support his mental health. Mr McGeough recognised that his biggest challenge when moving would be reintegrating and engaging with other

prisoners. She agreed to give Mr McGeough some distraction packs and colouring pencils.

69. On 29 November, a police officer contacted the prison and told them that Mr McGeough's sister had died. A chaplaincy volunteer visited Mr McGeough and broke the news immediately. Mr McGeough was distressed by the news and said that his other sister had also died recently. He was also concerned about his next of kin, though he said he would speak to his next of kin before deciding whether to apply for permission to attend the funeral. The chaplaincy volunteer said that Chaplaincy would try to support Mr McGeough.

70. Two days later, a prison chaplain checked on Mr McGeough, who said he had spoken with his next of kin and had decided not to attend the funeral. The chaplain suggested that the chaplaincy could hold a short service for her and Mr McGeough said that he would think about this.

71. On 4 December, Mr McGeough asked an officer for £10 emergency credit so that he could phone his family about his sister's death. There is no record that the prison's business hub received or processed an application for emergency credit.

72. Two days later, the chaplaincy volunteer checked on Mr McGeough, who thought his sister had taken her own life or died from a drug overdose. Mr McGeough spoke about his violent childhood and said that he had had a "wasted life". He did not record this information on NOMIS.

73. On 12 December, a forensic psychologist at Grendon noted that Mr McGeough was self-isolating and asked for confirmation that he was suitable before moving prisons. Four days later, a trainee forensic psychologist at Long Lartin replied that Mr McGeough was very motivated to transfer and that he was willing to engage with the regime, which he felt would be safer and more supportive.

Overnight stay at HMP Bullingdon

74. On 17 December, Mr McGeough was moved to HMP Bullingdon, where he spent one night. When he arrived, an SO completed the Reception SO Check Sheet and answered "no" to the question "Does the prisoner have any self-harm/ suicide warnings?" The SO checked Mr McGeough's Person Escort Record (PER) and Self-Harm Warning Forms but did not check NOMIS.

75. At 4.55pm, an officer completed a first night interview with Mr McGeough and recorded on NOMIS that he had not raised any issues. The officer created a Cell Sharing Risk Assessment for Mr McGeough but did not complete any of the evidence searches, which included reviewing NOMIS. The officer also did not complete the First Night Officer Assessment.

76. At 6.00pm, a nurse saw Mr McGeough for an initial health assessment. Mr McGeough said that he had not hurt himself while in prison and that he did not have any thoughts of suicide or self-harm. She answered "no" to the question "Has the patient had other recent life changing event?" although she noted that Mr McGeough was grieving following the death of his sister.

77. At 9.10pm, Mr McGeough told an officer that he wanted to speak to a Listener (a prisoner trained by the Samaritans) but one was not available so the officer

offered access to the Samaritans' phone. Staff at Bullingdon were unable to say why a Listener was not available.

78. On the morning of 18 December, a nurse saw Mr McGeough prior to his transfer and he did not express any concerns.

Transfer to HMP Grendon

79. Later that day, Mr McGeough was moved to Grendon. An officer completed a first night interview with Mr McGeough. Mr McGeough said that he was pleased to have transferred and that he did not have any thoughts of self-harm. The officer arranged a telephone call between Mr McGeough and his next of kin, and noted that he seemed emotional during the call.

80. The same day, a nurse saw Mr McGeough for an initial health assessment. Mr McGeough said he had not hurt himself in prison and he did not have any thoughts of suicide or self-harm. The nurse answered "no" to the life changing event question and did not note that Mr McGeough was grieving.

81. The same day, Mr McGeough completed a wing diary and wrote that he felt a "high level of anxiety and some self-doubt".

82. On the morning of 19 December, Mr McGeough spoke to a prisoner about his sister's death. He told staff that Mr McGeough cried throughout the conversation and said he felt distressed that morning. (He provided this information to staff after Mr McGeough's death.)

83. At 1.48pm, the managing chaplain at Long Lartin, emailed the Head of Chaplaincy at Grendon, and told him that Mr McGeough had suffered a recent bereavement so should be checked. At 1.54pm, the Head of Chaplaincy forwarded the email to the rest of the chaplaincy team, including a prison chaplain.

84. Later that afternoon, a prison chaplain saw Mr McGeough for a chaplaincy induction. The prison chaplain noted that Mr McGeough was polite but he refused to engage. There is no record that he spoke to Mr McGeough about the death of his sister.

85. On 20 December, Mr McGeough completed a wing diary and wrote that he had had a restless night so awoke anxious. He also wrote the he had low level anxiety and wondered whether grief was causing him to do enough to integrate.

Saturday 21 December 2019

86. At approximately 11.45am on 21 December, prison staff locked Mr McGeough and all other prisoners in their cells on G Wing for the lunchtime period.

87. At 12.35pm, Mr McGeough pressed the sanitation button in his cell, and his cell was unlocked remotely so that he could go to the toilet block. Eight minutes later, the sanitation system recognised that Mr McGeough had not returned to his cell and an alarm rang in the control room. An operational support grade (OSG), used the intercom system and asked Mr McGeough to return to his cell.

88. The OSG then tried to contact an officer by telephone but was unsuccessful. Two minutes later, the OSG spoke to the officer using the one-to-one feature on the radio and told her that Mr McGeough had not returned to his cell. The officer went to the landing gate and called to Mr McGeough but he did not respond. A short time later, the OSG asked a CM to go to G Wing. He went to the wing and met the officer at the landing gate.

89. A CM and the officer entered the landing, looked into the toilet and saw Mr McGeough hanging from a ligature. At 12.56pm, as noted on the Daily Communications Log, the CM called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing), though the OSG believed that the control room's clock was six minutes fast. The officer cut the ligature, which was made from three shoelaces and had been attached to a heating pipe, and they moved Mr McGeough to the floor. The CM then started cardiopulmonary resuscitation (CPR).

90. A nurse, a healthcare assistant and other officers quickly responded to the code blue emergency. They continued CPR, gave Mr McGeough rescue breaths using an Ambu-bag and attached a defibrillator which did not detect a shockable heart rhythm and advised to continue CPR.

91. According to the South Central Ambulance Service, the prison made two telephone requests for an ambulance at 12.58pm and 1.03pm. The OSG who made the first call gave basic information and the Ambulance Service gave it a lower priority response. Following the second call, the Ambulance Service sent an air ambulance and an ambulance to the prison and they reached Mr McGeough at 1.24pm and 1.30pm respectively. Paramedics took over the resuscitation attempt, inserted an airway, attached a LUCAS chest compression machine and gave Mr McGeough three doses of adrenaline. They were unable to resuscitate him and, at 1.52pm, an air ambulance doctor declared that he had died.

Contact with Mr McGeough's family

92. Following Mr McGeough's death, the prison noted that Mr McGeough had nominated his next of kin and that she lived in Devon. Due to the distance from Grendon, the Governor at Grendon telephoned the Governor at HMP Channings Wood, and asked him to break the news of Mr McGeough's death. Later that afternoon, the Governor of Channings Wood visited the home address of Mr McGeough's next of kin and broke the news of his death.

93. After the Governor of Channings Wood broke the news of Mr McGeough's death, the prison appointed an SO as the family liaison officer (FLO). At 11.05am on 22 December, the Governor and the FLO telephoned Mr McGeough's next of kin to offer their condolences and support.

94. The FLO continued to support Mr McGeough's mother until his funeral, which was held on 17 January 2020. The prison paid for the costs of the funeral in line with national instructions.

Support for prisoners and staff

95. After Mr McGeough's death, the Head of Operations 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.

96. The prison posted notices informing other prisoners of Mr McGeough's death, and offering support. Staff did not need to check whether any prisoners had been adversely affected by Mr McGeough's death, as no prisoners were assessed as being at risk of suicide or self-harm.

Post-mortem report

97. The post-mortem examination found that Mr McGeough's death was caused by hanging. A toxicological analysis detected a very low level of alcohol in Mr McGeough's urine and blood, which could have been drunk before his death or produced by bacteria following his death. The toxicological analysis did not find any other substances.

Findings

Assessment of Mr McGeough's risk of suicide and self-harm

Information sharing

98. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures that should be followed to keep prisoners safe. The PSI says that information sharing is vital to promote prisoners' wellbeing and it sets out a non-exhaustive list of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. These risks and triggers include a family history of suicide, childhood adversity, a family bereavement and feelings of hopelessness. Where risk factors are present, staff are required to take appropriate action, such as starting suicide and self-harm prevention procedures (known as ACCT) or referring to the mental health team.

99. PSI 05/2016, *Faith and Pastoral Care for Prisoners*, sets out the procedures that should be followed to deliver faith and pastoral care in prisons. These include that all chaplains should have access to NOMIS and that once news of a death has been given to a prisoner that information should be recorded on NOMIS, the Wing Observation Book and the Chaplaincy Team Journal. There is no reference to passing on the information to the healthcare department.

100. When Mr McGeough's sister died in late November, this information was known to Long Lartin's prison and chaplaincy staff. However, there is no record that the information was passed to the Inclusion team, and the Inclusion recovery practitioner, who saw Mr McGeough often, told the investigator that she did not know about it. During her interview, she said that she would have seen him that day if she had known.

101. On 6 December, Mr McGeough told a chaplaincy volunteer that he thought his sister had taken her own life or died from a drug overdose, and that he had experienced a violent childhood and had had a "wasted life". There is no record that him recorded this on NOMIS or passed it onto other staff. He told the investigator that he did not have access to NOMIS as his attempts to register had failed on six occasions.

102. We are concerned that not recording Mr McGeough's significant risks or passing information about his bereavement to the Inclusion team meant that there were missed opportunities to support him and for staff at Long Lartin, Bullingdon and Grendon to recognise that his risk of suicide had increased. We are also concerned that PSI 05/2016 does not require information to be passed to healthcare staff. We make the following recommendations:

The Governor, the Head of Healthcare and the Head of Chaplaincy of HMP Long Lartin should ensure that all staff have a clear understanding of the need to record and promptly share information about a prisoner's possible risk.

The Governor and the Head of Chaplaincy of HMP Long Lartin should ensure all chaplaincy staff have access to NOMIS and that they record their own contacts as soon as practicable.

The Director General of Prisons should amend Prison Service Instruction 05/2016 to say that chaplaincy staff should pass on information to healthcare staff after breaking the news of a relative or friend's death to a prisoner.

Self-isolation

103. Mr McGeough had been isolating for over a year before he was moved to Grendon and he recognised that his biggest challenge when moving would be reintegrating with prisoners. We are concerned that there is no record that staff at Long Lartin or at Grendon offered him specific support either before or after he transferred. We are also concerned that staff at Grendon, including an officer did not know that Mr McGeough had been self-isolating so did not pay particular attention to him. We make the following recommendation:

The Governors and the Heads of Healthcare of HMP Long Lartin and HMP Grendon should ensure that staff offer support to prisoners who self-isolate prior to and following a transfer.

Reception

104. PSI 07/2015, *Early Days in Custody*, sets out the processes that should be followed when a prisoner first arrives in prison. They include that staff should assess a prisoner's risk by examining all available documentation and by interviewing them. Prisoners who are staying for just one night before moving to another establishment are not excluded.

105. At Bullingdon, an SO and officer completed Mr McGeough's induction, though they did not review all relevant documents, including NOMIS, and they failed to complete significant parts of the induction, including the First Night Officer Assessment. During his interview, the officer said, for prisoners who were staying in Bullingdon overnight, that he would only create a Cell Sharing Risk Assessment and talk to the prisoner.

106. At Grendon, a nurse failed to note during the initial health screen that Mr McGeough had experienced a recent life changing event or that he was grieving for his sister. While Mr McGeough may not have mentioned it, despite having done so the day before at Bullingdon, we are concerned that the nurse did not note another nurse's entry on Mr McGeough's electronic medical record that he was grieving after the death of his sister.

107. By failing to properly complete Mr McGeough's induction, prison staff at Bullingdon and healthcare staff at Grendon were not aware of his bereavement so did not consider whether he needed additional support. We make the following recommendation:

The Governors and the Heads of Healthcare of HMP Bullingdon and HMP Grendon should ensure that staff manage newly arrived prisoners in line with national guidelines, including ensuring that they:

- **examine all available documentation on the prisoner and consider and record all known risk factors for suicide and self-harm; and**
- **interview the prisoner after examining all available documentation.**

Chaplaincy support

108. PSI 05/2016 says that a chaplain should offer care and support to a prisoner following the death of a family member.

109. After Mr McGeough transferred to Grendon, the managing chaplain emailed the Head of Chaplaincy at Grendon and suggested that they check on him as his sister had died. While a prison chaplain saw Mr McGeough on 19 December, as part of the mandatory chaplaincy induction, there is no record that they discussed his loss. The Head of Chaplaincy told the investigator that Grendon's chaplaincy team would not have specifically asked about Mr McGeough's loss as he had already received support from Long Lartin's chaplaincy team and that they wanted to allow him to grieve. While we appreciate the need to grieve, we are concerned that, by not talking about his loss, there was a missed opportunity for them to offer Mr McGeough additional support. We make the following recommendation:

The Governor and the Head of Chaplaincy of HMP Grendon should ensure that the chaplaincy team offers support to all prisoners who have recently suffered the death of a relative or friend.

Under threat allegation

110. Shortly after his arrival at Long Lartin, Mr McGeough alleged that he was under threat from other prisoners, though he refused to name the perpetrator. To minimise his risk, the prison moved Mr McGeough to a vulnerable prisoner wing, offered him a further move and placed him on a VR document, which instructed staff to monitor him. We are satisfied that the prison appropriately dealt with the allegation.

Mental health

111. The clinical reviewer concluded that, overall, the clinical care that Mr McGeough received was equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that the Inclusion recovery practitioner at Long Lartin recognised Mr McGeough's vulnerability due to his isolation and that she supported him with face-to-face sessions and in-cell activities.

112. However, the clinical reviewer considered that when Mr McGeough's told the Inclusion recovery practitioner on 20 May that he heard talking coming from the water in the toilets, this should have resulted in further discussion to rule out emerging psychosis. We make the following recommendation:

The Head of Healthcare of HMP Long Lartin should ensure that staff complete in depth assessments when a prisoner make statements that could suggest emerging psychosis.

Emergency response

113. Mr McGeough left his cell at 12.35pm to use the toilet, and eight minutes later, at 12.43pm, the sanitation system alerted staff that he had not returned to his cell. However, staff did not find him in the toilet block for between seven and 13 minutes (as a CM called the code blue at some time between 12.50pm and 12.56pm). While we cannot say whether the delay affected the outcome for Mr McGeough, we know that in an emergency situation, a delay of a few minutes may be critical. We make the following recommendation:

The Governor of HMP Grendon should review the processes when a prisoner has failed to return to their cell after using the sanitation system to ensure that control room staff immediately alert staff on the relevant wing and to minimise any delays finding the prisoner.

114. PSI 03/2013, *Medical Emergency Response Codes*, contains mandatory instructions that staff must use emergency codes to clearly convey the nature of the medical situation and that on hearing a code blue, control room staff must call an ambulance immediately.

115. In November 2016, HMP Grendon and the South Central Ambulance Service introduced a joint Emergency Call Out Protocol 2016-17 to ensure a timely and appropriate response to medical emergencies. The Protocol says that the Ambulance Service operator will ask whether the patient is breathing and what is wrong with them, and that the member of staff calling the emergency code should give this information over the radio.

116. A CM called the code blue between 12.50pm and 12.56pm but did not provide any further information and, according to the Ambulance Service, the prison did not call for an ambulance until 12.58pm, a delay of between two and eight minutes. We are also concerned that the first call gave insufficient information for the Ambulance Service to treat the call as an emergency, so the air ambulance and emergency ambulance were not despatched for a further five minutes. We make the following recommendation:

The Governor of HMP Grendon should ensure that control room staff call an ambulance as soon as an emergency code is called and that information about the prisoner's condition is obtained and promptly passed to the ambulance service.

117. During her interview, a nurse said that she did not insert an airway because she thought that Mr McGeough's neck was "occluded" (blocked) and used an Ambu-bag to force air into his lungs.

118. The clinical reviewer noted that the user guide for the I-gel airway does not record swelling of the neck as a reason for not inserting an airway and so

considered that it should have been attempted. We make the following recommendation:

The Head of Healthcare at HMP Grendon should ensure that staff know when it is appropriate not to attempt to insert an I-gel airway.

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