Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shaun Hughes, a prisoner at HMP Northumberland, on 20 March 2016

A report by the Prisons and Probation Ombudsman

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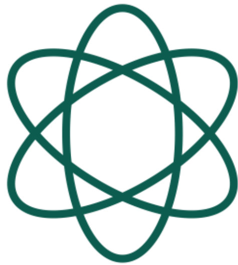
Our vision

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



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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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 Shaun Hughes died on 20 March 2016 of respiratory failure caused by the effects of a combination of illicit drugs at HMP Northumberland. Mr Hughes was 34 years old. I offer my condolences to Mr Hughes' family and friends.

Mr Hughes swallowed a package containing drugs that his mother had passed to him during a visit. Mr Hughes was not observed during the night and was found dead in his cell in the morning. If expert medical and nursing staff had monitored Mr Hughes in line with best practice guidelines, the outcome could have been different for him.

There were some deficiencies in the emergency response. I am concerned that this has continued to be an issue at Northumberland.

We have investigated further drug-related deaths at Northumberland since Mr Hughes' death and I am concerned that drugs still appear to be readily available in the prison.

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 McAlister
Prisons and Probation Ombudsman **March 2020**

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Summary

Events

1. On 15 January 2015, Mr Shaun Hughes was sentenced to three years and four months in prison for burglary, driving offences and possession of class C drugs.

1. On 18 February, Mr Hughes was transferred to HMP Northumberland. He was on a methadone maintenance programme to treat heroin addiction and was located in the prison's drug recovery unit.

2. Officers suspected that Mr Hughes frequently took drugs, including psychoactive substances (PS). Intelligence reports indicated that he was heavily involved in the prison's drug culture.

3. On 11 July, Mr Hughes swallowed a package in the visits hall. On 15 July, two officers noted that Mr Hughes was concealing a bottle of urine to use for a drugs test. The next day a multidisciplinary team meeting decided to remove him from the drug recovery unit and transfer him to a standard residential unit. Healthcare staff placed him on a rapid detoxification plan.

4. On 19 March 2016, at 3.40pm, an officer observing CCTV noticed that Mr Hughes' mother had passed a package to him during a visit. Staff intervened immediately and restrained Mr Hughes but he swallowed the package during a struggle. Both Mr Hughes and his mother told staff that the package contained drugs.

5. At 4.35pm, staff took Mr Hughes back to his cell and recorded that he should be observed once every 60 minutes. A nurse reviewed him immediately after the restraint and again in his cell at 5.40pm and assessed that he was fit and well. The nurse did not arrange for Mr Hughes to be observed by staff. Staff ended observations on Mr Hughes at around 5.45pm and he was not observed again during the rest of the evening or overnight.

6. On 20 March, at 5.57am during a roll check, a night patrol officer found Mr Hughes unresponsive in his cell. He phoned the orderly officer for assistance, who attended and radioed a medical emergency. Staff attended and paramedics arrived and took over resuscitation procedures. They were unsuccessful and Mr Hughes was pronounced dead at 6.47am.

Findings

7. We are concerned that there were no clear procedures in place at Northumberland to deal with incidents when prisoners swallowed drug packages.

8. We are also concerned that the nurse who saw Mr Hughes did not recognise that he was at risk of drug toxicity and did not take effective steps to ensure he was assessed and monitored.

9. The clinical reviewer found that Mr Hughes' care was not equivalent to that which he could have expected to receive in the community. Mr Hughes should have been transferred to a hospital for assessment and monitoring on 19 March, in line with the Royal College of Emergency Medicine's Best Practice Guidelines.

10. Both the clinical reviewer and the pathologist concluded that if expert medical and nursing staff had monitored Mr Hughes properly after the incident and at the time of his respiratory failure, the outcome could have been different for him.

11. Although it made no practical difference in this case, we are concerned that there is no evidence that Mr Hughes' segregation in his cell pending his adjudication was formally authorised on 19 March.

12. There were deficiencies in Northumberland's initial emergency response. Contrary to local and national policy, the night patrol officer did not consider entering Mr Hughes' cell and did not radio a code blue immediately.

13. Since Mr Hughes death, we have investigated further drug-related deaths at Northumberland and have recently recommended that the prison review its drugs strategy.

Recommendations

- The Head of Healthcare should ensure that healthcare staff:
    - manage prisoners' risk after swallowing a package containing drugs in line with the Royal College of Emergency Medicine Best Practice Guidelines (2014), *Caring for Adult Patients Suspected of Having Concealed Illicit Drugs*; and
    - use the National Early Warning Score (NEWS) in conjunction with clinical judgement to detect, monitor and escalate where a prisoner's health is deteriorating in cases involving prisoners who are believed to have swallowed a package containing drugs.
- The Director should provide the Ombudsman with evidence that there is now clear guidance for prison staff, agreed with the Head of Healthcare, on what to do in cases where prisoners have swallowed packages containing drugs.
- The Director should ensure that any use of segregation is formally authorised under Prison Service Order 1700.
- The Director should provide the Ombudsman with an updated copy of the prison's guidance on entering a cell at night when there is potentially a risk to life and report on the actions that have been taken to ensure that staff are aware of this guidance.
- The Director and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: Nurse A; Officer A; SO A; SO B; SO C; the duty director; and the night patrol officer.

The Investigation Process

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

15. The investigator visited Northumberland on 30 and 31 March 2016. He obtained copies of relevant extracts from Mr Hughes' prison and medical records and interviewed five members of staff.

16. The Metropolitan Police investigated the circumstances of Mr Hughes' death, including the actions of the nurse involved in Mr Hughes' care prior to his death. The police shared a copy of relevant statements with the investigator.

17. In line with our terms of reference and our protocol with the police, the investigation was suspended until the police had completed all their enquiries. We regret the long delay this has caused in issuing this report. The investigator did, however, provide feedback to the then Director of HMP Northumberland, on 18 January 2018 on our preliminary findings.

18. NHS England commissioned a clinical reviewer to review Mr Hughes' clinical care at the prison.

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

20. One of the Ombudsman's family liaison officers contacted Mr Hughes' next-of-kins to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They wanted to know:

    - What care provision did the prison put in place to monitor and observe Mr Hughes after he swallowed a package in the visits hall on 19 March? If no provision was made, why did the prison not place Mr Hughes on observations?
    - Why was Mr Hughes not located in a place where he could have been better monitored after he returned from the visits hall on 19 March?
    - The response of prison staff to the cell bell calls of other prisoners on Mr Hughes' unit during the night of 19 March, and the reasons for their calls.

21. Mr Hughes's next-of-kin received a copy of the initial report. She did not make any comments.

22. The prison service also received a copy of the initial report. They made accuracy comments which we have addressed in this report. Their response to our recommendations and action plan is annexed to this report.

Background Information

HMP Northumberland

23. HMP Northumberland is a training prison holding up to 1,348 men, predominately from the North East of England. Sodexo Justice Services manage the prison, G4S provide the primary healthcare services and Tees, Esk and Wear Valley NHS Foundation Trust provide mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Northumberland was carried out in August 2017. Inspectors found that the prison was suffering from the impact of drugs more severely than many other prisons. Prisoners admitted that it was easy to obtain illicit drugs and over a fifth said that they had developed a drug habit since entering the prison. Inspectors also found that a drug and alcohol strategy committee discussed supply and demand reduction initiatives but that attempts to address the widespread drug problem were not effective.

Independent Monitoring Board

25. 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, at the time of issuing our initial report, for the year to December 2018, the IMB found that like other prisons, Northumberland experienced an increase in the levels of psychoactive substances arriving through the impregnation of correspondence. The IMB also reported that the prison started to use two drug detention dogs and body scanners to tackle supply and demand. Despite these increased measures drug supply reduction was slow.

Previous deaths at HMP Northumberland

26. Mr Hughes death was the sixth death at Northumberland since January 2015. Since his death, there have been twelve further deaths, of which two were suspected drugs-related. We have identified in our investigations the need for staff to understand the importance of entering a cell immediately when a prisoner's life is at risk, when it is safe to do so. We have also raised concerns about the availability of drugs, particularly PS, at the prison and, in response to a drug-related death in May 2018, we recently recommended that the prison's local drugs strategy be revised by September 2019 to ensure that the key drug issues at Northumberland are identified and addressed.

Psychoactive substances (PS)

27. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious 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 PS 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.

Incentives and Earned Privileges (IEP) Scheme

28. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Key Events

29. In April 2012, Mr Shaun Hughes was sentenced to five years in prison for burglary, handing stolen goods, possession of class A and class C drugs and theft. He was released on licence on 1 October 2014 from HMP Durham.

30. On 14 October, Mr Hughes had his licence revoked for breaching his licence conditions. He was recalled to prison and was returned to Durham. On 15 January 2015, Mr Hughes was sentenced to three years and four months in prison for burglary, driving offences and possession of class C drugs.

31. On 18 February, Mr Hughes was transferred to HMP Northumberland. During an initial health screen, a nurse reviewed him and noted that he was fit and well. Mr Hughes told the nurse that he had no thoughts of self-harm or suicide and did not have a history of mental health issues. Mr Hughes smoked 10 to 19 cigarettes a day and the nurse referred him to smoking cessation services. He had a history of crack cocaine and benzodiazepine (tranquiliser) misuse and was on a methadone maintenance programme to treat heroin addiction.

32. The next day, during his second health screen, Mr Hughes told nurse that he aimed to reduce his methadone dose but wanted to stabilise it for a few weeks first. The nurse planned for him to continue with his methadone prescription and referred him to the Drug and Alcohol Recovery Team (DART). The nurse recorded that Mr Hughes showed no signs of intoxication or withdrawal. Mr Hughes was located on the drug recovery unit and engaged well with DART. He worked as a cleaner on the unit and officers did not note any concerns about him.

33. On 11 July, Mr Hughes appeared to have swallowed a package that was passed to him during a visit by another prisoner's mother. An officer took Mr Hughes away from the visits area and searched him but could not find anything. He submitted an intelligence report and made a note in his prison records. A nurse reviewed Mr Hughes and assessed that he was not intoxicated. Although Mr Hughes did not need immediate medical care, the nurse recorded in his medical notes that she was concerned that if the package burst inside him, he could become ill, so she had asked officers to observe him once every hour as a precaution. An officer recorded in Mr Hughes' prison record that an observations checklist had been opened because of concerns about Mr Hughes swallowing a parcel. Mr Hughes did not present with any major medical issues.

34. On 15 July, a health support worker asked Mr Hughes to provide a urine sample. Two officers searched him and found that he was concealing a bottle of urine. (Prisoners may try to use another prisoner's urine, rather than their own, to avoid testing positive for drugs.) The same day, Mr Hughes told a doctor that he had taken PS the previous Thursday and admitted that he had concealed urine in the past. The doctor explained the dangers of using PS and Mr Hughes said that he understood and would not do it again. The doctor planned to discuss Mr Hughes' case at the next Multidisciplinary Team Meeting (MDT).

35. On 16 July, a doctor, a nurse, an individual from DART and a senior manager discussed Mr Hughes' recent behaviour in the drug recovery unit at the MDT. They assessed that he was not suitable for the unit because of his use of illicit drugs. Officers transferred him to a standard residential unit and healthcare staff placed

him on a rapid detoxification programme. Healthcare staff monitored his detoxification closely until he became methadone-free on 23 July. The DART team also offered him support.

36. On 15 August, an officer noted that Mr Hughes was under the influence of drugs. He searched him and found a white tablet (possibly of Subutex, an opioid substitute). The nurse reviewed him, checked his eyes, gait, and assessed that he had taken an illicit substance. She placed him on substance misuse observations once every 30 minutes.

37. An officer placed Mr Hughes on a disciplinary charge for possession of the tablet and he was subsequently punished by forfeiture of privileges, including use of TV, for 21 days. The officer also submitted a report to the unit manager for Mr Hughes' IEP level to be reviewed and submitted an intelligence report.

38. Mr Hughes continued to take illicit drugs frequently at Northumberland. Three officers recorded that Mr Hughes was under the influence of drugs on 6 September, 10 September and 2 October 2015, and 8 January and 9 March 2016. On 8 January 2016, he was searched and a wrap of PS was found on him.

39. The officers submitted intelligence reports, placed Mr Hughes on disciplinary charges and reviewed his IEP status. Healthcare staff reviewed Mr Hughes following these incidents and placed him on substance misuse observations at least once an hour on each occasion.

Saturday 19 March 2016

40. At 3.30pm on 19 March, an Operational Support Grade (OSG) was observing the visits hall via CCTV. He saw that Mr Hughes' mother had passed him a package and alerted other officers.

41. Supervising Officer (SO) A and two officers approached Mr Hughes and asked him about the package. Mr Hughes became aggressive and uncooperative. Staff tried to restrain him but he swallowed the package.

42. The two officers took Mr Hughes to a holding room to be searched. Mr Hughes initially denied swallowing a package, but then told the officers that the package contained Subutex, Valium (a tranquiliser) and gabapentin (used for epilepsy and nerve pain, but also misused for its euphoric effects). He said it was not much and that he would be 'fine'.

43. SO A and the duty director spoke to Mr Hughes' mother who told them that she had passed him two gabapentin pills. SO A said he expressed doubt about this given the size of the package, and Mr Hughes' mother said something vague about it being in powder form. (She later described the package to the police as a 'little soft plastic white bag with some powder inside'.) SO A said that Mr Hughes' mother said that he would be 'fine'.

44. Mr Hughes' mother told the duty director that she was under pressure to bring the drugs into prison. She later told the police that the package was for Mr Hughes to pass to someone else in order to pay an outstanding debt. She said that her son owed money to other prisoners and that he had asked her on a number of occasions to deposit money in different bank accounts to pay for his debts.

45. We found no evidence that Mr Hughes was under threat by other prisoners or in debt at Northumberland. In fact, prison intelligence suggested that Mr Hughes was threatening other prisoners. The Head of Security and Operations told the investigator that Mr Hughes was not known for being victimised or under threat. The police investigation into Mr Hughes' death did not find any evidence that he was being threatened by other prisoners at Northumberland.

46. The duty director spoke to Mr Hughes. He told him that he was fine but was concerned about his mother. The duty director noted that Mr Hughes appeared fine, was not under the influence of drugs and was speaking coherently.

47. Nurse A responded to the general alarm when Mr Hughes was restrained. It is mandatory for a prisoner who has been restrained to be examined by a nurse or doctor afterwards to check for any injuries. At 6.21pm, Nurse A recorded in Mr Hughes' medical notes that he had assessed him at the scene and later in the reception area when he was searched. Nurse A recorded that Mr Hughes had some scratches to his knees, contusions around his torso and marks around his head as a result of the restraint, but nothing more serious.

48. Nurse A also recorded that Mr Hughes had initially denied swallowing anything but then told officers that he had swallowed a package but did not know what was in it. Nurse A told the investigator that Mr Hughes did not tell him directly that he had swallowed anything, but that he understood from prison staff that the package had contained Subutex.

49. Nurse A told the investigator that Mr Hughes showed no signs of intoxication. He said he repeatedly asked Mr Hughes whether he was feeling well. Mr Hughes said he was and Nurse A said he asked him to inform him immediately if he started to feel ill. He said he told the officers there did not appear to be anything further he could do at the time. He said he had spoken to doctors in the past and they had told him that, if a prisoner swallowed a package, there was nothing they could do unless the prisoner became unwell, and that the package would pass through the prisoner. He, therefore, returned to his normal duties.

50. Staff said that prisoners who swallow packages are usually taken the Care and Separation Unit (CASU, also known as the segregation unit) where they will automatically be checked every hour. As the CASU was full, however, SO B and an officer took Mr Hughes back to his cell at 4.20pm. The officer recorded that the duty director had said that Mr Hughes should remain in his cell, with his meals being taken to his cell, until his disciplinary hearing took place.

51. Nurse A told the investigator that prison staff use an observation checklist form when a prisoner appears to be under the influence of any substance and needs monitoring. He said that in those circumstances, nurses assess prisoners and ask wing staff to observe them as necessary. He said the checklist was not a tool he would use, and was not designed for a prisoner who was alleged to have swallowed something. He said he did not know if prison staff had documentation for that.

52. Officer A said that Nurse A asked staff to observe Mr Hughes once every 30 minutes before she completed the checklist.

53. At 5.20pm, SO B telephoned the nurse to complete the checklist. SO B said that Nurse A told him that staff should observe Mr Hughes once every 60 minutes and he filled the form in accordingly.

54. At about 5.35pm, Nurse A returned to the unit and went to Mr Hughes' cell with SO B and Officer A. SO B said that when they entered the cell he heard Mr Hughes snoring loudly. SO B and Officer A called his name several times and he grunted but did not respond verbally.

55. SO B said that he asked Nurse A whether he was happy with Mr Hughes' presentation and Nurse A said that he was. SO B and Officer A said that the nurse told them that he had no concerns about Mr Hughes and that they did not need to observe him.

56. Nurse A recorded in Mr Hughes' medical notes that he had seen Mr Hughes in his cell at 5.40pm when Mr Hughes was "resting" and that he "asked him to mention to staff if he felt unwell with this so that action could be taken".

57. SO B and Officer A said that the nurse wrote in the observation checklist that 'observations were no longer required'. SO B said that the nurse signed, dated and timed the form.

58. The prison provided a copy of the observation checklist form to the investigator, which showed the entries and annotations as described by SO B. The form had not been signed.

59. Nurse A told the investigator that he did not complete the observation checklist and did not ask for observations to be started or finished. He told the investigator that he asked officers to 'keep an eye on Mr Hughes, look after him and make sure that he is okay', and to let him know if there were any problems. (He usually finished work at 6.00pm on Saturdays.) Nurse A also told the investigator that he had nothing to do with opening the observation checklist and did not say anything to the officers about the required frequency of observations or when they should end.

60. He said he assumed the officers would carry out periodic observations. He said he was 'not privy' to how prison staff worked or what they did. He said that, as far as he knew, prison staff checked prisoners throughout the night, but he did not know for how long or what they did.

61. At 6.21pm, Nurse A recorded in Mr Hughes' medical record, "No need to action … fit and well." He did not take any clinical observations.

62. At 12.45pm the next day, after Mr Hughes' death, Nurse A made a further entry in the medical records, which he noted as a 'retrospective entry due to time constraints'. He wrote that on 19 March he had asked staff to 'look out for' Mr Hughes overnight and that staff had opened an observation chart, but that he could not remember how long he asked them to 'look out for' him.

63. The investigator asked Nurse A if swallowing a package of drugs might be a cause for concern to healthcare. Nurse A said it would be if the prisoner became unwell 'but if they are not becoming unwell and we don't know about it, then we can't act on it'. The investigator asked the nurse if he had been concerned that Mr Hughes might have a reaction to the drugs he had swallowed later. The nurse said that anyone might have a reaction and the timeframe would depend on their individual

build and metabolism. He said he did not know Mr Hughes and did not know if he was a regular dug user.

64. Nurse A told the investigator that with hindsight, he thought Mr Hughes should have been taken to the CASU where he would have been checked once an hour. He said he thought Mr Hughes should have been observed regularly during the night. He said he had told prison staff to keep an eye on him and he expected they would understand that as meaning they should do periodic observations. He said they were sensible people and he would have expected them to see everyone, or everyone there had been problems with, during the night.

65. SO C, who was the night orderly officer, said he came on duty at about 7.30pm and was told in his handover that Mr Hughes had swallowed a package and had been put on observations by healthcare. He said he went to Mr Hughes' houseblock at about 9.00pm to see another prisoner and spoke to the night patrol officer (an OSG), about Mr Hughes' observations. The night patrol officer told him that they had taken Mr Hughes off observations at 5.45pm after Nurse A visited him, and showed him the observations checklist to confirm this.

66. Mr Hughes spent the night in his cell, unchecked, pending a disciplinary hearing the following day.

67. Another prisoner told the investigator that he had known Mr Hughes for about 10 months. He said Mr Hughes told him on 19 March that he had swallowed "quite a bit" of Subutex, pregabalin and Valium. He said he advised Mr Hughes to get checked by healthcare staff because when you take as much as Mr Hughes said he had, it could be dangerous. The prisoner said that, as far as he was aware, Mr Hughes had no drug debts and was not being bullied by other prisoners.

Sunday 20 March

68. The night patrol officer told the investigator that he had patrolled Mr Hughes' unit during the night and responded to prisoners' cell bells, responding to general requests. He said Mr Hughes did not press his cell bell at any time.

69. At 5.50am, the night patrol officer started the routine morning roll check on the unit. When he reached Mr Hughes' cell he noted that his radio and light were on (which was not unusual as prisoners often left them on at night). He knocked at his door but there was no response. He told the investigator that Mr Hughes was on his bed, and he thought that he was breathing. He seemed to be in a deep sleep, looked comfortable and the officer did not see anything of concern. As the officer could not obtain a response, he switched off the electricity to Mr Hughes' cell in case he could not hear him over the radio. He continued to bang on the door, calling to Mr Hughes, but he did not receive any response.

70. At about 5.57am, the night patrol officer went to the office and phoned SO C and told him that Mr Hughes was not responding. SO C attended and they entered the cell together at 6.03am. SO C checked Mr Hughes' pulse but found none. He noted that his lips were blue, that he felt warm to the touch and had colour to his face.

71. At 6.05am, the night patrol officer radioed a code blue emergency, indicating that a prisoner is unconscious, not breathing or is having breathing difficulties. He asked the control room to call an ambulance.

72. Three officers responded and went to Mr Hughes' cell. One of the officers said that he saw Mr Hughes lying on his arm in his bed with his legs curled up. Two officers said that his skin looked pale, between white and grey in colour, but that he still felt warm. An officer and SO C placed Mr Hughes on the floor. An officer checked for a pulse again but found none and started cardiopulmonary resuscitation, while SO C gave breaths. They applied a defibrillator but no shocks were advised.

73. At 6.17am, the ambulance arrived at the gate and at 6.22am paramedics reached the cell and took over resuscitation procedures. At 6.46am, they pronounced Mr Hughes dead.

74. After Mr Hughes' death, prison staff searched his cell and found two wraps of PS as well as two smoking devices.

Post-mortem report

75. A post-mortem examination established the cause of Mr Hughes' death as respiratory failure due to bronchopneumonia (inflammation of the tissue of the lungs) and the effects of Valium, buprenorphine, pregabalin, delorazepam (a sedative) and quetiapine (an antipsychotic drug used to treat schizophrenia). None of these drugs had been prescribed to Mr Hughes.

76. The pathologist said that, individually, none of these drugs could have accounted for Mr Hughes' death, but that, taken together, they could cause respiratory failure and lead to bronchopneumonia (which would also contribute to respiratory failure).

77. The pathologist said that in his opinion, close observation by expert medical and nursing staff and resuscitation at the time of respiratory arrest could have altered the outcome for Mr Hughes.

78. Toxicology tests also detected some forms of PS in Mr Hughes' system. The toxicologist said that she could not rule out the possibility that Mr Hughes was experiencing the effects of PS at the time of his death.

Contact with Mr Hughes' family

79. At 11.00am, the police delivered the news of Mr Hughes' death to his mother who was his nominated next of kin. The police then interviewed her in the course of their investigation into the death.

80. On 22 March, Mr Hughes' father phoned an operational manager, who was appointed the family liaison officer. The operational manager offered support to Mr Hughes' father.

81. Mr Hughes' funeral was held on 31 March. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

82. After Mr Hughes' death, the duty director 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.

83. The prison posted notices informing other prisoners of Mr Hughes' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Hughes' death.

Police investigation

84. The Metropolitan Police investigated the circumstances of Mr Hughes' death. Mr Hughes' mother received a suspended sentence of four months for bringing a prohibited article into prison and a further four months for possession of class C drugs.

85. The police also investigated any possible criminal responsibility by the nurse who conducted the initial check on Mr Hughes. The Crown Prosecution Service (CPS) decided not to bring any charges against the nurse.

Findings

Clinical Care

86. The clinical reviewer concluded that the care Mr Hughes received at HMP Northumberland was not equivalent to that which he could have expected to receive in the community.

87. Under the Royal College of Emergency Medicine's Best Practice Guidelines (2014), Caring for Adult Patients Suspected of Having Concealed Illicit Drugs, prisoners should be transferred to a hospital following suspected swallowing of illicit drugs. The Guidelines advise that an adult should be observed in hospital for a minimum of six to eight hours after swallowing, and because of the risk of severe toxicity, respiratory failure and obstruction; these complications can only be investigated, treated and monitored in a hospital setting.

88. The Guidelines advise that if there is any doubt about how many drugs an individual has swallowed, healthcare staff should err on the side of caution and expect the patient to be at high risk of toxicity. They say that individuals who have swallowed packages in an unplanned attempt to avoid detection by authorities, may take several hours to develop symptoms and it is very variable depending on the type of wrapping of the package, and if suspicions are high, a patient should be kept under observation longer (usually 12 to 24 hours).

89. Mr Hughes was not transferred to a hospital following suspected swallowing of illicit drugs. Instead he was returned to his cell with no plan of observations in place. Both the clinical reviewer and the pathologist concluded that if expert medical and nursing staff had monitored Mr Hughes properly after the incident and at the time of his respiratory failure, the outcome could have been different for him.

90. We expect healthcare staff to respond appropriately and in line with professional guidelines. We are very concerned that the nurse who attended did not recognise that Mr Hughes was at risk of toxicity on 19 March and did not take effective or immediate action to minimise the risk. He did not take any clinical observations in accordance with the National Early Warning Score (NEWS: a scoring system used alongside clinical judgement to detect, monitor and escalate acute illness).

91. There are differing accounts as to whether the nurse told prison staff to start and/or finish observations, and we cannot say which is correct. At the very least, there was a significant misunderstanding.

92. Prison staff were clear that the nurse had told them observations were no long needed after he saw Mr Hughes at 5.40pm, and it seems unlikely that they would have decided to stop observations themselves without clinical advice.

93. However, the nurse was clear at interview that he did not start or stop observations and did not specify how often Mr Hughes should be observed or what staff should look for. He told us that he had asked prison staff to 'keep an eye' on him - although he did not record that request in Mr Hughes' medical notes that night. He told us that he assumed prison staff checked prisoners during the night but that he was 'not privy' to exactly what they did.

94. We consider that the nurse should have recognised that Mr Hughes was at risk and should either have arranged for him to go to hospital for monitoring or should have given prison staff clear instructions on how often to monitor Mr Hughes and what warning signs to look for.

95. We understand that the nurse's conduct is being investigated by the Nursing and Midwifery Council. The prison reported however, that there is no record of such referral or evidence of any investigation.

96. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff:

- **manage prisoners' risk after swallowing a package containing drugs in line with the Royal College of Emergency Medicine's Best Practice Guidelines (2014)*, Caring for Adult Patients Suspected of Having Concealed Illicit Drugs*; and**
- **use the National Early Warning Score (NEWS) in conjunction with clinical judgement to detect, monitor and escalate where a prisoner's health is deteriorating, in particular, in cases involving prisoners who are believed to have swallowed a package containing drugs.**

Segregation

97. Staff said that prisoners who swallow drugs are normally taken to the CASU, pending an adjudication hearing, and would automatically be checked once an hour there under the local CASU policy.

98. Because the CASU was full, Mr Hughes was taken back to his cell, pending his adjudication hearing. There is a note on his electronic record to say the duty director had said he was to be kept in his cell pending his adjudication and was not to be allowed out, even to collect meals. This appears to mean that Mr Hughes was segregated under Rule 53 (awaiting an adjudication). If so, Mr Hughes should have had an initial segregation health screen within two hours of being segregated.

99. However, we have seen no evidence that Mr Hughes' segregation under Rule 53 was formally authorised or that a segregation health screen was carried out. In practice, this made very little difference since a nurse saw Mr Hughes in his cell that evening. It is important, however, that segregation is always formally authorised and proper procedures are followed as there are obvious risks to allowing informal segregation practices to develop. We make the following recommendation:

The Director should ensure that any use of segregation is formally authorised under Prison Service Order 1700.

Local procedures

100. Given the lack of a clear steer from the nurse, we do not criticise prison staff for not observing Mr Hughes overnight.

101. However, according to the Head of Security and Operations, prisoners were swallowing drugs packages 'quite frequently'. Given this and given that there is no

healthcare cover at night at Northumberland, we are very concerned that there was no clear guidance for staff on what to do in these circumstances.

102. We make the following recommendation:

The Director should provide the Ombudsman with evidence that there is now clear guidance for prison staff, agreed with the Head of Healthcare, on what to do in cases where prisoners have swallowed packages containing drugs.

Emergency Response

103. At night, night patrol officers have a cell key kept in a sealed pouch for use in an emergency. Prison Service Instruction (PSI) 24/2011, which covers management and security at night, 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, 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 where they feel it 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.

104. Northumberland's local instruction, at the time of Mr Hughes' death said that, a member of staff on patrol duty at night, may unlock a cell in exceptional circumstances (such as to save a life) without waiting the arrival of a second member of staff if it is safe to do so. It also states that staff should consider entering a cell on their own if there is a potential or actual threat to safety of life, but must balance the preservation of life against the security of the prison.

105. We do not criticise the night patrol officer for not entering Mr Hughes' cell when he could not get a response from him. We recognise that he could not be sure if Mr Hughes was breathing or not and could not be sure if it was safe for him to enter on his own as he did not know Mr Hughes.

106. However, we are concerned that the night patrol officer told the investigator that he did not enter the cell because he had been told he should never enter a cell on his own for safety reasons and should always radio or call other officers for assistance, if necessary. As a result, he did not consider whether he should enter the cell.

107. We are also concerned that the night patrol officer did not radio a medical emergency code blue when he could not get a response from Mr Hughes, but instead walked to the office and asked SO C to attend. As the night patrol officer knew that Mr Hughes had swallowed a package of drugs earlier, we consider that he should have erred on the side of caution and called a code blue himself. As a result, there was a delay of about eight minutes before the code blue was called and an ambulance was requested. We cannot say whether that made a difference to the outcome in Mr Hughes' case, but it could be critical in other emergencies.

108. We have identified similar concerns in other investigations at Northumberland, including investigations into deaths in November 2016 and May 2017. After these investigations, we recommended that the Director should ensure that all staff understand the importance of entering a cell without delay when a prisoner's life is at risk and is safe to do so.

109. The prison responded in July 2017 that all staff were going to be reminded through verbal briefings of the guidance previously issued about entering a cell during night state in order to preserve life. The prison said that this requirement was going to be included in the night state guidance pack, which is used by night patrol staff. We make the following recommendation:

The Director should provide the Ombudsman with an updated copy of the prison's guidance on entering a cell at night when there is potentially a risk to life and report on the actions that have been taken to ensure that staff are aware of this guidance.

Illicit substances

110. It appears that Mr Hughes was able to obtain drugs without difficulty at Northumberland. He was regularly suspected of being under the influence of PS, was found in the possession of PS and had previously swallowed a package of drugs during a visit in July 2015. Toxicology tests also showed that he had taken PS before his death.

111. The Head of Security and Operations told the investigator that the prison had raised staff awareness about the dangers associated with prisoners' use of PS, issued notices and had taken measures to tackle its supply and demand. PS testing is also in place, as part of the prison's Mandatory Drug Testing.

112. After Mr Hughes' death, a PPO investigation into the death of another prisoner, in July 2016, also identified concerns about the availability of PS at Northumberland. The investigation recommended that the Director ensure that there was an effective supply and demand reduction strategy to help eradicate the availability of PS and other drugs, 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.

113. We made a similar recommendation in our investigation into the death of another prisoner in May 2017. In response to a further drug-related death in May 2018 (in which it appears the prisoner obtained drugs through a social visit) we recommended that the prison's drug strategy be revised by September 2019 to ensure that the key issues are addressed. We have not thought it necessary to repeat that recommendation in this case.

Other matters

114. We consider that it is important for staff who were involved in Mr Hughes' care to see the findings of our investigation and therefore we make the following recommendation:

The Director and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: Nurse A; Officer A; SO A; SO B; SO C; the duty director; and the night patrol officer.

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