

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Reilly, a prisoner at HMP Humber, on 4 March 2019

A report by the Prisons and Probation Ombudsman



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 John Reilly collapsed in the gym and died on 4 March 2019 as a result of ischaemic heart disease combined with synthetic cannabinoid use at HMP Humber. He was 51 years old. I offer my condolences to Mr Reilly's family and friends.

The clinical reviewer concluded that, overall, Mr Reilly's care at Humber was of a good standard and equivalent to that which he could have expected to receive in the community.

Mr Reilly had a history of substance misuse. He successfully undertook a methadone detoxification programme at Humber. I am satisfied that the prison's substance misuse team offered structured help and support.

Staff said they were not aware that Mr Reilly was using drugs before his death. However, I am concerned that there is no record that staff had any meaningful contact with Mr Reilly in the last five weeks of his life. This may have been a missed opportunity to identify that he was using drugs.

Since Mr Reilly's death, the prison has updated its drugs strategy with the aim of reducing supply and demand. The prison needs to ensure the strategy is regularly reviewed, to reduce the serious harm caused by drug use, and ensure that staff are vigilant for signs of drug use.

Although the emergency response by prison staff was prompt and efficient when Mr Reilly collapsed, the first nurse on the scene did not conduct an initial physical assessment or take the lead during the emergency response.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

May 2021

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	9

Summary

Events

1. In September 2017, Mr John Reilly was sentenced to two years, four months in prison for burglary. He spent time in several prisons and transferred to HMP Humber in May 2018. In June, Mr Reilly was convicted of further burglary offences and was sentenced to ten months imprisonment.
2. Mr Reilly had a long history of substance misuse in the community and was prescribed methadone (a synthetic opiate used to treat heroin addiction) during his time in prison. He continued with a methadone detoxification programme at Humber and fully engaged with the prison's substance misuse team until seven weeks before his death, when he said he no longer felt the need for their support.
3. On the morning of 4 March 2019, Mr Reilly collapsed while using the prison gym. Another prisoner alerted nearby prison staff. They arrived almost immediately and radioed an emergency medical code.
4. Prison staff began cardiopulmonary resuscitation (CPR). Paramedics arrived, and at 10.32am, they confirmed that Mr Reilly had died.
5. The post-mortem report gave Mr Reilly's cause of death as a combination of ischaemic heart disease and the use of psychoactive substances (PS).

Findings

Mr Reilly's substance misuse

6. Mr Reilly had a long history of substance misuse in the community and was on a methadone detoxification programme during his time at Humber. He received a good level of support from the prison's substance misuse team.
7. Staff said they saw no signs that Mr Reilly was misusing drugs. However, there is no record that Mr Reilly's personal officer had any contact with him, and his key worker recorded only two meetings, both in January 2019. There is no evidence that staff had any meaningful contact with Mr Reilly in the five weeks before he died, and this may have been a missed opportunity to identify that he was using drugs.

Drug strategy at HMP Humber

8. Humber has a comprehensive drug strategy but despite this, Mr Reilly was still able to obtain drugs in the prison. The prison revised its drug strategy following Mr Reilly's death, but must continue to work towards reducing supply and demand.

Emergency response

9. When Mr Reilly collapsed in the gym, the first nurse on the scene failed to assess him or to take the lead during the emergency response.

10. We are satisfied, however, that prison staff called a medical emergency code and started CPR promptly, and that the prison called an ambulance without delay.

Clinical care

11. The clinical reviewer concluded that the clinical care Mr Reilly received at Humber was equivalent to that which he could have expected to receive in the community.

Sharing of PPO reports

12. We consider that it is important for staff who were involved in Mr Reilly's care to see the findings of our investigation.

Recommendations

- The Governor should ensure that key workers meet their allocated prisoners regularly in line with Prison Service policy.
- The Head of Healthcare should ensure that roles and responsibilities at an emergency response are confirmed and a lead is identified to coordinate the emergency response.
- The Head of Healthcare should ensure that all clinical staff have up to date Immediate Life Support Training.
- The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Humber informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Reilly's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Reilly's clinical care at the prison. The review was received late which delayed the completion of this report.
16. The investigator interviewed four members of staff and three prisoners at HMP Humber on 15 and 16 April 2019. She and the clinical reviewer jointly interviewed prison and healthcare staff.
17. We informed HM Senior Coroner for Kingston-upon-Hull and East Riding of Yorkshire of the investigation. We suspended our investigation from 21 May until 18 June 2019, to await the results of Mr Reilly's post-mortem examination. We have sent the Coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Reilly's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Humber

20. HMP Humber is a medium security prison in Yorkshire that holds approximately 1,000 men. City Health Partnership provides healthcare services. There are always healthcare staff on duty.

HM Inspectorate of Prisons

21. The most recent full inspection of HMP Humber was in December 2017. Inspectors reported that two thirds of prisoners said that it was easy to get drugs in Humber and a third of prisoners said that they had developed a drug problem while there. Inspectors reported that the use of PS was particularly bad, although levels of supply had reduced after additional security measures were introduced, including the photocopying of mail to prevent paper soaked in PS from entering the prison. Inspectors also found that intelligence did not always result in timely suspicion drug testing and searching taking place, with prisoners suspected of using drugs often not being tested.
22. Inspectors reported that health services provided appropriate treatment for most prisoners, and access to them was generally adequate. Some elements of operational management were weak: for example, emergency equipment was not routinely checked, and there was a significant backlog of unanswered health care complaints.
23. Inspectors also reported that prisoners with long-term conditions and complex health needs were overseen by nurses who liaised with the GP to ensure a coordinated approach. Prisoners were involved in the creation of their individual care plans, which were good, supported continuity of care and were based on national clinical guidance.

Independent Monitoring Board

24. 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 their latest annual report, for the year to December 2019, the IMB reported that psychoactive substance use was still a major concern but a proactive approach by prison management had reduced the supply of drugs into the prison.
25. The Board noted that the recorded levels of prisoners under the influence of drugs or alcohol had decreased from February 2019, when there were high levels of violence and indiscipline. They found that the downward trend indicated a link to the reduced availability of drugs in the prison.

Previous deaths at HMP Humber

26. Mr Reilly was the 10th prisoner to die at HMP Humber since March 2017. Of the previous deaths, four were drug-related, three were from natural causes and two

were self-inflicted deaths. There have been two self-inflicted deaths at the prison since Mr Reilly's death.

27. We have previously raised concerns about the availability of PS at Humber and the need for the prison's drug strategy to be revised.

Psychoactive Substances (PS)

28. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a significant 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.
29. There are many types of PS, including synthetic cannabinoids, often referred to as "Spice".

Key Events

30. Mr John Reilly had many previous convictions and had served a number of prison sentences. On 20 September 2017, he was sentenced to two years, four months in prison for burglary. He transferred to HMP Humber on 22 May 2018. On 14 June, Mr Reilly was convicted of further burglary offences and sentenced to ten months in prison.
31. Mr Reilly had a history of substance misuse. At previous prisons there were many reports about him being under the influence of drugs. He was on a daily dose of methadone to treat his heroin addiction. The day before his transfer to Humber, Mr Reilly had been found in a semi-conscious state, under the influence of psychoactive substances (PS).
32. On his arrival at Humber, a nurse carried out Mr Reilly's reception health screen. She checked his observations, which were all within the normal range and noted no significant physical concerns. She noted that Mr Reilly was on a methadone detoxification programme and referred him to the prison's substance misuse team, DART (Drug and Alcohol Recovery Team). He continued with his methadone therapy and healthcare staff reviewed him regularly.
33. On 30 May, Mr Reilly told his DART keyworker that he was fine and wanted to undertake a rapid detox, and that he wanted to join the gym as part of his methadone therapy. He enrolled on the gym intervention programme which included daily gym sessions, circuit training and football. Mr Reilly attended his gym sessions regularly.
34. In July, staff suspected that Mr Reilly was under the influence of drugs, but he would not let healthcare staff assess him.
35. In December, Mr Reilly tested negative in a mandatory random drug test.

2019

36. On 8 January 2019, Mr Reilly had a meeting with his keyworker, who noted no concerns.
37. On 14 January, Mr Reilly told a clinical support mental health nurse that he did not need any further DART support. She discharged him from the DART service and told him that he could access the service again at any time.
38. On 26 January, Mr Reilly had a meeting with his keyworker, who noted that he was happy on the wing.
39. On 30 January, intelligence reports noted that there had been suspicious money transfers between Mr Reilly and another prisoner which needed to be monitored.

Events of 4 March

40. Mr Reilly began a circuit training session in the sports hall at approximately 8.50am. CCTV footage shows Mr Reilly participating in the circuit training session and then

taking a rest at the side of the hall. One of the prisoner gym orderlies asked Mr Reilly if he was ok and Mr Reilly said that he needed a little time out.

41. Mr Reilly left the sports hall and went into the weights room. A prisoner gym orderly said that he saw Mr Reilly fall off the leg press machine. As he ran towards the weights room, he shouted to alert staff that he had seen Mr Reilly collapse. He said that he was the first person to reach Mr Reilly, closely followed by a PE Instructor (PEI). The gym orderly said that Mr Reilly's body was rigid. The PEI checked Mr Reilly's neck for a pulse and placed him in the recovery position. Another PEI arrived and radioed a medical emergency code blue (to indicate a prisoner is unconscious or has breathing difficulties). Records show that the radio call was made at approximately 9.30am.
42. Nurse A responded and went to the gym carrying a paramedic bag with her which she said contained medication, airway and monitoring equipment. She said that she saw Mr Reilly on the floor in the weights room and opened the emergency bag to check what equipment she would need. An officer told her that Mr Reilly was unresponsive. She said that she took the oxygen tank out of her bag and began preparing the connections. CCTV shows she did not approach Mr Reilly closely or complete an initial assessment. Prison staff began chest compressions.
43. Nurse B was the second nurse to arrive. She did not complete an initial assessment. In her written statement she said that prison staff were already present. She said that she immediately began chest compressions. She also said that there was a bag valve mask on Mr Reilly's face, so she removed it to insert an IGel airway (a device used to support breathing), then replaced the mask and continued to bag valve. She said that she called for more healthcare staff to attend and continued assisting with the CPR compressions. She also said that five nurses and the non-clinical healthcare manager arrived. Four nurses helped with the CPR cycles. Nurse A said that another nurse took the lead. The incident log noted that prison gym staff and prison managers attended. The defibrillator was used and there were continuous chest compressions.
44. Paramedics were already at the prison attending to two other incidents. Once those were concluded, they arrived at the gym and assisted with CPR. At 10.32am, a paramedic confirmed that Mr Reilly had died.

Contact with Mr Reilly's family

45. Following Mr Reilly's death on 4 March the prison appointed a Family Liaison Officer (FLO). Mr Reilly had named his sister as his next of kin. The FLO visited Mr Reilly's sister to inform her of her brother's death.
46. The prison arranged and paid for Mr Reilly's funeral in line with national instructions.

Support for prisoners and staff

47. After Mr Reilly's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

48. The prison posted notices informing other prisoners of Mr Reilly's 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 Reilly's death.

Post-mortem report

49. The pathologist gave Mr Reilly's cause of death as a combination of PS use and ischaemic heart disease.
50. The pathologist noted that Mr Reilly's heart disease was sufficient by itself to account for his sudden death, particularly as physical exercise would have placed him under additional physiological stress. In addition, the toxicology tests showed that Mr Reilly had used PS before his death. Added to his heart disease, the use of PS increased his risk of an irregular heartbeat.

Findings

Mr Reilly's drug use

51. Mr Reilly had a long history of substance misuse in the community and he undertook a methadone detoxification programme during his time at Humber. He also engaged with the prison's substance misuse team until seven weeks before his death when he was discharged from DART at his own request. He was also able to take part in the specialist substance misuse gym sessions. We are satisfied that Humber offered Mr Reilly appropriate support for his substance misuse issues and that he was aware he could re-engage with DART at any time.
52. There was only one occasion, in July 2018, when staff suspected Mr Reilly might have used drugs during his time at Humber. Staff said they had no suspicions that Mr Reilly was taking drugs after that. However, Mr Reilly's personal officer noted in October 2018 that she had not yet had a chance to speak to Mr Reilly (five months after he arrived at Humber) and there is no record that she ever did. He then had two meetings with his key worker on 8 and 26 January. There are no further entries at all in his electronic prison record and no evidence that staff had any meaningful contact with Mr Reilly in the five weeks before his death. This may have been a missed opportunity to identify signs that Mr Reilly was misusing drugs.
53. The Governor said that at the time of Mr Reilly's death, the key worker scheme was still in the introductory stage, which meant that although the number of individual key worker sessions being delivered across the establishment were being gradually increased, they were not yet sufficient to reach the levels of provision required in order to achieve full implementation. We therefore recommend:

The Governor should ensure that key workers meet their allocated prisoners regularly in line with Prison Service policy.

Humber's Drug Strategy

54. The use of PS is a concern across the prison estate and has a profoundly negative impact on the physical and mental health of prisoners, as well as being associated with debt and bullying. Mr Reilly's death is an example of the dangers of PS and illustrates why prisons must do all they can to eradicate its use.
55. In April 2019, HM Prison and Probation Service published the National Drug Strategy. It set out their plans to reduce substance misuse in prisons by providing detailed guidance for prisons to help them identify issues and share best practice. It emphasised that each prison is different and needs to identify and tackle its own specific drug-related issues.
56. Humber published its local Drug Strategy in January 2019 (in force at the time of Mr Reilly's death), and a revised version was published in September 2019. The strategy aims to give clear direction on how the prison should tackle substance misuse by reducing demand, supply and promoting recovery for prisoners through clinical intervention, education, motivation and support while managing safety and harm prevention. It is a live document and includes increased emphasis on a peer mentor programme, key work programme and family work programme to provide a

network of support for prisoners who take drugs. This includes access to specific gym sessions for those in the process of detoxing and those who are in recovery, with the aim of increasing prisoners' physical wellbeing. The prison has committed to training staff on the effects of drug use on mental health and collaborative working between substance misuse, healthcare, wing staff and prisoners.

57. Given that the prison revised its guidance following Mr Reilly's death and that there have been no drug-related deaths since, we make no recommendation.

Emergency response

58. The clinical reviewer found that when Mr Reilly collapsed in the gym, Nurse A, who was first nurse to respond to the emergency, did not conduct an initial assessment of him, nor did she take the lead during the emergency response.
59. At interview, Nurse A said that she was up to date with her Immediate Life Support training, but that this was the first time she had been the first on the scene at a cardiac arrest. The clinical reviewer was concerned that she did not appear to have reflected on the incident or taken any actions to update her skills.
60. At interview, the Head of Healthcare said that he had seen the CCTV footage of the emergency response and was concerned that Nurse A had remained at least six feet away from Mr Reilly and had not assessed him or started CPR. He said that he was planning to meet with her to discuss the incident and identify any training needs. We make the following recommendations:

The Head of Healthcare should ensure that roles and responsibilities at an emergency response are confirmed and a lead is identified to coordinate the emergency response.

The Head of Healthcare should ensure that all clinical staff have up to date Immediate Life Support Training.

61. We are satisfied, however, that prison staff began CPR very promptly and that there was no delay in calling an ambulance.

Clinical Care

62. The clinical reviewer concluded that the care Mr Reilly received at Humber was good and equivalent to that which he could have expected to receive in the community.
63. Mr Reilly received his first and secondary health screen when he arrived at Humber. He told a nurse that he had a history of passing out, but nothing had been diagnosed. He reported no other health issues and no other physical health concerns were identified. We make no recommendation.

Sharing of PPO reports

64. We consider that it is important for staff who were involved in Mr Reilly's care to see the findings of our investigation. We make the following recommendation:

The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.

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