

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin McDonnell, a prisoner at HMP Nottingham, on 29 September 2022

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Kevin McDonnell was found hanging in his cell on 29 September 2022 at HMP Nottingham. Staff tried to resuscitate him but were unsuccessful. He died on the anniversary of his father's death. Mr McDonnell was 47 years old. I offer my condolences to his family and friends.

Mr McDonnell was the second person to take his life at Nottingham in three years.

Mr McDonnell was being monitored using suicide and self-harm prevention procedures (known as ACCT) when he died. My investigation found that some aspects were managed well but others less so, including lack of consistency in the staff attending case reviews and failure to hold a case review ahead of the anniversary of Mr McDonnell's father's death, which was a known trigger date.

In their last inspection of Nottingham in 2022, HM Inspectorate of Prisons identified that quality of ACCT documents varied greatly and many prisoners at risk of self-harm felt uncared for.

The clinical reviewer found that the mental health care Mr McDonnell received at Nottingham was not equivalent to that which he could have expected to receive in the community. She found that due to severe staff shortages in the mental health team, Mr McDonnell did not get the expected level of care.

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

Adrian Usher
Prisons and Probation Ombudsman

December 2023

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Summary

Events

1. On 7 July 2022, Mr Kevin McDonnell was remanded to HMP Nottingham charged with assault.
2. On the morning of 30 July, an officer started suicide and self-harm monitoring (known as ACCT) after Mr McDonnell cut his arm with a razorblade. Mr McDonnell said he had self-harmed because he was being targeted by other prisoners who were calling him a paedophile. He said he wanted to move to another wing.
3. Staff moved Mr McDonnell from E Wing to C Wing, and then to B Wing. However, he said that he continued to feel under threat. He asked to move to F Wing, the induction wing, but staff told him that this was not possible. He then said he would hang himself, so staff placed him under constant supervision. He was under constant supervision from 19 to 22 August and again from 26 August to 4 September.
4. Staff could find no evidence that Mr McDonnell was under threat, and there were concerns that he was paranoid. A nurse noted that Mr McDonnell said he heard prisoners shouting things about him which no one else heard.
5. On 5 September, Mr McDonnell told staff that the anniversary of his father's death was on 29 September. This was recorded in his ACCT document as a trigger date.
6. On 28 September, Mr McDonnell was scheduled to have an ACCT review. However, due to a prison-wide training day, this review was moved to the next day.
7. At 11.22am on 29 September, while delivering Mr McDonnell's lunch, an officer saw Mr McDonnell on the floor of his cell with a ligature around his neck. The officer shouted for staff assistance and entered the cell. When more staff arrived, they cut the ligature and started cardiopulmonary resuscitation (CPR).
8. Staff and ambulance paramedics were unable to resuscitate Mr McDonnell and at 11.42am, a paramedic pronounced that Mr McDonnell had died.

Findings

9. Staff held frequent, multidisciplinary ACCT reviews and recorded a clear care plan. However, the ACCT case coordinator changed far too frequently, as did the case review attendees, which meant that there was not a consistent group of people managing and inputting into Mr McDonnell's ACCT. Also, more effort should have been made to hold a case review before Mr McDonnell's known trigger date to reassess his risk.
10. The clinical reviewer found that the mental health care Mr McDonnell received at Nottingham was not equivalent to that which he could have expected to receive in the community. She found that, due to severe staff shortages within the mental health team, Mr McDonnell did not get the level of care that would have been expected given his risk level and needs.

Recommendations

- The Governor should ensure that staff manage ACCT procedures in line with prison policy including that:
 - There is a consistent ACCT case coordinator and case review team wherever possible.
 - A case review is held shortly before an identified trigger date (such as the anniversary of a death or anniversary of the offence).
- The Head of Healthcare should ensure there is adequate staffing within the mental health team to allow the team to provide the service for which it is commissioned.

The Investigation Process

11. HMPPS notified us of Mr McDonnell's death on 29 September 2022.
12. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator visited Nottingham on 15 and 16 December. He obtained copies of relevant extracts from Mr McDonnell's prison and medical records.
14. The investigator interviewed seven members of staff from Nottingham. He interviewed four in person while at Nottingham on 15 and 16 December.
15. NHS England commissioned an independent clinical reviewer to review Mr McDonnell's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator, interviewing three members of healthcare staff via video call on 14 December, 23 January and 9 February 2023.
16. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. He sent us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. The Ombudsman's family liaison officer contacted Mr McDonnell's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She asked why no prison staff attended her father's funeral despite promising to do so. We have addressed this in the report.

Background Information

HMP Nottingham

18. HMP Nottingham is a resettlement and local prison serving the courts of Nottinghamshire and Derbyshire. It has capacity for approximately 1,000 men. Healthcare for the prison is provided by Nottinghamshire Healthcare NHS Foundation Trust. Primary care provision, including substance misuse treatment is provided 24 hours a day, seven days a week. Recovery services are provided from 7.00am to 9.00pm Monday to Friday, and 8.00am to 6.00pm on weekends. Mental Health services are provided from 7.00am to 9.00pm seven days a week.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Nottingham was in May and June 2022. Inspectors noted that the number of self-harm incidents had increased substantially, and that Prisons and Probation Ombudsman (PPO) recommendations following self-inflicted deaths were not always addressed.
20. Inspectors noted that many prisoners at risk of self-harm felt uncared for. The quality of ACCT documents varied greatly. Most ACCT reviews were multidisciplinary and well documented, but actions to address risks and triggers were not always captured on care maps.
21. Inspectors found that only 55% of prisoners said they had a named officer or key worker compared with 81% at the previous inspection. Although after the COVID-19 pandemic the frequency and quality of key work had started to improve, the key work scheme at Nottingham was not effective enough.
22. Inspectors noted that over the previous 12 months, maintaining sufficient cover in the mental health team had been difficult. The team was operating under significant pressure which had been recognised as a service risk. They found that 73% of prisoners said they had needed help with a mental health problem during their time in prison. The team delivered a seven-day service and had developed contingencies to ensure that prisoners with the most acute need or overt risk were seen.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 28 February 2022, the IMB highlighted that there were fewer ACCTs opened during the reporting year. The sixth version of ACCT had been introduced, and the prison undertook assurance monitoring. The new process seemed to be taking some time to become embedded, and the quality of ACCTs had been variable throughout the prison.
24. The report stated that the prison had increased its provision of key work, however this remained an area for improvement, as prisoners' access to a key worker was limited and some prisoners said they had never received a key work session.

Previous deaths at HMP Nottingham

25. Mr McDonnell was the tenth prisoner to die at Nottingham since September 2020. Of the previous deaths, one was self-inflicted, one was drug-related and seven were from natural causes.

Assessment, Care in Custody and Teamwork

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

27. On 7 July 2022, Mr Kevin McDonnel was remanded in prison, charged with assault, and was sent to HMP Nottingham. It was not his first time in prison.
28. Mr McDonnel had a history of alcohol and substance misuse and was prescribed methadone (an opioid drug used to treat heroin addiction). He also had a history of depression, suicidal thoughts and self-harm, though he said he had no current thoughts of suicide or self-harm when he arrived at Nottingham.
29. A GP at Nottingham prescribed methadone and chlordiazepoxide (also known as Librium), thiamin and vitamin B compound to treat Mr McDonnel's alcohol withdrawal. The next day, following confirmation of Mr McDonnel's community prescriptions, a GP prescribed sertraline (an antidepressant).
30. Mr McDonnel was allocated a cell on F Wing, the induction wing, and remained there for his first five days. He was moved to E Wing (primarily the young adults' wing) on 12 July.
31. On 18 July, an officer noted that for the previous two days Mr McDonnel had declined the regime (exercise, shower, association etc) and food. He said he was under threat from other prisoners, as he had borrowed vape capsules and could not return them. She offered to move Mr McDonnel to another wing and start a 'self-isolation plan', but Mr McDonnel declined. (A self-isolation plan supports a prisoner while they choose to stay confined in their cell and ensures they still receive a regime.)

ACCT opened - 30 July

32. On 30 July, an officer noted that during a routine check, he found Mr McDonnel had self-harmed by cutting his right forearm with a razor blade. Mr McDonnel said he had done this because he felt under threat and wanted to move to another wing. The officer started suicide and self-harm prevention procedures (known as ACCT) and opened a challenge, support and intervention plan (CSIP). (CSIP is used to manage those prisoners who are violent or who pose a raised risk of being violent. Some prisons also use the CSIP framework to support victims of violence.) Staff moved Mr McDonnel from E Wing to C Wing (a standard wing). They closed the CSIP as Mr McDonnel said he felt better but he continued to be managed using ACCT.
33. The next morning, a Supervising Officer (SO) held the first ACCT case review. Mr McDonnel told him that prisoners had been kicking his door and calling him a paedophile. He said he had self-harmed because he felt anxious and thought it would speed up a wing move. When asked how he felt on C Wing, Mr McDonnel said he thought his issues had followed him as he had heard prisoners on E Wing talking to prisoners on C Wing about him and still felt anxious. The case review team set observations at one an hour and two conversations a day.
34. On 31 July, a mental health nurse assessed Mr McDonnel. She noted that he was acutely anxious and was visibly shaking and sweating a lot. He said that when he was moved from E Wing to C Wing, he heard prisoners from E Wing shouting to

other prisoners asking them to beat him up. She noted that she would ask a GP to review his medication and would arrange low-level anxiety work.

35. On 4 August, a SO held Mr McDonnell's second case review. Mr McDonnell said he was doing a little better but was still having thoughts of suicide and self-harm as he was still hearing threats coming from E Wing prisoners. The SO asked if Mr McDonnell had considered a move to the other side of C Wing, away from E Wing, and he said he would enquire about it. The case review team reduced observations to one every two hours and two conversations a day.
36. On 6 August, staff moved Mr McDonnell to B Wing (a standard wing).
37. On 12 August, a SO held the third case review. Mr McDonnell said he wanted to self-isolate as his issues had followed him to B Wing. The SO added a 'self-isolators' regime to Mr McDonnell's care plan. The case review team increased observations to one an hour.
38. At his fourth case review on 19 August, Mr McDonnell said he was being targeted and other prisoners were still calling him a sex offender. When the SO asked Mr McDonnell how staff could help him, he said he wanted to move to F Wing. The SO told him this was not possible because F Wing was the induction wing.
39. Mr McDonnell responded by saying that he would hang himself in his cell. The SO noted that Mr McDonnell was not open to other options and was fixated on a move to F Wing. Staff decided to place Mr McDonnell under constant supervision. (Constant supervision involves being in a cell with a transparent Perspex door through which staff, who monitor the prisoner at all times, can observe the occupant.) He noted that Mr McDonnell was unhappy about this decision but walked compliantly to the constant supervision cell on A Wing.
40. On 20 August, a prison manager held the fifth case review. Mr McDonnell said that nothing had really changed for him, and that it would be considered a success if he got out of prison next month without killing himself. The manager asked Mr McDonnell how he felt about the possibility of moving to D Wing, a standard wing he had not lived on before. Mr McDonnell said that he would "top himself" as it would only take a couple of days for news to get round the wing. The case review team kept Mr McDonnell under constant supervision.
41. On 22 August, a prison manager held the sixth case review. He noted that Mr McDonnell seemed less anxious, and more willing to consider other options. Mr McDonnell said he was still dreaming about suicide and self-harm, but his thoughts were not as strong. He noted that Mr McDonnell was still not happy with the idea of moving to D Wing but understood that he could not remain under constant supervision for the five weeks that remained of his sentence.
42. The case review team decided to stop constant supervision as they considered that Mr McDonnell's risk of suicide had reduced slightly. They set observations at three an hour and two conversations a day.
43. On 24 August, a prison manager held the seventh case review. Mr McDonnell said he still dreamt of self-harming and potentially taking his own life but that he felt fairly settled on A Wing and had been thinking about other cells he could move to that

might make him feel safer. The case review team assessed that Mr McDonnel was showing positive progress and reduced observations to two an hour.

44. On 25 August, staff moved Mr McDonnel back to B Wing. He was offered cells on A Wing, but they did not have a television or telephone, so he was moved to B Wing where there were in-cell facilities. (It is not clear why Mr McDonnel was moved to B Wing rather than D Wing as had been previously suggested.)
45. On 26 August, a Custodial Manager (CM) held the eighth case review. Mr McDonnel said he had six razor blades in his cell, which staff removed with Mr McDonnel's assistance. (It is unclear how Mr McDonnel obtained the razor blades.) The CM noted that IMHT had made a referral for Mr McDonnel to see a psychiatrist, but due to a lengthy waiting list it would be a while before he was seen. Mr McDonnel said that he had stopped taking his medication for anxiety and depression as they were "messing with his head" and made him feel worse. Mr McDonnel said that he had continuing thoughts of self-harm, including ones about cutting his neck open. He said he did not understand why he was back on B Wing as there were more prisoners out to get him on this wing. The CM noted that staff were concerned that Mr McDonnel had been moved back to B Wing as he had appeared to feel safer on A Wing. They decided to put Mr McDonnel back under constant supervision. The CM noted that IMHT would visit Mr McDonnel over the weekend.
46. Later that day, staff moved Mr McDonnel to a constant supervision cell on F Wing.
47. On 27 August, a prison manager held the ninth case review. Mr McDonnel said that prisoners on A and B Wings had been coming to his door and threatening him, but he could not give names. He asked if he could stay in a standard cell on F Wing, but she said she would have to check.
48. On 28 August, a prison manager held the tenth case review. Mr McDonnel said he still had suicidal thoughts and wanted to kill himself if he could get hold of a razor. He said that prisoners believed he was a paedophile. When a nurse from the mental health team asked Mr McDonnel who was saying this and why he was concerned about it if he was not a paedophile, he could not answer. The manager told Mr McDonnel that he would not be able to remain on F Wing and they were looking to move him to A Wing. Mr McDonnel became argumentative, and she explained that he could not stay in a constant supervision cell on F Wing and that they wanted him to progress and find a place he would feel safe.
49. Later that day, staff moved Mr McDonnel to a constant supervision cell on A Wing.
50. On 29 August, a CM held the eleventh case review. She noted that Mr McDonnel made good eye contact and she did not consider that he was currently in crisis, but he said that he would kill himself if he had a razor. He said he had not been eating for the past three days. She noted that he was clearly annoyed about being on A Wing. The nurse who attended the review, noted that prison staff were going to open a food refusal log.
51. On 3 September, an officer noted that during a welfare check Mr McDonnel said that he had not eaten for three to four days but was drinking liquids. She noted that Mr McDonnel began to say the food refusal was to do with his mental health, but

then said it was in protest for being not allowed to stay on F Wing, as he had issues on all other wings. She noted that she asked Mr McDonnell what the issues were, but he would not say.

52. On 4 September, a prison manager held the twelfth case review. She noted that when she asked Mr McDonnell how he had been over the past week, he said that there had been no change. When she challenged this by saying that he had had a stable week with no incidents, he became agitated. She noted that Mr McDonnell had settled on A Wing and there had been no issues. When she told him that he would remain on A Wing, he said that other prisoners were out to get him. However, he could not provide any names or give any witnesses. The case review team agreed that Mr McDonnell should come off constant supervision. They set observations at three an hour, with three conversations a day.
53. At his next case review on 5 September, Mr McDonnell said he felt ok, but nothing had changed. A CM noted that staff on the wing had reported there was no evidence that Mr McDonnell was under threat. The CM noted that Mr McDonnell had supplied trigger dates (when his risk of suicide or self-harm might increase) for his court appearance on 22 September, the anniversary of his father's death on 29 September, and his sister's death in mid-October, which were added to his care plan. The case review team kept observations at three an hour, with three conversations a day.
54. On 12 September, a CM held the fourteenth case review. Mr McDonnell said he was not feeling good and continued to hear threats and accusations from other prisoners. The CM noted that Mr McDonnell could not provide names.
55. The CM noted that Mr McDonnell wanted to continue self-isolation, as every time his door opened, he was fearful that other prisoners would rush in. He noted that Mr McDonnell wanted to be moved to the vulnerable prisoners (VP) Wing or D Wing. The CM said that the VP Wing was unlikely to be an option as Mr McDonnell was not a sex offender and D Wing would probably not be a good option as there were limited single cells and he would not be located near a wing office. The case review panel reduced observations to one an hour, with three conversations a day.
56. On 13 September, a CM noted that a decision was made to refuse Mr McDonnell's request to move to the VP Wing, as they wanted him to work with regular staff to build stability.
57. On 16 September, an officer noted that Mr McDonnell self-harmed by making cuts to his inner arm with a razor blade. Mr McDonnell said he had done this as he thought prisoners were at his door threatening him. She noted that no prisoners had been observed at Mr McDonnell's door. (There is no evidence in the ACCT plan that staff had considered whether Mr McDonnell should be allowed unsupervised access to razor blades.)
58. A nurse attended to Mr McDonnell. He noted that Mr McDonnell had allegedly swallowed a razor blade (but it is unclear if this was the case). Mr McDonnell declined treatment from healthcare staff.
59. On 20 September, a CM held the fifteenth ACCT review. He noted that the review was completed in preparation for Mr McDonnell's court appearance on 22

September, which had been identified as a trigger date. He noted that Mr McDonnell refused to come out of his cell, due to feeling under threat. He noted that Mr McDonnell showed some signs of paranoia.

60. A nurse from the mental health team, who was also in attendance, noted that it was unclear if Mr McDonnell was unwell, as he heard prisoners shouting things about him that no one else could hear. As Mr McDonnell was not a priority case for the mental health team, and due to his own caseload pressures, he took no further action.
61. On 23 September, a CM held the sixteenth case review. The CM noted that Mr McDonnell had not self-harmed for several weeks (this was not the case as Mr McDonnell had self-harmed on 16 September), but he still thought people were out to get him, did not feel safe, and thought that he would harm himself. He noted that Mr McDonnell's cell was close to the wing office and the constant supervision cells, where staff were stationed, but staff reported not hearing or seeing any threats against Mr McDonnell from other prisoners.
62. The CM noted that Mr McDonnell said he had not felt safe to attend his video court appearance the previous day, as he believed new prisoners from C and E Wings were going to get him. He noted that Mr McDonnell said that he was eating only sealed food, did not read or watch TV, and just sat in his cell with his earplugs in.
63. The CM noted the next video court appearance was on 6 October. He kept observations at one an hour and three conversations a day.
64. On 27 September, a nurse saw Mr McDonnell to review his methadone dose. He said he was not managing well on 30mg and needed an increase 'because of everything that was going on'. She noted that Mr McDonnell had previously been prescribed 50ml, and to stabilise him in preparation for his potential release from prison, she agreed to increase Mr McDonnell's methadone to 40mg.
65. The next ACCT review was originally set for 28 September, however, due to a prison-wide training day the review was changed to 29 September. A CM told the investigator he was not aware of the training day when he originally booked the ACCT review.
66. At around 8.45am on 28 September, a CM went to Mr McDonnell's cell to inform him that his ACCT review would not take place as planned, and that it was rescheduled for the following day.
67. At 9.00am, an officer conducted a welfare check on Mr McDonnell, as Mr McDonnell was on the Safeguarding and Self-Isolators lists, and because the following day was the anniversary of the death of Mr McDonnell's father (a trigger date). He spoke to Mr McDonnell for about two minutes. He told the investigator that Mr McDonnell said he was fine but wanted a transfer.

Events of 29 September

68. On 29 September, at around 4.00am, an officer noted that Mr McDonnell had been awake all night. He noted that Mr McDonnell was under the illusion that someone was after him, and that staff were in on it. He noted that Mr McDonnell had been

seeing and hearing things all night that related to him being imminently attacked. He noted that Mr McDonnell claimed to have heard on the radio that people were being unlocked and he had seen people on the stairs trying to sneak to his cell past the wing office. He noted that he reassured Mr McDonnell the best he could, by doing extra patrols and trying to convince him no one was around, but this had not been enough to alleviate Mr McDonnell's fears.

69. At 8.00am an officer took Mr McDonnell to collect his medication. He noted that Mr McDonnell was not typically talkative in the mornings, he did not really engage with him, but this was not unusual.
70. At 9.15am, an officer responded to Mr McDonnell's cell bell. He noted that he had a lengthy chat with Mr McDonnell who was excited about being released and asked about collecting property that he had left in the prison's reception. He noted that he told Mr McDonnell that he would investigate the matter, and that Mr McDonnell was thankful. He noted that with Mr McDonnell mentioning release and that he appeared in a positive mood, he had no concerns.
71. At 10.01am, Mr McDonnell rang his cell bell. An officer attended the cell and spoke to Mr McDonnell for around 90 seconds.
72. At 11.22am, an officer unlocked Mr McDonnell's cell door to provide him with lunch. She told the investigator that when she opened the door, she saw Mr McDonnell on the floor with a ligature tied around his neck and attached to the bed frame. She said Mr McDonnell was a strange purple colour. She shouted for staff support three times. An officer who was walking by responded. The officer entered the cell, quickly followed by her colleague.
73. One officer told the investigator she had difficulty removing the ligature from around Mr McDonnell's neck as it was very tight. She said she radioed for staff assistance and gave the cell number but was not able to get her words out due to panic and shock. She told the investigator that after removing the ligature, more prison staff attended, and they began cardiopulmonary resuscitation (CPR).
74. At 11.23am, a CM called a 'code blue' medical emergency.
75. At 11.24am, healthcare staff arrived at Mr McDonnell's cell. A nurse told the investigator that healthcare staff took over CPR, and that Mr McDonnell had no pulse, and the defibrillator registered as having no shockable rhythm. They tried to administer oxygen, but this was difficult due to the secretions in Mr McDonnell's mouth.
76. Control room staff called the ambulance service at 11.25am. At 11.32am, paramedics arrived, followed by a further ambulance crew.
77. At 11.42am, paramedics stopped CPR and pronounced that Mr McDonnell had died.

Contact with Mr McDonnell's family

78. On 29 September, the prison appointed a family liaison officer (FLO). Mr McDonnell did not have a next of kin recorded in his prison record, but the police managed to trace Mr McDonnell's sister, who then contacted his daughter.

79. The FLO and a prison manager visited Mr McDonnell's daughter on 4 October.
80. The prison chaplain conducted Mr McDonnell's funeral. The prison contributed to the costs of Mr McDonnell's funeral in line with national policy.

Support for prisoners and staff

81. After Mr McDonnell's death, prison and healthcare staff involved in the emergency response attended a debrief to ensure they had the opportunity to discuss any issues arising, and so they could be offered support. The staff care team also offered support.
82. The prison posted notices informing other prisoners of Mr McDonnell's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide and, or self-harm in case they had been adversely affected by Mr McDonnell's death.

Post-mortem report

83. The post-mortem report concluded that Mr McDonnell died from asphyxiation by hanging. Methadone and flecainide toxicity was listed as a contributory factor. Both drugs were prescribed to Mr McDonnell.

Findings

Management of Mr McDonnell's risk of suicide and self-harm

84. Prison Service Instruction (PSI) 64/2011, Managing prisoners at risk of harm from self, from others and to others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.
85. Staff monitored Mr McDonnell using ACCT from 30 July up to his death on 29 September. This included two periods under constant supervision.
86. We found that some aspects of the ACCT procedures were managed well. There were frequent case reviews, which were all multidisciplinary, and records were detailed, with clear explanations for the decisions taken. There was an appropriate care plan and staff tried to address Mr McDonnell's concerns about his safety by arranging wing moves.
87. However, we found that there was a lack of continuity with regard to attendees at the ACCT case reviews and there were six ACCT case coordinators. Also, while there was always a representative from the mental health team present, the attendee changed frequently with eight different representatives in all.
88. Wherever possible, there should be a consistent case review team for prisoners being supported using ACCT. This not only means that staff build up a good knowledge of the prisoner and their risks and needs but can also make it easier for the prisoner to engage if the case review team is familiar to them. While we appreciate that there can be difficulties getting the same people to attend case reviews, and that Mr McDonnell's frequent wing moves and periods under constant supervision did not help with this, we consider that the ACCT coordinator role should have been carried out by fewer people and there should have been more consistent attendance from members of the mental health team.
89. Staff did not hold a case review with Mr McDonnell before his trigger date of 29 September (the anniversary of his father's death). A CM told the investigator that at the time of setting the review date, he did not know that there was a prison-wide training day on 28 September, resulting in a lack of staff. He said that despite the training day, he tried to arrange for Mr McDonnell's ACCT review to go ahead, but due to his other responsibilities that day he was unable to conduct the review. Mr McDonnell's ACCT review was rearranged for the next day.
90. A nurse told the investigator that on the morning of 29 September, he tried to find the CM to conduct Mr McDonnell's ACCT review but could not. He told the investigator that he tried to find someone else to conduct Mr McDonnell's ACCT review with him. He said he spoke to a prison manager and with staff from the Safety Team, but he was unsuccessful. He told the investigator that he documented what he had done and then went to conduct another prisoner's ACCT review.
91. The CM told the investigator that on the morning of 29 September, he had a doctor's appointment and so arrived late to the prison. He said he intended to

conduct Mr McDonnell's ACCT review after he arrived, but shortly after his arrival he was told that Mr McDonnell had died.

92. We accept that the circumstances on 28 September made it more challenging for the CM to arrange a case review. However, having identified Mr McDonnell's trigger dates, staff needed an opportunity to assess whether his level of risk had increased and whether additional measures, such as more frequent observations or more support, were required. We consider that arranging a case review should have been prioritised.

93. We recommend:

The Governor should ensure that staff manage ACCT procedures in line with prison policy including that:

- **There is a consistent ACCT case coordinator and case review team wherever possible.**
- **A case review is held shortly before an identified trigger date (such as the anniversary of a death or anniversary of the offence).**

Clinical care

94. The clinical reviewer concluded that the mental health care Mr McDonnell received at Nottingham was not equivalent to that which he could have expected to receive in the community.

95. Mr McDonnell was referred for a mental health assessment on 7 July, following his reception health screen. However, he was not seen for a face to face assessment until 31 July, which was outside the expected five-day timescale. Mr McDonnell should have had an urgent mental health assessment when he was placed under constant supervision, but this did not happen.

96. The clinical reviewer found no evidence that a mental health care plan was created for Mr McDonnell at any time during his stay at Nottingham. When Mr McDonnell told staff on 5 September that the anniversary of his father's death was on 29 September, a nurse recorded this in his medical record but took no further action to escalate his care in the lead up to this date. There was also no escalation of his care when he told a nurse on 12 September that he was struggling, or when he self-harmed on 16 and 20 September.

97. At interview, the Acting Clinical Matron for Mental Health told the investigator and clinical reviewer that the mental health team was very short staffed at the time of Mr McDonnell's death, with only 3.5 mental health nurses in post when there should have been 12. As a result, they prioritised attending ACCT reviews, medical emergencies and seeing the patients most at risk. Mental health assessments and interventions were not routinely offered.

98. She said that Mr McDonnell had been assessed as an 'amber' patient (out of green, amber and red, with red being the highest risk). She said that on reflection, if the team had been fully staffed, Mr McDonnell would have been escalated to a complex case and managed as a 'red' patient. The Head of Healthcare has since told us that

the mental health team is now seeing 'amber' patients but that there are still two vacant posts within the team. We recommend:

The Head of Healthcare should ensure there is adequate staffing within the mental health team to allow the team to provide the service for which it is commissioned.

Governor to Note

Key worker support

99. The Prison Service's Manage the Custodial Sentence Policy Framework 2018, states that all prisoners within the male closed estate must be allocated to a prison officer who will have a key worker role. It also says that Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for the delivery of key work, which should include time with each prisoner.
100. During his 12 weeks at Nottingham, Mr McDonnel received only one key worker session, on 21 July 2022 from an officer. On 4 August, at an ACCT review, a SO recorded that he had allocated another officer as Mr McDonnel's key worker. However, no further key worker sessions are recorded, either by this officer or anyone else.
101. The prison was unable to explain why Mr McDonnel received only one key work session during his time at Nottingham. However, they said that the process for allocating key workers had changed and while it used to be done centrally on a random basis, officers were now allocated six prisoners on their wing to enable more consistent support. They said that every prisoner (apart from recent arrivals on the induction wing) was allocated a key worker and that officers were detailed to carry out key worker sessions (although sometimes redeployment meant they did not always happen). The prison also told us that for prisoners under constant supervision, consideration was given to whether they should be allocated a key worker from the Safety Team. If they remained with their wing key worker, then they would still be seen daily by an officer from the Safety Team.
102. We note that, according to the prison, a greater proportion of prisoners are allocated a key worker now (over 90%) than when HM Inspectorate of Prisons carried out its inspection in May and June 2022 (55%). We do not make a recommendation, but the Governor should monitor whether the key work system is delivering meaningful key work sessions to prisoners at Nottingham.

Prison-NOMIS case notes

103. PSI 23/2014 Prison-NOMIS (Prison National Offender Management Information System), states all staff who have contact with a prisoner and who have access to Prison-NOMIS must update case notes on a regular basis.
104. On 28 September, an officer conducted a welfare check on Mr McDonnel. He told the investigator he conducted this check as Mr McDonnel was on the Safeguarding and Self-Isolators lists, and because the following day was the anniversary of his father's death (a trigger date).

105. CCTV footage shows that the officer had a two-minute-long conversation with Mr McDonnell; but he did not record this conversation on Prison-NOMIS as a case note.
106. The officer visiting Mr McDonnell is evidence of good practice, however as stated in PSI 23/2014 he should have updated Mr McDonnell's Prison-NOMIS case notes. This would have ensured that information about Mr McDonnell was effectively shared with other staff to inform assessment and management of risk.

Inquest

107. The inquest, held from 9 to 19 July 2024, concluded that Mr McDonnell died by suicide. The jury found that failings by prison staff and healthcare staff in the management of Mr McDonnell's ACCT and in his mental health care, probably more than minimally contributed to Mr McDonnell's death by suicide.

**Prisons &
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