Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Smith, a prisoner at HMP Doncaster, on 22 April 2023

A report by the Prisons and Probation Ombudsman

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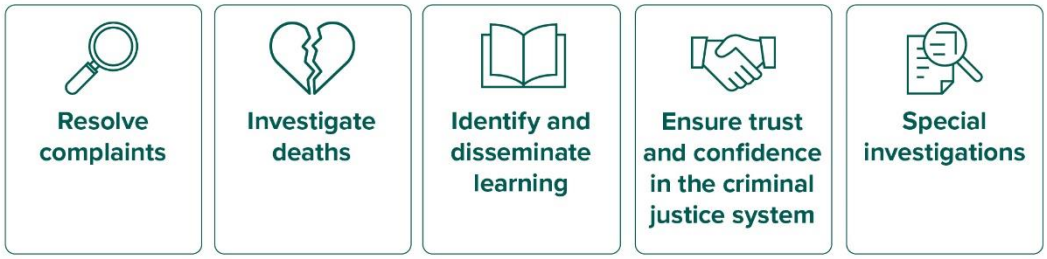
OUR VISION

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

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 Smith was found hanged in his cell at HMP Doncaster on 22 April 2023. He was 18 years old. I offer my condolences to his family and friends.

It was Mr Smith's first time in an adult prison, and he had been at Doncaster for under two months when he died. Mr Smith was concerned for his safety at the prison and, although he declined a cell move, little else was done to investigate his fears. Mr Smith's risk to himself was not considered holistically and was not well managed. Mr Smith did not benefit from a consistent key-worker to build a trusting relationship with.

The clinical reviewer found that Mr Smith's mental health care was not equivalent to that which he would have received in the community. In particular there was a lack of regular planned support from the mental health team.

I have been worried for some time about the impact for prisoners of running out of phone credit and being unable to call family or friends in times of crisis, which came up in this case.

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 **August 2024**

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Summary

Events

1. On 1 March 2023, Mr Kevin Smith, who was 18 years old, was remanded to HMP Doncaster charged with various offences including burglary and theft of a motor vehicle. Mr Smith had been released on licence from HMYOI Wetherby a little over a week earlier and had failed to arrive at an approved premises where he was required to live for a period of time.

2. Mr Smith was very briefly supported through prison suicide and self-harm monitoring procedures (known as ACCT) on three occasions in April 2023. On the first two occasions, Mr Smith cut himself and said he did so because he was under threat and was also having difficulties with his partner. On the third occasion, Mr Smith said that he had showed an officer his existing cuts and had just been wasting staff time as he was bored.

3. At 8.50am on 22 April, an officer found Mr Smith hanging from a ligature tied to the cell shelving unit. The officer radioed a medical emergency code and went into the cell, followed immediately by another officer. The officers cut the ligature and started cardiopulmonary resuscitation (CPR). Nurses arrived two to three minutes later. They noted that Mr Smith had signs of rigor mortis but continued to give CPR.

4. Ambulance paramedics arrived at 9.03am and after checking Mr Smith, they instructed that efforts to try to resuscitate him should stop as he was dead.

5. Staff found a letter in Mr Smith's cell which made clear his intent to die.

Findings

6. ACCT support for Mr Smith ended with insufficient exploration of his concerns or consistent attendance of healthcare staff at reviews.

7. Mr Smith did not have a consistent key-work officer. He ran out of phone credit twice in the days before his death, meaning he could not make calls to family or friends as and when he wanted or needed to.

8. Officers did not make a routine check of prisoners at 6.15am on 22 April as required.

Recommendation

- The Director and Head of Healthcare should ensure that there is a robust quality assurance process to ensure that healthcare staff attend ACCT reviews in line with policy to facilitate an informed and considered approach to risk management.

- The Director should ensure that intelligence regarding a prisoner feeling at risk is properly investigated, the prisoner is appropriately supported and that there is a quality assurance process in place to ensure that this is being routinely done.

The Investigation Process

9. HMPPS notified us of Mr Smith's death on 22 April 2023.

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

11. The investigator obtained copies of relevant extracts form Mr Smith's prison and medical records.

12. The investigator interviewed 13 members staff and two prisoners at HMP Doncaster between 27 July and 6 September.

13. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with clinical staff.

14. We informed HM Coroner South Yorkshire East District of the investigation. She provided us with a copy of the post-mortem and toxicology reports. We have sent her a copy of this report.

15. We contacted Mr Smith's father to explain the investigation and to ask if he had any matters that he wanted us to consider. Mr Smith's father raised the following questions and matters:

    - Why was his son not seen by a psychiatrist?
    - He was concerned about the way his son's ACCT was managed including ACCTs being closed before care plan actions were completed and without input from healthcare staff.
    - Why was no action taken in response to the threats that his son was being bullied, including the incident on 21 April when another prisoner dragged him into a cell.
    - Did the investigator interview another prisoner?
    - Why were no routine early morning checks made on his son on 22 April?
    - He was upset that he learned of his son's death from another prisoner.

16. We have addressed these issues in our report and in the clinical review. Mr Smith's father raised a number of other issues that we have addressed in separate correspondence.

17. Mr Smith's family received a copy of our initial report. The solicitor representing Mr Smith's father wrote to us asking two questions about our investigation that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

18. The initial report was also shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and clarification of information and this report has been amended accordingly.

Background Information

HMP Doncaster

19. HMP Doncaster is a local prison operated by Serco. It holds remanded or convicted men and young adult men. Practice Plus Group provides healthcare services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Doncaster was in February and March 2022. Inspectors found that levels of violence had reduced significantly since the previous inspection in September 2019 and were lower than at similar prisons. Inspectors noted that acts of violence were investigated promptly, and the dynamic daily residential meeting considered the initial findings from the incidents and considered options, such as relocation of the prisoners involved.

21. Inspectors noted that violence was managed by a separate team to the safer custody team, which focused on suicide and self-harm. Inspectors found that well-attended safer custody meetings were held monthly, and a safer custody analyst provided detailed data and analysis of trends. Doncaster had developed a strategy to reduce levels of harm, and the number of ACCTs opened had reduced over the last two years. Recent data had also shown a promising decline in the number of recorded incidents of self-harm. Inspectors found that most prisoners they spoke to felt cared for by staff and the quality of ACCT documents had improved since the last inspection and care plans generally reflected the issues identified. Inspectors also noted that wing supervisors checked the quality of ACCT documents every 24 hours and highlighted any concerns appropriately.

22. Inspectors found that key-worker sessions had continued throughout the pandemic and were recorded more regularly than normally seen. However, inspectors also found that key-worker sessions were often formulaic and that prisoners did not always see the same key-worker each time, affecting their ability to build rapport.

23. Inspectors found that the mental health team was rich in skill mix and experience delivering evidence-based treatment using the stepped care model. (The stepped-care model aims to deliver the most effective yet least resource intensive treatment first.)

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 November 2023, the IMB published a report that covered the period 1 October 2020 to 31 August 2022. The IMB explained that for most of the reporting period, the IMB had had only two active members and for much of the period, only one member. As a result, the IMB's capacity to carry out its full role had been significantly impacted. The IMB reported its view that across most observable indicators, the prison had improved and felt calmer, cleaner and with improved staff-prisoner engagement. Among a number of areas for development, the IMB noted

that some prisoners were uncertain how they should engage effectively with healthcare staff.

Previous deaths at HMP Doncaster

25. Mr Smith was the 26th prisoner to die at Doncaster since February 2020. Of the previous deaths, six were self-inflicted, four were from drugs and 15 were from natural causes. Since the death of Mr Smith, there has been one death due to natural causes.

26. In our investigation into a self-inflicted death in December 2020, we found deficiencies in the operation of the key-worker scheme at Doncaster. We again found deficiencies with the operation of the key-worker scheme in our investigation into a self-inflicted death in July 2022.

27. In our investigation into a death from natural causes in December 2020, we found that there had been no early morning check on the prisoner, and he was then found dead in his cell at 9.30am.

28. In an investigation in January 2021, staff attempted to resuscitate a prisoner despite clear indications that he had been dead for some hours.

29. We identified deficiencies with mental health input in three of the deaths we investigated between June 2020 and July 2022.

Assessment, Care in Custody and Teamwork

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

31. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key-worker scheme

32. The key-worker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key-worker who will spend an average of 45 minutes a week on key-worker activities, including having meaningful conversation which each of their allocated prisoners.

Key Events

HMYOI Wetherby

33. Between May 2021 and February 2023, Mr Kevin Smith spent time at HMYOI Wetherby on three separate occasions for a variety of offences including assault, arson, robbery, burglary and various motoring offences. He had a difficult childhood and while in custody often used illicit drugs and alcohol, was in possession of weapons and displayed inappropriate behaviour towards female staff and violence towards other prisoners.

34. During his time at Wetherby, Mr Smith was supported a number of times by prison suicide and self-harm monitoring procedures (known as ACCT). Incidents that led to ACCTs included Mr Smith being found with a ligature around his neck, making cuts to his hand and swallowing screws and a battery. This usually followed Mr Smith receiving bad news and he would often assure staff that he would not repeat the self-harm.

35. On 10 March 2022, Mr Smith was alleged to have stabbed another prisoner with an improvised weapon. This led to an additional criminal charge that remained outstanding for a year.

36. On 13 February 2023, staff checked on Mr Smith after receiving a telephone call from a friend expressing concerns about him. Staff found Mr Smith with a ligature around his neck. A nurse noted that Mr Smith was conscious and talking but he was pale and shaking and had a red mark to his neck. Staff re-opened a recently closed ACCT that remained open for Mr Smith's remaining week at Wetherby.

37. On 20 February, Mr Smith was released on licence and met his offender manager at his local probation office. As part of his licence conditions, Mr Smith was initially required to live in an approved premises, but he failed to arrive and his whereabouts were unknown.

HMP Doncaster

38. On 1 March, Mr Smith was arrested and remanded to HMP Doncaster charged with various offences including burglary and theft of a motor vehicle allegedly committed between 24 and 27 February. It was Mr Smith's first time in an adult prison.

39. A nurse noted that Mr Smith's Person Escort Record (PER) that accompanied him from court to Doncaster, stated that he had harmed himself three days before, but he refused to tell the nurse more details. Mr Smith said he had no current thoughts of suicide or self-harm and the nurse noted he seemed unconcerned about being back in prison. She noted that Mr Smith had attention deficit hyperactivity disorder (ADHD), for which he received medication. (People with ADHD can seem restless, may have trouble concentrating and may act on impulse.) The nurse referred Mr Smith to the mental health team.

40. A prison custody officer (PCO) in the first night centre noted that they had seen the PER, and that Mr Smith had a history of self-harm, but also noted that Mr Smith had

no present thoughts of suicide or self-harm. There is no record that the reception officer discussed Mr Smith's recent self-harm with him.

41. On 2 March, a psychiatrist prescribed Mr Smith medication for ADHD. He did not see Mr Smith in person.

42. On 3 March, a chaplaincy worker met Mr Smith to give him information about the services offered by the chaplaincy team. The chaplaincy worker noted that Mr Smith raised no issues or concerns.

43. The same day, during a further screening Mr Smith told a PCO that he was in a relationship, he had two children from previous relationships and good support in the community. He said that he did not need help in managing his temper or impulsivity and he had no current thoughts of suicide or self-harm.

44. On 7 March, a mental health nurse reviewed Mr Smith. He said he had no thoughts of suicide and self-harm. The nurse told the investigator that Mr Smith had good support from his partner and father and from his presentation she had no concerns for his safety. However, she referred him to the learning disabilities nurse for support.

45. On 13 March, Mr Smith moved to a single cell on Houseblock 2D. He remained in this cell until his death. Mr Smith had been assessed as high risk for sharing cells due to his history of violence towards other prisoners.

46. On 23 March, a PCO saw Mr Smith for a key-worker session. Mr Smith said that he was feeling in good general health but was waiting to speak to the mental health team. He also said that he had good family support but was not able to telephone them as he had no money. He said that he enjoyed going out for exercise and associating with other prisoners.

47. On 29 March, a PCO saw Mr Smith for a key-worker session. Mr Smith said that his main concern was that he had no job and no other income which meant that he was limited in making canteen orders (canteen is the prison shop) and telephone calls to his family. Mr Smith said that he had good support from his father and partner and that she was going to visit him at the weekend. Mr Smith said that he had a history of self-harm, but he had no current thoughts of suicide or self-harm.

48. Also on 29 March, a nurse who specialises in learning disabilities (the learning disabilities nurse) saw Mr Smith. He noted that Mr Smith was anxious about a video-link court hearing later that day and he also reported having problems with his sleep. He sent a task to the psychiatrist to review Mr Smith’s medication. He added Mr Smith to his caseload, but he did not formally review him again. However, he said he met him informally a number of times when visiting other prisoners and he had no concerns about him. He said that he told Mr Smith to come to him at any time if he wanted to chat.

49. During his video-link court hearing that afternoon, Mr Smith was further remanded into custody until 11 May. A PCO spoke to Mr Smith after the hearing and noted that he said he was unconcerned about the outcome and did not need any support.

50. On 2 April, the psychiatrist reviewed Mr Smith’s medical records and prescribed him Promazine to help with stress and problems sleeping. He noted that Mr Smith’s

ADHD medication seemed to be working, so he made no adjustment to that prescription.

51. Also on 2 April, Mr Smith had a key-worker session when he said that he felt safe on the wing. He said that he did not have much that he needed help with, although he still had no job.

52. On the same day, Mr Smith had a video-conference with his solicitor after which he raised no issues with staff.

53. On 7 April, wing staff noted that Mr Smith was unsteady on his feet and possibly under the influence of an illicit substance. A nurse tried to examine him, but he refused to be examined or treated. Staff notified the substance misuse team and submitted an intelligence report.

54. On 11 April, a substance misuse worker telephoned Mr Smith on his in-cell phone and asked if he had been taking illicit drugs. She told the investigator that Mr Smith was adamant that he did not use drugs, but he said that he and his cousin were both under threat on their wing and they needed to move to a different wing. She telephoned the wing office to report the conversation, and an officer told her that Mr Smith had already reported the threats.

55. The same day staff submitted an intelligence report. This indicated that Mr Smith and another prisoner were possibly under threat due to drug debts. The report stated that the information had been shared with the houseblock managers and the safer custody team but that no further action was required at that time.

56. At just before 6.00pm on 13 April, Mr Smith rang his cell bell and told a PCO that he needed a nurse as he had made cuts to his neck. He said that he was under threat on the wing and also had issues in his home life. The PCO opened an ACCT and a manager set Mr Smith's observation at one an hour pending an ACCT review. At interview (in March 2024), the PCO could not recall whether she had done so for Mr Smith but told the investigator that her normal practice would have been to call a nurse. There is no record that a nurse assessed Mr Smith.

57. In the early morning of 14 April, a PCO noted that Mr Smith had had a calm and settled night. He had asked for writing paper and envelopes and had written some letters. He also spent time watching television and had then slept well for the rest of the night.

58. On the afternoon of 14 April, a Custodial Operations Manager (COM) chaired an ACCT review with Mr Smith. A PCO also attended the review, along with a mental health nurse and a senior mental health practitioner. Mr Smith said that he had cut his neck the day before as he was frustrated following an argument with his partner. He said that he now regretted his actions and had no current thoughts of suicide or self-harm. He said that he was seeing the learning disabilities nurse and was taking medication for ADHD. He also said that he was looking forward to his next court appearance as he believed he would soon be released from custody but would like a job in the meantime so he could keep busy and earn some money. The COM wrote an ACCT care plan that included an action for Mr Smith to move to a different Houseblock as he did not feel safe on Houseblock 2D. He noted that staff were in process of moving him at that time. The COM noted that everyone at the review

agreed that the ACCT could be closed. (The other actions on the care plan were for Mr Smith to take his ADHD medication, to attend the gym on a regular basis and for him to maintain family contact. The COM marked all these actions as completed.)

59. Despite the COM's care plan entry, Mr Smith remained on Houseblock 2D.

17 April

60. On 17 April, Mr Smith telephoned his partner a number of times between 4.00pm and 8.00pm. In their final conversations, Mr Smith's partner confronted him about his contact with another woman, possibly an ex-partner. Mr Smith's partner ended their final two calls abruptly.

61. At around 8.30pm, a PCO was making a welfare check on all prisoners when he found that Mr Smith had made some cuts to his neck, and he said that he was not going to make it through the night. The PCO radioed a code red emergency (to indicate a prisoner is bleeding).

62. A nurse associate responded to the code red. She noted that Mr Smith had minor wounds, which she dressed. Mr Smith said that he self-harmed because he did not have enough credit to telephone his partner. (His telephone account confirms that he had used up his remaining credit by 7.50pm that evening.)

63. A PCO re-opened Mr Smith's ACCT and the officer in charge set observations at two an hour pending an ACCT review.

18 April

64. At an ACCT assessment interview on the morning of 18 April, Mr Smith told a PCO that he had been frustrated the evening before after arguing with his partner. He also said that he was having issues on Houseblock 2D and wanted to move as soon as possible. Despite these concerns, Mr Smith said that he had no current thoughts of suicide or self-harm and would tell staff if that were to change.

65. Later that morning, a COM chaired an ACCT review with Mr Smith. Another COM and a PCO also attended; no healthcare staff were present. Mr Smith said that he had made scratches to his neck the night before as he was frustrated at having to wait for a doctor's appointment which he had self-requested on the ATM (at Doncaster, the wings have ATMs on which prisoners make applications for services they need). The COM noted that Mr Smith understood that he needed to wait for an appointment to be set. (According to the information provided, Mr Smith did not have an outstanding doctor's appointment. He had last requested a medical appointment on 25 March and was seen on 29 March.) Mr Smith told staff that he had family support and was looking forward to another visit from his family that weekend. Mr Smith again said that he was due in court in the near future and was expecting to be released. Mr Smith spoke about having issues on Houseblock 2D and the COM noted that staff had found a single cell for him on Houseblock 2B to which he agreed to move. Staff closed Mr Smith's ACCT.

66. The COM told the investigator that when staff told Mr Smith that the cell on Houseblock 2B was ready, he no longer wanted to move.

67. At around 10.15pm that evening, a PCO noted that Mr Smith had re-opened the cuts to his neck and he said that he was planning to hurt himself further. The PCO re-opened Mr Smith's ACCT and called the officer in charge to complete an immediate action plan. The officer in charge set Mr Smith's observations at two an hour pending an ACCT review the following morning. Mr Smith refused to see a nurse.

19 April

68. A senior mental health practitioner emailed a contribution ahead of Mr Smith's ACCT review that day saying that he was on the learning disabilities nurse's caseload (this was correct, but the nurse was not seeing Mr Smith formally). The practitioner wrote that Mr Smith was receiving medication for ADHD and was also receiving medication for stress and sleep disturbance. She wrote that Mr Smith had previously said that he would self-harm as a means of release, rather than with any intent to end his life.

69. A COM chaired an ACCT review with Mr Smith later that morning. A PCO attended the review, and the COM noted the senior mental health practitioner's written contribution. He told the investigator that Mr Smith said that he had not self-harmed the previous evening but had showed the officer the same cut marks from a few days earlier. He said that he had been bored so had wasted staff's time. The COM said that Mr Smith was a confident and boisterous man and he never believed that he was at risk of taking his own life. He noted in Mr Smith's record that all of the care plan issues were resolved and that the ACCT could be closed.

20 April

70. On the afternoon of 20 April, Mr Smith attended a remand hearing by video-link in connection with the incident from March 2022, when he was alleged to have stabbed another prisoner. Mr Smith was further remanded into custody until his next hearing date on 18 May. Staff noted that Mr Smith raised no concerns after the hearing, and he declined support from healthcare or a prison buddy (buddies are prisoners who provide social and welfare assistance to other prisoners).

71. Mr Smith telephoned his partner several times between 5.00pm and 8.00pm that afternoon and evening. Mr Smith asked his partner to send him some money and he also asked her to tell his mother about getting her name added to his list for video-conference calls. With his final call to his partner, Mr Smith again used up all of his remaining telephone credit.

72. Also on 20 April, Mr Smith called Doncaster's prisoner advice line (PAL) and told them that he was struggling with his mental health and would like to see the mental health team. He also said that officers took two hours to answer cell bells. Prisoners answer the calls on the PAL (supervised by staff) and pass messages on the prisoner's behalf where necessary. The prisoner taking the call filled in a form with the details Mr Smith gave. Staff told the investigator that the request was sent to the mental health team and that Mr Smith would have been told to submit a formal prison complaint about cell bell delays. Staff said that if the prisoner taking the call had had any concerns about Mr Smith's risk these would have been communicated directly to staff present who would have passed them on to wing staff immediately.

There is no evidence that the prisoner taking Mr Smith's call had any immediate concerns about him.

21 April

73. CCTV shows that at 9.20am on 21 April, Mr Smith was standing on the ground floor landing when another prisoner approached him, appeared to check his pockets, and then pulled him into a cell followed by several other prisoners. At that moment, a PCO walked across the landing towards the cell and the group came out of the cell and dispersed. The PCO spoke to the other prisoner and Mr Smith, who had initially walked away but then walked back again. Doncaster's then Head of Safer Custody told PPO investigators that the CCTV had not been viewed until after Mr Smith's death and, when asked by the prison, the PCO said that he had not noticed anything untoward that morning, he had just been patrolling the landing as usual. (The Head also said that the group of prisoners involved had been split to different Houseblocks to prevent any further incidents.)

74. The investigator spoke to another prisoner about the incident. He said Mr Smith was in debt to other prisoners for vapes, and that was why other prisoners had tried to intimidate him. He said that he spoke to Mr Smith that evening to check if anything was wrong and said he would help him with any debts. However, Mr Smith said that there was nothing wrong and he did not need help.

75. After prisoners were locked in their cells for the evening, CCTV shows that Mr Smith was checked at 8.13pm and again at 1.12am on 22 April (these were routine checks made on all prisoners at those times). The investigator was unable to establish what the officers observed when making their checks on Mr Smith. Of the three officers who last checked him, two had since left Doncaster and the third could not recall his interaction with Mr Smith. None of the officers responsible for checking him raised any concerns that night.

22 April

76. The investigator watched CCTV footage. He also obtained information from Yorkshire Ambulance Service. The following account is based on these sources and documentation relating to the emergency response.

77. All prisoners on Houseblock 2D should have been checked at around 6.15am. This check did not take place on 22 April.

78. At 8.50am, a PCO was unlocking prisoners on Houseblock 2D. When he got to Mr Smith's cell, he looked through his observation panel and saw him hanging from a ligature made from a torn curtain and tied to a shelving unit. He radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). Control room staff immediately called an ambulance. He unlocked Mr Smith's cell and went in, immediately followed by another PCO. He supported Mr Smith's weight and his colleague cut the ligature. They placed Mr Smith on the floor noting that he was cold and rigid. The other PCO began CPR.

79. Nurses arrived within two to three minutes. One nurse told the officers to bring Mr Smith onto the landing where there was more room. She noted that Mr Smith was cyanosed (where the skin turns blue through lack of oxygen), and that rigor mortis

was present (stiffening of a body that sets in following death). She noted that it was not possible to pass an airway into Mr Smith's mouth as his jaw was locked. Nurses continued to deliver CPR and tried to administer oxygen. Paramedics reached Mr Smith at 9.03am and, after checking him, instructed that efforts to resuscitate him should stop as he was dead. It was 9.05am.

80. Mr Smith had left a letter in his cell addressed to his partner which made clear his intention to die. He wrote that nothing had gone well for him, that he did not get the help he needed when he asked so his mental health problems took over.

Contact with Mr Smith's family

81. A PCO was appointed as family liaison officer and was told at around 10.00am that Mr Smith's father had already contacted the prison as another prisoner on the wing had telephoned him to tell him of his son's death. (We do not know who contacted Mr Smith's father but all cells at Doncaster are fitted with a phone.) Due to the circumstances, the PCO telephoned Mr Smith's father to confirm what he had already been told. He made several further calls to Mr Smith's father, both that day and in the following days.

82. Doncaster contributed to the cost of Mr Smith's funeral in line with national instructions.

Support for prisoners and staff

83. After Mr Smith's 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. Staff were offered further support from the care team.

84. The prison posted notices informing other prisoners of Mr Smith'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 Smith's death.

Post-mortem report

85. The pathologist gave Mr Smith's cause of death as hanging.

86. Toxicology results found a therapeutic level of Mr Smith's prescribed ADHD medication in his system. (A therapeutic level means a dose prescribed to effectively treat an illness.)

Findings

Assessment and management of risk of suicide and self-harm

87. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making. Mr Smith had a number of risk factors: he had a history of suicide attempts and self-harm, he had ADHD, he was a young man in an adult prison for the first time, he was still in his early days in prison, and he had a history of conflict with other prisoners.

88. An early learning review (ELR) carried out by Yorkshire Prisons Group immediately following Mr Smith's death identified various shortcomings in the management of his risk of suicide and self-harm. The review identified that staff did not ask Mr Smith about information on the PER that he had self-harmed three days before arriving in prison. The ELR noted that when Mr Smith self-harmed on 13 April, one of the reasons he gave was that he felt under threat. However, the nature of the threat and the names of potential perpetrators were never explored with Mr Smith. The ELR noted that moving wings was one of the ACCT care plan actions and was marked as completed on 14 April even though Mr Smith never moved from Houseblock 2D. The ELR also found that when ACCTs were subsequently reopened and closed again on 18 and 19 April, there was again a failure to properly explore Mr Smith's concerns about being at risk.

89. Doncaster's present and previous Heads of Safer Custody told the investigator that Mr Smith had been offered a wing move, however he then declined to move. They said that in that circumstance, Doncaster would not enforce a move. However, they acknowledged the findings of the ELR. They said that reception staff generally explore warnings in PER forms, and they believed in Mr Smith's case the issue was that any such discussion was simply not recorded. They said that a secondary measure to capture information for new arrivals is the use of a first night booklet to note any information about thoughts of suicide or self-harm (this recorded that Mr Smith was in a positive mood). They also said that all prisoners in the first night centre are observed once every two hours.

90. The Heads of Safer Custody said that Doncaster has since done a lot of work to upskill ACCT case managers to ensure that ACCT care plan actions are SMART (specific, measurable, attainable, relevant, timebound) and properly address the prisoner's risks and needs. They said that they have provided in-house training on this, concentrating in particular on risks and triggers. They were confident that there were no longer problems in this area. They said that ACCTs are quality assured on an ongoing basis and where deficiencies are identified, advice and guidance is given to the individuals involved.

91. There were also omissions in the summary section of the ACCT form (this section captures the prisoner's mood and behaviour during the morning, afternoon, evening

and night). The Heads of Safer Custody said that they had identified similar omissions during their quality assurance checks and in the last 18 months, had provided training and guidance to ensure that staff complete good quality summaries.

92. While there is some clear evidence to suggest that Mr Smith might have been in debt to others and was at potential risk because of this, we note that he was offered a wing move which he declined. We also note the evidence of the prisoner who told us that Mr Smith declined his offer of financial help on the evening of 21 April, as well as noting Mr Smith's comments in his goodbye letter when he spoke about his mental health problems. Staff spoke about Mr Smith presenting as a confident young man and this might have affected some of the judgments made in assessing his risk.

93. Mr Smith ran out of phone credit twice in the week before his death. He had said that his family and partner were protective factors and being unable to call them when he wanted or needed to may have added to his mental distress. We draw no conclusions about the link between this and his death, but prisoners being able to make calls to people outside prison who can support them is clearly important.

ACCT review attendance

94. PSI 64/2011 says that healthcare staff must always be invited to ACCT reviews or to provide a written contribution if unable to attend. The policy also says that where possible healthcare staff should be given sufficient advance notice of ACCT reviews and the healthcare representative should be somebody with knowledge of the prisoner when possible. Two healthcare representatives attended Mr Smith's first ACCT review on 14 April, but there were no representatives at his other two reviews on 17 April and 19 April. All three reviews were the first review following the opening of the ACCT and the ACCT was closed each time at this first review. Mr Smith specifically mentioned on 14 April that he had ADHD and was seeing the learning disabilities nurse. The learning disabilities nurse told us that he could not be sure that he was ever made aware that Mr Smith had been supported by an ACCT. (Doncaster informed us that a report is published each day with a list of prisoners being supported through ACCT and that the learning disabilities nurse was on the circulation list). When staff closed the ACCT on 19 April, a senior mental health practitioner gave a written contribution detailing that Mr Smith was having regular contact with the learning disabilities nurse, but this was not the case.

95. While we cannot say for certain that Doncaster could have anticipated Mr Smith's true level of risk, we concur with the findings of the ELR that there should have been greater exploration of the concerns he presented. The clinical reviewer noted that Mr Smith's distress was not evident through his appearance, presentation or what he said. This indicates that more careful ongoing risk assessment and management was needed, including attendance by a nurse, to further explore Mr Smith's risks and what further support he needed. We acknowledge the action already taken by Doncaster to address the issues outlined in the ELR and make the following recommendation:

The Director and Head of Healthcare should ensure that there is a robust quality assurance process to ensure that healthcare staff attend ACCT

reviews in line with policy to facilitate an informed and considered approach to risk management.

Clinical care

96. The clinical reviewer found that the care Mr Smith received for his physical health and substance misuse needs was of a reasonable standard and equivalent to that which he would have received in the community.

97. However, the clinical reviewer considered that Mr Smith's mental health care was not of the required standard and was not equivalent to that which he would have received in the community. In particular, the clinical reviewer noted that there was an absence of regular planned support from the mental health team. In view of his vulnerabilities, including his very recent history of self-harm and risk of impulsivity from his ADHD, she concluded that more formal support could have been put in place to support Mr Smith and to try to mitigate his risk. However, the clinical reviewer also noted that the learning disabilities nurse had a caseload of between 40-70 prisoners at any time which could make regular scheduled contact difficult. While we make no recommendation, the Head of Healthcare will wish to consider the clinical reviewer's findings about the equivalence of mental healthcare Mr Smith received at Doncaster.

98. The clinical reviewer was also concerned about aspects of the healthcare input in Mr Smith's ACCT management which we have already detailed.

Key-worker scheme

99. Mr Smith had three key-worker meetings in his brief time at Doncaster. This is more than we often see at comparable prisons, however, we note that the sessions were delivered by three different officers. We note that HMIP found that key-worker sessions at Doncaster were often formulaic, and that prisoners did not always see the same key-worker each time.

100. Staff who met Mr Smith generally seemed to view him as a happy, chatty and open young man. However, the letter that he left behind in his cell indicates that he was clearly troubled. A consistent key-worker might have been able to start forming a deeper and more trusting relationship, more conducive to Mr Smith revealing his true feelings. We consider that a good key-worker relationship was particularly important for an 18 year old man in an adult prison for the first time with evident vulnerabilities.

101. Following our investigation into a death at Doncaster in December 2020, we contacted the HMPPS Executive Director of Custodial Contracts about our repeated findings and recommendations to Doncaster on the key-worker scheme, as well as other areas of concern. The Executive Director responded to us in July 2021 to say that following a review, the assessment team had been assured that the minimum compliance requirements at Doncaster were being met. Despite this assurance, we again identified deficiencies in the operation of the key-worker scheme in our investigation into a death at Doncaster in July 2022. We note that this was also a concern for HMIP when they last inspected Doncaster in March 2022.

102. The Heads of Safer Custody told the investigator that once Mr Smith arrived on Houseblock 2D, he should have been assigned a permanent key-worker. They assured us that Doncaster has been working to ensure the scheme is now working properly - they provided data to show that for the first five months of 2024 the prison was delivering between 69% and 152% of the target for delivery of key-work sessions. Given these positive figures, we make no recommendation, but the Director will want to continue to monitor the delivery of key-work.

Risk to Mr Smith

103. CCTV shows that on the morning of 21 April, another prisoner appeared to attempt to check Mr Smith's pockets before he and several other prisoners pulled him into a cell. Within seconds, the group dispersed, and Mr Smith came out of the cell as an officer crossed the landing walking towards the cell. The officer said that he had not noticed anything untoward, he had merely crossed the landing as he was carrying out his duties.

104. Another prisoner told the investigator that Mr Smith was in debt to other prisoners for vapes. As Doncaster were apparently unaware of the incident at the time it happened, there was no investigation and no discussion with Mr Smith that day about whether he was under threat. We note however, that once prison staff had watched the CCTV footage after Mr Smith's death, they dispersed the group of prisoners involved across the prison.

105. Mr Smith spoke about feeling unsafe on Houseblock 2D and that he wanted to move. Staff had found a cell on another Houseblock for him, but when he was told this, he said that he wanted to stay on 2D. However, there is no evidence that staff explored Mr Smith's initial reasons for requesting a move.

106. The Heads of Safer Custody told the investigator that Doncaster has procedures for dealing with violence, including referrals to the safety intervention meeting (SIM) and use of a challenge, support and intervention plan (CSIP). CSIPs are individualised plans that are used for both potential victims of violence and potential perpetrators of violence. We have found no evidence that staff properly explored any concerns Mr Smith might have had on Houseblock 2D or whether there was ever any consideration for a referral for him to the SIM or for a CSIP. We make the following recommendation:

The Director should ensure that intelligence regarding a prisoner feeling at risk is properly investigated, the prisoner is appropriately supported and that there is a quality assurance process in place to ensure that this is being routinely done.

Routine checks

107. Staff made a standard welfare check on Mr Smith at 1.12am on 22 April while checking all prisoners on the Houseblock. Staff did not check Mr Smith again until 8.50am when they unlocked him. We cannot say when Mr Smith died, but when he was found, he had signs of rigor mortis so it is clear that he had been dead for some time.

108. The published regime said that staff should make routine checks on all prisoners at 6.15am. The primary purpose of these checks is to confirm that all prisoners are present and correctly accounted for. Not completing the check is, therefore, a serious breach of security. However, these checks are also an opportunity to check on prisoners' well-being and to identify any obvious signs that a prisoner may be ill or dead.

109. During an investigation into a death in Doncaster in December 2020, we also discovered that staff failed to make a routine early morning check. The circumstances surrounding the omission in that case were different to those in Mr Smith's case. However, in response to our recommendation the Director issued a notice to staff reminding them of the times of the four standard checks of the day between 6.15am and 7.30pm and adding two further checks at 8.00am and at midnight. The Director stressed in his order the need to take extra care in looking after prisoners' welfare.

110. The Heads of Safer Custody told the investigator that the staff on duty that day had been confused whether the standard regime applied as it was the weekend. Since Mr Smith's death, they said that the regime had been republished, and that managers make random checks to ensure compliance. They said that there had been no omissions since Mr Smith's death and if any omissions were to occur, that would lead to a full disciplinary investigation.

111. We cannot say that if he had been found sooner, the outcome would have been any different for Mr Smith, but carrying out effective routine and welfare checks is critical to the safety and security of prisoners and staff. We are reassured by steps the prison have taken to address this recurring issue and make no further recommendation.

Family liaison

112. Mr Smith's father complained that he learned of his son's death from another prisoner. Unfortunately, there is always the possibility that a family might be told the distressing news of the death of a relative before the prison is able to deliver the news, and in this case, a prisoner had called Mr Smith's father within an hour of Mr Smith's death. While we have sympathy for Mr Smith's father, Doncaster could not have reasonably prevented other prisoners from contacting him.

Director to note

Cell Bells

113. On 20 April, Mr Smith complained on the prisoner advice line that officers took too long to answer cell bells. The investigator was not able to check Mr Smith's cell bell records for his final days as the data could not be downloaded due to a technical problem. However, the investigator was able to review Mr Smith's cell bell records for the period 15 to 17 April. On those three days, Mr Smith rang his cell bell 15 times. Most of the time, the bells were answered within the five minute response target, but on five occasions it took staff between 8 and 15 minutes to respond.

114. The Heads of Safer Custody told the investigator that a prisoner survey on use of cell bells found that the system was misused 98% of the time with prisoners ringing bells to ask basic questions or to request items such as toilet rolls. They said that officers are now expected to explain clearly to a prisoner that cell bells are for emergencies only and if a prisoner misuses their cell bell three times, they a liable to punishment by a reduction in their incentives and earned privilege level. It is imperative that prisoners understand that cell bells should not be misused and that when bells are used, that officers respond promptly. The Director will wish to assure himself that officers are compliant in answering cell bells within target and that sanctions are being fairly and consistently applied where prisoners misuse their bells.

Head of Healthcare to note

Attempted resuscitation

115. In September 2016, the National Medical Director at NHS England wrote to Heads of Healthcare for prisons to introduce new guidance to help staff understand when not to perform cardiopulmonary resuscitation (CPR). This guidance was designed to address concerns about inappropriate resuscitation following a sudden death in prison. It was taken from the European Resuscitation Council Guidelines which states, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”. The European Guidelines were updated in May 2021, but the same principles apply.

116. Mr Smith had signs of rigor mortis when he was found. These normally set in between two and six hours after death, indicating that Mr Smith had been dead for some time. Both prison and healthcare staff carried out CPR until paramedics arrived. A nurse told us that she was aware of the guidelines but it was the first time she had seen signs of rigor mortis and did not feel confident to stop resuscitation. Other nurses were also present and continued CPR. On arrival, the paramedics immediately pronounced Mr Smith dead. The Head of Healthcare will wish to consider how best to build staff confidence in this sensitive area.

Inquest

117. An inquest into Mr Smith’s on 25 September 2024 concluded that his cause of his death was suicide by hanging.

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