Investigation into the circumstances surrounding the death of a man at HMP Doncaster in July 2006

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is a report into the circumstances of the death by hanging of a remand prisoner at HMP Doncaster, on 3 July 2006. He was 26 years old.

The man was found suspended in his single cell in the Segregation Unit and was subject to suicide and self-harm monitoring. He was detoxing from heroin.

At various times after his arrest, the man had told police officers, prison healthcare staff and prison custody officers that he had harmed himself in the past or was considering doing so. At Doncaster, staff did not act on the information. Three hours before his death, they opened a suicide and self-harm plan after he had spoken to a Buddy. Two hours later, the man gave staff a letter addressed to his partner that contained an explicit statement that he was going to commit suicide that evening. A prison custody officer read the letter but took no action except to continue his checks. At 10.00pm, he discovered the man and raised the alarm. After a delay of several minutes, staff entered the cell and attempted resuscitation. There was a further delay in getting the ambulance into the prison. Finally, the paramedics attended and took the man to hospital where a doctor confirmed his death. I must also offer my sincere sympathy and condolences to the man's family and friends for their loss.

I apologise for the length of time it has taken to produce this report. After the man died, the South Yorkshire Police opened an investigation into the circumstances. I postponed my investigation until their enquiries were complete.

The investigation was carried out on my behalf by one of my colleagues. A clinical review of the man's healthcare at Doncaster was undertaken on behalf of Doncaster Primary Care Trust. I am grateful for the review, which I received on 13 February 2009. I would also like to thank the Director of Doncaster and his staff for their co-operation and assistance with this investigation.

The man spent only four days in Doncaster. However, in that short time, staff in different units made decisions that had a serious and negative impact on the care that he received. Several decisions might not of themselves have had such serious consequences, but cumulatively they meant that staff did not support the man as their duty required. I am alarmed and saddened by much that happened to the man and trust that my report will ensure a radical examination of Doncaster's policies, procedures and training.

I make 13 recommendations, primarily covering record keeping, self-harm measures and staff training in these procedures and incident response.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2009**

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SUMMARY

The man was born on 22 April 1980 and died at the age of 26 on 3 July 2006 in his segregation unit cell in HMP Doncaster. On Friday 30 June 2006, he was arrested and appeared in court where he was remanded in custody. During his time in police and court custody, the man was on self-harm monitoring procedures. That information was passed on to staff at Doncaster before his arrival.

In Reception at Doncaster, several staff spoke to the man and a nurse and a nursing assistant assessed his health. The man told them that he was a heroin user and he was put on a detox programme. He also said that he had taken an overdose of anti-depressants the previous year. The senior nurse read the self-harm warning form that the escort contractor had opened for the man but judged that he was "fine". As she did not consider that he was at risk of self-harm, she neither opened an ACCT plan nor referred him for a mental health assessment. (The ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give him the additional support he needs to help during a period of crisis.)

The man spent the next two days on the Detox Unit, where he initially asked to move cells to share with his half-brother. At lunchtime on Monday 3 July, he was told it was not possible and he then assaulted a prison custody officer. Staff restrained him and took him to the Segregation Unit. He had a visit from his partner that afternoon and asked to see a Buddy afterwards. The man spoke of his problems and told the Buddy that he was thinking of killing himself.

The Buddy reported this to staff and an ACCT plan was immediately opened. The duty manager spoke briefly to the man and she then set the frequency with which staff had to check him. After she left the unit, the man asked for and was given writing paper and envelopes. At 9.15pm, he passed a letter to a member of staff. It was addressed to his partner and talked about his intention to take his own life that night and set out the arrangements for his funeral. The officer read the letter, sealed the envelope and put it in the post tray. He increased the frequency of his checks on the man but took no other action.

At 9.56pm, the officer saw the man slumped on the floor with a ligature attached to the taps of the sink. He called for assistance, and then he and the nursing assistant who was watching another prisoner stood outside the cell. The two emergency response nurses arrived and joined them. After five minutes, the duty manager arrived and unlocked the cell. The nurses assessed the man and then asked for an ambulance to be called. They began cardio pulmonary resuscitation.

The ambulance arrived very quickly at the prison gate. However, staff could not unlock an internal gate and, after a delay of seven minutes, the paramedics went to the cell on foot. Eventually, they managed to move the ambulance through the prison to the Segregation Unit and carry the man into it. They took him to Doncaster Royal Infirmary where a hospital doctor certified his death.

My report identifies a number of serious shortcomings on the part of prison staff and I make 13 recommendations.

THE INVESTIGATION PROCESS

1. The man died on 3 July 2006. My investigator opened the investigation four days later when she visited the prison. She met the Director, a trade union representative and a member of the Independent Monitoring Board. She saw the man's cells on C wing and the Segregation Unit and was given copies of his prison records. She also met the man's half-brother in one of the wings and explained the scope and purpose of my investigation. She asked the Director to display notices to staff and prisoners about my investigation.

2. The investigator returned to Doncaster on 8 July to meet with a team of detectives from South Yorkshire Police who had begun an inquiry into the care the man who died had received. The officer leading the inquiry asked that my investigation be suspended until their investigation, and any subsequent court proceedings, had been concluded. In return, the police agreed to share the information they gathered, including the witness statements.

3. One of my family liaison officers (FLOs) and the investigator met separately with the man's partner, and his mother and father and grandparents, to explain the reasons for my investigation being suspended. They offered to meet again once the investigation was resumed.

4. The police investigation was closed in 2008 and the case papers were delivered to my office in May that year. The FLO and investigator met with the man's father, mother and grandmother again and explained how my investigation would be conducted. The family raised various issues, including self-harm procedures, the failure to act on the man's letter, the delay in opening the cell, the delay in the paramedics arriving at the cell, and managers' contact with the family after the man's death.

HMP DONCASTER

5. HMP Doncaster opened in 1994. It is a purpose-built category B male prison, privately managed under contract by Serco Home Affairs. The prison is made up of three houseblocks, each with four wings and has a maximum capacity of 1,145 prisoners. Its principal function is to serve the local courts and the majority of its population are sentenced prisoners.

6. The report of the prison's Independent Monitoring Board that covered the period October 2006 to September 2007 highlighted no concerns relevant to the man's time in the prison.

7. The most recent inspection by HM Chief Inspector of Prisons, Dame Anne Owers, was an unannounced full follow-up inspection carried out from 11 – 15 February 2008. The report expressed concern over some ACCT procedures and described health services as "poorly managed".

8. Between 2004 (when my office became responsible for investigating all deaths in prisons) and the man's death in 2006, there had been one other self-inflicted death at Doncaster. The circumstances have some similarities to the man's death. Both men were on an open ACCT/2052SH. In my earlier report, I discussed, "… the tendency of staff to base their decisions about the man's management on individual events rather than on the totality of his behaviour."

KEY FINDINGS

30 June to 2 July

9. On 29 June 2006, the man was arrested and taken to Doncaster Police Station. Whilst in custody, he told officers that he suffered from depression and had recently tried to harm himself. The custody sergeant placed him on constant supervision. A drugs test showed that he had taken heroin and he later told the police doctor that he had taken it earlier that day. After being charged, he was released on bail.

10. The following day, he was again arrested and charged with driving offences. The custody sergeant placed him on constant supervision and highlighted self-harm and drugs issues on the prisoner escort record (PER). (The PER is a form that that accompanies each prisoner between court and prison. It provides information about both the prisoner's needs and the risk he poses to others.) The man then appeared at Doncaster Magistrates Court and was remanded into custody until 4 July.

11. Whilst at court, the GSL custody staff placed the man on frequent observations and put him in a cell with another prisoner. They also contacted the reception clerk at HMP Doncaster and informed him that the man was showing signs of suicidal feelings. The clerk then put "SH", indicating self-harm, against the man's name on the reception booking-in sheet. The GSL court staff completed a suicide and self-harm warning form and again telephoned the reception clerk to pass on this information. The suicide and self-harm warning form was included in the paperwork that went with the man to Doncaster. The form is bright orange to alert prison staff to the prisoner's needs. It included the erroneous information that the man had tried to hang himself whilst in police custody.

12. During the afternoon, the unit manager who was the reception clerk's manager and the nurse working in reception that day came into the clerk's office and asked about the new prisoners who would be arriving later. The clerk said he told them that the man was on his way and highlighted the information from GSL staff about the possibility of self-harm. In interview, the clerk recalled showing them the daily reception sheet and the letters "SH" next to the man's name.

13. When the man arrived at Doncaster, he went through the reception process. A prison custody officer checked his identity and the warrant remanding him in custody and completed the first section of the Cell Sharing Risk Assessment form. The man told the officer that he would prefer a single cell when one became available as a cell mate had assaulted him during a previous prison sentence.

14. The duty staff nurse in reception, a registered general nurse, interviewed the man and completed the First Reception Health Screen form. A duty healthcare assistant was also present and she completed the Secondary Health Screen form during the interview. She noted that the man appeared to be under the

influence of alcohol or drugs, although he said he was fit and well. She referred him to the doctor. She also wrote, “No concerns have been raised with regard to the prisoner’s mental health.”

15. The reception nurse said when interviewed that the man “was pleasant, very open” and made good eye contact with her. He spoke about his girlfriend and child. His answers to her questions were relevant and he said nothing to make her think he was suicidal. When she reached the section of the form that asks whether the prisoner has thoughts of self-harm, she recalled the man saying, “Oh no, no. I don’t do things like that. I won’t do things like that.” She read the warning form from GSL staff and asked the man about the attempted hanging. He denied it, saying, “They must be mixing me with someone else.”

16. However, when the nurse asked whether he had ever attempted suicide in the past, the man said he had taken an overdose of anti-depressants a year earlier. The First Reception Health Screen form instructs staff that, when a prisoner answers “yes” to that question, they should refer him for a mental health assessment. The nurse failed to do so. In her interview, she said that she did not do so because her assessment was that “there was no problem with him”. For the same reason, she did not admit the man to the Healthcare Centre or open an ACCT plan.

17. When the nurse asked the man about his use of drugs and alcohol he said that he was withdrawing from drugs. The nurse said at interview that she opened a detox watch log. Once the log is opened, staff check the prisoner every 30 minutes and enter the time and their signature in the log. However, after the man’s death, prison managers could not produce the log and it was unavailable for both the police and my investigation.

18. From Reception, the man went to Wing 1C, which then housed the Detox Unit. A prison custody officer (PCO) recalled at interview that the man arrived at about 8.00pm along with another new prisoner, the man who had shared a police cell with the man who died. He put them both in cell 1-31 on the upper level. The member of staff who brought them from Reception gave the PCO the main records file and the detox sheet for the man who died. The following morning, healthcare staff assessed him and prescribed medication for a standard seven-day opiate detox. The prescription charts in the man’s medical records show that he received the first set of medications during the morning.

19. The wing PCO told police that, over the next two days, he checked the man regularly and made entries in the detox log. However, this cannot be verified as the log could not be produced. He said that he talked a lot to the man, whose major concern was the possibility of receiving a long sentence at court. The man said that if that happened, he would miss his family. The PCO said that, although the man “sounded worried”, he did not say or do anything that indicated that he was considering harming himself.

20. On Saturday afternoon, 1 July, the man’s girlfriend visited him. She later told police that the visit had not gone well. the man told her that he had not yet received any medication for detoxifying (although he had) and was in pain.

She felt he was suffering from withdrawal symptoms. The man ended the visit early, telling her that he did not want her to see him "in that state". However, she also said that, "Although clearly he was not well and off colour, he wasn't depressed and certainly not in the frame of mind of harming himself."

21. The man's cellmate gave a statement to the police after the man's death in which he said that he knew the man quite well before meeting him in prison. He said that he and the man "got on fine" and laughed and joked together. He said that the man spoke about problems with his girlfriend and facing a long prison sentence, but not about harming himself or committing suicide. Although the two men got on well, the man wanted to share a cell with his brother. On Sunday 2 July 2006, they told officers they had "fallen out" in the hope that staff would then allow the man to move to his brother's cell. Before going off duty, The wing PCO completed his handover report which included the man's request to move cells. The PCO told the police, "I think we forgot to mention that he wanted to be moved in with his brother."

Monday 3 July

22. The following day, a different PCO moved the man's cellmate to the cell next door and moved another prisoner into the man's cell. At some point during the morning, the man asked to speak to a Buddy. (Buddies are prisoners who have been given training in listening to and helping other prisoners with their problems.) A Buddy went to the man's cell and the man asked for help in writing a letter. The Buddy told him that he did not have time then, but that he would return later and help him. The man appeared cheerful and did not say why he wanted to write a letter.

23. After lunch, the man told the PCO that he "wasn't happy with his new cellmate" and wanted to be moved in with his "cousin" (he had previously talked about wanting to move in with his brother). The PCO told him that this was not possible as "the logistics and workload made it not possible." The PCO said at interview that the man then "started shouting and swearing at me". He told him that he was putting him on a disciplinary report and then locked him in his cell. (When prison staff think a prisoner has broken a prison rule, they may put him "on report". The prisoner must be told within 48 hours what offence he is accused of having committed. A disciplinary hearing, also called an adjudication, is then held. If the charge is proved, the adjudicator imposes a penalty.)

24. The PCO opened the cell door a short while later to allow the man's cellmate to enter. The man came to the door and stood very close to the PCO. He was again verbally abusive and said he wanted to "knock out" the PCO. The PCO told the man to move back into the cell but he did not. Instead, he pushed the door with some force, causing it to rebound off the PCO's hand and fingers. The man still refused to move back into the cell, and the PCO and several other officers then used control and restraint methods to restrain him on the floor.

25. The Detox Unit manager arrived and handcuffed the man. Shortly afterwards, the man became calm and staff helped him to sit on a chair. Once the two duty

nurses arrived, they accompanied the manager and an officer as they walked the man to the Segregation Unit. One of the nurses later told the police that the man laughed and joked with staff on the way to the Segregation Unit. She said that he did not mention feeling suicidal but seemed “in good spirits”.

26. In the Segregation Unit, staff removed the handcuffs and searched the man. All prisoners in the unit wear prison clothing, so the man put on prison tracksuit trousers, a tee-shirt and slippers. The nurses examined him and, although he complained of soreness in his leg, wrist and face, they did not see any injuries. One nurse described him as appearing “fit and healthy”. The Segregation Unit manager spoke to the man who said that he was concerned about his property which was still on the wing. He said that he was due to appear in court the next day, and did not expect to return to prison, so needed all his property together. The man then used the telephone but there is no information about who he called.

27. Later that afternoon, the man had a two-hour visit from his partner and their young son. His partner told prison staff after the man’s death that she had taken their son with her as he had specifically asked her to bring him. According to his partner, he was, “his usual self” and they laughed and joked together. They arranged that she would attend court the following day. They also spoke about arrangements for the next time she visited. The visit ended at 3.38pm and a PCO escorted the man back to the Segregation Unit. The man told him that he was facing a long sentence. Approximately an hour later, when a Segregation Unit PCO checked on the man, he asked to speak to a Buddy. The PCO passed the request to the unit manager, who arranged for a Buddy to come from another unit.

28. At 5.15pm, the man asked to speak privately to the nurse who had arrived in the unit to give the prisoners their medications. After the staff nurse gave him his medications, he told her that he was feeling depressed and was ashamed of being back in prison. He said that he had previously taken an overdose and that he felt “low and lonely” in the Segregation Unit. He also said that his girlfriend had ended their relationship and then he cried as he spoke about his son. He said he was expecting to be sentenced to five years imprisonment. During the conversation, the nurse stood in the open doorway of the man’s cell and the PCO stood nearby, but out of earshot.

29. When the nurse left the cell, she told the PCO of her conversation with the man and passed on his request to see a Buddy. The PCO spoke to his colleagues who said that a Buddy had been arranged. The Buddy eventually arrived in the Segregation Unit at 7.07pm. He asked the man how he was feeling. The man said, “I don’t want to be here. Life isn’t worth living any more. I want to kill myself.” He told the Buddy that he had just split up with his girlfriend as she did not want to be by herself when he was in prison. (This was not actually the case.) He also told the Buddy that he had been assaulted by his cell mate during a previous prison sentence. The two men spoke for about 30 minutes and the Buddy tried to reassure him. The man then said, “You’re alright to go now. I’m sound.” The Buddy wished him luck at court and left.

30. The PCO and the night duty PCO were waiting outside the cell and the Buddy said to them, “I’d advise you to keep an eye on him. He’s talking about killing himself.” He then spoke further about his conversation with the man. (Buddies should normally respect the confidentiality of their conversation but not where there is a risk to life.)

ACCT monitoring

31. As the Buddy spoke, the PCO opened a blank ACCT booklet and began to complete the Concern and Keep Safe Form. He noted that the man “had thoughts of killing himself. Nothing to live for.” He also ticked the box that indicated that the man’s mood was very low. He signed the form, put the time as 7.45pm and then left the unit to complete his shift in another unit. Meanwhile, the night PCO telephoned the duty director and reported the opening of the ACCT.

32. The PCO went into the man’s cell and asked him what was wrong. The man replied that he was in court the next day when he could be sentenced to five years imprisonment. He said, “I’ve just had enough, basically.” At interview, the PCO said that the man did not appear upset as he said this.

33. At 8.38pm, the manager who had taken over as duty director, came to the Segregation Unit to interview the man and complete the Immediate Action Plan of the ACCT. This section must be completed by a unit manager and lists all the ways staff should help the prisoner on the ACCT. The manager spoke to the man through the observation hatch in the cell door, and the CCTV timer shows the conversation lasted two minutes. She said in interview that she recognised the man from his previous times in Doncaster, and he recognised her.

34. The man told her that his solicitor had said he could be facing five years imprisonment and, if that was the case, his girlfriend would not wait for him. He said that he was upset about that. He then asked about his property as he needed it to be available when he went to court the next day. The manager went to the office and arranged for his property to be ready the following day. Twenty five minutes later, she returned briefly to the man’s cell and opened the door. While she spoke to the man about his property, the PCO lit a cigarette for him.

35. At interview, the manager said that the man’s main concern was his property, which she had resolved. She said, “He was highly delighted that I’d done that.” She did not see any indications that he would harm himself, describing him as “chatty” and “in high spirits”. At 8.20pm, she completed the form and put the man on 30 minute observations. As all prisoners in the Segregation Unit are observed every half hour, this meant that the frequency with which staff observed the man was not increased. In interview, the PCO recalled the manager saying to him that the man “was not going to harm himself.”

36. At night, in common with all other prisons, Doncaster operates with a reduced staff. During night patrol state, only Oscar 1 carries a full set of keys to unlock

all gates and cells. Wing staff and nurses do not have access to keys allowing them free access around the prison and have to be escorted. However, prison custody officers are each issued with a cell key in a sealed pouch for use in emergencies. The staff instructions are that during the night state, a cell may only be unlocked by a single member of staff where there is, or appears to be, immediate danger to life.

37. After the manager left, the man asked the PCO for writing paper and envelopes, which he then gave him. At 9.15pm, the man passed the PCO a letter that was addressed to his girlfriend. In it, the man wrote very clearly of his intention to commit suicide that night and gave detailed instructions about his burial. The PCO read the letter, sealed it in the envelope and put it in the tray for out-going mail. He began checking the man more frequently but took no additional action.

38. The man in the neighbouring cell later told police that, at about 9.30pm, the man called to him asking if he had any tobacco, to which he replied that he did not. A few minutes later the man said to him, “I’m in court tomorrow.” When the other prisoner asked him how long a sentence was he expecting, the man replied “life”. This ended the conversation. About ten minutes later, the other prisoner heard a metallic banging noise from the man’s cell that he thought sounded like taps being pushed down. He said in interview, “Very shortly after, I heard a spluttering cough coming from the man’s cell. I presumed that it was the man and that he might have got his cigarettes after all.”

39. When the PCO checked the man at 9.56pm, he saw him lying slumped against the sink with some sort of cloth attached to the taps. The sink was to the right of the door and on the same wall. The man’s back was to the sink and he was facing into the cell so the PCO could not see his face or neck. The PCO used his radio to call for assistance. He did not enter the cell immediately but asked a nurse on the unit for advice.

40. A nursing assistant was in the Segregation Unit that night to keep another prisoner under constant observation. She told the police that she advised the PCO not to enter the man’s cell until other staff arrived as he was on “a three-man unlock”. In spite of seeing something clearly amiss and having opened the man’s cell earlier in the evening without three members of staff being present, the PCO and the nursing assistant waited outside the cell. The PCO repeated his call at 9.59pm.

41. Two nurses responded as the emergency healthcare response team. All four staff then waited outside the cell. The night orderly officer arrived at 10.00pm, along with another PCO. The night orderly officer unlocked the door and staff entered the cell. A nurse saw a ligature round the man’s neck, attached to the taps of the sink, and asked for it to be cut. The PCO did so with his anti-ligature knife and the nurses laid the man on the floor, with his head towards the door. The man did not appear to be breathing, he had no pulse and his pupils were fixed and dilated. The nurses began to administer cardiopulmonary resuscitation (CPR). The night orderly officer went to the unit office and

telephoned the communications room to ask for an ambulance. The control room log timed the request at 10.00pm.

42. The ambulance arrived at the main gate five minutes later and was escorted into the prison by a waiting PCO. Once through the main entrance the ambulance and paramedics were delayed for approximately seven minutes while the PCO struggled unsuccessfully to open an internal gate. Rather than wait any longer, the paramedics decided to go to the cell on foot and they carried their equipment and a stretcher into the building. The PCO guided them through the prison. When they reached the stairwell leading to the first floor of the Segregation Unit, they found that the space was too narrow to let them carry the stretcher up the stairs. They left the stretcher at the foot of the stairs and went to the man's cell on the upper landing.

43. The paramedics took over CPR from the nurses and attached a defibrillator to the man. (A defibrillator is a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart.) The machine showed that the man had no pulse, so they gave him pure oxygen and continued CPR. The female paramedic asked a nurse to take over from her and she then returned to the ambulance, collecting the stretcher on the way.

44. The officer who accompanied her then told her to drive to a different gate, which she did. However, in her statement to police, she said that it was "several minutes" before this gate was opened for her to drive through. She parked at the end of the wing and, carrying the stretcher, re-entered the Segregation Unit through the door in the end wall. They put the man on the stretcher and moved him to the ambulance through the outside door. The ambulance left the prison at 10.54pm. During the journey to Doncaster Royal Infirmary, the male paramedic continued CPR. Sadly, on arrival, a hospital doctor examined the man in the ambulance and pronounced him dead at 11.02pm.

45. The prison chaplain, the duty director and a uniformed prison custody officer went to see the man's partner at her home at 2.00am and broke the news. They arranged for her mother and step-father to come and support her and also for one of the man's cousins to come to the house. Later that morning, staff visited the other members of the man's family. The man's father visited the prison to break the news to the man's half-brother. Staff then opened an ACCT plan for him. The following day, the family, in two groups, visited the prison and met the Deputy Director. During the meetings the family raised a number of issues and questions about the man's time at Doncaster and the circumstances surrounding his death.

ISSUES

Cell Sharing Risk Assessment form (CSRA)

46. When a new prisoner arrives in prison, one of the first forms to be completed is the CSRA. The form is used to assess the potential risk the prisoner would present to a cell mate. In Reception, an officer completes the first section and the duty nurse the second. The induction officer completes the final part, very often on the wing. Section 1 contains a list of documents that may accompany a prisoner into custody.

47. The man arrived at Doncaster with a self-harm warning form from GSL, the escort contractors. In Section 1 of the Cell Sharing Risk Assessment, the third document on the list is F2052SH (sic) (open/closed) and tick boxes for yes or no. This has been ticked as "No" which is technically correct as the warning form is not an ACCT plan. However, this important document conveys crucial information about a prisoner's potential risk of self-harm and, in my view, should feature on the CSRA.

    The Prison Service should add the self-harming warning form to the list of documents in Section 1 of the CSRA the next time the form is revised.

Health

48. The clinical reviewer raises several issues in his report. (The full review is at Annex 1.) He begins the areas of concern section of his report with his findings on documentation and standard of record keeping. He concludes that, "The overall standard of documentation appears to be below adequate levels." He adds:

    > "The documentation made available does not demonstrate that a safe, effective nursing process was followed in the provision of nursing care for this gentleman. In particular they do not provide clear evidence of the care planned and the decisions made."

49. The reviewer makes eight recommendations altogether, which I endorse. They cover record keeping, reception screening, ACCT procedures and the delay in entering the man's cell.

    The Director and Head of Healthcare should ensure that all staff are trained in and kept updated with the standards that are required in relation to record keeping and that the standards have an audit plan in place.

    The Head of Healthcare should review the care planning process and documentation to ensure that all patients receive a full assessment with adequately documented plan of care to meet all their needs.

First Reception Health Screen

50. When the man arrived at Doncaster, his papers included a form warning that he was at risk of harming himself. The reception staff nurse read it and questioned the man about the information it contained. He said the information was inaccurate and denied having any thoughts of self-harm. The nurse decided that his answers and general behaviour did not warrant opening an ACCT plan or admitting him to the healthcare centre. She did not change her opinion even when the man told her that he was detoxing from heroin. When asked at interview whether a prisoner who is detoxing is at an increased risk of self-harm, she said that, in her experience:

> "If they're coming off drugs the main problem is physical … I've not seen a detoxer before who told me they are depressed because they are coming off drugs. They've just told me 'Oh I'm ill, Miss. I feel so ill'".

51. The ACCT training that all staff receive highlights very clearly that the process of detoxing is one of the factors that can heighten the risk of prisoners harming themselves. (I will return to ACCT training later in this report.) However, the nurse focused on the fact that the man made good eye contact with her and told her that he had no current thoughts of self-harm. She told the police,

> "He answered questions relevantly and I didn't identify anything that suggested he was suicidal."

52. The nurse focussed on the man's manner as he spoke to her and relied on this, rather than the other information she had. As a result, in spite of having the GSL self-harm warning form, and knowing that the man was detoxing, and that a year earlier he had taken an overdose of anti-depressants, she decided that he was not at risk of harming himself.

53. Although the man denied any current thoughts of self-harm, he did tell the nurse that he had taken an overdose a year earlier. A positive answer to this question requires a mental health referral. This is not optional or at the nurse's discretion. The nurse should have referred the man for a mental health assessment but chose not to. In her statement to police she indicated that, despite the instruction on the form, her understanding was that she only needed to make a referral if she thought it was necessary. As already noted, because her view was that the man was fine at the time, she thought she did not need to refer him to the mental health team.

54. The clinical reviewer has considered the way in which the reception nurses assessed the man. He concludes that, "Documentation surrounding this decision is not clear and does not meet the NMC [Nursing and Midwifery Council] standards on documentation."

55. When the police asked the nurse if she had any concerns about the man, she said she had not. She described seeing him afterwards in the Reception

waiting area. He was watching a football match on television and was cheering. She took this as another indication that he was “fine”. I am aware that, had she made the mental health referral, it would in all probability not have led to an assessment before his death as the following two days were the weekend. However, it is essential that the referral process is followed to prevent other prisoners being put at risk through not receiving a mental health assessment.

The Director and Head of Healthcare must ensure that all staff make the referrals required by the First Reception Health Screen.

56. The reception nurse is a registered general nurse whose area of competence is physical ailments. As such, she appeared to concentrate on the physical presentation that the man gave. She discounted factors that might have indicated that he was at an increased risk of harming himself. I am aware that an increasing number of prison healthcare managers now assign registered mental nurses to reception duties. This ensures that the nurse who sees new prisoners has the expertise to assess their mental health needs fully. I commend this as a way forward for reception screening at Doncaster.

The Head of Healthcare should consider assigning reception duties primarily to registered mental nurses.

Detox watch log

57. When a prisoner goes to the Detox Unit, a record is kept of the times at which staff observe him. The policy at Doncaster is for these observations to be made every 30 minutes. After the man’s death, staff were unable to produce his detox log and it has never been discovered. The reception nurse was clear that she opened a detox log during the health screen after the man told her he was “rattling”, that is, suffering withdrawal symptoms. The Detox Wing PCO said that he made entries in the log after checking on the man.

58. However, assuming there was indeed a log, it had been lost by the time the man’s prison records were collected after his death. This would tend to indicate that filing procedures on the Detox Wing are not sufficiently robust.

The Director should ensure that detox watch logs are stored in a way that guarantees their safekeeping.

Segregation Observation Log

59. Staff in the Segregation Unit must observe all prisoners every 30 minutes. They note the time and their initials in a log for each prisoner. The log for the man shows the night duty PCO’s signature against times beginning at 7.45pm and every 30 minutes thereafter until 12.15am. The PCO appears to have completed the log in its entirety at a single point in his shift. Given that the log has entries for times after he discovered the man hanging, it is likely that he completed the log near the beginning of his shift.

60. The falsification of such documents renders them meaningless and is unprofessional. It is also disturbing that the PCO appeared confident that his actions would not be picked up by management checks.

The Director must ensure that his staff are fully aware of the necessity of recording observations at the time of making them and that management checks ensure compliance.

61. In the event, the PCO's actual checks were better than those recorded in the log. They were also better than required for the ACCT plan, as they were both more frequent and irregular. Irregular observations, especially for prisoners on ACCT documents, are good practice. They mean that prisoners cannot be sure when the next check will take place. They cannot, therefore, plan any action such as self-harm knowing that a certain time will elapse before being discovered. The CCTV footage shows that the PCO made frequent and irregular checks on the man. In the hour before the man's death, he checked him four times, rather than twice as required.

ACCT

62. Staff understanding of why and how ACCT documents should be opened and completed is an area that needs to be thoroughly addressed. During the man's time at Doncaster, staff showed a worrying lack of rigour in assessing and meeting his needs. Although I discuss the actions of named members of staff below, I consider that the training of all staff ought to be considered.

The Reception nurse

63. The duty nurse in Reception did not open an ACCT for the man as, according to her assessment, "there was no problem with him." She seemed unaware of the fact, highlighted during ACCT training, that detoxing can heighten the risk of a prisoner harming himself. Her focus was on how the man appeared to her then and there.

64. She also thought that because she had opened a detox watch log for him, he would be observed every 30 minutes. She assumed that, if an ACCT had been opened, the man would have been observed twice an hour – the same as for a detox log. However, there is an important difference between checks for a detox log and the interactions required by an ACCT plan.

The day shift PCO in the Segregation Unit

65. After the Buddy told Segregation Unit staff of his conversation, the PCO immediately opened an ACCT plan. According to the Buddy, this PCO took a blank booklet and, as he spoke began to complete it. His timely and appropriate actions are in sharp contrast to those of his colleagues who took over the ACCT plan.

The night shift PCO in the Segregation Unit

66. As noted above, the night PCO's checks on the man were better than the manager stipulated. (Paradoxically, his falsification of the document understated the actual observations he conducted.) However, his actions after he read the man's letter were totally inadequate. The information in the letter should have alerted him to the fact that the man's state of mind had deteriorated. The man's intention to take his life that night was stated clearly and he gave detailed instructions about his funeral. The PCO should have notified the night orderly officer of the letter immediately so that the man could be given a higher level of support. The night orderly officer could have increased the level of observations or had the man admitted to the in-patient unit in the Healthcare Centre. The PCO's failure to inform her meant that the opportunity to increase the support for the man was missed.

67. When the police investigation ended, Serco took disciplinary action against the night PCO and dismissed him. It is therefore unnecessary for me to make a recommendation about his actions.

The day shift unit manager

68. The manager completed the unit manager's sections of the ACCT plan. She told the police that the only information she had about the man was that he had assaulted an officer that morning, and that there was no information about him being "down or depressed". However, according to the reception clerk, the manager knew that the man had been identified as being in danger of harming himself even before he had arrived at Doncaster. The manager must also surely have known that the day shift PCO had opened the ACCT after a Buddy told him that the man had said that he wanted to kill himself. Finally, her entry in the On-going Record section of the ACCT plan contained the information that:

> "He is at court tomorrow, expecting 5 years. Says his girlfriend has dumped him as she won't wait 5 years for him."

In other words, the manager must have known that the man had other matters on his mind (in addition to worrying about having his property at court the following day). Having made arrangements for his possessions to be available the next day, she appears to have regarded his problems as solved.

69. The manager told the police that when she spoke to the man he was "chatty" and "in high spirits". As with the Reception nurse, the manager focussed less on what he said, than how he said it. ACCT training emphasises that the first few days in prison are a time when some prisoners can be especially at risk of self-harm. Additionally, the man was undergoing detox and was in the Segregation Unit, both factors that can heighten risk.

70. However, the manager decided to set the frequency of observations as "Two obs per hour not more than 30 minutes apart." This requirement forces staff to

make the checks exactly 30 minutes apart and thus turns irregular checks into regular observations. As explained above, irregular observations are far preferable which is why ACCT procedures insist on them. It is worrying that a manager made such a decision, particularly a manager who was responsible for training staff in ACCT procedures.

71. There are two further issues with the manager's instructions. As all prisoners in the Segregation Unit are checked twice an hour, the man was not allocated additional support as far as observations were concerned. The manager also stated, "3 x quality entries in the wing history file per day." When a prisoner has an open ACCT plan, the entries should be made in the ACCT document, not the wing file. Once an ACCT plan has been opened, it goes with the prisoner as he moves around the prison. The information needs to be contained in one place rather than in several documents.

72. The actions and inactions of the Reception nurse, the unit manager and the night PCO all illustrate areas of ACCT training that need to be addressed. I am very concerned that three members of staff, with different roles and grades in the prison, displayed such shortcomings in their performance. This suggests that this is less an individual problem and more of an institutional one. The clinical reviewer shares my concern and makes recommendations about ACCT training and processes.

    The Director should review the effectiveness of ACCT training to rectify any deficiencies and ensure that there is on-going monitoring.

    The Director must ensure that staff know where to obtain support and guidance when they have concerns or are unsure of what action to take in relation to ACCT plans.

Delays after the discovery of the man

73. When the night PCO saw the man with a ligature round his neck, he raised the alarm but did not enter the cell. The instructions for staff in this situation are very clear and the PCO should have known what to do. Director's Rule 18.2 "Cut down procedures" states:

    > "Where possible, a minimum of two PCOs will enter the cell … If only one PCO is available, he or she must not waste time and must endeavour to cut the noose while giving some support to the body."

    Because the PCO found the man during the night patrol state, Director's Rule 10-14 "Night operating procedures" applied. It states:

    > "Procedure for unlocking a cell – Houseblock 1,2,3 and Segregation Unit during night duty. In a life or death situation (ie, a prisoner hanging) you will need to enter the cell/ward immediately, but before doing so, transmit the radio message: 'Prisoner hanging in cell (number). I am now entering. Immediate help required.'"

74. The PCO should have made the call on his radio, then opened the cell with his emergency key and gone inside. However, he stayed outside and asked the nearby nursing assistant for advice. Even after the two emergency response nurses arrived, the PCO did not enter the cell. There was therefore a delay of five minutes before the man was cut down and CPR began.

75. The PCO had received first aid training, including resuscitation techniques, in August 2005. He should have been able to begin CPR if he had entered the cell immediately. The clinical reviewer concludes that:

> "From the evidence reviewed, it is not possible to comment on whether or not this delay made any significant difference to the man or not."

Nevertheless, such a delay could be critical in similar circumstances in the future.

The Director should ensure that all staff are aware of their duty on discovering a prisoner who has self-harmed, particularly during night patrol state.

76. The ambulance arrived at the main gate of the prison five minutes after the request was made. An escort was waiting and the vehicle moved quickly into the prison. However, the escort spent seven minutes trying to unlock an internal gate before the paramedics decided to go to the cell on foot. The route the escort took through the prison meant that the stretcher could not be taken onto the landing. Finally, when the ambulance was directed to another gate, it took several minutes for the escort to open it.

77. It is unclear what caused the problem with the internal gates. The officer who struggled to open the first one was told (over his radio) that the double lock was not on. However, staff had great difficulty in opening the gates and this delayed the paramedics. The route through the buildings led to a further delay as they tried unsuccessfully to take the stretcher up the stairwell. Again, it is not possible to say whether these delays made a significant difference to the man.

The Director should review the contingency plans for moving an ambulance through the prison as quickly as possible and ensure that all staff are aware of the quickest routes when escorting paramedics.

Family liaison

78. Doncaster is privately run by Serco and the company's logo includes the strap line, "Bringing service to life". When the Director wrote to the family after the man's death, the letter was printed on headed notepaper. I am afraid the worthy aspiration of the strap line was in such sharp contrast to the condolences being offered that it caused the family additional distress. It would be more sensitive for letters to bereaved families to be headed by a logo without the strap line or for the logo to be omitted altogether. I also commend

the example of a Governor of another prison, whose condolences were offered in a hand written, blank card.

The Director should ensure that, when writing to bereaved families, the letter does not include the company strap line.

79. Senior managers at the prison offered to help the family with funeral expenses. However, the payment was not made until very late in the day and only after the man's grandmother had twice telephoned the finance section. Prison Service Order (PSO) 2710 "Follow-up to a death in custody" advises prison staff to support the family by liaising directly with the funeral directors.

The Director should ensure that the instructions in PSO 2700 are fully complied with in respect of financial assistance.

Conclusion

80. When the man arrived at Doncaster, it was his sixth time there since 2000 and my investigator discovered that many of the staff said they "knew" him. This appears to have contributed to a general air of complacency in how staff reacted to him. Several members of staff discounted information about the man's past and current risk of self-harm. Their focus was on how he appeared to them as he spoke to them. Staff inaction at key points during the four days the man spent in the prison significantly increased his risk.

81. I urge the Director and his senior management team to improve policies, procedures and training to tackle such complacency and ensure that their duty of care to all prisoners is delivered to the highest standard. Having had the mournful duty of issuing reports on many hundreds of self-inflicted deaths in prison, I have to say that this is amongst the most alarming.

RECOMMENDATIONS

1. The Prison Service should consider adding PEC's self-harming warning form to the list of documents in Section 1 of the CSRA the next time the form is revised.

   The Prison Service responded:
   "It is important to note that the CSRA process is focused on assessing potential risk to a cell mate when in a shared cell and not on assessing self harm risk. The Cell Sharing Risk Assessment (CSRA) process (and the accompanying form) are currently being revised as part of a review of NOMS' violence reduction strategy and the relevance of a reference to the self-harming warning form will be examined as part of the review."

   Recommendation 2 – 13 have all been accepted.

2. The Director and Head of Healthcare should ensure that all staff are trained in and kept updated with the standards that are required in relation to record keeping and that the standards have an audit plan in place.

3. The Head of Healthcare should review the care planning process and documentation to ensure that all patients receive a full assessment with adequately documented plan of care to meet all their needs.

4. The Director and Head of Healthcare must ensure that all staff make the referrals required by the First Reception Health Screen.

5. The Head of Healthcare should consider assigning reception duties primarily to registered mental nurses.

6. The Director should ensure that detox watch logs are stored in a way that guarantees their safekeeping.

7. The Director must ensure that his staff are fully aware of the necessity of recording observations at the time of making them and that management checks ensure compliance.

8. The Director should review the effectiveness of ACCT training to rectify any deficiencies and ensure that there is on-going monitoring.

9. The Director must ensure that staff know where to obtain support and guidance when they have concerns or are unsure of what action to take in relation to ACCT plans.

10. The Director should ensure that all staff are aware of their duty on discovering a prisoner who has self-harmed, particularly during night patrol state.

11. The Director should review the contingency plans for moving an ambulance through the prison as quickly as possible and ensure that all staff are aware of the quickest routes when escorting paramedics.

12. The Director should ensure that, when writing to bereaved families, the letter does not include the company strap line.

13. The Director should ensure that the instructions in PSO 2700 are fully complied with in respect of financial assistance.

ANNEXES

1. Documents considered during the investigation