The circumstances surrounding the death of a man

at HMP/YOI Doncaster in September 2005

Report by the Prisons and Probation Ombudsman
for England and Wales

June 2007

This is the report of an investigation into the death of a young man who was found hanging in his cell at HMP/YOI Doncaster shortly after 5am on 20 September 2005. He was just 18 years old. His tender age should be borne in mind throughout the pages that follow. Just two days before he died, he was calling out for his "Mummy".

The investigation was conducted by two colleagues. I also commissioned an independent clinical review of the management of the man's health needs while he was at Doncaster. This was conducted by a representative of the Doncaster Central Primary Care Trust. I am most grateful to the PCT for their work.

My thanks also go to the Director and staff at Doncaster for their help and co-operation during the investigation.

During his short time in custody, the man's behaviour and mood declined dramatically. Aside from the impact of imprisonment itself, I have identified no other reasons to explain why this occurred. He apparently ended his own life in the prison's healthcare centre, subject to a two-man unlock, and in a grilled cell to which a sheet of opaque Perspex had been fixed - making it difficult for him to see out or for staff to see in.

The man had made a series of attempts at self-harm in the week before his death. The attempt he made on 16 September was the fourth in as many days. No doubt the Coroner's inquest will wish to consider if his death could have been prevented had more robust measures been taken following the self-harm. In the meantime, I hope that the recommendations made in this report will assist all prisons – public and private alike – to avoid similar tragedies in the future.

Stephen Shaw CBE **June 2007**
Prisons and Probation Ombudsman

SUMMARY

The man was remanded in custody to HMP/YOI Doncaster on 25 August 2005 to await further court appearances. He was 18 years old at the time and had not been in prison before.

During the reception procedures carried out upon his arrival, it was noted that the man had no concerns about his physical health, had never tried to harm himself and the experience of being imprisoned did not make him feel suicidal. He was assessed as being fit to go to work in the prison, and to be allocated to a houseblock. A cell sharing risk assessment concluded that he presented a low risk of harming others. He was therefore allocated to shared accommodation.

The man spent his first 17 days at Doncaster in a number of different double cells, first in C wing and later in A Wing, where he could complete his induction programme. During that period he got on reasonably well with other prisoners, but had some difficulty in his relationships with staff. Between 2 and 9 September, he was given repeated warnings about his conduct. On 10 September, he assaulted a fellow prisoner and was moved to another unit to await a disciplinary hearing. The next day, he assaulted an officer. The man claimed that his behaviour had been caused by his concern that other prisoners were planning to beat him up because they thought he had AIDS. He also claimed that ropes had been found under his bed that were going to be used by officers to hang him. After assaulting the officer, he was forcibly restrained and then escorted to the healthcare centre primarily to be checked for injuries. On his way to the centre, he told his escort that he wanted to end his life. Upon his arrival at the healthcare centre, he was seen by a nurse who decided to open a F2052SH (self-harm monitoring document) and to admit him to the centre for observation.

Thereafter, the man remained in two different cells on the upper floor of the healthcare centre. For most of the time, he could only be unlocked if at least two members of staff were present, such was his volatile behaviour. He remained subject to self-harm monitoring procedures until the day he died. Frequent F2052SH case reviews were held, but the man was not present at any of them. A nursing care plan was also opened and maintained for him, but this was used more as a log of events than as a proactive, forward-looking management tool.

At approximately 5pm on 13 September, the man made a ligature from his bedding in cell 2.27, placed one end around his neck and wedged the other end in the door frame. At the time, he was subject to a 30 minute watch. Fortunately, this act of self-harm was discovered immediately. He was moved to cell 2.28, a cell variously described by staff as “anti-ligature”, “ligature free”, and “safer cell”. The man remained on a 30 minute watch. At approximately 5:30pm, he made a ligature from his t-shirt and suspended himself from the door in his new cell. As a result, he sustained red marks on his neck. He was kept in the same cell after this self-harm attempt because it was deemed to be the safest cell available, but was placed on a 15 minute watch. Despite the

fact that he had twice attempted to self-harm within the space of 30 minutes, and despite the fact that he had successfully suspended himself from the frame of his cell door, no action was taken to prevent him from making a further self-harm attempt beyond continuing to observe him every 15 minutes.

On 14 September, the man tried to cut his arms. His injuries were slight and did not required suturing. Once again, he was kept in the same cell and remained on a 15 minute watch. On this occasion, a nurse attempted to contact his family but was unsuccessful.

On 15 September, a psychiatrist conducted an interview with the man through his cell door after being advised that he presented a risk of assault. As the cell door was fitted with a dark blue Perspex sheet that, over time, had become heavily scratched, the psychiatrist found it difficult to see or hear. The psychiatrist felt that he could not exclude the possibility of underlying mental illness. He recommended that the man should continue with a course of chlorpromazine prescribed earlier and agreed to keep him under review.

On 16 September, the man was discovered to have made another ligature from his t-shirt in cell 2.28. At the point of discovery, he had not placed the ligature around his neck. He remained in cell 2.28 and was again kept on the same level of observations.

Throughout the weekend of 17/18 September, staff continued to observe the man every 15 minutes. He continually displayed paranoid and noncompliant behaviour but did not repeat his earlier self-harm attempts.

At 11.15am on 19 September, the man was seen by the clinical manager at Doncaster who noted that he had become extremely agitated. As a consequence, the option of administering oral doses of haloperidol and lorazepam were considered by the psychiatrist and the medical officer. It was decided that if the man was not compliant, an intra-muscular injection of these drugs could be given. However, as the clinical manager was not sure what oral dosage had been taken by him, she decided not to administer an injection.

The member of staff who was on duty on the upper floor of the healthcare centre during the night of 19/20 September noticed that the man had calmed down. He was observed every 15 minutes throughout the night. He was seen sleeping on his bed until about 3 am. At that time, the night patrol noticed that the man was asleep against the door of his cell, wrapped in his quilt. At about 5am, the night patrol saw that his head had dropped forward and that his lips looked odd. On closer examination, he saw a ligature wedged into the door frame. After failing to obtain a response from him, the night patrol raised the alarm. He and the other staff who arrived at the cell attempted to resuscitate the man. However, all attempts to revive him failed. He was pronounced dead at 5:41am by paramedics.

The investigation found that genuine efforts were made to provide with the mental health care he needed. However, his nursing care plan tended to be

somewhat reactive and referrals to the mental health in-reach team were informal. I express concern about some aspects of the suicide prevention measures used to monitor and review the man's risk, and about the tendency of staff to base their decisions about his management on individual events rather than on the totality of his behaviour. I am critical of the fact that, at the time of the investigation, F2052SH case reviews did not make provision for the attendance of the prisoner under review. I am also critical of the fact that a Perspex sheet fitted to the door of the man's cell impaired the ability of healthcare and specialist staff to see and hear and to communicate with him. I say that the self-harm attempts made on 13 September and 16 September should have sent clear signals to staff that the cell in which he was located was not as safe as was thought, and that these factors should have prompted more robust measures to prevent him from making further attempts on his life.

I make eight recommendations about these and related issues. Nine further recommendations are made in the clinical review.

INVESTIGATION PROCESS

The investigation was opened on 22 September, when my investigators met with the Director, chair of the Independent Monitoring Board and a representative of the Public Service Union at Doncaster. They were briefed on the nature and scope of the investigation. On the same day, notices were issued to staff and to prisoners announcing the investigation and inviting those with information about the man's death to make themselves known to the investigation team.

My investigators interviewed six specialist staff, eleven Prison Custody Officers, three Unit Managers, three prisoners and the Suicide Prevention Co-ordinator at Doncaster. They also had informal discussions with three prisoners who got to know the man in prison.

On 9 November, my investigator and one of my Family Liaison Officers met with members of the man's family in their solicitor's office. They explained how the investigation was proceeding and gave them an opportunity to raise any concerns about the care given to the man while he was at HMP/YOI Doncaster. His family expressed a number of concerns, all of which are addressed in this report.

HMP/YOI DONCASTER

Doncaster is a large, privately-managed local prison and young offender institution run by Serco Home Affairs. Although the prison is certificated to accommodate 771 prisoners, its operational capacity (maximum crowded capacity) is for 1,120 male young offenders and adult prisoners. The accommodation consists of three houseblocks, each of which contain four units or wings holding 90 prisoners.

Healthcare at Doncaster is directly provided by Serco. The healthcare centre offers 24 hour nursing and medical cover, and has inpatient facilities for up to 29 prisoners on the upper floor of the building. However, as so many of its occupants require to be accommodated in unshared cells, the average number of inpatients does not normally exceed 18. The inpatient floor is staffed predominantly by Prison Custody Officers who receive special training in the care of those prisoners admitted as inpatients, but who are not nurses. The middle floor is designated as an outpatients department. This is where the nursing staff are normally based. It is from this floor that they are deployed to respond to incidents anywhere in the prison that require nursing or medical attention. Nursing staff also deploy to the upper floor when necessary as part of their ordinary care for inpatients. The lower floor of the building is no longer part of the healthcare centre.

The most recent inspection of Doncaster by Her Majesty's Chief Inspector of Prisons took place in April 2003. The report of that inspection contained a number of recommendations, none of which I consider to be relevant to this investigation.

On 21 April 2004, another prisoner died at Doncaster after taking an overdose of heroin. The findings and recommendations contained in my report of the investigation into that death do not apply here.

EVENTS PRIOR TO THE NIGHT OF 19/20 SEPTEMBER

Arrest and imprisonment

The man was arrested in February 2005 on suspicion of possessing a class A drug. He had run away from the police and dropped a package that was later recovered and sent away for analysis. In the meantime, he was bailed to his aunt's address and told to report to the police station at a later date. He failed to attend on the due date and was then arrested and subsequently remanded in custody by magistrates on 25 August to await further court appearances. He was taken to Doncaster prison. He had never been in prison before.

25 August

Reception health screen

On arrival at Doncaster at about 7pm that day, the man underwent a reception health screen. During this procedure, he said that he was on remand until 2 September and that this was his first time in prison. He said that he had been charged with supplying a class A drug. He had recently seen a doctor for a minor ailment, but had no outstanding appointments. He reported that he had no concerns about his physical health and that he had never received treatment from a psychiatrist. He said that he drank alcohol occasionally and smoked cannabis daily. He said that he had never tried to harm himself and that he did not feel like harming despite being in prison. He felt no need to see a doctor.

During a secondary health screen completed by a nursing assistant, it was noted that the man exhibited no abnormal behaviour, that he did not appear to be under the influence of alcohol or drugs, and that there were no concerns about his mental health. A Staff Nurse who completed the primary health screen felt that it was not necessary to refer the man to a doctor. He was assessed as being fit for work, did not need to be admitted to the healthcare centre and was not in need of detoxification.

Custody assessment

An initial custody assessment was also completed as part of the reception procedures. The man said that he did not need any help in respect of substance misuse. He also said that he was unemployed and in full time education. He reiterated that he was due back in court on 2 September. He was expecting to receive visits while in custody.

Cell sharing risk assessment and allocation to houseblock

As is routine, the man was also subject to a cell sharing risk assessment. He was assessed as presenting a low risk of harming others and could therefore be allocated, if necessary, to a shared cell. In line with normal practice for newly received prisoners, he was initially allocated to the induction unit in

Houseblock 3. However, upon his arrival in the unit, it was discovered that there were no vacancies. The man was therefore accommodated in Houseblock 1 on a temporary basis, and was initially allocated to a double cell on the first floor of C Wing. The records show that he remained in this cell for only one minute from 7.46pm. My investigators were told that the reason for the rapid change of cell was probably the fact that staff did not want him to share a cell with the occupant, who was a drug addict under detoxification. He was therefore moved to another double cell on the same floor of C wing, where he remained until 7:11pm the next day. He was then moved to A Wing in Houseblock 1 where he occupied a double cell until 2:03pm on 8 September. During this initial period, he got on reasonably well with other prisoners. However, he had difficulty relating to staff.

Behaviour warnings

On 2 September, the man received a warning for his conduct after saying that one of the Prison Custody Officers (PCOs) working in C Wing was 'talking shit'. He was told that he should demonstrate more respect for staff. That day, he was taken to Leeds Magistrates' Court where he was again remanded in custody, this time until 30 September. During the evening, he was late returning to his cell for the evening lock up period.

During the morning of 4 September, the man received a formal warning after again being disrespectful towards staff and taking too long to return to his cell at lock up. Later that day, he was also warned for smoking on the landing at the tea time lock up.

During the night of 7 September, the man used insulting language to a member of the night staff. The following morning, the Unit Manager spoke to him about his rudeness.

On 8 September, the man was relocated to Houseblock 3D so that his induction programme could be initiated. This was some two weeks after he had arrived. He was placed in cell 3D2.49, where he remained until 10.17am on 10 September.

During the night of 9/10 September, the man repeatedly kicked his cell door and swore at the night duty officer. The next day, he was given another formal warning about his behaviour.

10 September: Assault on a fellow prisoner

At approximately 7:30am on 10 September, another prisoner who was located in a neighbouring cell, complained to a Prison Custody Officer (PCO) that the man had assaulted him. The man was confronted with this information by the PCO and admitted that the assault had taken place. The PCO therefore placed him on a disciplinary report. He was then relocated to Houseblock 2 to await his adjudication. My investigators were told that prisoners who are placed on report are sometimes moved to this unit and placed on a basic

regime whilst awaiting the adjudication (disciplinary hearing) rather than being formally segregated.

11 September

Admission to the healthcare centre and initiation of self-harm monitoring procedures

At approximately 1pm on 11 September, the man (who at the time was occupying a shared cell) started shouting and kicking at his cell door. A PCO heard the noise and approached his cell. As the PCO opened the cell door, the man lunged at him and pushed him in the chest. Two PCO's restrained him and led him to another cell to allow him to settle down. At interview, one of the PCO's told my investigators that the man had earlier asked to move to another cell because he "was having problems with his cellmate and because other people on the wing thought he had AIDS." The PCO said that the man believed his cellmate "was going to beat him up" because of this. The PCO explained that, once the man had calmed down, he took him to the healthcare centre so that he could be seen by a nurse in case he had sustained any injuries as a result of being restrained. The PCO said that when he arrived at the centre he said to a nurse, "I've brought him down to be checked for injuries that might have been caused by restraint but he's been talking about ending it all."

The nurse decided to admit the man to the healthcare centre and made the following entry in his medical record at 3:15pm that day:

> "HCA: The man was brought to the HCC (healthcare centre) following being C&R (controlled and restrained). He stated that some hanging ropes were found under his bed and that prison staff were going to use it to hang him. Before they do that he will do it himself. He felt paranoid that the whole wing were talking about him being HIV positive when he stated that he is not. F2052SH (self-harm monitoring document) opened, on a L3:30.(level 3 observation - every 30 minutes). Admitted upper healthcare for adjudication. [The nurse later clarified that he meant to use the word "assessment" instead of "adjudication".] Above action sanctioned by myself."

The nurse also completed a Form F213 (report of an injury sustained by a prisoner). On the form he wrote that no treatment was required. At interview, the nurse confirmed that the man had sustained no injuries.

My investigators were unable to establish whether the man's reference to the discovery of hanging ropes was real or imagined. At interview, neither of the PCO's made any reference to such a discovery. The nurse told my investigators that he questioned the man about these claims and formed the opinion that they were not true.

12 September

Examination by doctor

On 12 September, a prison doctor saw the man at 9:15am. The doctor wrote in his F2052SH,

> "Currently very paranoid. Thinks that everybody is plotting against him. Agitated. Watch raised due to threat of SH (self harm). Ref for Psych opinion."

The doctor wrote in the man's medical record,

> "Complains of paranoid ideation and agitated. PMH (past medical history) seen by psych as a child. On examination - definite paranoid ideation. Refer psych for opinion."

Opening of nursing care plan

A nursing care plan, or inpatient clinical pathway of care, was opened for the man upon his admission to the healthcare centre. The document was indexed as follows:

1. First admission assessment
2. First 24 hour core care plan
3. 48 hour assessment
4. Individual multi-disciplinary care plan
5. Care plan evaluation sheet
5. Communication sheet
6. Discharge procedure and summary

First admission assessment

The information recorded on the proforma used for the first admission assessment included a brief analysis of the risk the man presented in a number of areas such as violence, arson, self-harm, substance misuse, depression, psychotic illness and sleeping problems. The findings emanating from that risk assessment were summarised as follows:

> "Stated PMH (past medical history) seen by psychiatrist as a child. S/B (seen by) Dr 12/9/05. Refer psychiatrist for assessment."

First 24 hour core care plan

This listed 12 targets that were to be achieved that day, of which nine were initialled as having been met.

48 hour assessment

The copy of the care plan presented to my investigators did not include any information relating to a 48 hour assessment.

Individual multi-disciplinary care plan

This noted that there were two main areas of concern: self-harm ideation and mental health. The plan recorded that the man's care treatment aimed to prevent self-harm and to promote his mental health wellbeing. The plan included the following interventions:

- monitor 30 minute observations
- report on mood
- allow to voice anxieties
- reassurance to be given /offered
- refer for RMN assessment
- refer to psychiatrist
- give prescribed medication and monitor effect

Care plan evaluation sheets / communication sheets

The copy of the nursing care plan presented to my investigators contained a number of evaluation sheets and communication sheets that, together, were used to record daily occurrences during the time was in the healthcare centre.

Adjudication

Later on 12 September, the man was taken to the segregation unit from the healthcare centre to face an adjudication (disciplinary hearing) for assaulting a PCO on 10 September and another PCO on 11 September. The records show that the man was considered by the doctor to be fit to undergo the adjudications but unfit to undergo cellular confinement if imposed. The man pleaded guilty to both charges. He explained to the adjudicator that he had assaulted one of the PCO's because he, the PCO, had shouted out of his cell window that he was HIV positive. He also explained that he had pushed past the other PCO so that he could get out of his cell because he feared for his life and because he had heard that he was going to be hanged that night. The adjudicator decided to adjourn each hearing so that a report on the man's medical condition could be acquired. In the event, no medical report was forthcoming before the man died. The adjudication was therefore never completed.

First High Risk Assessment Team case review

On the same day, an initial self-harm case review was convened by the High Risk Assessment Team (HRAT). My investigators were told by the

establishment's Suicide Prevention Co-ordinator (SPC) that she was responsible for ensuring that the cases of any prisoner subject to self-harm monitoring procedures were regularly reviewed by the HRAT and that she chaired all such reviews. The SPC explained that she made sure that staff throughout the prison were aware of the names of every prisoner who was on a F2052SH (self-harm monitoring document). She also explained that the practice at Doncaster was that, prior to each case (or HRAT) review, an appropriate member of staff interviewed the prisoner and submitted a report of that interview, with recommendations, for consideration. The SPC said the policy at Doncaster was that a minimum of three staff should attend each HRAT case review. The panel normally comprised a nurse, the appropriate residential manager and herself. If necessary, the SPC discussed the review report with the author, if that person was unable to attend as a panel member. The SPC told my investigators that, at Doncaster, prisoners did not attend their own reviews. She said that it was her experience that prisoners felt intimidated by the process.

In keeping with this policy, the man was not present at his first case review on 12 September, or indeed at any of the other reviews convened to consider his case. The review was summarised as follows:

> "F2052SH opened on 11/9/05 on 2C as he said that Officers on the wing were plotting to hang him. Before they do he will do it himself. He presented as paranoid and on edge. He thinks Officers are after him. Admit to Health Care. He is feeling insecure and anxious. He said self-harm was an option.
>
> MO (Medical Officer): Currently very paranoid. He thinks everybody is plotting against him. Very agitated. Refer for psychiatric opinion. Not much interaction due to him being on 53/4 (a prison rule under which prisoners can be segregated whilst awaiting a disciplinary hearing). No self-harm voiced. He appeared to sleep.
>
> SPC findings: The man is on remand until 30/9/05. He states he fears for his safety after overhearing staff threaten to hang him and make it look like suicide. He states he has no thoughts of self-harm or suicide but is clearly agitated and feels paranoid. He is quite clear and rational in his own beliefs. He states food at lunchtime was contaminated with mucus and hair. He states that other prisoners are spreading rumours he is HIV to the extent he believes his friends in his home town have been telephoned and told. He states he has no history of drug use other than cannabis. He genuinely believes he will die if he is sent back to the Houseblock.
>
> Medical record: Nothing of relevance.

> HRAT: The man has been referred to the psychiatrist and will be seen on Thursday. His adjudication was remanded for medical reports. He will remain on Health Care until reviewed by the psychiatrist. He says he is not suicidal but HRAT agreed to continue the F2052SH for a further period of observation."

The panel decided that the man was to remain on a 30 minute watch.

Although the man later seemed to be more settled in the healthcare centre, he was described as a little confused. He told a member of staff that he thought he was in danger on the upper floor of the healthcare centre. He was reassured, but continued to display paranoid behaviour that night. He believed that, if he went to sleep, staff would try to hang him. He thought he could hear people talking about him and his problems.

13 September: self-harm attempts

On two separate occasions on 13 September, the man made a ligature in his cell. The first occasion was at 5:05pm, when staff discovered that he had made a ligature from his bedding. He had placed one end around his neck and had attached the other end to the heating pipes in his cell (2.27 on the upper floor of the healthcare centre). The Form F213SH completed afterwards noted that, on this occasion, he had sustained no injuries. As a result of this self-harm attempt, the man was moved to cell 2.28 which was designated as an "anti-ligature" cell.

At about 5:30pm, the man made another ligature, this time from his t-shirt. He had placed one end around his neck and had wedged the other between the cell door and the door frame. He was found in a sitting position immediately behind his door. A PCO noted on the F213SH that there were red marks on the man's neck. A nurse made the following entry in his medical record:

> "Seen after attempted hanging. States he did this before the officers do it to him. Also stating that he feels guilty because he neglected his younger brother who, he feels, he should be taking care of. States his mother's voice is telling him to kill himself as he is not worth it. Talked about being abandoned by his parents and being brought up in care. Had drawn a number of pictures and written phrases in his book. Watch raised to level two -15 minutes."

My investigators were unable to trace the book mentioned above. However, the man wrote a letter to his brother that day, expressing his love for him and wishing him a happy birthday.

The same nurse also made a similar entry in the F2052SH. Besides increasing the frequency of observations, staff removed the ligature and all his clothing other than his underpants.

Throughout the night of 13/14 September, the man continued to shout and bang the furniture in his cell. He told a member of the night staff that he knew that person was going to hang him that night and would not listen to any reasoning. The man threatened to slit the officer's throat as soon as he had a chance to do so. His behaviour was such that other prisoners became agitated.

14 September: Second HRAT case review, assault on staff and further self-harm attempt

At 8:10am on 14 September, the man's case was again reviewed by the High Risk Assessment Team. The man was not present at the review. The form used to record the panel's deliberations contains a box which purports to show the members of staff present at the review. On this occasion one of those listed was the nurse who made the entry in the man's medical record. However, at interview, the nurse said that she had never attended a case review. My investigators were later told that the list shown on the form was indicative of who was eligible to attend rather than a statement of who was actually present.

The review was summarised as follows:

> "Last review: 12/9/05
>
> The man seems a bit more settled. He seems to think he is in danger on Health Care. He was reassured. He says Officers are going to try to hang him.
>
> 13/9/05 – found in cell with a ligature round his neck made from a bed sheet and was holding it. No injuries evident.
>
> He was found to have made a ligature from a t-shirt. F2052SH raised to level 2. Red marks were noted, no other injuries evident. He said he attempted hanging before Officers could do it. He also stated he wanted to die. He is upset his parents abandoned him and he has let his brother down who is now in care. He flooded his cell and was not listening to reason. He was constantly banging and shouting all night and verbally abusive to staff and other prisoners.
>
> He asked for a chat and tried to force his way past staff. He had to be restrained twice. He is constantly shouting and very incoherent and paranoid.
>
> MO (Medical Officer): Still very paranoid, not seen Psychiatrist yet, seeing him tomorrow, medication prescribed.
>
> Another member of staff wrote: I did not speak to the man personally as staff felt it would aggravate him further.

> Information was obtained from Officers. The man is currently feeling paranoid believing staff are going to get him. He refuses to talk to them until other prisoners are around. He also has issues regarding debts outstanding on the wing. He spends the majority of his time banging in his cell. He has a history of self-harm though denies any future self-harm intent. He is due to see the Psychiatrist tomorrow to determine any issues underlying his behaviour.

(My investigator was unable to discover what role the author played at Doncaster.)

> HRAT: The man was fine when he attended Middle Health Care earlier today. The MO has prescribed medication but given his current volatility it may not be possible to administer it. In-reach are very concerned about him. HRAT agreed to continue F2052SH at Level 2."

Later that morning, the man was seen by a doctor who wrote in the medical record:

> "still very paranoid, not seen by psych yet."

The doctor decided to prescribe chlorpromazine 50mg twice daily. Chlorpromazine is an anti-psychotic drug normally prescribed to reduce aggression and to suppress abnormal behaviour. It can have a tranquilising effect on the patient.

A Staff Nurse who had last seen the man during the reception procedures carried out on 25 August, was now so concerned about him that she attempted to contact his next of kin. At interview, she said that the man she now saw in the healthcare centre was very different from the man she had seen in reception. The nurse made the following entry in his medical record:

> "Registered with CPA (Care Pathway Approach) in Leeds. They have his name, date of birth, and address, but no referral details on file. GP's contacted via health authority- nothing on file. NOK (next of kin) ... (sister) - no number for that address on file. Girlfriend ... mobile number not recognised. No persons for that name and address with BT."

At approximately 10:30am that day, the man rang his cell bell and asked a PCO if he could speak to him. As the PCO unlocked the cell door, the man tried to force his way out of the cell. The PCO struggled with him in order to prevent him from leaving the cell. As he did so, the PCO's keys snapped away from his key chain but remained in the door lock. Another PCO arrived at the scene and called a response team. A nurse also arrived and secured the PCO's keys to her key chain. A number of other staff responded and used force to bring the man under control. He was initially placed on the floor

outside his cell. The Operations Manager supervised the incident. Knowing that the man's mental health was being monitored, the Operations Manager decided that he should be kept in the same observation cell. He therefore ordered the staff to reduce the level of restraint they were applying to the man so that he could be placed back in the cell. As they did so, he kicked and attempted to bite one of the PCOs. Restraint was therefore reapplied. The man was then relocated into the cell. As staff withdrew from the cell, he grabbed the edge of the cell door preventing it from being closed. Further restraint was therefore applied to him inside the cell. This time, staff were able to close the cell door. The man was not injured, although the F213 completed after the incident shows that he sustained red marks on his torso caused by being wrestled to the ground.

In the healthcare centre daily handover log for 14 September, a PCO made the following entry:

> "After opening the man's cell door, he tried to push past me. He snapped my keys and had to be C&R'd (restrained). On putting him in his cell, he kicked off again and had to be C&R'd again. He is now a 2-man unlock."

My investigators were told that the term "2-man unlock" refers to the minimum number of staff who should be present in order safely to unlock a prisoner known to be volatile or prone to assaulting staff or other prisoners. At Doncaster, approval for this measure must be sought from an Assistant Director. Whilst my investigators could find no written evidence that such approval was given in the man's case, it is clear that, in view of his behaviour, it was a necessary and appropriate precaution.

At 11am, a note was made in the man's F2052SH that he was constantly shouting that staff and other prisoners were trying to kill him. He was described as very incoherent and paranoid.

At about 3pm, the man tried to cut his arms with a plastic knife. No F213SH was presented to my investigators in relation to this incident. However, a nurse recorded in his F2052SH that his injuries were cleaned and dressed, and that he then settled. The nurse recorded in the F2052SH that he was to be observed at "level 3 - 30" (every 30 minutes) and then replaced that entry with "level 2 -15" (every 15 minutes). In the medical record, the nurse wrote that the man was to be observed at "level 3-30". It was clear to my investigators that the inconsistencies in the entries made in each document were a record keeping error on the nurse's part and that the level of observation she meant to record in both documents was level two rather than level three. However, inaccuracies such as this could lead to confusion and potential omissions.

Wherever they are located at Doncaster, prisoners are provided with plastic knives, forks and spoons with which to eat their meals. It was one such implement that the man used to cut himself.

At 3:25pm, the man was described as paranoid and unpredictable. An entry made in his F2052SH at 6:30pm shows that he was still banging and shouting and that he remained abusive. His behaviour remained thus throughout the following night.

15 September: Consultation with psychiatrist and third HRAT case review

At 5:15am on 15 September, an entry was made in the man's F2052SH to record that he had been shouting and then sleeping intermittently throughout the night. However, he had not voiced any intentions to self-harm.

Later that morning, the man was seen by a psychiatrist. Because of his volatile behaviour, the psychiatrist thought it unwise to enter his cell to interview the man. He therefore remained outside the cell door while he talked to him. The cell door took the form of a metal grille gate onto which a dark blue Perspex sheet was fitted. At interview, the psychiatrist explained to my investigators that his normal practice was to interview prisoners in a separate room. He said that, if the healthcare staff had any concerns about the safety of staff, they would advise that the prisoner should be seen in his cell and interviewed through the hatch in the door or, as in this man's case, through the Perspex sheet. The psychiatrist said he had been advised that the man's behaviour was unpredictable and that his (the psychiatrist's) safety could not be guaranteed. The psychiatrist found it difficult to see clearly through the darkened Perspex, even when the two of them were only inches apart. Despite the difficulties, he proceeded with the interview. The following is a paraphrased version of the entry made in the man's medical record by the psychiatrist:

> "I examined him on 15/09/05 through the cell door. It was difficult to actually see him because of the Perspex. He stood in his underpants and his mattress was located immediately behind the cell door. He was able to converse with ease but somewhat demanding. He asked for a cigarette and toast, which was duly supplied. He said that when he arrived at HMP Doncaster he was aware others in the wing were spreading a rumour he was HIV positive. He then stage managed a suicide attempt in order to be placed elsewhere. He acknowledges he rushed at a prison custody officer, injuring the latter. He denies any prior history of contact with psychiatric services. He asked for my identification and was easily assured when this was produced. He appeared somewhat guarded and probably suspicious. He was not obviously hallucinating and certainly not thought disordered.
>
> At this time I would not exclude the possibility of underlying mental illness but I am not certain this is indeed the cause of his presentation. At the time of my interview with him on

15/09/05 he was fit for adjudication. He will continue in receipt of Chlopromazine and we will monitor his progress."

On the same day, the High Risk Assessment Team reviewed the man's case. The man was not present. The review was summarised as follows:

"Last review: 14/9/05.

The man cut his arm with a plastic knife. The injuries were cleaned and dressed. He will not listen to reason and presents as paranoid and unpredictable. He has been very abusive, banging and shouting. He takes meals behind his door. He was shouting through the night and slept on and off. He voiced no self-harm. He was seen by the Psychiatrist through his door.

Psychiatric review: Unable to make a proper assessment at this time. Fit for adjudication.

SPC findings: The man is very unpredictable at the moment. He is quite rational in his beliefs then becomes volatile and aggressive. He states his self-harm yesterday was a game of attention seeking. He is adamant he is not suicidal. He wants his medication one minute and then is questioning what the reason is for it the next. He wants to speak to the Psychiatrist and explain he does not need to be in the Health Care or on a watch. He was shouting to the prisoner in the next cell then talking in a rational manner to myself.

HRAT: The nurse reported that the man has been a lot more settled than yesterday but he is still unpredictable. HRAT agreed to continue the F2052SH at Level 2."

16 September: further self-harm attempt

At about 9:45am on Friday 16 September, whilst carrying out his observations of the man, a PCO discovered that he had made a ligature from his t-shirt. The man had pushed one end of the ligature through the door frame but, when discovered, had not placed the other end around his neck. He was in cell 2.28 at the time. This cell was classified as an anti-ligature cell. The PCO made the following entry in the man's F2052SH:

"Found during checks to be making a noose out of his tee shirt. Ligature pushed through gate but not attached to his neck. Says he wants to kill himself rather than die a painful death - says that people are going to stab him. Asked me to give him tablets to help him die. Advised he will only be given what he is prescribed."

A similar entry was made in the man's medical record. The signature of the nurse who made the entry is illegible. At interview, a nurse suggested that it was probably made by her nursing colleague who attended the cell with her. The nurse could not remember who that was. She examined the man in his cell immediately after the noose was discovered, and made the following entry in the F2052SH. It read as follows:

> "Seen on upper healthcare after making a noose. Says he wants some tablets so that he can die. Unable to see further than this ideation. L2-15."

Similar entries were made in the man's medical record. At interview, the nurse was asked whether, in view of the man's manifestations of suicidal expressions, she had considered placing him on a constant watch. The nurse told my investigators that she was not unduly concerned about the man at the time. She thought that her decision not to place him on a constant watch may have been influenced by the fact that, although he had fashioned a ligature from his t-shirt, he had not placed it around his neck.

At 1pm that day, an entry was made in the man's F2050A (record of events) showing that he had spent the morning shouting and banging on his cell door as well as "asking for his mum".

Weekend 17/18 September

Regular observations were made on the man throughout the weekend. The observation log used at Doncaster merely requires staff to place their initials against the times at which they make each observation, and to place a tick on the form if the prisoner is asleep, or a cross if the prisoner is awake. No qualitative entries were therefore made on the form used to record the observations made on the man. These were reserved for the continuous record in his F2052SH.

During the night of 16/17 September, the man's behaviour continued in the same vein. At 4:57am on Saturday 17 September, the following entry was made in his F2052SH:

> "Shouting and banging most of the night. Very disruptive to UHCC (upper healthcare centre) harmony. No self-harm voiced. Shouting for Mummy and Dad. Also shouts that they are going to kill him. Also whistling and banging pipes, cups and heating pipes."

Further entries made in his F2052SH on Sunday 18 September show that the man behaved in a similar fashion throughout the day. One particular entry made at 6pm that day stressed that he needed "to be watched carefully when taking his meds - twice today he tried to palm his tablets." On the same day, an entry made in his medical record refers to "six days of unrelenting outbursts at the cell door". It was decided that the man should be given one

10mg dose of diazepam to test its effect. Diazepam is normally prescribed for short term use in cases of anxiety or insomnia. The man was also to be referred to the Mental Health In-reach Team (MHIT). The clinical review attached to this report comments that no formal referral was made.

19 September: Seen by psychologist prior to next HRAT case review

On Monday 19 September, the man was seen by a psychologist who completed a report for consideration at his next F2052SH case review. The psychologist wrote:

> "At time of interview it wasn't possible to open the man's cell due to his two-man unlock status. He was quite agitated and it seems has been over the weekend. He told me the police were coming to take him away in a helicopter. He then continued to shout"

The psychologist made a similar entry in the man's F2052SH at 9:15am.

Oral/intramuscular medication

At 11.15am, the following entry was made in the man's medical record by the Clinical Manager:

> "Seen by in-reach - extremely agitated - doctor contacted - liaised with psychiatrist to have oral Haloperidol 10mg and Diazepam 5mg 6-8 hrly. If not compliant, to have Lorazepam 2mg IM (intra muscularly) with Haloperidol 10mgs IM. If condition deteriorates psychiatrist will arrange a consultation before Thursday."

At interview, the doctor explained this matter as follows:

> "... on 19 September, I did speak to the psychiatrist because, having seen the man and seeing how he was, I felt that he needed a further urgent review by the psychiatrist. His condition had deteriorated from when I'd seen him on the 15th. In the interim period, what I suggested was that we had an interim review by a psychiatrist again for any possible further intervention he may have felt was appropriate. I also gave instructions to the nurses that he should given some diazepam until the lorazepam arrived. Both drugs are of the same class of medication. They didn't have any oral lorazepam at the time in the prison pharmacy, so the substitute drug, which is diazepam, was to be given to try and calm him down until the psychiatric assessment could take place. I left instructions to get hold of the psychiatrist and see if he could come in as soon as possible to see this chap. After I had left the prison, I actually rang the psychiatrist from my mobile and explained that this chap was

> quite agitated and his mental state had deteriorated more than when I had seen him on the 14th. So it was worse than that and probably worse than the 15th when the psychiatrist had seen him. I asked if he could offer some advice. The psychiatrist gave me further instructions as to what he should be given. He said that he couldn't actually attend himself at that time. However, if he didn't settle with the medication that he suggested, then arrangements would have been made to get either himself or one of his team to attend to reassess the prisoner."

During his interview, the psychiatrist was reminded of the entry that had been made in the man's medical record at 11.15am on 19 September. The psychiatrist was asked if had been given any of those drugs (lorazepam and haloperidol) orally. He said that he did not know and that he had not seen any medication card or the man's medical record.

My investigators examined the prescription charts contained within the man's medical record. These show that an entry was made in the 'once only prescription' section on 19 September for haloperidol 10mg and lorazepam 2mg. An entry made against these drugs in the 'directions' section shows that each drug was to be given intra-muscularly. However, neither entry was signed by a doctor and no entry was made in the section of the chart marked 'given by'. Beneath the entries that had been made is the comment, "(verbal message doctor.) Agree with psychiatrist." These entries appear to support the suggestion that no intra-muscular administration of either lorazepam or haloperidol was given to the man.

The Clinical Manager told my investigators that she spent nearly two hours that day talking to the man and trying to persuade him to take his medication. She was sufficiently concerned about him to telephone the doctor for advice. The Clinical Manager said that the doctor told her to try to give the man some haloperidol as well as diazepam orally. She explained that haloperidol is an anti-psychotic drug that has a calming effect on a patient. The Clinical Manager explained that any medication prescribed for the man had to be pushed under his cell door because of the risk of assault. It was therefore difficult to determine what medication he had taken. The Clinical Manager said that in view of this uncertainty, she did not proceed with an intra-muscular injection.

The Clinical Manager told my investigators that, although the man was not rational at the time, she did not think he was suicidal. She said that, for most of the time she spent with him, there was very little interaction with him. She recalled that he did settle down during the afternoon, but was aware that he often did. It is not clear whether the man settled down because he had taken the oral medication offered to him.

Another entry, timed at 12:15pm, was made in the medical record above the earlier entry, described above. It reads as follows:

> "Referral accepted by in-reach. Unable to interview at this time due to 2 man unlock and volatile presentation."

This entry was made by a member of the in-reach team. At 2:55pm, the following entry was made in the F2052SH:

> "Quite disruptive - appears to have taken medication on the instructions of the doctor. Under in reach team. For urgent psychiatric review. HRAT: remain L2-15."

The final entry made in the man's F2052SH was made at 6pm on 19 September. It read:

> "Banging and shouting most of the morning. This afternoon a little quieter."

The final entry made in his medical record was:

> "HRAT review. Remain L2.15."

The man's final HRAT was summarised as follows:

> "The man has been very disruptive, shouting and banging. This behaviour has continued all weekend. 16th September 2005: Made another noose with tee shirt.
>
> HCA1 (Healthcare Assessment 1) - issues over safety, mental health issues
> HCA2 (Healthcare Assessment 2) - made a noose, cannot make sense of problems, mental health issues, to remain on a L2 15 minute watch.
>
> The man has been shouting and banging and asking for his mum, palming medication and is currently on a 2-man unlock.
>
> Psychologist's findings: At the time of interview it was not possible to open the man's cell due to his two-man unlock status. He was quite agitated and it seems has been over the weekend. He told me the police were coming to take him away in a helicopter, he then continued to shout.
>
> HRAT: Agreed remain on L2 15 minute watch."

The case review summary bore the SPC's signature and was dated 28 September 2005. My investigators were told that this short delay was due only to the fact that the person upon whom she relied to type the review summary was on leave at the time.

EVENTS DURING THE NIGHT OF 19/20 SEPTEMBER

During the night 19/20 September, a Prison Custody Officer was on duty in the healthcare centre as a night patrol. At interview, he told my investigators that he was aware of the fact that the man was forever banging and shouting in his cell and that his behaviour disrupted the smooth running of the healthcare centre. However, at about 7:50pm on 19 September, when the PCO began his night duty, he noticed that the man was asleep. At the PCO's hand-over briefing, he was told that the man had received some medication. The PCO thought this was the reason why he was asleep.

The PCO's shift commenced at 8pm and finished at 6am the next day. He was alone on the upper floor of the healthcare centre, but knew that nursing staff were available throughout the night on the floor below.

The PCO was aware of the fact that the man was to be observed every 15 minutes. When he began his shift, he saw that the man was asleep on his bed. However, the PCO told my investigators that in the early hours of 20 September, possibly at about 3am, he noticed that the man was asleep by his door. The PCO did not witness the man moving from his bed to the door. According to the PCO, the man was in the habit of placing himself by the door so that he could shout through it or sleep there.

The PCO made a record of the observations he made of the man on a form entitled "Suicide Watch Log and Notes". The form shows that he observed the man at 15 minute intervals throughout the night. The recorded timings of each observation fell precisely at 15 minute intervals, suggesting that the man might have been able to predict exactly when the PCO was due to visit his cell. However, the PCO assured my investigators that his routine involved the observation of a number of prisoners, including the man, and making entries on the proforma at the end of each patrol. The PCO stressed that no prisoner would have known precisely when the next observation was to be made and that his actual observations were not made precisely every 15 minutes.

The PCO said that he saw nothing unusual until about 5am when he noticed that the man was asleep on the floor of his cell, leaning against the door in a sitting position and wrapped in his quilt. The PCO noticed that the man's head had dropped forward and that his lips looked really weird". The PCO said that the man's lip was "sticking out and looked unusual". The PCO shone his torch into the cell to get a better view. He then saw a ligature wedged between the door and the frame. He told my investigators that he was not sure whether the ligature was in place earlier in the night.

The PCO wanted to be sure that the man was not "setting a decoy" as he knew that he had recently injured two members of staff and, as a result, was on a "two-man unlock" (the procedure whereby two members of staff must be present before unlocking a prisoner known to be volatile). The PCO therefore

tried to push the knot to force a reaction from the man. However, the ligature would not move. At that point, the PCO raised the alarm by calling for assistance from the first-response team over the radio. He then broke the seal on his emergency pack of keys and unlocked the man's cell door. As he pushed the door open, the ligature fell from the door frame, causing the man to fall to the floor. The PCO moved in to the cell and cut the ligature away from the man's neck. He could find no pulse, nor any signs that the man was breathing. At this point, he laid the man flat so that he could commence cardiopulmonary resuscitation (CPR).

At about 5:05am, a nurse and a PCO arrived at the man's cell. They both helped to administer CPR. At about the same time, the Night Orderly Officer, who was at the gate when the call for assistance was sent, made her way to the healthcare centre and on arrival began to supervise the staff involved and co-ordinate their activities. She gave instructions to a PCO to ask the Communications Officer to call for an ambulance.

The log shows that the ambulance was called at 5:05am and that it arrived at the prison about 15 minutes later. Three PCO's escorted the paramedic crew to the healthcare centre. When the crew arrived at the man's cell, they took over CPR from the staff.

It is clear that prolonged attempts were made to revive the man. Sadly, they were unsuccessful. He was pronounced dead by the paramedics at 5:41am. No suicide note was found.

After police officers had completed their examination of the cell, the man's body was removed from the prison at approximately 11am.

An Assistant Director and the chaplain from Doncaster informed the man's sister of his death at 5pm that day at her home.

The man's funeral took place in October 2005. Two members of the Doncaster chaplaincy team attended. The prison contributed £1,000 towards the funeral costs.

ISSUES

Here I address the concerns expressed by the man's family. I also examine the quality of mental health care afforded to the man and the effectiveness of the suicide prevention measures taken to assess and manage his risk.

- *Why did the man change so radically between 25 Aug and 11 Sept?*

During the initial health screen carried out as part of the reception procedures on the day the man first arrived at Doncaster, he told staff that he had no concerns about his physical health and that he had never received any treatment from a psychiatrist. He said that he had never tried to harm himself and that he did not feel like doing so now that he was in prison. He felt no need to see a doctor. The nursing assistant who completed a secondary health screen noted that the man exhibited no abnormal behaviour, that he did not appear to be under the influence of any alcohol or drugs and that there were no concerns about his mental health. The man was assessed as being fit for work. He did not need to be admitted to the healthcare centre and was not in need of detoxification. He was therefore allocated to a houseblock where he was to share a cell. However, it was immediately discovered that the prisoner with whom he was to share a cell was a drug user under detoxification. The man was therefore moved to another cell in the same wing. The next day, he was moved to yet another cell, this time in A Wing, where he remained for two weeks. Although he got on reasonably well with other prisoners during this period, he had difficulty relating to staff. As a result, he was given several warnings about his disrespectful attitude and poor conduct.

On 8 September, the man was moved to another houseblock so that his induction programme could commence. During the night of 9/10 September, he repeatedly kicked his cell door and swore at the night duty officer. The next day, he assaulted a fellow prisoner. On 11 September, the man started shouting and kicking at his cell door. He then assaulted one of the officers who came to his door and claimed that his cellmate was going to beat him up because he had heard that he had AIDS. The man had to be forcefully restrained and was taken to the healthcare centre. On the way to the centre, he said to staff that he "wanted to end it all". He also said that ropes had been found under his bed and that staff were going to use them to hang him. was seen by a nurse.

The nurse told my investigators that as soon as the man arrived in the healthcare centre, he "singled him out" to talk to him. The nurse therefore thought that if he gave the man his attention "things might get better". The man repeated to the nurse his claim that ropes had been found under his bed. The nurse told my investigators that he did not believe this was true. He said that he told the man he would help and protect him and that he did not think that there were any ropes. The nurse thought that the man was ill and knew

that if he were to return to the wing his health would be adversely affected. The nurse therefore decided to admit him and to open a F2052SH.
The next day, the man was seen by a doctor who diagnosed him as suffering from paranoia and decided to refer him for psychiatric assessment.
The dramatic change in the man over a period of a little over two weeks is impossible to explain. It is possible that he quickly became frightened by being locked up for the first time in a prison cell with people he did not know and that this was the basis of his paranoia. It is also possible that he had access to mood altering drugs on his wing: the toxicology report showed evidence of "earlier use of cannabis". But there is no evidence to confirm that he did take drugs after his arrival at Doncaster or to show this may have contributed to the deterioration in his mental state.

- *How was the man able to hang himself given the layout of the cell? How did he connect the ligature in the door?*

The man died in a cell on the upper floor of the healthcare centre. The cell was designed in such a way as to minimise the risk of the occupant harming himself by any means. It contained a bed that was totally boxed in and affixed to the floor without any springs or sharp edges. The bed could not, therefore be moved. There were no points on or around the bed from which a ligature could be fixed. The bedding provided comprised a mattress, pillow and quilt. Affixed to the wall were a toilet and a sink. All fittings lacked ligature points or any items that could be removed or used for self-harm purposes.

The cell door took the form of a metal grille-gate rather than a solid door. By this means, observation into the cell could be maximised. However, to prevent the bars on the door from being used as ligature points, a sheet of Perspex, a few millimetres thick, was fitted to the inner surface. The Perspex was dark blue and heavily scratched. Around the perimeter of the sheet was a tiny gap between it and the door frame. However, at the bottom of the door the gap was sufficiently large to enable items to be pushed along the floor and into the cell. The investigation found that not only did the presence of the Perspex sheet impede observation into the cell, it also impeded communication.

To the casual observer, the possibility that a ligature could be attached to the door frame seemed remote. At the top and sides of the door the gap between the Perspex and the frame was no more than two or three millimetres. However, the man succeeded in placing the ligature he had made from his quilt in the gap that was available and placing the other end around his neck. When he was discovered, he was in a sitting position with his body weight against the door. It appeared that he had, in that position, possibly pulled down on the ligature and asphyxiated himself.

- *Why was the man provided with bedding and clothing with which he could kill himself?*

The investigation found that the only bedding in the man's cell at the time of his death was a mattress and a quilt. When he was discovered hanging, he

was dressed only in his underpants. The ligature he used was fashioned from a piece of material he had torn from his quilt cover. I am satisfied that the materials that were available to him at this time drew an appropriate balance between reducing his risk of self-harm and depriving him of basic comfort. However, I have the following comments to make about certain aspects of the management of his attempts at self-harm earlier in September. On 13 September, he made a ligature from his t-shirt and used it to try to hang himself in his cell. This was a serious attempt by the man to harm himself: the tautness of the ligature left red marks on his neck. At the time, he was being observed every 30 minutes. As a result of this development, the frequency of observations was increased to level two - every 15 minutes. This seems to be an appropriate reaction by the healthcare staff. However, the investigation found no evidence to show whether the man's t-shirt was removed.

On 16 September, the man made another ligature, again fashioned from a t-shirt. On this occasion, although he had pushed the ligature through the cell door, he did not place it around his neck. This time, the t-shirt was removed. Although I have concerns that this may not have been done on the first occasion, I am satisfied that sufficient account was taken of the man's risk of carrying out yet another similar self-harm attempt by removing his t-shirt on this second occasion.

- *Why was the man not on a constant watch given his previous attempts at self-harm?*

The following table shows the cell locations and level of observations decided upon after each of the man's self-harm attempts at Doncaster:

Date	**Details of self-harm**	**Cell**	**Observations at time of self-harm**	**Decisions made**
13 Sept 5pm	Made a ligature from his bedding. Wedged one end in the door and placed the other around his neck.	HCC 2.27	Level 3: every 30 minutes	Moved to cell 2.28 No change in observations
13 Sept 5:30pm	Made a ligature from his t-shirt. Wedged one end in the door and the other around his neck. Red marks left on his neck.	HCC 2.28	Level 3: every 30 minutes	Observations changed to level 2: every 15 minutes. No change in cell location
14 Sept 3pm	Tried to cut his arms with a plastic knife.	HCC 2.28	Level 2: every 15 minutes	No change in observations. No change in cell location
16 September 9:45am	Made a ligature from his t-shirt. Wedged one end in the door but did not place it around his neck.	HCC 2.28	Level 2:every 15 minutes	No change in observations. No change in cell location

Each decision made in respect of the frequency of observations to be applied to the man was made by a nurse. After each of his self-harm attempts, the High Risk Assessment Team convened to review his case.

The panel that met on 14 September, following the man's two self-harm attempts the previous day, agreed that, in line with the decision made by a nurse, the man should continue to be observed every 15 minutes. The member of staff who submitted a report to the case review admitted that he did not interview him prior to the review because he thought by doing so he might aggravate him. However, information offered to the review by staff suggested that the man was concerned that he was in debt on the wings, and that he was feeling paranoid. It was reported that he spent most of his time banging and shouting in his cell and that he was due to see a psychiatrist the following day to determine whether there were any issues underlying his behaviour. It was noted that he had a history of self-harm, but that he said he denied any future self-harm intent. The HRAT concluded that he should continue to be observed every 15 minutes.

The man's second attempt at self-harm on 13 September resulted in red marks on his neck, such was the tautness of the ligature. At the time, he was being observed every 30 minutes and was in cell 2.28. It is fortunate that he was found early enough to prevent him from inflicting more serious harm. The options available to staff for preventing a further attempt at self-harm were limited. There was no better cell available, but the frequency of observations could have been increased either to level two (every 15 minutes) or to a constant watch. I believe that, in view of the nature of the information available, the decision to increase the frequency of observations to level two, rather than to a constant watch, was justified. However, as I will argue later, I am concerned that insufficient account was taken of the fact that the man had placed a ligature in the door frame and had suspended himself from that ligature point in a cell regarded as the safest cell in the healthcare centre.

After the man's next self-harm attempt on 14 September when he tried to cut his arms with a plastic knife, the HRAT agreed, once again, that the frequency of observations to be applied to the man should continue at 15 minute intervals. The case review summary took account of a report from a nurse that the man was more settled than he was the day before, but was still unpredictable. The summary also mentioned that he had said that his self-harm attempt of the previous day was an attention seeking game and that he was not feeling suicidal. The man had been seen by the psychiatrist earlier that day. The case summary referred to the fact that the psychiatrist felt unable to make a proper assessment at that time. With the benefit of hindsight, one might feel that a different judgement should have been made as to the risk of suicide the man presented on 15 September. However, given the information and evidence available, I believe the decision that he should continue to be observed every 15 minutes was justified.

The self-harm attempt the man made on 16 September was his fourth attempt at self-harm in as many days. The review of his case following this episode did not take place until Monday 19 September. The record shows that his review was chaired by the Suicide Prevention Co-ordinator and attended by a nurse and the Clinical Manager. The review summary noted that over the weekend, the man had been banging and shouting in his cell, "asking for his mum", and "palming medication". The summary also referred to the fact that

the psychologist who wanted to assess him prior to the review was unable to do so in the cell a the man was still on a “2 man unlock”. Nevertheless, the psychologist submitted to the panel his view that the man had remained “quite agitated” over the weekend and referred to a comment made by him that “the police were coming to take him away in a helicopter”.

The cumulative effect of yet another episode of self-harm was mitigated by the fact that, when discovered, the man had not placed the ligature around his neck. However, the option of increasing the frequency of observations to a constant watch was available.

My investigators interviewed a nurse who saw the man that day after the ligature had been found. The nurse was asked whether she considered placing the man on a constant watch. She said that, at the time, she was not unduly concerned about him. The nurse thought that she might have been influenced by the fact that the man had not placed the ligature around his neck.

When seen in isolation from the man’s earlier self-harm attempts, this particular episode may not have justified a decision to place him on a constant watch. However, I am concerned that a number of other factors do not appear to have been taken into consideration by staff in judging how best to manage the man’s propensity for self-harm:

- He was being held in a cell that was described to my investigators variously as an anti-ligature or ligature-free, or reduced-risk cell. At 5.30pm on 13 September, he sustained red marks on his neck after trying to hang himself. As a result, the frequency of observations was increased to a 15 minute watch. But that event clearly demonstrated that it was possible for a prisoner to hang himself in the cell. The Perspex sheet fitted to the interior aspect of the cell door actively inhibited visibility into the cell. It also made it difficult to communicate with the occupant. Such difficulties were brought into sharp relief by the psychiatrist’s description of his interview with the man from the corridor on 15 September. The man had already demonstrated on 13 September how quickly he could, unobserved, place a ligature in the door frame of the cell. Thus, not only did it inhibit monitoring of the man, but it must also have had a debilitating effect on him. At a time when his mental state was unstable, his sense of isolation was probably increased by an inability to see or hear properly any person who spoke to him.

- The self-harm attempt on 16 September was the fourth such event in as many days. It is clear that the healthcare staff and the High Risk Assessment Team considered the man’s current presenting behaviour after each self-harm attempt. It is less clear whether they took into account the totality or the pattern of his behaviour over a period of time.

- Cell 2.28 is located farthest from the office on the upper floor of the healthcare centre in which staff are situated. Thus, the only time its

occupant is likely to be observed is when a planned observation is made. There is a case for considering whether the cell should be sited nearer the staff office or if closed circuit television equipment should be installed in the cell itself.

I believe that the options available for the better management of the man's self-harm should have included the replacement of the dark blue sheet of Perspex in cell 2.28 with a totally transparent sheet that left no gap between it and the door frame. The healthcare staff or the High Risk Assessment Team should have considered inviting the man to attend his case reviews. They should also have agreed a proactive and strategic approach to his management rather than reacting each time he self-harmed. They should have considered the totality of his behaviour rather than dealing with each self-harm attempt in isolation.

I must be careful not to intrude into matters that have yet to be considered by a Coroner's jury. However, I believe that, on 16 September, there was a case for placing the man on a constant watch. This option could have been initiated in conjunction with either the removal or the replacement of the Perspex sheet. The Coroner's jury may wish to consider if the man's death could have been prevented had these actions been taken, and had the overall pattern of his behaviour been examined that day.

The Director should, as a matter of urgency:

- **Either: arrange for the removal of the Perspex sheet fitted to the inside of the door in cell 2.28 in the healthcare centre so that the cell can only be used as a gated cell,**

  or: arrange for the replacement of the dark blue Perspex with a totally transparent sheet that leaves no gap between it and the door frame.

  (These options should be discussed with Safer Custody Group in NOMS Headquarters.)

- **Review local suicide prevention policy to ensure that prisoners considered to present a risk of suicide or self-harm attend their own case reviews as a norm unless there are exceptional reasons for not doing so. Any such reasons should be fully documented.**

- **Issue clear guidance as to what criteria should be used in judging whether an at risk prisoner should be placed on a constant watch.**

- **Consider the merits of re-siting the staff office on the upper floor of the healthcare centre so that it is nearer the cells that hold prisoners in need of frequent observation.**

- **In conjunction with Safer Custody Group in NOMS Headquarters, consider the merits of installing closed circuit television equipment in cell 2:28 on the upper floor of the healthcare centre.**

• *Did the man store drugs so that he could overdose?*

On 16 September, a nurse recorded that the man had asked for tablets so that he could die. He was told that he would only be given medication that had been prescribed.

The nurse concerned explained that no medication was kept in the possession of inpatients. Rather, it was administered from the drug trolley under supervision. She told my investigators that, even so, it was not possible to prevent a prisoner storing drugs so that he could overdose. The nurse said that it was possible for a prisoner to swallow tablets and later to regurgitate them.

The investigation found no corroborative evidence that the man was storing drugs with the intention of overdosing. The toxicology report submitted to the Coroner commented as follows:

> "The results reflect earlier use of Cannabis. They do not suggest intoxification with cannabis at the time of death. The concentration of Diazepam is low and would be unlikely to reflect regular therapeutic range dosage. Procyclidine (traces of which were present) is occasionally abused. It is also often co-prescribed with oral or injected neuroleptic or anti-psychotic drugs. These drugs may not be detected on routine screening. Further directed analyses may be possible if the deceased was prescribed anti-psychotic medication."

Neither the toxicology report nor my investigation into the man's death uncovered evidence that he took an overdose of any drugs, whether prescribed or not.

• *Was the man's mental health properly assessed and managed?*

Upon the man's admission to the healthcare centre on 12 September, a nursing care plan was opened. The plan was based on an assessment of his current mental state and on his psychiatric history.

The interventions planned for him listed a number of objectives designed to prevent his self-harm and to promote his mental health wellbeing, including recommendations for his referral to a registered mental nurse and to a psychiatrist.

The entries made in the daily review communication sheets that form an integral part of the nursing care plan logged frequent descriptions of the events that occurred while the man was an inpatient.

In the clinical review, the author makes the following comments about the quality of the mental health care afforded to the man in general, and specifically about the quality of the nursing care plan:

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> "Whilst there is evidence of an initial plan of care there is no evidence of subsequent amendments or reviews to his plan of care. The man's progress is documented as indicated in the IMR, weekly care plan evaluation sheet and daily review communication sheet, but this represents a diary rather than any systematic review and reappraisal of his plan of care in light of subsequent problems and events."

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> "It is clear from the documentary evidence that his progress and care were well documented. However, it is difficult to determine from the care plan whether an holistic plan of care had been determined as it focussed principally on the physical dangers associated with his attempts at self-harm. Other physical and mental health issues do not appear to have been explored from the point of view of treatment and so underlines what seems to have been a reactive strategy."

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> "The man's pathway of care is described in the various documents presented. However, the main purpose of these documents would appear to detail progress rather than determine a cause. There is evidence of care planning. However, this seems to be rather limited in its scope in terms of any holistic approach …
>
> "… From interviews with members of the Mental Health In-reach Team, it would appear that efforts were made to determine what, if any, previous mental health problems the man had suffered. However, this had little success and provided little information. Referral to the Mental Health In-reach Team would appear to have been informal as they stated that they became aware of him simply because of his disruptive behaviour due to the proximity of their office and the upper health care unit and they could hear him and so intervened informally."

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> "… Evidence is provided that the regime of treatment had been reviewed and amended. However, there is no evidence of any other form of therapy or treatment. Intervention seemed principally to be reactive."

At interview, my investigators asked the prison doctor what forms of treatment had been considered for the man other than medication. The doctor said:

> "There isn't any other formal prescription of treatment. If his mental condition was deteriorating to such an extent that he needed to have more intervention, he would have been sectioned under one of the Mental Health Acts. And that is an option that we would take, and have taken before. He would then be removed from the prison and taken to another facility where he could be treated. Under the Mental Health Act you can instigate treatment as necessary but we cannot do that in prison. We do it in conjunction with the psychiatrist but we are guided by the consultant psychiatrist's assessment of the patient. They have the experience and the knowledge for that, but I cannot do it on my own."

The doctor could not clearly recall whether he discussed this option with the psychiatrist. However, the doctor told my investigators that he and the psychiatrist were considering the use of acuphase. The doctor explained as follows:

> "Acuphase is a drug that is administered intra-muscularly for people who are extremely disturbed or agitated. We have a protocol for administering that. We just can't say that the doctor says give him acuphase. We have to have a formal assessment by a psychiatrist and then mental health nurses need to assess him as well and make a decision. We video tape the whole procedure to prove that we have actually done that. The other possibility would have been sectioning him and removing him from the prison. Yes, on reflection I may have discussed that with the psychiatrist and that's why he said to me, 'Give him the medication (lorazepam and haloperidol). See what happens to him and we will reassess him again.' And part of the reassessment would have been these options."

During his interview with my investigators, the psychiatrist said that, after assessing the man on 15 September, he thought there might be "some suggestion of underlying mental illness", but he was not sure. The psychiatrist gave no indication that he had considered the option of transferring him to a psychiatric unit, but it is clear from the treatment he recommended after seeing the man that he was prepared to review his case again if necessary.

In his clinical review of the management of the man's health needs, the author of the clinical review comments:

"Evidence is provided that the regime of treatment had been reviewed and amended. However, there is no evidence of any other form of therapy or treatment. Intervention seemed principally to be reactive."

The clinical review includes a specific recommendation that care planning at Doncaster should be reviewed to emphasise the importance of a holistic approach.

- *How could the psychiatrist carry out an effective assessment of the man on 15 September through the door of his cell?*

The psychiatrist told my investigators that it was his normal practice to interview prisoners in a room in the healthcare centre. The only circumstances in which he would not do this were if he was advised by prison staff that there were safety issues. In such circumstances, he would talk to a prisoner with the cell door open or through the hatch in the door, or, as was the case with this man, through the Perspex. On 15 September, the psychiatrist was advised that it was unsafe for him to interview the man with the cell door open. This was because he had earlier rushed past an officer as he opened the cell door, with the result that the officer was injured. The psychiatrist therefore remained outside the cell and talked to him through the Perspex. He told him the man that he could not see him properly. The man therefore came to the door and stood against the Perspex. An officer stood nearby, out of earshot. The cell next to the man was occupied by another prisoner. At interview, the psychiatrist said he felt that the confidentiality of his interview with the man was not impaired by his proximity to the other prisoner or to the officer. However, he recalled that both the Perspex and the cell lighting made it difficult for him to see. He said, “The assessment circumstances were far from ideal in the sense that it was not face to face, it was through Perspex.”

Nevertheless, the psychiatrist completed his assessment of the man and was able to reach a conclusion that he should continue with chlorpromazine and that his progress should be monitored.

It is much to the psychiatrist’s credit that he continued to conduct an interview with the man in such adverse circumstances. That said, and however much I recognise the need to protect staff from volatile and unpredictable prisoners, and the limited resources available at Doncaster for private consultations, it was entirely inappropriate for the psychiatrist to have to interview the man in such circumstances. He could hardly see the man, let alone speak to him. There was no guarantee of privacy. Whatever difficulties the psychiatrist experienced, it is not hard to imagine the limitations placed on the man or himself during the interview.

The Director should take urgent steps to provide appropriate facilities and resources that allow specialists to see patients in conditions of both safety and appropriate privacy.

- *Why was the man’s family not informed that he had been admitted to the healthcare centre and that he had tried to self-harm?*

The Prison Service has issued guidance to staff about the involvement of relatives and friends in ACCT Reviews. At page 11 of the ACCT form, the following general guidance is given:

"**Ideas to help diffuse a crisis and address problems:**

Has suicide plan: Disable the plan
Practical problem triggering pain: Neutralise pain/help solve problem
Mental health or withdrawal problems: Refer to health worker
Alone: Link to social support (e.g. family, friend, Listener, staff)
Feels low: Help get more active, involve in regime
Pattern of self injury: Distraction, comfort, alternatives
Known factors that indicate higher risk: Note these in trigger boxes and monitor for these occurring."

At page 12 of the ACCT document, the following specific advice is given in relation to the conduct of effective reviews:

> "Consider asking the individual if he/she wishes a friend/relative/Listener to attend the Case Review. If so, you must ensure that the individual (if an adult) has signed a consent form for the relative/friend/Listener to attend. For the under 18, it is good practice to involve the Child Protection Co-ordinator and YOT worker, and if appropriate, the parents/carer."

The man was admitted to the healthcare centre on 11 September. Three days later, a nurse became so concerned about him that she felt it necessary to contact his next of kin. On 14 September, she wrote in his medical record the passage I quoted earlier:

> "Registered with CPA (Care Pathway Approach) in Leeds. They have his name, date of birth, and address, but no referral details on file. GP's contacted via health authority-nothing on file. NOK (next of kin) ... (sister) - no number for that address on file. Girlfriend ... mobile number not recognised. No persons for that name and address with BT.

At interview, the nurse said to my investigators,

> "I remember trying to contact his family, his sister and his girlfriend. I attempted to contact his GP for information and we came across a brick wall all the way. The phone numbers that he had given us for his sister and his girlfriend were unobtainable. I can say that because I made both calls. I also then checked with BT to make sure that I had written the number correctly. I gave them names and addresses and there was nobody listed for either addresses he'd given us. I

> can't remember if he gave me his GP's address but I contacted the health authority at his home address to see which GP he was registered with. I contacted that GP's surgery and they had nothing."

The nurse explained that, at the time, she was trying to establish if the man's current behaviour was typical of his normal presentation. She said:

> "If perhaps the day that he came into prison he'd had half an hour of lucidity, I would have been fortunate enough to sit opposite him and to establish whether his presentation was normally so bizarre or whether his bizarre behaviour was due to his incarceration."

The nurse emphasised that the only person to whom she spoke was the GP's receptionist and so she did not disclose any information about the man. She said that, had she been able to speak to a family member, she would not have discussed such issues over the phone. Rather, she would have asked the family to come in to the prison to talk about his disposition face to face. The man's sister and aunt told my investigators that they were aware that attempts had been made to contact them but that none was successful. However, they suggested that someone could have contacted them via his aunt's address to which he had been bailed, or with the help of his solicitor or the police.

I sympathise with the family on this point. It is clear that the nurse did think of contacting them and that she made a genuine effort to do so. If there was reason to contact the family by 14 September, there were certainly good grounds for doing so thereafter, given the deterioration in the man's demeanour. There was no evidence that any further attempts were made to communicate with, or to involve, the family after 14 September. The investigation could not find any evidence to show that the man gave his consent for staff to contact his family. However, it is acknowledged that the nurse's efforts were in his best interests.

The Director should develop a policy for communication with, and involvement of, prisoners' next of kin, using evidence based best practice.

The healthcare provider and Director should review the learning identified in the clinical review and develop an action plan to address the points raised.

- *The Post Mortem report says that there were scratches on the man's chest and describes these as evidence of self-harm.*

My investigators took advice on this point from the author of the clinical review. The author expressed the view that the marks found on the man's chest were likely to have been caused by the intervention of the paramedic

crew in using specialist equipment to attempt to revive him. There is no evidence that the marks were the result of any self-harm attempts by the man.

- *Why did it take so long to break the news of the man's death to the family?*

The man's sister told my investigators that, at about 10.30am on 20 September, a man she did not know knocked on her door and told her that "something had happened to her brother." She said that she went to her aunt's house and that her aunt then telephoned the prison twice. On the first occasion, her aunt was not certain what the person on the other end of the phone was talking about. She therefore phoned again at about 2:30pm and spoke to a woman whose name she did not know. On this occasion, she said her aunt was told that her brother had died and that the chaplain would be visiting her at about 5pm. She said the chaplain and someone else arrived at 4pm.

My investigators spoke to the Director of HMP/YOI Doncaster and interviewed the chaplain about this point. The Director explained that he rang the telephone number listed in the man's prison record for use in an emergency in order to break the news of his death. The number was that of his girlfriend. However, there was no answer. As there was no other contact telephone number listed, the Director next rang the man's Probation Officer who offered an alternative number. At the same time, a prisoner rang the man's uncle to tell him about the man's death. The uncle rang the prison to find out more details and was put through to the Director. As the Director did not know the uncle, and as he was not listed as the man's next of kin, he was initially reluctant to give any further details. However, in view of the risk that other prisoners might do so, the Director decided to confirm the man's death to the uncle there and then.

At interview, the Chaplain told my investigators that, shortly before the man's death, an agreement had been reached with the local police that before any family was visited by officials from the prison, a risk assessment had to be carried out because, occasionally, such visits had caused difficulties in the community. The Chaplain explained that the completion of a risk assessment gave the police the opportunity to consider the most appropriate way to manage family visits.

When the West Yorkshire Police were contacted, they explained that there was a tall ships race taking place that day, attracting a huge number of spectators. The police therefore advised that, in view of the heavy traffic in the area, they were better placed to break the news of the man's death to his relatives. However, my investigators could find no evidence that the police actually informed his family of his death.

At about 5pm that day, one of the Assistant Directors at Doncaster accompanied the Chaplain to the home of the man's family to break the news

personally. When they arrived, they discovered that the family had already been informed by a prisoner.

I recognise that the man's relatives must have been very distressed by the manner in which they came to learn of the news officially so long after he had died. However, it is clear that the Director and his staff made reasonable attempts to contact the family as quickly as possible. Their attempts were frustrated by a telephone call made by a prisoner to the man's uncle and by other circumstances beyond their control.

RECOMMENDATIONS

I make the following recommendations:

The Director should, as a matter of urgency :

1. **Either: arrange for the removal of the Perspex sheet fitted to the inside of the door in cell 2.28 in the healthcare centre so that the cell can only be used as a gated cell,**

   or: arrange for the replacement of the dark blue Perspex with a totally transparent sheet that leaves no gap between it and the door frame.

   (These options should be discussed with Safer Custody Group in NOMS Headquarters.)

The Prison Service accepted this recommendation and said:

"New specially designed doors have been fitted to cells 2.27 and 2.28 which incorporate safety glass. The identified reduced risk cells are not gated and the transparent panels leave no gap between the safety door and the frame. These would be the only healthcare cells used for constant observation."

2. **Consider the merits of re-siting the staff office on the upper floor of the healthcare centre so that it is nearer the cells that hold prisoners who are considered to be most in need of frequent observation.**

The Prison Service did not accept this recommendation, and said:

"There are procedures in place to monitor prisoners, e.g. continuous observation for those considered to be at a high level of risk. It would not be reasonable to expect that an officer should remain located in an office at all times for this purpose, and in fact officers would be encouraged to move about the unit."

3. **In conjunction with Safer Custody Group in NOMS Headquarters, consider the merits of installing closed circuit television equipment in cell 2-28 on the upper floor of the healthcare centre.**

The Prison Service partially accepted this recommendation and said:

"HMP/YOI Doncaster would not wish to rely on a person observing a TV on UHCC. However, we would undertake a continuous observation if someone was considered to be at a high risk. Where this occurs, there would be staff member outside the cell. As an additional resource, this might be useful. However, we would not wish it to detract from one to one interaction and observation with the patient/prisoner."

4. **Review local suicide prevention policy to ensure that prisoners considered to present a risk of suicide or self-harm attend their own case reviews as a norm unless there are exceptional reasons for not doing so. Any such reasons should be fully documented.**

The Prison Service accepted this recommendation and said,

"The current ACCT process ensures that prisoners are present at their own case reviews. If this is not possible, a record of this would be made in the appropriate documents. This process is overseen by the dedicated Suicide Prevention Co-ordinator."

5. **Issue clear guidance as to what criteria should be used in judging whether an at risk prisoner should be placed on a constant watch.**

The Prison Service accepted this recommendation and said:

"Clear guidance is given in Director's Rule 18.1, within the ACCT paperwork and via suicide prevention training."

6. **Take urgent steps to provide appropriate facilities and resources that allow specialists to see patients in conditions of both safety and appropriate privacy.**

The Prison Service accepted this recommendation and said:

"An interview room is available on UHCC and on the middle healthcare location."

7. **Develop a policy for communication with, and involvement of, prisoners' next of kin, using evidence based best practice.**

The Prison Service accepted this recommendation and said:

"The revised Prison Service Order 2700 lays greater emphasis on the involvement of families in the ACCT process. This will be published in Spring 2007. The Suicide Prevention Co-ordinator intends to lead a discussion around communication with next of kin and a local policy will be devised."

8. **The healthcare provider and Director should review the learning identified in the clinical review and develop an action plan to address the points raised.**

The Prison Service accepted this recommendation and said:

"Immediate actions were taken following the death of this man, i.e. change of doors."

The recommendations made in the clinical review are:

1. **Although no criticism is inferred in this case, the importance of vigilance during reception screening needs to be emphasised ensuring the process does not become mechanistic. This needs to be communicated to staff and staff training for reception screening reviewed.**

The Prison Service accepted this recommendation and said:

"The reception process has been reviewed and changed in line with Prison Service guidelines for first night reception screening. HMP/YOI Doncaster have also developed their own secondary screening process and staff have undertaken training."

2. **The processes which ensure effective communication between Prison Custody Officers and Nursing staff in the Healthcare Centre working on the Upper Health Care need to be reviewed. Effective liaison needs to be ensured so that staff feel adequately supported. It would be preferable that one common record is used between Prison Custody Officers and Nursing Staff ensuring continuity and a shared understanding of the patient's care and progress.**

The Prison Service accepted this recommendation and said:

"The Healthcare Manager is currently in discussion with PCT with a view to developing integrated notes into which the officers and other identified persons may contribute. A dedicated nurse is also identified on a daily basis and alongside the Healthcare Manager and Senior Nurse/s would be the link between Officers and nurses. Officers also attend case reviews for ACCT on a regular basis and provide a valuable contribution."

3. **Where patients are thought to have significant mental health problems, referral to NHS Mental Health services should be routinely considered and any discussion and decision documented. Referral process should be reviewed and any changes cascaded ensuring staff fully understand when this should be considered and the mechanism to do so. Problems encountered in terms of referral and/or appropriateness of services available should be raised with the commissioning PCT.**

The Prison Service accepted this recommendation and said:

"Referrals are made to a contracted Forensic Consultant Psychiatrist. Following assessment if referrals are required to NHS Mental Health Services they would be initiated at this point. There is also a referral process in place for secondary mental health issues via the mental health in-reach team."

4. **Care planning needs to be reviewed emphasising the importance of a holistic approach, strengthening the review process clearly providing a rationale for action. It should demonstrate the therapeutic role of care/intervention rather than a purely monitoring function as is supported by the Nursing and Midwifery Council Guidelines for Record Keeping (2005).**

The Prison Service accepted this recommendation and said:

"Currently all healthcare patients are subject to an individual care planning process. The implementation of integrated notes will enhance this process."

5. **Accurate record keeping is essential. The prison should ensure that all prisoner/patient records meet established record keeping guidelines (Nursing and Midwifery Council Council (2005), Guidelines for Record Keeping, Department of Health, 2006, NHS Code of Practice Records Management). Each entry should be signed and authors should print their name to facilitate identification. The prison should consider routinely undertaking a record-keeping audit to ensure record keeping standards are maintained.**

The Prison Service accepted this recommendation and said:

"A record keeping audit has been undertaken and this will advise for future training issues. This will be undertaken bi-annually. Ongoing individual refresher training is being undertaken."

6. **The process for deciding the level of watch for patients at risk of self harm needs to be reviewed and any changes clearly cascaded and understood by all staff. The mechanism needs to be transparent and documented.**

The Prison Service accepted this recommendation and said:

"Director's Rule 18.1 clearly states how to document and cascade information in line with ACCT procedures."

7. **The HRAT team needs to ensure the active involvement of the patient in review. This may include attendance by the patient, or patient's advocate. The role, purpose and outcome of the review needs to be communicated to patients so that they understand this.**

This Prison Service accepted this recommendation and said:

"The ACCT process is multi-disciplined and the patient is invited to the review if he is deemed fit to do so."

8. **As a matter of urgency the 'safer custody cell' needs to be reviewed:**
    - **Potential ligature points identified and removed/minimised.**
    - **Perspex cover needs to be replaced with clear rather than tinted Perspex, this needs to be assessed and renewed as necessary when significantly scratched/damaged.**
    - **In order to ensure effective observation it is recommended a closed circuit TV camera should be considered, securely positioned in the cell ensuring continuous monitoring. It should be emphasised to staff the need for actual physical monitoring and this should include interaction with the patient when appropriate to determine mood, behaviour and response to treatment.**

The Prison Service accepted the first two of these three recommendations and partly accepted the third. The Service's response the first two recommendations was as follows:

"The cells were reviewed and urgent attention was paid to the revision of cells."

The Service's response to the third recommendation was the same as for recommendation three above.

9. **Following significant events such as this it is recommended that the prison consider facilitating Significant Event Analysis for staff, in an open, blame free environment they can discuss underlying issues, tease out learning points both positive and negative and support each other. This should be in addition to any routine debriefing following such an event.**

The Prison Service accepted this recommendation and said:

"A process for significant event analysis is now being undertaken in conjunction with our PCT colleagues. Routine de-briefing is undertaken as a matter of course following any significant event and there is also a process for referral and support by the staff care team.