Investigation into the death of a man whilst in the custody of HMP & YOI Doncaster in February 2010

Report by the Prisons and Probation Ombudsman for England and Wales

September 2011

This is the report of an investigation into the circumstances surrounding the death of the man at HMP & YOI Doncaster in February 2010. The man was an Iranian national on remand for the murder of his ex-girlfriend. He had been in the prison for just six days when he was found hanging in his cell. I would like to offer my condolences to his family and friends.

The man's death was investigated by one of my senior investigators and my senior family liaison officer contacted the man's cousin and offered him the opportunity to tell us about any questions or concerns he had about his cousin's death. At a late stage my family liaison officer was also contacted by solicitors representing the man's mother. A copy of the draft report was sent to both. I received final comments from the family on 22 September 2011.

A clinical review was commissioned by a clinical reviewer at HMP Durham and HMP Frankland. Because Doncaster is a privately run prison I have no formal agreement with the PCT to provide a clinical review and rely on the Department of Health to assist me to identify a suitable reviewer. Unfortunately, the clinical reviewer was not appointed until some six weeks after the man's death. I did not receive his final report until 9 December 2010. I offer my sincere apologies to the man's family and to all interested parties for the long delay in issuing this report.

I am grateful to the Director and staff of HMP Doncaster for their co-operation with this investigation. I would also like to thank the senior investigations officer for Serco, for sharing his findings with my investigator.

This investigation raises concerns about the reception procedures at Doncaster and the ability of staff to appropriately identify prisoners at risk. I am alarmed that staff do not refer prisoners for mental health assessments when prompted by the reception screening tool, particularly as we made a recommendation on this issue in a previous investigation. In a report into a subsequent apparently self-inflicted death at Doncaster I raise a concern that a risk identified at reception was not passed on to other staff at the prison.

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

Nigel Newcomen
Prisons and Probation Ombudsman **September 2011**

CONTENTS

SUMMARY

The man was charged with the murder of his ex-girlfriend on 3 February 2010. He appeared at Rotherham Magistrates Court on the same day and was remanded into custody at HMP Doncaster. He had not been in prison before.

The police informed G4S court custody staff that the man was at risk of suicide/self harm. The police wrote in the risk indicator table on his Person Escort Form (PER) that he had attempted to take his own life in December 2009. The G4S court custody records show that a suicide/self harm warning form (SSHWF) was opened.

When the man arrived at HMP Doncaster the SSHWF was not in his PER. The receiving officer did not notice the entry in the risk indicator column. He was the only person to look at the man's PER.

The nurse who completed the man's first reception health screen was aware that prisoners charged with the homicide of a partner or family member are considered to be at exceptionally high risk of suicide/self harm. Nevertheless she did not refer the man to the mental health team when prompted to do so by the health screen form.

The man presented as quiet and polite to staff and prisoners. He seems to have mixed well with a small group of prisoners and, for the most part, did not appear to be under stress. He had two family visits on 4 and 9 February. Following the visit on 9 February, he appeared very stressed and told his cellmate that he wanted to kill himself. His cellmate tried to reassure him and thought that he had calmed him down. The man's cellmate did not tell anyone what the man had said.

The cellmate returned to his cell at the end of afternoon association and found the man hanging from the bunk bed. He raised the alarm and three prisoners and a member of staff cut the ligature. Two prisoners began Cardio Pulmonary Resuscitation (CPR) and were relieved by nursing staff after a minute. The man was pronounced dead by paramedics after 20 minutes.

I am critical of the risk assessment and reception process at Doncaster and of the actions of two members of staff. I also note the prompt response of staff and prisoners, their wholehearted attempt to save the man's life and the excellent care offered to staff and prisoners in the aftermath of his death.

I make seven recommendations including one to formally recognise the efforts made by the four prisoners involved in the attempt to save the man's life.

THE INVESTIGATION PROCESS

1. I was notified of the man's death. The case was allocated to my investigator on 11 February. My Assistant Ombudsman visited HMP Doncaster on 15 February. He met with the Head of Internal Affairs, collected the relevant documents, visited the wing where the man died and spoke informally to the prisoner who was second on the scene. He also spoke to the Ministry of Justice Controller.

2. Notices of investigation were issued and put up around the prison, inviting staff and prisoners who wished to contribute to contact the investigator. No responses were received.

3. My investigator visited Doncaster three times during February and March 2010 and interviewed eight staff and five prisoners. She also met the Ministry of Justice Controller, the Deputy Controller, and the Senior Investigations Officer for Serco. My investigator visited Rotherham Magistrates Court in April 2010 and interviewed three members of the custody staff and copied relevant documents. She also spoke by telephone to the G4S Custody Manager for court custody suites in South Yorkshire. My investigator viewed Closed Circuit TV (CCTV) footage from Houseblock 3 recorded on 9 February 2010. Regular feed back on the progress of the investigation was provided to the Head of Internal Affairs.

4. The clinical reviewer wrote a clinical review of the medical care received by the man in Doncaster. The clinical reviewer was commissioned by the Department of Health and agreed to undertake the review on 25 March 2010. I received his final report on 9 December and it appears at Annex 1.

5. My senior Family Liaison Officer, spoke to the man’s cousin by telephone. She asked him for any questions and concerns he had about his cousin’s time in Doncaster. He was concerned that the man had been isolated in Doncaster and had not had visits or access to monies that he had on him when he was arrested. He thought that the man should have had a mental health assessment because he had previously attempted to take his own life. He was concerned that there was sufficient television cable in the man’s cell to allow him to hang himself in the way that he did. He added that Doncaster had offered financial and practical assistance with the repatriation of his cousin’s body to Iran which had been helpful.

The man

6. The man was born in Iran and moved to the United Kingdom in 2005. He lived in Rotherham and, together with a business partner, ran a pizza and kebab shop. Apart from one cousin, all of the man's family live in Iran.

7. According to the police report, the man began a relationship with a woman in Rotherham and moved into her flat in 2008. The relationship ended in late 2009. The man found the break up difficult and, on 25 December 2009, he took an overdose of alcohol and tablets. He was taken to hospital and recovered.

HMP & YOI DONCASTER

8. HMP Doncaster is a purpose built prison holding remand and sentenced adult males and young offenders. It opened in 1994 and is privately managed under contract by Serco Home Affairs. It is a local prison serving the courts of South Yorkshire and has a maximum overcrowded capacity of 1,145 prisoners.

9. Every privately operated prison has a Controller appointed by the Ministry of Justice. The Controller is responsible for monitoring the contractor's compliance with the contract. The prison is required to follow the operational guidance contained in the Prison Service Orders (PSOs) and Prison Service Instructions (PSIs) that apply to public sector prisons. In addition, private prisons have their own set of procedural Director's Rules specific to each prison.

10. An unannounced inspection by Her Majesty's Inspector of Prisons (HMCIP) took place in the week beginning 8 November 2010. The prison was previously inspected in an unannounced follow-up inspection in February 2008. HMCIP found the arrangements to receive, settle and induct newly arriving prisoners operated well. At the time there was an average of 600 new prisoners per month. Reception was found to be well organised with staff taking steps to minimise delays during the busiest periods. HMCIP found the induction procedure to be thorough, with the appropriate involvement of specialist departments. At the time of writing the average number of new prisoners per month was 466.

11. The latest available annual report of the Doncaster Independent Monitoring Board (IMB – independent volunteers who monitor the day to day life in prisons) for 2008/2009 did not raise any concerns about issues that are relevant to this investigation.

12. There have been 14 deaths at Doncaster since the Ombudsman took responsibility for investigating deaths in custody in April 2004. Two of these were apparently self-inflicted. I draw some parallels between the man's first reception health screen process and that of a prisoner who died apparently by his own hand in 2006. There have been three apparently self-inflicted deaths since the man died, three natural cause deaths and from methadone toxicity. In the only report into these published at the time of writing I raise a concern that a risk identified in reception was not passed on to other staff.

KEY EVENTS

13. On 28 January 2010, the man's ex-girlfriend was found dead in her flat. He was arrested by police in Rotherham on 31 January. He was held in police custody until 3 February when he was charged with her murder. He appeared at Rotherham Magistrates Court the same day and was remanded into custody in Doncaster.

14. The custody suite and escort services at Rotherham MC are run by the private company G4S. Senior custody officer told my investigator that, at 7.10am on 3 February, he collected the PER forms and property of the prisoners who were due in court. He was briefed by the police that the man had been charged with murder and had an indicator on his PER that he was at risk of suicide or self harm. The G4S, senior custody officer said he passed this information to his colleagues at the morning briefing at 8.53am and made an entry on the daily briefing sheet highlighting the man as a risk.

15. The court occurrence book for 3 February shows that the man was collected from the police by a member of court custody staff at 9.20am. All prisoners transferring between police, court and prison custody have a person escort record (PER) form. The PER is in the form of a booklet. Page two lists any indications that the prisoner may be at risk. In the suicide/self harm column of the man's form the police wrote "Attempt overdose Dec 2009." At 9.26am custody staff opened a suicide/self-harm warning form (SSHWF). This is recorded in both the court occurrence book and part B of the PER form. The SSHWF is a separate document that should be placed inside the PER and travel with the prisoner wherever they go. It consists of a front page and two different coloured carbon copy sheets. Its existence should also be recorded on the front cover of the PER. The front cover of the man's PER and the SSHWF have not been found.

16. Court custody staff told my investigator that the man was allocated cell number seven because it was near to the custody office and therefore made it easier for staff to make regular checks on him. Part B of the PER shows that checks were made at 9.37am and 9.56am and that the man was called to court at 10.05am. He was remanded into custody pending trial at Sheffield Crown Court. He was returned to his cell at 10.11am and four more checks were made before escort staff took over his care at 11.04am.

17. The man arrived in reception at Doncaster at 12.19pm. Prisoner Custody Officer (PCO) was the receiving officer. The receiving officer is responsible for checking the prisoner's PER form for a SSHWF and indications of any risk and passing them on to the nurse who interviews the prisoner and completes the first reception health screen. At Doncaster, the receiving officer is the only person who reads the prisoner's PER before it is placed in his custodial documents file. The receiving officer is also responsible for completing the first and second

parts of the Cell Sharing Risk Assessment (CSRA) form (those that deal with indications of violent and anti-social behaviour, drug use and whether the prisoner has a SSHWF).

18. The receiving told my investigator at interview that he did not notice the suicide/self harm risk indicator on the man's PER. He said that he had forgotten his reading glasses that day. He said there was no SSHWF in the PER. He added that it is his usual practice to ask the escort staff whether there is anyone who is deemed to be a risk and the G4S escort officer usually tells him anyway. The escort officer did not tell him either that the man had a SSHWF or that he had an indication to that effect on his PER.

19. The receiving officer explained that his first concern when looking at a PER is to check the page that lists the property and valuables belonging to each prisoner. Once it has been confirmed that the PER tallies with the property that has arrived in the van, the prisoner can be brought into reception. He said he remembered the man because he had a significant amount of money. He recalled that he was polite, confident and made good eye contact with him throughout the reception process.

20. The receiving officer said that, at the time, it was the practice at Doncaster that the third part of the CSRA (the medical assessment) was completed first by the nurse during the first reception health screen. He thought he might have put the man's name, date of birth, reception date and offence on the CSRA before he passed it to the nurse but he did not complete sections one and two. He completed the rest of the CSRA later before the man transferred to the first night centre.

21. The nurse who completed the man's first reception health screen. All prisoners have their health screen interview in a separate room with the nurse and, usually, a health care assistant (HCA). The nurse goes though the screening process and enters the information onto the prisoner's electronic medical record and the HCA completes the paper first reception health screen. The only paperwork that the nurse sees is the part-completed CSRA and a SSHWF (if there is one). At interview the nurse said she remembered the man. She said he was polite, spoke good English and appeared fit and healthy. Nothing in his demeanour gave her any cause for concern.

22. The nurse said she was aware of the nature of the charge against the man. She said that when she asked him what his offence was, he had replied, "they say allegedly I killed my ex-girlfriend". At the end of the first section of page two of the health screen it says in bold type, "if charged with murder or manslaughter, refer for mental health assessment". At interview the nurse said she had not referred the man for an assessment. She said she had either forgotten to refer him or had gone though a conscious process and decided he did not merit a

referral. When asked in the section on mental health whether he had tried to harm himself in the past, the man replied that he had not. Question 11 asks the nurse to record their impression of the prisoner's behaviour and mental state. The nurse did not complete this section.

23. The nurse also completed the second reception health screen. At interview she said that ideally this form should be completed at a later date and within the first 72 hours of custody. She thought for practical reasons it was completed in reception at Doncaster. Finally the nurse completed section three of the CSRA. She ticked the form to indicate that the man was suitable for sharing a cell and that no concerns had been raised about self harm. She wrote on the form "Nil issues" and "NOC" (nature of charge).

24. The man returned to the main part of reception. The receiving officer completed sections one and two of the CSRA. He ticked to indicate that he had received the man's PER and warrant. He wrote in the additional important information section that the man was charged with murder. He ticked 'no' in answer to the question of whether the man had an open 2052SH (a form no longer in use indicating a prisoner is subject to self harm monitoring) and gave the source of this information as 'I' (for inmate). The receiving officer completed the man's personal summary sheet. The man told him that his next of kin was a friend who lived in Doncaster.

25. Once the reception process was complete, the man was taken to the first night centre on Houseblock 3. A Senior Prisoner Custody Officer (SPCO) took him through the induction process. The purpose of the induction process is to introduce the prisoner to the wing regime and facilities and establish whether they have any issues from their lives outside prison such as housing and employment. The induction officer will confirm whether the prisoner is suitable to share a cell.

26. The induction officer told my investigator that he remembered the man as respectful, well educated and able to speak good English. The induction officer said that he had sight of the man's CSRA but not his PER or warrant as these were in his custodial documents file held in the discipline office (administration centre of the prison). He knew that the man was charged with murder but was not aware who the victim was. He was unaware that people charged with domestic murder are statistically at higher risk of harming themselves. Based on the CSRA completed in reception, the induction officer confirmed that the man could share a cell. The man was allocated cell 3D-48 (Houseblock 3, D wing, cell number 48 – on the upstairs landing).

27. The induction officer said that the man had appeared fine when he spoke to him. He had shown a little concern about how his business partner would cope without him but the he said he had no concerns about the man after speaking to him.

28. The following day, on 4 February, the man received a visit from his cousin and his friend. Later that afternoon he was taken to reception by the induction officer to witness two officers from Doncaster CID remove money and a set of keys that he had in his possession when he was arrested on 31 January. The induction officer said he asked the man how he was getting on and he replied that he had slept well. He said the man was obviously not overjoyed to find himself in prison but had been quite sociable.

29. On 5 February, the man attended Sheffield Crown Court. The accompanying PER showed no indications of risk. The man returned to Doncaster the same day. There are no entries on his record between the court appearance and 8 February.

30. The second prisoner on the scene, who worked as a wing painter on Houseblock 3, told my investigator that he first spoke to the man on the night he arrived. He said the man appeared to be fine and he also saw him the next morning at breakfast. The man usually sat with him and his friends at mealtimes. He recalled that in his first few days on the Houseblock, the man said on several occasions that the police did not have a case and he was innocent of the charge against him. After about three days, the man appeared to withdraw more. He said he tried to encourage the man to tell him why he was quieter but he did not respond.

31. Two other prisoners said they spoke to the man at mealtimes. Both described him as quiet and polite. The first prisoner said that everyone was aware of the nature of the charge against the man but that he had not come under pressure from other prisoners. The second prisoner said that the man had not shown any outward signs of stress about his situation.

32. On 8 February, the man was referred to the Immigration and Nationality Department (IND) Criminal Casework Team in the Home Office. All foreign national prisoners are automatically referred to IND for consideration for deportation. On the same day the foreign national prisoner representative, spoke to the man and completed an internal foreign national referral form. The man said that all of his family lived in Iran. He also completed an international call form in order to telephone his mother in Tehran. The foreign national prisoner's representative told my investigator that the man had seemed relaxed when he spoke with him.

33. On the same day a prisoner arrived at Doncaster and became the man's cell mate. The man's cellmate told my investigator that the man had seemed calm when he first talked to him in their cell. However, after talking about the charge against him, the man became stressed. The man's cellmate said the man kept repeating that he had not killed his ex-girlfriend. The man said he tried to reassure the man that if he

was innocent he would not stay in prison. He said the man kept repeating, “I can’t be here now, I don’t want to be here.”

34. The next day the man received a telephone card that would enable him to call his mother in Iran. He also received a visit from his cousin at about 9.30am. The man’s cellmate said that the man was “very stressed” after this visit. He said he thought that the man had received some bad news about what evidence the police might have against him. The man’s cellmate said that the man had told him that he was going to kill himself. The cellmate said he tried to reassure the man. He told him that suicide was against their religion (they were both Muslims) and he should keep praying. The cellmate said the man talked about his family in Iran. He said they did not know he was in prison and other family members had told them that he was away. The man said that if he killed himself then at least they could tell his family that he was dead.

35. The man’s cellmate said the man appeared to calm down after he talked to him and they even laughed about something. A third prisoner said in a statement that the man had sat next to him at lunch. He said that that the man had seemed happy. He spoke to his cellmate in a different language. When he had finished eating he smiled at the third prisoner and then went back to his cell. At about 2.10pm, the man’s cellmate said their cell was unlocked for afternoon association and he went for a shower. When he returned to the cell he could see that the door was locked so he went down to the main association area. He did not see the man there as he expected but did not think anything of it.

36. The man’s cellmate said that, towards the end of the association period, he saw an officer unlocking the cell doors and returned to his cell. He pushed the door open and saw the man hanging from the end of the bunk beds. The man’s cellmate said he shouted for help and three prisoners ran past him into his cell.

37. The first PCO on the scene was on duty on Houseblock 3 and had unlocked the man’s cell at about 3.20pm. He did not look into any of the cells but unlocked the doors and moved on to the next one. Once he had unlocked the cells on the upstairs landing he returned to the lower level. He heard the man’s cellmate raise the alarm and ran back upstairs followed by a second PCO. On the way to the cell, the second PCO used her radio to call for assistance. The radio operator’s monitoring log shows that the call was made at 3.23pm.

38. The first prisoner on the scene told my investigator that he was in his cell on Houseblock 3 when he heard the man’s cellmate shout that the man was hanging. He ran to the cell and arrived a step ahead of the second prisoner on the scene. The first prisoner on the scene said he thought that the man was dead. He was blue in colour and cold to the touch. His eyes were white and he had congealed blood and saliva hanging from his mouth. He noticed that the ligature was a television

cable that had been tied in such a way that the plug prevented the cable from slipping from the frame of the bed. The first prisoner on the scene said he and the second prisoner on the scene held the man up. There was a lot of shouting and several people in the cell. A third prisoner on the scene tried to undo the cable but it was too tight so he shouted for the first PCO on the scene to cut it and the man landed in his arms. The man was lowered to the floor and then a fifth prisoner on the scene arrived and pulled the man out on to the landing where there was more space.

39. The second prisoner on the scene told my investigator that he too was in his cell on Houseblock 3 when he heard the man's cellmate shout, "he's hanging". He said he immediately ran to the cellmate's cell, arriving just after the first prisoner on the scene who went into the cell first. The second prisoner on the scene saw the man was hanging from the frame of the bunk beds with his knees touching the floor. The man had used the cable from his television to hang himself. He had also tied his hands together across his chest. The second prisoner on the scene said that his first impression was that the man was dead. He touched his neck and could not feel a pulse. He and the first prisoner on the scene lifted the man up and a fourth prisoner on the scene tried to undo he television cable but was unable to. The first PCO on the scene used his personal issue cut down tool to cut through the television cable.

40. When he arrived at the man's cell, the first PCO on the scene said he saw a group of prisoners holding him up. He saw that the man had the television cable around his neck which was attached to the frame of the bunk beds. He confirmed that he used his personal issue cut down tool to cut the cable in two places. The prisoners put the man on the floor and a fifth prisoner on the scene began giving him rescue breaths. The first PCO on the scene said that other staff had arrived and the SPCO, the unit manager, directed him to begin locking the other prisoners in their cells.

41. The fifth prisoner on the scene said he was standing with the first prisoner on the scene and the third prisoner on the scene when he saw the man's cellmate go to his cell. He did not hear what the man's cellmate shouted and assumed it was a fight. The first prisoner on the scene and the third prisoner on the scene ran to the cell but he "stayed put". The fifth prisoner on the scene said he then heard someone shout, "he's hanging" and immediately ran over to the cell. He saw the first prisoner on the scene, the second prisoner on the scene and the first PCO on the scene laying the man on the floor. The fifth prisoner on the scene said he had been in the army and knew how to administer Cardio Pulmonary Resuscitation (CPR). He had also recently attended a CPR course at HMP Everthorpe.

42. The fifth prisoner on the scene said that he shouted to everyone present to move out of the way and pulled the man out on to the landing where there was more space. He checked the man's mouth for obstructions. The man was not breathing so he tipped his head back and began rescue breaths. The first prisoner on the scene began chest compressions. They worked at the rate of 30 compressions to two breaths. The fifth prisoner on the scene said the man was grey in colour and cold. He had blood and mucus coming from his mouth and a severe indentation around his neck. The fifth prisoner on the scene said he thought there was a faint sign that the man was breathing for himself but it was not strong so he continued rescue breaths. He was then told to move away and nursing staff moved the man into the recovery position.

43. The unit manager told my investigator that he heard a medical emergency called over the radio at the end of afternoon association. He said that no code was given (Doncaster operates an emergency code system - code blue means a person is not breathing, code red means there is a blood injury). When he arrived at the man's cell he realised the nature of the emergency and used his radio to call for the orderly officer (the officer responsible for the day to day running of the prison) and for an ambulance. The radio operators' monitoring log shows that this call was made at 3.25pm. The unit manager then directed staff to begin locking the prisoners in their cells.

44. The first nurse on the scene said she was in the nurse's room on Houseblock 3 with the second nurse on the scene when they heard a call for emergency response on "3D" (D wing on Houseblock 3). Neither of them heard an emergency code called so they were unaware of the nature of the incident. The first nurse on the scene said that, although neither of them was designated as an emergency response nurse that day, they went to D wing anyway. They arrived at the man's cell at the same time as the unit manager and the induction officer. She said she saw a group of prisoners performing CPR.

45. The first nurse on the scene said that the man appeared to be breathing and she thought she felt a faint pulse in his neck. She, the second nurse on the scene and the SPCO put the man in the recovery position. The SPCO felt the man's wrist for a pulse and said it was getting fainter so they put him back on his back and she inserted a geudel airway (a medical device that prevents an unconscious patient's tongue from blocking their windpipe).

46. The SPCO began rescue breaths and the first nurse on the scene did chest compressions. The second nurse on the scene used her radio to call for a defibrillator. The incident log records this call was made at 3.25pm. She let the fifth prisoner on the scene into the shower area so that he could wash blood from his mouth. The defibrillator arrived very quickly and she attached it to the man's chest. It advised not to shock (a sign that there is no electrical activity in the heart) and so they

continued CPR. The second nurse on the scene said she thought that the man was already dead as he had changed colour and was cold to the touch. The second nurse on the scene noticed that the man's hands were tied with a shoelace and his legs were also bound below the knee with an article of clothing. He had deep ligature marks around his neck.

47. Three other nurses went to Houseblock 3 after hearing a call on the radio for a defibrillator to be brought there. A sixth nurse collected the defibrillator from the adjacent Houseblock. The third nurse on the scene and fourth nurse on the scene relieved the SPCO and the first nurse on the scene. CPR continued until the prison medical officer, arrived. He checked the man for signs of life and then told nurses to continue CPR.

48. The incident log records that the ambulance arrived at the prison gate at 3.30pm. At 3.35pm paramedics were directed from healthcare to Houseblock 3. The paramedics took over CPR from staff. The prison medical officer assisted them by giving the man adrenalin. At 3.50pm the paramedics stopped CPR and the prison medical officer pronounced the man dead.

49. A hot debrief was held in the prison at 5.40pm the same afternoon. (A hot debrief takes place straight after an emergency. It allows staff to discuss the effect the incident has had on them and to identify any immediate lessons which need to be learnt.) The Director led it and the first nurse on the scene, the SPCO on the scene, the first PCO on the scene and the second PCO attended.

50. The assistant director, the reverend, the prison chaplain, the prison Imam, and a police officer went to the man's friend's address in Doncaster at 7.15pm to break the news of the man's death. Unfortunately the friend was not at home. The police subsequently contacted him at 9.40pm. They also contacted the man's cousin the same evening.

51. A Critical Incident Debrief was held the following day on 10 February. (This is a meeting held in the days after a serious incident to review procedures and also to offer support to staff.) A trained counsellor was present to offer support. The assistant director sent a hand written letter of condolence to the man's friend. The five prisoners who attempted to resuscitate the man were taken to the prison chapel for their own debrief with the chaplain.

CCTV footage

52. The clock on the CCTV footage viewed by my investigator did not show the correct time compared to the prison incident logs (the clock on the CCTV being some ten minutes fast). I am satisfied that the timings of the incident logs are correct. The incident logs and the statements from staff and prisoners are borne out by the CCTV pictures. The following is a summary of events on Houseblock 3 D wing on the afternoon of 9 February. The timings are taken from the CCTV tape.

53. The first PCO on the scene is seen unlocking the cells on the upper landing for the afternoon association period. The man and the man's cellmate come out of their cell. The man walks around the landing and then goes down to the lower level. The man's cellmate talks to the PCO and appears to show him some paperwork. The man's cellmate returns to the cell and comes out with a towel. He then disappears from view. The man comes back up the stairs and goes into the cell. A minute later he comes out of the cell and walks along the landing looking around before going back inside. A couple of minutes later he is seen in the cell doorway. He looks down to the lower level and walks around the upper landing looking around. There is no one else in the picture. He goes back in but comes out almost immediately looks around again and then goes back in at 2.28pm.

54. Two minutes later a PCO and a prisoner are seen walking along the landing. Eighteen minutes after that, another PCO comes up the stairs following a prisoner and lets him in to the cell three doors down from the man. A further 43 minutes later, at 3.30pm, the first PCO on the scene unlocks the cells on the upper landing. He does not look into any of the cells.

55. Three minutes after the cell has been unlocked and an hour and five minutes after the man has last been seen, the man's cellmate returns to the cell at 3.33pm. The man's cellmate goes into the cell and comes out immediately, waving to attract attention. Prisoners run from the other side of the landing and into the cell followed by the first PCO on the scene. The pictures show the man being brought out onto the landing within a minute and CPR being started. The unit manager arrives within a minute of the alarm being raised. The first and second nurses on the scene arrive within two minutes of the man coming out of the cell.

56. It is then difficult to distinguish exactly what happens but emergency bags arrive within two minutes of the first and second nurses on the scene. The paramedics arrive 11 minutes after the man's cellmate raised the alarm.

ISSUES CONSIDERED

The assessment of the man's risk

The suicide/self harm warning form

57. On the morning of 3 February, the police briefed the G4S senior custody officer at Rotherham Magistrates Court that the man was charged with murder and they had written on his PER form that he was at risk of suicide/self harm. The court occurrence book (an electronic record) and part B of the PER form record that a suicide self harm warning form (SSHWF) was opened at the court. SSHWFs should be placed in the relevant PER with the prisoner's other documents in trays in the court custody office. Escort staff collect the paperwork and put it in the van. They pass the pink and yellow carbon copies of the SSHWF to reception staff at the receiving prison and retain the original white copy. The white copy is bundled together with copies of all the paperwork that has travelled with that van and sent to the G4S archive. Neither my investigator nor the Serco investigator, have been able to find any part of this form. The G4S custody manager in South Yorkshire told my investigator that the white copy was not in the G4S archive.

58. I do not know what happened to the missing SSHWF. It does not appear to have arrived at Doncaster. The front cover of the PER has a box for escort contract staff to indicate whether there is a SSHWF inside the PER. My investigator was told that staff in reception in Doncaster could not find this cover. Inside the PER there is a section listing other the forms enclosed. None of the entries are marked in the man's PER, including that for a SSHWF. The receiving officer said there was no SSHWF in the PER when it arrived at Doncaster. I have seen no evidence that the SSHWF left the court with the escort staff.

59. The absence of the SSHWF was the first step in a chain of events that meant that the man's risk of suicide/self harm was not adequately appreciated until he was found hanging in his cell. The chain of custody in communicating risk between the police, the court custody and escort service and prison is crucial. If one link in the chain is broken it can greatly undermine the ability of those further up the line to exercise their duty of care.

60. In terms of an audit trail I am greatly concerned that no one in G4S can show me physical evidence that such an important form ever existed.

I recommend that G4S instruct their custody suite staff to make a copy of all suicide/self harm warning forms opened by their staff and keep the copy in a file in each custody suite.

Initial reception and the first reception health screen

61. The receiving officer told my investigator that, when he looks at a prisoner's PER, he always looks for the pink slip of a SSHWF because they are immediately obvious. He also said that it is his practice to ask the escort staff whether anyone is at risk that he needs to be aware of. He said that escort staff are usually proactive about warning him of such prisoners. The escort staff did not mention the man to him on 3 February.

62. Nevertheless, it is the responsibility of the receiving officer to check the prisoner's PER form. By his own admission, the receiving officer did not notice the entry on the risk indicator page of the man's PER where the police had marked in the suicide/self harm box, "attempt overdose Dec 2009". He told my investigator that he had left his reading glasses at home that day. He also told my investigator that it is his practice to turn immediately to the page listing the prisoner's property and cash because his first task is to make sure that the entries on the PER correspond with what has arrived at the prison.

63. Unfortunately the information on the PER was perhaps the most important information of all - the fact that the man had attempted to kill himself in December 2009, just a few weeks before his remand. The single biggest indicator that a person will attempt to kill themselves is if they have tried to do it before. This omission was the second step in the chain of events that meant that the man's risk of suicide was not recognised.

64. Because there was no SSHWF and because the receiving officer did not notice the risk indicator on the PER, the nurse who completed the first reception screen was not immediately prompted that the man might be at risk of suicide/self harm. However, during the course of the first reception health screen the man told her that he had been charged with murdering his ex-girlfriend. The nurse told my investigator that she was aware that persons charged with domestic homicide are statistically at high risk of suicide/self harm. She said however that nothing in his presentation indicated that he was at risk if suicide/self harm and she did not take any further steps to assess the risk.

65. The nurse who completed the first reception screen did not refer the man for a mental health assessment when prompted to by the first reception health screen. At interview she told my investigator that she either forgot or that she had decided from the man's presentation that he did not need to be referred. Neither did she record her impression of the man's mental state at question 11 on the first reception health screen. In the clinical review, the clinical reviewer says:

> "It is most unfortunate that an entry was not made here as the failure to refer for formal mental health assessment could only really be justified if a clear description of the current mental state was given and it was not."

66. Prison Service Order 2700 Suicide Prevention and Self Harm Management chapter four paragraph 10 parts one and two say:

> "Prisoners charged with homicide are a particularly high risk group, and within this prisoners charged with homicide against a partner or family member are at an exceptionally high risk of suicide. *Reception/first night staff must be made aware of the suicide and self harm risks associated with prisoners who are charged with offences related to violence against a family member and/or homicide.* [italics in original] …
>
> "*Establishments must make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and/or domestic murder of a family member. Such provision must include ensuring a record is maintained to show what action has been undertaken* [italics in original]."

67. It is alarming that none of the discipline staff interviewed by my investigator – all of them based either in reception or on the first night centre and some of them very experienced - were aware that prisoners charged with the murder of a partner or relative presented a particularly high risk of suicide. The procedural failures in this case - the absence of the SSHWF and the receiving officer's failure to see the PER indicator – could have been mitigated had staff been aware of this fact. At the time there was no provision at Doncaster for the additional risk assessments referenced in PSO 2700.

68. I am also concerned that the nurse who completed the first reception screen, despite being aware of the heightened risk of someone charged with domestic murder, did not highlight this to staff on the first night centre. Even if she did not think that the man presented as being at risk of suicide /self harm, I consider that this is important information that should have been passed on. The nurse wrote 'NOC' (for nature of charge) in the issues section of the CSRA, but I do not consider this was sufficient, especially as she wrote above it "Nil issues".

69. Neither did the nurse who did the first reception screen refer the man for a mental health assessment when prompted by the first reception health screen. She told my investigator that she was not sure whether she had forgotten to do this or had gone through a conscious risk assessment and decided the man did not require a referral. Whichever is the case the prompt to refer a prisoner charged with murder for a mental health assessment is mandatory and does not give the nurse discretion.

70. In a previous death in custody at Doncaster in 2006 a different nurse also failed to refer the prisoner for a mandatory mental health assessment when prompted by the first reception health screen. In that case I made a recommendation in July 2009 that "The Director and

Head of Healthcare must ensure that all staff make the referral required by the first reception health screen." The recommendation was accepted. I am disappointed to discover that this omission has been repeated. I consider that mandatory prompts to refer prisoners for assessment if they fit known high risk categories (in the man's case because he was charged with domestic murder and in the 2006 case because the prisoner had previously attempted suicide) are an excellent idea. If there are gaps in knowledge about the nature of risk, these prompts act as a failsafe. If they are not followed however, the system fails.

71. There are other factors too that should have led to further consideration of the man's risk. Paragraph 6.16 of PSO 0500 Reception (in force at the time the man arrived in Doncaster but since replaced by PSI 52/2010) lists prisoners who may be more prone to suicide/self harm. The list includes: those in prison for the first time; those accused of particularly violent offences, especially those against a family member; and potential deportees. It was the man's first time in prison and he was a foreign national prisoner. This, like the nature of his offence, was information which was known to staff at Doncaster.

72. I accept that throughout the reception process, the man appeared calm and confident and gave no outward appearance of stress about finding himself in prison in a foreign country. However, the guidance in PSO 2700, PSO 0500 and the prompts on the first reception health screen are there for very good reason. In this case there was both a lack of awareness amongst staff about the nature of risk and a failure to follow procedures properly.

73. Immediately after the man's death, the Director amended Director's Rule 18.1 (the local suicide and self harm strategy) as follows:

> "14.9 PSO 2700 4.10 to 4.10.2 provides information on prisoners charged with violence against a family member or homicide. Establishments must make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and/or domestic murder/murder of a family member. Such provision must include ensuring a record is maintained to show what action has been undertaken. **Doncaster's policy is that all prisoners charged with domestic murder, extreme violence including that of a sexual nature against family members will be placed on an ACCT plan. All prisoners charged with murder who are also first time in prison will also have an ACCT** [the process used in prison to monitor prisoners thought to be at risk of harming themselves] **plan opened.** [emphasis in original]"

I am satisfied that the Director took prompt action in response to the man's death and I consider that the changes brought in via DR18.1 above tighten procedure at Doncaster. Nevertheless, I will send a copy of my report to the Controller of HMP Doncaster so that she can monitor the implementation of the Director's Rule. The following recommendations are intended to fill an apparent training need and to ensure that the reception process in general is working as it should.

I recommend that the Director provides reception staff and healthcare staff who complete first reception health screens with refresher training on the provisions of chapter four of PSO 2700.

I further recommend that the Director of Offender Management for Yorkshire and Humberside in consultation with the Ministry of Justice Controller satisfies himself that the reception process at Doncaster, including completion of the first reception health screen, complies with PSI 52/2010 and Director's Rule 18.1.

Completion of the man's CSRA

74. PSO 2750 Violence Reduction deals with the cell sharing risk assessment process. The purpose of the CSRA is to draw together information about the risk a prisoner might pose to his peers in a locked cell and to make the best use of documentary evidence. Paragraph 15 provides that, if available, the PER and warrant must be consulted when the CSRA is being completed.

75. According to the receiving officer, the practice in reception at Doncaster in February 2010 was that the receiving officer put the name and number of the prisoner, and sometimes also the offence, at the top of the CSRA before passing it to the nurse. This information was gathered from the PER and the warrant and then those documents were placed in the prisoner's custodial documents file. The nurse completed the third part of the CSRA (the medical assessment) during the first reception health screen. Reception staff completed the first and second parts of the CSRA when they had time. These sections deal with indications of violent and anti-social behaviour, drug use and whether the prisoner has a SSHWF. It is my understanding that the PER and the warrant are not looked at again once they have been placed in the custodial documents file and are therefore not used to complete any of the first three sections of the CSRA.

76. PSO 2750 does not prescribe in what order the CSRA should be completed. However, I consider that if they are routinely completed in the way described by the receiving officer, then the opportunity to use the PER and the warrant to help identify risk is being missed. This is contrary to the guidance in PSO 2750. Furthermore the nurse is potentially also starved of important information that would inform the first reception health screen. In the man's case another opportunity to notice the vital risk indicator on the PER was thereby missed.

I recommend that the Director of Doncaster issues a new Director's Rule to ensure that both the receiving officer and the nurse complete their part of the CSRA with reference to the PER and the warrant and any other available documents.

Other reception matters

77. Lastly I note that paragraph 10 of Director's Rule 17.1 (which covers the reception process at Doncaster) says:

> "All new prisoners received at HMP&YOI Doncaster will be immediately assessed by a qualified nurse and within a 24 hour period by a qualified medical practitioner."

I have seen no evidence that the man was seen by any member of healthcare staff other than by the nurse who completed the first reception screen.

78. My investigator raised this with the clinical reviewer but he was not unduly concerned by this because the man did not appear to have any reason to see a doctor. Nevertheless I draw it to the attention of the Director and the Head of Healthcare.

The prison's response to finding the man hanging

79. The response from both staff and prisoners was swift. The prisoners were proactive in putting the man on the floor and giving him CPR. The fifth prisoner had received CPR training in the Army and also while he was a prisoner at HMP Everthorpe. The first prisoner on the scene had also received training through working previously as a gym instructor. At interview the fifth prisoner on the scene described a textbook response to finding a person unconscious and administering first aid. The first and second PCOs were on the scene immediately. The first PCO on the scene used his cut down tool to cut the ligature and the second PCO on the scene used her radio to call for emergency assistance.

80. The first and second nurses on the scene arrived within two minutes of the man being found. They were not the designated emergency response nurses and carried no emergency equipment. Both had received recent refresher training in emergency aid. The emergency equipment arrived with the other nurses very soon afterwards. The SPCO on the scene is a qualified first aid instructor.

81. When the nurses and the SPCO arrived, the fifth prisoner on the scene told them he thought the man had started breathing faintly. Accordingly they did not immediately take over CPR but moved him into the recovery position while they checked his breathing and pulse. When they were satisfied that the man was not breathing sufficiently

well they returned him to his back and started CPR. This is consistent with best practice. Paramedics were on the landing within ten minutes of the ambulance being called.

82. In the clinical review, the clinical reviewer concludes that the emergency aid offered to the man was timely and in accordance with the latest Resuscitation Council guidelines. The necessary equipment was brought but he notes that a connection was found to be missing from the ventilation bag. He did not feel that this contributed to the man's death but it is clearly extremely important that emergency equipment is in full working order at all times.

I recommend that the Head of Healthcare review the procedures for checking emergency equipment to ensure they are satisfied that regular checks are made.

83. I am very impressed with the response of the prisoners in this case. They acted swiftly and provided a professional level of first aid. They also went back to their cells when asked to by staff. I note particularly that the fifth prisoner on the scene performed rescue breaths on the man without a mask and despite the presence of blood.

I recommend that the Director should formally commend the prisoners for their committed attempts to save the man's life.

84. The prison's death in custody contingency plan was followed. An incident log was kept at the scene and all appropriate agencies were contacted in a timely manner.

85. At interview none of the staff who heard the call for emergency assistance over the radio could recall hearing a code. They were therefore unaware of the nature of the emergency to which they were responding. A code system is in operation at Doncaster but does not appear to have been used in this case.

I recommend that the Director issues a notice to staff reminding them of the importance of using emergency codes when using their radios to ask for emergency assistance.

Support for staff and prisoners

86. All the staff interviewed by my investigator told her that they had felt very well supported in the aftermath of the man's death. There was a hot debrief on the same afternoon and a critical incident debrief the following day. All staff were offered a session with a trained counsellor and were visited by the staff care team. The counsellor proactively approached staff and asked them if they wanted to see the counsellor.

87. Immediately after the man's death all the prisoners involved in the attempt to save his life plus another prisoner and the man's cellmate

were taken to a separate room away from the wing and given hot drinks and cigarettes. Security staff took their statements and they were given a meal. They were all allowed to use the telephone in the room to call home. They were also spoken to by the staff care team. The next morning the same prisoners were taken to the Chapel to have their own critical incident debrief with the chaplain. The second officer on the scene told my investigator that he had also subsequently been visited by members of the mental health team and the staff care team. The first officer on the scene told my investigator that he had been, "brilliantly well looked after".

88. The man's cellmate said that he had been visited by the care team, the Imam, the chaplain and by healthcare staff. The prison doctor gave him some medication to help him cope with anxiety. He had been moved to another Houseblock and was obviously still struggling to come to terms with what had happened. Houseblock staff were aware that he was being interviewed by my investigator. Staff had opened suicide monitoring procedures on the man's cellmate following the man's death. He told my investigator that staff on his new Houseblock checked on him regularly.

89. Staff and prisoners were all looked after well. I am particularly impressed with the sensitive way in which the prisoners were treated.

Family liaison

90. The prison chaplain and the prison Imam travelled with the Assistant Director to inform the man's next of kin personally of his death. Unfortunately the man's friend was out and he was told by the police later the same evening. I am pleased that prison staff attempted to break the news of the man's death in person. The next day the imam left a message for the man's cousin and also contacted the Doncaster Coroner to help arrange a Muslim funeral at Doncaster Mosque.

91. The reverend subsequently spoke to the man's cousin and it was agreed that his body would be sent back to Iran for the funeral. The reverend and the imam kept in touch with him and the prison offered financial assistance. The man's cousin also visited the prison. He told my senior family liaison officer that the prison had been very helpful about arranging for the man's body to be flown to Iran.

92. On 10 February, the director wrote a handwritten letter of condolence to the man's cousin. The letter was sensitively written and offered the family appropriate assistance.

93. The man's cousin raised some concerns with my family liaison officer. He was concerned that the man had been isolated in Doncaster and had not had visits or access to money. Evidence from the five prisoners spoken to by my investigator shows that the man formed part of their group at mealtimes. There was another prisoner who spoke his

first language (he was transferred to another prison before my investigator could interview him) with whom the man appears to have got on well. The man also appears to have been able to talk freely to his cellmate who shares his faith. I am satisfied that he was not isolated or withdrawn in the short time that he spent in prison.

94. The man was in Doncaster for six days only. During that time his visits record shows that he received two visits – on 4 and 9 February. He arrived at Doncaster with a considerable amount of money in his possession. This was seized by the police the following day as evidence. When a remand prisoner arrives in a prison with no money, he is given an advance of his unemployed basic prison wage in order that he can make purchases at the prison canteen. The man's canteen record shows that he made several purchases from the canteen on 4 February and was not without money.

95. The man's cousin was concerned that the man should have had a mental health assessment because he had attempted suicide in December 2009. I have dealt with concerns about the man's risk assessment above. Clearly he should have been referred for a mental health assessment. He was also concerned that the man had access to sufficient television cable in his cell to be able to hang himself. It is my understanding that at the time my senior family liaison officer spoke to him, the information received from the police was that the man had used the cable as a ligature and also tied it around his arms and hands. In fact the cable was of standard length. From the accounts of the staff and prisoners present I believe that the man used a shoelace to bind his hands and an item of clothing to tie his legs. Because the man was not recognised as presenting a risk of suicide there were no extra restrictions on what he could have in his possession.

CONCLUSION

96. The man appears to have made a determined effort to kill himself when he knew he would be alone in his cell for sufficient time. The CCTV footage shows him looking around the wing a few times before returning to his cell for the last time. In all his dealings with staff and his peers, the man presented as a confident and calm person. The only person to whom he revealed that he was struggling to cope and considering suicide was his cellmate. The man's cellmate did not believe that the man was serious about taking his own life and did not tell anyone else. The man did not display any overt signs that he presented a risk of harming himself.

97. Nevertheless, there is compelling statistical evidence that people charged with the murder of a partner or family member are at increased risk of attempting suicide. The man was also a member of another particularly high risk group – those who have previously attempted to take their own lives. The latter fact was missed during the reception process at Doncaster and the former, though known, was not given the recognition that the guidance in PSO 2700 requires. There is no guarantee that the man's death would have been prevented had his potential risk been identified during the reception process or by the mental health referral that should have been made. However, the chances of staff being able to exercise their duty of care and keep him safe were seriously undermined as a result.

98. I am pleased to note the prompt response of staff and prisoners, their wholehearted attempt to save the man's life and the excellent care offered to staff and prisoners in the aftermath of the man's death.

RECOMMENDATIONS

For G4S

1. I recommend that G4S instruct their custody suite staff to make a copy of all suicide/self harm warning forms opened by their staff and keep the copy in a file in each custody suite.

Accepted: "G4S operating procedures have been amended to instruct staff to retain a copy of suicide self-harm warning forms opened by G4S staff in the custody suite."

Local and Area recommendations

2. I recommend that the Director provides reception staff and healthcare staff who complete first reception health screens with refresher training on the provisions of chapter four of PSO 2700.

Accepted: "Director's Rule 18.1 section 14 and the appendix to Director's Rule 18.1 Reception Local rules on page 5 paragraph g was amended immediately after the death of the man to read:

'Prisoners charged with domestic violence. Action PSO 2700 4.10 to 4.10.2 provides information on prisoners charge with violence against a family member or homicide. Doncaster's policy is that all prisoners charged with murder, extreme violence including that of a sexual nature against family members will be placed on an ACCT plan. All prisoners charged with murder who are also first time in prison will also have an ACCT plan opened.'

The introduction of PSI 09/2011 will also result in refresher training for reception staff and HCC staff."

3. I further recommend that the Director of Offender Management for Yorkshire and Humberside in consultation with the Ministry of Justice Controller satisfies himself that the reception process at Doncaster, including completion of the first reception health screen, complies with PSI 52/2010 and Director's Rule 18.1.

Accepted.

4. I recommend that the Director of Doncaster issues a new Director's Rule to ensure that both the receiving officer and the nurse complete their part of the CSRA with reference to the PER and the warrant and any other available documents.

Accepted.

5. I recommend that the Head of Healthcare review the procedures for checking emergency equipment to ensure they are satisfied that regular checks are made.

Accepted.

6. I recommend that the Director should formally commend the prisoners for their committed attempts to save the man's life.

Accepted: "All prisoners to be contacted in writing by the Director and commended on their actions."

7. I recommend that the Director issues a notice to staff reminding them of the importance of using emergency codes when using their radios to ask for emergency assistance.

Accepted: "Staff will be reminded via note on the daily morning meeting notes. The communication room will report any issues of wrong codes or no code called when staff request support to the Assistant Director Security. They will ensure the information is passed to the respective area and the member of staff made aware of the correct procedure."