PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at hospital in July 2011 while in the custody of HMP Doncaster

Report by the Prisons and Probation Ombudsman for England and Wales

August 2013

This is a report into the death of a man. He was found unconscious in his cell at HMP Doncaster on 5 July 2011, less than a week after arriving at the prison, apparently having choked on some toast. He was taken to hospital but never regained consciousness and died a few days later. He was 64 years old. The post-mortem report concluded that he died of bronchopneumonia and hypoxic brain injury as a result of choking. I offer my condolences to his family and friends.

A clinical reviewer completed a review of the man's clinical care. I apologise for the delay in issuing this report.

The man suffered from paranoid schizophrenia and had serious alcohol problems. He had spent some time on remand at Doncaster earlier in the year in February 2011, when he was moved from the substance intervention unit (SIU) to the healthcare inpatient unit after two days because of concern about his mental health. On 29 June 2011, he was remanded to Doncaster again although the judge, aware of his mental health problems, said she did not feel that prison was a suitable place for him. He was monitored under procedures designed to reduce the risk of suicide and self-harm after an alert from the police. He was allocated to the SIU and given medication for withdrawal from alcohol, although he had no withdrawal symptoms. He shared a cell with another vulnerable older man with mental health needs. He had an upper bunk which was inappropriate for a frail man of his age and poor health. Officers and healthcare staff had concerns about his mental health and suggested a move to the inpatient unit, but a mental health in-reach nurse, without assessing him, decided he would be most appropriately supported in the SIU.

During the short time he was at Doncaster, the man often indicated that he did not wish to live. On the morning he was found unconscious, he had earlier injured himself by apparently falling from the top bunk of his cell. There is a suggestion that this injury and his choking were attempts to harm himself, rather than accidents.

The investigation has identified a number of concerns about the man's care at Doncaster, including deficiencies in the operation of the suicide prevention and detoxification arrangements, and the need for appropriate allocation and support for prisoners with both mental health and substance use problems. It has not been possible to conclude whether his actions on the morning of 5 July were deliberate acts of self-harm. While Doncaster does not appear to have managed him well, this very sad case graphically illustrates the difficulties local prisons face in dealing with mentally ill men remanded to custody.

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 CBE
Prisons and Probation Ombudsman **August 2013**

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SUMMARY

1. Before his current period of custody, the man had been remanded to Doncaster on 23 February 2011. He had suffered from schizophrenia for over forty years, had a long history of threats to self-harm and was a heavy drinker. He received monthly injections of antipsychotic medication and was supported by a community mental health team. When he first arrived, he was observed in the substance intervention unit (SIU) for signs of alcohol withdrawal which he did not display. After two days, at the request of a mental health nurse, he moved to the prison's inpatient unit. He remained in the inpatient until his release on 24 March.

2. The man was remanded to Doncaster again on 29 June, 2011. A self-harm warning form was opened at court and suicide and self-harm monitoring procedures were started at the prison when he arrived. He was referred to the prison's mental health in-reach team and, because of his history of alcoholism he was prescribed medication to relieve the symptoms of alcohol withdrawal although he displayed no clear symptoms. The doctor decided that he should go to the SIU rather than the inpatient unit because the SIU had 24 hour nursing cover there. He shared a cell with another vulnerable older man with mental health problems and was given the upper bunk.

3. Officers on the unit were concerned about the man's behaviour and his mental health and believed his needs would be better met in the inpatient unit. Two days after his arrival, a mental health qualified nurse who worked on the SIU and had recommended he should move to the inpatient unit when he was at Doncaster earlier in the year, again suggested he should move. After consultation with the mental health in-reach manager, it was concluded that he should remain on the unit until his detoxification was completed. No one from the mental health in-reach team saw him to assess him before this decision was made and he did not have a mental health assessment during his time at the prison.

4. The man told officers he felt very low in mood. He often put his hands around his neck and indicated he was going to choke himself. His first ACCT review did not involve any healthcare staff and set inappropriate Caremap goals of completing detoxification and speaking to in-reach staff. There were no healthcare staff at the second review on 1 July either. Despite concerns on 1 July which led to the level of his ACCT observations being raised, his risk of suicide and self-harm was assessed as low. The entries in his ACCT document were of poor quality and not all the required observations were recorded. Although he continued to show no withdrawal symptoms, his alcohol detoxification medication continued.

5. On 5 July, at approximately 5.15am, his cell mate called for staff help as the man appeared to have fallen from the top bunk. He was treated for a cut to the side of his head. Later that morning he collected some toast for breakfast and returned to his bunk. His cell mate described him as "scoffing" his toast, and then realised something was wrong after he went quiet for a while. He called an officer who found him unconscious. This was at 8.38am. The

officer moved him from his bunk to the floor, radioed for medical help and began resuscitation after removing some toast from his mouth. The unit manager requested an ambulance at 8.42am.

6. A nurse arrived and helped with resuscitation, but it was difficult to establish an airway because of an apparent obstruction in the man's throat that staff could not see to remove. Paramedics arrived at 8.55am and after several attempts with specialist equipment, were able to dislodge a large piece of toast from his throat. He was still unconscious and was taken to hospital. After some initial delay, the prison found contact details through the police for his brother, who was able to visit him. During the next days he did not regain consciousness and he died in hospital several days later.

7. The investigation has identified a number of concerns about the man's care and management and we make twelve recommendations. He should have had an assessment by the mental health in-reach team and his treatment indicated a lack of coordination of services for those with both mental health and alcohol problems. We question the appropriateness of his treatment for alcohol detoxification. Suicide and self-harm prevention procedures were not well managed and implemented. Finally, attempts to contact his family were not carried out as soon as he became ill.

THE INVESTIGATION PROCESS

8. An investigator was appointed. A colleague attended HMP Doncaster on her behalf on 15 July 2011 and collected documents the man's records. He saw the man's cell and spoke to his cell mate. The investigator interviewed prison staff at Doncaster on 10 and 23 August and 21 and 28 September 2011. Notices about the investigation were posted in the prison asking staff and prisoners who had any relevant information to contact the investigator. No one came forward.

9. HM Coroner for the South Yorkshire East district was informed of the investigation. A copy of the investigation report will be sent to the Coroner. The investigator liaised with the investigating police officer, who provided copies of police statements from staff and prisoners. The Ambulance Service provided a copy of their incident report.

10. An independent clinical reviewer reviewed the medical care that the man received in custody. He received all the necessary documents relating to the man's medical care.

11. One of the Ombudsman's family liaison officers spoke to the man's brother on 3 August, 2011. He had not been aware that his brother was in prison until he was informed he had been taken to hospital. He asked specifically:

    - Why his brother was in prison as his brother had suffered from mental health problems for 30 years and should have been in a mental health institution?
    - How was his brother able to choke on toast?

12. The man's remand to prison custody is a matter for the courts and not one on which the PPO can comment. We hope the report helps to explain the circumstances which led to him choking. We very much regret that the issue of this report had been severely delayed due to a backlog of cases which we are striving to clear.

13. A copy of the draft report was sent to the National Offender Management Service (NOMS). They reported that there were no factual errors and accepted all of the recommendations. The responses to the recommendations are repeated verbatim in the relevant section.

14. The man's brother received a copy of the draft report as part of the consultation period. He agreed with the findings of the investigation and were particularly concerned about his health and medication and being allocated to a top bunk bed. His brother was concerned that he fell from the top bunk, and was unhappy that the prison had not got in touch with him sooner.

HMP DONCASTER

15. HMP Doncaster is a privately run prison. It is a local prison holding up to 1,145 young adult and adult male prisoners, both sentenced and on remand. There are three identical house blocks, each compromising four separate wings. Each wing houses prisoners in cells on two levels surrounding an association area.

16. Since April 2011, primary care and inpatient services have been provided by a NHS Trust. Previously these were run by a private company. The inpatient healthcare centre (known as upper healthcare) has 18 beds in 12 cells and caters mostly for mental health patients.

17. When the man was at Doncaster in June 2011, the inpatient unit had an average occupancy of eight patients. The inpatient unit is staffed by one mental health nurse, a nursing assistant and two or three officers during the day. At night the inpatient unit is staffed by officers with nurse cover when needed provided by one of two nurses based in the substance intervention unit. Two other nurses cover the rest of the prison at night.

Integrated Drug Treatment System (IDTS)

18. IDTS aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on:

    - early custody
    - improving the integration between clinical and CARAT [drug and alcohol support workers] services
    - reinforcing continuity of care from the community into prison, between prisons, and on release into the community

19. At Doncaster, the IDTS wing is referred to as the substance intervention unit (SIU). It has its own dedicated medical staff with between four and eight nurses during the day subject to staff availability and nurses on duty at night. The SIU can hold up to 90 prisoners, and was nearly full when the man was at Doncaster. A doctor attends the unit from 8.00pm to see all new receptions with drug and/or alcohol problems. Most of the prisoners on SIU have drug rather than alcohol problems.

Assessment, Care in Custody and Teamwork (ACCT) procedures

20. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be

very high, the prisoner may be constantly observed. Where the perceived risk is lower, the level of observations may be several times an hour or day. Checks should be irregular to prevent the prisoner anticipating when they will occur.

21. Part of the ACCT process involves drawing up a Caremap. A good Caremap will identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for resolving each goal. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the Caremap have been completed.

HM Inspectorate of Prisons (HMIP)

22. The most recent inspection of Doncaster by Her Majesty's Inspector of Prisons was in November 2010. The Inspectorate found that staff-prisoner relationships were good and that prisoners reported favourably against comparator prisons about being treated with respect and having a member of staff they could approach for help.

23. In relation to the SIU, the Inspectorate reported:

> "The atmosphere on the unit was relaxed and there were good staff-prisoner relationships … Nurses provided assessments, drew up basic care plans and, together with CARAT staff, undertook five-day reviews. However, most of the their time was spent administering medication"

24. The mental health in-reach team was described as:

> "providing services for prisoners with severe and enduring mental health disorders and liaison with NHS providers to ensure continuity of care. The team comprised of two community forensic psychiatric nurses, an HCA [healthcare assistant], administrative support and visiting forensic psychiatrist. The team carried a small caseload and contributed to ACCT reviews".

25. HMIP reported on alcohol detoxification and for prisoners with dual diagnoses of substance use and mental health problems:

> "There was insufficient support for prisoners undergoing alcohol detoxification … and no designated dual diagnosis service for this group.
>
> The care co-ordination of dual diagnosis prisoners was ad hoc; multi-disciplinary meetings no longer took place and the skill mix of mental health teams did not include dual diagnosis expertise. IDTS nurses who were dual trained and qualified did not have the time to run clinics".

26. With regard to suicide and self-harm prevention procedures the report said:

> “The quality of the large number of assessment, care in custody and teamwork (ACCT) documents was inconsistent and many were poor. Care mapping was underdeveloped, attendance at case reviews was irregular and written entries on observation forms demonstrated insufficient knowledge of the individual circumstances or needs of the prisoners”.

Previous deaths at Doncaster

27. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, there have been 17 deaths at Doncaster both from natural causes and self-inflicted. Three previous investigation reports have made recommendations about referrals to the mental health in-reach team. The man had been referred to the team but was not seen by them before he died.

KEY EVENTS

Previous custody in Doncaster

28. The man had been in Doncaster once before, when he was remanded into custody on 23 February 2011. When he arrived it was recorded that he was a chronic schizophrenic, suffering from alcohol withdrawal. Information from the court psychiatric services indicated that he received depot medication (injected antipsychotic medication) and was under the care of a community health team, including a community psychiatric nurse (CPN), social worker and consultant psychiatrist. He lived in supportive housing and had been suffering from mental illness for over forty years.

29. The man was an alcoholic and had an extensive history of making threats to self-harm, which he sometimes acted on. A 'suicide at risk' form was completed by court staff and given to prison reception staff. No ACCT was opened and there is no recorded explanation for this. A report from Sheffield Health and Social Care said:

> "He continues to express suicidal ideas on a daily basis. Asking if suicide is the way out, by reflecting this back to him he then decides it is not. Given his history it is quite conceivable that one day he will act on these suicidal thoughts particularly while under the influence of alcohol".

30. The man was originally allocated to the SIU, where he was observed for alcohol withdrawal symptoms but was not prescribed any medication for alcohol detoxification. He continued to be prescribed medication to manage his mental health problems and diabetes. As he was thought to be withdrawing from alcohol and at risk of a seizure, a bottom bunk was requested.

31. On 25 February, a mental health qualified nurse who worked on the SIU asked for the man to be moved to the inpatient facility because he was "very bizarre, suspicious, hostile and intimidating at times". A senior nurse agreed the move.

32. On 1 March, it was agreed that the man would be accepted on the mental health in-reach team caseload. A Community Psychiatric Nurse (CPN) conducted a mental health assessment and concluded he should remain on the inpatient unit. The CPN recorded that he "stated that he wished to die but this is a longstanding feature of his presentation". A mental health multi-disciplinary care plan was prepared on 10 March and it was agreed he would be seen weekly. There is no record of him being seen subsequently by anyone from the mental health in-reach team before his release on 24 March.

Remand to Doncaster in June 2011

33. The man was remanded to Doncaster on 29 June 2011 after he was charged with an offence of harassment. The judge said that she did "not feel prison is the right place for him" and "the way forward is for mental health services to consider other accommodation well away from the offending area". While in police custody, he was considered at risk of suicide, and a suicide warning form was passed to the prison. A forensic medical examiner (FME) prescribed a dose of diazepam while he was in police custody. At court, he was seen by a CPN from the court diversion service, who completed a self-harm warning form which indicated he said "he's had enough and wants to kill himself. Repeats this over and over". Copies of his community mental health team records were forwarded to the prison which said that he often made threats to self-harm and had acted on these in the past. He was due back at court on 13 July.

34. When the man arrived at Doncaster he was assessed as suitable to share a cell. A mental health nurse completed a first reception health screen and noted his mental health problems, that he was diabetic and that he had ulcers on both thighs which needed to be examined by a doctor. She wrote that he "states wants to cut off his head but feels he will be better in prison and it will do him some good. He is chronic alcoholic". She opened an ACCT at 7.40pm citing:

> "Long history of mental health problems. Chronic alcoholic well known to nursing staff. Threats to cut throat but has apparently never acted upon this. ACCT opened due to vulnerability".

35. The nurse also completed a prison community mental health referral form for the mental health in-reach team recording that the man was schizophrenic and gave the name of his doctor and the clinic. She did not specify whether the referral was urgent, in which case he would be expected to be seen within 72 hours, or routine, when the expectation would be an appointment within 10 working days.

36. The nurse and a reception officer completed an ACCT immediate action plan which recorded that the man was to be placed on the SIU in a shared cell, have hourly observations and three quality entries per shift, be given a phone call in reception and the support of the Buddy scheme (a scheme where prisoners offer support to new prisoners). There was a note saying "staff may have difficulty locating with other prisoners because of appearance and mental health illness".

37. A psychiatrist and a mental health nurse based on the SIU saw the man who said that he had no suicidal thoughts. He told the psychiatrist that he drank about two to three litres of cider a day. He was quite agitated but not aggressive. The doctor wrote "his schizophrenic illness is under control with depot injection and his mental state is thoroughly stable at the time of the interview obviously". The psychiatrist prescribed a standard clinical alcohol detoxification programme to start the next day, 30 June. An alcohol

withdrawal observation chart was started. He scored zero, which indicated that he did not have any withdrawal symptoms at that stage. (According to the guidance, a score below 8 indicated that no medication was required.)

38. The psychiatrist explained that he decided to prescribe chlordiazepoxide for alcohol withdrawal despite the man showing no withdrawal symptoms at the time. He said this was because he was well known to the detoxification service at Doncaster and had a long standing history of alcohol dependency. He said the alcohol withdrawal observation chart was completed as a supportive aid. Taking into account his diabetes and age he considered it appropriate to put him on a standard alcohol detoxification. The psychiatrist did not explain in the clinical records why he deviated from the instructions on the alcohol withdrawal chart to prescribe him detoxification medication.

39. The psychiatrist told the investigator that he considered the SIU the more appropriate place for the man as the inpatient unit did not have a nurse on duty at night. He was concerned that he was withdrawing from alcohol and combined with his age, diabetes, schizophrenia and the fact that he was on anti-psychotic medication it was more appropriate that he remained on the SIU where he could be monitored throughout the night by qualified nurses. The psychiatrist said that as some of the nurses on the unit had mental health qualifications his mental state would be monitored anyway. He said:

> "The management plan was to keep him because of his physical vulnerability under care of the nurses in the detox wing [SIU] with a view that if he becomes actively suicidal and is observed by the nursing team or by prison officers he can be always reassessed and then moved to the other location".

40. However, the Head of Healthcare explained that staffing pressures meant that the role of qualified mental health nurses on the SIU was limited to delivering detoxification programmes, mainly though administering drugs. She said that mental health nurses on the unit did not have time to carry out mental health assessments or monitoring.

41. A PCO arranged for the man to share a cell with another prisoner of a similar age as she thought they would relate to each other. The psychiatrist had not specified that he have a bottom bunk as he did not have a history of epilepsy and the doctor believed the demand for bottom bunks would outweigh supply, because many residents were withdrawing from alcohol. The other prisoner was already living in the cell and had the bottom bunk, but the officer said she checked with him whether he would prefer the bottom bunk and he said he was fine with the top. The medical section of his cellmate's CSRA said he "does suffer from mental health problems is stable at this time. No evidence noted of any DSH or suicide ideation. Detox issues".

42. The next day, 30 June, the man's alcohol withdrawal treatment began, and he was given chlordiazepoxide. There is no record that his alcohol withdrawal symptoms were checked. Telephone checks were made with his GP for

details of his depot injection and it was recorded that information about his mental health had been received from the mental health in-reach.

43. The nurse who asked the man for information about his GP that morning was concerned about his presentation. She spoke to officers who told her that an ACCT assessor was just about to carry out an assessment. She also noted in his medical record that she had asked a mental health nurse who worked on the SIU to speak to him. There is no record that such a conversation took place.

44. A trained ACCT Assessor, who worked as a clerk in the custody office, carried out an ACCT assessment at 11.35am that morning and concluded:

> "Has stated he tried to commit suicide many times. Tried to overdose 42 years ago with tablets and drink has very good memories from the past … first good night's sleep for 30 years … keeps touching himself and trying to get me to look at some sores … has told a nurse he is going to kill himself told me he is going to cut his head off doesn't know what with but says he will do it 'in a bit' the same as he told the nurse who also informed me when she came onto the wing. Speaks about God, the devil and dying ... He has obviously got mental health issues may need to see in-reach team. Is quite willing to talk about his issue…"

45. At about 1.00pm, the unit manager and a PCO from the SIU carried out the first ACCT case review. No healthcare staff were present. The man's risk was assessed as low. The Caremap was completed with the goals of 'completing detox' and 'speak to in-reach'. He was given the responsibility to achieve these goals, and staff took no responsibility for achieving them, although a manager was to review whether the in-reach appointment had happened on 6 July. The unit manager recorded on the ACCT case review papers that he phoned in-reach at 1.18pm. He thought that by speaking to them, he had made a referral. He was unable to recall who he spoke to, but believed it would have been one of the healthcare assistants. He expected that the mental health in-reach team would start working with him before the next ACCT review scheduled for 6 July so they could make a valuable contribution to the review. The mental heath in-reach team had no record of the telephone call or an invitation to the ACCT review.

46. The PCO described the man:

> "When you first meet him you have this initial instinct that he shouldn't really be on the wing, he's got mental health issues. He's childlike in his behaviour and shouldn't really be mixing with everyone else…"

47. A PCO wrote an entry in the ACCT at 5.55pm, "declined exercise and association and states that he doesn't trust anyone and thinks people are going to attack him". She spent some time trying to ask him if a specific individual had threatened him but concluded this was not the case.

48. On 1 July, at 9.30am, a further ACCT case review took place. The man had approached a PCO to say that he felt worse and he thought he might as well be dead. She discussed him with the unit manager that day, who agreed that an ACCT case review should be held to increase his observations. In a brief note of the review, the unit manager wrote "He has approached staff and informed them he is feeling low in mood and depressed. ACCT observation raised to 30 mins". Despite the level of observations being raised to two an hour his overall level of risk remained assessed as low.

49. At 10.15am, a CARATs worker saw the man. (CARATs or Counselling, Assessment, Referral, Advice and Throughcare services staff provide support for prisoners withdrawing from alcohol or drugs.) The worker wrote in his ACCT that he "aggressively stated he wants to die" and "constantly made a slicing movement around his neck with his finger". He said the worker should die as well. His file was then marked that officers should be present when non-discipline staff saw him.

50. A nurse gave the man his depot injection that afternoon. At interview, she said that officers "were concerned about him because he was just difficult to manage for them because of his presentation which was more or less exactly the same as it had been in February". As she had done a few months earlier, she discussed him being moved to the inpatient unit. She spoke to a CPN, who recorded in his medical records

> "Discussed problematic behaviour on detox wing [SIU]. I feel he should finish his detox on IDTS wing [SIU] and then review the best place to manage him in prison".

51. The CPN did not see the man in person to assess him. He said he was told by officers and nurses that he was annoying other prisoners. The CPN thought that, after detoxification, the inpatient unit would be the most suitable place for him. He spoke to his manager, who agreed. (She later told the investigator that she would have expected the CPN to have seen him before making that decision.) There are no more entries in his medical records until the emergency response on 5 July.

52. According to his Alcohol Withdrawal Observation Chart, the man was assessed as displaying no withdrawal symptoms on 1, 2 and 3 July. There are no further records after this date.

53. There were two significant entries in the man's ACCT on 2 July by a PCO. The first one, at 12.40pm, described him staying in his cell and said he "feels low, poor eye contact" and that staff were monitoring him closely. At 5.35pm, the PCO made the following entry:

> "He took medication from nursing staff this afternoon. Stayed in his cell for association. Came out for evening meal. Spoke to myself during meds round. Said he feels 'lower and lower and lower and lower'. Poor eye contact when spoken to".

54. At 12.20pm the next day, 3 July, the PCO wrote that the man said he felt low and then at 5.35pm he recorded:

> "getting lower and lower and lower and lower and lower and lower. Still says he intends to self-harm or kill himself due to the way he feels. Says he is getting fed up of people. Staff have been keeping close eye on him".

55. On 4 July, at 11.50am, it was recorded that the man was out of his cell but sitting alone and that "he doesn't appear to be mixing very well on the wing only with his cell mate". At 5.20pm, a PCO wrote in his ACCT document:

> "He has been out for meal. Chose to decline exercise. Had a little time out on association then asked to go behind his door. He stated he needs to talk to someone and then grabbed his neck while the nurse was giving out medication. She said she would come back and have a chat with him".

56. The nurse referred to by the PCO said she did not get back to see the man as she did not have time.

57. A number of officers interviewed said that they did not feel the man was suitable for the SIU because of his mental health problems. One of the SIU managers said he asked the manager of the inpatient unit to consider admitting him because of officers' concerns. He did not record the conversation and could not recall when it took place. He said he was told that his alcohol detoxification had to take precedence, and the SIU was the best place for him because of the number of nurses available to offer specialist care for those detoxifying.

<u>5 July 2011</u>

58. At approximately 5.15am on the morning of 5 July, The man's cell mate said he heard a loud thud and found him on the floor next to the bed. He told him he had slipped out of bed. His cellmate used the cell bell to call an officer for help.

59. A PCO looked through the hatch and saw the man sitting on a chair. He said he got up to show him an injury to his head. When the prison is in patrol state at night, officers can only unlock cell doors by themselves in life threatening situations, using a cell key in a sealed pouch. The PCO did not regard this as an emergency so radioed for medical assistance. He told the investigator that the blood on the man's head and on the floor seemed to be dry, which he found strange if he had just fallen and needed immediate attention. He had been responsible for undertaking ACCT observations every 30 minutes and said he had not observed any problems earlier. We cannot verify this as the time and comments for each observation were not recorded, a matter we discuss later. The PCO wrote a brief entry in the ACCT on-going record to reflect that the man had fallen out of bed, hurt his head and was seen by nurses.

60. At that time, a PCO was accompanying four nurses to the gatehouse to collect their keys for the day shift when he heard the radio call for medical assistance so he and the nurses went to the SIU. The PCO unlocked the cell door and the man was taken to the nurses' station where a nurse cleaned his wound, which was a cut to the right hand side of his face, and dressed it. The nurse then carried out clinical observations (pulse, blood pressure) and recorded them all as fine. The PCO described him as incoherent during this exchange.

61. The unit manager in charge of the prison that night arrived while the man was being treated. He took him back to his cell and said his cell mate made a cup of tea for them both at about 6.00am. He said he told his cell mate that the man would go on the top bunk. When he left both prisoners were drinking tea with the man sitting on the chair. He told the investigator he had no suspicions about the fall. The incident was not recorded on the daily handover sheet.

62. A PCO came on duty that morning. She told the investigator that when she heard about the man falling out of bed during the night she had questioned whether this was what had happened. She believed that if he had fallen from the bed he would have hurt himself more. She said when she did her first checks he was pacing round the cell. She thought something was wrong and said she told staff coming on duty, and the night nurse who was leaving duty, that she was concerned that he might have tried to self-harm. She made no record of her concerns or that she had passed them on to other members of staff.

63. The PCO wrote in the ACCT at 6.15am that she saw the man "pacing round his cell". He was next seen for morning medication and according to a nurse he said he was "getting lower and lower". The PCO said that this was something he used to say a lot.

64. The unit manager that day signed the man's ACCT record at 7.45am. He said that he had asked staff about him and the incident during the night. They said he was no problem and walking round his cell.

65. Later that morning, according to the man's cell mate's account to the police, he returned from collecting his breakfast eating toast. His cell mate said he had another two pieces of toast in his hand and "he appeared to be hungry as he was scoffing it down - he went back up to his bunk and continued eating". He went quiet for a while so he checked on him and realised something was wrong, shook him and got no response. He left the cell and told a PCO, who heard him say something about "choking." The PCO assumed he meant that the man had his hands round his throat again and went to the cell. The PCO told the police that he spoke to his cell mate at 8.38am.

66. The PCO said as he entered the cell he could he could see that the man's lips were blue and he thought he was dead. He pulled some toast out of his mouth. As he was very light, the PCO was able to move him to the floor and place him in the recovery position. He slapped him on the middle of his back

and some more toast came out. He left the cell and shouted for a code blue medical response. The communications room received the emergency radio call at 8.39am. (A code blue is used when someone is not breathing, so healthcare staff know what equipment to bring with them.)

67. A Senior PCO (SPCO) and a PCO arrived and entered the cell. The PCO checked for a pulse but could not find one. The SPCO slapped the man on the back. After lying him back down, he used his resusci-aid device to give him two rescue breaths and then started chest compressions. In the meantime, the other PCO ran upstairs to get the nurse, who was dealing with a prisoner at the nurses' station and they returned to the cell. The nurse did not have any emergency equipment with her, but she continued with rescue breaths, although she could see his chest was not rising. She was unable to see if anything was causing an obstruction. When the unit manager got to the cell he asked for an ambulance at 8.42am. The ambulance report recorded the call at 8.43am.

68. A senior nurse and a HCA responded to the code blue and arrived at the cell at 8.46am with a defibrillator and oxygen box. When they arrived the nurse and the SPCO were carrying out cardiopulmonary resuscitation (CPR), alternating between chest compressions and managing his airway. Again, the senior nurse could see that the chest was not rising and put in another airway but still could not see anything causing an obstruction.

69. A prison GP attended at 8.55am and listened to the man's heart with a stethoscope, but there was no cardiac output. In her statement, she said she returned to her clinic as the paramedics' arrival was imminent.

70. Paramedics got to the cell at 8.56am, when CPR was being continued. The paramedics inserted an endotracheal (a tube inserted through the mouth for establishing and maintaining an airway) device and could see a blockage. They used a pair of forceps and suction, and it took several attempts to retrieve a folded piece of toast which they recorded as "very compacted – initially unable to clear". The senior nurse said that the ambulance staff used the prison's electronic suction machine which had been brought over from healthcare but it was not effective and could not move the toast.

71. The paramedics administered several rounds of adrenalin but there was no response. After the fourth attempt they got a heart beat and the man was taken to hospital. The ambulance left the prison at 9.30am.

72. At 12.43pm, the escorting officers contacted the prison as the doctors had asked for the man's family to be informed. He had not given any details of his next of kin and the prison asked the police to help. The police found contact details for his brother and the prison chaplain telephoned him that afternoon to let him know the situation. His brother visited him in hospital later that day. Sadly, he never regained consciousness and was pronounced dead several days later. The prison paid the funeral costs.

73. After the man was taken to hospital a debrief was carried out at the prison for staff involved. They were offered the support of the care and welfare team. The chaplain counselled his cellmate, who was placed on an ACCT as a precaution. All other prisoners subject to ACCT were reviewed in case they had been affected by his death.

ISSUES

Mental health assessment.

74. The man was referred for an in-reach mental health assessment when he arrived at the prison in June. The acting Head of Healthcare explained that all prisoners with mental health issues should have a primary mental health assessment within five days. At reception, a nurse also completed a referral for a secondary mental health assessment which should take place within 72 hours for urgent cases and 10 days for others. He was not assessed by the primary care mental health team or the in-reach team before his death, and received no mental health support.

75. The acting Head of Healthcare said that the prison did not meet mental health referral targets because of capacity issues. At one stage, the mental health qualified nurses working on the SIU were able to undertake assessments but at that time they did not have the capacity to do so because of staff shortages.

76. Aside from the reception nurse's referral, the man had been brought to the attention of the mental health in-reach team on at least two occasions and was still not seen. On 30 June, the unit manager telephoned the mental health in-reach team to invite them to an ACCT review and assumed that this was another referral. This call appears not to have been recorded or noted by in-reach, and there is only a brief record on the ACCT case review with no explanation. The nurse spoke to the CPN from the in-reach team on 1 July when she asked whether he could be moved to the inpatient unit. The CPN spoke to staff who explained that he was difficult to manage on the SIU, but he did not speak to him himself.

77. The man had been accepted by the in-reach team in February and staff were aware that he was back in the prison. It is a concern that he was not assessed by either the primary mental health team or the in-reach team. His mental health needs were not met despite his bizarre behaviour, his known history of mental health treatment, staff having difficulties in managing him and two additional referrals to the mental health team.

The Director and Head of Healthcare should ensure that mental health assessments are carried out within the required timeframe.

Alcohol detoxification

78. Doncaster's Protocol for First Night Assessment for Alcohol Dependence states that "chlordiazepoxide (a benzodiazepine sedative) should only be started once there are documented signs of withdrawal" and should not be given if the person is intoxicated. It is not started until the following morning after reception into prison.

79. The man was known to be a heavy user of alcohol which complicated his mental health problems. He was prescribed chlordiazepoxide for alcohol withdrawal the evening he arrived at Doncaster even though he had no

withdrawal symptoms that night. The next day, 30 June, when he started the seven day detoxification, no alcohol withdrawal observations were recorded either. On the next three days he scored zero on the alcohol observation chart. (Medication is not normally considered necessary if symptoms are assessed as under eight.) When he had previously been in Doncaster in February 2011, he was monitored for withdrawal signs. He did not present with any and was not prescribed medication for detoxification.

80. We are surprised that the man was prescribed medication despite having no withdrawal symptoms, as this was contrary to Doncaster's own protocol. The psychiatrist told the investigator that he took into account his history of alcohol abuse, age and diabetes when he wrote up the detoxification prescription. Although he said he took account of additional clinical issues, the reasons for departing from the policy were not recorded on his clinical record. We consider it important that clinical staff should record the reasons for prescribing detoxification medication outside the agreed protocol, and we make the following recommendation:

The Head of Healthcare should ensure that clinicians fully record their reasons for prescribing detoxification medication when acting outside the alcohol detoxification protocol.

81. The investigator was told that SIU nurses were badly affected by staffing shortages in July 2011. As the Inspectorate highlighted, nurses spent most of their time administering medication, missing out some of the basic requirements of the IDTS programme.

82. Prison Service Instruction (PSI) 2010/45 – Integrated Drug Treatment System requires observations of those going through stabilisation to be taken twice a day for a minimum of five days. Although we were told that the main reason that the man could not go to the inpatient unit was the need to monitor his alcohol withdrawal, his observation chart was completed only once daily, and there were no observations on 30 June. There were no other entries made by nurses in his medical notes between 1 and 5 July or on his ACCT.

83. The PSI describes the need to provide unrestricted observation for prisoners because of the risks associated with withdrawal. Observations were limited and mandatory requirements were not met.

The Director and the Head of Healthcare should ensure that, for at least the first five days, twice daily observations are carried out for all prisoners withdrawing from alcohol.

<u>Dual diagnosis</u>

84. The man was both mentally ill and recorded as a heavy user of alcohol, so he had a dual diagnosis. The acting Head of Healthcare explained that there were dual diagnosis trained nurses working on the SIU and that staff were able to call on the secondary mental health services for additional support.

85. The clinical reviewer comments:

> "It is my opinion that staff were not working in an integrated way regarding offering treatment for alcohol dependence and treatment for mental health issues. One is left with the impression that current care pathways at HMP Doncaster would either place the man on the drug stabilisation unit (SIU) or the hospital wing. Having reviewed the case I was left with the impression that a patient could not be confident of accessing adequate alcohol/drug treatment and subsequent monitoring for drug stabilisation if based on the hospital wing".

86. The Inspectorate commented on the lack of dual diagnosis expertise among healthcare staff at Doncaster and the ad hoc approach to managing prisoners with more than one pressing health need. The man's experience demonstrates that dual diagnosis prisoners were not receiving appropriately integrated treatment at that time.

87. The man's mental health needs should have been addressed, as well as his substance misuse needs. The clinical reviewer makes the following recommendation which we endorse:

The Head of Healthcare should ensure prisoners with dual diagnosis receive appropriate integrated treatment.

<u>The man's location</u>

88. The SIU is a busy unit of up to 90 prisoners going through detoxification. The inpatient unit held on average eight prisoners and was described as a much quieter environment than the SIU.

89. Despite the limited evidence of alcohol withdrawal symptoms, the principal reason given for the man to stay on the SIU was alcohol detoxification, yet his clinical observations were not taken as required. The doctor who made the assessment took into account that the inpatient unit had no medical cover at night, whereas the SIU had 24 hour nursing presence. There is no record of any healthcare observation of him overnight.

90. In his ACCT on-going record, the man is often recorded as not leaving his cell or associating with other prisoners and he appears to have spent most of his time in his cell. Officers told the investigator that his unusual way of expressing his low mood was mocked by other younger prisoners who used to mimic him. Officers said that they challenged this behaviour, but he told officers that he did not trust other prisoners and was fed up with them. Most of the prisoners on the IDTS unit were significantly younger than him and the unit was described as very busy by several officers.

91. While the inpatient unit might not have had 24 hour nursing cover, several staff, including nurses believed that the SIU was not suitable for the man and that his needs would have been met better in the smaller and quieter unit.

There was no consideration of the impact that living on a busy wing had on his mental health or level of risk.

92. When the man arrived at Doncaster he was on an open ACCT document. He was placed in a shared cell with a cell mate who was himself extremely vulnerable and mentally ill. A PCO explained that as they were both older prisoners and similar in their needs and presentation, she thought they would be suitable cell mates. His ACCT document stated that it might be difficult to place him with another due to "his appearance and mental illness". There were no reports of any friction between them. However, two vulnerable prisoners were locked up together with no additional support and in unsuitable bunk bed accommodation.

93. The man slept in the top bunk, despite his alcohol withdrawal and frail condition. He apparently fell from the top bunk on 5 July and cut his head. The PSI for IDTS advises that the use of bunk-beds during the initial stabilisation period should be subject to risk assessment. Those at risk of fitting, or those who are unwell in any way which would make climbing in and out of a top bunk undesirable or unsafe, should only be given a bottom bunk bed. In particular, the PSI says some medication used to manage withdrawal causes drowsiness which may make someone unsteady, and therefore their location on a top bunk unsafe.

94. The acting Head of Healthcare said that "everyone knows that if there is a risk of seizures that they go on the bottom bunk". However, neither the assessing doctor on the SIU nor the specialist nurses working on the unit knew this instruction.

The Director and the Head of Healthcare should ensure that prisoners are located appropriately in the prison taking into account their age, and mental and physical health and other relevant factors. Older prisoners and those withdrawing from alcohol should not be given upper bunks in shared cells.

<u>ACCT management</u>

95. We are concerned that ACCT processes at Doncaster did not adequately manage prisoners' risk of suicide or self harm. The Inspectorate found the quality of ACCT was varied and many were poor, particularly in relation to Caremaps. Similarly, the man's ACCT did not effectively manage or monitor his risk to himself.

Case reviews

96. Prison Service Order (PSO) 2700, in operation at the time, required case reviews to be attended by at least a named case manager, a residential officer and an appropriate member of non-discipline staff. The man had his first case review on 30 June and his second on 1 July. The reviews were attended by a unit manager and one PCO, although no one attended both case reviews to provide continuity. There was no healthcare input to either

review, despite the concerns about his mental health needs and the availability of nurses working on the unit. A member of the in-reach team was invited to the second case review, but no one attended.

The Director should ensure there is continuity of case managers at multidisciplinary ACCT case reviews to enable appropriate and consistent assessment of risk.

On-going record

97. The man's ACCT required three quality entries per day in his on-going record. Very few entries in his ACCT described a meaningful conversation with him. In addition to three quality entries per day for him, staff were initially required to observe him hourly and then, after his risk was raised, every 30 minutes.

98. Serco Internal Director's Rule on Suicide and Self harm paragraph 4.45 states "The manager – for each shift – of the unit where the prisoner resides is responsible for ensuring that conversations and observations are completed as per the requirements set out on the front cover the ACCT Plan" and that under the section ACCT quality control, the unit manager should ensure that "the level of conversations and observations are being maintained to the required standard".

99. The Assistant Director of Doncaster provided a written explanation about the recording of observations. He drew attention to the Prison Service Order (PSO) 2700 Annex G regarding the on-going record. (This has since been replaced by Prison Service Instruction (PSI) 64/2011.)

> "Significant events, conversations with and observations of the at-risk prisoner must be recorded in the On-Going Record, and accompanied by the recording member of staff's printed name and signature. The minimum required frequency of conversations and observations is stated in the 'required frequency of conversations and observations and required frequency of recording' box on the front cover. The purpose of recording observations is to help form a picture of the individual's state of mind and so contribute to care. A good-quality, meaningful entry once an hour or at the end of the shift can communicate more than page of meaningless comments, such as 'correct when checked', written at intervals of a few minutes. The requirement to record should not be so onerous that it reduces the care that staff are able to offer prisoners."

100. The Assistant Director explained that the prison based its strategy regarding the recording of observations and conversations on the PSO. He said that managers could use CCTV to monitor staff at random to provide assurance that the observations are carried out at with the correct timescales.

101. PSO 2700 and its replacement both recognise that one good quality entry can communicate more than frequent meaningless comments. The entries in the man's ACCT were rarely meaningful. While there is no requirement for staff to record every observation in the ACCT ongoing record we consider it is

important that there is a least a written and signed record that a check has taken place, even if it is not accompanied by an observational comment.

The Director should ensure that entries in an ACCT on-going record are meaningful and that observations are carried out and recorded at the required frequency.

Caremaps

102. As well as poor recording, the man's ACCT Caremap did not effectively manage his risk of harm. The responsibility for the goals set in his Caremap – to complete detox and to see in-reach – were recorded as his alone. Officers were given no responsibility in the Caremap for any of the measures to manage his risk of suicide or self-harm. We agree that it is important for the person on an ACCT to be given some personal responsibility for improving their situation. However, it was not appropriate for the goal of seeing in-reach or completing detox to be described as his responsibility, because these actions could only be carried out by officers or healthcare staff.

The Director should ensure that Caremaps address the cause of the individual's distress, that realistic goals are set, and that responsibility for achieving goals is balanced between the individual and named members of staff.

Identifying self-harm

103. Earlier on the morning the man died, he was injured after apparently falling out of bed. A number of staff thought he would have sustained more serious injuries if he had accidentally fallen, given the height of the bunk bed and his fragility. However, officers did not explore this further at the time. A PCO told the investigator that she was concerned that he might have self-harmed because she did not believe he had fallen. Despite this belief she made no record of her concerns, although she recalled telling other staff that morning.

104. After every act of self-harm, a multi-disciplinary case review must be held to ensure that appropriate measures are being taken to support the person at risk. As there was no assessment or investigation into whether the man's injuries were self-inflicted, no consideration was given to the need to hold a further ACCT review.

The Director should ensure that where there are grounds to suspect an injury is self-inflicted full consideration is given to the need to hold an ACCT review.

<u>Emergency response</u>

105. The clinical reviewer comments that healthcare staff might not have made sufficient attempts to clear the man's airway before starting mouth to mouth resuscitation and cardiac compressions. The SPCO was first aid trained, as was the PCO. They slapped him on the back in line with the guidance for

someone who has an obstruction in their throat. Staff were aware that his chest was not rising and that the effectiveness of their CPR was hampered by an obstruction that they could neither see or remove.

106. Specialist medical equipment was brought to aid removal when the paramedics arrived. The paramedics tried the prison's equipment but it was not effective so they used their own equipment, but in their own report recorded the difficulty they had and how it took several attempts. In light of the paramedics' report, we consider that staff's attempts to clear his airway were adequate in the circumstances.

107. We are surprised to note that the doctor left the scene before the paramedics arrived. As the most senior member of healthcare staff in the prison at the time, we consider that the prison doctor should have stayed with the man, to hand over care to the paramedics and assist if necessary with any further medical intervention.

The Head of Healthcare should ensure that senior healthcare staff present at an emergency remain with the prisoner until a handover has taken place to paramedics.

Contact with the man's next of kin

108. When the man was taken out to hospital at 9.30am he was known to be very seriously ill. Prison Rule 22 says that "if a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of a mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin". The prison should have looked to see if they had a contact address for his next of kin when he was first taken to hospital on the morning of 5 July. Instead, attempts to contact his brother did not start until the afternoon, when requested by hospital staff. It was then discovered that there were no family contact details for him on record and the police were asked to help. He was a vulnerable, mentally ill man under the care of a community mental health team before his arrival at Doncaster and we consider the prison should have made earlier efforts to establish his next of kin through them if necessary.

The Director should ensure that a prisoner's family are informed of a prisoner's serious illness or death as soon as possible.

CONCLUSION

109. When the man had previously been in Doncaster, he had been located in the inpatient unit and was released from custody without incident. During this second period in custody, he was given detoxification medication although there is no clear evidence that he needed it and was kept on the SIU because of this perceived need. We are concerned that the SIU was not the appropriate place for him and, despite a number of referrals to the in-reach team, his mental health was not assessed during his time in the prison. Officers and healthcare staff did not use ACCT processes effectively, so did not adequately monitor or manage his risk of self-harm. On 5 July, he choked while eating toast and never recovered consciousness. He was on an ACCT and had spoken about feeling increasingly low in the days before his death, but we do not know whether or not his actions were a deliberate act of self harm.

RECOMMENDATIONS

1. The Director and Head of Healthcare should ensure that mental health assessments are carried out within the required timeframe.

   Accepted. All patients deemed to have a mental health issue or learning disability receive an initial assessment within 5 days of initial health screen received on reception into the establishment.

2. The Head of Healthcare should ensure that clinicians fully record their reasons for prescribing detoxification medication when acting outside the alcohol detoxification protocol.

   Accepted. All medical prescribers are aware of appropriate and detailed documentation during consultation. It is anticipated there will be no clinical need to prescribe outside of protocol. In the event of such prescribing clinicians are advised to complete incident reports.

3. The Director and the Head of Healthcare should ensure that for at least the first five days twice daily observations are carried out for all prisoners withdrawing from alcohol.

   Accepted. The guidelines for medical assisted withdrawal for alcohol dependant patients clearly states levels of observations.

4. The Head of Healthcare should ensure prisoners with dual diagnosis receive appropriate integrated treatment.

   Accepted. Dual diagnosis clinics occur 1x week. An appropriately trained nurse carries a caseload and ensures all patients receive appropriate integrated care.

5. The Director and the Head of Healthcare should ensure that prisoners are located appropriately in the prison taking into account their age, and mental and physical health and other relevant factors. Older prisoners and those withdrawing from alcohol should not be given upper bunks in shared cells.

   Accepted. All patients are assessed in reception for suitability of location. This information is documented on the Cell Sharing Risk Assessment. This document is a shared document with custodial staff who also contribute to the decision making process.

6. The Director should ensure there is continuity of case managers at multidisciplinary ACCT case reviews to enable appropriate and consistent assessment of risk.

   Accepted. Case managers are invited to attend reviews and when and where this is not possible an overview is given either in writing or over the phone to the person who is chairing the review.

7. The Director should ensure that entries in an ACCT on-going record are meaningful and that observations are carried out and recorded at the required frequency.

   Accepted. All Residential staff have been issued with a guide booklet with reference to the quality of daily entries in ACCT books. 10% checks of all ACCT files are conducted by the Suicide Prevention Manager; any points to note will be addressed with the senior manager in the area and also discussed at the monthly safer custody meetings.

8. The Director should ensure that Caremaps address the cause of the individual's distress, that realistic goals are set, and that responsibility for achieving goals is balanced between the individual and named members of staff.

   Accepted. All residential Mangers have been issued with a guide booklet in relation to the completion of care maps which must meet the individual prisoner's needs.

9. The Director should ensure that where there are grounds to suspect an injury is self-inflicted full consideration is given to the need to hold an ACCT review.

   Accepted. Where a prisoner has deliberately harmed himself or there is any kind of injury that is believed to be self-inflicted, an ACCT review is held with the appropriate mangers and staff. This also includes any changes of circumstances that affect the prisoner's well being.

10. The Head of Healthcare should ensure that the senior healthcare staff present at an emergency remain with the prisoner until a handover has taken place to paramedics.

    Accepted. All medical emergencies are supervised by appropriately trained clinicians. Training received to date ensures there is a clear understanding of leadership at such incidents, note taking and hand over procedure.

11. The Director should ensure that a prisoner's family are informed of a prisoner's serious illness or death as soon as possible.

    Accepted. All prisoners are reminded of the importance of providing the prison with their NOK details. This is openly advertised on all wing locations and on the Induction power point. A system is also in place where the safer custody department periodically check prisoners NOK details.