



**Investigation into the circumstances surrounding the
death of a man in August 2011
at HMP Doncaster**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

May 2012

This is the report of an investigation into the death of a man at HMP Doncaster. He was found by his cell mate one evening in August 2011, with a ligature around his neck. He was 21 years of age at the time of his death.

I extend my condolences to the man's family. It is hoped that the report goes some way to answering any questions they may have.

A clinical review was conducted for the purpose of this investigation. I am grateful to the Director and staff of HMP Doncaster for their co-operation with the investigation.

The man arrived at Doncaster on 9 June 2011. Although he told staff that he had previously harmed himself at HMP Leeds, no referral was made for him to be seen by a member of the prison's mental health team. A few weeks later, he told staff that he was hearing voices. This time, a referral was made, but he was still not seen by mental health. Just under three months later, he told his girlfriend that he was going to commit suicide. Despite his girlfriend informing the prison of their discussion and his situation being reviewed by a member of staff, he took his life that evening while his cell mate slept.

This report highlights a number of concerns with regard to the care that the man received whilst he was in Doncaster. The mental health referral system at Doncaster has been the subject of criticism in previous investigations. It is of concern that staff did not effectively record or share significant information about risk on the day that he died. The Director will need to review systems in place to ensure that these circumstances do not arise again in the future.

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

May 2012

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SUMMARY

1. On 9 June 2011, the man was remanded in custody at HMP Doncaster. During the reception process he underwent a first reception health screen. (All prisoners are given a first reception health screen when they arrive at the prison. The aim of the screen is to identify any needs or health concerns that the prisoner might have. It includes identifying a prisoner's past medical history, including mental health.) Despite his history of alcohol misuse, the substance misuse section of the health screen was not completed.
2. During the screen, the man told the nurse that he had tried to hang himself whilst at HMP Leeds four months previously. The nurse did not make a mental health referral as required by the first reception health screen document for all prisoners who say that they have self-harmed. However, the reception nurse opened Assessment, Care in Custody and Teamwork (ACCT) procedures as a precautionary measure. (ACCT procedures are used to assess, observe and support prisoners at risk of harming themselves. They highlight problems and possible trigger points of a prisoner at risk of harming himself and make a multidisciplinary plan to give support and help through a period of crises.)
3. The following day, the man was reviewed by one of the prison doctors who recorded that he was, "generally fit". He denied any thoughts of suicide or self harm, and displayed no sign of mental health illness.
4. During an ACCT review on 17 June, the man told staff that he heard voices in his head, and a referral to the prison's mental health team was made. However, he was not seen. His ACCT procedures were closed on 28 June, because staff had assessed that he was no longer at risk of harming himself. Although little is recorded in his prison record, over the following months, he appears to have settled into life at Doncaster, mixing well with other prisoners. He also received regular visits and spoke frequently with his girlfriend on the telephone.
5. In the days leading to his death, the man spoke on the telephone with his girlfriend several times a day. During many of these calls they would argue and he appears to have struggled with being apart from her.
6. In August the man received a difficult visit from his girlfriend. Later that day he had several "heated" telephone conversations with her, which culminated in him threatening to take his own life. His girlfriend rang the prison and told them what he had said. This information was relayed to his wing and he was spoken to by one of the officers. He assured the officer that the threat was not serious. The officer judged that he was not at risk of self harm and no further action was taken.
7. Later that evening, at approximately 8.10pm, the man was found by his cell mate having tied a ligature to the end of their bunk bed. The cell mate raised the alarm and staff immediately responded. Resuscitation was

attempted by nursing staff and paramedics but proved unsuccessful. He was pronounced dead by a prison doctor at 9.00pm.

8. This report into the man's death repeats a recommendation about the referral system for mental health services made in previous reports by this office. It also examines the procedure for requesting previous medical records, emergency response and information sharing and makes related recommendations. The report concludes that he was not provided with the support and intervention required which may have prevented him from taking his life.

THE INVESTIGATION PROCESS

9. A senior investigator from this office was appointed to conduct the investigation into the circumstances surrounding the man's death. A colleague of his opened the investigation on his behalf on 23 August 2011, when she visited Doncaster. She met with the Senior Investigations Officer and the investigation liaison officer.
10. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Doncaster. The notices were displayed around the prison and invited staff and prisoners to contact the investigator with any information relevant to the investigation. No prisoners came forward to speak with the investigator. The investigator also asked to speak with a member of the Independent Monitoring Board (IMB), but none were available. (The IMB monitors day to day life in the prison to ensure that proper standards of care and decency are maintained.)
11. The investigator conducted a number of interviews with staff at the prison on 28 September and 3 November. He was shown the cell and wing where the man spent the last weeks of his life. The investigator reviewed his prison and health records and other documentation relating to the time that he spent at Doncaster and listened to recordings of the telephone calls that were made by him to his girlfriend in the days before his death. During the course of the investigation, he provided verbal feedback to the Deputy Director and to the Controller. Feedback was confirmed in writing to the Director of Doncaster.
12. A clinical reviewer conducted a review of the medical care given to the man while in custody at Doncaster.
13. The investigator also liaised with a Detective Sergeant from South Yorkshire Police, who is acting on behalf of the Coroner. He has also been in contact with the Coroner's Office and a copy of this report will be sent to the Coroner to assist with her enquiries.
14. One of the Ombudsman's family liaison officers contacted the man's family, informing them of the Ombudsman's role and investigation. On 26 October, the family liaison officer and the investigator met with the man's parents and other family members. During the meeting the family raised a number of issues, which the investigator was able to address either during the meeting or in subsequent correspondence from the family liaison officer.
15. The family's main concern was what, if any, action was taken by the prison on receiving information from the man's girlfriend about his threat to kill himself. It is hoped that this report answers this and any other questions that they may have. In a subsequent later meeting, the family said that:

“The man was a polite well mannered young man who enjoyed life. He was a care-free person with lots of friends. He had a wicked sense of humour and was the life and soul of any gathering and his family adored him.”

HMP DONCASTER

16. HMP & YOI Doncaster is a privately run prison operated under contract by Serco. It opened in 1994 as a local prison, and accommodates up to 1,145 prisoners. Its principal function is to serve the local courts and the majority of its population are sentenced prisoners. The Governor of a private prison is known as a Director. In prisons managed by the private sector, there is also a Controller employed by the Ministry of Justice to ensure that the terms of Serco's contract with the government are adhered to. If the contract is breached, fines can be levied on the company.
17. The prison consists of three houseblocks, each made up of four separate wings. In addition to the residential units and healthcare unit, the prison also has a re-orientation unit, formally, known as the segregation unit. Healthcare is provided by Nottinghamshire NHS Trust. The prison contains its own in-patient facility and has both mental health and substance misuse teams.

HM Inspectorate of Prisons Report 2010

18. The last inspection by Her Majesty's Chief Inspector of Prisons was an unannounced inspection in November 2010. At the time of his inspection he reported no concerns with regard to the delivery of mental health at the prison. However, he did report that despite reasonable conditions prisoners generally spent too long in reception, which was in part due to the long wait for initial medical assessments. He also reported that:

“... wing files were poor, with few key officer entries and generally few entries unless a prisoner exhibited poor behaviour... There were no regular management checks on the quality of key officer input.”

(Key officers or personal officers, as they are also known, are assigned to each prisoner and are someone that a prisoner can turn to should they need help. This officer is also required to have regular conversations with the prisoner and record these interactions.)

Independent Monitoring Board Report 2009/10

19. The Independent Monitoring Board (IMB) reported in their annual report 2009/10 that staffing levels at the prison continued to be low, but that the prison regime still ran effectively.
20. The IMB also reported that the delivery of acute mental health services had improved significantly over the year, with the introduction of a dedicated team of mental health nurses.

Previous self inflicted deaths at HMP Doncaster

21. The man's death is the sixth apparently self-inflicted death at Doncaster since the Ombudsman started investigating deaths at the prison in April 2004. In this report into his death we make a similar recommendation made by this office in respect to three deaths at the prison, one in 2006 and two in 2010. Then, as in this case, mandatory referrals to the mental health team were not made during the reception healthcare assessment.

KEY EVENTS

22. The man was remanded in custody at HMP Leeds on 3 January 2011 for common assault. He had previously received a number of suspended sentences for minor offences, but this was his first time in prison. On 7 January, he was released from prison having received a further suspended sentence.
23. The man returned to custody at Leeds prison on 1 February, having committed further offences. He was released on 28 April. On 8 June, he was charged with assault occasioning actual bodily harm (ABH). The following day, 9 June, he appeared at Magistrates' Court. The court refused him bail and he was taken into custody at HMP Doncaster later that day.
24. During the reception process, staff recorded the man's personal details on page one of his Core Record F2050, (the reception record completed for all new prisoners). He provided the details of his father as his next of kin. A Cell Sharing Risk Assessment (CSRA) was also completed. (A CSRA is used to assess the risk that a prisoner would present to other prisoners when sharing a cell.) He was assessed as a low risk.
25. A registered mental nurse completed the man's first reception health screen. In the 'Physical Health' section of the form, she noted that he had no concerns about his physical health. The 'Substance Use' section of the form was not completed. She told the investigator that she forgot to fill out that section of the report, but believed she made a referral for him to be seen by a member of the substance misuse team. (However, the clinic list for referral to the substance misuse team showed no such referral for him.)
26. Under the section 'Mental Health', the nurse recorded that the man told her that he had not had any contact with psychiatric services or received medication for mental health problems. When asked if he had ever tried to harm himself in prison, he said that he had attempted to hang himself in March, at Leeds. However, he told the nurse that he had no thoughts of harming himself at that time. She told the investigator that she could not recall why she did not make a referral for him to be assessed by a member of the mental health team. She also completed 'Part 2, Healthcare Assessment' part of the CSRA. The nurse wrote, "Recent attempt of hanging whilst in prison. Remains stating he feels depressed, Alcohol issues".
27. The nurse started Assessment, Care in Custody and Teamwork (ACCT) procedures as a precautionary measure. Whilst in reception, Healthcare Assistant (HCA) wrote in the man's continuous clinical record, "Past self harm and feels low in mood, previous ACCT".
28. After completing the reception procedures, the man was taken to the induction unit. He signed a number of forms to confirm he understood

prison rules and what was expected of him. He was also provided with a smoking pack, (a pack provided to new prisoners which contains smoking materials), and given access to the telephone.

29. The following day, 10 June, as part of the ACCT process, the man was assessed by a Prison Custody Officer (PCO). He told her that he had thoughts of harming himself and felt suicidal. He said that this was due to him coming back into prison, missing his girlfriend and alcohol withdrawal. He told her that he wanted to try antidepressants and that he was currently “detoxing”. He said that he had previously been prescribed medication at Leeds to treat his alcohol misuse.
30. After the assessment by the PCO, an ACCT case review was held to discuss what support was needed to decrease the man’s risk of harming himself. During the case review he again told staff that he had previously attempted to take his life whilst in Leeds. He said that he felt low in mood. He told the PCO that although he thought about harming himself he knew that this was “... not the way forward”. In his CAREMAP (a plan of care, support and intervention), the support plan devised to address a prisoner’s individual needs, he was assessed as requiring contact with his family and to participate in purposeful activity.
31. Later that day, the man was examined by one of the prison’s doctors with experience of substance misuse. She noted that he was:

“Generally fit and well not on any meds, attempted hanging in Armley [Leeds] during previous sentence. Denies thoughts of suicide or self harm. Positive attitude, no other issues.”

She told the investigator that he displayed no sign of mental illness at that time and did not require assessment by a mental health nurse. This information was contrary to what he told the PCO the previous day.
32. The investigator asked the doctor about the man’s substance misuse. The doctor said that during her assessment of him, he “... didn’t appear as a person using alcohol or withdrawing from any substances...” and “... definitely didn’t display any withdrawal symptoms”. She said that if he had been suffering from withdrawal he would have experienced symptoms, which she would have noted on his medical record.
33. On 13 June, a HCA completed a secondary health screen. This is a more detailed review of the health of prisoners and identifies healthcare needs. She took the man’s blood pressure, recorded his weight and height and further details about his medical history. She noted that there were no concerns raised at that time.
34. The man was seen by a CARATs worker on 16 June. (CARATs, or Counselling, Assessment, Referral, Advice, and Throughcare services staff provide drug misuse intervention services in prisons.) He told her that he wanted support in dealing with emotions and insecurities, saying

that he had witnessed his friend die at the age of 17. He said he was “paranoid” his girlfriend was going to leave him. During the interview, he denied any thoughts of harming himself.

35. According to staff entries in the ACCT on-going record, the man mixed well on the wing and generally raised no concerns with staff. During an ACCT review on 17 June, chaired by a PCO, he said that he had no thoughts of harming himself and that he was getting on well with his cell mate. However, the PCO noted that the ACCT was to remain open, noting “... due to hearing voices that have decreased in last week ACCT remain open”. The PCO added an additional goal on his ACCT CAREMAP, namely not to hear voices or act on their instruction. The PCO made a referral for him to be assessed by the mental health team. However, the investigator could find no evidence that the referral was received or acted upon by the mental health team.
36. On 22 June, the man was seen by the CARATs worker for a second time. She noted in the ACCT document that, “... he seemed a lot more positive than our last meeting, he stated that this is due to visit from girlfriend and phone calls”. He told her that he had no current thoughts of self harm and she noted that he, “... seemed a lot more motivated”. The CARATs worker advised him to speak with staff if he felt low in mood. According to an entry in the ACCT on-going record that afternoon, he “Received a visit from girlfriend. Arguing a lot. Having a drink. Seems to be talking things through. No problems voiced”.
37. During an ACCT case review on 28 June, chaired by a Unit Manager, the man said he had had a bad week when he initially came into prison, but was feeling much better. He said he was more relaxed, that he had a “good” cell mate of similar age. He received regular visits from his girlfriend, mother and friends. He told staff he had no thoughts of harming himself, and felt he could speak with staff if needed. As a consequence of the assessment, and with the agreement of him, the ACCT procedures were closed.
38. The man continued to have regular contact with the CARATs worker. During a meeting on 30 June, he told her that he had just finished a telephone call with his girlfriend and said that he was getting paranoid that she was spending time with his friend. She met with him again on 5 July, and provided him with the contact details of a drug awareness group in Pontefract should he be released from court on 7 July. The CARATs team tried to see him several times in July, but he was unavailable, or failed to attend.
39. The man appeared in court on 7 July. He was convicted for ABH, but was not sentenced at that time.
40. An ACCT post closure review, to ascertain the man’s progress after the closure of his ACCT document, took place on 10 July. He told a PCO that he had settled at the prison and had no further thoughts of harming

himself. He told the officer that he hoped to complete his sentence at Doncaster and regularly received visits from his girlfriend and mother. He also phoned them on a regular basis. The PCO noted in the review that he associated with other prisoners, went on exercise most days and had a “good, clean appearance”.

41. There is little recorded in the man’s wing history sheets throughout his time at Doncaster. On 3 July, and again on 11 July, it was recorded that he returned late to his cell when required to do so after periods of association. On 20 July, he was caught smoking in the communal area of the wing whilst waiting to use the telephone (smoking is only permitted in cells). On 26 July, he was observed constantly going in and out of other prisoner’s cells and on 30 July, he was issued his first formal warning, for entering other people’s cells and again smoking in the communal area. The final two entries in his case history sheets were made on 31 July and 8 August, and noted that he returned late to his cell.
42. The man’s next meeting with the CARATs worker was on 12 August. During the meeting, he was advised to attend South Kirkby Drug Services should he be released after his next court appearance, on 8 September. At a meeting on 16 August, he and the CARATs worker discussed issues surrounding stability and relationships with those close to him, and how these acted as a positive motivation to tackle his substance misuse.
43. A PCO who worked on the wing knew the man well. She described him as “quiet”, but thought he would approach her if he needed someone to talk to. She told the investigator that he mixed with other prisoners, and in her opinion at no time showed any signs of self harm or depression during his time at Doncaster.
44. The man’s cell mate was released and someone else moved in to share the cell with him on 18 August. In a statement to police, the cell mate said that he had been introduced to him before they shared the cell. He said that on learning that each of their previous cell mates had been released they requested that they share a cell together. He said that during their time together the man spoke very little about his girlfriend and his family in general. He described him as a, “... comical person who enjoyed a laugh and a joke” and said that they both got on well.
45. In the days leading to his death, the man spoke to his girlfriend several times a day. During many of these calls the couple argued and he accused his girlfriend of seeing someone else whilst he was in prison. However, subsequent calls were more measured and the couple appeared to settle their issues. In a telephone call with his girlfriend on the morning of 20 August, his speech was slurred and during the telephone call he told his girlfriend that he was drunk.
46. Following the fifth telephone conversation with his girlfriend that day, the man became involved in a period of indiscipline, orchestrated by a number of other prisoners on the wing. During the disturbance he received a

graze to his face which was subsequently treated by one of the prison's nurses. He later returned to his cell.

47. Following the disturbance, prisoners remained in their cells for most of the next day. They were unlocked, several at a time, to collect their meals and make telephone calls or use the showers. At 10.18am, the man spoke with his girlfriend and explained that he had not called because he had been locked in his cell due to the "riot" on the wing. He told his girlfriend that he had been involved and was concerned that another prisoner was out to "get him". During the telephone call, his girlfriend expressed her concern for him. (The investigator found no evidence to suggest that he was the subject of bullying.)
48. At 9.23am on the morning of 22 August, the man received a visit from his girlfriend. The couple talked for over an hour and a half before she left. The couple appeared distant when they parted. We understand from his family that he had discussed funeral arrangements during the visit. However, no staff were aware of this fact at the time.
49. In his police statement the cell mate said that when the man returned from his visit he told him that his girlfriend had "... walked off...". He said he did not think that this bothered him that much and that after a while he calmed down. He said that morning he and the man chatted, watched television and listened to the radio. He said that the man never mentioned his girlfriend and that everything "... seemed to be back to normal".
50. In his incident statement, PCO A said that he started work at 9.00am. Prisoners were still locked behind their cell doors following the incident that weekend. When he got back from his visit, the man told the PCO that he had had a "fall out" with his girlfriend. He told the officer that it was a disagreement over nothing, but asked to use the telephone. The PCO told him that he would be able to make a call later that afternoon. The PCO said that the man "... wasn't upset or anything like that, he was just normal". The man, along with his cell mate, was unlocked for their lunch at 11.55am. Both prisoners left their cell to collect their lunch, returning five minutes later.
51. At about 1.15pm, the PCO began unlocking a few prisoners at a time, in order that they could make telephone calls and use the wing facilities. The PCO said that the man and his cell mate were the last prisoners to be unlocked that afternoon. At 2.37pm, he and his cell mate left their cell and proceeded to the telephones on the wing's lower level.
52. Between 2.40pm and 2.49pm the man made five short telephone calls to his girlfriend. During the telephone calls he told his girlfriend that he was going to end his life that evening and appeared to indicate that his cell mate was aware of what he was going to do.
53. In her incident statement, Visits Booking Clerk said that she received a call from the man's girlfriend, at about 2.45pm, to tell her that he had said

he was going to commit suicide. (Records show that the telephone call was actually made at 2.51pm.) The Clerk took her details and advised she would call her back as the wing's telephone was engaged. She said she spoke to an officer on the wing advising them that the man's girlfriend had called to say that he had threatened to commit suicide. In her statement she said:

"The wing officer replied 'I'll have a word'. I then asked if he needs to be on a watch. The wing officer replied, 'I'll have a word with him, he's always saying that'."

The Clerk then telephoned the man's girlfriend back, but her telephone was busy. She left a message to say that she had spoken to the wing.

54. Later that day, the Clerk said she received another call from the man's girlfriend. She said that, while placing her on hold, she phoned the wing a second time and spoke with PCO A, who advised that the man was currently on the telephone. The officer said he would speak with him when he had finished his call. The Clerk said she reassured the man's girlfriend that someone would speak with him. (The investigator listened to the telephone calls made to the Visits Booking Clerk about the man that afternoon. He observed that the second call appeared to have been made by another person, probably the man's girlfriend's mother, at 4.33pm. This would perhaps account for the fact that when the Clerk telephoned the wing she was told by the PCO that the man was actually on the telephone to his girlfriend at that time.)
55. The PCO said that he received a call at about 2.45pm from someone on the visits booking line about the man. The officer said that this was the only call that he had from the visits booking line that afternoon. He said that he was told the man's girlfriend had called to say that he was threatening to commit suicide. He said that he found this strange as the man was on the telephone at the time and remained so for the next 30 minutes. He said that he had to ask him to finish his call so that others might have use of the telephones.
56. In his statement, the PCO said that he spoke with the man when he finally finished his telephone conversation. He asked him about what his girlfriend had said. In his statement, the PCO said that he had told him:
- "... he was only winding her up to get a reaction after his fall out with her on visits. He did not seem upset and as I knew him quite well, did not seem out of character for him. I then made a judgement call based on my assessment of him at that time and decided no further action was necessary at that time and no ACCT was opened. During the afternoon a prisoner whose name I cannot recall spoke to me and said that he was only winding up his girlfriend on the phone."

The PCO went on to say:

“Around teatime he put his cell call light on and asked me for some writing paper. I told him to ask the wing rep, failing that ask me again at tea time. Once again his mannerisms did not voice any concerns.”

57. The PCO told the investigator that if he had had any concerns about the man he would have opened ACCT procedures. However, he said that it was his judgment that it was not necessary to open an ACCT at that time. The investigator asked the PCO if he had discussed the information he had received with any one else on the wing. The PCO said that he had not and that neither did he make a note in the man’s wing history sheets or in the wing’s observation book. When asked why he had not made any entries, he said it was due to the, “pure volume of work” that day following the disturbance, but he would normally have recorded such an event in the wing observation book.
58. In his final telephone call to his girlfriend, at 2.54pm, the man told her that he had rung to say good bye and that he loved her. She told him that she would ring the prison and let them know what he was planning to do. When she suggested that staff would not let him do anything he said, “... all they can do is check every half hour...” and said that his cell mate had apparently told him, “... everybody goes anyway. Everybody does what they have to do”. She told him that his cell mate, “... needs to get in trouble for not telling nobody, you and him making plans so he can get out”. Towards the end of the telephone call he talked to the PCO about the credit on his telephone card and assured the officer that he was getting off the telephone. At the end of the call, both he and his girlfriend appeared upset and exchanged their love for one another before the call was ended at 3.34pm.
59. The man’s cell mate returned to the cell at 3.15pm, followed by the man at 3.45pm, before both were locked behind their cell door. At 5.40pm, he and his cell mate were unlocked to collect their tea, returning to the cell five minutes later.
60. The PCO made a second statement to the Director, two days after his initial incident statement. In the second statement, he said that on the morning of 22 August at about 8.55am:

“I stepped onto the wing to be met by a very irate, flustered, angry and under pressure workmate (PCO B). Prisoners were banging on their cell doors and the wing was a mess, cell lights lit up the wing, too many to answer. She informed me that the wing was locked down due to an incident of severe disturbance that weekend.”
61. The PCO told the investigator that there would normally be three officers on duty on the wing but only two officers were scheduled to work on 22 August. He said that it was becoming more common for the wing to be staffed by two officers since April 2011. He said that officers on the wing had been “struggling” and that staff from other departments had often

been deployed to cover the shortfall.

62. In her statement, PCO B said that she spoke to the man several times during the day. For example, he asked for a light at 6.18pm. She said that at no point during the day was she told that he had threatened to commit suicide. At about 7.10pm the Senior Operations Manager said that he saw the man in his cell when he again asked for a light. In his statement, the Manager said at no time did he receive a phone call from the visits booking line concerning the man about his threats of self harm. The Unit Manager (UM) who was working that day also confirmed that he was not told about the man's threats of suicide. The UM also said that he had not received any telephone calls from the booking line.
63. In his statement to police, the man's cell mate said that he decided to go to sleep at about 6.30pm (although he could not be sure of the exact time). He said that a short time later he got up to use the toilet. The man was propped up in his bed staring out into the cell and said nothing. He said that he requested some toilet paper, returned to his bunk and went back to sleep. He told police that the next time he woke up, he discovered him and raised the alarm.
64. At about 6.45pm, both PCOs finished their shift. PCO A told the investigator that he gave a verbal handover to the oncoming staff. PCO C confirmed with the investigator that PCO A provided a handover. He said:

"It was a very quick handover because I could see that they'd been extremely busy that day because there was only two members of staff on... they were rushed off their feet... he said just keep an eye on the man, he's had a bad visit so I says okay no problem..."
65. At about 7.15pm, PCO C said that whilst conducting a routine check of the cells he noted that the man and his cell mate were watching television. He said that he spoke briefly with him and did not notice anything wrong. He said that whilst passing the cell a little later that evening, he asked for a toilet roll.
66. At about 7.35pm Oscar 1, the manager responsible for running the prison at night attended to another prisoner on the wing, who had tried to harm himself. PCO D also attended and was asked to stand outside of the cell while the UM spoke to the prisoner inside.
67. Five minutes later, at 7.40pm, the PCO noticed that the man's cell call sounded on the opposite side of the wing. (All prisoners have bells in their cell, which they use to call for assistance from staff when they are locked in. When the bell is activated, a light goes on outside their cell so that officers can see who needs assistance.) He answered the bell three and a half minutes later and was told: "It doesn't matter boss, tell PCO C not to bother with the toilet roll because I have already got some". The PCO could not see into the cell and therefore he was not certain whether he spoke to the man or his cell mate.

68. PCO D returned to the other officers in the wing waiting room. PCO E asked him what the prisoners had wanted and he was told that they wanted a toilet roll. At 7.48pm, PCO E gave the toilet roll to the man. (PCO E said in his incident statement that he was asked by PCO C to hand a toilet roll to Cell 153, the man's cell.) PCO E remembered that he took the toilet roll from him and his cell mate was standing at the back of the cell. He then left the wing to attend an incident in another area of the prison.
69. PCO F also responded to a further call for assistance by the UM, who was dealing with the prisoner who had harmed himself on the wing. When he got to the wing, he was speaking to PCO D when he noticed the man's cell light went on. It was 8.10pm and PCO F said he went to the cell immediately. As he approached, the officer heard someone banging and kicking the door. He opened the cell door's observation flap and saw that the man was hanging from the top bunk with his back towards the cell door. He instructed the cell mate to move the man's feet away from the door in order that he could get into the cell.
70. Alerted by the shouts of PCO F, PCO D reached the cell within a minute. Both officers went in and PCO F took the weight of the man, whilst PCO D untied the ligature. The officers moved him out of the cell and PCO D tried to find a pulse, but could not. PCO F told the investigator he checked the man's pulse, airways before he made attempts to resuscitate him by commencing Cardio Pulmonary Resuscitation (CPR) by starting chest compressions. (CPR is a procedure used when a patient's heart stops beating and breathing stops. It can involve compressions of the chest or electrical shocks, delivered by a defibrillator, a portable electronic device that diagnoses heart rhythms after cardiac arrest, along with rescue breathing. Face masks provide a device that provides a safety barrier between rescuer and victim when carrying out CPR and are often used during the process.)
71. While PCO F attempted resuscitation, PCO D requested emergency healthcare assistance by calling a code blue. (Many prisons use emergency code systems, to summon emergency healthcare assistance, such as red (for blood loss) and blue (for breathing difficulties.) The codes inform staff of the nature of an emergency in language that is easily understood.) A nurse responded to the emergency call, and got to the wing by 8.13pm. She had brought the emergency response bag which contained basic first aid equipment. By the time she arrived the man was on the landing and PCO F was doing chest compressions. She checked for signs of life. She told the investigator that "there was no pulse in his neck, his eyes were fixed and dilated and there were no signs of life".
72. When she heard the emergency radio call, the HCA collected the oxygen and defibrillator from the wing office and arrived at the cell with another nurse. Both nurses continued with resuscitation, assisted by the HCA. The defibrillator was attached but it advised not to apply an electrical

shock to restart the heart. While she was trying to resuscitate the man, the first nurse said that she asked for an ambulance to be called. The nurses continued resuscitation attempts until the paramedics arrived on the wing at 8.30pm.

73. Several other officers and nurses arrived on the wing in response to the emergency radio call, including the UM. The UM told the investigator that she radioed for an ambulance to be called when she got to the cell, several minutes after the alarm was raised. She explained why an ambulance had not been called sooner. She said:

“You attend the scene and you make the decision then. Sometimes you’ve got a code blue [an emergency call sign that indicates a prisoner is having breathing difficulties] you’ll find it’s a prisoner who’s had a fit so he’s come out of his fit, they’ve put him in the recovery position and he’s okay so you don’t need an ambulance.”

74. However, PCO D told the investigator he called for an ambulance. According to the control room communication log, the ambulance was called for at 8.16pm, six minutes after the man was found hanging. Yorkshire Ambulance Service’s own records show that the request to attend the prison was made at 8.17pm.
75. Paramedics and nursing staff stopped attempting CPR at 8.45pm. The man was pronounced dead at 9.00pm by one of the prison doctors.
76. The man left a note in the cell addressed to his girlfriend explaining the reasons for his actions and requesting arrangements with regard to his funeral. Apparently, he also wrote letters to each of his parents in the days before his death.

Prisoner support

77. Initially, the man’s cell mate was asked to remain in the cell. Upon the arrival of nursing staff, he was taken from the cell by PCO D. A short time later he was taken to the healthcare unit, where he was cared for and ACCT procedures were started. He told PCO D that he had been asleep and woke to find the man hanging when he raised the alarm. He later told police that the man never mentioned harming himself during the time that they shared a cell.
78. In light of the man’s death, all open ACCTs were reviewed. Other prisoners were informed of the death the following morning. Support and help were offered to all prisoners on the wing who felt they had been affected by the events of the previous evening.

Staff support

79. Some of the staff involved in the discovery of the man were invited to a hot debrief. (A hot debrief is a meeting to give staff the opportunity to

share their feelings following involvement in a traumatic incident.) Staff were supported at the meeting by two managers. Nurses who were involved in the response did not attend and there were no members of the prison's staff care or welfare team present during the meeting.

Family Liaison

80. The man's girlfriend rang the prison at about 10.20pm. The investigator has not been able to obtain a recording of this telephone call, but understands that she made enquiries about his well being. As the man's listed next of kin had not been informed of his death at that time, staff could not break the news of his death to her during this telephone call.
81. The man's father, his nominated next of kin, was advised of his son's death at 12.30am the following morning. A prison family liaison officer (FLO) and two other managers visited him to break the news in person. He then told other family members, including his mother that his son had died.
82. The man's mother phoned the prison the next day for more information. However, she was informed that her son's father was his nominated next of kin and therefore their first point of contact. The following day, 24 August, the man's father spoke with the FLO, advising her that he had no problems with the prison liaising with his son's mother as well. Unfortunately, no further communication was made with her until 30 August, when he asked the FLO again to keep her informed. The prison subsequently made contact with her.
83. An invitation was made for the man's family to visit the prison, but to date the family have declined. His personal possessions were returned and the prison made a contribution to the funeral expenses, which was accepted by the family.

Post-Mortem Examination and Toxicology

84. A post-mortem examination was conducted. Toxicology results revealed that no alcohol or drugs were detected in the man's blood. The pathologist concluded that death was likely to have been due to compression of the neck as a consequence of hanging.

CLINICAL ISSUES

Referral to mental health

85. The clinical reviewer, in his report, comments why the man was not referred to the mental health or substance misuse teams at Doncaster. In the first reception health screen, he told the nurse that he had previously attempted to take his own life whilst at Leeds. The form prompts an onward referral to the mental health team if a prisoner indicates a history of self harm. However, he was not referred despite the nurse indicating on the template that a referral was made. He says:

“It is my opinion that an opportunity was missed to offer the man mental health nursing support. However, the nurse did open an ACCT document which provided a mechanism for ongoing monitoring of his mental health. Therefore on the balance of probabilities it is unlikely that the failure to refer for mental health nursing support would have been a causal factor in his death. He did receive support whilst on an open ACCT for a number of weeks until his mental health stabilised.”

86. We note similarly that in the investigations into the death of a man at Doncaster in 2006 and of the deaths of two men in 2010, the reception nurse failed to make mandatory referrals to the prison’s mental health team. It is a matter of great concern that yet again, in our investigation into the man’s death; a referral to the prison’s mental health team was not made despite previous recommendations by this office. Although the clinical reviewer does not believe this failing contributed to the death of the man, he makes the following recommendation which we endorse.

The Director and Head of Healthcare should ensure that staff act on prompts in screening tools for onward referral. Where such prompts are not acted upon, explicit clinical reasoning should be recorded in the healthcare record.

87. The clinical reviewer concludes that the ACCT opened by the nurse provided ongoing monitoring of the man’s mental health, and was an adequate substitute for a mental health treatment. However, no staff involved in the ACCT process were clinically trained in mental health. On 17 June, he told staff, for the first time, that the “voices in his head” had decreased. As a consequence of this remark a PCO made a referral for him to be seen by a member of the mental health team. Despite this referral there is no evidence that he was ever assessed.
88. It is essential that all referrals to the mental health team are acted upon. We are also concerned that the man’s ACCT was closed 11 days later without checks being made as to whether or not he had been seen by a member of the prison’s mental health team.

The Director and Head of Healthcare should ensure that the mental health referral system results in the timely assessment and

treatment of prisoners with possible mental health needs.

Referral for substance misuse treatment

89. The clinical reviewer notes that the nurse did not complete the substance misuse section of the first night reception form, despite the man telling her that he had alcohol problems and wanted assistance with detoxification. However, he notes that the man was assessed by a doctor who specialised in substance misuse the following day and that the doctor did not note any treatment needs. Neither did the doctor record that he asked for treatment for substance misuse.
90. The clinical reviewer concludes that he did, "... not feel the act of withholding a detoxification prescribing regime from the man was causal in his death". Nevertheless, the clinical reviewer makes the following recommendation in light of the failure to complete to record his substance misuse history and needs in the first reception health screen:

The Director and Head of Healthcare should ensure that staff complete all sections of clinical assessment tools.

Request for previous medical records

91. Despite the man's attempted suicide at Leeds, the clinical reviewer reports that he was unable to find any indication that health care records were requested from Leeds prison. He says that:

"... the fact that the man was "hearing voices" should have been a prompt for healthcare staff to request healthcare records from HMP Leeds."

92. Prison Service guidance makes provision for prisons to consider the retrieval of information from other healthcare providers that individuals may have been in contact with. Prison Service Order (PSO) 3050, Continuity of Healthcare for Prisoners, Chapter 2, Retrieving Information, section 2.1 states:

"When a prisoner enters reception a new clinical record is created ... Efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with."

93. Although not a mandatory requirement, previous medical records would have enabled healthcare staff to make informed decisions about what care an individual may require, based on their medical history. Indeed, the clinical reviewer considers that not requesting previous medical records represented a failing in healthcare systems at Doncaster. The clinical reviewer goes on to say that:

"It is possible that such a failing contributed to the death of the man.

Past behaviour can help predict future behaviour and more details should have been obtained regarding the circumstances of his attempted hanging at HMP Leeds. An assumption was made that there was no intent behind his threats to his girlfriend to commit suicide. Full details of his previous history could have helped challenge such assumptions.”

94. Although healthcare staff were not aware of the voices that the man told staff that he heard, the clinical reviewer makes the following recommendation with regard to the failure to request previous medical records, which we endorse:

The Director and Head of Healthcare should ensure that a system is in place whereby past medical records are always requested from previous GP services, be they community or prison-based.

Resuscitation and delay in calling an ambulance

95. The clinical reviewer reports on the resuscitation attempts by members of staff at Doncaster. He says:

“Attempts at resuscitation appeared to be reasonable although there was a delay in calling for paramedic support. All staff (and not just healthcare staff) should feel it legitimate to call for paramedic support once a decision has been made to start resuscitation. On the balance of probabilities it is unlikely that such a delay was a significant contributing factor in the man’s death since only a minority of patients are successfully resuscitated following cardio respiratory arrest.”

96. Emergency ambulance assistance should be called as soon as possible. The investigation was unable to establish who requested an ambulance. However, the evidence shows that the ambulance was not called until some six minutes after the alarm was raised, and staff had commenced resuscitation attempts.

97. Doncaster’s local guidance, “Director’s Rule, Emergency First Aid / Emergency Phones”, section “Assessment”, paragraph two says:

“If an ambulance/ Doctor is required the nurse on scene is to advise Oscar One who will liaise with the communications / COMMS Department.”

98. The Director of Offender Health and the Chief Executive Officer, National Offender Management Service, wrote to all Governors and Directors on 17 February 2011. They emphasised the importance of prisoners having rapid access to emergency services. In the letter, they say:

“It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement in every case for a member of the prison healthcare

team to attend the scene before emergency services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call has been made, a member of the Health Care Team arrives and after assessment of the patient deems that an emergency ambulance response is not required.

The most important aspect of emergency care is that an ambulance is called in all cases where there are grave concerns about the immediate health of a prisoner.”

99. As the guidance suggests, it is essential that ambulances are called immediately to emergency situations. Any delay can have a significant impact on a person’s chances of survival. Doncaster’s own guidance requires that an ambulance is only summoned on the advice of a nurse, but this does not reflect the guidance issued by Director of Offender Health. We therefore concur with the clinical reviewer’s findings and make the following recommendation:

The Director and Head of Healthcare should ensure the guidance issued to staff with regard to the summoning of an ambulance in an emergency meets with the requirements laid out by the Director of Offender Health.

100. The clinical reviewer concludes his clinical review:

“... on the balance of probabilities it is unlikely that healthcare failings contributed to the death of the man. Nevertheless there are areas of healthcare that did not fulfil best practice.”

OTHER ISSUES

Request for Previous Records

101. On his arrival at Doncaster the man told the nurse that he had made a serious attempt to self harm whilst at Leeds. As a precautionary measure she opened an ACCT. During subsequent assessments and reviews by staff, notes of his previous attempts of harming himself were made. However, despite this information there is no evidence of attempts by staff to obtain additional information, including previous ACCTs opened at Leeds, to assist with regard to their consideration of his risk.

102. Prison Service Order (PSO) 2700 "Suicide Prevention and Self-Harm Management", section 4.16.2 sets a mandatory requirement for prisons. It states that:

"Where a new prisoner has been on an ACCT Plan ... during a previous period in custody, these must be obtained as soon as possible to help inform care planning decisions by the wing manager responsible for that prisoner. A record must be maintained to show this has been done."

103. It is surprising that staff did not obtain information about his previous suicide attempt from Leeds, given his account at reception. As outlined in the PSO, it is imperative that previous records relating to self harm are sought from previous custodial assessments. As there is no evidence to suggest that staff at Doncaster made such a request to their colleagues in Leeds. As such we make the following recommendation:

The Director should ensure that when a prisoner reports self harm in a previous establishment, contact is made with that establishment to secure all relevant information.

The man's threat to commit suicide

104. At about 2.45pm PCO A received a call from visits booking clerk informing him that the man's girlfriend had called the prison saying that her boyfriend had threatened to commit suicide. The PCO spoke with him when he finished his telephone call. The PCO said the man:

"... did not seem too upset and acted quite normally and I found nothing out of character with him. I knew him quite well having helped him in the past with phone calls from the office when he had had no credit. Based on my past experience of 17 years and what I have been told by him and my previous knowledge of him, and my assessment of his demeanour and overall mannerisms, I then made a judgement call and decided that no further action was necessary at that time and no ACCT was opened.

"Later that afternoon at teatime I think a prisoner who I cannot now

recall reinforced my decision not to take any action when he told me that he had spoken to him and that he had said that he was only winding up his girlfriend to get a reaction.”

105. The PCO acted on the information from the visits booking clerk and spoke to the man directly. As an experienced prison custody officer, he made the judgement that he was not at risk of self harm. Therefore, despite the man’s girlfriend’s concerns, it was his view that it was not necessary to open ACCT procedures.

Information sharing on the wing

106. PSO 2700 “Suicide Prevention and Self Harm Management”, section 4.17.1 sets out a mandatory requirement to ensure that information advising of risk is shared with all staff. It states that:

“Establishments must have in place robust systems for receiving and recording, and passing to the area of the prison where the prisoner resides, information coming into the establishment from families, agencies, Offender Managers/Supervisors and other parties outside the establishment who have a concern for a prisoner who may be at risk of self-harm or suicide.”

107. Although the Clerk spoke with the PCO about the information received from the man’s girlfriend, he in turn failed to tell any of his colleagues about the threats. When he advised PCO C to keep an “eye on” the man as he had had “a bad visit”, during a brief handover between shifts, he did not mention his threats of suicide. Nor did he note his conversation with the Clerk in the wing observation book, or the man’s wing history sheets. As a consequence other members of staff working on the wing that afternoon and evening, including Unit Managers, were not aware of key information about the man’s level of risk.
108. We appreciate that in a busy local prison staff often have pressing demands placed upon their time. However, it is of the utmost importance that staff record all significant interactions and observations of prisoners, including information received from outside sources such as family members and friends and also record any change in a prisoner’s demeanour or behaviour. The absence of any entry recording the threats the man made to his girlfriend prevented other staff from accessing significant information about his risk. Entries in the wing observation book and in his wing history sheets would have been one way of communicating the concerns expressed by his girlfriend that afternoon, as would a full and considered handover to the oncoming staff. On this occasion neither was completed. This is deeply worrying and as such we make the following recommendation:

The Director should ensure that staff record any significant interaction and information with regard to a prisoners risk, in particular that received from outside sources, in both wing

observation and wing history sheets.

Key officer / Personal officer scheme

109. There were few meaningful entries about the man in his wing history sheets. All but two of the entries were negative. In part, this was a reflection of the poor operation of the key officer scheme. (Each prisoner is assigned a key officer who acts as the officer that they can turn to should they need help. This member of staff is also required to have regular conversations with the prisoner and record these interactions.) A UM told the investigator the "... personal officer scheme doesn't particularly work and we don't have enough staff to run it then that is why his [wing sheet] entries are poor".
110. Her Majesty's Inspectorate of Prisons commented on the key officer scheme in their inspection last year, asking that the Director ensure that the key officer scheme makes clear the responsibilities of the key officer. The Inspectorate also asked for an increase the standard required for written wing file entries. We make a similar recommendation with regard to this matter:

The Director should ensure that all staff are aware of their responsibilities under the key officer scheme and satisfy himself that adequate and frequent entries are being made about prisoners in their wing history sheets.

Hot debrief

111. A number of staff involved in the response efforts were not invited to attend the hot debrief which took place following after the man's death. (A hot debrief provides staff with an opportunity to talk through the incident. Its purpose is to establish what happened and to provide reassurance and support.) Despite their key role in response efforts, no healthcare staff attended the hot debrief.

The Director should ensure that a hot debrief involves all relevant staff, including healthcare staff.

Care and Welfare Team

112. A number of staff interviewed said that they did not know how to access the staff care and welfare team. The investigation established that there was no support welfare team at Doncaster at the time of the man's death. The investigator was assured that the matter was being dealt with. An assistant director wrote to all staff to invite them to speak to him should they have any concerns. One member of staff said a colleague who had been particularly affected by the man's death had been seen by a member of the chaplaincy team. However, no trained welfare team members were available to give staff support through this difficult time.

The Director should ensure that the care and welfare team are reinstated.

Family Liaison

113. Although the man's mother did not raise any concern with the prison at the time, she told the Ombudsman's family liaison officer and investigator that she felt excluded after her son died. His next of kin was listed as his father and he was the first point of contact in accordance with Prison Service guidance. However, this meant that there was little contact between his mother and the prison's family liaison officer. Once the prison had consent from his father, they should have contacted his mother and updated her on the circumstances of her son's death. The prison is aware of this matter and as such we make no formal recommendation.

CONCLUSION

114. It is clear from our investigation that the man had a difficult relationship with his girlfriend and in particular issues with regard to trust. It maybe that the outcome might have been different if there had been earlier intervention by mental health services at Doncaster and if mental health support for him had been provided, although we note that his contact with the CARATs team provided him with some support.
115. There was clear evidence about the man's risk of self harm that was not effectively shared and disseminated amongst staff. We are concerned that the omissions with regard to mental health and not noting the telephone call meant that he was not provided with the support and intervention required which may have prevented him from taking his life.

RECOMMENDATIONS

1. The Director and Head of Healthcare should ensure that the mental health referral system results in the timely assessment and treatment of prisoners with possible mental health needs.

Accepted – The Trust has a KPI that instructs all new receptions will be referred to the Primary Mental Health Services within five working days; this is monitored by an independent analyst. There is now a robust system in place to ensure this is adhered to December 2011 and January 2012 demonstrated 100% compliance with this target

2. The Director and Head of Healthcare should ensure that staff complete all sections of clinical assessment tools.

Accepted – All clinical assessments are compliant with NICE Guidelines and are nationally recognised assessment tools.

3. The Director and Head of Healthcare should ensure that a system is in place whereby past medical records are always requested from previous GP services, be they community or prison-based.

Accepted – Work has been undertaken to build working relationships between healthcare staff, who make every effort to retrieve information from the hospital regarding treatments and results etc, and the PCT and hospital stakeholders. Work has been undertaken by managers to oversee the chasing up of records and results. SystemOne will be installed in April 2012 which will alleviate some of the problems the prison has in obtaining results etc. from the hospital in a timely manner. Managers will continue to oversee the efforts made by staff in the retrieval of records and to ensure that stakeholders are effectively managed. GP information is requested for all new receptions this is a standard process.

4. The Director and Head of Healthcare should ensure the guidance issued to staff with regard to the summoning of an ambulance in an emergency meets with the requirements laid out by the Director of Offender Health.

Accepted – All staff are aware of the guidance for emergency procedures. In addition Nottinghamshire NHS Trust reviewed systems and processes with additional Standard Operating Procedures formulated. A full review of Directors Rule 18.1 has been carried out. Paras 7.1 to 7.6 provide clear instructions on what to do on discovering a prisoner requiring assistance. The colour coding system instructs staff, "If there is any doubt to the risk of life, then the communications room will be informed and an ambulance requested as an emergency". This information will be conveyed to staff via meetings and daily briefings.

5. The Director should ensure that when a prisoner reports self harm in a previous establishment, contact is made with that establishment to secure

all relevant information.

Accepted – Directors Rule 18.1 has instructions added at 3.1g and 9.16 informing staff to seek information from other establishments when it is known the prisoner was previously on an ACCT plan at the establishment. This information will be relayed to staff via the morning meeting notice and via management briefings. Managerial quality checks will provide assurance that these aspects have been rectified.

6. The Director should ensure that staff record any significant interaction and information with regard to a prisoner's risk, in particular that received from outside sources, in both wing observation and wing history sheets.

Accepted – Directors Rule 18.1 paragraphs 9.00 to 9.3 provide information on how visitors and outside agencies can provide information and raise concerns. It provides information on how the information will be passed on once received. Staff will be reminded of the importance of making entries in ACCT files and wing observation books. This information will be relayed to staff via the morning meeting notice and via management briefing. Managerial quality checks will provide assurance that these aspects have been rectified.

7. The Director should ensure that all staff are aware of their responsibilities under the key officer scheme and satisfy himself that adequate and frequent entries are being made about prisoners in their wing history sheets.

Accepted – Staff will be reminded of the importance of making entries in ACCT files and wing observation books. Managerial quality checks will provide assurance that these aspects have been rectified. This information will be relayed to staff via the morning meeting notice and via management briefings. Managerial quality checks will provide assurance that these aspects have been rectified.

8. The Director should ensure that a hot debrief involves all relevant staff, including healthcare staff.

Accepted – In line with the requirements of PSI 64/2011 all staff directly involved in the incident including health care staff will be involved in the hot debrief chaired by at least a member of the Senior Management Team. This information will be relayed to staff via the morning meeting notice and via management briefings.

9. The Director should ensure that the care and welfare team are reinstated.

Accepted – The Care and Welfare Team have been reinstated and are operating within the prison.