PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Doncaster in May 2014

Our Vision

*‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’*

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Doncaster in May 2014. He was 18 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care at Doncaster. The prison co-operated fully with the investigation.

The man arrived in Doncaster on remand on 3 May. He told reception staff that he his father had recently killed himself and that he had taken an overdose in response. Staff managed him under Prison Service suicide and self-harm prevention procedures, known as ACCT. He told a nurse that he had been taking anti-depressant medication, but he did not have any with him. She referred him to see a mental health nurse the next day.

At an ACCT review the next day, the man was distressed about not receiving his anti-depressant medication. No healthcare staff were present at the review, despite this being a mandatory requirement. The man saw a mental health nurse, who thought his problems related to the recent death of his father and referred him for bereavement counselling. An officer ended ACCT monitoring on 16 May at the man's request. That afternoon, the man attended Muslim prayers and made a declaration of faith to adopt Islam.

The next day, Saturday 17 May, the man spent some time in the exercise yard with other prisoners, ate his lunch and ordered some items from the prison shop. He locked himself in his cell and, shortly after 1.00pm, asked another prisoner to close the observation panel on his door. At 2.21pm, an officer opened the cell to let the man's cellmate in. His cellmate found the man hanging. Officers began to attempt resuscitation, joined shortly by nurses. Paramedics arrived quickly, but were unable to save the man.

The man was a young man, in prison for the first time. His father had recently killed himself and he had attempted suicide in response. He was facing serious charges. Prison staff rightly identified that he was at risk of suicide and self-harm and began support measures. However, I am concerned, that this did not lead to the man receiving adequate care. There were many failures to operate the ACCT procedures effectively, including insufficient healthcare involvement and ending the support too quickly. I am also concerned that a GP never saw the man during his time at the prison, to consider whether he should have been prescribed the anti-depressant medication that he had been taking in the community.

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 **February 2015**

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SUMMARY

1. The man arrived in Doncaster on Saturday 3 May, on remand for charges of rape and sexual assault. He was just 18, in prison for the first time and his father had recently committed suicide, after which he had taken an overdose. Court staff had alerted staff at the prison about the man and staff began Prison Service procedures, known as ACCT (Assessment, Care in Custody and Teamwork) as they recognised that he had a number of factors which increased his risk of suicide and self-harm. To keep him safe until his first ACCT case review, the unit manager decided that the man should share a cell and that officers should check him at least every 30 minutes.

2. At an initial reception health screen, the man told a nurse that he was upset about his father's death and that he had thoughts about killing himself. He said he had tried to kill himself the previous year and his GP had recently prescribed him medication for depression and anxiety. The nurse noted that healthcare staff should confirm his medication with his community GP and referred him for a mental health assessment.

3. At the mental health assessment the next day, the man was distressed, which the nurse thought was because of his recent bereavement. He told her that he had been prescribed medication for mental health problems in the past, and had seen a psychiatrist. He said he had suicidal thoughts. The nurse did not consider that the man was suffering from depression, and referred him to the chaplaincy team for bereavement counselling.

4. An ACCT assessment and first case review took place on 4 May. The man said that he would have tried to kill himself the previous night if it had not been for his cellmate talking to him. He said that he would feel much better if he had his anti-depressant medication. Although it is mandatory for a member of healthcare staff to attend first ACCT case reviews, there was none present and the manager who chaired the review noted on the form that a manager should chase up the man's medication. The man did not receive any anti-depressant medication while he was at Doncaster.

5. The man continued to be managed under ACCT procedures until 16 May, when he asked an officer if it could be closed. The officer convened an impromptu review. In interview he said this was with another officer, though in their response to the draft report NOMS said that no other officer was present. No other member of staff was present. The man said that he no longer felt that he needed the support of the ACCT process and did not need his medication. He said he had become interested in Islam and was attending Muslim prayers. The officer agreed to end the ACCT. That afternoon, the man attended Muslim prayers and asked to be inducted into the faith. He made the required declaration and was welcomed into Islam.

6. The next day, Saturday 17 May, the man spent some time on the exercise yard and had his lunch. He ordered some drinks from the prison shop for the following week. After lunch on Saturdays, prisoners are unlocked and can socialise with each other, but the man chose to remain locked in his cell. When

an officer unlocked his cell in the early afternoon, the man was found hanging from a belt tied to the upper bunk. Prison staff tried to resuscitate him, but without success. Paramedics arrived and pronounced his death.

7. The early days in custody are a critical time for any prisoner and particularly for a young man like the man, who was in prison for the first time, charged with a serious offence and without any obvious support. He was grieving for his father who had recently committed suicide. Court staff were concerned about him and alerted the prison. Officers correctly identified the man's risk factors for suicide and self-harm when he arrived at Doncaster. Despite telling staff that he had been prescribed anti-depressant medication, a doctor never saw him at Doncaster and his medication was not reviewed. Healthcare staff did not refer him to a psychiatrist although he told a mental health nurse that he had previously seen one. The ACCT document does not suggest that staff carried out the required level of observations and junior officers closed it inappropriately and prematurely without input from healthcare staff, despite an unresolved issue about his medication. We found that there were serious failings in the operation of ACCT procedures. The clinical reviewer found that the standard of healthcare the man received at Doncaster was not equivalent to that he would have received in the community. We make five recommendations.

THE INVESTIGATION PROCESS

8. The investigator, issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

9. The investigator spoke to prisoners who had known the man at Doncaster on 29 May and obtained copies of his prison record. He later interviewed members of staff at Doncaster in June and informed the Director of the preliminary findings of the investigation.

10. NHS England, West Yorkshire Area Team, commissioned Nina Murphy Associates to review the man's healthcare and treatment at the prison. The investigator and the reviewer from Nina Murphy Associates, jointly interviewed staff.

11. We informed HM Coroner for Doncaster of the investigation who sent us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted the man's mother to explain our investigation and invite her to identify any issues she would like the investigation to consider. The man's mother asked for clarification of the ACCT process and why the ACCT was opened and closed. She asked for details of the regime at Doncaster and questioned how no one stopped the man from taking his own life. The man's mother also asked for information about his conversion to Islam. She asked if there was any explanation for his actions, as he had recently written to a friend and talked about his future. The man's mother also asked us to consider whether the emergency response was appropriate.

13. We sent a copy of the draft report to the man's mother. The investigator and family liaison officer met her and the solicitor representing her to discuss their response. The solicitor subsequently wrote to us confirming their comments. The report has been amended accordingly. They also raised some questions that do not impact on the factual accuracy of the report, and we have provided clarification by way of separate correspondence to the solicitor.

HMP DONCASTER

14. HMP Doncaster is a local prison holding 1,145 remand and sentenced men over 18. There are three houseblocks, each with four wings holding 90-96 prisoners. It is operated by Serco. NHS Nottinghamshire trust provides physical, mental and substance misuse healthcare under a separate contract with NHS England.

Her Majesty's Inspectorate of Prisons' report

15. The most recent inspection of Doncaster was in March and April 2014. Inspectors found that, although most prisoners at risk of suicide and self-harm said they felt supported, information about suicide and self-harm triggers and ACCT caremaps were inadequate. ACCT reviews were not multidisciplinary and many staff were not up to date with their training. Mental health staff were not involved in reviews even when mental health had been identified as a primary concern. Inspectors found that there were no Samaritan-trained Listeners and insufficient peer supporters to meet prisoners' needs. Inspectors also noted that Doncaster had appropriately implemented the PPO's recommendations from two previous investigations into self-inflicted deaths at the prison, but there was no ongoing follow-up.

Independent Monitoring Board (IMB) report

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to September 2013, the IMB reported that Doncaster was an efficiently run establishment and that staff showed a true duty of care. Healthcare provision had improved after concerns the IMB had had the previous year.

Previous deaths at Doncaster

17. The man was the third apparent suicide at Doncaster since the beginning of 2011. We have previously made recommendations about mental health referrals, obtaining previous medical records and use of appropriate emergency codes.

Assessment, Care in Custody and Teamwork (ACCT)

18. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed.

Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

19. The man was remanded to Doncaster from Leeds Magistrates' Court on Saturday 3 May 2014, charged with two counts of rape and two of sexual assault. He had no previous convictions. A supplement to his remand warrant noted that he might be vulnerable because of his young age, it was his first time in prison, and his father had recently taken his own life. The man's escort record contained a police risk assessment, which noted that he told the police that he suffered from depression for which he took medication. He said that he had taken an overdose two months previously and had cut himself in the last year. When he was arrested, he had smelled of alcohol but was not drunk. The man said that he was dependent on alcohol and became fidgety, lost his temper easily and suffered from the shakes when he did not drink.

20. Court staff alerted the prison to the man while he was still at court. A prison custody officer assessed his circumstances from the information he had available before he arrived. There are recognised factors that raise the risk of prisoners harming themselves which are listed in Doncaster's reception area. The officer noted that the man had recently taken an overdose and decided to open an ACCT plan before he arrived. The unit manager, completed an immediate action plan for the man to share a cell for support and that staff should check him at least every 30 minutes and have a minimum of three proper conversations with him each main shift (morning, afternoon and evening). The unit manager noted that healthcare staff should assess the man and consider referring him to the mental health team.

21. When he arrived, a nurse completed a reception health screen. The nurse told the investigator that she remembered that the man had appeared fairly upbeat at first, but then became distressed. He said he had been close to his father, who had taken his own life in February 2014, which had led to a rift in the family. He told the nurse that he had thought about killing himself and still thought that he might, though he did not have any actual plans to do so at that time. The nurse said that, apart from this, he appeared to be acting normally. She did not think he would harm himself in the short term, but might in the future. She noted the record that he had overdosed in December, when he had taken all the medication he could find. He had collapsed in the street and been taken to hospital. He said that he had cut himself as recently as 2013, and had done so for several years as a way of relieving stress. He said that he took daily doses of fluoxetine (an anti-depressant) and diazepam (for anxiety). He said that he had no history of substance abuse, no history of mental disorder, and no significant medical history. The nurse referred him for a mental health assessment the following day. She noted on his record that he had said he took prescribed medication and that colleagues should contact his doctor to confirm this, when the surgery was next open.

22. Staff then completed the rest of the reception process and noted on the man's personal summary sheet that it was his first time in prison. He did not give any contact details for a next of kin and said that he had no religion. The man said that he did not have any immediate needs or concerns and he chose not to make a telephone call. Staff assessed him as suitable to share a cell. An

officer noted that he should move to Houseblock 3A, the prison's vulnerable prisoner unit (for prisoners at risk from other prisoners because of the nature of their charges of offences) when there was space. (There is no further reference of the man going to the vulnerable prisoner unit during his time at Doncaster.) There was no mention in the induction or reception records to the reference in the police risk assessment to the man's alcohol use.

23. The man went to the prison's first night centre on Houseblock 1D, and shared a cell with another prisoner. He had his evening meal, and staff noted in his ACCT document that he did not mention any concerns. Staff should have observed the man at least once every 30 minutes. However, the only entries from officers in the ongoing record were at 7.00pm, 9.02pm, 10.00pm, and then 2.00am, 5.00am and 7.00am on 4 May. None of these entries indicated any problems. There were no further entries after the 7.00am entry, until later that afternoon.

24. At 2.43pm, the man saw a nurse for a mental health assessment. He was tearful throughout the consultation, but the nurse said he was fully orientated. The nurse told the clinical reviewer that the man was distressed, because he was in prison. He told her that he had been prescribed fluoxetine for mental health problems and had seen a psychiatrist in 2012. She noted his recent overdose on his medical record and that he still had suicidal thoughts. He said that he had taken the overdose because of his father's death. He had been unable to attend the funeral and was having difficulty coming to terms with his loss. The man scored very highly for anxiety and depression on standard assessment tools. However, when interviewed, the nurse said that she did not feel that the scores were unusually high for prisoners.

25. The nurse said that she considered that bereavement issues were the main cause of the man's problems, not depression. She referred him to the chaplaincy for bereavement counselling. She did not believe that the man needed medication immediately and thought the issue of his medication was being followed up with his community GP. The nurse did not note anything in the man's ACCT document.

26. That afternoon, one of the prison chaplains spoke to the man as part of his induction to the prison. He told the man that the chaplaincy ran groups on Tuesdays and Thursdays (some bereavement sessions, and some general bible sessions) and that he would be welcome to attend. He said that they had volunteers who came to the prison who could help with his bereavement issues.

27. An officer interviewed the man for an ACCT assessment and noted that the man had not been to prison before. The man said that he had last attempted to harm himself three months before and said that if it had not been for the man's cellmate talking to him the previous night, he would have tried to harm or kill himself. The man was concerned that he was not getting his anti-depressant medication and said he would feel much better with it. He told the officer that he had a child on the way. (After the man's death it became clear that this was not the case, but the man had thought it was at the time.) The man told the officer that his father had died recently. He had been unable to go to the

funeral and had not had the opportunity to say goodbye. He said that he would be willing to speak to someone from the chaplaincy team about this.

28. After the assessment, the unit manager held the first ACCT case review. The officer attended but there was no member of healthcare staff present, which is a mandatory requirement of ACCT procedures for first case reviews. The unit manager told the investigator that the man had appeared relaxed and did not appear distressed. He said that he had no current thoughts of harming himself, but that he found it difficult during the night without his medication. He said that he had few friends and no family contact. He was still grieving the recent loss of his father. The unit manager assessed the man's risk of harming himself as low and noted on an ACCT caremap that the unit manager should contact healthcare staff to pursue the man's medication. (This does not appear to have been done.) Staff were still expected to check the man once every 30 minutes and record three quality interactions each day. The unit manager set the next review for 9 May. He said that he did not expect to be the case manager at the next review, as the safer custody department would take responsibility.

29. An entry in his ACCT ongoing record at 12.05pm said that the man had left his cell for an association period (when prisoners are able to socialise with each other, make telephone calls and have showers) and had had a meal. Although timed at 12.05pm, this entry came after the unit manager's report of the case review, which was timed at 1.30pm. There were no more entries in the ACCT record until 5.15pm, when staff agreed that the man and the man's cellmate could continue to share with the man's cellmate as they moved from a first night cell, to another cell, G33, on Houseblock 1D. The man had his evening meal and staff noted that he did not express any concerns.

30. The next ACCT entries recording observations were at 7.00pm, 7.55pm, 2.00am, 2.30am, 5.00am and 6.00am. They did not identify any problems. The next entry, at midday on Monday 5 May, which was a bank holiday, said that the man had been out of his cell for morning association and had had brunch. He had gone out for exercise, appeared to be relaxed and was mixing well. When asked, he said that he had no issues to raise with staff. The next entry, at 6.05pm, recorded that the man had been out of his cell for his evening meal, and told staff that he had no problems when they asked him. Officers noted again that he was mixing well. The next entry was at 9.45pm, when the man appeared to be asleep. There were three entries during the night, which noted no concerns.

31. On 6 May, an administrator in the healthcare department faxed Orchard Croft surgery asking for confirmation of the man's medical history and prescriptions. (This was not the surgery where the man had said he was registered. The man had told staff that he was registered at King Street surgery.) The man's medical record showed that the surgery telephoned the prison and said that the man had not been there for a long time and as far as they knew, he was not on any medication.

32. Staff made no entries in the man's ACCT document between 6.00am (when he was sleeping) and 1.00pm on 6 May, when a senior manager noted that the

officer who had opened the ACCT had not signed the document. Although appearing below the 1.00pm entry, the next entry was timed at 12.50pm. It said that the man had been out for an association period and exercise. He had said that he had no thoughts of self-harm. The next entry is at 4.30pm and said that the man had moved to cell 113 on Houseblock 1A, which he shared with another prisoner. He had not told staff of any concerns. The next entry, at 6.00pm, noted that he had eaten his evening meal and mixed with other prisoners. The next entries at 10.15pm, 11.20pm, then 1.15am, 4.30am and 6.05am on 7 May, all noted that the man was asleep.

33. The next entry at 1.10pm on 7 May, recorded that the man had been out for an association and exercise period with no concerns. He had applied to join an education class and staff supported his application, commenting that he was a polite prisoner who conformed to the prison's rules. At 6.00pm, an officer noted on the ACCT that the man had settled on the wing and had made friends with a few other prisoners. Entries at 10.23pm, 10.35pm, and 1.25am, 4.00am and 6.15am on 8 May reported that the man was sleeping.

34. The unit manager checked the ACCT document at 9.12am on 8 May and wrote that the plan directed that staff should interact with the man, not just observe him. At 12.15pm, the next entry was by an officer who recorded that the man was in good spirits.

35. On the afternoon of 8 May, the man saw one of the prison chaplaincy volunteers. He told her that his father had recently died and he blamed himself, although he did not say why. The chaplaincy volunteer was aware that he was being supported under ACCT procedures, but did not note in the ACCT document that she had spoken to the man. The man spoke to another chaplaincy volunteer about his circumstances. The second chaplaincy volunteer told the man about a bible discussion group he ran.

36. The next ACCT entry at 6.40pm, noted that the man had said that he was thinking about his father and felt suicidal. The prisoner wing representative (who liaises between staff and prisoners) spoke to him and reassured him. A note on the ACCT document said that the staff would observe him closely. The next entry, at 10.25pm, recorded that there were no further concerns. There was a management check at 10.30pm, which did not identify any concerns about the ACCT procedures. There were then entries at 1.18am, 4.20am and 6.00am on 9 May, all of which recorded that the man was asleep at the time.

37. There were no further ACCT entries until 1.05pm on 9 May, when an officer recorded that the man had been to the gym and said that he felt better than he had the previous day. The officer had asked someone from the education department to come and see the man to discuss him attending classes. At 3.30pm, the man attended Muslim prayers.

38. At 3.45pm on 9 May, a manager from the safer custody department, held an ACCT review. The man attended, along with a member of staff from the safer custody department and the manager on the man's houseblock. No one from the healthcare team was present. The manager from the safer custody

department recorded that the man was still not receiving his medication and did not know what was being done about it. He was expected to begin bereavement counselling with the chaplaincy team the next week, but this had not been confirmed. The man said that he had started to talk to others on the wing, and wanted to start work with the education department. He said that he felt low, and was finding it difficult to adjust to prison life. He said that he had attended Muslim service that afternoon, "just to see what it is about". The manager from the safer custody department assessed his level of risk of suicide as low, and left the level of observations unchanged at once every 30 minutes. He did not make any amendments to the caremap and set the next review for 20 May.

39. An ACCT document entry at 5.30pm said that the man had had his evening meal and was in high spirits. At 9.30pm, he pressed his cell bell and asked an officer for some phone credit. The officer was unable to do anything as the prison was locked up for the night. At 9.45pm, the man pressed his bell again, and told the officer that he felt a bit upset. He asked if the wing representative was still awake and if he could talk to him. The officer asked if the man wanted to talk to her instead but he did not want to. The officer checked the man again at 10.15pm, and he was sitting with his head on his desk. He nodded when the officer asked if he was okay. Apart from a manager's check at 11.45pm, the ACCT document had further entries at 1.45am, 4.30am and 7.00am on 10 May. All noted that the man was asleep.

40. At 12.45pm on 10 May, an officer noted in the ACCT ongoing record that the man had had breakfast, then spent the rest of the morning in bed. He spoke to him, and the man did not raise any concerns. There is no record of whether the man attended Muslim prayers that day.

41. On 10 May, another prisoner moved into cell 113 as the man's new cellmate. They had not known each other previously, but the prisoner told the investigator that they were soon on friendly terms. The man told him that he was being monitored under ACCT procedures, but the prisoner said that he never saw the man looking distressed or upset.

42. The next entry ACCT entry at 5.50pm noted that the man had eaten his evening meal and had not raised any concerns. An entry at 6.50pm also noted no concerns. Entries after that, at midnight, and 5.00am and 7.00am on 11 May, all noted that the man was asleep.

43. There were no further entries on the ACCT document until midday on 11 May, which recorded that the man had had breakfast, and been out for an exercise and association period. There were only two other entries that day which noted that the man was not very talkative, but there were no specific concerns. Three checks during the night, noted that he was sleeping.

44. On the morning of 12 May, the man went to the gym. The only other ACCT entries during the day, at 12.30pm and 5.45pm, noted just that he had eaten his meals and there were no apparent concerns. Checks at 9.15pm and 10.05pm

reported that he was in bed watching television. There were three entries during the night, when he was asleep.

45. On 13 May, the man attended the second chaplaincy volunteer's bible discussion group. The second chaplaincy volunteer later said that the man had participated in the group and engaged well. After the group session, the man told the second chaplaincy volunteer that he was planning to attend the bereavement group on Thursday 15 May.

46. ACCT entries at 12.30pm and 6.30pm on 13 May, noted that the man had collected his meals and associated with other prisoners. Staff reported that he had been laughing and joking and they had no concerns about him. At 10.15pm, he was watching television. Three entries during the night noted he was sleeping.

47. On the morning of 14 May, the man went to the gym. An ACCT entry at 12.30pm showed that he had had lunch and mixed with other prisoners. There were no noted concerns. At 2.00pm, a senior manager wrote on the ACCT record that the unit manager should ask the man to sign the concern and keep safe section of the document (which had been completed on 3 May) and to remind staff to make quality entries. The manager did not note that there was no record of observations at the agreed frequency. The next entry at 6.30pm recorded that the man had eaten his evening meal and raised no concerns, as was the case at 10.15pm, 4.00pm and 6.00pm.

48. On the morning of 15 May, the man saw the chaplaincy volunteer again. He said that he was not sleeping and had not received his anti-depressant medication since he had arrived at the prison. The chaplaincy volunteer thought he seemed emotional, and he told her he felt very lonely and sad. After this individual session, another prisoner joined them for a group discussion on bereavement. After being quiet at first, the man joined in. He said that he did not feel that he could show emotion on the wing. The chaplaincy volunteer noted this on the man's ACCT document and told one of the man's wing officers what he had said.

49. An hour later, an officer noted on the man's ACCT document that he still seemed to be upset but was settling down. He had been out of his cell for an association period and for lunch and had mixed with other prisoners. He had not mentioned any thoughts of suicide or self-harm. He had registered for an IT course. At 3.30pm, an entry noted that he had attended education classes and had been quiet and worked well.

50. The chaplaincy volunteer had discussed the man with one of the chaplains and that afternoon they went to see him on the houseblock. All the man wanted to discuss was getting off the houseblock, although he did not specify why. He told the chaplaincy volunteer that he felt sad, but she thought he seemed more positive than he had been earlier.

51. A note on the man's medical record on 15 May said "medication on summary". There was no medication recorded on the summary or on the man's medication

record, but there was a fax in the record from King Street Surgery dated the same day, containing an extract from a walk-in centre which showed that the doctor prescribed a seven-day supply of fluoxetine to the man on 30 April. There is no record that the fax was referred to any member of the clinical team in the prison.

52. At 6.00pm, the man told an officer that he wanted to move to Houseblock 1C, where he had a friend. The officer said that he would be able to do so when a space became available. Entries on the ACCT document at 10.15pm, then 4.00am and 6.00am noted no concerns.

53. On the morning of 16 May, the man went to the gym. He asked gym staff if he could join in the prison's rugby sessions. He then went to an IT class.

54. At 1.35pm on 16 May, the man asked an officer who managed ACCT plans in the safer custody department, if his ACCT review could be brought forward. The officer said that this was not an unusual request. Although he was not the case manager, he told the investigator in interview that he and the officer who knew the man from working on his wing, held a case review. (In their response to the draft report, NOMS said that the officer was not present but that the officer consulted him outside the review process.) The officer did not ask any healthcare staff, or anyone else, to attend.

55. The man said he felt fine, had no problems and had settled on Houseblock 1. An officer agreed that the man had settled and started to mix well. The officer asked the man about the medication issue noted on his caremap. The man said that he did not need it now as he had signed up to play rugby and was going to the gym, which had given him a lift. The officer confirmed that he had been attending the gym. The man said that he had attended Muslim prayers (the officers did not ask him anything further about this), and the officer said he knew that the man was undertaking bereavement counselling with the chaplaincy. These were all protective factors. The man said that he wanted a prison job, so the officer phoned the design workshop manager, and arranged for the man to discuss this with him.

56. The man said that he wanted to move to a different wing, where he had a friend and the officer said that he would have to raise this with his wing officers. When interviewed, the officer said that he had asked the man if there were any problems with bullying that had caused him to ask for a move, and the man said there were not, but he wanted to be near a friend. The officer did not note this on the record of the review at the time.

57. The officer wrote that the man had not disclosed any issues about self-harm and he had not identified any. He assessed his risk of suicide and self-harm as low and closed the ACCT.

58. After the ACCT review, the man went to Muslim prayers. The Muslim chaplain had arranged for two prisoners to be inducted into the Muslim faith during prayers that day and, once they had made their declarations of faith, the man said that he too wanted to make the declaration. The muslim chaplain said that

he asked if he was sure, and the man was adamant that he was. The Muslim chaplain then asked the man to make the declaration, translating the words from Arabic to English. He welcomed the three prisoners to the religion, and asked the rest of the congregation to help them in any way possible.

59. The man's new cellmate said that the man told him that evening that he had converted to Islam, but they did not discuss it further. The cellmate told the investigator that he saw no indication that the man had been under any pressure to convert.

60. 17 May was a Saturday, when prisoners were allowed out of their cells from 10.00am until 2.30pm for breakfast, use the showers and exercise yard, and socialise with each other. Lunch was served between 12.00am and 1.00pm. In the morning, the man went out in the yard with other prisoners. He had breakfast and, at 12.04pm, ordered some drinks from the prison shop, which would be delivered the next week. His cellmate said that he had not noticed any particular change in the man in the previous days, but that morning he had seemed happier than previously.

61. While prisoners are out of their cells for the association period, officers lock their cells to secure their belongings. Some prisoners chose to stay in their cells and some ask to be let back in during the association period. The man's cellmate stayed out of the cell for the entire association period but the man went back to their cell for a sleep, which he often did. (There is nothing to suggest he was avoiding anyone because of bullying or any other reason.) At 12.21pm, the officer locked the cell doors on the man's landing, including the man's, who was in his the cell at the time.

62. CCTV footage shows that at 12.55pm, a prisoner (who we have not been able to identify) looked into the man's cell, then did so again a minute later. The man's cell was by a large window and there was a space on the landing, where some prisoners were sitting and talking. At 1.03pm, the man knocked on the inside of his door and asked if someone would close the observation panel. One of the prisoners did this for him. He said that he did not notice anything unusual and the man did not appear to be distressed. He assumed this was to block the light and noise to help the man sleep.

63. No one went to the man's cell after that, until 2.21pm, when officers began opening the cells for prisoners to go back in for the lock-up time of 2.30pm. AN officer unlocked the cells along the man's spur, without opening the doors or looking into the cells. When the cellmate tried to go into the cell two minutes later, he found something obstructing the door. He pushed harder and saw that the man was hanging from a belt attached to the upper bunk bed frame. CCTV footage shows that the cellmate moved away from the cell and shouted for help. The officer was nearby and ran to the cell.

64. When the officer saw the man hanging, he shouted to officers nearby and called "first response" over the radio. According to the radio log, this was at 2.21pm (the times on the radio log and the clock on the CCTV footage differ by two minutes but are otherwise consistent). The officer arrived and the first

officer lifted the man, while the other officer cut the belt. By then, a third officer had arrived and radioed a code blue emergency, (which indicates a life-threatening situation such as when a prisoner is unconscious or not breathing.) This code blue call was at 2.22pm, and the incident log shows that communications room staff called an ambulance at 2.23pm. Two of the officers laid the man on the floor and began cardiopulmonary resuscitation (CPR).

65. A nurse and a healthcare assistant responded to the emergency call and took the emergency response bag to the man's cell. They arrived just as the officers had begun resuscitation. The officer was doing chest compressions and the officer was managing the man's airway. When we interviewed her, the nurse said that, because of his appearance, she thought that the man was dead. She radioed to check that an ambulance was on the way, then checked the man for signs of life, but could not find any. She attached a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) to the man. The defibrillator did not detect any heart rhythm so the staff continued to attempt resuscitation in turn, joined and helped by other nursing staff. A first response paramedic arrived at 2.37pm followed by an ambulance crew at 2.40pm. At 2.53pm, paramedics agreed that the man had died.

Informing the man's family

66. One of the prison's managers, acted as the prison's family liaison officer. As the man had not given any details of his next of kin, The prison family liaison officer asked the police to help trace them. The police had an address, but when the family liaison officer went there the house was empty and unoccupied. She continued to try to find the man's family and, on 19 May, established where the man's mother was. As his mother lived a long distance from the prison, local police then went to his mother's home and told her that the man had died. The man's mother telephoned the prison and spoke to the prison family liaison officer, who continued to keep in contact. The prison offered to contribute towards funeral costs, in line with national Prison Service guidance.

Support for staff and prisoners

67. After the man's death, managers debriefed the staff involved in the emergency response, to ensure they had the opportunity to discuss any issues arising. Managers offered the services of the staff care team.

68. Staff reviewed prisoners being managed under ACCT procedures, in case they had been affected by the news of the man's death and spoke to them all individually. Staff opened an ACCT to support the man's cellmate. Prisoners the investigator spoke to said that staff had offered them support.

Post-mortem report

69. The post-mortem recorded the cause of death as hanging. As well as injuries consistent with hanging, the pathologist found, what he described as, several minor injuries on his body.

Police investigation

70. After the man died, police interviewed a number of staff and prisoners. The man's previous cellmate told police that the man had said to him while they were cellmates that he thought he might take his own life. The prisoner had not reported this to staff at the time. Another prisoner, told the police that the previous week the man's cellmate had "nipped" the man on the arm. The post-mortem report showed a bruise on the man's left arm. Despite this, we have not found any evidence that the man was being bullied.

ISSUES

Management of risk of suicide and self-harm

71. When the court advised Doncaster that the man was coming to the prison, an officer assessed his circumstances in advance and opened an ACCT plan. He did not see the man personally. Although it is unusual to open an ACCT in advance, the staff had recognised, even before he arrived, that the man had a number of factors that made him at heightened risk of suicide and self-harm, including his age, alleged offence, mental health history, recent bereavement (particularly as it was suicide) and that it was his first time in prison. When he arrived, staff told the man that they had opened an ACCT and what it meant. We are satisfied that reception staff rightly identified that the man was at heightened risk of suicide and self-harm and correctly began ACCT procedures. The unit manager completed an immediate action plan, and required staff to check the man at least every 30 minutes.

72. However, we are very concerned about the way staff at Doncaster implemented the ACCT as there is little evidence that the man subsequently received much meaningful support. We list our concerns below and then discuss some in more depth:

    - There was no member of the healthcare team present at the first ACCT review, even though this is a mandatory instruction in PSI 64.2011;
    - The caremap was of poor quality and did not refer to the man's bereavement issues, his young age or other risk factors;
    - There was a lack of action on the two recorded caremap actions, in particular regarding the man's medication. He had still not received his medication by the time he died;
    - ACCT checks were not conducted at the required frequency, or were not recorded in the ongoing record;
    - Management checks twice showed that staff were not making appropriate records of interaction, but there was little improvement in quality and managers did not identify other concerns;
    - Some sections of the ACCT form were not completed correctly
    - At the ACCT review on 9 May, the man's level of risk was assessed as low even though the day before he had said that he was suicidal and his risk factors remained;
    - After this review, the next review was set for 20 May, which we consider to be too long given the man's risk factors and very recent arrival in prison;
    - There was no consistency in case management and the reviews were not multi-disciplinary;
    - The ACCT was closed at an ad-hoc review, with no member of the healthcare team present, even though one of the caremap actions related to medical issues and had not been completed;
    - On several occasions, ACCT records indicate that the man sought help but these requests did not result in meaningful support;

- The case manager who closed the ACCT was a Band 3 officer, when PSI 64/2011 requires case reviews to be conducted by staff who are at least Band 4. (In their response to the draft report, NOMS have said that the PSI refers to NOMS Band 4 but does not stipulate grades for private prisons. NOMS would expect Directors of private prisons to satisfy themselves that those undertaking the task were able to do so. As the officer was employed as an ACCT Case Facilitator and trained in ACCT case management, SERCO felt that he had the required seniority to carry out case reviews. However, since the man has died SERCO have reconsidered and issued an instruction that ACCT case reviews must be carried out by a manager.)

73. We have noted that there no member of the healthcare team was present at the ACCT reviews. During the investigation, a nurse told us that they frequently had very little notice of ACCT reviews and no time to prepare for them. The lack of healthcare staff at a first case review is in breach of a mandatory instruction in PSI 64/2011, but, as importantly, this meant that there was no healthcare input into the major action on the caremap, which was to resolve the issue of the man's anti-depressant medication. There was a clear lack of ownership of this action which had been shown as for the unit manager to resolve. When interviewed, the unit manager told us that he expected the healthcare team to resolve the issue and that the next case manager would check this. Although staff at the reviews assumed that healthcare staff would resolve this, there is no evidence that anyone checked.

74. PSI 64/2011 makes it clear that ACCTs should not be closed until all the caremap actions have been completed and it is concerning that the ACCT was closed before this was done. The caremap should have actions designed to reduce a prisoner's risk of suicide and self-harm, and there should be a named person responsible for completing each action. In this case, there was a complete breakdown in the process, which meant that the main listed action, which should have helped protect the man, was never resolved. The lack of consistency in case management might also have been a factor. We consider that a number of issues, such as the man's recent bereavement, should have been listed on the caremap, with effective actions to ensure he received structured support which could then be monitored and reviewed at each ACCT case review.

75. When a prisoner is on an ACCT, they should be observed at intervals which reflect their assessed risk of suicide and self-harm. When the man arrived at Doncaster, staff were expected to observe him at least every 30 minutes and to record three effective interactions with him. While the interactions are recorded, there is no evidence from the ongoing record to show that staff carried out checks at the required frequency. Many of the entries give only scant information. A management check on 8 May noted that officers should record interactions, not just observations, but the quality of the ACCT records remained variable and another management check made the same point on 14 May.

76. There were long periods when there were no entries in the ACCT ongoing record at all. On 5 May, there is only one entry between 6.00am and 6.00pm. On 6 May, there are no entries between 6.00am and 1.00pm. On 7 May, there is only one entry between 6.05am and 6.00pm. On 8 May, only one entry between 9.00am and 6.40pm. On 10 May, only one entry between 7.00am and 5.50pm, on 11 May, no entries between midday and 7.10pm, on 12 May only one entry between 9.10am and 3.35pm, and on 13 May only one entry and a unit manager check between 6.00am and 6.30pm. This does not reflect the level of care that had been agreed.

77. The nurse made the first entry on the ACCT ongoing record, but that was the only time any member of the healthcare team wrote on the document. We note from minutes of meetings of the safer custody team from March, April and May that the prison had identified that nursing staff who had interactions with prisoners at risk, were not recording these in ACCT documents. The only further interaction the man had with healthcare staff was with the nurse on 4 May, but the nurse did not record this meeting in the ACCT record, even though they discussed the man's current state of mind and issues such as his father's death by suicide.

78. Some of the entries on the ACCT record indicated that staff had discussed issues with the man, but that these discussions had not resulted in further action. On 8 May, an entry at 6.40pm said that the man felt suicidal, and staff would observe him closely. There are no further entries until 10.25pm, almost four hours later. On 9 May, the man asked if he could have some credit on his telephone account but that was not possible at the time. Records do not show that anyone addressed this at the next opportunity. Fifteen minutes later, he asked another officer if the wing representative was still awake, as he was upset and wanted to talk to him. The officer said she did not know. There is no record that she checked whether the wing representative was available or offered other support, other than offering to talk to him herself, which the man did not want to do. Overall, there is little evidence of supportive and proactive care for the man reflected in the ACCT document.

79. We are concerned that the ACCT was closed, effectively at the man's request, at an ad hoc, unplanned ACCT case review, which was not multi-disciplinary. As noted, the officer did not establish that the man's medication issue had been resolved. When interviewed, the officer said that he thought that the man had several other protective factors in place – his conversion to Islam, desire to play rugby, use of the gym and ongoing bereavement sessions. He said that the man had told him that he did not need his anti-depressant medication any longer and therefore did not need to address this issue. However, this was without the benefit of any healthcare input and we consider that the officer was too influenced by the man's desire for the ACCT to be closed, rather than an objective assessment of his outstanding risk factors.

80. We consider that the man did not receive sufficient, meaningful, documented support through appropriate use of the ACCT process, which was not managed in line with national instructions. Shortly before this report was issued, we received a letter from the Director at Doncaster in response to our initial written

feedback. He said that, having conducted his own review, he had similar concerns and had asked a safer custody lead from outside the prison, to undertake a full review of ACCT processes at Doncaster. We welcome this initiative and make the following recommendation:

The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **A multidisciplinary approach for all case reviews with continuity of case management;**
- **Healthcare staff attending all first case reviews and receiving sufficient notice of further reviews;**
- **Staff familiarising themselves with relevant issues before holding reviews;**
- **Setting ACCT caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and which identify who is responsible for them;**
- **All staff, including healthcare staff, recording observations and interactions with prisoners as required;**
- **Staff documenting action taken in relation to problems raised;**
- **Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.**

Clinical care

81. Overall, the clinical review concludes that the man's clinical care was not comparable to that which he could have expected in the community.

82. At his initial health screen, the man told the nurse that he had been taking medication prescribed for depression. Before providing the medication, healthcare staff needed to confirm the prescription with the man's GP. As the man arrived on a bank holiday weekend, the first opportunity to do so was Tuesday, 6 May.

83. Although the man said that he was registered as a patient with King Street Surgery, healthcare staff sent the first request to another surgery, apparently in error. When healthcare staff eventually received confirmation on 15 May, that a doctor had prescribed the anti-depressant medication, no one referred this to a doctor as should have happened. A doctor did not see the man at any time during his stay at Doncaster, although he had said he was distressed and that his state of mind would be better if he received the medication he relied on. Even after the prison received confirmation that he had recently been prescribed an anti-depressant, no one re-assessed him. We are concerned that a doctor did not see the man in person to assess his need for medication.

84. The clinical reviewer noted that the system for confirming prisoners' medication leads to delays that could interrupt a prisoner's effective treatment. Even if the system had worked as planned, the earliest the man could have received his anti-depressant was 7 May, four days after he arrived at Doncaster. The clinical reviewer was unable to establish whether it would have been possible

for a doctor or nurse prescriber to have seen the man when he arrived and prescribed an anti-depressant. .

85. In a recent Learning Lessons bulletin on young adults in prison, we noted that there needed to be effective arrangements for medication to ensure consistent and continuous care. We are not satisfied that Doncaster has appropriate arrangements to meet this need. We do not know whether receiving his medication would have altered the outcome for the man, but it is evident that not receiving it caused him additional stress and anxiety. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners receive medication as soon as possible after arrival and that there are no unnecessary breaks in treatment.

86. The nurse referred the man for a mental health assessment. On 4 May, a nurse assessed him and noted that he said he had been taking fluoxetine before he arrived at Doncaster. However, the nurse did not record when it had been prescribed to him, why, or for how long and she assumed that the system for following up prescriptions would ensure the man received any medication he needed. She noted that he had seen Child and Adolescent Mental Health Services (CAMHS) but did not note why or what the outcome was. She also did not request the man's medical records from his GP so that his needs could be properly assessed.

87. The nurse said that she felt that the man's distress was because of the recent death of his father. Although he scored very highly in tests for anxiety and depression, she did not think that his distress was out of the ordinary for prisoners and referred him to the chaplaincy for bereavement counselling. The clinical reviewer was concerned that even though the man had been identified as at risk of suicide and self-harm, said that he had a history of depression, and was clearly vulnerable, no one referred him to a doctor or more senior nurse to assess if he needed treatment. Nobody referred him to mental health services or to see a psychiatrist. The chaplaincy's bereavement team is made up of experienced volunteers, but they are not qualified counsellors. No one spoke to, or sought the man's records from, either his GP or from CAMHS. We consider that the man's mental health needs were not properly addressed during his time at Doncaster and we make the following recommendation:

    The Head of Healthcare should ensure that the mental health team assess all new prisoners with identified mental health problems using all relevant information, including from community services, to ensure appropriate continuity of care and follow-up.

88. Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners, gives guidance on the clinical management of prisoners. As well as initial health assessments, the PSO requires prisons to offer every prisoner a general health assessment to gather and provide further information and check how the prisoner is settling. They should do this in the week following first reception. The man did not have a secondary health screen at Doncaster. The nurse's

assessment was a mental health assessment and not a secondary health screen. We make the following recommendation:

The Head of Healthcare should ensure that prisoners have secondary health screenings in line with PSO 3050.

The man's adoption of Islam

89. Prison Service policy on faith is contained in Prison Service Instruction (PSI) 51/2011, which says that the Prison Service recognises and respects prisoners' right to register and practise their faith while in custody. Doncaster's local policy says that a prisoner who wishes to change his religion should discuss this with the chaplain who, if they are satisfied that the request is sincere, will arrange for instruction with the appropriate minister. There are no restrictions on a prisoner's right to change his religion. The man did not mention his interest in Islam to the chaplaincy team, although he did mention it to the officer at his final ACCT review. We have not found any evidence that the man was coerced into converting to Islam.

90. As the man stood up and declared at Muslim prayers that he wanted to convert, the Muslim chaplain did not have the opportunity to discuss this with him. He asked the man if he was sure that was what he wanted and the man said it was. The policy is that prisoners should discuss changes of religion in advance. However, as the Muslim chaplain pointed out, if a prisoner wanted to become a Muslim, there was nothing he could do to prevent them doing so as they could convert by making the declaration of faith in front of two witnesses: there is no obligation to do this before an imam. In the face of the man's apparent determination to make the declaration, the Muslim chaplain decided that he would welcome him into the faith and go through other details afterwards. He planned to see the man the following week, although in the event he did not get the opportunity. The Muslim chaplain's actions do appear to contradict Doncaster's policy, but it is hard to see that his decision had any effect on the man's death. There was little the Muslim chaplain could have done in the circumstances.

91. The Muslim chaplain said that he was not aware of any prisoners converting to Islam in Doncaster because they had been pressured to do so. He said that one of the crucial concepts of Islam was that there should not be any coercion or pressure to enter the faith. When he went back to his cell on the evening of Friday 16 May, the man told his cellmate that he had converted to Islam. The cellmate said that they did not discuss it any further, but he did not think that he had done so under duress and there is no security information about this.

92. Chaplaincy records show that there were 64 changes of religious registration at Doncaster between April and September 2014. These do not all reflect an actual change in religion. Some prisoners who have not worshipped for some time declare no religion when they arrive at prison, but then return to their beliefs. Of these 64, only six prisoners were re-registered to Islam.

Emergency response

93. When the officer found the man hanging, he radioed a “first response” call, giving the location. This is a recognised call sign at Doncaster, meaning that all staff on first response duties, including nursing staff, should go to the area specified. He also called to colleagues nearby for assistance. The officer then radioed a code blue emergency over the radio. The nurse said that there was only a few seconds between the calls and the radio log shows that the officer made the response call at 2.21pm, and the other officer the code blue call at 2.22pm.

94. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes,* stresses the importance of efficiently communicating the nature of a medical emergency. It specifies that all Governors/Directors must have a Medical Emergency Response Code protocol based on the PSI. Doncaster reviewed their emergency response codes in 2010 and an email was sent to all staff saying that if a prisoner is not breathing, they must call a code blue emergency. A further email was sent to all staff in August 2013 reminding them that when calling a medical emergency they must use a code red or code blue call. Apart from these emails, Doncaster did not have a protocol for staff reflecting the guidance in the PSI at the time of the man’s death.

95. While in this case we are fully satisfied that there was no delay in obtaining emergency assistance, it is apparent that when the officer found the man hanging he did not use the appropriate emergency code. A colleague rectified this quickly, but we cannot be sure that this would happen on another occasion. It is important that all staff fully understand and use the emergency medical code system and that Doncaster has clear procedures which reflect the national instructions. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Doncaster has a medical emergency response code protocol which reflects the national instruction.

RECOMMENDATIONS

1. The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

    - A multidisciplinary approach for all case reviews with continuity of case management;
    - Healthcare staff attending all first case reviews and receiving sufficient notice of further reviews;
    - Staff familiarising themselves with relevant issues before holding reviews;
    - Setting ACCT caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and which identify who is responsible for them;
    - All staff, including healthcare staff, recording observations and interactions with prisoners as required;
    - Staff documenting action taken in relation to problems raised;
    - Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.

2. The Head of Healthcare should ensure that prisoners receive medication as soon as possible after arrival and that there are no unnecessary breaks in treatment.

3. The Head of Healthcare should ensure that the mental health team assess all new prisoners with identified mental health problems using all relevant information, including from community services, to ensure appropriate continuity of care and follow-up.

4. The Head of Healthcare should ensure that prisoners have secondary health screenings in line with PSO 3050.

5. The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Doncaster has a medical emergency response code protocol which reflects the national instruction.

Action Plan

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: ▪ A multidisciplinary approach for all case reviews with continuity of case management; ▪ Healthcare staff attending all first case reviews and receiving sufficient notice of further reviews; ▪ Staff familiarising themselves with relevant issues before holding reviews; ▪ Setting ACCT caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and which identify who is responsible for them; ▪ All staff, including healthcare staff, recording observations and interactions with prisoners as required; ▪ Staff documenting action taken in relation to problems	Accepted	A review of the management of prisoners at risk of self harm has been undertaken, an action plan to identify issues raised has been put in place, and managers and staff are being reminded of responsibilities in their refresher training. All of the specific points raised in recommendation one have been noted and staff and healthcare partners have been advised and reminded of their specific responsibilities. Head of Healthcare, Nottinghamshire NHS have been informed that attendance at first case reviews is mandatory. In addition to the routine safer custody refresher process, the Safer Custody Manager is undertaking one to one sessions with individuals that have been identified as needing support in this area.	31/12/14 Director / Safer Custody Lead / Head of Healthcare, Nottinghamshire NHS	

	raised; ▪ Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all care map actions have been completed				
2	The Head of Healthcare should ensure that prisoners receive medication as soon as possible after arrival and that there are no unnecessary breaks in treatment	Accepted	System and processes have been reviewed and there is a clear pathway and Standard Operating Procedure in place to ensure medication reconciliation at point of reception. GP/Medication checks and medicines reconciliation are now performed by Pharmacy Technicians. A weekly audit of GP checks is performed each week to control quality.	Completed Head of Healthcare, Nottinghamshire NHS	
3	The Head of Healthcare should ensure that the mental health team assess all new prisoners with identified mental health problems using all relevant information, including from community services, to ensure appropriate continuity of care and follow-up.	Accepted	Mental health administration routinely contact GP and Community mental health service providers to obtain clinical and risk information to inform risk assessments and care planning. All nurses within the mental health team have been re trained in the use of risk assessment templates and care planning to ensure consistency and improve quality of assessments and plans. All Mental health nurses are undertaking a modular training programme addressing deliberate self harm, risk management and treatment interventions. Risk assessment and care plan documentation are routinely audited to assure quality	Completed Head of Healthcare, Nottinghamshire NHS Completed Head of Healthcare, Nottinghamshire NHS Completed Head of Healthcare, Nottinghamshire NHS Completed Head of Healthcare, Nottinghamshire NHS	

4	The Head of Healthcare should ensure that prisoners have secondary health screenings in line with PSO 3050	Accepted	All new receptions into the establishment receive secondary health screens within 48 hours of admission. This process forms part of the record keeping audits.	Completed Head of Healthcare, Nottinghamshire NHS	
5	The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Doncaster has a medical emergency response code protocol which reflects the national instruction.	Accepted	A Directors notice has been issued to all staff reminding them of PSI 03/2013, this message has and will continue to be reinforced through briefing and communications channels	31/12/14 Director	