Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Tye a prisoner at HMP Doncaster on 6 June 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Tye was found hanged in his cell at HMP Doncaster on 6 June 2015. He was 34 years old. I offer my condolences to Mr Tye's family and friends.

The week before Mr Tye arrived at Doncaster, on 6 May, his father had died, after which Mr Tye had attempted suicide. Staff appropriately assessed Mr Tye as at risk of suicide or self-harm when he first arrived at the prison. While some aspects of Mr Tye's care at the prison were good, I am concerned that, despite my repeated recommendations, staff at Doncaster continue not to record all checks for prisoners being monitored because of their risk of suicide and self-harm. I am also concerned that staff assessed Mr Tye's risk as low, despite a recent serious suicide attempt and that there was no record that anyone assessed his risk of suicide and self-harm when he returned to the prison after his father's funeral.

While there is no indication this affected the outcome for Mr Tye, I am concerned that staff did not telephone for an ambulance as soon as a medical emergency was called. This is another matter I have raised with the prison before and the Director needs to make sure that changes made as a result of previous investigations are sustained.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2016**

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Summary

Events

1. On 6 May, Mr Thomas Tye was sentenced to 20 weeks imprisonment and was sent to HMP Doncaster. He had been released from Doncaster in February 2015. The police had completed a suicide and self-harm warning form as Mr Tye had cut his wrists and tried to hang himself the previous week, in reaction to his father's death ten days before. Prison staff began suicide and self-harm prevention procedures when he arrived.

2. Mr Tye, who had substance misuse problems, began a methadone maintenance programme and was prescribed diazepam, in line with his community prescription. The next day, the prison GP prescribed the diazepam on a weekly reducing basis, after his community GP advised that he did not need it. Mr Tye complained that the dose was being reduced too quickly, and a GP agreed to slow down the rate of reduction, but Mr Tye remained unhappy about this. On 28 May, he cut his arm in protest.

3. On 5 June, two officers escorted Mr Tye to his father's funeral. He was handcuffed to one of the officers. The officers said a nurse spoke to him in reception when he got back but the nurse did not record this or any assessment of his risk of suicide and self-harm. When he got back to his houseblock an officer and a nurse spoke to him and he said he was all right. He told his cellmate that the funeral had gone well.

4. In the early hours of 6 June, Mr Tye's cellmate woke and found Mr Tye was awake. He woke again at about 6.15am, and Mr Tye was still sitting awake. They had a cigarette together and his cellmate went back to sleep.

5. At about 7.40am, Mr Tye's cellmate woke and found that Mr Tye had hanged himself by a sheet attached to the frame of the bunk bed. He pressed the cell bell and kicked the door to alert staff.

6. A prison officer went into the cell immediately and radioed a code blue medical emergency. He cut the sheet from around Mr Tye's neck. He could find no signs of life so began chest compressions. Nurses arrived quickly with emergency equipment and administered oxygen and continued chest compressions. The control room waited to get confirmation from a member of healthcare staff before calling an emergency ambulance. Paramedics arrived, examined Mr Tye, and recorded that he had died.

Findings

7. The investigation found that, as in previous investigations, staff at Doncaster did not properly record checks for prisoners assessed as at risk of suicide or self-harm. When checks were recorded, they were at predictable intervals. We are also concerned that, although staff monitored Mr Tye frequently, they underestimated his level of risk, after a serious suicide attempt when his father had died. No one formally assessed his risk of suicide and self-harm, when he returned from his father's funeral. He killed himself that night.

8. As we have also found before at Doncaster, a member of staff in the control room waited for a nurse to confirm that an ambulance was required, causing an unnecessary delay.

Recommendations

- The Director should ensure that prison staff take into account all risk factors when assessing a prisoner's level of risk of suicide and self-harm and record all ACCT observations immediately, or as soon as possible after they are made.
- The Director and Head of Healthcare should ensure that prisoners returning through reception from events likely to have an affect on their health and wellbeing have a recorded assessment of their risk of suicide and self-harm.
- The Director should ensure that control room staff call an ambulance immediately they receive an emergency medical code call.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator visited Doncaster on 11 June 2015. She obtained copies of relevant extracts from Mr Tye's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Tye's care at the prison. The investigator and clinical reviewer interviewed 15 members of staff and a prisoner on 8 and 9 July 2015.

12. We informed HM Coroner for Doncaster of the investigation. At the time of issuing the initial report, we had not received the post-mortem and toxicology report. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers wrote to Mr Tye's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They were also sent a copy of the initial report. We received no reply.

Background Information

HMP Doncaster

14. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men over 18. There are three houseblocks with four wings, each holding between 90 and 96 prisoners. Nottingham Healthcare provides physical and mental health services, and substance misuse services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Doncaster was in March and April 2014. Inspectors reported a serious problem with illegal drugs in the prison. Prisoners told them that the use of new psychoactive substances, such as Spice, was common.

16. Inspectors reported that, although most prisoners at risk of suicide and self-harm said they felt supported, information about situations that might trigger suicide and self-harm and caremap actions to help reduce risk, were inadequate. ACCT reviews were not multidisciplinary and many staff were not up to date with their training. Inspectors were concerned that mental health staff were not involved in reviews, even when mental health issues had been identified as a primary issue.

17. Doncaster had responded promptly to PPO recommendations, after previous deaths at the prison, but inspectors were not confident that these changes would be long-term.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to September 2014], the IMB reported that there had been an increase in prisoners self-harm and the number of suicide prevention procedures that had been opened had increased dramatically over the past year.

Previous deaths at HMP Doncaster

19. Mr Tye was the third apparent suicide at Doncaster since the beginning of 2014. In two reports in 2014, we were critical of ACCT processes and emergency procedures. We identify similar issues in this report.

Assessment, Care in Custody and Teamwork (ACCT)

20. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. On 6 May 2015, Mr Thomas Tye was sentenced to 20 weeks in prison for theft and breach of licence and was sent to HMP Doncaster. He had been at Doncaster three times before, most recently in February 2015.

22. Mr Tye had cut his wrists and attempted to hang himself after his father's death ten days before. The police noted this on a suicide and self-harm warning form and this was also recorded on Mr Tye's escort record. The escort record also noted that Mr Tye used heroin and cocaine.

23. When he arrived, an officer began ACCT suicide and self-harm procedures. Another officer completed an ACCT immediate action plan, which required staff to check Mr Tye every 30 minutes and to write three quality observations about him each shift. The officer recorded that Mr Tye had telephoned his partner. He told him that he could speak to someone from the chaplaincy or a Listener if he needed support. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners.)

24. At an initial health screen, a nurse reviewed prescriptions that Mr Tye had with him. She confirmed that he had been prescribed diazepam (for anxiety) by a community substance misuse service and methadone (which he had received in police custody) as well as medication for epilepsy and asthma. Mr Tye said he had a long history of mental health problems and she referred him for a mental health assessment. He tested positive for cocaine, benzodiazepine, opiates and methadone and she assessed him as experiencing mild withdrawal symptoms. She referred him to a doctor.

25. That evening, a GP prescribed 20 ml of methadone, continued his prescription of diazepam, and referred Mr Tye to the substance misuse team for further assessment. He noted that Mr Tye's father had died ten days before.

26. Mr Tye had a shared cell in the stabilisation unit for prisoners with drug and alcohol problems. Although staff were required to check him every half an hour, there were only four entries in the ACCT record for 6/7 May, at 10.00pm, 12.52am 4.00am and 6.15am.

27. On 7 May, healthcare staff received Mr Tye's community health records, which showed that he had been prescribed pregabalin for pain and methadone. However, his GP had decided that he should not be prescribed diazepam, because he had been going to different community medical services seeking to get prescribed diazepam, which he did not need. As the GP had already prescribed diazepam, a nurse prescriber changed Mr Tye's prescription so that the dose would be reduced by 5mg every week. Mr Tye was prescribed 56ml methadone daily in line with his community prescription.

28. An officer assessed Mr Tye as part of ACCT procedures, that afternoon. Mr Tye said he had never tried to take his own life before (which was not the case), but said he had wanted to be with his father. Mr Tye said that, although he was also taking illicitly obtained subutex (an opiate substitute) to help with his withdrawal symptoms, he was still having trouble sleeping. Mr Tye told the officer that he

had anxiety and depression, and problems with his medication. He said he wanted to be in prison so he could "get clean".

29. Shortly afterwards, a manager chaired Mr Tye's first ACCT case review, which the officer Warren, a mental health nurse, a houseblock officer, and a member of the safer custody team attended. Mr Tye said he was feeling down because of his father's death and was not dealing well with his loss. He mentioned issues with his medication, but said healthcare staff were resolving these. The manager assessed Mr Tye as at low risk of suicide and self-harm, but decided he should still be checked every half hour. The next ACCT case review was scheduled for 15 May.

30. The manager completed an ACCT caremap with actions for someone from the chaplaincy team to speak to Mr Tye about his father's death, for the security department to arrange for Mr Tye to go to his father's funeral and for healthcare staff to review Mr Tye's medication. The mental health nurse agreed to check his medication that day.

31. On 8 May, Mr Tye told a nurse at a mental health assessment that he had severe depression and anxiety. She considered that Mr Tye needed continued support for his mental health problems as well as structured support for substance misuse. Another nurse assessed Mr Tye for opiate withdrawal symptoms that afternoon and recorded that he still had mild withdrawal symptoms.

32. A prison chaplain told the investigator that he had discussed Mr Tye's bereavement with him. (This was not recorded in the ACCT document or Mr Tye's prison records.) The chaplain said he spoke to Mr Tye about his father's death and the funeral arrangements, on routine visits to the houseblock.

33. Between 8 and 12 May, staff were expected to check Mr Tye every half an hour. Checks were recorded every half hour at night, but only three were recorded during the day.

34. On 13 May, a drug support worker reviewed Mr Tye's substance misuse plan. They spoke about the dangers of mixing drugs and the risks of injecting. They agreed that Mr Tye would continue to receive support for his substance misuse and mental health problems and he said that he would contact a community drug team to support Mr Tye when he was released.

35. Mr Tye spoke to his partner that day and told her that he was going to get himself "settled and sorted". On 14 May, Mr Tye left a telephone message for his brother to tell him he was back in Doncaster prison.

36. On 15 May, a manager and an officer held the second ACCT case review. The manager contacted a member of the drug support team for a contribution before the review. Mr Tye said he was still concerned that his diazepam was being reduced too quickly, but he did not need to be subject to ACCT monitoring, as he had no thoughts of suicide or self-harm. Mr Tye said he needed to find out about when his father's funeral would be and whether he could attend. The manager reduced the required level of observations to hourly. The next case review was scheduled for 22 May.

37. Later on 15 May, a mental health nurse reviewed Mr Tye. She noted that Mr Tye became aggressive when he talked about his diazepam being reduced too quickly. He soon calmed down but said he would cut his wrists again if his medication was not sorted out. He said he did not want to kill himself. They spoke about his father's death and Mr Tye agreed to be referred for bereavement counselling. Mr Tye said he had spoken to a chaplain and that he was waiting to hear about whether he could attend his father's funeral. She concluded that Mr Tye was mildly depressed and wrote in Mr Tye's ACCT record that his risk of self-harm was linked to problems with his medication.

38. On 15 May, Mr Tye telephoned his brother and asked him to contact his solicitor for him, as he was concerned that his diazepam was being reduced too quickly. Mr Tye sounded tearful during the call. (Mr Tye made no further telephone calls.)

39. On 18 May, officers called for urgent healthcare assistance when Mr Tye appeared to be having a seizure in his cell. A nurse responded and found Mr Tye fitting on the cell floor. When Mr Tye came round, he said he had not taken any illicit drugs and attributed the seizure to the reducing dose of diazepam. Nurses checked Mr Tye later that day. He said he felt fine, just a little sleepy.

40. The next morning, 19 May, Mr Tye told a GP that he had had six fits in the previous 11 months. He said he had been referred for a neurological appointment at hospital, but had not gone. He thought his diazepam medication was being reduced too quickly. The GP agreed to slow the diazepam reduction down, once his dose had reduced to 5mg daily. The GP prescribed epilim chrono (a drug to control seizures).

41. On 22 May, a manager chaired Mr Tye's third ACCT case review, with another manager and a nurse. Mr Tye said he had recovered from his seizure and had no thoughts of suicide or self-harm. Mr Tye said his medication problems had been resolved and that he was expecting a visit from his brother. Mr Tye reiterated that he did not want to be subject to ACCT monitoring. The manager updated Mr Tye's ACCT caremap to reflect that a chaplain was seeing him about his bereavement. The nurse had said that his medication issues had been resolved, and he had completed his induction to the houseblock. The review agreed to end ACCT monitoring. A post-closure review was scheduled for 29 May.

42. On 28 May, an officer told Mr Tye that his father's funeral had been arranged for 5 June. He explained that the security department had all the details and would assess whether Mr Tye would be able to attend.

43. Later that morning, an officer responded to Mr Tye's cell bell and found he had cut his left arm. He took Mr Tye to the healthcare centre and a nurse stitched the wound Mr Tye told her he had cut himself because his diazepam was being reduced. A GP saw Mr Tye shortly afterwards and told him that he would continue on epilim when he finished diazepam, to manage his seizures and that his diazepam would still be reduced. The officer began ACCT procedures again. Officers were required to check Mr Tye half hourly, but only three observations were recorded in the ACCT record that day and four during the night.

44. At an ACCT case review the next morning, a manager, an officer and a nurse discussed Mr Tye's self-harm the day before. Mr Tye said his diazepam dose had been reduced too quickly, but it had now been reviewed. Mr Tye said he felt anxious, did not like to mix with other prisoners, and preferred to stay in his cell. He said he was still not sleeping well and intended to speak to a doctor about this. The manager decided that Mr Tye was at low risk of suicide or self-harm and did not change his level of observations. These observations continued to be recorded only infrequently in the ACCT record.

45. On 4 June, Mr Tye told a nurse that his diazepam had been reduced too quickly and this made him feel stressed. He denied any thoughts of suicide or self-harm. The nurse explained the reasons why his medication was being reduced, but Mr Tye remained anxious about this. The nurse recorded that it helped Mr Tye to talk about his medication. They discussed his recent self-harm and he said he did not have any more thoughts of harming himself. The nurse scheduled another mental health appointment for two weeks' later.

46. At 2.05pm on 5 June, a manager held an ACCT case review with the safer custody manager and a nurse. She recorded that it was the day of Mr Tye's father's funeral and that it had been agreed he could attend. The funeral was at 3.45pm, but no one had told Mr Tye the decision. Mr Tye said he was upset about not knowing whether he could go to the funeral. She said that Mr Tye could not be told for security reasons because of the risk of escape. (It is difficult to see why he could not have been told of the decision during his case review.) Mr Tye said he was still having problems with his medication, and was not happy about the reasons he had been given, for reducing his diazepam. Mr Tye's level of observations remained at every half hour. The next case review was scheduled for 12 June.

47. After the case review, Mr Tye was told he could go to his father's funeral. Two officers escorted him and he was handcuffed to one of them. After the funeral, Mr Tye arrived back at the prison at 5.00pm and thanked the staff for taking him. The escort officers said that Mr Tye seemed teary and a nurse spoke to him in reception. There is no record of this in his medical record and we have been unable to establish which nurse spoke to Mr Tye.

48. An officer took Mr Tye back to the houseblock and a nurse gave Mr Tye his medication. She asked how he was after the funeral. She said that Mr Tye told her he was all right. She thought he seemed low, but she did not think he was particularly distressed.

49. Mr Tye's cellmate said that he had told him the funeral had gone well and there had been a very good turnout. Mr Tye ate some biscuits and cereal and then lay on his bed to watch television. He said that Mr Tye was not very talkative. At approximately 8.45pm, he realised that Mr Tye had fallen asleep. He carried on watching television for another hour, and then went to sleep.

50. The night officer's shift on the houseblock started at 9.30pm. He said that about 15 prisoners on the houseblock were subject to ACCT monitoring, with different observation times. Although Mr Tye was required to be checked every half hour, he did not record anything in the ACCT record until 11.05pm, when he noted that Mr Tye appeared asleep. He made the same entry at 1.05am and 4.10am. He

told the investigator that he had checked Mr Tye every 30 minutes, but did not record this every time. He said that with so many prisoners subject to ACCT monitoring, he did not have time to record every check he made, and he understood this was the practice at the prison.

Saturday 6 June 2015

51. Mr Tye's cellmate said he woke up early in the morning of 6 June and Mr Tye was sitting on the toilet seat. He asked the time. Mr Tye said it was 5.15am and jokingly asked him if he was getting up. He went back to sleep. CCTV footage shows that the night officer checked Mr Tye's cell at 6.09am and 6.32am, although he did not record these checks in the ACCT record.

52. Mr Tye's cellmate woke again at about 6.15am, and said Mr Tye was still sitting on the toilet seat. He asked Mr Tye if he wanted a cigarette and they smoked a cigarette together. He then went back to sleep.

53. At approximately 6.45am, the night officer handed over to another officer. The officer did a roll check to ensure that all prisoners were in their cells and said he did not notice anything unusual. The CCTV showed that he check Mr Tye's cell at 6.48am.

54. At 7.16am, the officer did an ACCT check. He said he did not notice anything unusual and thought that both Mr Tye and his cellmate were asleep in their beds at the time. He noted in the ACCT record that Mr Tye appeared asleep. He then began unlocking prisoners individually and took them to collect their medication from the houseblock medication hatch.

55. Just before 7.40am, Mr Tye's cellmate said he woke up again and noticed a towel hanging from the end of the top bunk. He got up and saw Mr Tye had hanged himself by a sheet attached to the frame of the bunk bed. He immediately rang his cell bell and began to shout and kick the door to alert staff.

56. The officer saw that a cell bell had been pressed (a red flashing light illuminates on the cell door and buzzes). He was waiting for a prisoner to get dressed to go to the medication hatch, so he left him and went to the cell. He then heard the cellmate kicking the cell door and shouting that Mr Tye had hanged himself.

57. The officer went into the cell and radioed a code blue medical emergency at 7.40am. Mr Tye was tied to the end of the bunk bed, but was slumped on the floor. He tried to lift him up and asked the cellmate to pass him his anti-ligature knife from his belt. The cellmate gave him the knife and he cut the sheet and lowered Mr Tye to the floor. He could find no pulse and noted that Mr Tye's eyes were fixed and dilated. He started chest compressions to try to resuscitate Mr Tye.

58. An operational support grade (OSG) was working in the prison's control room and heard the officer's code blue call. She relayed the call over the open radio net so all staff could hear that there was an emergency.

59. Two nurses responded quickly and brought an emergency bag. Two healthcare staff were giving out medication on the houseblock when they heard the code blue emergency. One went immediately to Mr Tye's cell, arriving at 7.40am,

while her colleague locked up the medication and followed a bag of emergency equipment, two minutes later. When they arrived, the officer was doing chest compressions. A nurse noted that Mr Tye looked blue and used a suction device to clear his airway before administering oxygen. Another nurse attached a defibrillator, but it found no shockable heart rhythm.

60. The OSG in the control room said she had waited for a nurse to radio before she called for an emergency ambulance, which she said was usual. At 7.42am, a manager radioed a request for an ambulance as soon as she arrived at Mr Tye's cell. The OSG then telephoned for an ambulance, two minutes after the code blue call.

61. A nurse and an officer were leaving the prison at the end of a night shift, when they heard a code blue over someone's radio in the gatehouse. They went straight to Mr Tye's cell.

62. When they arrived, the officer was carrying out chest compressions, while two nurses were administering oxygen. One nurse then took over chest compressions and another took an oxygen saturation monitor out of the emergency bag, to check Mr Tye's oxygen level. A nurse asked an officer to collect more oxygen, as she thought the bottle they had was not sufficient.

63. At 7.47am, an ambulance arrived at the prison and more paramedics arrived at 7.56am. The paramedics examined Mr Tye and established that he had no pulse or heart rate. At 8.03am, the paramedics recorded that Mr Tye had died.

64. Later that day, a prisoner told an officer that he had heard that Mr Tye had been given a package of drugs at the funeral which he had swallowed, but the package had burst. The investigator spoke to the prisoner, who said he knew nothing about this. The prison passed this information to the police later that day, but heard nothing back. The security department also received anonymous information that Mr Tye had been desperate to move off the houseblock as two prisoners were bullying him as he was in debt to them for Spice, a new psychoactive substance. This was investigated and officers searched these prisoners' cells, but found no evidence of this.

Contact with Mr Tye's family

65. Mr Tye had not given next of kin details when he arrived at the prison, but had named his partner as a contact during the ACCT procedures. The prison could not contact her. (They later learned that she was out of the country.)

66. Staff found an address for Mr Tye's sister in his previous prison custody records, who he had previously named as his next of kin. The deputy director and two family liaison officers went to visit Mr Tye's sister but learnt from a friend that she was in hospital. The friend gave them Mr Tye's mother's address and they went to her house and explained what had happened. They offered condolences and support. Mr Tye's mother said she would inform other family members. In line with national policy, the prison offered to contribute to funeral expenses.

Support for prisoners and staff

67. On the morning that Mr Tye died a manager scheduled a debrief for the staff involved in the emergency response, but this was cancelled because of an emergency incident at the prison. Staff were sent letters to let them know the date had been rearranged for 18 June, but nobody attended. The care team and managers spoke to some of the staff involved individually at the time of Mr Tye's death.

68. The prison posted notices informing other prisoners of Mr Tye's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Tye's death. Officers assessed the cellmate as at risk of suicide and self-harm and started ACCT monitoring and support.

Post-mortem report

69. We had not received the post-mortem and toxicology report at the time this initial report was issued.

Findings

Management of risk of suicide and self-harm

70. Although Mr Tye's risk of suicide and self-harm was appropriately identified by the prison when he arrived at Doncaster, we have some concerns about the operation of ACCT procedures. We identified similar concerns in the reports into the deaths of prisoners at Doncaster in May and December 2014.

71. Staff assessed Mr Tye as at low risk of suicide and self-harm at every ACCT case review. Risk is generally determined to be low if a prisoner has no plan or idea of suicide, no symptoms of depression, no mental illness and no self-harm behaviour. As Mr Tye had recently tried to kill himself in response to his father's death, it is difficult to see how he could have been considered at low risk of suicide and self-harm.

72. Despite being assessed as at low risk of suicide or self-harm, staff checked Mr Tye very frequently, every half an hour or hourly. However, officers often did not record ACCT observations at the time they were done so it was difficult to be satisfied that they were all done at the agreed frequency. We were concerned that some staff said that it was not possible to record all checks as they were done, within existing staffing levels. The prison had accepted a recommendation in a previous investigation into a death at the prison in 2014 that there should be sufficient staff on duty at all times to allow staff to carry out the required level of observations. This should include the capacity to record those observations.

73. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires that,

> "*Staff must follow the level of observations and conversations as stated in the 'required frequency of conversation and observation box' on the front of the ACCT.* ***These must be recorded immediately or as soon a practicable thereafter****."*

74. In response to a previous death at the prison, a Director's Order 02/2015 was issued in February 2015, requiring the following:

> *"The Residential Manager, or equivalent, is responsible for ensuring that conversations and observations are completed AND RECORDED as per the requirements set out on the front cover of the ACCT plan."*

75. Despite the PSI and the Director's Order, we found that staff did not understand their responsibility to record every ACCT observation immediately. We make the following recommendation:

The Director should ensure that prison staff take into account all risk factors when assessing a prisoner's level of risk of suicide and self-harm and record all ACCT observations immediately, or as soon as possible after they are made.

76. We are concerned that when Mr Tye returned from his father's funeral in the early evening of 5 June, there was no record that anyone formally assessed his

risk of suicide and self-harm when he arrived back at the prison. As Mr Tye had attempted suicide, shortly after his father's death, this should have been identified as a potential trigger for suicide or self-harm. The officers who escorted Mr Tye said that a nurse spoke to him in reception but there is no record of this in Mr Tye's medical record and no evidence of any formal assessment for risk of suicide and self-harm, after he got back from the funeral.

77. Prison Service Order 3050, Continuity of Healthcare, states, "Events that require a prisoner to leave the prison and pass back through prison reception can have a significant impact on the health of a prisoner". The PSO gives examples such as attending court, sentencing at court, and returning from home visits. It requires prisons to have protocols for screening such prisoners for any potential healthcare, or suicide and self- harm issues. The list of potential events that might affect a prisoner's risk in the PSO is not exhaustive, but we would expect prisons to recognise that attendance at the funeral of a close family member should prompt an assessment of risk. This was particularly important in Mr Tye's case, as his father's death had triggered an earlier suicide attempt. We make the following recommendation:

The Director and Head of Healthcare should ensure that prisoners returning through reception from events likely to have an affect on their health and wellbeing have a recorded assessment of their risk of suicide and self-harm.

Emergency response

78. An officer immediately radioed a code blue as he went into Mr Tye's cell. The operational support grade in the control room heard the call, but did not telephone for an ambulance immediately. She said it was the practice to wait for a member of healthcare staff to confirm that an ambulance was required. A manager radioed for an ambulance at 7.42am, and the OSG telephoned seconds later. This was a two-minute delay from the time that the officer called the code blue.

79. PSI 03/2013, Medical Emergency Response Codes, specifies that all prisons must have a Medical Emergency protocol based on the PSI. Doncaster's protocol, contained within Director's Rule 18.1 July 2013, Annex 1, instructs that an emergency code should automatically trigger the control room to call an ambulance. However, this does not seem to be the established practice at the prison. The deputy director told the investigator that the Director's Rule had been issued to all control room staff on 21 July, and they had signed to confirm they had read it.

80. There was a quick emergency response and only a relatively short delay and there is no evidence that this affected the outcome for Mr Tye. However, in other emergencies, such a delay could be crucial. We have raised this matter with prison before and repeat the following recommendation:

The Director should ensure that control room staff call an ambulance immediately they receive an emergency medical code call.

Clinical care

81. Mr Tye thought that his diazepam prescription was being reduced too quickly. The clinical reviewer concluded that his managed reduction of diazepam was appropriate and would have stopped more quickly in the community. She concluded that Mr Tye received regular input from both the substance misuse and mental health teams and that the clinical management of his substance misuse was appropriate. She said that Mr Tye received the standard of care he could have expected to receive in the community.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141