



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
in December 2014, a prisoner at HMP Doncaster**

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 hanged himself in his cell at HMP Doncaster in December and died in hospital the next day. He was 36 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in prison was undertaken. The prison cooperated with the investigation.

In April 2013, the man was recalled to prison from a previous sentence and moved to Doncaster in July. In December 2013, he received a further prison sentence of 11 years for burglary. He had no history of self-harm or mental health problems and appeared to settle well at the prison. However, he had frequently used 'Spice', a new psychoactive substance, and his cellmate said he began to appear paranoid. On 30 November 2014, he cut his neck and said he was at risk from other prisoners. Officers began to manage him under Prison Service suicide and self-harm prevention procedures and moved him to a different landing for closer observation. He refused to engage with suicide prevention procedures and did not want any mental health intervention. On 2 December, staff moved him to another unit, with less frequent observation. He cut himself again the next day. One morning in December, an officer found he had hanged himself in his cell.

The investigation found that the prison did not follow mandatory national procedures for managing prisoners at risk of suicide and self-harm, including observing the man at the required intervals. Although staff were supposed to check him at least twice an hour, no one had checked him for at least an hour and a half before he was found hanged. No one investigated his claim that other prisoners had threatened him. I am also concerned that resource constraints appear to have influenced the frequency of observations set, rather than his assessed level of risk.

We do not know whether the use of new psychoactive substances played any part in the man's death, but this is a problem the prison needs to tackle. The emergency response procedures were poor and led to an unnecessary delay in calling an ambulance. I have raised a number of these matters with the prison before and the Director needs to ensure that required changes are implemented.

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

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SUMMARY

1. In April 2013, the man was recalled to prison. He transferred to Doncaster from HMP Leeds in July. On 10 December 2013, he was sentenced to 11 years six months for burglary. He appeared to settle well at the prison.
2. The man's cellmate said he had smoked Spice, (a new psychoactive substance, a synthetic cannabinoid) for some time and towards the end of November, began to behave in a paranoid way. On 30 November, he cut his neck. He seemed to believe he was a police officer and told officers there was a contract out on him. He said that if he had not cut himself, another prisoner would have done so. Officers started suicide and self-harm procedures (known as ACCT), but he refused to participate. Staff moved him to a different landing, above the healthcare centre, where officers could monitor him more closely.
3. In the early hours of 1 December, the man opened the cut on his neck and needed hospital treatment. On 2 December, he moved to a shared cell in the prison's drug detoxification unit, where he shared a cell. The next day, he cut his neck again. The nurse and officers recommended that his observations should be increased and that he should move back to the landing above the healthcare unit. A manager disagreed, and he remained in the drug detoxification unit. Officers were expected to check him twice every hour.
4. A few days later, an officer found the man had hanged himself in his cell and alerted other staff. An officer radioed an emergency medical code but the control room did not call an ambulance until specifically requested, two minutes later. Staff raised the alarm, cut ripped bedding from his neck and began to attempt resuscitation. Paramedics re-established a pulse and took him to hospital. He remained in a critical condition overnight, and did not regain consciousness. The next morning doctors removed life support and he died shortly after.
5. The investigation identified serious concerns about the operation of ACCT suicide and self-harm procedures at Doncaster, including the management of reviews and recording ACCT observations and interactions. We did not consider the prison implemented ACCT procedures in line with national guidance, a matter we have raised with the prison before. No one investigated whether the man's claim that he was under threat from other prisoners was true. Emergency procedures were poor and resulted in a two-minute delay before anyone called an ambulance. There is also a need to tackle the increasing use of new psychoactive substances. We make five recommendations.

THE INVESTIGATION PROCESS

6. 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.
7. The investigator obtained copies of relevant documents from the man's prison and medical records. He subsequently interviewed 20 members of staff at Doncaster and spoke to several prisoners.
8. NHS England commissioned a clinical reviewer from Spectrum Community Care to review the man's clinical care at the prison.
9. We informed HM Coroner for Doncaster of the investigation who sent the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted the man's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He said he was disappointed that the prison had not contacted him when his son had first self-harmed. He received a copy of the draft report. He did not raise any further issues, or comment on the factual accuracy of the report.

HMP DONCASTER

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

Her Majesty's Inspectorate of Prisons' report

12. The most recent inspection of Doncaster was in March and April 2014. Inspectors found a significant use of illegal drugs in the prison, and prisoners told them that the use of new psychoactive substances, such as spice, was common.
13. 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.
14. Inspectors reported that staff appeared overwhelmed by the challenges facing them on the wings and lacked control of busy houseblocks, especially when there were only two officers on duty. Inspectors commented that management did not show visible leadership and support.
15. Doncaster had responded promptly to PPO recommendations, after previous deaths at the prison, but inspectors were not confident that the changes would be long-term.

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 2014, the IMB reported that Doncaster had taken on board a number of changes following the findings of Her Majesty's Inspectorate of Prisons. The IMB reported an increase in the use of spice, which had led to a rise in incidents of violence and self-harm. They noted that the prison had distributed leaflets highlighting its danger to prisoners.

Previous deaths at Doncaster

17. The man was the fourth apparent suicide at Doncaster since the beginning of 2011. In our last report into the death of a man at the prison in May 2014, we were critical of ACCT processes and of the emergency response. We identify similar issues in this report.

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. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. 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. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Upper healthcare landing

19. The upper healthcare landing (known in the prison as 'upper healthcare') is a residential unit with 13 cells. The unit previously accommodated prisoners who required close observation for either physical or mental health issues and those with disabilities. Mental health nurses had worked on the landing, but it never operated as an inpatient facility and closed in 2013.
20. The landing is now used as overflow accommodation, mainly for prisoners subject to ACCT monitoring who need more than four checks an hour. It is not in constant use and is opened only when required. (Not all prisoners being checked this frequently go to the upper healthcare landing and some remain on residential houseblocks.) There are no formal admission criteria.

KEY EVENTS

21. The man had been in prison several times. He was released on licence from HMP Moorland on 24 December 2012, after serving four years for burglary.
22. On 23 April 2013, he was charged with several counts of burglary and his licence was revoked. He was sent to HMP Leeds, then transferred to HMP Doncaster on 18 July. On 10 December 2013, he was sentenced to a further 11 and a half years in prison.
23. The man appeared to settle well at Doncaster. He mixed with other prisoners and was a wing representative. He shared a cell with his co-defendant and a close friend. They made their cell as comfortable as possible. The co-defendant told the investigator that he and the man had always looked out for each other, had no problems, and got on well with most other prisoners. He said the man had smoked Spice for a long time, but had always been fine. He told the investigator that prisoners could get spice easily on the houseblock. He thought that the man could have also been using illicitly obtained subutex (an opiate-based drug used to treat heroin addiction).
24. In telephone calls to a friend two weeks before his death, the man sounded in good spirits. He said he was happy to get on with his sentence and described Doncaster as not a bad place.
25. The co-defendant said the man began to get worried about officers finding his drugs, and often imagined that noises outside the cell were made by officers about to search him. He said that, for a couple of months before his death, the man had been paranoid about other prisoners watching him and this had got much worse over a few days at the end of November. He recalled that the man stayed in their cell on Friday 28 and Saturday 29 November and would only let close friends near their cell. He said the man had told him that other prisoners thought he was a police officer and, because of this, he had a price on his head. The co-defendant did not take this seriously.
26. On 29 November, the co-defendant left the cell for a short time. When he got back, the man had locked their cell from the inside and said he was a police officer. When he eventually let him back in, the co-defendant said the man was not himself and behaved oddly. When he suggested playing a game on his PlayStation, the man stared at the controls and the television.

30 November 2014

27. On Sunday 30 November, the man told the co-defendant that he had cut his neck sometime during the night. The co-defendant reported this to officers at about 10.00am. An officer and the unit manager went to their cell. The man told the unit manager that he had cut his neck because he had wanted to go to sleep and not wake up. He told the officer that he was a police officer and other prisoners were out to get him.

28. The unit manager told the man he would need treatment for the cut, but he would not leave the cell. He told her that if he had not cut his neck, another prisoner on the houseblock would have done it. After some persuasion, he walked to the treatment room. On the way, he told her that there was a contract out on a police officer, but would not say who was involved. The co-defendant said the man was delusional and he told him to sort his head out, and tried to reassure him that no one was out to get him. The unit manager told the investigator that she had assumed he was nervous because he was in debt.
29. A nurse treated the cut in the man's neck, which was about five inches long. The unit manager told a colleague about his self-harm. She said he needed to be moved to the upper healthcare landing, be monitored constantly and that he thought he was in danger. Her colleague agreed that he should move to the upper healthcare landing, but decided that he should be observed twice an hour.
30. An officer opened an ACCT at 10.00am. He noted that the man was abnormally quiet, extremely low in mood and acting out of character.
31. At about lunchtime, the unit manager took the man a television, as well as some magazines from the co-defendant. He told her there was a contract on him, and if he did not kill himself, someone else would. She told him that he did not have to go back to Houseblock One. She said he nodded his head in agreement and said he felt safer on the upper healthcare landing.
32. An officer told the unit manager that two prisoners on Houseblock One had told her that the man was at risk of hurting or being hurt by other prisoners on the unit. She completed an incident report, and recommended that he should not return to Houseblock One. She sent the report to a member of the Safer Custody Department and the Head of Internal Investigations. There was no further investigation into this allegation.
33. At 2.00pm, the unit manager completed an ACCT immediate action plan. She noted that the man was aware of "prison buddies", (prisoners trained to offer support to other prisoners) and that he could use the telephone. She agreed with a manager that officers should check him twice an hour. The manager asked an officer to assess him as part of the ACCT process, but he refused to be interviewed. No assessment was completed.
34. A member of chaplaincy saw the man at 4.00pm, during a routine visit to the upper healthcare landing. He told the chaplain that he was okay but did not want to talk to him. He spent some time in the open air in the afternoon and seemed more settled, calm and talkative. That evening, he ate some food and officers noted no further concerns.
35. At about 11.30pm, the man asked an officer if he could see a nurse, as he had opened the wound on his neck. The nurse considered he needed to go to hospital for treatment, in case the wound became infected. At first, he refused to go, but later agreed. A hospital doctor asked him why he had self-

harmed, and he said that he should have left the spice alone.

1 December

36. When the man got back to the prison at 3.00am, a nurse noted the hospital had prescribed antibiotics and that his stitches should be removed in five days. As a precaution, staff increased his observations to four an hour.
37. At 7.00am on 1 December, an officer wrote in the ACCT record that the man was asleep and there were no concerns. There were no more entries in the ACCT document until 6.00pm, when an officer noted that he was asleep.
38. At 9.30am, the man hit another prisoner in the face and accused him of spitting in his drink. An officer charged him with a disciplinary offence and a nurse treated both prisoners.
39. At 4.30pm, a unit manager chaired the man's first ACCT case review with two officers and a nurse from the prison's mental health team. He refused to leave his cell to attend the review or engage with the nurse. The review agreed that his risk of suicide was raised (on a scale of low, raised and high) and kept his observations at four an hour. The manager wrote one action in the ACCT caremap: that he should start to speak. The triggers section of the ACCT was not completed.
40. A nurse said he spoke to the man briefly. The nurse noted in his medical record that he did not want to answer any questions about his health, drug use, or if he had intended to take his life, but said, "I am dead either way". He refused to say if he felt threatened in prison or had problems at home. (The nurse told the investigator he understood that the man might have been in debt or involved in supplying drugs on the houseblock.) The nurse said he could not understand his sudden change in behaviour and referred him to the mental health team for assessment.
41. At 8.50pm, an officer opened the man's cell so a nurse could give him his antibiotics, but he refused to take them. He appeared confused and seemed to find the officer threatening. The nurse tried to assure him that he was safe. He then threatened them, so they left the cell. The nurse wrote in his medical record that he had acted bizarrely and it looked as if one of his stitches had come out.

2 December

42. At 8.14am, an officer gave the man written notice that he was being charged with a disciplinary offence for hitting the prisoner the previous day. He told the investigator that the man was not bothered. He noticed that the cut on his neck was slightly open and arranged for a nurse to see him. He refused a hot drink and told the officer he was going back to bed.
43. Later that morning, the man told the officer that he had been using Spice. The officer thought he wanted to leave the upper healthcare landing, but was

nervous of other prisoners elsewhere. A nurse checked his wound and arranged for him to have a stitch put in it. (There is no record that this happened.)

44. A manager chaired the man's second ACCT review at 12.20pm with an officer. The record of the case review showed that the man did not attend, but the officer told the investigator that he had been there. The manager told the investigator that he had asked a nurse if he wanted to attend the review, but the nurse had said that if the man did not want to engage, there was no point. Nevertheless, the manager noted a small improvement in the man's contact with staff. He had showered, eaten and spoken to staff. The officer said that they told the man during the review, that he would be moved to Houseblock Three, but this was not recorded. His level of risk remained assessed as raised, but the review reduced the frequency of observations to two an hour. The manager noted in the ACCT caremap that the man had engaged. No new objectives were set. The next ACCT review was scheduled for 5 December.
45. At 12.30pm, the manager wrote in the ACCT record that the man was to be moved to a shared cell in the prison's drug detoxification unit, Houseblock Three. He later noted in the man's case history that he had stabilised but needed more observation. He said he did not want him to remain in isolation on the upper healthcare landing, but to take part in a normal regime, as he had not self-harmed again. By moving him to Houseblock Three, staff could increase observations quickly, if necessary, because healthcare staff were based on the unit to deliver prisoner detoxification.
46. At 2.00pm, a nurse from the prison's mental health in-reach team made an initial assessment of the man's mental health to establish whether he needed a formal mental health assessment. She noted in the medical record that he did not want to talk, but had answered the questions she asked him. He told the nurse he had been smoking new psychoactive substances (Spice) for two years. He said that he had last smoked spice three days earlier, but had no recollection of cutting his neck. He said he had liked being on Houseblock One, got on with other prisoners and enjoyed being a wing representative. He said he had no contact with his family. She said he shrugged his shoulders and was confused when she asked him if he had a contract on his head. She wrote that she could not assess his risk of self-harm as he refused to answer any questions about it. The nurse arranged to discuss him at the mental health team's multidisciplinary meeting, the next day.
47. That afternoon, an officer brought the man more of his property from Houseblock One and told him that his friends were thinking of him. She noted that he would not talk or make eye contact with her and was not himself.
48. The co-defendant said officers told him that he could not see the man. Officers told the investigator that he had said he did not want to see the co-defendant, but there is no record of these conversations in his prison records or in the ACCT document.

49. After lunch, an officer took the man to Houseblock Three and put him in a cell with another prisoner. The prisoner said an officer asked him to keep an eye on him. At 4.45pm, one of the unit managers checked on him. She noted that he was happy to share a cell with the prisoner.
50. The prisoner told the investigator he knew the man from outside prison and described him as a cheerful person. He said when the man arrived on Houseblock Three he had seemed depressed, but did not talk about harming himself. The man told him he was suffering from the side effects of smoking spice constantly for two years. He said that he heard him crying during the night. He told the investigator that he did not think that the man was fit enough to be on the houseblock and he had sat up with him all night.
51. Staff noted no further concerns about the man that day.

3 December

52. At lunchtime on 3 December, a mental health in-reach team meeting with medical staff agreed that a nurse would see the man the next day in preparation for a full assessment. There was no corresponding entry in his medical record and no evidence of any minutes of the meeting.
53. At 12.30pm, an officer noted in the ACCT record that the man had not replied when he asked him about cuts on his neck. The officer asked the unit manager to see him in his cell, and she called a nurse. The cellmate told the officers that he thought the man might have a razor blade in his hand. He eventually handed the blade to staff. A nurse assessed him, but he did not need treatment for any cuts. He told her that he would cut himself again and again, but he wanted to be left alone. She told the investigator that she thought he was going to do something serious.
54. A manager waited outside the cell while the nurse spoke to the man. She told the managers that she considered that he needed constant supervision, or at least four observations an hour, and should move to the upper healthcare landing. One manager agreed, but the other said that there were insufficient resources to increase the frequency of his observations and refused. (Moving him to the upper healthcare landing for increased supervision would have required the landing to be opened with an officer to staff it.)
55. The manager told the investigator that he believed the man had not seriously self-harmed and he thought that returning him to the upper healthcare landing could make him feel isolated. He decided that staff should continue to observe him twice an hour and that they should try to talk to him during his ACCT review that afternoon.
56. An officer searched the man's cell and removed two razor blades.
57. A unit manager chaired the man's third ACCT review at 2.45pm, with a nurse. She had invited a mental health nurse as he was already on the houseblock and she wanted someone from the mental health team to attend. This nurse

did not speak to other nurses before the review.

58. During the ACCT review, the mental health nurse asked the man why he felt like killing himself, and he replied by telling them to hang or kill him. The review assessed that his risk remained raised, and his observations stayed at two an hour, as the manager had decided.
59. The mental health nurse wrote in the man's medical record that officers thought he was under threat from other prisoners. He would not say if he was having any paranoid thoughts or hallucinations, but said he would continue to harm himself and thought he might be better off dead. The nurse planned a primary mental health assessment and a possible referral to a psychiatrist. He noted that officers were investigating alleged threats (although there is no evidence of such an investigation and this is not mentioned in the note of the ACCT review).
60. The man's cellmate said that the man slept all afternoon and they chatted in the evening. At 6.50pm, an officer noted that he would not come out of his cell. At 9.10pm, two officers answered a cell bell. He had been crying, but told the officers to leave him alone. An officer wrote this in the ACCT record and the other officer informed the unit manager.
61. At 10.15pm, an officer noted in the ACCT record that the man had asked for some paracetamol. The man's cellmate told the investigator that when a nurse gave him the paracetamol, he was very confused and started swearing at a man on the television.
62. At around 1.30am, the cellmate heard the man crying in bed. He told the investigator that the man was trying to remove the blade from a pencil sharpener, and he had to stop him from opening the wound on his neck with a pen. He said the man had not taken any drugs.
63. At about 1.30am, the cellmate pressed the cell bell to report that the man was harming himself. He said that Officer A, who responded, was not interested because he was not from that houseblock. The officer noted in the ACCT document that the man had tried to put something in the cut on his neck. He recorded that he had said he was okay, had made himself a drink and the cellmate had said he would keep an eye on him. The officer said he was not concerned because he seemed calm and made good eye contact. He said he did not think the wound on his neck looked open and therefore he thought he had not harmed himself.
64. The cellmate told the investigator that, later that night, he told a nurse that the man should not be on Houseblock Three. He said the nurse had told him that the man would have to wait until the morning for any move. There is no record of this conversation.
65. At 5.30am, Officer A noted in the ACCT record that he had completed the night checks and that the man appeared to be asleep. He told the investigator that he had checked on him twice an hour during the night,

although these checks were not recorded at the time. He finished his shift at 6.15am.

66. At 6.00am, an officer, who was detailed to work on D Spur, signed the ACCT document to say that he had taken over monitoring the man that morning. However, there are no further entries in the ACCT document from him to record any checks. Officer B arrived for duty at 8.15am, and was the only officer detailed to work on the man's spur, B Spur, that morning. He told the investigator that there was no member of staff there when he arrived, he did not receive a handover from and the spur was locked up. Officer C, who was originally scheduled to work on another spur, joined him on B Spur at around 8.30am, and a unit manager joined them later that morning.
67. The investigator viewed the prison's CCTV of the outside of the man's cell. It was difficult to see what happened before that, but it was apparent that no one checked him between 7.07am and 8.41am, when Officer C unlocked his cell, despite observations being set at twice an hour.
68. Both officers began unlocking cells at 8.40am, about ten minutes later than scheduled. Officer C unlocked the man's cell. The officer asked him if he wanted to leave the cell, but he was dismissive. Initially, his cellmate stayed in the cell with him. He said the man pulled his bedcover over him and appeared asleep. He later left the cell to get a drink and talk to other prisoners. The man remained locked in the cell. (While prisoners are out of their cells for the association period, officers lock cell doors. Some prisoners choose to stay in their cells and some ask to go back to their cell before the association period is over.)
69. CCTV shows that an officer last appeared to check the man at 9.09am. However, there is no other record of this check, which was not entered in the ACCT record, or who completed it. Officer B left the wing at around 9.30am, for 40 minutes, to escort a prisoner. At 10.40am, when Officer B unlocked the cell door to let the cellmate back in, they found that the man had hanged himself using a sheet attached to the cell window. Officer B shouted to Officer C, who radioed a code blue emergency, (which indicates a life-threatening situation such as when a prisoner is unconscious or not breathing).
70. The cellmate and Officer B went into the cell followed by Officer C. The cellmate lifted the man, while both officers cut the sheet from around his neck. They then laid him on the floor. Officer B found a faint pulse, so put him in the recovery position. A healthcare assistant arrived at the cell with an emergency response bag, a minute after the alarm was raised.
71. About two minutes after he had called the code blue, Officer C called the control room and asked them to call an ambulance. The officer working in the control room told the investigator that she did not automatically call an ambulance as soon as the code blue was called. She said that, after an emergency medical code was received, the practice was to wait to hear from a nurse or officers at the emergency before calling an ambulance.

72. The response nurse told the investigator that she arrived at the cell just as the healthcare assistant was putting an oxygen mask on the man. She also found a faint pulse. Other healthcare staff arrived. The man's pulse stopped, so two nurses started cardiopulmonary resuscitation. Nurses attached a defibrillator, (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). The defibrillator advised not to give a shock, so they continued to attempt to resuscitate him.
73. Paramedics arrived at 10.55am, followed by an ambulance crew at 11.07am. They joined the prison nurses trying to resuscitate the man. The defibrillator advised a shock on two occasions, after detecting a heart rhythm. Paramedics re-established a pulse and, at 11.34am, the paramedics decided that he was stable enough to transfer to hospital.
74. The man remained in a critical condition in hospital overnight on life support, but never regained consciousness. The next morning a hospital consultant decided to switch off the life support machine. Doctors pronounced him dead at 11.38am.

Family Liaison

75. The prison's family liaison officer tried to contact the man's parents, but could not get hold of them and asked the police to help. At 1.50pm, the police informed them that their son had been admitted to hospital. He introduced himself to them when they visited their son in hospital and remained in contact with them after his death. The prison offered to contribute to funeral expenses in line with national policy.

Support for staff and prisoners

76. Managers debriefed staff involved in the emergency response shortly afterwards. Those involved said they found it helpful and that the prison's care and welfare team had given them good support.
77. Officers reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been affected by the news of the man's death. The cellmate said that prison staff had supported him well after the incident. The co-defendant also said he received appropriate support.

Post-mortem report

78. A post-mortem examination concluded that the man died from significant brain damage, caused by hanging. Toxicology tests detected no drugs or alcohol in his blood when he died. (His blood was not tested for the presence of synthetic drugs, such as Spice.)

ISSUES

Management of risk of suicide and self-harm

79. An officer appropriately opened an ACCT after he discovered that the man had harmed himself on 30 November. However, after that, we have serious concerns about the prison's management of his risk of suicide and self-harm. We raised similar concerns about the prison's operation of ACCT suicide and self-harm prevention procedures in our report into the death of a man at Doncaster in May 2014, which was published just before the man's death.
80. The first ACCT review was not held within twenty-four hours, there were no triggers or warning signs listed on the first page of the man's ACCT document and there was no ACCT assessment. Although he had refused to engage, ACCT instructions require the assessor to undertake the assessment based on all other available information. Other deficiencies in ACCT procedures are set out in more detail below.

Observations and interactions

81. Officers should have checked the man between two and four times an hour during the four days he was subject to ACCT monitoring. We found that officers did not record ACCT observations at the agreed frequency at any time over those four days.
82. Staff were required to record at least three meaningful interactions with the man each shift. We recognise that he was reluctant to engage with staff, but there is little evidence that staff actively attempted to engage with him. Most of the entries are observational and reflect little attempt to understand what he was thinking or feeling.
83. During the four days that the man was being managed under ACCT procedures, staff were expected to check him, sometimes up to four times an hour. However, there is no evidence from the ACCT record that staff checked him at the required frequency. Officers merely noted at the start of each shift that they were taking over the required observations. There is therefore no assurance that these checks were done. We know that they did not take place at the required frequency on the morning that he hanged himself. CCTV footage of B Spur showed that officers did not check him between 7.07am and 8.15am or between 9.09am and at 10.40am, just before he was found hanged. Officers should have checked him at least twice an hour at that time.
84. 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 observations box' on the front cover of the ACCT. These must be recorded immediately or as soon as practicable thereafter."

85. PSI 64/2011 outlines that the ACCT on-going record should give staff a good understanding of how a prisoner is coping, which will inform decisions about the management of a prisoner's risk of suicide and self-harm.
86. Officers did not check the man in line with his perceived level of risk and his ACCT on-going record did not reflect how he was coping. We do not consider that the prison effectively monitored his risk of suicide or self-harm.

Caremap

87. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. Caremaps should aim to address issues identified in the ACCT assessment interview and consider a range of factors including health interventions, peer support, location, provision of diversionary activities, including occupations in cell and access to gym and other activities. Each action on the caremap must be tailored to meet the individual needs of the prisoner, be aimed at reducing risk to themselves and be time bound.
88. The absence of an ACCT assessment made setting caremap actions more difficult, but one of the issues that ACCT reviews should consider is whether family contact would be beneficial. There is no evidence that the ACCT reviews discussed whether an action about family contact should be included on the caremap. Although the man told a nurse on 3 December, that he had no contact with his family, this was not discussed in the context of the ACCT procedures.
89. There is only one entry in the man's caremap from 1 December: that he should engage with the ACCT process by starting to speak. While we recognise that he did not cooperate with his ACCT assessment, it is concerning that staff did not identify any other issues, such as family contact, his location, possible threats, substance misuse or mental health, which, if addressed, might have helped reduce his level of risk. No one revisited the caremap or updated it after his first review.

ACCT reviews

90. The man had three ACCT case reviews. A mental health nurse attended two of the reviews, although another nurse had accepted the man onto her caseload. The mental health nurse did not consult two nurses who had been more actively involved in his care. The man refused to engage with the mental health nurse, so his contribution to the case review was limited.
91. There was no recorded discussion at any of the case reviews about the man's mental health, threats from other prisoners, or his location in the prison.
92. When the man self-harmed on 3 December, a senior manager rejected a unit manager's and nurse's advice to move him back to the upper healthcare landing with increased observations, again outside a formal case review. When the unit manager held a case review shortly afterwards, she did not feel

able to contradict the views of her senior manager, so he remained on twice hourly observations on Houseblock Three. We are concerned that the level of resources required was too much of an influencing factor in the senior manager's decision not to accept the unit manager's and nurse's advice about the level of observations needed to reflect the man's risk.

93. The man tried to open the cut on his neck again. Officer A did not recognise this as a further act of self-harm and did not organise an ACCT case review for the following day or inform the duty manager. We consider that this act of self-harm represented an increase in his risk, which should have triggered a case review or at least some consideration of whether a review was required. This was a missed opportunity to have a further assessment of whether his level of risk meant that the level of observations needed to be increased, on the morning that he hanged himself.

Conclusion

94. The man's behaviour made it difficult to manage him effectively under the ACCT process. Nevertheless, there were some significant deficiencies in the ACCT process. We 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:

- **Holding multi-disciplinary ACCT reviews when there is an increased risk or further act of self-harm, which ensure continuity of case management and include all relevant people involved in a prisoner's care;**
- **Recording all relevant information about the risk of suicide and self-harm in the ACCT record, using all available information when the prisoner has not engaged with the ACCT assessment;**
- **Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, include issues of family contact where relevant and which identify who is responsible for them;**
- **Setting levels of observations which reflect the prisoner's actual risk rather than the resources required;**
- **Completing ACCT checks at the required frequency; and Recording ACCT observations immediately or as soon as possible after they are made.**

Investigating allegations of threats

95. Officers and healthcare staff were aware that the man had said that he felt threatened by other prisoners on his houseblock. After an officer told a unit manager that two prisoners had said that he was at risk from other prisoners, she completed an incident report, but staff took no action to investigate the alleged threats. She told the investigator that it was easier to move him than investigate.

96. Our investigation found little evidence to suggest that the man was under threat from other prisoners, other than the incident report, which the unit manager completed. However, Doncaster's Safer Custody Policy instructs the Safer Custody Manager to carry out a detailed investigation of allegations of bullying if required. Although it is possible that his allegations of threats were the result of paranoia, we are concerned that no one investigated the allegations further at the time, or took any action, other than to move him. We make the following recommendation:

The Director should ensure that all information indicating potential bullying or threats against a prisoner is fully investigated and that, when the information concerns a prisoner identified as at risk of suicide and self-harm, this is highlighted in the ACCT document and discussed at ACCT case reviews to check that the prisoner is receiving effective support.

Staff cover

97. The night officer on B Spur should have handed over to an officer beginning an early shift at 6.00am. On the day of the incident there was no officer scheduled to work the early shift. However, the officer who was not detailed to work on the unit signed that he had taken over observations for the man. It appears that he was covering two spurs, although there were a number of other prisoners being monitored under ACCT procedures on B Spur, which would have made this very difficult. When Officer B arrived at about 8.15am to start his shift, there was no member of staff on duty on the spur and he received no handover.
98. We are concerned that the spur did not have enough staff cover to ensure prisoners' safety on the day of the incident. This meant that officers did not check the man for nearly an hour and a half that morning. We make the following recommendation:

The Director should ensure that there are sufficient staff on each houseblock and spur at all times to ensure prisoners' safety and to allow staff to carry out the required level of observations for prisoners being monitored under ACCT procedures.

Emergency Response

99. The officer called an emergency code blue, but the control room did not call an ambulance until he contacted them again almost two minutes later. The two officers in the control room told the investigator that they do not automatically call an ambulance when they hear a code blue. They wait for an update from a nurse before doing so.
100. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, specifies that all prisons must have a Medical Emergency Response Code protocol based on the PSI. Doncaster's protocol, contained within Director's Rule 18.1 July 2013, Annex 1, Medical Emergency Response

Codes, instructs that an emergency code should automatically trigger the control room to call an ambulance. However, this does not appear to be established practice among control room staff.

101. Although it seems unlikely that the outcome would have been different with a prompter response, the albeit brief delay in this case is a particular concern as the man had a faint pulse when he was found hanged. We have commented previously on the delay in calling an ambulance in our report into the death of a man at the prison in May 2014. We make the following recommendation:

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

Clinical care

102. The clinical reviewer concluded that the standard of healthcare the man received at Doncaster was equivalent to that he could have expected to receive in the wider community. A mental health nurse spoke to him on 1 December but he was reluctant to talk. The nurse appropriately made a mental health referral and another nurse from the mental health in-reach team triaged him for a mental health assessment on 2 December. Although this was not minuted, the nurse accepted him onto her caseload and discussed him at an in-reach team meeting on 3 December. She planned to see him for a full assessment but, sadly, he hanged himself before this took place. The clinical reviewer identified some areas for improvement in aspects of healthcare procedures, including record keeping and mental health referrals, which the Head of Healthcare will need to address. As they were not directly related to the circumstances of his death, we do not repeat them in this report.

New Psychoactive Substances

103. The man's friend and cellmate said that the man had been smoking 'Spice', a synthetic cannabis substitute for a long time. He said that the man had always been fine, but reported that he had exhibited some paranoid behaviour in the last months of his life, which became extreme at the end of November. The man admitted to a nurse that he had been using Spice, for two years and had smoked Spice on 30 November when he had cut his neck. There is no evidence that the nurse referred him to substance use services.
104. New Psychoactive Substances, (NPS) are an increasing problem across the prison estate, and they are difficult to detect, as they are not identified in current drug screening tests. The clinical reviewer noted that the use of such substances often results in a broad range of physical, psychological and behavioral responses that are out of character for the individual.
105. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances in prison can also lead to debt, violence and intimidation, which

also increase the risk of suicide or self-harm among vulnerable prisoners, as well as adding to the security and control problems facing staff.

106. We do not know whether the man's actions were as a result of his use of new psychoactive substances but we note with concern that both the HM Inspectorate of Prisons and the Independent Monitoring Board for Doncaster identified the use of such substances as an increasing problem at Doncaster. We make the following recommendation:

The Director should ensure that prisoners identified as using new psychoactive substances, (NPS) are referred to drug treatment services and that the prison includes a specific approach to tackling the use of NPS in its drug supply reduction and violence reduction strategies.

RECOMMENDATIONS

1. The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Holding multi-disciplinary ACCT reviews when there is an increased risk or further act of self-harm, which ensure continuity of case management and include all relevant people involved in a prisoner's care;
 - Recording all relevant information about the risk of suicide and self-harm in the ACCT record, using all available information when the prisoner has not engaged with the ACCT assessment;
 - Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, include issues of family contact where relevant and which identify who is responsible for them;
 - Setting levels of observations which reflect the prisoner's actual risk rather than the resources required;
 - Completing ACCT checks at the required frequency and
 - Recording ACCT observations immediately or as soon as possible after they are made.
2. The Director should ensure that all information indicating potential bullying or threats against a prisoner is fully investigated and that, when the information concerns a prisoner identified as at risk of suicide and self-harm, this is highlighted in the ACCT document and discussed at ACCT case reviews to check that the prisoner is receiving effective support.
3. The Director should ensure that there are sufficient staff on each houseblock and spur at all times to ensure prisoners' safety and to allow staff to carry out the required level of observations for prisoners being monitored under ACCT procedures.
4. The Director should ensure that the control room calls an ambulance immediately they receive an emergency medical code call.
5. The Director should ensure that prisoners identified as using new psychoactive substances, (NPS) are referred to drug treatment services and that the prison includes a specific approach to tackling the use of NPS in its drug supply reduction and violence reduction strategies.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> ▪ Holding multi-disciplinary ACCT reviews when there is an increased risk or further act of self-harm, which ensure continuity of case management and include all relevant people involved in a prisoner's care; ▪ Recording all relevant information about the risk of suicide and self-harm in the ACCT record, using all available information when the prisoner has not engaged with the ACCT assessment; ▪ Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, include issues of family contact where relevant and which identify who is responsible for them; 	Accepted	<p>An Assistant Director (AD) for Safer Custody was appointed at HMP Doncaster in May 2015 in recognition that this area of the business required additional senior manager support.</p> <p>All case managers and assessors will be required to attend further mandatory training on key elements of case management and ACCT processes to reflect the points identified;</p> <p>The Safer Custody Manager will complete a 10% monthly governance audit of all closed ACCT documents and any failings on ACCT will be addressed in writing with individuals and documented in staff personal development records (PDRs);</p> <p>The Safer Custody monthly committee meeting will review the findings of ACCT audits.</p> <p>The Directors rule requiring all ACCT observations to be recorded at the required frequency and as soon after the check will be communicated once more to all staff. The Safer Custody Manager will conduct daily</p>	<p>AD Safer Custody</p> <p>30th September 2015</p> <p>August 2015</p>	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<ul style="list-style-type: none"> ▪ Setting levels of observations which reflect the prisoner's actual risk rather than the resources required; ▪ Completing ACCT checks at the required frequency and ▪ Recording ACCT observations immediately or as soon as possible after they are made. 		<p>checks of the process to ensure it is embedded. Failings to adhere to the process will be addressed formally with individuals and documented in staff PDRs</p> <p>Case Managers will be responsible for setting levels of observations without influence from staff not involved in case reviews.</p>		
2	<p>The Director should ensure that all information indicating potential bullying or threats against a prisoner is fully investigated and that, when the information concerns a prisoner identified as at risk of suicide and self-harm, this is highlighted in the ACCT document and discussed at ACCT case reviews to check that the prisoner is receiving effective support.</p>	Accepted	<p>The AD Safer Custody is currently working through a violence reduction action plan. The VR action plan incorporates a number of actions which has seen the recruitment of a Violence Reduction Coordinator appointed in June 2015, and the planned re-launch of the anti-bullying scheme.</p> <p>The Safer Custody Team will coordinate responses/investigations to alleged bullying.</p> <p>Reports of bullying will be reviewed at a multi-disciplinary weekly violence reduction meeting to ensure potential bullying is followed up.</p>	<p>AD Safer Custody</p> <p>August 2015.</p>	

