Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ira Wilde a prisoner at HMP Doncaster on 20 April 2017

A report by the Prisons and Probation Ombudsman

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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 Ira Wilde died unexpectedly on 20 April 2017, of a gastrointestinal haemorrhage at HMP Doncaster. Mr Wilde was 38 years old. I offer my condolences to Mr Wilde's family and friends.

We are concerned that Mr Wilde may have been unresponsive for some time before he was discovered. Mr Wilde should have been regularly observed on the morning of his death, and we are very concerned that several of these checks were not performed. While this may not have affected the outcome, if he had been discovered earlier, the emergency response may have been triggered sooner.

We are also concerned that Mr Wilde was located in the segregation unit despite displaying serious mental illness. We would have expected alternative locations to have been properly investigated, and his location to have been kept continually under review.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **October 2017**

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Summary

Events

1. On 6 April 2017, Mr Ira Wilde was charged with threatening behaviour and remanded to HMP Doncaster while awaiting trial. Mr Wilde did not have a reception health screen on his arrival at Doncaster because of his unpredictable and irrational behaviour. He was immediately located in the care and separation unit (CSU), also referred to by staff as the segregation unit, and monitored on a regular basis.

2. Mr Wilde was managed under suicide and self harm prevention (ACCT) procedures from his admission to Doncaster. He was initially subject to five observations per hour, which were reduced to two per hour by the time of his death.

3. For the first week or so, healthcare staff only assessed Mr Wilde from a distance because of his behaviour. On 14 April, a prison GP managed to perform clinical observations, which were recorded as unremarkable.

4. On the morning of 19 April, Mr Wilde had blood samples taken by a prison doctor. That afternoon, the results returned, indicating that he might be anaemic. A prison doctor reviewed Mr Wilde immediately, but could find no evidence of acute bleeding. The prison doctor consulted with a specialist at the hospital, and they concluded that Mr Wilde should be monitored at the prison and kept under review following further blood tests.

5. On 20 April, Mr Wilde was last seen conscious at 9.45am, as part of his ACCT observations. At 11.30am, prison officers found him unresponsive and an emergency call was made. An officer started cardiopulmonary resuscitation (CPR) immediately. Shortly afterwards, prison healthcare staff arrived on scene and took over his emergency care.

6. The ambulance crew arrived at approximately 11.45am and continued resuscitation for a further 20-25 minutes but at 12.10pm the ambulance paramedics pronounced Mr Wilde dead.

Findings

Reception

7. While we are concerned that Mr Wilde did not have a reception health screen when he was first admitted to Doncaster, we are satisfied that healthcare staff did all they reasonably could to monitor him appropriately during his time at Doncaster.

Mr Wilde's location in the CSU

8. We are concerned that the initial decision to segregate Mr Wilde was made without the prison properly considering alternatives for him, especially since he was also on an ACCT at the time. We recognise that Mr Wilde demonstrated challenging behaviour but he was clearly suffering from serious mental health problems. While we accept that he prison may have considered alternative

locations for him at the time, we can find insufficient documentary evidence to support this decision.

9. We welcome the prison's decision's decision to review Mr Wilde's segregation promptly the following day, and to set a further review date. However, we are concerned that the prison did not actively review Mr Wilde's segregation within that time.

Observation and ACCT

10. At the time of his death, Mr Wilde was subject to two observations per hour under ACCT procedures, and to hourly checks due to his location in the CSU. We are very concerned that Mr Wilde was not checked for one hour and 45 minutes before being found unresponsive. This meant that at least three observations were missed. We are also concerned that Mr Wilde's CSU observation log was not completed for over five hours, despite him being seen during that time.

11. We cannot say whether an earlier check would have affected the outcome for Mr Wilde. However, if he had been observed as unresponsive earlier, there is every chance that an emergency response would have been triggered sooner. While we appreciate there was a shortage of properly trained staff on the CSU that morning, this cannot excuse these observations not being performed.

Emergency response and CPR

12. When Mr Wilde was discovered at 11.30am, the emergency response was prompt and healthcare staff attended the scene quickly. CPR was started immediately and, following their arrival, healthcare staff coordinated Mr Wilde's life support well. However, we are concerned that prison staff did not have access to the defibrillator, and were not trained to use it. While this did not appear to delay matters too long in this instance, we would have expected staff to have access to this equipment and be trained to use it.

Clinical care

13. The clinical reviewer concluded that the care Mr Wilde received at Doncaster was of a good standard and equivalent to that he could have expected to have received in the community. Mr Wilde's health needs were managed appropriately, and specialist advice was sought where necessary. We agree with the clinical reviewer that healthcare staff could not have predicted the events of 20 April.

Staff support

14. The staff involved in Mr Wilde's emergency response, were debriefed after the incident, and were offered support. While we accept there were concerns about working the next day, overall, staff said the support offered was very good.

Recommendations

- The Director should ensure that exceptional circumstances to justify the segregation of a prisoner subject to ACCT procedures should actually be exceptional, and that all other options should have been considered and

discounted and the reasons for this clearly documented in line with PSI 64/2011.

- The Director should ensure that staff manage prisoners subject to an ACCT in line with national guidelines, in particular, ensuring that the required frequency of observations and conversations is maintained and that this is recorded by staff.
- The Director should ensure that all staff in the segregation unit observe prisoners according to the required frequency, and record this in the observation log.
- The Director and Head of Healthcare should ensure that all staff have access to emergency defibrillator equipment.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact him.

16. The investigator visited Doncaster on 27 April 2017. He obtained copies of relevant extracts from Mr Wilde's prison and medical records.

17. The investigator interviewed three members of staff at Doncaster on 27 April.

18. NHS England commissioned a clinical reviewer to review Mr Wilde's clinical care at the prison.

19. We informed HM Coroner for Doncaster of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

20. The investigator wrote to Mr Wilde's mother to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Doncaster

22. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men. Nottingham Healthcare NHS Foundation Trust provides physical and mental health services, and substance misuse services. HMP Doncaster directly employs qualified paramedics as part of their healthcare team, who respond to emergency calls within the prison.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Doncaster was conducted in October 2015. The Inspectorate found that prisoners were negative about their experience of healthcare and there was evidence that provision had deteriorated, mainly because of staff shortages. They found that prisoners had reasonable access to an appropriate range of primary care services, though the management of prisoners with long-term conditions was underdeveloped. Some prisoners had experienced delays in receiving their medication and too many external hospital appointments were cancelled because of a lack of escort staff. The Inspectorate also commented on the number of prisoners who had been located in the CSU while on ACCT case management, and said that they were not assured that such exceptional circumstances were always warranted.

Independent Monitoring Board

24. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. The IMB published its annual report for the year to July 2017, shortly after Mr Wilde's death. The Board expressed its concern at the high number of prisoners with severe mental health issues who were being housed in the CSU, although it acknowledged that the prison was investigating alternative locations for mentally unwell prisoners. The Board was concerned about the overall standard of healthcare at Doncaster, which it regarded as below that offered in the local community.

Previous deaths at HMP Doncaster

25. Mr Wilde was the fourth prisoner to die of natural causes at Doncaster since January 2016. There were no similarities between the circumstances of Mr Wilde's death and the previous deaths at the prison.

Assessment, Care in Custody and Teamwork

26. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent and pressing issues, set goals to help resolve the issues and identify who is

responsible. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

27. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody).*

Key Events

28. On 6 April 2017, Mr Ira Wilde was charged with threatening behaviour and remanded to HMP Doncaster while awaiting trial.

Reception and location

29. On his arrival at Doncaster, a nurse recorded that Mr Wilde was "taken straight to a holding cell due to presenting as irrational, unpredictable and volatile". She further recorded that a "reception screen could not be completed" and that he was "going to be taken straight to segregation". She noted that the plan was to attempt a reception screen later on. The following morning, another nurse recorded that a reception screen would need to be performed once Mr Wilde was mentally stable and compliant.

30. A Custodial Manager (CM) completed a cell sharing risk assessment for Mr Wilde on his admission to Doncaster. He considered Mr Wilde to be at increased risk because he was "presenting in mental distress and unable to perform a reception screen". He concluded that Mr Wilde was unsuitable for normal location and required a single cell.

31. Mr Wilde was immediately located in segregation in Doncaster's CSU. The *authority for initial segregation* form, dated 6 April, stated that Mr Wilde exhibited: "severe mental distress, was unable to complete the medical and reception screen, and was unpredictable and volatile". A nurse completed a segregation health screen within 90 minutes of Mr Wilde's segregation, which concluded that there were mental health reasons against segregating Mr Wilde at this time.

32. An Assistant Director chaired a segregation board to discuss this advice from healthcare. No one from the IMB was available to attend this board. The board decided to override the mental health objection. The document recording this decision asks: "What alternatives to Segregation or Special Accommodation have been considered? State why they were considered unsuitable". The answer provided was: "Very unpredictable behaviour and aggressive to Unit staff and displaying bizarre behaviour". There was no mention of whether which, if any, alternatives to the CSU had been considered or why they were considered unsuitable for Mr Wilde.

33. On 7 April, a segregation review board upheld this decision. The *authority for continued segregation* form stated that Mr Wilde must remain in the CSU until 21 April, or sooner if circumstances changed. The form stated that Mr Wilde would remain in segregation "until mental health complete an assessment". A member of the IMB was present at this review, and indicated they were satisfied that correct procedures were followed, and that the decision was reasonable. Mr Wilde was placed on hourly observations while he was in the CSU, and these were recorded and signed by an officer.

34. Mr Wilde was also placed on an ACCT plan immediately on entering Doncaster. He was subject to five observations per hour. An *authority to segregate a prisoner on an open ACCT* form was completed at the same time. This stated that the exceptional reasons for Mr Wilde's segregation were his: "unpredictable nature in reception and severe mental problems". The form asks what alternative

options to segregation were considered, but the answer simply stated: “5 x hourly obs”. Again, there was no mention of whether any alternatives to segregation had been considered or why they were considered unsuitable.

35. On 7 April, Mr Wilde’s ACCT was reviewed, and he remained at a raised level of risk with five observations per hour. A caremap was created for him, which specified that he should have a full physical health assessment with nursing staff, and a full psychiatric assessment. Mr Wilde’s ACCT plan was reviewed regularly and, on 13 April, it was noted that he remained a risk but had not self-harmed since his arrival. As a consequence, his observations were reduced to three per hour. Following a further ACCT review held on 19 April, Mr Wilde’s observations were reduced to two per hour.

36. Mr Wilde was subject to a three person unlock during his time at Doncaster for security reasons. This meant that three officers had to be present whenever his cell was entered. This remained the case during his time at Doncaster.

37. Mr Wilde demonstrated very challenging behaviour throughout his time at Doncaster. Prison officers reported that he was noisy, aggressive and verbally abusive. In interview, an officer recalled that Mr Wilde was “good one minute, and growling the next – covered in and eating his own faeces”. He added that staff always showered Mr Wilde last because they then had to disinfect the communal areas. He further observed that Mr Wilde gradually improved, and in his last few days he was behaving much better.

Mr Wilde’s clinical care at Doncaster

38. On the morning of 7 April, a nurse unsuccessfully attempted to assess Mr Wilde’s mental state. She noted that he had presented as acutely psychotic the previous day, and recognised the absence of medical details for him due to the lack of a health screen. She contacted the team responsible for his mental health services in the community, and obtained a brief summary of Mr Wilde’s mental history. This disclosed his past history of illicit substance misuse and paranoia, and the medication he had been taking. She consulted a psychiatrist, who agreed to re-prescribe this medication straight away. She managed a limited mental assessment of Mr Wilde later that day, and noted that he was highly agitated and incoherent in conversation. She also noted that he was frequently naked, covered in faeces and verbally threatening to staff.

39. Over the next few days, Mr Wilde was monitored regularly by both physical and healthcare staff, but a proper assessment was not possible due to his volatility. On 11 April, a member of the substance misuse team observed Mr Wilde in his cell. She noted that there were no signs of withdrawal symptoms.

40. On 12 April, a psychiatrist reviewed Mr Wilde, together with a nurse. His impression was that Mr Wilde had florid psychosis (acute symptoms of schizophrenia, including hallucinations, delusions and other thought disorders). He discussed Mr Wilde’s case with another psychiatrist, and they agreed to change his medication with a view to increasing the dose if necessary.

41. On 14 April, a prison doctor saw Mr Wilde in his cell, and managed to engage with him and perform clinical observations. He recorded these as unremarkable.

Three days later, he reviewed Mr Wilde in his cell and observed that he had taken his anti-psychotic medication consistently over the weekend.

42. On the morning of 19 April, a prison doctor saw Mr Wilde and noted that he was more compliant and allowed blood samples to be taken. That afternoon, his blood test results returned from the hospital, and showed that his haemoglobin (red blood cell level) was very low. This indicated that he might be anaemic. The doctor saw Mr Wilde in his cell immediately. Mr Wilde said he was tired and short of breath, but denied having any blood in his stool. He recorded that there was no blood to be seen in the faeces on the floor, and he could find no evidence of acute bleeding when he examined Mr Wilde.

43. A prison doctor consulted a registrar at the hospital, and they concluded that since Mr Wilde's observations were stable and there were no signs of active bleeding, they would not transfer him to hospital at this time. They regarded Mr Wilde's condition as chronic, and took the decision to monitor him and repeat blood tests. Later that evening, the doctor recorded a conversation with the registrar, in which he stated they awaited further results for Mr Wilde. He also recorded: "If clinically stable doesn't require urgent admission. Can be followed up as an outpatient when mental state more stable".

The events on 20 April

44. An officer signed the CSU observation log to record that Mr Wilde was observed at hourly intervals over the early hours of the morning. The last entry recorded in this log was at 6am.

45. Officer A was the most senior officer on duty in the CSU that morning. With him was Officer B, who was also performing other duties at the start of the day. Officer C had been seconded from another unit, along with another officer in training, who was shadowing her. At interview Officer A expressed concerns that he was the only regular CSU officer on duty until 9.45am. He also said that staffing levels in the CSU were an issue.

46. At 7.45am, the Acting Director of the unit performed Mr Wilde's ACCT observation, and recorded that there were no issues.

47. At 8.10am, Officers A and B took Mr Wilde's breakfast to his cell, and completed his ACCT log entry. They were accompanied by the chaplain, and Officer A recalled Mr Wilde speaking briefly to the chaplain at that time.

48. At 9am, Officer B completed an ACCT log entry, and recorded no concerns. At 9.45am, a nurse observed Mr Wilde in his cell, and noted that: "he was laid in bed, movement noted at time, but did not communicate. Breathing noted". This is the last record of Mr Wilde being seen alive.

49. The prisoner in the cell immediately adjacent to Mr Wilde's, was on constant watch. This meant that a member of staff was seated outside his cell monitoring him continually. This member of staff did not report any sound of distress or alarm from Mr Wilde's cell that morning.

50. At approximately 11.20am, two more officers arrived at the CSU to collect a prisoner who was being relocated. Officer A asked Officer D if he could assist

Officer B to serve the cold lunches on the unit, because he was busy completing paperwork from an earlier incident.

Emergency response

51. At approximately 11.30am, Officers B and D entered Mr Wilde's cell with his lunch. Officer D recalled in interview that Mr Wilde was in bed, so he placed the food to the side and said something but received no reply from Mr Wilde. He then looked at Mr Wilde who was very pale. He continued speaking to him and shook Mr Wilde's arm but got no response. Officer B also received no response. Officer D called a code blue emergency. (This is an emergency radio code indicating someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.) The control room log recorded that the emergency call was received at 11.33am.

52. At this point, two more officers entered the cell. Officer D placed Mr Wilde on his back, while Officer C checked his airways. Officer D applied a breathing mask to Mr Wilde and began performing cardiopulmonary resuscitation (CPR). Medical staff arrived on the scene while Officer D was performing the first cycle of CPR.

53. A prison paramedic and a nurse were the first medical staff to arrive on scene. The paramedic stated in interview that Officer D was doing a very good job of CPR, so she allowed him to continue while she went to collect the defibrillator from the medications room. (Only healthcare staff have keys to this room.) When the paramedic returned she attached the defibrillator pads. CPR was suspended while the machine was turned on, but the defibrillator indicated no signs of life. Healthcare staff took over CPR, and Officer D left.

54. The paramedic recalled in interview that three cycles of CPR were performed before she asked someone to take over giving Mr Wilde breaths, because he was now oxygenated. She noted that Mr Wilde was white and cold to the touch, but there were no obvious signs of blood loss. She attempted to inject life-saving drugs directly into Mr Wilde's veins, but observed that his veins had shut down. She recalled that the ambulance arrived at about 11.45am, and paramedics worked on Mr Wilde for a further 20-25 minutes. She stated that the ambulance paramedics had much better life-preserving equipment, and were able to inject drugs directly into Mr Wilde's bone marrow, something she was unable to do with the equipment she had.

55. At 12.10pm, the ambulance paramedics pronounced Mr Wilde dead.

Contact with Mr Wilde's family

56. Shortly after Mr Wilde's death, the prison appointed an officer as the family liaison officer. Mr Wilde's next of kin was his mother.

57. On 20 April, at 2pm, the officer visited Mr Wilde's mother, together with the Director and the Assistant Director of Safer Custody. They informed Mr Wilde's mother about his death, and offered their support. Mr Wilde's funeral was held on 10 May. The prison contributed to the costs in line with national guidance.

Support for prisoners and staff

58. After Mr Wilde's death, the Assistant Director debriefed some of the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The Deputy Director chaired a second debrief later for staff who were unable to attend the first. The staff care team also offered support to all staff involved.

59. Officer A told us at interview that: "the people here have been fantastic", but he felt that he should not have been on shift the following day. He said that while he did not ask for leave of absence because he was aware how busy it was, he felt the onus should have been on management to check whether staff were fit to work.

60. The prison posted notices informing other prisoners of Mr Wilde's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Wilde's death.

Post-mortem report

61. The post-mortem concluded that Mr Wilde died from a gastro-intestinal haemorrhage, caused by a duodenal ulceration.

62. The pathologist stated that there was no evidence to suggest drug toxicity was a contributory factor in Mr Wilde's death, and that it was possible his condition could have developed without major symptomatology (a set of symptoms characteristic of a medical condition).

Findings

Mr Wilde's reception

63. Prison Service Instruction (PSI) 07/2015 – *Early Days in Custody* instructs that:

> "prisoners who are about to spend their first night in prison custody must undergo a detailed medical examination before lock-up to assess their physical and mental health, including any safer custody concerns or substance abuse issues, and to determine whether there are any clinical needs that must be followed up".

64. Mr Wilde did not have a reception health screen when he was first admitted to Doncaster, because his behaviour was erratic and he was considered a risk to himself and others. Mr Wilde never had a formal health screen while he was at Doncaster, but he was kept under regular observation by healthcare professionals from all disciplines. A nurse recognised the lack of a reception health screen, and managed to liaise with the team who had cared for Mr Wilde in the community. She obtained a brief summary of his medical history and performed a limited health assessment on Mr Wilde on 7 April.

65. When his mental health started to improve, and a GP performed clinical observations on 14 April (eight days after his admission) and blood samples were taken on 19 April (the day before his death).

66. We are concerned that staff did not perform a reception health screen for Mr Wilde, but are satisfied that they did all they reasonably could to ensure he was monitored appropriately during his time at Doncaster.

Mr Wilde's location in the CSU

67. Prison Service Order (PSO) 1700 – *Segregation,* states that under Prison Rule 45, prisoners can be:

> "segregated in their own interests if there are good and sufficient reasons for believing that the prisoner's safety and well being cannot be assured by other means."
>
> Or,
>
> "segregated for reasons of good order or discipline when there are reasonable grounds for believing that the prisoner's behaviour is likely to be so disruptive or cause disruption that keeping the prisoner on ordinary location is unsafe."

68. It is unclear whether staff at Doncaster took the decision to initially locate Mr Wilde in the CSU in his own interests or to maintain good order or discipline, although it seems to be a combination of the two.

69. There is a requirement under PSO 1700, that, "if the mental health of the prisoner is so at risk that they will be totally unable to cope with segregation then they should not be kept in the segregation unit". PSO 1700 further directs that a

doctor or a registered nurse must complete an initial segregation health screen within two hours of a prisoner first being segregated.

70. Prison Service Instruction (PSI) 64/2011 – *Safer Custody* states:

> "Prisoners on open ACCT plans must only be located or retained in Segregation Units only in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include others options that were considered but discounted." [Italics indicate mandatory instructions.]

71. Where there are exceptional reasons to justify holding prisoners who are managed under ACCT procedures in segregation units, there are some additional requirements that need to be met by prisons. As well as the initial health screen for all prisoners moved to a segregation unit, PSO 1700 makes it clear that prisoners subject to ACCT procedures should have a mental health assessment within the first 24 hours of their segregation. An ACCT review should also be held within 24 hours. Mental health safeguards, for example observations and dialogue, should be put in place, and consideration given to the possibility of moving the prisoners to a safer cell or monitoring by CCTV. The PSO makes it clear that prisoners on ACCTs should remain in segregation only as long as the exceptional circumstances continue to apply.

72. In a Learning Lessons Bulletin we issued in June 2015, we highlighted a number of investigations where prisoners subject to ACCT procedures were segregated: "without sufficient evidence that staff had considered other options or identified exceptional circumstances to justify their segregation".

73. In Mr Wilde's case the segregation health screen concluded that the CSU was an inappropriate location for Mr Wilde, due to his mental health concerns. Mr Wilde was also placed on an ACCT, and should only have been located in the CSU in exceptional circumstances.

74. We recognise that Mr Wilde's behaviour was extremely challenging and it may be that the CSU was the only suitable location for him. However, we have seen no evidence that locations other than the CSU were considered at the time or why other locations were not considered suitable. In subsequent correspondence the prison has told us that other locations were considered but discounted. If so, this should have been recorded.

75. PSO 1700 adds that a Segregation Review Board must review any decision to segregate within 72 hours, and may only permit further segregation for a maximum period of 14 days before a further review is required. There is no mandatory requirement that a member of the IMB should be present at the review hearing, but if they do attend they should: "indicate their satisfaction, or otherwise, with the procedures of the review board and the decision reached".

76. In line with PSO 1700, Mr Wilde's segregation was reviewed the following day, and a member of the IMB was present. We recognise that PSO 1700 allows for continued segregation for a maximum of 14 days before a further review. However, given Mr Wilde's exceptional circumstances, we are concerned that his continued segregation not reviewed within that time.

77. We recognise that Mr Wilde was closely monitored by mental health nurses, and reviewed by two different psychiatrists while he was in the CSU. His mental health appeared to improve steadily during his time in the CSU, and Mr Wilde was engaging much more with staff towards the end of his time there. Mr Wilde's ACCT was regularly reviewed, and his observations were reduced as his risk level reduced. However, we find that there is insufficient evidence to demonstrate that alternative locations were properly considered for Mr Wilde, other than the CSU. We are also concerned that he remained in the CSU for as long as he did, without a further review of that decision.

The Director should ensure that exceptional circumstances to justify the segregation of a prisoner subject to ACCT procedures should actually be exceptional, and that all other options should have been considered and discounted and the reasons for this clearly documented in line with PSI 64/2011.

Observation and ACCT

78. While we accept that Mr Wilde was appropriately managed according to ACCT procedures, we are very concerned that on the morning of 20 April at least three ACCT observations were missed. Mr Wilde was last seen alive at 9.45am, and then found unresponsive at 11.30am, an hour and 45 minutes later. If Mr Wilde had been observed as frequently as he should have been, it is possible that he may have been discovered unresponsive earlier, although we cannot say whether this would have affected the outcome.

79. We are also concerned that the CSU observation log was not completed for five hours on the morning of Mr Wilde's death. If the CSU observations been performed, Mr Wilde may have been discovered sooner.

80. We understand that there were staffing shortages on the CSU on the morning of Mr Wilde's death. There were only two regular segregation officers on duty that morning, and one of them was performing other tasks in the unit until 9.45am. We are concerned that this may have impacted on the ability to perform regular ACCT checks and CSU observation logs.

The Director should ensure that staff manage prisoners subject to an ACCT in line with national guidelines, in particular, ensuring that the required frequency of observations and conversations is maintained and that this is recorded by staff.

The Director should ensure that all staff in the segregation unit observe prisoners according to the required frequency, and record this in the observation log.

Emergency response and CPR

81. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two code medical emergency response system in place. On establishing that Mr Wilde was unresponsive, Officer D made a code blue call on his radio. This was picked up by other officers and healthcare staff who arrived on the scene promptly. An ambulance was also called without delay. We are satisfied that the initial emergency response was appropriate.

82. Officer D started CPR promptly and performed it to a high standard. The prison paramedic coordinated Mr Wilde's life support appropriately following her arrival, but observed that the defibrillator was in a locked room to which prison staff did not have access. While this might not have affected the outcome in this instance, we are concerned about any delay in starting emergency procedures.

The Director and Head of Healthcare should ensure that all staff have access to emergency defibrillator equipment.

Clinical care

83. The clinical reviewer concluded that the care Mr Wilde received at Doncaster was of a good standard and equivalent to that he could have expected to have received in the community. Mr Wilde was a very challenging prisoner, but was well managed throughout for his physical and mental health needs. Prison doctors and healthcare staff managed him appropriately according to the symptoms he presented with, and consulted with external specialists where necessary. We agree with the clinical reviewer that healthcare staff could not have predicted the outcome on 20 April, and make no recommendation.

Staff support

84. The staff involved in Mr Wilde's emergency response, were given a debrief immediately after the incident, and offered support. While we accept that Officer A had concerns about working the next day, he did say that the support offered by staff at Doncaster was "fantastic", and we make no recommendation.

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Independent Investigations

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