

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Shaun McDonald a prisoner at HMP Exeter on 31 October 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*



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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.

Our 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 Shaun McDonald died on 31 October 2017, when he was found hanged in his cell the day after his arrival at HMP Exeter. He was 54 years old. I offer my condolences to Mr McDonald's family and friends.

Mr McDonald arrived at Exeter with warnings from court about his vulnerability. It was his first time in prison and he was charged with an offence that can increase the risk of self-harm. Staff at the prison rightly identified him as needing support and put the appropriate Prison Service procedures (known as ACCT) in place. He was due to have a mental health assessment the following morning which might have helped the prison to a better understanding of his risks but this was interrupted when he was called to attend court via videolink.

Although our investigation identified some administrative deficiencies in the operation of the ACCT procedures, I commend the actions of Mr L who demonstrated high levels of commitment to Mr McDonald's welfare.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

February 2019

Contents

Summary 1
The Investigation Process 4
Background Information 5
Key Events 7
Findings..... 12

Summary

Events

1. On 30 October 2017, Mr McDonald was remanded in custody on suspicion of murdering his mother. His escort papers included a warning that he seemed very depressed. Reception staff began procedures for managing prisoners at risk of suicide and self-harm (ACCT). He was also designated as a vulnerable prisoner. A reception health screening identified some health issues and that Mr McDonald had not been taking all his medication and had missed some recent hospital appointments. He was referred for a mental health assessment.
2. Staff checked on Mr McDonald through the night and he was awake each time. In the morning he was taken to the reception area to travel to court, but he declined to go. Arrangements were made for him to appear via videolink.
3. The prison officer who carried out Mr McDonald's ACCT assessment interview did not have any concerns that he presented an imminent risk of harming himself. A mental health nurse met Mr McDonald to assess him, but during the assessment, Mr McDonald was called to appear in court. The court appearance was via videolink, but the nurse did not realise this and rescheduled the mental health appointment for the following day.
4. After observing him during the videolink hearing, Mr McDonald's solicitor was concerned about his wellbeing and telephoned the prison. She spoke to a member of the chaplaincy and to a prison manager, and passed on her concerns. Each of them spoke to Mr McDonald. He told the manager that he had a medical appointment pending. The manager checked and asked the wing manager to tell Mr McDonald that the appointment had been rescheduled for the following morning.
5. That afternoon, Mr McDonald's wing manager and a chaplain reviewed his ACCT status. No healthcare staff were present but the manager had spoken to a member of the healthcare team to prepare for the review. Mr McDonald engaged with the review but expressed concerns about his safety. Neither member of staff considered that he was at risk of imminent harm but the wing manager felt that Mr McDonald would still benefit from the support of ACCT procedures. He reduced the level of observations. Mr McDonald asked to speak to the chaplain after the ACCT review. The chaplain said in interview that they spoke about avenues of support, and about religion. The chaplain did not have any concerns that Mr McDonald was at imminent risk of harming himself, and arranged to speak to him again the following day.
6. Shortly after 5.30pm, prison officers were unlocking prisoners for their evening meal, and found Mr McDonald hanging. They raised the alarm, cut Mr McDonald down and, having been joined by nurses, tried to revive him. Ambulance paramedics arrived but at 5.59pm Mr McDonald was pronounced dead.

Findings

Risk assessment

7. Staff in reception identified Mr McDonald as vulnerable. They rightly began ACCT procedures and he was referred for mental health assessment. Checks were made through the night as directed.
8. Mr McDonald's solicitor was concerned at his demeanour during the videolink hearing and telephoned the prison twice as a consequence. She spoke to a community chaplain and to a prison manager. They both spoke to Mr McDonald, but the extent of the solicitor's concerns was not reflected on his ACCT record.

Mr McDonald's ACCT

9. When Mr McDonald arrived in Exeter, ACCT procedures were rightly begun. The initial administrative tasks were completed although no triggers or warning signs were noted. Staff checked on Mr McDonald through the night as directed. The assessment interview was held the following morning within appropriate timescales.
10. The officer who conducted the assessment interview was not at the first ACCT review. Nor were any healthcare staff present although the case manager had spoken to a nurse who checked Mr McDonald's medical file. After the ACCT review, the case manager significantly reduced the observations staff should make on Mr McDonald.

Healthcare

11. The clinical reviewer noted that Mr McDonald received healthcare equivalent to that which he could have expected in the community.
12. When Mr McDonald's mental health assessment was interrupted to allow him to attend court, the nurse assumed that he was going out of the prison and would therefore be assessed by healthcare on his return. He was, however, only attending via videolink and prisoners are not routinely reassessed after such a hearing.
13. The clinical reviewer recommended that when prisoners who have medical appointments pending refuse to attend court, prison officers should inform healthcare staff so they can reschedule assessments as necessary.
14. The emergency response was prompt and resuscitation attempts were appropriate.

Recommendations

- The Governor and Head of Healthcare should ensure that the welfare of prisoners who have appeared before court via videolink is reviewed in the same way as that of prisoners who attend in person.
- The Governor should ensure that concerns relayed from outside the prison are properly noted in wing observation books and prisoners' ACCT documents.

- The Governor should ensure that ACCT procedures are operated in line with national guidance, in particular that case reviews are multidisciplinary, that healthcare staff attend first case reviews and that the reasons for decisions are fully recorded and documented.
- If prisoners with pending medical appointments decline to attend court, reception staff should inform the healthcare department.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
16. The investigator visited Exeter in December 2017. He obtained copies of relevant extracts from Mr McDonald's prison and medical records. The investigator interviewed eight members of staff at Exeter.
17. NHS England commissioned a clinical reviewer to review Mr McDonald's clinical care at the prison.
18. We informed HM Coroner for Exeter and Greater Devon of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Mr McDonald's father and his ex-wife to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They did not raise any specific issues.
20. Mr McDonald's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report. They did offer some comments on Mr McDonald's care, which have been shared with the Prison Service.

Background Information

HMP Exeter

21. HMP Exeter is a local prison holding a maximum of 560 men on remand, convicted or sentenced. The prison serves the courts of the south west England. Care UK provides health services to HMP Exeter and sub-contract mental health service provision to Devon Partnership NHS Trust. The prison has 24-hour healthcare cover.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Exeter was conducted in August 2016. Inspectors found that the levels of self-harm and the number of ACCT documents opened for prisoners at risk of suicide or self-harm were far higher than at other local prisons. Inspectors found that the healthcare team, including mental health, learning disability and general psychiatry practitioners provided a comprehensive approach to complex, serious and enduring illnesses and responded well to mild-to-moderate needs.

Independent Monitoring Board

23. 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 annual report to December 2016, the IMB repeated previous concerns about the accommodation for vulnerable prisoners. It highlighted that B Wing did not provide enough accommodation for all those assessed as vulnerable. It said that this had led to the unsatisfactory measure of housing some vulnerable prisoners on C Wing - a standard residential wing which included C1, the first night centre.

Previous deaths at HMP Exeter

24. Mr McDonald was the tenth prisoner at Exeter who apparently took his own life since 2015. In previous reports we expressed concerns over about the management of suicide and self-harm procedures. Exeter agreed to implement the recommendations we made, yet we have made a similar recommendation in a report issued last month and have further concerns in this investigation. There has been a further apparently self-inflicted death at Exeter since Mr McDonald's death.

Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used 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 the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the

actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. 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

26. On 30 October 2017, Mr Shaun McDonald was remanded to HMP Exeter on suspicion of murder. The victim was his mother. Mr McDonald arrived at Exeter from court at 3.25pm, and his escort papers included a suicide/self-harm warning form. The form noted that Mr McDonald seemed very depressed and was having difficulty coming to terms with the offence he had been charged with, seeming confused about being in custody. He told the escort officer that he did not have his sleeping tablets with him, and the escort papers noted that he was in very low mood and had said that his life was over. The papers also showed that Mr McDonald had previously suffered from leukaemia, as well as anxiety and depression, for which he was prescribed medication.
27. Officer A saw Mr McDonald in the prison's reception area. He noted the self-harm warning form from the court. Mr McDonald told him that he felt that his life was over and he had nothing to live for. He was anxious and depressed, and said he needed sleeping tablets. Exeter uses a risk assessment form that lists potential triggers for self-harm. Officer A noted that Mr McDonald was remanded on suspicion of having murdered his mother, which is a potential trigger. Officer A judged that Mr McDonald needed the support of Prison Service procedures for those assessed to be at risk of harming themselves (ACCT). He noted on the ACCT form that Mr McDonald appeared vulnerable, and that staff should check on him at least once every 30 minutes.
28. Nurse B, one of Exeter's senior nurses, gave Mr McDonald a reception health screening. For his medical history, Mr McDonald reported that he had an enlarged spleen, and suffered from chronic fatigue. He said that he was borderline epileptic, had been prescribed a number of medications, including one for depression, but had not been taking them for some months. He had also recently missed hospital haematology appointments and had been homeless for the past few weeks. He said that in August he had self-harmed by drinking bleach, and did have current thoughts of harming himself. He had been under the care of a psychiatrist in the past. Nurse B noted that Mr McDonald looked unwell.
29. Dr C, one of the prison's doctors, then saw Mr McDonald. Dr C noted that Mr McDonald appeared vulnerable and anxious. The doctor referred him to the mental health team for assessment, and requested confirmation of Mr McDonald's medical history from his GP and the hospital where he had been treated. He asked for information on whether Mr McDonald had any outstanding appointments.
30. Mr McDonald's cell sharing risk assessment noted that he was vulnerable to assault and that there was also a risk that he might assault a cellmate, although the form did not indicate what level of risk he was judged to present. Staff assessed that Mr McDonald should be designated a vulnerable prisoner, and he was allocated to a single cell in the vulnerable prisoner unit. Pressure of places meant that his cell was in the unit's overspill area on C wing rather than the main unit on B wing. Staff noted in the wing observation book that Mr McDonald was being managed under ACCT procedures and should be checked at least once every 30 minutes.

31. Mr McDonald's records showed that during his basic custody screening interviews he said that he was estranged from his wife and children. He said that he had had thoughts of taking his own life. The interviewing officer noted concerns about his vulnerability and that he was being managed under ACCT procedures, although he did not make a note in the ACCT document.
32. Mr McDonald's first night immediate risk and needs assessment noted that he had poor interpersonal communication skills, and was low and depressed. He did not have any issues around detoxifying from alcohol or drug use. It noted that it was his first time in custody, and that he had thoughts of self-harm or suicide.
33. Supervisory Officer (SO) D spoke to Mr McDonald and completed the ACCT form's immediate action plan. He confirmed that Mr McDonald was very vulnerable and was rightly designated a vulnerable prisoner and appropriately held in a single cell. He confirmed that Mr McDonald had been referred to the mental health team, that wing staff were aware of Mr McDonald's situation and the frequency with which they needed to check on him, and that a note had been made in the wing observation book to inform any staff subsequently coming on duty. Supervising Officer D made sure that Mr McDonald was aware of support available from the Samaritans by designated telephone, or from Listeners (prisoners trained by the Samaritans to provide peer support).
34. Prison officers checked on Mr McDonald in line with his observation levels through the night. He was awake at every observation. At 4.20am, Officer S spoke to him, and Mr McDonald said he was concerned that people on the landing were planning to kill him.
35. Mr McDonald was due to appear in court the following morning, 31 October. He was taken to the reception area at 7.15am but once there he refused to go any further. He said that everyone was against him and wanted to kill him. Arrangements were therefore made for him to use videolink facilities instead, and officers took Mr McDonald back to his cell to await the video hearing.
36. At 9.00am, Officer E conducted Mr McDonald's ACCT assessment interview. Mr McDonald said that he was "shocked at having seen his mother the way he had done". He said he thought he had coped reasonably well in the last 24 hours. He said that he had been diagnosed with depression after the breakdown of his marriage 12 months previously, and that he suffered from anxiety, having panic attacks when situations became too much for him. He felt mentally worn-out by recent events. He said that he got on well with people, had never self-harmed or tried to take his own life, and had no current thoughts of doing so. He said that reasons for living included seeing his children again. His father and step-mother knew that he was in prison but he did not yet know if they would be supportive. It was his first time in prison and he wanted to know more about the regime and about being designated a vulnerable prisoner. Officer E explained that this meant that he would only have very limited contact with a small number of other prisoners. Officer E said in interview that he had no concerns that Mr McDonald presented any imminent risk of harming himself.
37. Supervising Officer F was the manager of C wing, and was due to conduct a review of Mr McDonald's ACCT management that day. At approximately

10.30am he spoke to Senior Nurse G to obtain any medical information he might need to know for the review. Senior Nurse G opened Mr McDonald's electronic medical record and told Supervising Officer F which interventions had been made and which were planned.

38. Mr McDonald had been referred for a mental health assessment interview and, at 11.00am, Nurse H took Mr McDonald into an interview room. As soon as they had sat down, a prison officer came to the room and said that Mr McDonald had to go to court. Nurse H was unaware that this would be via videolink and assumed he was being taken away to attend court in person. Nurse H therefore rescheduled Mr McDonald's appointment for the following morning. She said in interview that Mr McDonald did not display any level of anxiety that was inappropriate to his situation. She knew he was under ACCT management and, as she thought he was to attend court, that he would be assessed by a nurse on his return to prison.
39. At 11.00am, Mr McDonald went into the videolink facility and conferred with his solicitor. He subsequently had his court hearing via the videolink. Staff took him back to his cell at midday. At 12.30pm he collected his lunch, and when staff checked him at 1.00pm Mr McDonald was sitting on his bed.
40. Mr McDonald's solicitor was concerned at his presentation during the videolink hearing and telephoned the prison. She was put through to the chaplaincy office and spoke to Mr J, a community chaplain working for a charitable organisation that helps prisoners resettle into the community after release. She (the solicitor) told Mr J that she was concerned about Mr McDonald, and during their interview he had indicated that he would like to see a chaplain. Mr J went to see Mr McDonald and told him that he would arrange for a prison chaplain to come and see him. Mr McDonald said that he had committed a serious crime. Mr J thought that he seemed on edge. Mr J then returned to the chaplaincy office where he told Rev K what had happened, and made a note in the chaplaincy journal.
41. Mr L was the manager in charge of the prison that day. At approximately 1.20pm he was on C wing when Mr McDonald called to him through his cell door, telling him that he had a doctor's appointment. Mr L said that the day's regime was running late but if he had an appointment he would be taken across after lunch. Shortly afterwards, Mr McDonald's solicitor telephoned the prison again and was put through to Mr L. She told him that during their videolink interview that morning, Mr McDonald had said that he felt unsafe and was worried about being attacked by other prisoners. Mr L assured her that Mr McDonald was in a safe place, and had support. He was being managed under ACCT procedures, was being checked at least every 30 minutes and, as a designated vulnerable prisoner, he was separated from other prisoners. On finishing the call, Mr L telephoned the C wing office and told them about the call. The officer he spoke to said that someone had just made an ACCT check on Mr McDonald and he was okay. Mr L told the officer to make a note in Mr McDonald's ACCT document of the solicitor's concerns. Mr L then went to speak to healthcare staff and told them that Mr McDonald thought he had an appointment. A nurse said that he had been due an appointment that day but, when interrupted, it had been rescheduled for the following morning. Mr L went to C wing and updated the

- wing manager, Supervising Officer F. Supervising Officer F said that he was planning to conduct an ACCT review after lunch. He said that he would pass on the information about the rescheduled medical appointment to Mr McDonald.
42. Mr McDonald's ACCT document shows that when checked at 1.50pm, he was walking up and down his cell. At 2.20pm, he was standing at the door looking out of the observation panel, something he was also doing at 2.50pm.
 43. Supervising Officer F conducted the ACCT case review at approximately 2.45pm. (The times on the ACCT document for the last ACCT check and the case review do not quite tally by a few minutes). Mr McDonald attended, along with Rev K. Supervising Officer F said that Mr McDonald was open and engaged in the process but he felt that staff and prisoners on C wing were targeting him. He was aware of the hostility the offence he was charged with could create. He accused Supervising Officer F of plotting to stab him. Supervising Officer F tried to reassure him that all he wanted to do was keep him safe. Mr McDonald would not be placed in contact with any prisoners who might want to harm him and, when space was available, he would move to B wing. Mr McDonald said that he had had to miss his medical appointment that morning. Supervising Officer F passed on Mr L's message that the appointment had been rescheduled for the following morning.
 44. Mr McDonald said that he had never had thoughts of suicide or harming himself in the past, and had none at the present time. Supervising Officer F made sure Mr McDonald was aware of the support mechanisms available to him. He noted that, based on the evidence and on how Mr McDonald presented, he would keep ACCT procedures open but reduce the observation levels to one conversation and two observations between 7.00am and 9.00pm, and five observations through the night. The form indicated that the caremap was reviewed.
 45. Mr McDonald asked to speak to Rev K privately so he remained behind after the review. Mr McDonald repeated that he was concerned that prisoners would attack him. Rev K reiterated the avenues of support available. They talked about religion and Rev K said in interview that Mr McDonald seemed to relax. Mr McDonald once more said that he had no thoughts of harming himself, and Rev K said he had no concerns that he would do so. He said that he would like to talk to Mr McDonald further, and told him that he would see him again the following day. He said in interview that he had no concerns that Mr McDonald would harm himself.
 46. At approximately 5.42pm Officer M, who was unlocking prisoners for meals, arrived at Mr McDonald's cell. She found him hanging from a ligature tied to the window bars. Officer M shouted for assistance and opened the cell door. Other prison officers were nearby and ran to help and Officer N used his radio to call a code blue emergency (meaning a prisoner is unconscious or having difficulty breathing). This automatically prompted the control room to request an ambulance.
 47. Healthcare staff nearby responded to the emergency call and arrived as the prison officers cut the ligature and lowered Mr McDonald to the floor. Nurses then began to try to resuscitate him. They applied a defibrillator (a machine that in some circumstances can restart the heart) but it could not detect a shockable

rhythm. Nurses continued with attempts to revive Mr McDonald until ambulance staff arrived. At 5.59pm, the ambulance staff pronounced Mr McDonald dead.

Contact with Mr McDonald's family

48. The Governor, Mr P, went to Mr McDonald's father's home to inform him of what had happened. The following day one of the prison's family liaison officers, Officer Q, contacted Mr McDonald's ex-wife and informed her. In line with Prison Service policy, Exeter offered a contribution towards the costs of Mr McDonald's funeral.

Support for prisoners and staff

49. After Mr McDonald's death, Ms R, one of the prison's managers, and Senior Nurse G debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
50. Prisoners were notified of Mr McDonald's death by notices posted on the wings, which indicated where they could get support if they felt it necessary. All prisoners subject to ACCT monitoring had their circumstances reviewed in case they had been affected by Mr McDonald's death.

Post-mortem report

51. The post-mortem report showed that Mr McDonald died from hanging. He had no natural disease that contributed to his death and there were no traces of drugs or alcohol in his system.

Findings

Risk assessment

52. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others* (Safer Custody), and PSI 7/2015, *Early Days in Custody – Reception in, first night in custody, and induction to custody*, both list a number of risk factors and potential triggers for suicide and self-harm. These factors include a history of depression, being charged with an offence of violence against a family member, and being in prison for the first time. All staff who come into contact with prisoners are expected to be aware of these risk factors. We published a Learning Lessons bulletin in February 2016 on early days in custody. This noted that a history of self-harm, and the fact of a prisoner being in the early days of custody are both known risk factors for self-harm.
53. Staff judgement is fundamental to assessing risk. The system relies on staff using their experience and skills, as well as local and national assessment tools. It is not an exact science. Mr McDonald's vulnerability was recognised at reception and he was rightly put onto ACCT measures. He was referred for a mental health screening, designated a vulnerable prisoner, and staff observed him in line with the regularity stipulated on his ACCT document. There were, though, gaps in the risk assessment process.
54. As a vulnerable prisoner, Mr McDonald was kept physically separated from other prisoners. However, because he was located on the overspill wing, other prisoners would have been near his cell while they were unlocked. When ACCT checks were made during the night of 30-31 October, Mr McDonald was awake each time. At 4.20am, Officer S spoke to him and Mr McDonald told him that people on the landing were planning to kill him, but there is no evidence to support this. Mr McDonald told Officer E that he thought he heard someone shout something about his offence while he was on the vehicle transferring prisoners from court to prison. He also told Supervising Officer F that he had been threatened, although he did not say by whom and Supervising Officer F did not ask. When speaking to Rev K, Mr McDonald said that he was concerned for his safety but did not say that he had been threatened. There was no evidence that Mr McDonald's fears had any basis and he did not identify anyone who had threatened him. Staff were aware of Mr McDonald's vulnerability, they monitored him under ACCT procedures, and kept him away from other prisoners. There is no evidence of any failing by staff in assessing risk in this context.
55. When prisoners attend court, they are seen by healthcare staff on their return to prison. Possible changes in circumstances may mean that the level of risk they present has changed, and they are reassessed. When Mr McDonald's mental health assessment was interrupted, Nurse H was under the impression that he was attending court and would be assessed on his return. Prisoners who appear in court via videolink, however, are not reassessed after their court appearances. Yet they are subject to the same potential changes as if they physically attend court, and should be reassessed in the same way. After speaking to him via videolink, Mr McDonald's solicitor was concerned enough about his state of mind to telephone the prison twice to pass on her concerns but he was not seen by a member of the healthcare team. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the welfare of prisoners who have appeared before court via videolink is reviewed in the same way as that of prisoners who attend in person.

56. Mr McDonald's solicitor spoke to Mr J, a community chaplain who works in Exeter one day a week. Mr J told Mr McDonald that he would arrange for a chaplain to come and see him. He noted this in the chaplaincy journal, and told Rev K, the prison chaplain. He did not make an entry in Mr McDonald's ACCT document. Rev K saw Mr McDonald and said that nothing in his dealings with him gave any reason to think that he might take his own life.
57. Mr McDonald's solicitor also spoke on the telephone to Mr L. Mr L telephoned the C wing office and asked someone to make a note on Mr McDonald's ACCT document reflecting the solicitor's concerns. Mr L also spoke to the healthcare department to confirm that Mr McDonald's appointment had been rescheduled for the following day, and asked Supervising Officer F to let Mr McDonald know. The note on the ACCT, however, just says that the solicitor had called in a welfare check, and does not detail her concerns.
58. Both of the solicitor's phone calls were acted upon. There is, however, only a brief note in Mr McDonald's ACCT document reflecting that she had called, and no indication of what her concerns were. There is no note in the wing observation book. We make the following recommendation:

The Governor should ensure that concerns relayed from outside the prison are properly noted in wing observation books and prisoners' ACCT documents.

Mr McDonald's ACCT

59. When Mr McDonald arrived in Exeter, ACCT procedures were appropriately begun. Staff were to check on him at least every 30 minutes. The Concern and Keep Safe form was comprehensively completed, as was the Immediate Action Plan, although there are no triggers or warning signs noted on page two of the document. Staff checked on Mr McDonald through the night as directed. The assessment interview was held the following morning within specified timescales.
60. Prison Service Instruction (PSI) 64/2011 requires a multidisciplinary approach for ACCT case reviews, with relevant people involved in the prisoner's care. Where possible, healthcare staff should attend the first review. It states that a case manager should hold a first ACCT case review within 24 hours of starting ACCT monitoring, ideally immediately after the assessment interview, with the assessor present.
61. There were no healthcare staff at Mr McDonald's case review. Because of the number of ACCT documents opened in the prison, Exeter do not habitually ask healthcare staff to attend case reviews. They do ask that healthcare staff are consulted and, in line with this, Supervising Officer F spoke to Senior Nurse G on the morning of 31 October. Senior Nurse G accessed Mr McDonald's electronic health record and told Supervising Officer F what the record said. She had not met Mr McDonald.

62. Officer E conducted Mr McDonald's assessment interview at 9.00am and the case review was held at 2.45pm. Supervising Officer F said in interview that he held the review at the earliest opportunity. Officer E was still on duty in the prison at the time but did not attend the review. Supervising Officer F said in interview that he did speak to Officer E before holding the review but, because of Mr McDonald's apparent mistrust of prison staff, he wanted to minimise any discomfort that having uniformed staff present might cause.
63. In light of the ACCT review, Supervising Officer F reduced the number of observations staff needed to make on Mr McDonald from every half hour to three times during the day and to five times during the night. Supervising Officer F said that while he thought he still needed the support of ACCT procedures, he was satisfied at the time that Mr McDonald did not seem to present an imminent risk of harming himself. He said Mr McDonald expressed no intention of doing so and said he had never harmed himself. (Although he had said in reception that as recently as August he had drunk bleach.) He said that he had children, which Supervising Officer F thought would be a protective factor. This was nevertheless a significant reduction in observation levels, and was made before Mr McDonald had been assessed by the mental health team and without healthcare staff present. Nor does the note of the review indicate the level of risk that Mr McDonald was then judged to present.
64. Supervising Officer F noted on the ACCT document that the care map had been reviewed, although it was blank. Supervising Officer F said in interview that he was about to complete the care map when the emergency call was made. We note that 3 hours had elapsed since the ACCT review.
65. Exeter have in place a comprehensive risk assessment process that identifies prisoners who may be at risk of self-harm. They manage a higher number of ACCTs than many other prisons. We have made previous recommendations to Exeter about risk assessments and while we are pleased to see that the risk assessment process in reception is so thorough we note the absence of a decision on the level of risk presented or recorded reasons for the reduction in observations following the ACCT review. We consider that despite the administrative failings noted above, staff were diligent and thorough in acting on concerns which were raised. In particular we commend the efforts taken by Mr L to respond to various concerns. Nevertheless, ACCT procedures should be operated in line with guidance. We make the following recommendation:

The Governor should ensure that ACCT procedures are operated in line with national guidance, in particular that case reviews are multidisciplinary, that healthcare staff attend first case reviews and that the reasons for decisions are fully documented and recorded.

Healthcare

66. The clinical reviewer noted that Mr McDonald received healthcare equivalent to that which he could have expected in the community. The reception health screening was appropriate and correct referrals made. His GP records were requested and received promptly, although while confirmation of Mr McDonald's medication had arrived from his GP by 10.00am on 31 October, it had not been re-prescribed before he died. Mr McDonald did say on reception that he had

been erratic in complying with his medication, and Dr C saw Mr McDonald on 30 October. If he had been concerned about him not receiving his medication for the next 24 hours he could have prescribed something himself. He did not feel it necessary to do so.

67. The reviewer also noted that Mr McDonald declined to go to court early on 31 October. If this had been conveyed to the mental health team, they would have had the opportunity to reschedule his assessment. When a prison officer interrupted the mental health assessment he said that Mr McDonald had to attend court. Nurse H naturally assumed that this meant he was going out of the prison to attend in person, which meant that there would not be time to reschedule the assessment for later that day. The clinical reviewer recommends that when prisoners who have pending medical appointments refuse to attend court, prison officers should inform healthcare staff so they can reschedule as necessary. We endorse this:

If prisoners with pending medical appointments decline to attend court, reception staff should inform the healthcare department.

68. The clinical reviewer noted that the emergency response was prompt and that resuscitation attempts were appropriate.

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