Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Eugene O'Donnell a prisoner at HMP Durham on 16 February 2018

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.

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

Mr Eugene O'Donnell was found hanged in his cell at HMP Durham on 16 February 2018, three days after he had arrived. He was 35 years old. I offer my condolences to Mr O'Donnell's family and friends.

Mr O'Donnell had a history of alcohol misuse and had been in prison many times before. He had been released on licence for only five weeks before being sent back to prison on 13 February. He had committed several offences including breaching a restraining order.

Mr O'Donnell's risk factors for suicide and self-harm were not properly considered when he arrived at Durham. He was not monitored appropriately while undergoing an alcohol detoxification programme. Although there was minimal delay in the emergency response, one of the staff members who found Mr O'Donnell was not carrying a radio and was therefore unable to call a medical emergency code over the radio network as she should have done.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **June 2019**

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Summary

Events

1. Mr Eugene O'Donnell arrived at HMP Durham on 13 February 2018 after he was sentenced to 26 weeks custody. He had been released from custody on 5 January. He had a history of alcohol, substance misuse, anxiety and depression.

2. On 14 February, Mr O'Donnell was assessed by the prison doctor who noted that he was withdrawing from alcohol. The doctor started Mr O'Donnell on a course of alcohol detoxification and asked that he be reviewed the following day. The clinical monitoring team assessed him at 8.05pm that evening and noted no significant concerns. Mr O'Donnell received his medication that evening.

3. On 15 February, Mr O'Donnell refused to see the drug and alcohol team (DART) duty doctor. The doctor wrote in his medical record that he did not see him but noted he was on an alcohol detoxification and being monitored. Mr O'Donnell continued to receive his medication at the required times but there is no record that he had any further monitoring by healthcare staff.

4. On 16 February, Mr O'Donnell's cellmate returned from Friday prayers at approximately 2.30pm and found him hanging from the bunk bed. He shouted for staff and two officers attended immediately. The officers cut Mr O'Donnell down and one of them, who did not have a radio, went onto the landing and shouted for assistance, while the other started cardiopulmonary resuscitation (CPR). Another officer responded and used his radio to call a medical emergency code. Healthcare staff arrived promptly and took charge of the resuscitation until the paramedics arrived. Paramedics took over resuscitation at approximately 2.56pm but they were unsuccessful and at 3.33pm, they pronounced Mr O'Donnell had died.

Findings

5. Mr O'Donnell had several risk factors for suicide and self-harm, including that he was estranged from his family and had a history of depression. Reception staff failed to consider these factors and did not properly assess whether he was at risk of suicide and self-harm.

6. Staff failed to monitor Mr O'Donnell appropriately while he was undergoing alcohol detoxification. Although he received his medication as required, he was not appropriately referred for clinical monitoring. Therefore, he was not seen by the clinical monitoring team at any time after the evening of 14 February.

7. One of the officers who found Mr O'Donnell did not have a radio to call a medical emergency code. While another officer responded quickly to her shouts for help and used his radio to call the code resulting in minimal delay, we are concerned that some officers at Durham are not carrying radios for use in emergency situations.

8. We found that some staff involved in the emergency response were not invited to attend a debrief following Mr O'Donnell's death.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff:
  - are aware of all known risk factors for suicide and self-harm;
  - identify prisoners' risk factors from the information and documents available to them; and
  - record the risk factors they have considered and the reasons for decisions.
- The Head of Healthcare should ensure that:
  - a process is put in place to ensure that a referral to the clinical monitoring team has been made when appropriate;
  - ongoing checks are made when specified, even if the prisoner fails to attend a clinic appointment; and
  - checks continue until the prisoner's condition has stabilised.
- The Governor should:
  - review the current provision of radios to ensure it is sufficient to meet the needs of the prison; and
  - remind staff of the need to use their radio in the event of a medical emergency and to use the correct medical emergency code.
- The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody, that all those involved in the incident are invited to attend, and that the list of attendees is accurately recorded.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr O'Donnell's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr O'Donnell's clinical care at the prison.

12. The investigator interviewed eight members of staff at HMP Durham and five members of staff by telephone. The interviews took place in June and July 2018.

13. We informed HM Coroner for Durham of the investigation who sent us the results of the post-mortem examination. We have given the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr O'Donnell's sister to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr O'Donnell's sister wanted to know whether her brother had been appropriately assessed and monitored in relation to his substance misuse and mental health. She also asked if he had raised any concerns with staff or other prisoners.

15. Mr O'Donnell's family received a copy of the initial report. They did not raise any concerns regarding factual accuracy of this report.

Background Information

HMP Durham

16. HMP Durham, which holds up to 996 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. G4S provides nursing and administration services, Spectrum provides pharmacy and GP services, and Tees, Esk and Wear Valley NHS Trust provides mental health services. Psychosocial support for drug and alcohol misuse is provided by CGL.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that they were not confident that the risks and vulnerabilities of newly arrived prisoners were properly identified and they considered first night processes were poor. Inspectors said the service provided by the drug and alcohol recovery team (DART) had improved but a chronic shortage of nursing staff meant that some prisoners were not being offered the appropriate level of emotional support.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report for the year to 31 October 2017, the IMB reported that the prison had changed to a reception prison and, as such, the reception area had been refurbished and remodelled. However, they criticised the poor design of the reception area which resulted in a lack of privacy during initial interviews and an ability to easily identify vulnerable prisoners who were seen in a separate area. They noted that 82% of prisoners felt they were treated with sensitivity and respect on arrival at the prison. The IMB commended the work of the substance misuse service in delivering excellent rehabilitative work with a high level of engagement from prisoners.

Previous deaths at HMP Durham

19. Mr O'Donnell was the 16th prisoner to die at Durham since February 2015. Of the previous deaths, six had taken their own lives and nine were due to natural causes. We have previously criticised the failure of reception staff to identify prisoners' risk factors and properly assess the risk of suicide and self-harm. A recent investigation also identified concerns about the availability of staff radios and lack of staff support following a death in custody. Since Mr O'Donnell's death, two prisoners have taken their own lives, two have died due to drug misuse and one has died from natural causes.

Early Days in Custody and Substance Misuse

20. A PPO Learning Lessons bulletin, published in February 2016, identified that the most common theme among deaths in early days and weeks of custody was a failure to act on information about known risk factors. Prison Service Instruction (PSI) 07/2015 requires staff to be alert to the increased risk of suicide and self-harm among new prisoners. They are required to interview new prisoners to

assess the risk of suicide and self-harm and act appropriately to address any concerns, including starting suicide and self-harm prevention measures if necessary. All staff that come into contact with prisoners are expected to be aware of these risks. The NHS document 'Clinical Management of Drug Dependence in the Adult Prison Setting' notes the heightened suicidal risk in prisoners dependent on drugs. The risk is particularly high in the first seven days in prison but remains raised throughout the first 28 days. This risk is also identified in PSI 45/2010.

Key Events

21. Mr Eugene O'Donnell arrived at HMP Durham on 13 February 2018. He had been sentenced to 26 weeks custody for offences of criminal damage, theft and breach of a restraining order. Mr O'Donnell had last been released on licence from HMP Northumberland on 5 January 2018 where he had been serving a 12-week sentence for assault and criminal damage.

22. Mr O'Donnell had a long history of offending behaviour, mainly triggered by his excessive use of alcohol and illicit substances, and he had been in prison many times before. Due to his offending behaviour, there were restraining orders in place preventing contact with his ex-partner, his children and other family members. The further offences, including breach of a restraining order, were committed against family members.

23. On arrival at Durham, Mr O'Donnell had a reception healthcare screening with a nurse. The nurse had access to the Person Escort Record (PER – a document that accompanies prisoners between courts, police custody and prison establishments) which noted concerns about substance misuse, domestic violence and restraining orders in place. Mr O'Donnell told the nurse that he had a history of depression and anxiety but he said he had no thoughts of suicide or self-harm. The nurse told the investigator that he did not consider Mr O'Donnell required a mental health referral and he had no concerns about suicide or self-harm. Mr O'Donnell's reception urine sample tested positive for benzodiazepines, cocaine and Subutex (a heroin substitute) but he denied taking any illicit drugs. He did, however, tell the nurse that he was drinking alcohol excessively. The nurse referred him for further assessment.

24. Mr O'Donnell was assessed by a nurse. Mr O'Donnell told her that he was prescribed antidepressants but was not taking them. The nurse recorded this on his medical notes but she told the investigator she did not think it necessary to take any further action as she had no immediate concerns about suicide or self-harm. She discussed Mr O'Donnell's substance misuse issues with him and prescribed chlordiazepoxide (medication to alleviate the symptoms of alcohol withdrawal) and a vitamin B supplement. She noted on his medical record that he should be monitored for alcohol withdrawal symptoms during the night.

25. A nurse recorded that she saw Mr O'Donnell at 10.15pm and gave him his medication. She also carried out an alcohol withdrawal assessment which indicated that Mr O'Donnell was experiencing alcohol withdrawal symptoms. She recorded that she also observed Mr O'Donnell asleep at 1.30am and again at 4.45am.

26. On 14 February, Mr O'Donnell saw a doctor in the Drug and Alcohol (DART) clinic at approximately 10.00am. Mr O'Donnell said he was experiencing withdrawal symptoms, including shaking, nausea and vomiting. He also said he had been seeing speckles of dust in front of his eyes. The doctor started Mr O'Donnell on a course of alcohol detoxification treatment, prescribing a 10-day dose of chlordiazepoxide and a supply of vitamin B. He noted that he was concerned about Mr O'Donnell's visual hallucinations and felt that he needed close monitoring. He wrote in his medical record that Mr O'Donnell should be

reviewed again by the DART duty doctor the following day. He told the investigator that he was aware that Mr O'Donnell had been prescribed antidepressants but he was not taking them. He said, based on Mr O'Donnell's presentation, he was not concerned about his mental health or any risks of self-harm. However, he did not specifically ask Mr O'Donnell if he had any thoughts of suicide or self-harm.

27. A healthcare support worker was also present at the assessment with the doctor. She had responsibility for ensuring that appropriate clinical monitoring was put in place for Mr O'Donnell and she made a referral to the clinical monitoring team.

28. Mr O'Donnell was seen by a healthcare support worker with responsibility for clinical monitoring at 8.05pm on 14 February. She wrote in Mr O'Donnell's record that he was experiencing shakes and nausea and she advised him to drink plenty of water. She also recorded that he had asked about his medication and she told him he would receive a dose later in the evening. She reported no other concerns. Mr O'Donnell received his medication at around 11.00pm that night.

29. On 15 February, Mr O'Donnell was due to be reviewed again, as advised by the doctor the previous day. The DART duty doctor made a note in Mr O'Donnell's medical record to say that he had refused to come to the clinic. He wrote that Mr O'Donnell was already on an alcohol detoxification programme and he was being monitored regularly so he should be reviewed if his symptoms worsened. He told the investigator that it was not unusual for prisoners to refuse to be seen and there was not much the staff could do about that. He described a very busy clinic environment where he had lots of people to see so it would not have been possible for him to go and see Mr O'Donnell unless he had concerns about him. He said no concerns had been raised by any staff and he was satisfied that Mr O'Donnell was receiving his medication and being monitored.

30. A healthcare support worker wrote an entry in Mr O'Donnell's medical record at 11.21am on 15 February, stating that she had seen him in the clinic and he had refused to see the duty doctor earlier in the morning. She told the investigator that this entry was incorrect as she had not in fact seen Mr O'Donnell that day at all. Her entry was supposed to reflect the fact that Mr O'Donnell had not seen the doctor. She said it was her responsibility to ensure that clinical monitoring continued, even though Mr O'Donnell had not attended the clinic with the doctor. However, she did not make the necessary referral for this to happen and she was unable to explain why.

31. Mr O'Donnell continued to receive his medication as required throughout the rest of the day and night. However, due to the healthcare support worker failing to make the referral to the clinical monitoring team, no one clinically assessed him at any time on 15 or 16 February.

32. On the morning of 16 February, Mr O'Donnell received two doses of his medication at approximately 9.20am and 11.50am. No concerns were noted in his medical record by healthcare staff.

33. At approximately 12.45pm on 16 February, Mr O'Donnell's cellmate was due to attend prayers and he was collected by an officer. The officer said that he did

not speak to Mr O'Donnell but saw him lying on his bed when he left the cell with his cellmate. The officer stayed with the prisoners throughout prayers and returned his cellmate, along with other prisoners, to E Wing after the service approximately 90 minutes later.

34. Officer A heard Mr O'Donnell's cellmate shouting that he needed to be let back into his cell at approximately 2.30pm and she went to open the door for him, telling him that he did not need to shout at her. She said that she opened the door without looking into the cell and then locked it behind Mr O'Donnell's cellmate. Shortly after Mr O'Donnell's cellmate went into the cell, Officer A heard him shouting and kicking the cell door. As he had been quite aggressive towards her previously, she asked Officer B to accompany her back to the cell to see what was wrong. As they opened the cell door, Mr O'Donnell's cellmate ran out shouting and pointing into the cell and they both saw that Mr O'Donnell was hanging from the bunk bed, having used a sheet as a ligature.

35. The officers cut Mr O'Donnell down and placed him on the floor of the cell. Officer A was not carrying a radio so she went onto the landing and shouted for staff assistance, stating that it was a code blue (medical emergency code that indicates a prisoner is unresponsive and requires an ambulance). Officer B started cardiopulmonary resuscitation (CPR) and Officer C arrived and used his radio to call a code blue. The ambulance log shows that an ambulance was called from the control room of the prison at 2.36pm. Two healthcare support workers responded first as they were working nearby and had heard Officer A's shouts for assistance. A nurse attended shortly afterwards and advised staff to move Mr O'Donnell onto the landing so that they had more room to attempt to resuscitate him. Other healthcare staff, including the nurse who was the appointed first responder, arrived with emergency equipment and took over CPR until the paramedics arrived at 2.56pm. Paramedics took over resuscitation but their attempts were unsuccessful and at 3.33pm, they pronounced that Mr O'Donnell had died.

Contact with Mr O'Donnell's family

36. Mr O'Donnell's partner was listed as his next of kin. A prison chaplain and an officer went to her parents' home address on 16 February at approximately 4.45pm but she was not at home. They therefore broke the news to her parents in person and later spoke to Mr O'Donnell's partner on the telephone. The prison chaplain and officer also visited Mr O'Donnell's brother and sister at their home address at 6.15pm to inform them of their brother's death. The prison contributed to the cost of Mr O'Donnell's funeral, in line with Prison Service instructions.

Support for prisoners and staff

37. Staff involved in the emergency response attended a debrief led by a senior manager, but some healthcare staff were not invited to attend. Staff said that they were offered support by the prison's care team and felt supported by managers and other colleagues.

38. The Governor posted a notice for prisoners informing them of Mr O'Donnell's death and offering support. Staff reviewed all prisoners assessed as at risk of

suicide and self-harm, in case they had been adversely affected by Mr O'Donnell's death.

Post-mortem report

39. The post-mortem report concluded that Mr O'Donnell's death was due to hanging. Toxicology results showed the presence of chlordiazepoxide and diazepam in levels consistent with alcohol withdrawal treatment. Tests also detected traces of amphetamine but it was not possible to establish when the substance was taken and how it might have affected Mr O'Donnell at the time of his death.

Findings

Identifying and managing risk of suicide or self-harm

40. Mr O'Donnell was found hanged after only three days at Durham. The PPO's Learning Lessons Bulletin, Early days and weeks in custody, published in February 2016, highlights the importance of identifying prisoners who are at heightened risk of suicide and self-harm when they first arrive so that appropriate monitoring can be put in place. The assessment process in reception is the best time for risks to be identified and recorded.

41. The PPO's Learning Lessons Bulletin, Self-inflicted deaths of prisoners – 2013/14, published in March 2015, also highlighted the importance of reception staff identifying risk factors for suicide and self-harm, and that they should record what they have considered and the reasons for decisions. It also says that restrictions on contact with family can be known triggers for suicide and self-harm, and being subject to a restraining order can be a sign of increased vulnerability.

42. Prison Service Instruction (PSI) 64/2011 lists several factors that might increase a prisoner's risk of suicide and self-harm. Mr O'Donnell had several of these risk factors, including alcohol/drug misuse, family/relationship breakdown and depression.

43. Mr O'Donnell's Person Escort Record (PER) said that he was not allowed to contact his children and other members of his family. It also said that his offence was breaching a restraining order. Mr O'Donnell told staff that he had a history of depression and anxiety and had been prescribed antidepressants, which he was not taking.

44. We found that no one formally took these factors into account in considering Mr O'Donnell's risk to himself and we therefore consider his risk of suicide and self-harm was not properly assessed. The First Night, Induction and Initial Assessment form did not require the assessor to consider the risk factors identified in PSI 64/2011.

45. Three members of healthcare staff saw Mr O'Donnell within 24 hours of his arrival at Durham and all were made aware of his history of anxiety and depression, yet none of them asked him if he had any thoughts of suicide or self-harm. While we consider that it was appropriate for staff to focus on Mr O'Donnell's substance misuse, we are concerned that his risk of suicide and self-harm was overlooked.

46. We have raised concerns previously about Durham's reception screening process. We are aware that, since Mr O'Donnell's death, the prison has improved its First Night Initial Assessment form to highlight the relevant risk factors and to ensure that staff record their decision-making around ACCT monitoring. Nevertheless, we make the following recommendation:

The Governor and Head of Healthcare should ensure that reception staff:

- **are aware of all known risk factors for suicide and self-harm;**
- **identify prisoners' risk factors from the information and documents available to them; and**
- **record the risk factors they have considered and the reasons for decisions.**

Substance misuse monitoring

47. PSI 45/2010 states, "there is a significant relationship between drug/alcohol withdrawal and suicide, the risk of which may be substantially reduced if prisoners are assessed on reception and provided with effective needs based treatment commenced on the day of reception".

48. Although Mr O'Donnell was provided with medication to help alleviate the symptoms of alcohol withdrawal on his reception to Durham, we found that he was not monitored appropriately.

49. The prison's Drug and Alcohol Monitoring Guidelines states, "During alcohol detoxification – monitor twice a day (morning and evening), as well as when dispensing medication, for the duration of the detoxification". The healthcare support worker was responsible for making a referral to the clinical monitoring team but, after Mr O'Donnell refused to attend a clinic appointment with the doctor on the morning of 15 February, she failed to ensure that clinical monitoring was in place. As a result, Mr O'Donnell was not seen by the clinical monitoring team on 15 or 16 February and we found no evidence that he spoke to anyone else about how he might have been feeling during that time. We therefore make the following recommendation:

The Head of Healthcare should ensure that:

- **a process is put in place to ensure that a referral to the clinical monitoring team has been made when appropriate;**
- **ongoing checks are made when specified, even if the prisoner fails to attend a clinic appointment; and**
- **checks continue until the prisoner's condition has stabilised.**

Emergency response and availability of radios

50. After the officers had cut Mr O'Donnell down, Officer A went onto the landing and shouted for assistance. She told the investigator that as she did not have a radio her instinctive reaction was to shout for assistance, stating that it was a code blue emergency. She said she was unaware at the time that Officer B was carrying a radio. Officer C responded to Officer A's call for assistance and used his radio to call the code blue. We found there was a minimal delay in calling for an ambulance and we found that healthcare staff responded promptly. However, we are concerned that the initial response was confused.

51. The investigator spoke to many prison staff who expressed concerns about the lack of availability of radios. We heard that those who arrive on later shifts have less chance of getting a radio as they will already have been taken by other members of staff. The Head of Operations told the investigator that the prison has 115 radios. Each wing has four radios allocated each day and there are also specific roles where a radio needs to be available to that specific member of staff.

52. He said that there is a significant cost implication in providing every member of staff with a radio and that there are alternative ways of raising an alarm such as shouting, pressing the general alarm, using a telephone, or using a whistle. He said that the prison is in the process of trying to acquire a further 20 radios, but that would still leave a shortfall or around 30 radios if every member of staff on duty were to be issued with one.

53. We are concerned, both by what we were told and by what happened when Mr O'Donnell was found, that emergency responses may be constrained by limited numbers of radios and confusion amongst staff as to the actions they should take when an emergency code needs to be transmitted.

54. In light of these concerns, we consider that the provision of a radio to all staff working directly with prisoners should be a priority. We make the following recommendation:

The Governor should:

- **review the current provision of radios to ensure it is sufficient to meet the needs of the prison; and**
- **remind staff of the need to use their radio in the event of a medical emergency and to use the correct medical emergency code.**

Support for staff

55. While the majority of staff said they felt supported by colleagues, managers and the prison's care team following the death of Mr O'Donnell, some members of the healthcare team who were involved in the incident were not invited to attend the debrief. Furthermore, the record of the debrief incorrectly showed that staff were present when they were not. Safer Custody PSI 64/2011 states, "In line with PSI 08/2010 Post Incident Care, a 'Hot Debrief' must be held immediately after all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. It may be useful to keep a record of those who attend".

56. One of the nurses said that she did not attend the debrief as it was held at 8.00pm and she had gone off shift by 5.45pm. However, the debrief record shows that she attended. Other members of healthcare staff involved in the incident who could have been invited to the debrief and were on shift at 8.00pm were not invited to attend. This is not in accordance with PSI 64/2011and we have raised this before in previous investigations at Durham. We make the following recommendation:

The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody, that all those involved in the incident are invited to attend, and that the list of attendees is accurately recorded.

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