Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Alan Smith a prisoner at HMP Doncaster on 5 September 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

Our Vision

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

Our Values

We are:

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

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

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

Mr Alan Smith was found hanged in his cell on 5 September 2018 three weeks after arriving at HMP Doncaster. He died from brain hypoxia (when the brain is deprived of oxygen) caused by hanging. He was 57 years old. I offer my condolences to his family and friends.

Staff at Doncaster managed Mr Smith under suicide and self-harm prevention measures (known as ACCT). However, there were some deficiencies in the way they did so. Healthcare staff did not attend most of the ACCT reviews and prison staff failed to take Mr Smith's many risk factors sufficiently into account when assessing and managing his risk. I am concerned that staff failed to assess Mr Smith's risk appropriately and that they did not fully identify and record his needs, which meant that he did not receive the support he required.

I am also concerned that the care Mr Smith received for his complex mental, physical and social care needs was not equivalent to that he could have expected to receive in the community. This affected his day-to-day living and his wellbeing and did nothing to decrease his risk of suicide and self-harm.

Despite these failings, I do not consider that there was anything to indicate to staff that Mr Smith was at imminent risk of suicide on the day of his death.

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

Sue McAllister CB
Prisons and Probation Ombudsman **June 2019**

Contents

Summary

Events

1. On 14 August 2018, Mr Alan Smith was remanded to HMP Doncaster. It was his first time in prison. He arrived at Doncaster with a suicide and self-harm warning form which noted that he had cut his arms two days earlier.

2. At an initial health screen, a nurse recorded that he had anaemia, Crohn's disease, rheumatoid arthritis, anxiety, depression and psychosis, for which he was prescribed a number of medications. Although the nurse referred him to the mental health team, no mental health assessment was completed before he died. During his reception interview staff started suicide and self-harm prevention procedures, known as ACCT.

3. Mr Smith continued to be monitored under ACCT procedures until his death. Staff completed six ACCT reviews but a member of healthcare staff only attended one.

4. Mr Smith regularly complained of pain, and his physical illnesses restricted his mobility and affected his mental health. Mr Smith's medical records indicate that he was sometimes unable to collect his medication because of his pain. Staff referred him to a physiotherapist, the social care team and the complex care needs team for assessment. However, there is no evidence that these appointments took place, or that healthcare staff created care plans to manage his physical illnesses.

5. On the morning of 5 September, an in-house paramedic saw Mr Smith after he complained about pain in his side in his cell, and an officer and another prisoner took him to the healthcare unit where he was seen by a nurse and a healthcare assistant and had a wound on his foot dressed. None of those who saw Mr Smith that morning had any concerns about his wellbeing.

6. At 11.05am, the officer locked Mr Smith in his cell. When she returned at 11.28am to give him his lunch, she found him hanging from a ligature made from a shoe lace.

7. The officer shouted for assistance and another officer radioed a medical emergency code promptly. The control room called an ambulance immediately. Staff tried to resuscitate Mr Smith until the paramedics arrived and took over. They transferred him to hospital but Mr Smith was pronounced dead at 1.37pm.

Findings

Management of risk of suicide and self-harm

8. When Mr Smith arrived at Doncaster, staff appropriately assessed that he was at risk of suicide and self-harm and monitored him under ACCT procedures. However, there were some deficiencies in the way they did so.

9. Staff failed to take Mr Smith's many risk factors sufficiently into account when assessing and managing his risk.

10. Mr Smith had a number of mental and physical health problems which affected his wellbeing. Despite this, no one from the healthcare or the mental health team attended five out of six ACCT reviews and there is little evidence that prison and healthcare staff worked jointly to address Mr Smith's needs. The ACCT caremap did not include that Mr Smith had been referred for a mental health assessment (which did not take place before he died) and there is no evidence that healthcare staff made any progress in assessing his social care and physical health needs.

11. We consider that, as a result of these failings, staff under-estimated Mr Smith's risks to himself.

Clinical care

12. The clinical reviewer concluded that the healthcare that Mr Smith's received at Doncaster was not equivalent to that which he could have expected to receive in the community.

13. During Mr Smith's reception screen, healthcare staff identified a number of risk factors for suicide and self-harm. Despite Mr Smith's complex physical and mental health needs, he was not assessed by the mental health, social care or complex care needs teams before he died. Staff missed opportunities to address his needs. This affected his day-to-day living and his mental wellbeing and did nothing to decrease his risk of suicide and self-harm.

Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that:
    - Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.
    - Staff have a clear understanding of their responsibilities and the need to record and share promptly relevant information about recognised risk.
    - Prison and healthcare and/or mental health team staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review and subsequent reviews if the prisoner has a serious health concerns.
    - Staff hold multidisciplinary ACCT reviews, with the same case manager and which involve staff who contribute to a prisoner's care.
    - Case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.
- The Head of Healthcare should ensure that healthcare staff fully assess and appropriately prioritise prisoners with a history of mental health problems, and record their actions and the outcome.

- The Head of Healthcare should ensure that a reported head injury or loss of consciousness is properly and promptly evaluated and recorded in the clinical records.
- The Head of Healthcare should ensure that staff appropriately assess a patient's pain to inform prescribing and good pain management.
- The Director and the Head of Healthcare should ensure that mobility needs are assessed promptly, risks identified and prisoners given necessary aids promptly.
- The Head of Healthcare should ensure that the clinical record provides a complete, clear and accurate record of all contact with a patient, including any action or referrals made.

The Investigation Process

14. 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. No one responded.

15. The investigator visited Doncaster on 13 September. He obtained copies of relevant extracts from Mr Smith's prison and medical records.

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

17. The investigator interviewed 10 members of staff and one prisoner at Doncaster on 19 October and 3 December, some jointly with the clinical reviewer.

18. We informed HM Coroner for Yorkshire South East of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The investigator contacted Mr Smith's brother to explain the investigation. Mr Smith's brother asked why Mr Smith had access to shoe laces if he was on suicide watch. We have answered Mr Smith's brother's question in separate correspondence.

20. Mr Smith's brother received a copy of the initial report. He did not make any comments.

Background Information

HMP Doncaster

21. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 prisoners who have been remanded into custody or sentenced. 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. They respond to emergency calls in the prison.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Doncaster was in July 2017. Inspectors noted that health services had improved considerably since the previous inspection in October 2015 and overall, were reasonably good. They noted that the management of prisoners with long-term conditions had improved. They found that many prisoners were assessed as being at risk of suicide and self-harm, and the prison needed to ensure that they received a consistently high level of care. Inspectors noted that the quality of some ACCT documents remained inadequate, with poor care plans and poorly attended reviews.

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 latest annual report for the year to July 2017, the IMB noted their concern about the overall healthcare provision at Doncaster, and considered that the service was not equivalent to that which could be expected in the community.

Previous deaths at HMP Doncaster

24. Mr Smith was the second prisoner since September 2016 to take his own life at Doncaster. There are no similarities between Mr Smith's death and the previous death. We are currently investigating the death of another prisoner who took his own life in January 2019.

Assessment, Care in Custody and Teamwork (ACCT)

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.

26. 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 multidisciplinary reviews, involving the prisoner.

27. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the caremap actions 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.

Key Events

28. Mr Alan Smith had a history of significant physical and mental health issues, including hallucinations, paranoia, emotionally unstable personality disorder, depression, chronic pain, anaemia, rheumatoid arthritis and Crohn's disease (an inflammatory bowel disease). While in the community, Mr Smith was under the care of the mental health team, the Gastroenterology Department at a Pain Clinic at a hospital. He was prescribed a number of medications for neuropathic pain, chronic pain, rheumatic arthritis, anxiety, depression and psychosis.

Events from 12 August 2018

29. On 12 August 2018, Mr Smith was charged with coercive behaviour and arson. He had set fire to his family home while he and his wife were inside.

30. On 14 August, Mr Smith was remanded to HMP Doncaster. It was his first time in prison. He arrived with a Person Escort Record (PER) and a suicide and self-harm warning form which noted that he had recently self-harmed by cutting his arm and had mental and physical health issues, for which he was prescribed medication. These included amitriptyline, oxycontin, oxynorm, pregabalin, sertraline and aripiprazole.

31. A Custodial Operations Manager (COM) completed Mr Smith's reception screening. He started suicide and self-harm prevention procedures, known as ACCT, and initially monitored Mr Smith twice an hour. The COM noted that it was Mr Smith's first time in prison and that he had no thoughts of suicide or self-harm. Mr Smith was due to return to court on 14 September. The COM assessed that he should have a single cell in the Loft because he was vulnerable and had mental health issues. (The Loft is a unit which holds up to 14 prisoners with social care and other needs, including mental health needs.) Mr Smith named his wife and step-daughter as his next of kin but said that he had no family support.

32. A nurse from the mental health team completed Mr Smith's first reception health screening. He noted that Mr Smith was taking a number of prescribed medications, appeared vulnerable and paranoid, and had auditory hallucinations. He had previously been under the care of community mental health services and it was noted that he had a "previous head injury". Mr Smith said that he had no thoughts of suicide or self-harm. The nurse did not consider it appropriate to allow Mr Smith to keep his prescribed medication in his cell due to his recent history of self-harm. He referred Mr Smith to the prison GP and the mental health team for assessment.

33. The name printed on the medication label that Mr Smith brought into Doncaster was William Quinn. Mr Smith told healthcare staff that he had used that name when he was in hospital. Healthcare staff noted that Mr Smith's community GP would confirm his medical history.

34. That evening, Mr Smith complained of stomach pain but when an in-house paramedic, attended his cell to examine him, he was asleep.

35. On 15 August, prison staff found Mr Smith on his cell floor at 4.20am, complaining that he was “in agony”. The in-house paramedic examined him in his cell, and noted that he was relaxed, breathing and talking normally. She noted that he did not appear in pain but asked for pain relief medication, which he was given.

36. That morning, the complex care needs team (a multidisciplinary healthcare team which meets weekly to review and agree a care plan for prisoners with multiple health needs) reviewed Mr Smith’s records. A nurse recorded that Mr Smith had an appointment scheduled to see a prison GP.

37. Later that morning, healthcare staff noted that Mr Smith’s community GP had confirmed that he was registered with them.

38. At 11.10am, a COM completed Mr Smith’s ACCT assessment. She was concerned about his mental health as Mr Smith did not fully engage with the process. She considered that the ACCT assessment and first case review should be completed simultaneously. Another COM, a unit manager, and a mental health nurse joined her.

39. A COM noted that Mr Smith was tearful, confused, his mood was low and he said that he wanted to die. Mr Smith talked about being trained by the Special Air Service in the use of firearms and said he had been protecting his wife and step-daughter at the time he had set fire to their home. He said that he had cut his arm three days before that, and had also harmed himself six months earlier. Mr Smith said that he was unsure if he still wanted to take his own life. A COM noted that Mr Smith was concerned about his mental health and needed a mental health assessment. He also needed a walking stick and for his medication issues to be resolved. The mental health nurse agreed to follow up these issues.

33. The ACCT panel agreed to monitor Mr Smith twice an hour, and assessed that his risk level of suicide or self-harm was low. They scheduled his next ACCT review for 17 August. A member of the mental health team was expected to attend that review. Mr Smith’s ACCT caremap noted that he should try to maintain family contact.

40. A nurse did not record his attendance at the ACCT review in Mr Smith’s medical records. Instead, another nurse (who did not attend the review) noted that a mental health triage assessment would be booked for Mr Smith. The medical records do not give any further information about whether any further action was taken.

41. A member of staff, who worked for Catch 22 offender management and resettlement services, completed Mr Smith’s basic custody screening. She noted that he said that he did not misuse alcohol or drugs. He lived on the induction wing but was waiting for a cell in the Loft due to his physical ailments and difficulty walking. She noted that Mr Smith’s behaviour was unusual when she talked about his mental health. His speech was slow and he recited random numbers, getting confused. Mr Smith said that he had still not received his medication and wanted support to manage his temper and impulsivity.

42. A prison GP and a nurse completed Mr Smith's secondary health screen. She noted that Mr Smith had a history of losing consciousness and not knowing for how long.

43. A prison GP noted that no GP had been available to see Mr Smith when he arrived at Doncaster. He confirmed that he had now reviewed the summary of Mr Smith's medical records from his community GP and noted that he had Crohn's disease and rheumatoid arthritis. The community GP had prescribed Mr Smith opiate-based medication: oxycontin (twice a day), oxynorm (three times a day) and meptazinol (three times a day) for pain relief. The prison GP considered that the prescribed medications were a "highly unusual opiate combination". He wanted to confirm the prescriptions with Mr Smith's doctors at the pain clinic he attended in the community. Mr Smith told the prison GP that he received weekly methotrexate injections for his arthritis. He explained that he had changed his name to William Quinn six years earlier. His community medical records confirmed this.

44. The prison GP changed Mr Smith's opiate prescription to fit with the prison's medication dispensing times. He increased Mr Smith's prescription for oxycontin in place of oxynorm. He prescribed Mr Smith pregabalin, sulfasalazine, sertraline, aripiprazole and amitriptyline. He confirmed that Mr Smith needed to attend his next appointment (on 3 October) at the pain clinic, and that the prison would confirm whether he should continue his weekly methotrexate injections.

45. Mr Smith had a hospital appointment for weight loss (as a result of his Crohn's disease) scheduled for 10 September. A prison GP said that this appointment would be cancelled as Mr Smith's weight loss had not been significant and the prison would monitor him instead. He asked for some routine blood tests and agreed to review Mr Smith in four weeks. He noted that he would write to Mr Smith's community GP for more information.

46. On 16 August, healthcare staff recorded that wing staff had contacted them numerous times to ask them to bring Mr Smith's medication to his cell as he had said that he could not walk to collect it. Healthcare staff said that this was not possible, especially as his medication had to be administered by healthcare staff. Wing staff said that Mr Smith refused to walk to the medication hatch and they could not find a wheelchair. Mr Smith therefore missed his medication.

47. On 17 August, the in-house paramedic attended Mr Smith's cell to treat an injury to his heel at 4.07am. She noted that he had a broken skin lesion on the heel of his right foot which appeared infected. She applied a temporary dressing and noted that his wound should be assessed during the day.

48. A healthcare assistant later saw Mr Smith to assess his heel injury. Mr Smith said that he felt suicidal, although he admitted that he had felt that way since he arrived. He said that his heel injury was a rat bite which he had incurred in the community. He said that he had attended hospital about it and they had said that he was okay. Mr Smith attended the healthcare unit only wearing socks on his feet. He said that the only shoes he had were large boots, but these hurt his feet. She gave Mr Smith a pair of slippers. She noted that Mr Smith's right foot appeared swollen. Mr Smith said that he had worn a leg brace for over ten years but had not used it for the last two weeks and this might have caused his foot to

swell. He added that he normally walked with a walking stick. She cleaned and dressed Mr Smith's wound. She referred him to the social care team to assess his needs and to a physiotherapist. She also referred him to a prison GP who reviewed him straight away.

49. A prison GP recorded that Mr Smith had an ulcer on his right heel and prescribed flucloxacillin, an antibiotic. (Mr Smith had regular wound reviews and dressing changes on 20, 31 August and 3 September and 5 September.)

50. On the same day, Mr Smith failed to attend a scheduled appointment with a mental health nurse. His medical records do not explain why he had not attended.

51. On 18 August, a COM chaired an ACCT review. A Prison Custody Officer (PCO) was present. No one from the healthcare team attended. Mr Smith initially told the panel that he wanted to die but he appeared to calm down as he continued to talk and said that he would feel much better if the issue with his pain relief medication was resolved. Mr Smith said that he had no plans to harm himself and would ask staff for support if he needed it. The review panel noted that Mr Smith's risk remained low and the frequency of monitoring remained at twice an hour. No additional caremap actions were added. The next ACCT review was scheduled for 20 August.

52. Shortly afterwards, a prison GP recorded in the ACCT records that he had told Mr Smith that his pain relief medication would be prescribed.

53. On 20 August, wing staff called a nurse to attend Mr Smith's cell at 1.22am because he was concerned that he had lost the feeling in his legs. He said that he was in pain and was unable to pull himself into his bed. Mr Smith told the nurse that he had fallen over three days earlier and had not told anyone about it. The nurse examined Mr Smith and staff helped to put him back into his bed. She gave Mr Smith paracetamol, and noted that he had already been prescribed strong doses of painkillers and may need a risk assessment to establish his mobility needs. She added that the healthcare team should review Mr Smith during the day shift.

54. Later that morning, a COM chaired an ACCT review, assisted by a PCO. No one from the healthcare team attended. Mr Smith said that he still wanted to die. He said that he had not had any contact with his step-daughter and wanted to speak to her. The review panel made no changes to his risk, observation levels or caremap actions. The next ACCT review was scheduled for 22 August.

55. On the same day, healthcare staff recorded in Mr Smith's medical record that he had failed to collect his morning medication despite reminders. His records do not explain why not.

56. On 21 August, a nurse saw Mr Smith at 2.26am after he shouted for help from his cell. Mr Smith said that he had struggled to use the emergency cell bell to call for assistance because he was unable to move due to the pain in his legs. The nurse examined him and noted that he had mobility problems and rheumatoid arthritis. She referred Mr Smith to Doncaster's complex care needs team to assess his social care needs. She gave Mr Smith ibuprofen and paracetamol to help relieve his pain.

57. At 7.12am, healthcare staff recorded that Mr Smith had a social care appointment that day. (There is no record that this took place.)

58. On 22 August, a COM chaired an ACCT review, and a PCO attended. No one from the healthcare team attended. The COM noted that Mr Smith had Crohn's disease and that it had been arranged for him to receive a special diet. Mr Smith said that he was happy and settled on the wing and another prisoner was helping him with his daily care needs. Although he denied thoughts of suicide or self-harm, Mr Smith said that he often found himself in a "bad place" and would then harm himself. The COM updated his caremap to note that Mr Smith should be located in the Loft as his mental health was poor. The panel reduced the frequency of ACCT monitoring to when staff conducted roll checks during the day and hourly at night. His next ACCT review was scheduled for 29 August.

59. Mr Smith failed to attend a wound review appointment that day. His medical records do not explain why.

60. On 23 August, a prison GP saw Mr Smith who complained of waking up at 3.00am each morning in pain. He thought that this was because he received his evening pain medicines too early at 4.00pm. The prison GP reintroduced Mr Smith's painkiller, oxynorm, twice a day and reduced his oxycontin. She noted that she would speak to the Head of Healthcare, to see whether Mr Smith could receive his medication at 8.00pm. (The last supervised medications are routinely given between 4.00pm and 5.00pm.)

61. That evening, a PCO recorded in Mr Smith's ACCT record that his walking had improved.

62. On 24 August, Mr Smith failed to attend a wound review appointment. His medical records do not say why.

63. On the afternoon of 24 August, a PCO recorded that Mr Smith appeared okay and had collected his medication and lunch. He had also booked an appointment with the healthcare team about getting a walking stick.

64. On 25 August, a member of staff from the social care team, saw Mr Smith in his cell. It is unclear from the records whether he assessed Mr Smith's social care needs. Mr Smith said that he could meet his personal hygiene needs himself. He was waiting to be issued with crutches and struggled to move without them. Mr Smith said that he was currently using a broomstick as a walking aid. He said that he would pass this information to the nurse in charge that day. No further information is recorded about the outcome.

65. A prisoner, who lived in the same unit as Mr Smith, said that he was concerned about Mr Smith who struggled with mobility issues and chronic pain. He often brought Mr Smith to the medication hatch and to collect his food. He had also given Mr Smith a broomstick to help him walk. He said that it was difficult for staff to attend to Mr Smith because of the difficulties of dealing with prisoners on a busy wing. He considered that Mr Smith should have been located in the Loft.

66. A PCO worked on the wing where Mr Smith lived and often had contact with him. He told the investigator that because of his mobility issues, Mr Smith generally sat outside his cell during the periods when prisoners socialised with each other

and talked to other prisoners. He said that at times, Mr Smith struggled to walk and staff and prisoners then brought his meals to his cell.

67. On 26 August, a senior nurse noted that Mr Smith had been referred to her because of his mobility issues. She noted that Mr Smith was on the agenda for discussion at a complex care case review meeting on 28 August. (There is no evidence that Mr Smith was discussed at that meeting or that further action was taken to help with his mobility.)

68. On 27 August, a nurse attended Mr Smith's cell at 3.20am and treated a cut on his foot. Later that day, healthcare staff recorded that Mr Smith had failed to collect his lunchtime medication. No reason is recorded.

69. On 28 August, Mr Smith again failed to collect his medication at lunch time. No reasons were recorded. When Mr Smith attended the healthcare unit that afternoon to redress the wound on his foot, he told the nurse that he had missed previous wound care appointments because he had been unaware of them. The nurse explained that Mr Smith needed to log into the prisoner ATM kiosk system on the wing (which provided details of appointments).

70. During a routine ACCT check at 7.30pm that day, a PCO found Mr Smith headbutting his cell wall. He said that he wanted to kill himself. The PCO told the night manager who increased Mr Smith's ACCT monitoring to every 30 minutes. Although wing staff completed a Form 213 (note of injury to a prisoner) and sent it to the healthcare unit, there is no evidence that healthcare staff saw Mr Smith.

71. The PCO told the investigator that he had had several conversations with Mr Smith. From these, he learnt that Mr Smith used the name "William Quinn" as an alter ego which he associated with negative thoughts. For example, Mr Smith said that when he wanted to hurt himself or was hearing voices, he answered to the name "Mr Quinn". The PCO said that when this happened, he talked to Mr Smith and reassured him. He said that Mr Smith appeared to "snap out" of thinking negatively. The PCO said that he was aware that Mr Smith had mental health problems and that he understood he was under the care of the mental health team.

72. On 29 August, an unnamed officer recorded in the wing observation book that staff should ensure that Mr Smith collected his evening medication at 4.00pm. (There was no reference to a change of time to 8.00pm.)

73. A COM chaired an ACCT review in the afternoon, with a PCO present. No one from the healthcare team attended. Mr Smith said that he was not a well man and although his medication issues had now been resolved, he had not yet been issued with a walking stick. He asked to be moved to the Loft. The frequency of his ACCT observations remained the same.

74. That evening, Mr Smith failed to collect his medication from the medication hatch again. There are no records to explain why. Prison staff brought Mr Smith's evening meal to his cell but recorded no concerns about him.

75. On 31 August, a COM chaired an ACCT review, with another COM present. No one from the healthcare team attended. Mr Smith said that he felt okay during

the day and a prisoner helped him a lot. However, he said that he had pain at night and wanted to end his life. The panel assessed Mr Smith's risk of harm as low and did not change the frequency of his observations. The next ACCT review was scheduled for 3 September.

76. On 1 September, a PCO found Mr Smith crying on his bed when he checked him at 12.30pm. He tried to talk to Mr Smith but he did not want to engage with him. The PCO returned to check on Mr Smith 20 minutes later and noted that he appeared okay. Later that evening, a PCO noted that Mr Smith told him that he was hearing voices in his head. At the time, Mr Smith was writing a letter to his step-daughter.

77. On 2 September, a PCO noted that Mr Smith told him that he was hearing voices in his head and needed to see the mental health team. The PCO asked Mr Smith what the voices were saying but Mr Smith gave no further details. The PCO told the investigator that he left a telephone message for the mental health team raising his concerns about Mr Smith. He did not know whether the mental health team had dealt with this.

78. On 3 September, Mr Smith told staff that he felt better.

5 September

79. On 5 September, an in-house paramedic examined Mr Smith in his cell at 9.10am after he complained of pain in his side. He said that he had fallen over two days earlier. Mr Smith had bruising on the left side of his chest and he told Ms Wilkinson that he had back pain. She told Mr Smith to rest and to ask the prison GP about pain relief as he already had a "large regime of other medicines". She noted that she would speak to the GP when he arrived for duty.

80. A PCO escorted Mr Smith to the healthcare unit at 10.25am to have his foot wound redressed. A prisoner pushed Mr Smith's wheelchair. A nurse met them there. The prisoner asked the nurse if Mr Smith could be referred to the social care team for an assessment. The nurse agreed to discuss it with social care staff. Afterwards, an assistant practitioner redressed Mr Smith's foot. She told the investigator that Mr Smith appeared okay and she had no concerns about his presentation or how he interacted with her.

81. Afterwards, a PCO escorted Mr Smith to collect his medication from the medication hatch and then back to the wing. She told the investigator that Mr Smith seemed happy and talkative. A prisoner pushed Mr Smith by wheelchair to the wing. The prisoner said that he had no concerns about Mr Smith that morning. Before Mr Smith went into his cell at 11.05am, he thanked the PCO for her help. The PCO then collected the lunch trolley for the wing. She returned to Mr Smith's cell at 11.28am to give him his lunch.

Emergency response

82. A PCO opened Mr Smith's cell door and noticed that he was on his knees. She shouted to ask if he was okay but saw a ligature made from a shoelace tied to the bed and around Mr Smith's neck. (As he was on remand, Mr Smith could wear his own clothing.) The PCO said that Mr Smith was grey. She immediately shouted for staff assistance and radioed a medical emergency code blue (which

indicates that a prisoner is unconscious or has breathing difficulties). The control room log recorded this at 11.28am and the control room called an ambulance immediately.

83. Three PCOs were standing nearby and ran to help the PCO. They arrived in seconds. Two PCOs cut the ligature and laid Mr Smith on his back on the floor. A PCO checked Mr Smith but found no signs of life. Another PCO started cardiopulmonary resuscitation (CPR), assisted by a PCO. A COM arrived and made sure that other prisoners were locked in their cells.

84. A nurse and a healthcare assistant responded to the code blue. They arrived at Mr Smith's cell within four minutes and brought a medical emergency bag.

85. The nurses took over resuscitation efforts. The nurse examined Mr Smith and set up the emergency equipment and applied oxygen to him. Further healthcare staff arrived within two minutes. A nurse and a prison paramedic applied the defibrillator (which monitors electrical activity in the heart and provides an electric shock to reverse abnormal rhythms) and used further medical equipment to assess and try to revive Mr Smith. Staff moved Mr Smith to the wing landing to continue CPR.

86. Ambulance paramedics arrived at 11.43am and took over Mr Smith's care. They found a pulse and took him to hospital by ambulance. Hospital doctors later confirmed that Mr Smith had died at 1.37pm.

Family liaison

87. An administrative support officer and a PCO were appointed as the prison's family liaison officers (FLO). The Deputy Director and the family liaison officers visited Mr Smith's wife at 2.15pm but no one was in. They contacted Mr Smith's step-daughter who accompanied them to her home, where her mother was staying. They broke the news to Mr Smith's wife and offered support. Doncaster contributed to the cost of Mr Smith's funeral in line with national instructions.

Support for prisoners and staff

88. On the same day, The Deputy Director debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The prison posted notices informing other prisoners of Mr Smith's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Smith's death.

Post-mortem report and toxicology results

89. The post-mortem examination established that Mr Smith died from brain hypoxia caused by hanging. Toxicology test results confirmed the presence of medications prescribed to Mr Smith in his system when he died.

Findings

Management of risk of suicide and self-harm

90. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody list risk factors and potential triggers for suicide and self-harm. Mr Smith had a number of these risks when he arrived at Doncaster. It was his first time in custody, he had a history of self-harm, he had arrived with a suicide and self-harm warning form, he had significant mental and physical health issues, he had been remanded for a serious and domestic offence, and he was vulnerable. Staff appropriately started ACCT procedures when Mr Smith arrived at Doncaster and he was then managed under ACCT procedures until his death.

91. While his mood was generally low, Mr Smith gave staff no indication that he was at heightened risk of suicide in the days before he died. He had a lot of contact with prisoners, prison and healthcare staff on the morning of his death and no one raised any concerns about him. We do not consider that staff at Doncaster could have foreseen that Mr Smith intended to take his own life on the morning he died.

92. However, we do have concerns about the management of the ACCT process.

ACCT reviews

93. PSI 64/2011 requires a multidisciplinary approach for ACCT case reviews and, where possible, the ACCT assessor and staff from the healthcare team, including the mental health team, should attend the first ACCT review. Mr Smith's first ACCT review met these requirements. However, there were six ACCT reviews in total and there was little continuity of care: a number of different prison staff were involved in them and the majority were not multidisciplinary and had no healthcare representation.

94. The lack of healthcare representation was particularly important in Mr Smith's case given his complex physical and mental health issues which significantly affected his wellbeing. As a result, there was poor communication between prison and healthcare staff, a lack of input from healthcare staff and important information was not appropriately shared or addressed.

95. For example, Mr Smith had disclosed that he wanted to die at two of his ACCT reviews. This should have triggered urgent mental health assessments, but this did not happen. Prison and healthcare staff had suggested that Mr Smith should be located in the Loft, which would have better supported his complex needs. This move never took place and records do not indicate that this was seriously discussed. Mr Smith asked for his medication to be given to him later in the day to reduce his pain at night. There is no evidence that this was considered, most likely because there was no input from the healthcare team during the majority of his ACCT reviews. There is no record of intervention from the healthcare team when Mr Smith harmed himself on 28 August 2018. There is no evidence that they were aware of the incident. We are also concerned that Mr Smith was identified with mobility issues but relied on a broom stick as he was not given an appropriate walking aid.

96. We do not consider that staff operated ACCT procedures appropriately. The approach to managing Mr Smith was not co-ordinated or prioritised despite his many risk factors for suicide and self-harm. Staff missed a number of opportunities to identify and address his needs using a multidisciplinary approach.

Caremaps

97. PSI 64/2011 requires caremaps to reflect a prisoner's needs, level of risk and the triggers of their distress. They should aim to address issues identified in the ACCT assessment interview. They should be tailored to meet prisoners' individual needs and reduce risk. They should also be time-bound and say who is responsible for completing the action.

98. Mr Smith's key concerns were his mental health, his pain relief medication and mobility issues. Although staff recognised these concerns, they failed to set and record clear and effective caremap actions aimed at addressing the issues. They kept no record of their progress in resolving his medication issues, his move to the Loft or accessing a mobility aid for him. This meant that these issues continued to affect Mr Smith's risk.

99. In addition, although the need to maintain family contact was listed as a caremap action after the first ACCT review, there is no evidence that anyone subsequently took action to follow this up. Staff also failed to include in Mr Smith's caremap that he had been referred to the mental health team for an assessment. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that:

- **Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.**
- **Staff have a clear understanding of their responsibilities and the need to record and share promptly relevant information about recognised risk.**
- **Prison and healthcare and/or mental health team staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review and subsequent reviews if the prisoner has a serious health concerns.**
- **Staff hold multidisciplinary ACCT reviews, with the same case manager and which involve staff who contribute to a prisoner's care.**
- **Case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.**

Clinical care

100. The clinical reviewer noted that overall the care that Mr Smith received for his reported head injury, his pain, mobility needs and his mental health was not equivalent to that which he could have expected to receive in the community.

Assessment of mental health

101. The initial health screen in reception is the first opportunity for staff to assess prisoners' mental health and their risk of suicide and self-harm. When he arrived at Doncaster on 14 August, Mr Smith was monitored under ACCT procedures because of his numerous risk factors and because he presented with possible mental illness. Although healthcare staff referred him for a mental health assessment on 14 August, he was not assessed in the three weeks before his death on 5 September.

102. Healthcare staff told the investigator that Mr Smith had a mental health appointment on 17 August but he failed to attend. This was not recorded in his medical record and there is no evidence that staff followed up why he did not attend or that they rescheduled another appointment.

103. Mr Smith had also indicated during his ACCT reviews that he had thoughts of dying (18 August and 20 August). On 28 August, Mr Smith had headbutted the wall and told wing officers that he wanted to kill himself. On 2 September, wing officers recorded that Mr Smith said that he needed to see the mental health team because he was hearing voices and left a message for the mental health team about this. Yet, there is no record that healthcare staff referred him.

104. Given Mr Smith's history of mental illness, his presentation when he arrived, his risk of suicide and self-harm and the serious offence for which he was remanded, we consider that healthcare staff should have arranged for him to have an urgent and full mental health assessment. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff fully assess and appropriately prioritise prisoners with a history of mental health problems, and record their actions and the outcome.

Assessment of physical health

105. During his reception screening, healthcare staff recorded that Mr Smith had previously incurred a head injury and had a history of losing consciousness. Yet, there is no record that staff investigated or assessed this. As Mr Smith's head injury was not assessed, we cannot know how serious it was or whether it warranted treatment. We recommend that:

    The Head of Healthcare should ensure that a reported head injury or loss of consciousness is properly and promptly evaluated and recorded in the clinical records.

106. The clinical reviewer noted that Mr Smith received appropriate care for the wound on his right heel, and that it was regularly reviewed and dressed. However, when Mr Smith failed to attend wound appointments on 22 August and 24 August, staff did not record why he did not attend.

107. Mr Smith's Crohn's disease and rheumatoid arthritis were longstanding illnesses. He regularly had pain which at times did not ease despite prescribed pain relief medication, including high doses of opiate-based medication. On some occasions, staff reported that Mr Smith was unable to collect his medication from

the healthcare hatch due to difficulty walking. Despite this, he was not given a walking stick and a wheelchair was not always available.

108. Although healthcare staff referred Mr Smith to the prison's complex care needs and social care teams, there is no evidence his mobility was assessed, especially to determine whether it was reasonable to expect Mr Smith to walk to the medication hatch. Staff referred Mr Smith for physiotherapy but there is no record that an appointment was made. Until an assessment took place, healthcare staff should have ensured that Mr Smith received his medication as prescribed.

109. Mr Smith also asked whether he could receive his pain relief medication later in the evening so that it would be effective at night and not disturb his sleep. While healthcare staff recorded that this was an issue, there is no evidence that it was addressed.

110. Staff also twice recorded that Mr Smith had fallen over (20 August and 5 September), but there is no record that healthcare staff took any action to determine the cause, particularly as he had mobility issues and was taking high doses of opiate-based medication.

111. The clinical reviewer noted that healthcare staff failed to create a care plan to manage Mr Smith's Crohn's disease or rheumatoid arthritis. She noted that healthcare staff should have used a systematic approach to assess, describe and score his pain which would have helped to inform the prescribing of pain medication and determine the extent of his mobility issues. This might in turn have lowered his risk of suicide and self-harm as his physical health and pain were risk factors.

112. While we cannot know whether or not this would have changed the outcome for Mr Smith, it was a missed opportunity for staff to address his needs. We make the following recommendations:

The Head of Healthcare should ensure that staff appropriately assess a patient's pain to inform prescribing and good pain management.

The Director and the Head of Healthcare should ensure that mobility needs are assessed promptly, risks identified and prisoners given necessary aids promptly.

The Head of Healthcare should ensure that the clinical record provides a complete, clear and accurate record of all contact with a patient, including any action or referrals made.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T I 020 7633 4100
F I 020 7633 4141