Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dane Whiteley, a prisoner at HMP Doncaster, on 29 June 2019

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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

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

Mr Dane Whiteley died on 29 June 2019, after being found hanged in his cell at HMP Doncaster. He was 24 years old. I offer my condolences to Mr Whiteley's family and friends.

The investigation found that staff at Doncaster may have underestimated Mr Whiteley's risk to himself because they relied on his presentation and assurances that he had no thoughts of suicide or self-harm, and did not give sufficient consideration to his risk factors.

Mr Whiteley had a significant history of illicit drug use, and toxicology tests showed that he had used psychoactive substances (PS) before his death. This may have affected his state of mind.

An officer did not complete the required checks on prisoners on the night that Mr Whiteley died. It is impossible to know if this could have affected the outcome for Mr Whiteley, but a failure to carry out checks could make a crucial difference in future cases and is clearly unacceptable.

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 **September 2020**

Contents

Summary

Events

1. Mr Dane Whiteley had a significant history of illicit drug use. He had been in prison before and was released from his last sentence on 8 February 2019. On 21 June, Mr Whiteley appeared at court charged with burglary and driving offences and was remanded into custody at HMP Doncaster. He was due to appear at Crown Court on 12 July.

2. On 29 June, at 10.07am, an officer found Mr Whiteley hanged in his cell. She requested an ambulance, and officers and nurses responded and began cardiopulmonary resuscitation. The paramedics arrived at 10.14am, and at 10.20am, they pronounced Mr Whiteley dead. Toxicology tests found that Mr Whiteley had used psychoactive substances (PS) before his death.

Findings

Assessment of risk

3. We found that Mr Whiteley had some risk factors, possibly compounded by his illicit drug use. We judge staff should have fully assessed Mr Whiteley's level of risk on his arrival at Doncaster on 21 June. We are concerned that prison staff assessed his risk on the basis of his presentation, rather than also taking his risk factors into account. If they had considered his risk factors, they might have decided to begin suicide and self-harm monitoring procedures.

Psychoactive Substances

4. There was no evidence or intelligence to indicate Mr Whiteley used drugs after he returned to Doncaster on 21 June. Doncaster has comprehensive policies to minimise and treat illicit substance misuse. Despite this, Mr Whiteley was able access drugs with apparent ease.

Clinical care

5. The clinical reviewer concluded that overall the care provided to Mr Whiteley was equivalent to that which he could have expected to receive in the community. Mr Whiteley had a significant history of substance misuse but declined referral to the substance misuse service. When Mr Whiteley arrived at Doncaster, staff recorded he had a history of anxiety but did not explore this with him.

Welfare Checks

6. We found that the member of staff on night duty had not completed any of the required checks. We cannot know whether the outcome for Mr Whiteley might have been different if the checks had been done.

Recommendations

- The Director should remind staff that they must actively identify a prisoner's risk factors for suicide and self-harm from the information and documents available to them, and that evidence of risk should be fully considered and balanced against the prisoner's presentation.

- The Director should ensure that the key drug issues at Doncaster are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

- The Director should ensure that staff are conducting welfare checks as required.

- The Director should ensure that all prison and healthcare staff involved in an emergency response attend a hot debrief and are offered support.

The Investigation Process

7. 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.

8. The investigator visited Doncaster on 9 July. He obtained copies of relevant extracts from Mr Whiteley's prison and medical records.

9. NHS England commissioned an independent clinical reviewer to review Mr Whiteley's clinical care at the prison.

10. The investigator interviewed seven members of staff at Doncaster in July.

11. We informed HM Coroner for South Yorkshire (East District) of the investigation. She gave us the results of the post-mortem examination and toxicology results and we have sent the coroner a copy of this report.

12. One of the PPO's family liaison officers contacted Mr Whiteley's next of kin, to explain the investigation and to ask whether there were any matters he wanted the investigation to consider. Mr Whiteley's next of kin wanted to know he had been assessed at risk of suicide, what he had used as a ligature and whether he was breathing when he was found. We have answered Mr Whiteley's next of kin's questions in this report.

13. Mr Whiteley's next of kin received a copy of the draft report. She did not make any comments.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Doncaster

15. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 prisoners who have been remanded in custody or sentenced. Care UK provides clinical services. The prison directly employs qualified paramedics as part of their healthcare team, and they respond to emergency calls in the prison.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Doncaster in September 2019. Inspectors were very concerned by the increased levels of self-harm, and by the fact that there had been five self-inflicted deaths in the year leading up to the inspection. Tragically there was another shortly after the inspection. The inspectors found not all recommendations from the Prisons and Probation Ombudsman in response to these deaths were being regularly reviewed, nor was action taken to ensure that they were embedded in operational practice. Inspectors were concerned at the poor quality of some ACCT documents and were not assured staff understood how to identify and manage risk. Inspectors reported that staffing levels did not meet the high demand for mental health services. Inspectors found the presence of illicit drugs was a real and continuing problem with prisoners saying it was easy to get hold of drugs.

Independent Monitoring Board

17. 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. No IMB report was produced for the reporting year 2017-2018 or 2018-2019.

Previous deaths at HMP Doncaster

18. Mr Whiteley was the thirteenth prisoner to die at Doncaster since January 2017. Four of these deaths were self-inflicted and nine were from natural causes. There are similarities between Mr Whiteley's death and one of the other self-inflicted deaths where early morning roll checks were not undertaken as required. Since Mr Whiteley's death, there has been another self-inflicted death. This was the second self-inflicted death in 45 days.

Assessment, Care in Custody and Teamwork (ACCT)

19. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

20. 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 prisons at risk of harm to self, to others and from others (Safer Custody)*.

Psychoactive Substances (PS)

21. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Key Events

22. Mr Dane Whiteley had a significant history of illicit drug use, specifically cannabis and PS, and a custodial history dating back to 2012. Mr Whiteley's previous prison sentence ended on 8 February 2019.

23. During Mr Whiteley's previous sentences, evidence and intelligence indicated he had a history of violence towards other prisoners, was involved in the use of drugs and mobile phones and was associated with a gang from the Sheffield area. There was no evidence that Mr Whiteley was ever bullied or in debt.

24. On 21 June, Mr Whiteley appeared at Sheffield Magistrates' Court charged with burglary and driving offences. He was remanded into custody at HMP Doncaster until his appearance at Sheffield Crown Court on 12 July.

25. A nurse completed Mr Whiteley's initial health screen. The nurse recorded that Mr Whiteley had been in prison before, had not seen a community doctor for several months and was not prescribed any medication. The nurse noted Mr Whiteley's history of drug use and recommended a referral to the substance misuse team. Mr Whiteley refused and said he had no issue with drugs. Mr Whiteley said he had no thoughts of suicide or self-harm.

26. The nurse recorded Mr Whiteley had a history of anxiety but was not prescribed any medication. The nurse did not record that she explored this further with Mr Whiteley. Mr Whiteley's prison medical records show that he was prescribed sertraline (an antidepressant) until November 2016.

27. A Prison Custody Officer (PCO) saw Mr Whiteley as part of the reception process. The PCO recorded that Mr Whiteley was on remand, had been in prison before and was a vape user. Mr Whiteley said he had no thoughts of self-harm or suicide. The PCO recorded that Mr Whiteley was allowed to make a call and that he had called his next of kin.

28. The PCO completed the cell sharing risk assessment which assessed that Mr Whiteley was at high risk of harm to others as, in previous sentences, Mr Whiteley had stated he was homophobic and racist. As a result, Mr Whiteley was allocated a single cell.

29. A PCO saw Mr Whiteley for a first night assessment. Mr Whiteley said he was racist, homophobic and was a vape user. He repeated that he had no thoughts of self-harm or suicide. The PCO recorded that Mr Whiteley had made a telephone call in reception, was issued a vape pack and there were no other issues or concerns about Mr Whiteley's wellbeing.

30. On 24 June, an offender supervisor saw Mr Whiteley for an initial needs assessment. Mr Whiteley said he had lived with his girlfriend before prison, but would not be able to live there when he was released. He said he was unemployed, had not claimed any state benefits but did have a bank account. He said he would not need help finding work after he was released. Mr Whiteley said drugs and alcohol had never been a problem for him. Again, he said he had no thoughts of self-harm or suicide. She noted that Mr Whiteley was due to

appear in court on 12 July. She told Mr Whiteley that he would be given assistance in finding accommodation nearer the time of his release.

31. On 25 June, CCTV footage shows that, at 4.08pm, Mr Whiteley walked up to another prisoner and punched him in the face in an unprovoked attack. A Custodial Operations Manager (COM) charged Mr Whiteley with assault and referred the matter for adjudication. The COM told the investigator that intelligence indicated this incident was connected to drugs (specifically PS) and Mr Whiteley's association with the Pitsmoor Shooter Boys gang.

32. On 27 June, at 8.30am, a resettlement officer saw Mr Whiteley for an initial assessment. Mr Whiteley said he was unable to return to his previous address when he was released and would like support in finding accommodation. She did not explore either his accommodation issues or any possible relationship issues with Mr Whiteley. Mr Whiteley said he suffered from pain following a knee operation and self-medicated while in the community. He said he had an appointment with a doctor on 28 June. Mr Whiteley said he had no thoughts of self-harm or suicide.

33. At 11.20am, the Assistant Director responsible for housing, saw Mr Whiteley to open the adjudication (disciplinary hearing) in his capacity as adjudicating Director. He recorded that Mr Whiteley pleaded guilty to the charge of assaulting another prisoner, and the matter was referred to South Yorkshire Police. The COM said she was present at the adjudication hearing and Mr Whiteley admitted his guilt and he told her he would accept his punishment following the outcome of the police investigation.

34. At 3.05pm, a healthcare assistant saw Mr Whiteley for a secondary health screen. Mr Whiteley was a vape user but did not want to be referred to the smoking cessation service. She recorded that Mr Whiteley was unable to give a urine sample. Mr Whiteley said he had no thoughts of self-harm or suicide. Mr Whiteley said he had pain in his left hand after he had punched a wall. She knew that he had punched a prisoner two days before and noted that Mr Whiteley's left hand was slightly swollen. A nurse prescribed and gave Mr Whiteley 16 ibuprofen and 16 paracetamol tablets. (It is standard practice for nurses to issue basic painkillers.)

35. On 28 June, Mr Whiteley declined to attend his appointment with the prison doctor when staff went to his cell to take him to the healthcare centre.

Saturday 29 June

36. At 5.30am, a PCO recorded that she had conducted the early morning roll checks (a security check that all prisoners are present) on the house block and she had no concerns about Mr Whiteley. Subsequent check of the CCTV footage shows that the PCO did not undertake any of the required checks throughout the night.

37. At 10.07am, a PCO arrived at Mr Whiteley's cell to let him out for morning association. The PCO opened the cell door and saw Mr Whiteley hanging from the window bars by a ligature made from bedding. She immediately radioed an emergency code blue, which indicates a prisoner is having difficulty breathing.

Staff and nurses responded within 60 seconds, cut the ligature and began cardiopulmonary resuscitation (CPR). The control room log shows the PCO called the code blue over the radio at 10.07am and an ambulance was called immediately.

38. A nurse told the investigator that when he arrived at Mr Whiteley's cell, Mr Whiteley was not breathing, his skin was mottled in colour, his tongue was swollen in his mouth, and there was some stiffness in his arms but flexibility in the rest of his body and there was no pooling of blood in his limbs.

39. Staff and nurses continued with the resuscitation and applied a defibrillator. The defibrillator found no shockable rhythm, so CPR continued until the paramedics arrived.

40. Yorkshire Ambulance Service records show that they received the 999 call at 10.07am, the paramedics arrived at 10.14am and at 10.20am, they pronounced Mr Whiteley dead.

Contact with Mr Whiteley's family

41. The Director of HMP Doncaster, and the family liaison officer (FLO), visited Mr Whiteley's next of kin at her home address at 1.10pm, to break the news of his death and offer condolences. In the days that followed, the FLO maintained contact with Mr Whiteley's next of kin and, in line with Prison Service instructions, the prison contributed to the costs of the funeral.

Post-mortem report

42. A post-mortem examination found that the cause of Mr Whiteley's death was "compression of the neck in the context of novel psychoactive substance use". Toxicology results confirmed that Mr Whiteley had used 4F-MDMB-BINACA (a form of PS known as 'spice') before his death.

43. The toxicologist said that PS may result in a number of psychological disturbances including anxiety, agitation, delirium, hallucinations, paranoia, suicidal ideation and self-harm behaviours amongst many other psychiatric symptoms.

Support for prisoners and staff

44. An Assistant Director held a debrief for staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

45. However, a nurse told the investigator that none of the healthcare staff were involved in the hot debrief.

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

Findings

Assessment of risk

47. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

48. As we have noted many times in individual investigation reports, thematic reports and annual reports, too often staff make decisions about risk based on their perceptions of a prisoner's presentation and statements from the prisoner that they do not have any thoughts or intention of suicide or self-harm. Known risk factors which might increase the prisoner's risk, such as anxiety, relationship issues and substance misuse, can often be overlooked. The lesson we have identified repeatedly is that evidence of risk should be fully considered and balanced against the prisoner's demeanour.

49. It is clear that Mr Whiteley had some risk factors, in particular his significant history of illicit drug use, his accommodation and possible personal issues, his history of anxiety and his remand to custody facing a new custodial sentence, which should have been fully explored with him. These factors may not have amounted to a risk of suicide or self-harm, but we will never know.

50. We judge staff should have assessed Mr Whiteley's level of risk on his arrival at Doncaster on 21 June. We are concerned that prison staff assessed his risk solely on the basis of his presentation, rather than also taking his risk factors into account or exploring possible risk factors with him. If they had spoken to him about his possible risk factors, they may have concluded that it may have been appropriate to open an ACCT. We, therefore, recommend:

    The Director should remind staff that they must actively identify a prisoner's risk factors for suicide and self-harm from the information and documents available to them, and that evidence of risk should be fully considered and balanced against the prisoner's presentation.

Psychoactive Substances

51. Mr Whiteley had a significant history of illicit drug use. Mr Whiteley's security records show he was involved in the use of illicit drugs, mobile phones and was associated in gang culture in prison. Mr Whiteley denied he had any issues with drugs and refused support and advice from the substance misuse team.

52. Toxicology results show that Mr Whiteley had used PS before his death and the pathologist found that the cause of Mr Whiteley's death was "compression of the

neck in the context of novel psychoactive substance use". It is not possible to say what effect Mr Whiteley's PS use had on his state of mind when he took his life.

53. Doncaster has a strategy to address both the supply of and demand for PS and illicit drugs. It includes numerous actions intended to reduce the supply of drugs into the prison and movement of drugs around the prison. Examples of this include photocopying mail to prevent paper soaked in PS entering the prison and providing additional staff resources to carry out mandatory drugs tests and cell searches. There are also measures to educate prisoners about the dangers of PS and support those known to use the drugs, plus additional disciplinary measures to deter drug use.

54. We are concerned that, despite this, Mr Whiteley could obtain PS with apparent ease at Doncaster. HM Inspectorate of Prisons have expressed concern about the ready availability of drugs at Doncaster and it is obviously a cause for concern that Mr Whiteley was able to obtain and use them.

55. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are, for the most part, doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works, and we welcome the fact that such guidance was issued in April 2019, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

56. In relation to reducing the supply of drugs, we note that the Prison Service strategy says:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

We, therefore, recommend:

The Director should ensure that the key drug issues at Doncaster are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

Clinical care

57. The clinical reviewer concluded that overall the care provided to Mr Whiteley was equivalent to that which he could have expected to receive in the community. The clinical reviewer commented that Mr Whiteley had a previous history of illicit drug use and declined to be referred to the substance misuse service. She also commented that Mr Whiteley had a history of anxiety but gave no indication he

was anxious or depressed. Nevertheless, she thought that he could have been assessed using a mental health screening tool, to explore this further.

Welfare and Roll Checks

58. CCTV footage confirmed a PCO did not conduct any of the required checks during her night shift, as she was required to do. It is impossible to know if the PCO had done the checks, whether she would have found Mr Whiteley hanging earlier, and if so, whether the outcome might have been different.

59. The Director of Doncaster immediately suspended the PCO and instigated an internal investigation. We understand that the PCO has resigned from her employment at HMP Doncaster and we therefore make no recommendation about her.

60. On 1 July 2019, the Director of HMP Doncaster issued a notice to all staff setting out the requirement for effective prisoner welfare checks to be conducted, including during the night. This instruction states:

> "A welfare check is a physical observation carried out to ensure that prisoners are safe from any incident such as self-harm attempt, security breach, bullying in multi cells, fights, fires etc. Staff **must** ensure they can visually see all prisoners in the cell."

For those staff working nights the instruction states:

> "3 checks to be carried out between 1800hrs and 0600hrs. The times of these checks should be recorded at the bottom of the Night Patrol Log. Note during patrol state these must be done through the observation panel."

61. While we welcome the action taken by the Director, we recommend:

The Director should ensure that staff are conducting welfare checks as required.

Actions following a death in custody

62. PSI 64/2011 sets out the actions that prisons should undertake after a prisoner's death. Chapter 12 of the PSI contains a mandatory action that a 'Hot Debrief' must be held immediately after a death in custody. A senior member of staff must act as a debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. A nurse told the investigator that healthcare staff did not attend a debrief. This did not follow the national mandatory instruction.

63. We, therefore, recommend:

The Director should ensure that all prison and healthcare staff involved in an emergency response attend a hot debrief and are offered support.

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