

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Azaz Sheikh, a prisoner at HMP Doncaster, on 21 June 2020

**A report by the Prisons and Probation Ombudsman**

## Our Vision

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

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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

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 Azaz Sheikh was found hanging in his cell at HMP Doncaster on 21 June 2020. He was taken to hospital but died later that day. He was 34 years old. I offer my condolences to Mr Sheikh's family and friends.

Staff started suicide prevention procedures (known as ACCT) on 20 June, after they found Mr Sheikh with a ligature around his neck. Two hours later, staff again found Mr Sheikh with a ligature around his neck and moved him to a safer cell. The next day, staff reassessed his risk, reduced his observations and moved him back to a standard cell. He was found hanging later that afternoon.

I am concerned that staff failed to properly assess Mr Sheikh's risk of suicide and moved him from the safer cell, and reduced his observations, too quickly. I have made several previous recommendations to Doncaster about staff's poor assessment of risk and this is an issue that needs to be addressed.

The clinical reviewer found that the standard of mental health care Mr Sheikh received at Doncaster was not equivalent to that he could have expected to receive in the community. A nurse made a mental health referral for Mr Sheikh when he first arrived at Doncaster in January 2020, and yet he never received one, despite repeated requests. Also, despite Mr Sheikh's medical records showing that he was prescribed an antidepressant in the community, this was overlooked by prison healthcare staff and his prescription was not continued in prison.

I also found failings in the operation of the key worker scheme at Doncaster. Mr Sheikh did not have a consistent key worker. It is possible that a consistent, supportive key worker relationship could have made a difference for Mr Sheikh. Again, this is an issue I have raised previously with Doncaster.

I am concerned that we have repeatedly identified the same shortcomings in our investigations into deaths at Doncaster. I have, therefore asked the Executive Director of Custodial Contracts to write to me saying what he has done to satisfy himself that processes are in place at Doncaster to implement and embed our recommendations effectively.

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**

**March 2021**

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# Summary

## Events

1. On 30 January 2020, Mr Azaz Sheikh was remanded in prison custody, charged with trespass and theft, and sent to HMP Doncaster.
2. Mr Sheikh had depression and a history of self-harm. He also had a history of substance misuse.
3. On 20 June, an officer responded to Mr Sheikh's cell bell and found him with a kettle cord around his neck. He had been asked to share a cell that morning and said he could not cope with sharing and wanted to die. The officer started suicide prevention procedures (known as ACCT). Two hours later, an officer again found Mr Sheikh with a ligature around his neck and moved him to a safer cell. Staff reviewed Mr Sheikh's cell sharing risk assessment and approved single cell status.
4. At the ACCT assessment interview at around 9.30am on 21 June, Mr Sheikh said he wanted to die. The assessment officer told the investigator that she was concerned about Mr Sheikh and said to officers on the wing that he should remain in the safer cell. At the ACCT case review just over an hour later, to which the assessment officer was not invited, staff reassessed Mr Sheikh's risk as low and reduced observations from four an hour to two an hour. Staff moved Mr Sheikh out of the safer cell that afternoon.
5. At 4.20pm, while delivering food to Mr Sheikh's cell, an officer saw that he had tied a ligature around his neck. She called a medical emergency code and healthcare staff attended. Staff in the control room called an ambulance four minutes later. Paramedics arrived and took Mr Sheikh to hospital, but he died at 6.02pm that evening.

## Findings

6. We consider that staff failed to assess Mr Sheikh's risk properly at the ACCT case review. In our view, they moved Mr Sheikh out of the safer cell, and reduced observations, too quickly. We also have some concerns about the accuracy of the case review record.
7. The clinical reviewer found that the standard of mental health care Mr Sheikh received at Doncaster was not equivalent to that he could have expected to receive in the community. Mr Sheikh never received a mental health assessment at Doncaster, despite a referral having been made when he first arrived in January 2020. Also, despite his medical records showing that he was prescribed an antidepressant in the community, this was overlooked by prison healthcare staff and his prescription was not continued at Doncaster.
8. Mr Sheikh's key work sessions were with a variety of staff, making it difficult to build any rapport. Failings with the key worker scheme is an issue we have raised with Doncaster before.

9. There was a four-minute delay in control room staff calling for an ambulance after the medical emergency code was called.
10. We have repeatedly made recommendations to Doncaster about poor ACCT risk assessments, lengthy delays before mental health assessments are undertaken, and poor implementation of the key worker scheme. Although our recommendations have all been accepted, we are concerned that the fact that we have had to repeat them, means they have not been implemented effectively.

## Recommendations

- The Director should initiate an investigation into CM A's actions in relation to the ACCT case review on 21 June with a view to considering whether disciplinary action is appropriate.
- The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:
  - invite all relevant staff to ACCT case reviews, and obtain contributions from those unable to attend;
  - assess risk based on the prisoner's known risk factors, including any recent suicide attempts and incidents of self-harm, and set an appropriate level of observations based on the level of risk;
  - mark caremap actions as completed only once they have been actioned fully; and
  - keep accurate records of case reviews and who attended.
- The Head of Healthcare should review the task system on SystemOne to ensure that requests for continuation of medication are actioned appropriately.
- The Head of Healthcare should review the mental health appointment system and ensure that all referrals are seen within the appropriate timescales.
- The Director should ensure that:
  - the key worker scheme is effective at providing meaningful support to prisoners;
  - a named key worker is allocated to each prisoner and any changes in key worker allocation are kept to a minimum; and
  - contacts take place in accordance with the national policy framework.
- The Executive Director of Custodial Contracts should:
  - satisfy himself that processes are in place at Doncaster to ensure that the PPO's recommendations are being implemented and embedded; and
  - write to the Ombudsman to report his findings.

- The Director should ensure that control room staff call an ambulance immediately when a medical emergency code is called.
- The Director and Head of Healthcare should share this report with CM B and Officer A (when she returns to work) and arrange for a senior manager to discuss the Ombudsman's findings with them.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her.
12. The investigator obtained copies of relevant extracts from Mr Sheikh's prison and medical records.
13. The investigator interviewed 13 members of staff and a prisoner on various dates between June and October 2020. NHS England commissioned an independent clinical reviewer to review Mr Sheikh's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed healthcare staff. Due to coronavirus restrictions, all interviews were conducted by telephone.
14. We informed HM Coroner for Yorkshire South East of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Sheikh's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any concerns but asked to see a copy of our report.
16. We shared aspects of this report with the prison, in line with our advance disclosure process.
17. We sent HM Prison and Probation Service (HMPPS) a copy of the initial report. They pointed out some factual inaccuracies which have been amended in this report. They provided an action plan which is annexed to this report.
18. We sent Mr Sheikh's family a copy of the initial report. They did not identify any factual inaccuracies.

## Background Information

### HMP Doncaster

19. 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

20. 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, and that action was not being taken to ensure that they were embedded in operational practice.
21. 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

22. 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 30 September 2019, the board noted that the prison, as a whole, had improved over the last three years but there were many inexperienced staff. ACCT procedures were not always being followed and an ACCT Improvement Plan had been put in place. They also considered that access to mental health services was not always timely.

### Previous deaths at HMP Doncaster

23. Mr Sheikh was the 15th prisoner to die at HMP Doncaster since June 2018. Eight previous deaths were self-inflicted and six died from natural causes. We have previously made recommendations about poor assessment of risk of suicide and self-harm, delays in carrying out mental health assessments and failings in the operation of the key worker scheme.

### Assessment, Care in Custody and Teamwork

24. 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.

25. 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)*.

### **Key worker system**

26. The key worker system is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:
  - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
  - Key workers must have completed the required training.
  - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
  - Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

## Key Events

27. On 30 January 2020, Mr Azaz Sheikh was remanded in prison custody, charged with trespass and theft, and sent to HMP Doncaster. This was not his first time in prison.
28. A nurse carried out Mr Sheikh's initial health screen. Mr Sheikh told her he had a history of substance misuse including heroin, crack cocaine and cannabis. The nurse noted that Mr Sheikh's urine tested positive for opiates and cannabis and that he showed some signs of withdrawal. Mr Sheikh said he had ongoing depression with a history of paranoia and hallucinations and a history of self-harm in prison, but he said he had no current thoughts of self-harm. He also said he had learning difficulties. The nurse noted that Mr Sheikh had not seen a doctor in the past few months and was not receiving any prescribed medication. She referred Mr Sheikh to another nurse.
29. The second nurse put Mr Sheikh on a methadone (opiate substitute) programme and referred him to the mental health team.
30. Custodial Manager (CM) A and a nurse (indecipherable signature) carried out Mr Sheikh's cell sharing risk assessment. CM A concluded that Mr Sheikh should only share a cell with prisoners who shared his ethnicity and who were not known to be homosexual. He was considered to present a high risk to potential cell sharers.
31. On 31 January, a healthcare administrator noted that Mr Sheikh's community medical records showed that he had recently been prescribed mirtazapine, an antidepressant. She noted that she sent a task to doctors to review this. Her request was not actioned.
32. On 5 February, an officer noted NOMIS (prison record) to say that another officer had held a key worker session with Mr Sheikh. He noted that Mr Sheikh said he felt safe in the prison and had no concerns but was very shy and nervous and suffered with anxiety and depression.
33. On 10 February, Mr Sheikh was relocated to the Segregation Unit after refusing to share his cell with a newly arrived prisoner. Mr Sheikh had become forceful, pushing past officers and raising his hands.
34. On 13 February, a nurse saw Mr Sheikh because he had not taken all his methadone the day before. Mr Sheikh said he wanted to reduce his methadone and the nurse told him to speak to his substance misuse worker.
35. On 14 February, a recovery worker saw Mr Sheikh and reduced his methadone. He saw Mr Sheikh again on 17 February for a drugs review. He noted that Mr Sheikh had been on mirtazapine in the community and gave him advice about methadone reduction and toxicity issues on release. He also noted that he had made a mental health referral for Mr Sheikh.
36. On 19 February, Mr Sheikh told staff he did not want to take any more methadone and it was stopped.

37. On 21 February, an operational support grade (OSG) made a key worker session entry on NOMIS on behalf of Mr Sheikh's key worker (unnamed). She noted that Mr Sheikh said that he felt safe in the Segregation Unit but did not feel safe sharing a cell. He said he struggled to understand the questions asked of him during the session but 'is happy to go home'.
38. On 25 February, a nurse recorded that he was supposed to see Mr Sheikh for a mental health review, but he was unable to because of 'other responsibilities and time constraints'.
39. On 27 February, an OSG made a key worker session entry on NOMIS on behalf of a key worker officer. She noted that Mr Sheikh said that he did not feel safe from what he saw and heard from others and had informed staff. He said his general health was okay and he had no concerns around substance misuse. He also said he had no family support, visits or contact, but he felt okay and had no thoughts of self-harm. He found the wing too loud and would prefer to be located on Delta wing as he knew some people on there. The entry said there were no follow up actions from the session.
40. On 28 February, a recovery worker noted he went to see Mr Sheikh in the Segregation Unit, but Mr Sheikh did not want to see him but said he needed to see someone from the mental health team.
41. On 1 March, a nurse saw Mr Sheikh and noted that he had requested to see a mental health nurse and asked for some distraction material. She noted that a distraction pack was to be taken to the unit and that he wanted to see someone to talk about his mental health. Mr Sheikh did not wish to elaborate further at the time of contact, but she noted he had an assessment appointment booked within the next couple of days.
42. On 2 March, Mr Sheikh returned to a standard wing. A nurse recorded that Mr Sheikh was due to be assessed but because of 'duties' and 'reallocations' he had not been. The nurse rebooked the appointment for 26 March.
43. On 9 March, an OSG made a key worker session entry on NOMIS on behalf of a secondary key worker officer. Mr Sheikh said that he felt safe and had no immediate concerns. His general health was good, and he had no concerns around substance misuse. He said he had no problems with his accommodation either inside or outside of the prison. Mr Sheikh also said he had family support, and a good attitude. He did not report any financial problems and was not attending education or employment.
44. On 23 March, a caseworker in the Offender Management Unit made a note on NOMIS on behalf of an officer about a key worker session that took place on 17 March. He noted that Mr Sheikh said he felt safe and in good health and had no immediate concerns. He noted that Mr Sheikh had a positive attitude and said he had good support from family and friends and was receiving visits.
45. On 26 March, Mr Sheikh's appointment for a mental health assessment was cancelled due to COVID-19 restrictions.
46. On 29 April, an officer made a note on NOMIS that Mr Sheikh had refused a direct order to relocate to a shared cell. Mr Sheikh said he would take any

prospective cellmate hostage and assault them. Staff restrained Mr Sheikh, during which Mr Sheikh tried to bite staff. When he was told he was going to be taken to the Segregation Unit he complied. (He was only there for the day.)

47. On 12 May, an OSG made a key worker session entry on NOMIS on behalf of a 'primary' key worker officer. Mr Sheikh had said he felt safe but was concerned some of his property was missing. He had completed a complaint form about it and was waiting for a response. He said he had coughed up some blood but had not made staff aware of this and that his general health was fine. The entry noted that no follow up actions were required.
48. On 17 June, a nurse noted that he had attempted to contact Mr Sheikh on his in-cell telephone several times that day for a mental health review without success.

## 20 June

49. On the morning of 20 June, an officer went to Mr Sheikh's cell for a key worker session. She noted that Mr Sheikh said he had only just woken up and did not want to engage. At interview, she said that Mr Sheikh asked her to come back later which she agreed to do.
50. Later that morning, an officer asked Mr Sheikh to share a cell with another prisoner. Mr Sheikh became aggressive and smashed his TV against the wall.
51. At 12.40pm, when an officer responded to Mr Sheikh's cell bell, she saw him with a kettle cord around his neck attached to the top of his bunk bed. She asked him to remove the cord from around his neck, which he did, and then she and another officer entered the cell. Mr Sheikh said he could not cope with sharing with someone else and wanted help to die. The officer noted that she removed the kettle cord and other visible items that could be used as ligatures from the cell. She started ACCT procedures.
52. CM B and an officer completed the Immediate Action Plan around an hour later and set observations at two an hour.
53. At around 2.50pm, a prisoner in a cell near to Mr Sheikh's called to an officer. He had heard a noise from Mr Sheikh's cell which concerned him. The officer attended and found Mr Sheikh had tied a ligature (made from clothing) around his neck which was attached to the bed. The officer called a code blue and went in with a colleague to his cell and cut the ligature. Healthcare staff attended but Mr Sheikh was not injured. Staff moved him to a safer cell and increased observations to four an hour. A nurse noted on his medical record that Mr Sheikh would be reviewed by someone from the mental health team the next day.
54. At 4.43pm, a nurse recorded on SystmOne (electronic medical record) that she had made a referral to the mental health team.
55. CM B told the investigator that she discussed Mr Sheikh with an Assistant Director. She considered that a review of Mr Sheikh's cell sharing status and awarding him single cell status was likely to significantly reduce his concerns. (Cell sharing statuses are usually only reviewed annually or after a violent incident.) CM B conducted the review and approved single cell status. She said

that Mr Sheikh was pleased about this when he was told at the case review the next day.

## 21 June

56. On 21 June at 9.27am, an officer carried out the ACCT assessment interview. Mr Sheikh refused to answer some of the questions and had to be encouraged to engage. He did not make eye contact. The officer noted that Mr Sheikh said he did not want a cellmate, even a Muslim one. He said he had a headache and wanted to be dead.
57. The officer summarised the key issues as: 'Talk to mental health'; 'Engage with staff'; 'Support from Imam'. The officer told the investigator that after her assessment she said to some of the officers on the wing that Mr Sheikh's ACCT observations should not be decreased and that he should remain in a safer cell. An officer told the investigator he remembered the officer saying this.
58. CM A held the first case review at 10.50am. He recorded that an officer, CM B and a nurse attended. However, the officer told the investigator she was not invited to attend or give a verbal contribution, and she told the investigator she was shocked to later learn she had been listed as having been there.
59. Mr Sheikh attended the review and CM A noted that he was making good conversation and eye contact. Mr Sheikh said that he did not speak to his family apart from his father. He also said he got bored in the cell and CM A noted that distraction packs and in-cell gym workout sheets would be given to Mr Sheikh that day. CM A also noted that substance misuse staff and the Imam were to be invited to the next review. Mr Sheikh had said he had finished his methadone programme and that was why he wanted to speak to substance misuse staff. Mr Sheikh said he had no thoughts of self-harm and regretted his actions. CM A also recorded that Mr Sheikh was to engage with the learning disabilities team. The case review team assessed Mr Sheikh's risk of harming himself as low and reduced observations to two an hour with three interactions with staff a day.
60. The care map listed the first issue as 'boredom' and that the actions required were an in-cell work out and a distraction pack. Both were signed off by CM A as having been provided that day. The second issue listed was 'medication', and the action was 'MHIT [mental health in reach team] to look at assessment'. The status of the action was noted as 'looking at GP prescription' and again signed off by CM A. When interviewed, CM A said that the GP prescription probably related to the fact Mr Sheikh's community GP had prescribed him medication and the reasons for that needed to be revisited. The third issue was listed as 'speak to Imam' and CM A has indicated CM B did this after the review, so the action was signed off. The fourth issue listed on the caremap is 'learning disability'. The action was for the mental health team but the column relating to what happened is indecipherable although the action was ticked off.
61. The investigator asked the nurse what this entry meant, and she did not know. She was only able to say that Mr Sheikh had said he had some learning difficulties. CM A thought from memory that it meant that the learning disability nurse would be asked to see Mr Sheikh. The last issue is listed as 'SCS' (single cell status). The caremap noted that this action had been completed.

62. At 11.48am, CM A made ACCT notes on NOMIS adding that Mr Sheikh had been told he would be moved out of the anti-ligature cell.
63. At 4.34pm, the nurse made a detailed note on SystmOne about the ACCT review with CM A and CM B. Mr Sheikh had ligatured the previous day and said this was due to frustrations that his TV was skipping too much and that he had been told he had to share his cell when he did not want to share a cell. Mr Sheikh was reassured by CM B that he had been given single cell status, and this was recorded on all systems to minimise any confusion. Mr Sheikh said he regretted his actions and although at the time it was his intent to die, on reflection he was glad he had not.
64. Mr Sheikh had denied any further thoughts of self-harm or suicide. He said he had a family and children, and he wanted to get better so he could build up a life with his family. He was working towards this with support from a recovery worker who CM A would invite to the next review. The nurse told Mr Sheikh he would be given a new TV following a short period of risk assessment. Mr Sheikh had said he felt reassured and his issues had been dealt with. He said that lock down had not been easy as he had been bored; he agreed that he needed in cell activities and distraction paraphernalia. He said he liked going to the gym and wanted a job once cleaning COVID-19 restrictions were lifted. In fact, he wanted some cleaning materials to be able to clean his own cell properly as he said he felt better when things were clean and tidy.
65. Mr Sheikh also said that he thought he was going to be released in two weeks and said he had everything in place for life in the community. He wanted to see the Imam, and this was to be arranged by the prison managers - furthermore the Imam would be invited to the next ACCT review. Mr Sheikh said he had been on antidepressants in the community and a mental health referral was needed to look into this. Mr Sheikh also said he had learning difficulties but was unable to identify specifics – a learning disabilities referral was required.
66. Mr Sheikh was optimistic and wanted to get well for his wife and children. The nurse recorded that all issues identified had been resolved by the MDT and Mr Sheikh denied any thoughts of self-harm or suicide at time of review. She also recorded that he had made good eye contact and was coherent, though slowly spoken. There was no evidence he was responding to hallucinations, and she considered him to be orientated to time, place and person. He had no sleep issues. The nurse concluded that Mr Sheikh had presented in a settled manner, albeit a bit sluggish but engaged well and had articulated his thoughts and feelings:
67. At some point on 21 June, Mr Sheikh was moved from the safer cell to a standard cell.

### **Emergency response**

68. At approximately 4.20pm, an officer was taking food to Mr Sheikh's cell with a prisoner, who was assisting. She unlocked the cell and saw that Mr Sheikh had ligatured using bed sheets attached to the top of his bedframe. She called a code blue and a second officer, who was delivering food to the cell next to her, attended straightaway.

69. A third officer also attended and called a code blue. She told the investigator she was confident the first officer would have called a code but as lots of staff had not immediately responded she wondered if the call had been lost among radio traffic as sometimes happened.
70. Officer A was on duty in the control room. Her log shows that the code blue was called at 4.20pm. An entry at 4.21pm states, 'Do you require Ambulance Service?', and then below it, 'Not at this time'. The first officer said she did not have a conversation with control room staff and the second officer said she only heard her call the code blue. The control room log shows that an ambulance was called at 4.24pm.
71. The first officer tried to cut the ligature but it was too thick (Mr Sheikh had twisted a whole bed sheet to make a thick rope). The other two officers attempted to lift Mr Sheikh up but could not. Two nearby prisoners, who were both serving workers, helped and the prisoner who had been delivering food to the cell climbed onto the top bunk to untie the ligature from the bed frame. Staff and prisoners lifted Mr Sheikh up and loosened the ligature. They brought Mr Sheikh out of the cell and put him into the recovery position.
72. Two nurses had just finished a medication round when they heard the code blue. One of them said the call was initially just for medical assistance but a couple of seconds later was upgraded to a code blue and the alarm went off. They responded and went to the cell, collecting the emergency bag from the wing's clinical room on the way.
73. The nurses connected Mr Sheikh to oxygen. The matron arrived, and they placed Mr Sheikh on his back, connected a defibrillator and placed the pads on his chest and started cardiopulmonary resuscitation (CPR). Mr Sheikh was blue in colour.
74. At approximately 4.30pm the ambulance arrived. The nurse and matron said that paramedics suggested that an ambulance had been cancelled. None of the staff the investigator spoke to knew anything about this and the emergency services have not provided their records.
75. Paramedics continued with efforts to resuscitate Mr Sheikh and took him to Doncaster Royal Infirmary at 5.32pm where he died at 6.02pm.

### **Contact with Mr Sheikh's family**

76. The prison appointed an officer as the family liaison officer at 5.50pm. She went to Doncaster Royal Infirmary but she arrived at 6.09pm, after Mr Sheikh had died. At 6.24pm, an Assistant Director called the family to let them know.

### **Support for prisoners and staff**

77. After Mr Sheikh was taken to hospital, an Assistant Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

78. The prison posted notices informing other prisoners of Mr Sheikh'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 Sheikh's death.

**Post-mortem report**

79. The post-mortem report concluded that Mr Sheikh died as a result of hanging.

# Findings

## Management of Mr Sheikh's risk of suicide and self-harm

80. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm.
81. Staff started ACCT procedures shortly after 12.40pm on 20 June, when they found Mr Sheikh with a kettle cord around his neck. Around two hours later, after Mr Sheikh was again found with a ligature around his neck, staff moved him to a safer cell and increased his ACCT observations from two to four an hour.
82. An officer carried out the ACCT assessment interview at 9.27am on 21 June. She noted that Mr Sheikh's level of engagement was poor, and that he did not make eye contact. He said he was worried he would have to share a cell. He also said that he had a headache and wanted to die. The officer told the investigator that following the interview, she was concerned about Mr Sheikh and told officers that his observations should not be decreased, and he should not be moved from the safer cell. One of the officers corroborated her account.
83. CM A chaired the ACCT case review at 10.50am on 21 June. Staff assessed Mr Sheikh's risk as low and reduced his observations to two an hour. Staff subsequently moved Mr Sheikh out of the safer cell. He was found hanging that afternoon.
84. We are concerned that staff at the case review failed to properly assess Mr Sheikh's risk and that they moved him out of the safer cell and reduced observations too quickly. We note that by the time of the first case review, Mr Sheikh had been given single cell status, and so this did appear to address one of his main concerns. We also note that CM A recorded that Mr Sheikh made good conversation and had good eye contact. However, at the ACCT assessment interview just over an hour earlier, he was still saying he wanted to die. The officer said she was very concerned about him. Mr Sheikh had made two suicide attempts on 20 June. The first case review was held only 20 hours after Mr Sheikh's second suicide attempt, and we consider it was too early for staff to be satisfied that his risk had reduced, especially as key mental health issues remained unresolved.
85. We are concerned that some of the caremap actions that affected the assessment of Mr Sheikh's risk, particularly the action for a mental health assessment, were closed prematurely. The action listed is 'MHIT [Mental Health In-reach Team] to look at assessment', which was ticked as completed. Although the nurse who attended the case review subsequently noted in Mr Sheikh's medical record, 'Refer for LD [learning disability] and MH [mental health] assessment', it is unclear whether a referral had actually been made and certainly the mental health assessment had not been done when the caremap action was marked as completed.
86. We are also concerned about the record keeping on the ACCT case review. The case review form has a space for the ACCT assessor's name and below it says,

“If not attending state in record below how they contributed to the review.” CM A recorded the officer as the ACCT assessor and gave no other details in the record. It therefore appears from the case review record that the officer attended. However, the officer told the investigator that she had not attended (or been invited). When the investigator asked CM A about this, he said he had written her name as the assessor and had clearly not documented that she did not attend. CM A said he had spoken to the officer beforehand, but she refutes this. The officer told the investigator that she was not asked for a verbal contribution (which was the least she expected). She said she would have opposed any plan to move Mr Sheikh or reduce his observations. In fact, she said she may have argued for constant observations as Mr Sheikh had repeatedly told her he wanted to die. CM A has made no record on the case review of having spoken to the officer or of getting any contribution from her. There is therefore no evidence that a contribution was sought from the officer.

87. We are concerned that we have made repeated recommendation about the need to improve risk assessment at Doncaster, most recently in November 2020 (in relation to a previous self-inflicted death in November 2019). The prison has not yet responded to that recommendation and we, therefore, repeat it:

**The Director should initiate an investigation into CM A’s actions in relation to the ACCT case review on 21 June with a view to considering whether disciplinary action is appropriate.**

**The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:**

- **invite all relevant staff to ACCT case reviews, and obtain contributions from those unable to attend;**
- **assess risk based on the prisoner’s known risk factors, including any recent suicide attempts and incidents of self-harm, and set an appropriate level of observations based on the level of risk;**
- **mark caremap actions as completed only once they have been actioned fully; and**
- **keep accurate records of case reviews and who attended.**

### **Clinical care**

88. The clinical reviewer concluded that the clinical care Mr Sheikh received was of a mixed standard and not wholly equivalent to that he could have expected to receive in the community.
89. NICE guidance NG57 states that healthcare reception screening should ensure continuity of care for people transferring from one custodial setting to another (including court, the receiving prison or during escort periods) by accessing relevant information from the patient clinical record, person escort record and cell sharing risk assessment and checking medicines and any outstanding medical appointments.

90. At the initial health screen on 30 January 2020, the nurse noted that Mr Sheikh had not seen a doctor in the past few months and was not prescribed any medication. However, the SystmOne record shows that Mr Sheikh saw his community GP on 27 January 2020, complaining of low mood and suicidal thoughts, and that the GP prescribed mirtazapine (an antidepressant).
91. Care UK, the healthcare provider at Doncaster, completed a 72 hour report (providing an initial review of Mr Sheikh's care) and identified that Mr Sheikh's Summary Care Record (SCR - part of the SystmOne electronic record that documents contact with other health professionals and a summary of their interventions) was not available to the nurse at the time of the reception screen.
92. However, a medication reconciliation task took place after the initial screen and a healthcare administrator identified the recent mirtazapine prescription. She tasked doctors to review and consider continuing Mr Sheikh's medication, but the task was not picked up. We recommend:

**The Head of Healthcare should review the task system on SystmOne to ensure that requests for continuation of medication are actioned appropriately.**

93. There were also repeated failures to carry out a mental health assessment.
94. On 30 January, the day Mr Sheikh arrived at Doncaster, a nurse noted he had referred Mr Sheikh to the mental health team. On 14 February, Mr Sheikh's drug recovery worker noted that he had made another mental health referral.
95. On 25 February, a nurse was due to assess Mr Sheikh but noted he could not due to 'other responsibilities' and 'time constraints'. The nurse made a similar entry on 2 March. An assessment appointment for 26 March was cancelled because of COVID-19 restrictions, but the nurse did not attempt to assess Mr Sheikh again until 17 June. On that date he noted that he was unable to get in touch with Mr Sheikh on the in-cell phone. (Due to COVID-19 this was how assessments were being conducted.)
96. At interview, the nurse was unable to explain why he had been unable to complete the assessments in early March, offering only vague references to his workload and saying he could not really recall. He said that usually prisoners would be assessed within five days of a referral being made.
97. The nurse said he had been unable to contact Mr Sheikh on his in-cell phone for his appointment on 17 June. He said he thought he had asked an officer to check Mr Sheikh had a phone because he had been unable to get hold of him and the officer said he did. The nurse did not note this on Mr Sheikh's record and neither did the officer. The nurse rebooked the appointment for 22 June.
98. It is not acceptable that staff referred Mr Sheikh for a mental health assessment in January and he had still not received it by June. Regardless of the COVID-19 restrictions, there was still ample opportunity to arrange this assessment. The nurse's answers about the cancelled early March appointments are unsatisfactory.

99. With regards to Mr Sheikh not answering his phone in June, this should have prompted more action from the nurse than it did. Given that Mr Sheikh had been waiting almost six months for a mental health assessment and now was not answering his phone, the nurse should have asked staff to go and speak to him there and then and explain he was trying to call him to carry out the assessment. We recommend:

**The Head of Healthcare should review the mental health appointment system and ensure that all referrals are seen within the appropriate timescales.**

### Key worker system

100. All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner. However, on 24 March 2020, HMPPS suspended key work due to the COVID-19 pandemic. On 12 May 2020, key work was reintroduced but delivered in a more limited way, according to an Exceptional Delivery Model (where priority prisoners received key working).
101. Records show that Mr Sheikh had five key worker sessions up to 17 March. However, the investigator noted that the named key worker seemed to change frequently, entries were often made by colleagues and not by the key worker and sometimes entries were made retrospectively. For example, on 23 March, an officer made an entry on behalf of another officer – about a session that took place on 17 March.
102. The information recorded was also inconsistent, which was probably due to the lack of consistent key worker and the fact that the entries were often made by third parties. On 27 February, an OSG noted on behalf of an officer that Mr Sheikh had no family visits or support, but he was okay. He also said he did not feel safe in the prison. On 9 March, an OSG noted on behalf of an officer that Mr Sheikh said he did feel safe and had family support and visits. It may be that Mr Sheikh's attitude and circumstances had changed, but we have concerns that the lack of consistent key worker contact, and lack of prompt record keeping by the named key worker, may have led to inaccurate information and a distorted picture of Mr Sheikh's current circumstances.
103. The investigator spoke to the officer who in one entry was described as Mr Sheikh's primary key worker. He said that he was a new recruit in February and that the key worker training had been disrupted because of COVID-19. They had had no practical key worker training sessions, only classroom-based learning. He remembered that when he started working at the prison, lists of prisoner names requiring key worker sessions were given out and other officers picked up the responsibility if allocated key workers could not. He did not recall, however, that he was ever specifically told he was Mr Sheikh's allocated key worker.
104. The officer did not say how often the lists were given out but knew that key worker sessions were supposed to happen weekly and that officers should try to have a quality conversation with the prisoners. The officer also said that the

newly recruited officers did not have log-ins to access NOMIS and record their own entries so they relied on established officers doing that for them.

105. While we do not think that any individual officers are to blame for the inconsistencies in key workers or the recording of sessions, it is clear that the system was haphazard. It is conceivable that Mr Sheikh had more sessions than were ever recorded, but he had no chance to build up a rapport with a nominated key worker as they changed so frequently. Likewise, key workers could not be expected to build a rapport with him or identify mood changes or issues.
106. We acknowledge the logistical issues posed to prison regimes by COVID-19 but we note that Mr Sheikh was not seen frequently and consistently before the COVID-19 lockdown. We also expressed similar concerns following self-inflicted deaths at the prison in January and July 2019 and the prison told us in response that the key worker scheme had been fully implemented at Doncaster during January 2019 and that quality assurance procedures were in place.
107. We are, therefore concerned to have to repeat the following recommendation:

**The Director should ensure that:**

- **the key worker scheme is effective at providing meaningful support to prisoners;**
- **a named key worker is allocated to each prisoner and any changes in key worker allocation are kept to a minimum; and**
- **contacts take place in accordance with the national policy framework.**

**Repeated recommendations**

108. We have repeatedly made recommendations to Doncaster on the issues highlighted above: the need to improve staff's assessment of prisoners' risk of suicide and self-harm; the need to improve the timeliness of mental health assessments; and the need to improve the operation of the key worker scheme.
109. In our investigations into the eight self-inflicted deaths that took place at Doncaster in the two years before Mr Sheikh's death, we found in five of them that staff had poorly assessed the prisoner's level of risk; in three that there were delays in mental health assessments, and in two, that there were serious failings in the key worker scheme. We are not confident that Doncaster is implementing the recommendations we make effectively. In a previous report in November 2020, we made a recommendation to the Executive Director of Custodial Contracts. As he has not yet had the opportunity to respond, we repeat that recommendation here:

**The Executive Director of Custodial Contracts should:**

- **satisfy himself that processes are in place at Doncaster to ensure that the PPO's recommendations are being implemented and embedded; and**
- **write to the Ombudsman to report his findings.**

## Emergency response

110. PSI 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency code is called. Doncaster has such a protocol.
111. Officer A's log shows that the code blue was called at 4.20pm. Entries at 4.21pm suggest that Officer A asked whether an ambulance was required and was told 'Not at this time.' Nobody at the scene has been able to corroborate that this conversation took place and Officer A has been on long term sick, so we have not interviewed her. However, the PSI is clear that an ambulance should be called as soon as a medical emergency code is called and that confirmation is not needed from healthcare staff before calling one in response to a code. There was a three-minute delay between the code blue and an ambulance being called. We cannot say whether the delay affected the outcome, but we know that in an emergency situation, a delay of a few minutes may be critical. We recommend:

**The Director should ensure that control room staff call an ambulance immediately when a medical emergency code is called.**

112. The matron told the investigator that a paramedic took her aside and asked who had stood the ambulance down. A nurse also made a SystmOne entry to say he heard a similar conversation taking place between paramedics. The emergency services have not provided us with any information about the incident, and no one the investigator spoke to said they had stood the ambulance down. We make no recommendation.

## Learning from this report

113. We consider it important that staff should learn the lessons from this report. We therefore recommend:

**The Director and Head of Healthcare should share this report with CM B and Officer A (when she returns to work) and arrange for a senior manager to discuss the Ombudsman's findings with them.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations