Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Donoghue, a prisoner at HMP Leicester, on 14 December 2019

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 Joseph Donoghue died in hospital of a brain injury on 14 December 2019 while a prisoner at HMP Leicester. He had been found in his cell with a ligature around his neck four days earlier, less than two weeks after he arrived at Leicester. He was 37 years old. I offer my condolences to his family and friends.

When Mr Donoghue arrived at Leicester, he was appropriately monitored under suicide and self-harm prevention procedures (known as ACCT). However, I am concerned that this monitoring stopped before all the actions on his risk reduction plan had been completed and before a mental health assessment had taken place, and that reviews were not multidisciplinary. I am also concerned that ACCT monitoring was not re-started when Mr Donoghue was segregated after being restrained while in the ACCT post-closure period.

Toxicology tests showed that Mr Donoghue had used psychoactive substances (PS) in the hours before his death. Although this is not likely to have caused his death, PS are known to have adverse effects on mental health. Four of our investigations into deaths at Leicester in 2019 referred to the continued availability of illicit drugs at the prison. Given this, I am concerned that staff did not investigate Mr Donoghue's substance misuse, particularly after his allegations that his cellmate had spiked his drink and after he told a nurse that he had brought drugs into Leicester.

I am also concerned that prison staff did not check on Mr Donoghue while he was in the segregation unit as frequently as they should have done, and that the unit was left unstaffed for ten minutes at around the time that Mr Donoghue tied a ligature around his neck.

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 **October 2021**

Contents

Summary

Events

1. On 27 November 2019, Mr Joseph Donoghue was recalled to HMP Leicester. He had served several previous custodial sentences.

2. Mr Donoghue had a history of mental health issues and had been previously monitored under Prison Service suicide and self-harm prevention procedures, known as ACCT, most recently in August 2018. He also had a history of taking illicit substances and of assaulting others while in custody.

3. When Mr Donoghue arrived at Leicester, he was monitored under ACCT procedures after telling staff he had recently overdosed and was upset at being recalled to prison. Mr Donoghue was referred to the mental health and substance misuse teams, and ACCT monitoring was stopped on 4 December. During the brief time that Mr Donoghue was at Leicester, he remained in the induction unit.

4. On 10 December, Mr Donoghue was restrained by staff after reacting in an aggressive manner while apparently under the influence of an illicit substance. He was taken to the prison's segregation unit where he was restrained again while being searched. Mr Donoghue later alleged that his cellmate had "poisoned" his drink.

5. At around 7.50pm that evening, an officer found Mr Donoghue in his cell with a ligature tied around his neck. Staff and paramedics responded promptly and recovered a heartbeat. He was transferred to the Royal Leicester Infirmary, but he did not regain consciousness and died on 14 December.

6. Post-mortem toxicology test results showed that Mr Donoghue had used psychoactive substances (PS) before he died.

Findings

7. Prisons staff appropriately started ACCT procedures when Mr Donoghue arrived at Leicester but stopped them prematurely before actions on the risk reduction plan had been completed and before a mental health assessment had been completed. ACCT reviews were also not sufficiently multidisciplinary.

8. We are concerned that ACCT procedures were not restarted after Mr Donoghue was taken to the segregation unit during the ACCT post-closure period, even though he had just been restrained and was thought to be under the influence of drugs.

9. We are concerned that Mr Donoghue was able to obtain and use PS without staff being aware.

10. We are concerned that investigations into Mr Donoghue's drug use were not completed, particularly given that he had alleged that his cellmate had "spiked" his drink and that he had told a nurse that he had secreted drugs when he arrived in prison.

11. We are satisfied that the use of force on Mr Donoghue in the induction unit was reasonable and proportionate. We cannot take a view on the use of force in the segregation unit as the point at which force was initiated was not filmed.

12. We are concerned that the custodial manager present during both restraints used inappropriate language and did not attempt to de-escalate the situation.

13. We are concerned that for an hour before he was found, Mr Donoghue was not checked in the segregation unit as he should have been. We are also concerned that at around the time Mr Donoghue tied a ligature around his neck, the segregation unit was left unstaffed for about ten minutes.

14. The CPR performed by officers and healthcare staff was of a high quality.

Recommendations

- The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national instructions, ensuring that:
    - case reviews are multidisciplinary and include staff who have had previous contact with the prisoner, such as key workers or the ACCT assessor, where appropriate; and
    - risk reduction plans are specific, meaningful, tailored to the individual to reduce their risk and completed before ACCT monitoring is stopped.
- The Governor should ensure that when a prisoner is segregated:
    - staff establish whether the prisoner is subject to ACCT procedures or in an ACCT post-closure period; and
    - if so, they consider alternatives to segregation, hold an immediate ACCT review, and consider whether there are exceptional circumstances for continuing segregation.
- The Governor should share this report with the Head of Reducing Offending and discuss the Ombudsman's findings.
- The Head of Healthcare should share this report with the learning disabilities nurse and discuss the Ombudsman's findings.
- The Prison Group Director for the East Midlands should arrange a meeting with the Ombudsman to discuss continuing concerns about the quality of ACCT procedures at HMP Leicester.
- The Governor should ensure that:
    - officers carry out scheduled observations in the segregation unit; and
    - the segregation unit is not left unstaffed except in an emergency.
- The Governor should ensure that:

    - staff complete an intelligence report when a prisoner is suspected of substance misuse or of being involved in the prison's illicit drug culture; and
    - the security department investigates where appropriate.
- The Governor should commission an investigation into the use of force in the segregation unit on 10 December 2019 and the injuries Mr Donoghue sustained.
- The Governor should share this report with Custodial Manager A and discuss the Ombudsman's findings.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Leicester informing them of the investigation and asking anyone with relevant information to contact him. No one contacted him.

16. The investigator visited Leicester on 20 December 2019. He obtained copies of relevant extracts from Mr Donoghue's prison and medical records. The investigator also viewed CCTV and body-worn video camera (BWVC) footage of Mr Donoghue's restraints and relocation to the prison's segregation unit on 10 December.

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

18. The investigator interviewed 16 members of staff, some jointly with the clinical reviewer. The investigator also had access to a statement provided to Leicestershire Police by Mr Donoghue's cellmate.

19. We informed HM Coroner for Leicester City and South Leicestershire of the investigation. She provided us with a copy of the post-mortem report. We have sent her a copy of this report.

20. We contacted Mr Donoghue's next of kin to explain the investigation and to ask if they had any matters she wanted us to consider. The family asked whether Mr Donoghue had had contact with the prison's mental health team, if he was prescribed medication and if he had been assaulted during his time at Leicester. We have addressed their concerns in this report.

21. Mr Donoghue's next of kin received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Leicester

22. HMP Leicester is a local prison that holds around 350 men. The prison serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Nottinghamshire Partnership NHS Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

23. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Leicester in January 2018. Inspectors found significant improvement across many areas since their last inspection in 2015. However, Inspectors were concerned that the availability of PS remained a threat to the prison's stability. They reported that although there were good initiatives to address this, efforts to reduce the supply of drugs were not effective enough. Inspectors found that there were insufficient resources to act on intelligence received about drugs and made a recommendation about drug supply reduction. They reported that good work was being done by Turning Point (the substance misuse service) to address the demand for drugs.

24. Inspectors reported that the quality of ACCT documentation remained far too variable and identified that, on several occasions, caremaps had been closed without actions in the plan being completed, that reviews were not sufficiently multidisciplinary, that caremaps were not always updated or amended, and that night observations were too brief and predictable. Inspectors recommended that caremaps should be completed before ACCT monitoring is ended.

25. Inspectors reported that healthcare services had improved, although clinical records did not always contain a mental health care plan or report nursing reviews.

Independent Monitoring Board

26. 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 ending January 2019, the IMB reported that efforts continued to improve the management of ACCT. The Board found reviews to be well conducted, but that the quality of ACCT documentation continued to be variable. The IMB reported that the services delivered by the substance misuse team were highly regarded, and that planned and unplanned uses of control and restraint were used appropriately.

Previous deaths at HMP Leicester

27. Mr Donoghue was the fifth prisoner to take his life at Leicester since October 2017. There were also two drug-related deaths in this time.

28. In two of the previous self-inflicted deaths (in October and December 2017), we made recommendations about the management of those at risk of suicide and self-harm. As we had previously had concerns, we also made an additional recommendation to the Prison Group Director for the East Midlands to ensure

that action was taken to implement our recommendations on managing the risk of suicide and self-harm at Leicester. This recommendation was accepted in May 2019.

29. In our investigation reports into four deaths at Leicester in 2019, we highlighted issues about the availability of drugs at the prison. Leicester agreed to implement our recommendations about this in the three investigations which have been concluded.

30. Since Mr Donoghue's death, there have been a further two deaths at Leicester, both from natural causes, with no apparent similarities to Mr Donoghue's death.

Assessment, Care in Custody and Teamwork (ACCT)

31. 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. As part of the process, a risk reduction plan, also known as a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

32. 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. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

33. Leicester has been a pilot site for the new ACCT documentation, which is currently being rolled out across the prison estate.

Psychoactive substances (PS)

34. Psychoactive substances (PS) are a serious problem across the prison estate. They are difficult to detect and can affect people in many 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.

35. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

36. HM Prison and Probation Service (HMPPS) has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

Background

37. On 10 July 2018, Mr Joseph Donoghue was remanded into custody at HMP Leicester, charged with actual bodily harm and threatening a person with an offensive weapon. He had served a number of previous sentences, had a history of substance misuse and assault, and had been monitored under suicide and self-harm procedures, known as ACCT, during previous periods in prison.

38. In August 2018, Mr Donoghue made cuts to his arm, was monitored under ACCT procedures and was found under the influence of unknown substances.

39. In September, Mr Donoghue was sentenced to 16 months in prison. On 20 March 2019, Mr Donoghue was released on licence from HMP Humber. However, on 6 September, he was recalled to prison for not attending an appointment with his offender manager (probation officer), not living at an approved address and for displaying poor behaviour. From 7 September to 26 November 2019, he remained unlawfully at large.

HMP Leicester

40. On 27 November 2019, Mr Donoghue was taken into police custody and charged with actual bodily harm. On 28 November, he was transferred to HMP Leicester, with a suicide and self-harm warning form. This noted that Mr Donoghue had taken an overdose the previous day but that he said he had no current thoughts of suicide or self-harm. Staff began ACCT procedures. Mr Donoghue was assessed as being fit to share a cell, but it was noted that he had told staff that he would feel more comfortable in a single cell.

41. A nurse completed an initial health screen. Mr Donoghue told her he had had contact with community mental health services, although he said he was not taking medication. She noted that Mr Donoghue had recently taken an overdose, was tearful and expressed thoughts of self-harm. Mr Donoghue told her that he was upset at being recalled to prison and was worried about his father who was very ill and struggling to cope. She started ACCT procedures and referred him to the mental health team for further assessment. Despite a history of substance misuse, Mr Donoghue refused to be referred to the substance misuse team.

42. A Custodial Manager (CM) completed the ACCT immediate action plan and noted that Mr Donoghue's risk factors included the fear that his father may die. Mr Donoghue was given a phone call and told of the support available to him.

43. A nurse from the prison's substance misuse team, Turning Point, assessed Mr Donoghue. He told her that he had recently used "crack" cocaine and cannabis and had secreted diazepam (a tranquiliser), which he said he had taken since his arrest. He said that he had last used diazepam that morning in police custody, but he denied using PS. Mr Donoghue told her he had stomach cramps and was experiencing pain but did not allow her to assess him. She noted that Mr Donoghue was not under the influence of illicit substances and displayed no signs of alcohol withdrawal. She concluded that because Mr Donoghue had been in police custody for two days, there was no need for him to be given

alcohol withdrawal treatment. However, she noted that chlordiazepoxide, used to treat alcohol withdrawal symptoms, should be prescribed as needed and that he should be reviewed the following day.

44. On 29 November, an officer completed the ACCT assessment. She noted that Mr Donoghue was "very angry" about life and about the Probation Service recalling him to prison and his father being ill. Mr Donoghue said he wanted "to end it all" and that he had taken an overdose a few days earlier, knowing that he would be recalled. However, Mr Donoghue also talked about finishing his sentence and continuing with his business after release. He told her that he wanted to stay on the induction wing as there would be too much "drama" on the prison's main wing.

45. A healthcare assistant from the mental health team spoke to Mr Donoghue to gather information so that his needs could be considered at the next mental health team meeting. He noted that Mr Donoghue was restless and irritable. Mr Donoghue told him that he felt anxious and paranoid and needed his medication (but was unable to say what his medication was). He said that mental health services had not previously listened to him. The healthcare assistant told his colleagues that Mr Donoghue needed a further assessment. The assessment was not considered urgent and was scheduled for 5 December. (The mental health team have a target of assessing all referrals within five working days.)

46. That afternoon, a Supervising Officer (SO) chaired Mr Donoghue's first ACCT case review. A mental health nurse attended. An officer did not attend but told the SO about her earlier assessment of Mr Donoghue. The SO noted that Mr Donoghue answered questions honestly and openly but was frustrated that he had been recalled to prison as he felt he had done nothing wrong. The SO told Mr Donoghue he would ask his offender supervisor to speak to him to establish why he had been recalled. He said that Mr Donoghue would continue to be monitored under ACCT procedures until this had been done. An action to establish the reason for and length of Mr Donoghue's recall was identified in the risk reduction plan. It was later noted that Mr Donoghue would remain in the induction unit until his issues had been addressed.

47. A nurse later noted that Mr Donoghue had said he did not want to see the drug support service. He described them as "useless" and said that he did not think the mental health team would help him.

48. On 30 November, Mr Donoghue told an officer that he had been recalled to prison because of confusion about his housing. On 1 December, Mr Donoghue told another officer that his recall to prison was the Probation Service's responsibility, but that he was feeling okay and was mixing and talking with other prisoners. Mr Donoghue was given a further free telephone call to speak to his father. He was unable to make contact and said he would try the following day.

49. On 2 December, a governor gave approval for Mr Donoghue to remain on the induction wing as Mr Donoghue was worried about the possibility of being threatened by other prisoners on the prison's main wing. Leicester's transfer and allocation unit was asked to look at the possibility of transferring Mr Donoghue to another prison.

50. A prison offender manager met Mr Donoghue to complete a basic custody screen. At Mr Donoghue's request, she agreed to contact his community probation officer to clarify why he had been recalled to prison. He said that he had not been told that he had to live at the address that the Probation Service gave him. That afternoon, Mr Donoghue asked a prison offender manager to contact his community probation officer to ask why he had been recalled. The officer later emailed the prison offender manager to ask her to action the request. She did so on 3 December.

51. A worker from the substance misuse team invited Mr Donoghue to attend a welcome group on 7 December.

52. On 3 December, Mr Donoghue was given a warning for not attending education. That afternoon, he asked an officer for his new release date. He was moved into a shared cell after asking to share a cell with another prisoner from the Traveller community.

53. On 4 December, a SO chaired Mr Donoghue's second ACCT review. A nurse attended. The SO noted that Mr Donoghue was calm, polite and spoke openly. Mr Donoghue said that he would never kill himself because of the impact it would have on his family, that he felt supported by staff, was getting the help he needed and had a good support network around him. The SO told the investigator that Mr Donoghue was "gutted" at being recalled, was frustrated at not knowing why and blamed his offender manager for his situation.

54. The SO noted that the action on the risk reduction plan to establish the reason and length of Mr Donoghue's recall was complete. He noted that Mr Donoghue had no thoughts of self-harm and felt in control of his thoughts. He and the nurse agreed to end ACCT monitoring and a post-closure ACCT interview was scheduled for 11 December.

55. A resettlement worker met Mr Donoghue to discuss his resettlement plans. He told her that he was not happy at being recalled. He said he did not want to work with her and declined further support.

56. On 5 December, Mr Donoghue did not attend his mental health assessment with the learning disabilities nurse. He told officers that he no longer needed it. The nurse visited Mr Donoghue who told her that he did not want to be assessed. (She told the investigator that she could not recall the detail of her conversation with Mr Donoghue or why he did not want to be assessed.) Mr Donoghue also chose not to attend an appointment with the substance misuse team that day.

57. During the day a prisoner, who was Mr Donoghue's friend, arrived at Leicester. Mr Donoghue asked officers if the prisoner could share a cell with him. Officers agreed and the prisoner moved into Mr Donoghue's cell. The prisoner said that when he arrived on the wing, he saw Mr Donoghue smoking a joint which he believed contained 'Spice', a PS. The prisoner said that this was the only occasion that he saw Mr Donoghue take drugs at Leicester. The prisoner said that over the following days, Mr Donoghue appeared to be his "normal, happy-go-lucky self".

58. On 7 December, a worker told Mr Donoghue that if he did not want to attend the substance misuse group on the wing, she would meet him to discuss his concerns. Mr Donoghue agreed to meet her on 11 December.

59. On 8 December, the Church of England Chaplain spoke to Mr Donoghue because he was upset on learning of the death of another prisoner. She said Mr Donoghue was tearful and upset as he had known the prisoner, but that he expressed no thoughts of self-harm. She said that Mr Donoghue said that the death must have been a shock to the prisoner's family, and he would not like his family to go through that.

Events of 10 December

Use of force in the induction unit

60. The prisoner said that at around 11.20am on 10 December he and Mr Donoghue collected their lunch and returned to their cell, and after lunch he went to sleep. When he woke at around 1.30pm, he saw that Mr Donoghue had been sick. He believed Mr Donoghue had smoked PS because he could smell it and because of Mr Donoghue's presentation: he said Mr Donoghue's limbs were "stiff" and that his eyes were "all over the place".

61. The prisoner said he tried to clean Mr Donoghue up. A worker from the substance misuse team came to their cell door and asked if he wanted to take part in any courses. The prisoner said that he did not want the drug worker to see Mr Donoghue, so he blocked her view and spoke to her at the cell door. The prisoner said that after about 10 minutes, Mr Donoghue came round and became agitated, annoyed, aggressive and jumped up with "his fists clenched". The prisoner said that he tried to calm him down and when Ms Thomas walked back past the cell door, he asked her to let him leave the cell.

62. At 2.25pm, CCTV shows that a worker spoke to the prisoner through the cell's observation panel before asking an officer to unlock him. An officer unlocked the cell door, and the prisoner left the cell. Mr Donoghue followed immediately, and the officer can be seen trying to stop him. Mr Donoghue pushed past the officer and grappled with him, and the officer tried to hold him in a bear hug type hold. Mr Donoghue can be seen struggling with the officer. His arms appear to flail around, and he seems to be under the influence of drugs or alcohol.

63. Two officers and others ran to assist the officer, and two switched their body-worn video cameras (BWVCs) on. Mr Donoghue was taken to the floor and restrained and handcuffed, before being put back in his cell at 2.28pm. During the restraint, Mr Donoghue can be heard on the BWVC footage complaining to officers that the cuffs hurt and asking for them to be released. Custodial Manager (CM) A arrived during the restraint and can be heard on the BVWC telling the officers, "Let's have him on the fucking deck if he is not being compliant". Mr Donoghue told the officers he was being compliant. Officers then removed the restraints and he was told to sit on a chair at the back of the cell.

64. Mr Donoghue, who appeared to be under the influence of an unknown substance, told the officers that his actions were "nothing to do with you, lads", and then started to wave his arms in the air and complained that his wrists were

hurting. CM A told Mr Donoghue to put his hands down. Mr Donoghue complied with the instruction and as he did, he apparently touched the leg of one of the officers (although this cannot be seen on the BWVC). The CM can be heard saying in an aggressive tone," Don't touch my staff, do not touch my staff. You have already assaulted two members of my staff; you lay hands on another member of staff and I will restrain you, young man. Do you understand?" Mr Donoghue responded, "I understand, boss".

65. At 2.33pm Mr Donoghue rinsed his wrists in the sink while talking to staff. He appeared to be under the influence of drugs. When the officers asked him what had happened, Mr Donoghue said, "Don't listen … got sick as well … you won't believe it … I got poisoned … see there's a bag on the floor … see that bag … that was poison in that". His speech was slurred, and it is difficult to understand what he was saying. (CM A later confirmed that there was what appeared to be drug paraphernalia in the cell, which consisted of a small amount of a green leaf-type substance and a pipe, probably made from a pen.)

66. CM A told Mr Donoghue that he was going to be taken to the segregation unit in handcuffs (which had been authorised by the Head of Reducing Offending). Mr Donoghue complied with the instructions he was given and was taken out of the cell in cuffs. He can be heard asking if he could have his coffee and his vape "please".

Use of force in the segregation unit

67. Officers escorted Mr Donoghue to the segregation unit. He was compliant throughout. He arrived at the segregation unit at 2.37pm and was put in a cell before his handcuffs were removed. CM A told three officers to give Mr Donoghue a full search. (Full searches require the removal of a prisoner's clothing and are used routinely when a prisoner enter the segregation unit at Leicester to check for concealed drugs or weapons.)

68. Events in the cell were captured on CM A's BWVC. The footage shows that Mr Donoghue was compliant with staff instructions in the cell and that the handcuffs were removed. He can be heard saying he was "just messing about". The CM said, "I don't call assaulting two members of staff messing around". Mr Donoghue responded that he was not messing about with the staff but with "some of the lads" and told the officers, "I didn't assault you lads". His speech is slurred, and an officer asked him if he had been drinking or something and he said he had been taking medication.

69. Mr Donoghue complied with the officers' instructions to take his shirt off and put it back on. He was then asked to remove his shoes. CM A then left the cell briefly to call a nurse to come to examine Mr Donoghue. While he was out of the cell, officers restrained Mr Donoghue and took him to the floor. When he returned, the CM asked the officers if Mr Donoghue "just took a swing at you", and the officers confirmed that he had. The CM told the officers to continue the search under restraint. The camera was then covered (to protect Mr Donoghue's decency while the lower half of his body was searched) although it still recorded sound. The CM told the officers to part Mr Donoghue's legs to make sure he did not have any weapons. Mr Donoghue can be heard shouting and mumbling. At 2.43pm, the officers withdrew, leaving Mr Donoghue in the cell uncuffed.

70. The officers involved in the use of force in the segregation unit completed statements about what had happened (known as Annex As).

71. Officer A said in his statement that he explained the search procedure to Mr Donoghue and that Mr Donoghue then took a swing at him, so he restrained him and took him to the ground with the help of the other officers. He said Mr Donoghue was clearly under the influence of something and had used "a high level of violence" against other officers before he was taken to the segregation unit and was being "very aggressive and unpredictable" during the search. He said, when Mr Donoghue was on the ground, he remained non-compliant and was kicking his legs out. He then felt Mr Donoghue's teeth on his leg, so he used a defensive strike against Mr Donoghue's face to protect himself. (At the debrief he said Mr Donoghue had put his teeth on his leg but had not applied pressure.) They then completed the search and left the cell.

72. Two other officers both said in their statements that they knew Mr Donoghue from a previous sentence and that he had always been polite and respectful to staff and, apart from his use of PS, his behaviour had given no cause for concern. On this occasion he appeared to be under the influence of drugs or alcohol as he was swaying from side to side and slurring his speech. Officer B said he was a completely different person.

73. Both officers said that Mr Donoghue was initially compliant with their instructions during the search, but that when he was told to take his trousers off, he threw a punch at Officer A, which did not make contact, and was then taken to the floor and restrained. Officer C said that Mr Donoghue struggled and kicked out aggressively while on the floor and that he saw him "latch on" to Officer A's leg with his teeth, and Officer A gave him a defensive strike to the face with a closed fist. Officer B said that Officer A had to deliver a strike to Mr Donoghue as he was attempting to bite his leg. They then completed the search and left the cell. Both officers said that Mr Donoghue behaved bizarrely after the restraint, chanting, singing, laughing hysterically and crying his eyes out, and was still doing this when they gave him his meal an hour later.

2.45pm onwards

74. At 2.45pm, a nurse assessed Mr Donoghue after his restraint and transfer to the segregation unit. She said that Mr Donoghue "giggled" at her when she asked if he had any injuries and appeared to be under the influence of an unknown substance. Mr Donoghue refused to let her treat a minor injury to his face. She said she asked the officers to keep an eye on Mr Donoghue and that she later asked another nurse to check on him later that afternoon when she was due to dispense medication on the unit. (The nurse told the investigator that she could not recall this conversation with the first nurse.)

75. At 2.56pm, CCTV shows that Officer C looked briefly into Mr Donoghue's cell before walking away. He returned to the cell again at 3.14pm and briefly checked on Mr Donoghue and noted that he appeared asleep. At 3.31pm, he returned to Mr Donoghue's cell and spoke to him for around a minute before a nurse joined him and completed an initial segregation health screen. She noted that Mr Donoghue had not harmed himself during his current period of custody, did not appear acutely unwell or to be withdrawing from drugs. She assessed

that he could cope with a period of segregation, that no healthcare intervention was required and that there was no reason why Mr Donoghue should not be held in the segregation unit.

76. At 3.50pm, Officer A briefly checked on Mr Donoghue and Officer C checked again at 4.00pm.

77. At 4.11pm, the Head of Reducing Reoffending spoke to Mr Donoghue at his cell door. She said that Mr Donoghue was erratic, pacing up and down his cell. She said his speech was slurred and that it was not the Mr Donoghue "she knew". He told her that his cellmate had "spiked" his drink with drugs, which had made him feel strange and "out of his head" and that, as he was about to be sick, the cellmate had rung the cell bell to alert staff. Mr Donoghue said that when an officer unlocked the cell door, he tried to "go after" the cellmate and that he had had no issue with the officers, only with his cellmate. The Head of Reducing Reoffending signed the initial segregation health screen confirming there was no reason why Mr Donoghue should not be segregated and noted that she had spoken to him about being restrained.

78. At 4.34pm, segregation staff changed into personal protection equipment. Mr Donoghue's cell was unlocked, and he was given his evening meal, toiletries and a flask of hot water before he was locked back in his cell. Mr Donoghue told the officers that he "just wanted to beat the lads up on the wing and he attacked me, you twat", that staff had attacked him and that he had not taken any drugs. (As with much of the BWVC footage, the investigator was not fully able to understand what Mr Donoghue was saying.) Mr Donoghue told the officers that he was going "to get his head down".

79. Over the following hour, segregation unit officers either checked Mr Donoghue's cell or answered his cell bell on six occasions. Neither Mr Donoghue nor officers raised any concerns.

80. At around 5.33pm, the day shift officers left the segregation unit, leaving Officer D on her own. She checked Mr Donoghue's cell briefly at 6.01pm and again at 6.45pm and noted that he was lying on his bed and appeared asleep. She said on each of these occasions, Mr Donoghue's cell light was not on.

81. At around 7.40pm, Officer D went to collect Officer E, the night officer, from the prison gate. This took around ten minutes. As they walked back to the segregation unit, Officer D briefed Officer E about Mr Donoghue. When the officers returned to the wing around 10 minutes later and walked past Mr Donoghue's cell, Officer D said she noticed that the cell light was on and told Officer E that Mr Donoghue must be awake as he had been asleep previously and his cell light had not been on when she last checked him.

82. At around 7.52pm, Officer E checked Mr Donoghue during his roll check of the unit and saw him slumped at the back of the cell. He said he could just see Mr Donoghue's legs and did not see a ligature. He called out to Mr Donoghue and kicked the cell door but got no response. He shouted out to Officer D, who was in the office close by, and asked her to come to the cell. She arrived at the cell seconds later.

83. Officer D looked into the cell and saw that Mr Donoghue appeared to be sitting on the floor, but then saw that he was hanging from a ligature, made of bedsheets, tied to the end of his bed. She immediately went into the cell and cut the ligature from Mr Donoghue's neck. Officer E radioed a medical emergency code blue and asked for an ambulance to be called. (A code blue is used when a prisoner is unresponsive or having breathing difficulties and triggers an automatic request for an ambulance and for healthcare staff to attend). The officers checked for a pulse but could not find one and Officer E started cardiopulmonary resuscitation (CPR).

84. CM A arrived within a minute of the code blue being called. Two nurses arrived with an emergency response bag at around 7.57pm. The CM took over CPR from Officer E and the nurses attached a defibrillator, but it advised no shock. Officer E and the CM continued to give Mr Donoghue chest compressions until paramedics arrived at 8.06pm and took over resuscitation efforts. They established a heartbeat, and the CM and Officer E left the cell while paramedics stabilised Mr Donoghue's condition. At 8.58pm, he was taken by ambulance to the Leicester Royal Infirmary.

85. Mr Donoghue did not regain consciousness and he died at 10.10am on 14 December, with his family present.

Contact with Mr Donoghue's family

86. At 10.00pm on 10 December, the Governor of Leicester telephoned Mr Donoghue's next of kin to say that he had been admitted to hospital. Mr Donoghue's sister contacted the prison and his family arrived at the hospital to be with him in the early hours of 11 December. Staff met Mr Donoghue's family while he was in hospital. After Mr Donoghue's death, the prison contributed to funeral expenses in line with prison policy.

Support for prisoners and staff

87. CM A 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.

88. The prison posted notices informing other prisoners of Mr Donoghue's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Donoghue's death.

Post-mortem report

89. A post-mortem examination found that Mr Donoghue died from a hypoxic/ischaemic brain injury (lack of oxygen to the brain), following a period of cardiac arrest because he had applied a ligature around his neck.

90. The pathologist noted that he had recent blunt force injuries to the bridge of his nose, the right side of his forehead and his left chest wall. She said that these injuries could have resulted from impacts with objects or surfaces within the environment. She said the possibility that they were the result of blows from another individual could not be excluded.

91. The toxicological examination revealed the presence of synthetic cannabinoids (PS), together with medication that Mr Donoghue had been given in hospital. No alcohol or other illicit drugs were detected.

Findings

Management of risk of suicide and self-harm

92. Prison Service Instruction (PSI) 64/2011 on safer custody requires staff to start ACCT procedures when they receive information about a prisoner which may indicate that he is at risk of suicide or self-harm. Prison staff appropriately monitored Mr Donoghue under ACCT procedures when he arrived at Leicester. However, there were deficiencies in the way that they did so.

ACCT reviews

93. PSI 64/2011 states that ACCT reviews should be multidisciplinary, where possible. However, only two members of staff attended each of Mr Donoghue's ACCT reviews. Although his risk reduction plan had highlighted issues about his recall to prison, neither the prison offender manager nor anyone else was invited to attend or contribute to the second review, at the end of which the ACCT monitoring was stopped.

Risk reduction plan (care map)

94. PSI 64/2011 says that case managers must complete caremaps with actions aimed at reducing the risk of suicide and self-harm and reflect the prisoner's needs. At the first ACCT review on 29 November, an action was added to Mr Donoghue's risk reduction plan for his offender supervisor to speak to Mr Donoghue to establish the reasons for his recall to prison. Although a mental health nurse attended the review, Mr Donoghue's mental health assessment referral was not noted on the plan as it should have been.

95. At Mr Donoghue's second ACCT review, the action to clarify the reasons for his recall was marked as completed. This was not the case. In addition, when ACCT monitoring stopped, Mr Donoghue had not had a mental health assessment.

96. We consider that ACCT monitoring ended prematurely and should have continued until the reasons for Mr Donoghue's recall to prison had been established and explained to him and after his mental health had been assessed.

97. We make the following recommendation:

The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national instructions, ensuring that:

- **case reviews are multidisciplinary and include staff who have had previous contact with the individual, such as key workers or the ACCT assessor, where appropriate; and**
- **risk reduction plans are specific, meaningful, tailored to the individual to reduce their risk and completed before ACCT monitoring is stopped.**

Location in segregation unit during ACCT post-closure period

98. PSO 64/2011 and PSO 1700 on segregation state that prisoners being monitored under ACCT procedures should only be located in segregation units in exceptional circumstances as it heightens their vulnerability, and the alternative options considered must be clearly documented, together with the reasons they have been considered unsuitable.

99. We published a Learning Lessons Bulletin in June 2015 about the self-inflicted deaths of prisoners in segregation. We concluded that, all too often, prisoners at risk of suicide and self-harm were segregated without sufficient evidence that staff had considered other options or identified exceptional circumstances for them to remain in segregation. We noted that segregation reduces some protective factors against suicide and should only be used in exceptional circumstances for those at risk of taking their life.

100. PSI 64/2011 states that a post-closure review must take place within seven days of ACCT procedures ending. Mr Donoghue stopped being monitored under ACCT procedures on 4 December and his post-closure review was scheduled for 11 December. Mr Donoghue died before the review could take place.

101. As Mr Donoghue had just been restrained after apparently assaulting staff, we consider that the initial decision to segregate him on 10 December was not unreasonable. However, although the learning disabilities nurse and the Head of Reducing Reoffending asked whether Mr Donoghue was subject to ACCT procedures when they considered his fitness for segregation, neither sought clarification about whether he was in an ACCT post-closure period. We are concerned that no thought was given to re-starting ACCT procedures even though Mr Donoghue was in the ACCT post-closure period, had just been restrained and was thought to be under the influence of drugs.

102. If ACCT procedures had been re-started, as we consider they should have been, the Head of Reducing Reoffending would have had to consider whether there were exceptional circumstances that justified Mr Donoghue's continuing segregation. There should also have been an immediate enhanced ACCT review, and staff should have considered whether Mr Donoghue should be monitored more frequently than the standard once an hour that applies to all segregation unit prisoners at Leicester. We make the following recommendations:

The Governor should ensure that when a prisoner is segregated:

- **staff establish whether the prisoner is subject to ACCT procedures or in an ACCT post-closure period; and**

- **if so, they consider alternatives to segregation, hold an immediate ACCT review, and consider whether there are exceptional circumstances for continuing segregation.**

The Governor should share this report with the Head of Reducing Reoffending and discuss the Ombudsman's findings.

The Head of Healthcare should share this report with the learning disability nurse and discuss the Ombudsman's findings.

103. In response to concerns about the quality of ACCT procedures at Leicester, we have previously recommended that the Prison Group Director (PGD) for the East Midlands should assure himself that effective action is taken to implement PPO recommendations on managing the risk of suicide and self-harm at the prison. The PGD accepted our recommendation in August 2018. He said that the East Midlands Regional Safety Custody Lead would assess how the ACCT process was being managed at Leicester during bi-monthly visits, and that he would monitor subsequent action at his quarterly meetings with the Governor. We are, therefore, concerned to find failings in ACCT procedures in this case 16 months later. We make the following recommendation:

The Prison Group Director for East Midlands prisons should arrange a meeting with the Ombudsman to discuss continuing concerns about the quality of ACCT procedures at HMP Leicester.

Segregation Unit observations and staffing

104. Local policy requires all prisoners in the segregation unit at Leicester to be checked once an hour. Mr Donoghue was checked regularly from his arrival in the unit until 5.32pm. Officer D checked Mr Donoghue again at 6.01pm and for the last time at 6.45pm, when she noted that he was asleep in his cell. (She said she initially wrote 6.50pm in the segregation log, the time on the unit's clock, but amended the entry to the time on her watch, 6.45pm. She said she had used the time on her watch for her previous entries.) Mr Donoghue was not checked again until Officer E, the night shift officer, completed a roll check at around 7.52pm, more than an hour later, when he found Mr Donoghue with a ligature around his neck.

105. Although staff were required to carry out hourly observations, a check was not completed before 7.45pm, as it should have been.

106. At around 7.40pm Officer D left the segregation unit to collect Officer E from the prison's gate house. During this period, the segregation unit was left unstaffed for around ten minutes. Although we cannot be certain when Mr Donoghue tied the ligature, it is likely to have been shortly before he was found at 7.52pm, given that it was possible for paramedics to re-establish a heartbeat. He may, therefore, have tied it during the 10 minutes the segregation unit was left unstaffed.

107. There is nothing to suggest that Mr Donoghue tried to attract the attention of staff before he tied the ligature. We cannot therefore say that the outcome would have been any different for him if there had been staff in the unit. However, given the role of the segregation unit and the potential vulnerabilities of prisoners held in it, we do not consider that the unit should be left unstaffed, other than in an emergency. We make the following recommendation:

The Governor should ensure that:

- **officers carry out scheduled observations according to the levels set for prisoners in the segregation unit; and**

- **the segregation unit is not left unstaffed except in an emergency.**

Psychoactive Substances

108. It was clear to staff and is apparent from the CCTV and BWVC footage that Mr Donoghue was under the influence of drink or drugs on the afternoon of 10 December. The post-mortem report confirmed that he had used PS in the hours before he placed the ligature round his neck. Mr Donoghue said that his cellmate had spiked his drink with PS, while his cellmate said that Mr Donoghue had smoked it voluntarily. We cannot say what happened, but we note that Mr Donoghue had a history of using PS in prison.

109. Although the use of PS did not directly cause Mr Donoghue's death, it may have played a role in his decision to hang himself on 10 December. Staff who knew him said that his behaviour that day was out of character and that he was behaving bizarrely, alternately laughing and crying. We know that PS can have a negative effect on a person's mood and can precipitate or exacerbate mental health problems. It has also been linked to suicide and self-harm.

110. Following their January 2018 inspection, HMIP noted that PS remained a threat to stability at Leicester and that, although there were good initiatives to address the supply of drugs, they were not effective enough. HMIP made a recommendation to address this.

111. In April 2019, HMPPS published a National Drug Strategy, providing direction and detailed guidance to help prisons identify issues and share best practice. In response, Leicester updated their substance misuse policy in May 2019.

112. Despite this, Mr Donoghue apparently had no difficulty in obtaining and using PS in December 2019 without staff becoming aware. His death was one of five at Leicester in 2019 which were linked to substance misuse. Two of those deaths were of prisoners who had used PS in the hours before they took their own lives. We note that there have been no further drug-related deaths at the prison in the 10 months since Mr Donoghue's. We cannot say if this is due to the success of the prison's drug strategy or to the COVID-19 restrictions (which appear to have had the effect of reducing drug availability across the prison estate).

113. We are concerned that staff do not appear to have investigated Mr Donoghue's drug use. Officers at Leicester are expected to complete an intelligence report when prisoners are suspected of being under the influence of illicit substances.

114. CM A confirmed that he saw drug paraphernalia in Mr Donoghue's cell during the initial restraint and asked officers to remove the items as evidence. However, there is no record that this happened or that an investigation took place.

115. The Head of Reducing Reoffending said that when Mr Donoghue later told her that his drink had been spiked with drugs, she phoned the induction unit to ask for his cell to be searched. However, she said she was told that Mr Donoghue's cellmate had already been moved, that the cell had been cleared and that further action would be pointless. Given Mr Donoghue's presentation, the presence of drug paraphernalia in his cell and Mr Donoghue's comments to staff that he had been "poisoned" after pointing to a bag on the floor of the cell, we are concerned that staff did not remove the items as evidence and investigate what had happened.

116. Evidence of prisoners' use or supply of drugs must be recorded and reported to the prison's security department. Such intelligence is critical in identifying prisoners involved in prison drug culture and can support intelligence-led cell searches and drug testing.

117. We also note that soon after Mr Donoghue had arrived at Leicester, he told the nurse from the drug and alcohol services team that he had secreted diazepam. The nurse should have told reception officers and an intelligence report should have been submitted. However, no action was taken.

118. We make the following recommendation:

The Governor should ensure that:

- **all staff complete an intelligence report when a prisoner is suspected of substance misuse or of being involved in the prison's illicit drug culture; and**
- **the security department investigates where appropriate.**

The use of force

119. PSO 1600 on the use of force states that the use of force is justified and lawful only when it is reasonable in the circumstances, it is necessary, if no more force than is necessary is used, and if it is proportionate to the seriousness of the circumstances.

120. Mr Donoghue was restrained twice on the afternoon of 10 December. He did not suffer any serious injuries as a result and the restraints did not contribute directly to his death. They may, however, have played on his mind, particularly in combination with his use of PS, and we have therefore considered whether the use of force was reasonable, necessary and proportionate.

121. As far as the use of force in the induction unit is concerned, the CCTV shows Mr Donoghue appearing to lunge towards an officer Amiss. Whether or not he intended any harm, we are satisfied that it was not unreasonable for the officer to fear for his safety and to initiate the use of force. (We note in this context that Mr Donoghue's cellmate said that Mr Donoghue had become aggressive after using PS.) Having reviewed the CCTV and BWVC footage we are also satisfied that the officers used a necessary and reasonable level of force.

122. As far as the use of force in the segregation unit is concerned, we note that the CCTV and BWVC footage shows Mr Donoghue was compliant and polite when

he was escorted to the unit and during the first part of the full search. There is nothing to suggest that he was about to become aggressive and try to punch Officer A during CM A's brief absence from the cell with the BWVC. However, he had been flailing his arms about while under the influence of PS and people under the influence may behave in unpredictable and aggressive ways. In the absence of BWVC footage we cannot say what happened in the cell, but if Mr Donoghue did throw a punch, it would not have been unreasonable for Officer A to initiate the use of force. Similarly, if Mr Donoghue did attempt to bite Office A's leg, it would not have been unreasonable for the officer to have hit Mr Donoghue with a closed fist to defend himself. We note too that where the incident in the cell was captured on the BWVC, the officers were behaving in a calm and professional manner.

123. We are concerned, however, that Officer A's account of events in his Annex A statement differs in some respects from the accounts given by the other two officers and also from what can be seen on the BWVC. The other officers described Mr Donoghue as being compliant with the search of the top part of his body (which is borne out by the BWVC footage) and only taking a swing at Officer A when he was asked to remove his trousers. Officer A, however, did not mention that Mr Donoghue had originally complied with the search, and said that Mr Donoghue took a swing at him after he explained the full search procedure to him and that prior to this his behaviour had been aggressive and unpredictable. While we understand that it may be difficult to remember events clearly in the heat of the moment, it is important that Annex A statements are completed as accurately as possible. We also note that the pathologist could not rule out the possibility that the bruises to Mr Donoghue's chest were caused by blows.

124. We are concerned that CM A used language that we do not consider appropriate during the two restraints. We recognise that an unplanned use of force on a prisoner, where the safety of officers and others might be at risk, is a stressful situation. However, the CM was not personally involved in restraining Mr Donoghue and, as a custodial manager, we would expect him to remain calm and objective, to attempt to de-escalate the situation and to set an example of appropriate behaviour to more junior staff who were physically involved in the restraints. We consider that some of his language did not do this on 10 December. We recommend:

The Governor should commission an investigation into the use of force in the segregation unit on 10 December 2019 and the injuries Mr Donoghue sustained.

The Governor should share this report with Custodial Manager A and discuss the Ombudsman's findings.

Clinical care

125. Mr Donoghue had multiple contacts with the healthcare team, including primary care, mental health and the substance misuse services. The clinical reviewer concluded that the care that Mr Donoghue received at Leicester was of a good standard and was equivalent to the care that he could have expected to receive in the community.

126. The clinical reviewer did, however, note that the ACCT process was inappropriately closed before Mr Donoghue had had a mental health assessment, even though a mental health nurse was present at the ACCT review.

127. The clinical reviewer also noted that the ambulance paramedics and the air ambulance doctor who treated Mr Donoghue on 10 December had commented that the CPR by prison staff was of a high quality.

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