Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Taylor, a prisoner at HMP/YOI Doncaster, on 16 August 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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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 John Taylor died from the toxic effects of psychoactive substances (PS) on 16 August 2020, at HMP Doncaster. He was due to be released the next day. He was 35 years old. I offer my condolences to Mr Taylor's family and friends.

Mr Taylor had a long history of drug misuse and he continued to use drugs at Doncaster. In July and August 2020, there were four occasions when staff suspected that Mr Taylor was under the influence of drugs, including one occasion just over a week before he died, when he was found fitting on the floor of his cell.

I am concerned at the apparent ease with which Mr Taylor, and many others, obtained drugs at Doncaster. On the same day as Mr Taylor's death, there were multiple emergency incidents linked to drugs on his wing.

I am aware that Doncaster has taken steps to tackle the supply of drugs into the prison. However, this investigation has shown that more needs to be done to ensure that information about drug use is shared with the relevant staff. This would ensure that the extent of drug use across the prison is known, which can then inform the drug strategy.

I am pleased to note that Doncaster continued to provide the key worker scheme during the COVID-19 pandemic. However, while Mr Taylor continued to have contact with his key worker, there was little evidence of any meaningful engagement. I have made repeated recommendations to Doncaster about the effectiveness of its key worker scheme.

My investigation also found that the prison needs to improve the support provided to staff following traumatic incidents.

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

Sue McAllister CB
Prisons and Probation Ombudsman **October 2021**

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Summary

Events

1. Mr John Taylor was remanded in prison custody on 17 February 2020, charged with assault, and sent to HMP Doncaster. He was subsequently sentenced to one year's imprisonment and was due to be released on 17 August.

2. Mr Taylor had a history of drug misuse in the community and continued to use drugs at Doncaster. In July and August, Mr Taylor was suspected of being under the influence of drugs on four occasions. He told staff he was being bullied for money and they suspected he had built up drug debts which he could not afford to pay. He was assaulted on one occasion. Staff moved him several times.

3. On 5 August, staff found Mr Taylor fitting on his cell floor. Healthcare staff attended and thought Mr Taylor had taken psychoactive substances (PS). He recovered after being attended to by healthcare staff.

4. On the morning of 16 August, Mr Taylor made several telephone calls to a family member asking them to put money into an unknown person's bank account.

5. At about 2.00pm, Mr Taylor came out of his cell very briefly before being locked in by a prison officer. That was the last time a member of staff saw him alive. During the afternoon, other prisoners repeatedly gathered outside his cell door to look in and retreated whenever an officer appeared.

6. At around 4.00pm, an officer opened Mr Taylor's door so that he could collect his medication and found him slumped over a chair. The officer called a medical emergency code and several officers and healthcare staff attended. However, neither they nor the ambulance staff who arrived about 15 minutes later, were able to resuscitate Mr Taylor, who was pronounced dead at 4.40pm.

7. Later that day, there were several more medical emergencies on the same wing, all thought to be as a result of prisoners taking drugs.

8. A post-mortem examination and toxicology tests showed that Mr Taylor died from the toxic effects of PS.

Findings

9. The clinical reviewer concluded that the standard of Mr Taylor's clinical care at Doncaster, including his substance misuse treatment, was equivalent to that which he could have expected to receive in the community.

10. There were reports that prisoners had told staff that Mr Taylor was unwell on the afternoon of 16 August, and that staff ignored their concerns. We were not able to establish whether staff were aware that Mr Taylor was unwell. However, we cannot rule out the possibility that staff did not respond to the prisoners' concerns because Mr Taylor was frequently under the influence and drug use was common on Mr Taylor's wing.

11. Illicit drugs were far too readily available to Mr Taylor at Doncaster. We are aware that Doncaster has since taken steps to try to tackle the supply of drugs

into the prison. However, we are concerned that information about prisoners' drug use is not being shared, which means that the prison is not aware of the scope of the problem.

12. Doncaster continued operating the key worker scheme in challenging circumstances during the COVID-19 pandemic. However, there is little evidence that Mr Taylor's key worker provided him with meaningful support.

13. The prison needs to provide proper support to staff following traumatic incidents, which should include repeated medical emergencies.

Recommendations

- The Director and Head of Healthcare should ensure that information about suspected substance misuse is shared between prison and healthcare staff and intelligence reports are submitted where appropriate.
- The Director should ensure that managers encourage officers to identify and record signs of possible drug taking and bullying.
- The Director should ensure that all serious incidents, including code blues, are recorded in a prisoner's NOMIS record.
- The Director should ensure that key workers:
  - consult NOMIS notes before key worker sessions so that they have up-to-date information on the prisoner;
  - update NOMIS with the key issues following key worker sessions; and
  - provide meaningful support to prisoners.
- The Director should share this report with PCO A and arrange for a senior manager to discuss the Ombudsman's findings with her.

- The Director and Head of Healthcare should ensure that:
  - all prison and healthcare staff involved in a fatal incident are invited to a hot debrief and are offered support; and
  - all prison and healthcare staff involved in traumatic non-fatal incidents, such as serious code blue incidents, are offered support.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact him. The investigator received correspondence from two prisoners.

15. The investigator obtained copies of relevant extracts from Mr Taylor's prison and medical records.

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

    The investigator and the clinical reviewer jointly interviewed 15 members of staff between 26 October and 11 November 2020. Due to restrictions in place during the COVID-19 pandemic, all interviews were conducted by telephone.

17. The investigator listened to the telephone calls that Mr Taylor made in the days before his death. He was not able to view the CCTV footage in person but he obtained details from the police of the events shown on CCTV leading up to Mr Taylor's death.

18. 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.

19. The PPO's family liaison officer contacted Mr Taylor's parents to explain the investigation and ask if they had any matters they wanted us to consider. They did not have any questions but asked for a copy of the report.

20. The initial report was shared with Mr Taylor's mother and his father's solicitors. They did not make any comments.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies, but in consultation with the PPO, the second listed recommendation was amended to make it more specific in relation to prison officer actions. Their action plan is annexed to this final report.

Background Information

HMP Doncaster

22. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 prisoners who have been remanded in custody or sentenced. The Practice Plus Group provides clinical services.

HM Inspectorate of Prisons

23. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Doncaster in September 2019. They noted that the prison was busy and complex with a transient population. Inspectors acknowledged that much good work had been done to reduce the availability of drugs in the prison and said there was a reasonably good drugs strategy and action plan. However, they found that 61% of prisoners told them it was easy to get hold of drugs. They also found that too many prisoners did not have any meaningful activity which they said was a dangerous combination with the ready availability of drugs.

Independent Monitoring Board

24. 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. Their latest annual report for the year to 30 September 2019 expressed concerns about the loss of experienced prison staff and too high a proportion of inexperienced staff. They were also concerned that not all the mental health needs of prisoners were being met. However, they noted positive examples of planning with community services to help prisoners on release who had high risk of drug use and other chaotic behaviours. The report found the quality of healthcare to be good and responses to emergency incidents was one of the areas of good practice they highlighted.

Previous deaths at HMP Doncaster

25. Mr Taylor was the 16th prisoner to die at Doncaster since August 2018. Nine of the previous deaths were self-inflicted and six were from natural causes. We raised concerns about the effectiveness of the key worker scheme at Doncaster in three of those cases. We have also made recommendations previously about Doncaster's drug strategy.

26. In January 2021, we asked the HMPPS Executive Director for Custodial Contracts to write to the Ombudsman to set out the actions he intended to take to address her concerns. He said in response that he had served an Improvement Notice against Serco. He said that he was considering the findings and recommendations of a review of progress against the Improvement Notice and would write again when he had done that. The Ombudsman received an update in July. A review that took place in June found that Serco had achieved improvements in several key areas and were meeting minimum requirements. As a result, the Outstanding Issues Notice at Doncaster was lifted on 9 July. However, HMPPS will continue to monitor Serco's progress on the improvements made and the areas where they consider there is progress still to be made.

Assessment, Care in Custody and Teamwork (ACCT)

27. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Psychoactive substances (PS)

28. PS, formerly known as 'new psychoactive substances' or 'legal highs', are a serious problem across the prison estate. They are difficult to detect and can affect people in 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. There is emerging evidence to link PS use to endangering physical health, precipitating or exacerbating the deterioration of mental health and the risk of suicide or self-harm.

29. 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 staff and prisoners to be more aware 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.

Key worker scheme

30. The key worker scheme 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 scheme 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

Background

31. On 17 February 2020, Mr John Taylor was remanded in prison custody, charged with assault, and sent to HMP Doncaster. He was subsequently sentenced to one year's imprisonment.

32. Mr Taylor had a long history of illicit drug use, including crack cocaine, heroin and psychoactive substances (PS – often referred to as 'Spice'). He had been receiving methadone (opiate substitute) treatment in the community which continued at Doncaster.

33. On 18 February, Mr Taylor had paint thrown over his face. Mr Taylor said he had been threatened, but did not disclose what the reason was. He was moved to a different wing.

34. On 20 February, a prisoner in a cell near to Mr Taylor's, took his own life. At post-mortem, that prisoner was found to have taken PS before he died. Mr Taylor said that he was a close friend he had known since the age of six. Mr Taylor had a history of anxiety and depression and following this incident, staff supported him using suicide and self-harm procedures (known as ACCT), and referred him for a psychiatric assessment.

35. On 27 February, the prison's consultant psychiatrist, saw Mr Taylor and prescribed medication to help him with his distress. Staff closed his ACCT on 6 March. Mr Taylor had a follow up mental health appointment on 11 March, and was much more settled at that point.

36. On 7 April, staff started ACCT monitoring again after Mr Taylor attended the medication hatch with a self-inflicted wound on his arm. Mr Taylor had a history of self-harm by cutting. He said that he was unhappy with the reduction in some of his medication since coming to prison, including his methadone dose. The prison's consultant psychiatrist increased Mr Taylor's antidepressant medication. Staff closed his ACCT on 14 April.

37. On 4 May, Mr Taylor flooded his cell and water overflowed onto the landing. He said it was due to his vulnerabilities on the wing, but nothing more is known about the incident or whether he was trying to get a wing move.

38. On 7 July, when Mr Taylor attended the medication hatch, he had slurred speech, was unsteady on his feet, had bloodshot eyes and enlarged pupils. These signs were consistent with him having taken an illicit substance and the dispenser therefore refused to give him his prescribed medications (because of the risk of combining them with illicit drugs).

39. On 15 July and 22 July, Mr Taylor again appeared to be under the influence of an illicit substance when he went to collect his medication. On 21 July, Mr Taylor damaged his cell and flooded the landing. Nothing is recorded about his motive for doing this.

40. On 23 July, Mr Taylor told prison staff that he was being bullied for money and had been struck on the head the previous day, as well as being threatened in the

showers. Staff received information that Mr Taylor had drug debts that he was unable to pay. He said that he was feeling suicidal and was scared to leave his cell. Staff moved him to a different wing, but the following day he said that he was getting threatened in his new location and asked for a further move.

41. On 26 July, Mr Taylor was assaulted in the exercise yard. He had some swelling to his face but did not need to have any medical treatment.

42. The following day, staff started ACCT monitoring after Mr Taylor said he would take his own life if the bullying, beatings and extortion of money from him was not addressed. He also had input from Prison Custody Officer (PCO) B, the Violence Reduction Coordinator, who visited him several times in his capacity as a victim. He said he would be at risk on many of the standard residential wings in the prison.

43. On 28 July, Mr Taylor was moved to the Early Days Centre (EDC), the induction wing, where he was due to remain until his release from prison on 17 August. Although this was an unusual move, staff thought he would be safe there. Staff closed his ACCT the next day.

44. On 5 August, officers called a code blue (a medical emergency code) when they found Mr Taylor on his cell floor. He appeared to be having a fit and was frothing at the mouth and not responding although he was conscious. Healthcare staff attended and thought he was under the influence of PS, but as a precaution gave him naloxone (a medicine that rapidly reverses an opioid overdose), as well as oxygen. Staff stayed with him until he recovered and he did not need to go to hospital.

45. Mr Taylor was once again thought by healthcare staff to be under the influence of illicit drugs on the evening of 9 August.

46. On the morning of 15 August, Mr Taylor terminated a telephone conversation to his father because he said that there were sniffer dogs nearby and he had a stash of drugs in his bed. Shortly afterwards he called back and was laughing because he said the dogs did not detect his drugs.

Events on 16 August

47. Between 8.57 and 9.19am, Mr Taylor made several phone calls to his mother, saying that he needed some money to be put into the same account as on previous occasions. (He said that this was for a retaliatory beating, but in the light of events, it seems that it may have been for the purchase of drugs.) His mother initially refused, but eventually agreed to pay the money.

48. CCTV shows that shortly before 2.00pm an officer unlocked Mr Taylor's cell. In a period of about three and a half minutes, Mr Taylor wandered around apparently looking for someone or something. He spoke briefly to a couple of prisoners, and he went to the showers and into another prisoner's cell, both for only a few seconds, before asking an officer to lock him back in his cell.

49. Over the next two hours a group of prisoners looked into Mr Taylor's cell on many occasions. They seemed keen not to draw attention to whatever was going on inside as they always moved away when an officer appeared on the

wing. At around 3.55pm, the prisoners appeared to be trying to get Mr Taylor's attention from outside the cell and one of them kicked the cell door. Shortly after this, there were officers in the vicinity, but they appeared unaware of any problem.

50. At around 4.07pm, PCO B unlocked Mr Taylor's cell, and found him slumped over a chair. She alerted a colleague who called a code blue immediately. Additional prison staff were quickly on the scene and they started cardiopulmonary resuscitation (CPR) in the cell. Healthcare staff were with Mr Taylor very soon afterwards and arrived as officers were moving Mr Taylor outside the cell door, where there was more space to perform CPR. Ambulance crew arrived on the wing about 15 minutes after the code blue was called.

51. Neither staff nor ambulance paramedics were able to resuscitate Mr Taylor and he was declared dead at 4.40pm.

52. At around 5.30pm, there was another code blue on the EDC, the first of five on the EDC that evening as well as two others elsewhere on the houseblock. The vast majority of these, if not all, were thought to be linked to PS. None ended in fatalities.

Contact with Mr Taylor's family

53. An officer was appointed as the prison's family liaison officer (FLO), and she contacted Mr Taylor's nominated next of kin, his father, very shortly after he died. After appropriate checks by the prison, Mr Taylor's mother was added as a joint next of kin and included in all communications.

54. Doncaster contributed to the costs of Mr Taylor's funeral in line with national policy.

Support for prisoners and staff

55. A welfare check was carried out on all the prisoners on the wing after Mr Taylor's death. This was both to offer support and to encourage prisoners to hand over any illicit drugs. As a result of the welfare check, several prisoners were found to be under the influence of illicit drugs. All recovered.

56. The prison posted notices informing staff and prisoners of Mr Taylor's death, and offering support.

57. A hot debrief was held for staff by the Assistant Director (AD).

Post-mortem report

58. Toxicology tests showed that Mr Taylor had taken PS before he died. The pathologist gave Mr Taylor's cause of death as 'Spice' (PS) toxicity.

Findings

Clinical care

59. The clinical reviewer concluded that overall, the clinical care given to Mr Taylor was equivalent to that he could have expected to have received in the community.

60. Mr Taylor was on a substance misuse programme while he was at Doncaster, and his methadone prescription was reduced progressively while there. He was regularly reviewed by the Substance Misuse Service team and the clinical reviewer concluded that Mr Taylor's substance misuse programme at Doncaster was appropriate and equivalent to that which he could have expected to receive in the community.

Staff awareness of Mr Taylor's condition on 16 August

61. Mr Taylor's mother told the prison FLO that she had heard that prisoners had told an officer that her son was in a bad way on the afternoon of 16 August, but had been ignored. Prisoners had said that the officer's response was that Mr Taylor would be 'off his head like everyone else on the EDC'.

62. The PPO investigator received two letters from prisoners which made very similar allegations about staff not responding when they were told that Mr Taylor was unwell. The PPO investigator also saw a complaint from a prisoner, who had lost his job following the incident. He said that prisoners had been unfairly held responsible for Mr Taylor's death for not alerting staff in time. He said PCO B was the officer that he had informed about Mr Taylor's condition.

63. Both prisoners said they did not want to be interviewed while in prison and it was not, therefore, possible to follow up these comments with them. However, the investigator did put these allegations to staff at interview.

64. None of the interviewed staff said they had any direct knowledge about this. However, one interviewee said they had heard that prisoners had alerted a prison officer about Mr Taylor. Another said that, after Mr Taylor's death, a female prison officer had said she had noticed prisoners going up to Mr Taylor's door and giggling and that she 'kind of suspected something was happening'.

65. If a prisoner told an officer that they were worried about Mr Taylor, it is not evident from the CCTV of the wing. A prisoner wrote that it was difficult to alert staff about Mr Taylor's condition because of the risk of being seen as a 'grass'. Therefore, if attempts were made to let staff know what was happening, they may well not have been very explicit.

66. From the information available, it is not possible for us to say whether a member of staff was told that Mr Taylor was unwell. However, both staff and prisoners told us how common drug related incidents were at Doncaster at that time. We cannot rule out the possibility that staff were made aware that Mr Taylor was unwell after taking drugs and that they took no action on the basis that drug taking by Mr Taylor, and by prisoners on the wing generally, was a common occurrence.

Illicit drug availability at Doncaster

67. The most recent HMIP report in 2019 commented on the easy availability of drugs at Doncaster and the dangerous combination of that with a lack of meaningful activity for prisoners, a factor likely to have been made worse by the COVID-19 pandemic and loss of normal activities in the prison.

Local drugs strategy

68. In March 2019, Doncaster created a new role of Drugs Strategy Manager. The HMPPS National Drug Strategy was published in April 2019, providing detailed guidance for prisons to help them identify issues and share best practice. In line with this, Doncaster's Substance Misuse Strategy was revised in July 2019. We were told it is reviewed annually, the last time before Mr Taylor's death being June 2020.

69. At interview, the Drugs Strategy Manager said that there is a monthly drugs strategy meeting held at the prison, which has representation from across the prison as well as representation from community services. These meetings, which have continued throughout the COVID-19 pandemic, focus on restricting supply, reducing demand and building recovery. At interview, the Security Manager said there are now additional enhancements to the drugs strategy to reduce supply. These include placing all prisoners coming into prison on licence recalls into prison issue clothing, and subjecting all their clothing and possessions to checks by a drugs dog and the Rapiscan machine (a special device for detecting drugs).

70. Doncaster continue to make efforts to challenge the availability and demand of PS. In an update from Doncaster in July 2021, we were told that the prison has bolstered their fight against illicit substances getting into the prison through the following measures:

- Since the beginning of February 2021, a body scanner has been in place in reception which helps to prevent prisoners bringing drugs into the prison.
- Additional personnel have been added to the Dedicated Search Team (DST).
- Additional resources have been added to the Security team to manage corruption.
- There have been increased drug operations with external police support.
- A reconfiguration of residential areas will enable a drug stabilisation and rehabilitation unit to be established.
- The drugs strategy has been revised with a renewed emphasis to address key issues and risks within Doncaster.

71. Mr Taylor died during a challenging period for staff during the COVID-19 pandemic, which also meant it was not possible to conduct the normal drug tests on prisoners. But it is a concern that Mr Taylor was so easily able to obtain PS on repeated occasions.

72. In the light of the ongoing work, we do not make a recommendation about reducing the drug supply at Doncaster, although the Director will clearly need to ensure that the momentum and focus continue.

Sharing information about drug use

73. We are concerned that information about Mr Taylor's drug use was either not shared or was not sought out.

74. At interview, some staff who worked in the EDC said they knew about his drug taking. Others said they were not aware that Mr Taylor used drugs, although they knew he did not want to mix with other prisoners and generally asked to be taken to the medication hatch last and to be locked in his cell early during association. Since drug debts would have been the most obvious reason for this behaviour, we find it worrying that they did not show more curiosity about this. We recommend:

    The Director should ensure that managers encourage officers to identify and record signs of possible drug taking and bullying.

75. We are also concerned that staff would not have been able to find out much about Mr Taylor's drug taking from looking at his NOMIS prison record. There were several occasions when healthcare staff recorded in Mr Taylor's clinical record that they suspected he was under the influence of illicit drugs, but where these incidents do not appear in his NOMIS or his intelligence record. This means that anyone relying on either of these information sources about his suspected involvement with illicit drugs, would not get a full picture.

76. We also note that several of the code blue incidents that occurred on 16 August after Mr Taylor's death were not recorded in the NOMIS records of those prisoners.

77. It is a concern that serious incidents are not recorded on NOMIS for the benefit of other staff, including key workers.

78. Although Doncaster's substance misuse strategy mentions collaborative working between the healthcare provider and the prison, there is clearly scope for greater sharing of information between prison staff and healthcare staff and between prison staff and each other.

79. The large number of incidents requiring healthcare intervention that day, shows how widespread access to drugs was on the EDC. There have also been two further deaths since Mr Taylor's involving illicit drugs. We therefore recommend:

    The Director should ensure that staff record all serious incidents, including code blues, in a prisoner's NOMIS record.

    The Director and Head of Healthcare should ensure that information about suspected substance misuse is shared between prison and healthcare staff and intelligence reports are submitted where appropriate.

Key worker scheme

80. Doncaster continued to run the key worker scheme for priority prisoners throughout the COVID-19 pandemic.

81. Key workers are expected to get to know their prisoners and their concerns and needs well. We would therefore expect that a key worker would talk to other staff on the prisoner's wing and look at the input from other staff recorded in a prisoner's NOMIS record, so that they have a full picture about them before they have their key working discussions.

82. After moving to the EDC at the end of July, Mr Taylor had his first session with his new key worker (PCO A) on 7 August. She recorded that he felt safe and had no immediate concerns. There is no evidence that she had any discussion with him about the code blue incident recorded in his NOMIS notes which had happened two days earlier. The same day Mr Taylor spoke to a mental health professional and complained of low mood and said his mental health was deteriorating. At interview, PCO A said that Mr Taylor did not mention this in the key worker session.

83. After Mr Taylor's next key worker session on 12 August, PCO A again recorded that he felt safe and had no immediate concerns. Her very brief NOMIS record was almost word for word the same as her previous entry. She did not refer to the NOMIS entry immediately before hers where Mr Taylor's Offender Supervisor had recorded on 10 August that Mr Taylor was worried as one of his bullies was now on the same wing as him.

84. At interview PCO A said that because of constraints on time, she would not normally look through the NOMIS notes before a key worker session unless she was aware of particular issues. In Mr Taylor's case, he was new to the wing, but was also not expected to stay there for long as he was due for release on 17 August.

85. We are concerned that Mr Taylor came to the EDC on an ACCT and clearly had issues with drugs and bullying, and that his key worker sessions were too light touch to be meaningful. We do not suggest that this affected the outcome for Mr Taylor, but it may make a critical difference in other cases.

86. It is also a concern if key workers are not consulting a prisoner's record to inform their discussions with them. We make the following recommendations:

    The Director should ensure that key workers:

    - **consult NOMIS notes before key worker sessions so that they have up-to-date information on the prisoner;**
    - **update NOMIS with the key issues following each key worker session; and**
    - **provide meaningful support to prisoners.**

The Director should share this report with PCO A and arrange for a senior manager to discuss the Ombudsman's findings with her.

Post-incident support

87. Staff said at interview that code blues at Doncaster were extremely common and were predominantly linked to drugs. They described 16 August as a particularly stressful day, and some said it was the worst they had ever experienced. Both healthcare and prison staff said resources were stretched to the limits with multiple drug incidents the day of Mr Taylor's death. With each successive code blue, staff feared the worst as they encountered prisoners in various states of consciousness.

88. A hot debrief was held after Mr Taylor's death by the AD. One of the healthcare staff who attended said the debrief was excellent, but said that they had no follow up support from the healthcare provider.

89. We also note that both PCO B (who was the officer who unlocked Mr Taylor's cell and discovered him) and PCO C (who was the third officer to attend the incident) were not listed as attending the debrief. PCO C said he was told he was not needed at the debrief because he was not first on the scene.

90. In response to a query about this by the investigator, the AD said:

> "As the de-brief is intended to be attended by staff who were directly involved with the incident which has occurred due to the need to remain focussed on the specific incident with those identified staff. For this incident, I requested the staff who had direct and initial dealings with Mr Taylor. Everyone identified to me, who fits into that category attended my de-brief."

He added that managers on the unit would have followed up with support for the other staff. But it is not clear why PCOs B and C were not identified as relevant to the debrief.

91. Although some staff thought they had been sufficiently supported after the incident, and other staff mentioned good mutual support and team working, some staff said there had been a lack of follow up support, and it was clear from our interviews that some individuals could have benefitted from more follow up.

92. Because there was so much activity on the wing that evening, which also straddled shifts, and involved staff from other areas of the prison, it is possible that some follow up support was overlooked.

93. The effects on staff of an incident like that involving Mr Taylor are not always immediate. We therefore consider that even if individuals were missed on the day, there should have been subsequent follow up, particularly in this case with the additional stress on staff from the many other code blue incidents that evening.

94. We would not expect staff to be debriefed or offered support after every non-fatal incident. However, there were prison staff involved in the other code blues, who were all in a highly stressful situation, both because of the knowledge of what had happened to Mr Taylor and the number of incidents they were faced with.

From interviews, we know that at least one member of staff received no follow up. Although they said that they did not expect anything, we consider it would have been appropriate to consider offering support in this situation.

We recommend that:

The Director and Head of Healthcare should ensure that:

- **all prison and healthcare staff involved in a fatal incident are invited to a hot debrief and are offered support;**
- **all prison and healthcare staff involved in traumatic non-fatal incidents, such as serious code blue incidents, are offered support.**

Prisons & Probation Ombudsman
Independent Investigations

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