Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nathan Webster, a prisoner at HMP Doncaster, on 24 July 2019

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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

I carry out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Nathan Webster died on 24 July 2019, after being found hanged in his cell at HMP Doncaster. He was 26 years old. I offer my condolences to Mr Webster's family and friends.

Mr Webster had previously been at HMP Hull and transferred to Doncaster six weeks before he died. He had a significant history of illicit drug use and was frequently found under the influence of drugs, particularly psychoactive substances (PS), at Hull.

He received support from the substance misuse service at Hull and from January to April 2019, he said he was drug-free and felt positive about the future. However, he then began using drugs again. His behaviour deteriorated, he said he felt at risk from other prisoners and staff and he put nooses round his neck and started dirty protests and cell fires. Staff were concerned about his mental health.

He was, appropriately, monitored under suicide and self-harm prevention procedures (known as ACCT) during his last few weeks at Hull, but our investigation found that the management of these procedures and the assessment of his risk to himself was poor. I am also concerned that staff at Doncaster did not assess Mr Webster's risk to himself after his partner raised concerns with healthcare staff that his mental health was deteriorating.

The investigation also found there were significant deficiencies in the mental health care that Mr Webster received at both Hull and Doncaster. Although he was referred for a mental health assessment at Hull, this did not take place and the assessment carried out at Doncaster was not of the required standard and did not result in sufficiently urgent mental health care.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **September 2020**

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Summary

Events

1. Mr Nathan Webster had a significant history of illicit drug use. In 2015, he was sentenced to 54 months in prison. He was released from HMP Hull on licence on 20 March 2018.

2. On 1 May 2018, Mr Webster was recalled to custody at HMP Lincoln for breaching his licence conditions due to drug use. While at Lincoln, Mr Webster was monitored under suicide and self-harm procedures (ACCT) from 9 May to 16 May, as he had made a ligature but had not used it.

3. On 25 May, Mr Webster was transferred to HMP Stocken. On 12 October, a quantity of 'hooch' (illicitly brewed alcohol) was found in his cell. On 24 October, Mr Webster set a fire in his cell and was moved to the segregation unit.

4. On 30 November, Mr Webster transferred to HMP Hull. While at Hull there were several instances of Mr Webster being under the influence of an illicit substance. From January 2019, Mr Webster received ongoing support from the substance misuse service and he said he was no longer using drugs and was feeling positive about the future. However, from April onwards he started to use drugs again.

5. On 8 May, Mr Webster started a dirty protest, saying he did not feel safe on the wing and wanted a transfer. On 24 May, ACCT monitoring was started as Mr Webster had made a ligature. The ACCT was closed on 25 May and re-opened on 26 May after Mr Webster made another ligature and jumped on the netting.

6. On 26 May, Mr Webster was referred for a mental health assessment but this did not take place before he left Hull.

7. On 27 May, Mr Webster started a dirty protest, saying he thought staff wanted to harm him and he wanted a transfer to another prison. He was moved to the segregation unit. The ACCT was closed on 29 May.

8. On 3 June Mr Webster was again found with a noose round his neck and an ACCT was opened. The ACCT was closed on 7 June, as Mr Webster's risk was assessed to be low as he was going to be transferred to another prison.

9. On 14 June, Mr Webster transferred from Hull to HMP Doncaster, and was referred by the nurse in reception for a mental health assessment.

10. On 18 June, Mr Webster's partner contacted healthcare staff at Doncaster as she was concerned about Mr Webster's wellbeing due to his deteriorating mental health.

11. On 27 June, a mental health nurse assessed Mr Webster's mental health. The nurse recorded a diagnosis of paranoia, referred Mr Webster to the psychiatrist and recorded that an ACCT should be opened if necessary. Mr Webster was not seen again by healthcare staff before his death.

12. On 24 July, at 8.21am, an officer found Mr Webster hanged in his cell. She called an emergency medical code, an ambulance was called and officers and nurses responded and began cardiopulmonary resuscitation. The on-site paramedics arrived at 8.24am, and at 8.33am, they pronounced Mr Webster dead.

Findings

Management of risk of suicide and self-harm

13. Mr Webster was appropriately monitored under ACCT procedures at Hull. However, we consider that Mr Webster's risk to himself was not adequately assessed. Staff did not give sufficient weight to Mr Webster's significant risk factors. In particular, he was found with a ligature on three separate occasions in eleven days, along with a deterioration in his mental health.

14. We also found that ACCT procedures at Hull were not conducted in line with mandatory national instructions. The ACCT was closed, re-opened and closed again within the space of ten days, despite an outstanding mental health assessment and in advance of a planned transfer. Additionally, there was no post-closure review.

15. We found that staff at Doncaster did not assess Mr Webster's risk of self-harm in line with national instructions after his partner had contacted healthcare staff there to say she was concerned for his wellbeing because of his deteriorating mental health.

Clinical care

16. The clinical reviewer concluded the care provided to Mr Webster was not equivalent to that which he could have expected to receive in the community.

17. Mr Webster presented with early symptoms suggestive of a major mental health problem. He was paranoid and suspicious, and these symptoms appeared to worsen. We agree with the clinical reviewer that there should have been a full mental health assessment at Hull.

18. We are also concerned that there was an outstanding doctor's appointment at Hull, which did not take place because he transferred to Doncaster.

19. Although Mr Webster was assessed by a mental health nurse at Doncaster, the assessment was not of the expected standard and the plan following this assessment was for him to be reviewed in three to five weeks, rather than an urgent referral.

20. Officers raised further concerns with the mental health team but it appears these were not acted upon. In addition, Mr Webster's family contacted healthcare staff at Doncaster to express their concerns about his deteriorating mental health and there is no evidence that this was considered or acted upon.

Psychoactive Substances

21. Hull has comprehensive policies to minimise and treat illicit substance misuse. Despite this, Mr Webster, by his own admission, was able to access drugs at Hull with apparent ease.

22. There was no evidence or intelligence to indicate Mr Webster used drugs after he transferred to Doncaster on 14 June. Toxicology results show that Mr Webster was not under the influence of any illicit drug or alcohol at the time of his death.

Key worker system

23. Mr Webster was not seen weekly by his key worker at Doncaster in the two weeks before his death. This may have been a missed opportunity to understand Mr Webster's feelings and to assess his risk of suicide and self-harm.

Recommendations

- The Governor of HMP Hull should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

    - conducting ACCT reviews as specified in the national instructions;
    - assessing the level of risk and recording the reasons for decisions;
    - setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;
    - only closing an ACCT when all caremap actions have been completed; and
    - conducting ACCT post-closure interviews as specified in the national instructions.

- The Governor of HMP Hull should ensure that both SO's and a CM receive further training in ACCT assessment as a priority.

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

    - recording, considering and sharing information received from families to determine a prisoner's risk of suicide or self-harm.

- The Head of Healthcare at HMP Doncaster should remind all healthcare staff that they should share information with prison staff where necessary to ensure prisoner's safety.

- The Director of HMP Doncaster should ensure that this report is shared with a COM and arrange for a senior member of staff to discuss the Ombudsman's findings with her.

- The Head of Healthcare at HMP Hull should ensure mental health assessments take place promptly.

- The Head of Healthcare at HMP Hull should ensure a prisoner's outstanding health appointments have taken place before any transfer, and that a medical hold is put in place if required.

- The Head of Healthcare at HMP Doncaster should ensure the mental health service meets prisoners' needs, including timely mental health assessments and effective ongoing interventions.

- The Head of Healthcare at HMP Doncaster should arrange for a nurse's line manager to:

    - discuss this report with him;
    - consider whether any further action is required; and
    - provide a report to the Ombudsman.

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

- The Director of Doncaster should ensure that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

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

The Investigation Process

24. 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.

25. The investigator visited Doncaster on 29 July. He obtained copies of relevant extracts from Mr Webster's prison and medical records.

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

27. The investigator interviewed nine members of staff at Doncaster and seven members of staff at Hull in September. Twelve interviews were held jointly with the clinical reviewer.

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

29. One of the PPO's family liaison officers contacted Mr Webster's next of kin, to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Webster's next of kin wanted to know what mental health care her son received, why he was transferred and about any contact with the probation service. We have answered Mr Webster's next of kin's questions in this report.

30. Mr Webster's next of kin received a copy of the initial report. She did not make any comments.

31. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Doncaster

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

HM Inspectorate of Prisons

33. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Doncaster in September 2019. Inspectors were very concerned by the increased levels of self-harm, and by the fact that there had been five self-inflicted deaths in the year leading up to the inspection. Tragically, there was another shortly after the inspection. The inspectors found not all recommendations from the Prisons and Probation Ombudsman in response to these deaths were being regularly reviewed, and that action was not being taken to ensure that they were embedded in operational practice.

34. Inspectors were concerned at the poor quality of some ACCT documents and were not assured staff understood how to identify and manage risk. Inspectors reported that staffing levels did not meet the high demand for mental health services. Inspectors found the presence of illicit drugs was a real and continuing problem with prisoners saying it was easy to get hold of drugs.

Independent Monitoring Board

35. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. No IMB report was produced for the reporting year 2017-2018 or 2018-2019.

Previous deaths at HMP Doncaster

36. Mr Webster was the fourteenth prisoner to die at Doncaster since January 2017. Five of these deaths were self-inflicted and nine were from natural causes. Mr Webster's was the third self-inflicted death at Doncaster in 45 days. We found similarities between Mr Webster's death and one of the self-inflicted deaths, where the use of psychoactive substances was involved.

HMP Hull

37. HMP Hull is a local prison with a capacity of more than 1,000 men on remand, convicted or sentenced. The prison serves the courts of Hull, Grimsby and York. City Health Care Partnership CIC provides health services, including mental health.

38. In August 2018, Hull was selected to be part of the '10 Prisons Project', which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

39. HM Inspectorate of Prisons (HMIP) carried out an inspection of Hull in March 2018. Inspectors found reception procedures properly assessed presenting risk and induction arrangements were adequate. Hull had many experienced staff but also a significant tranche of newer staff, all of whom received good mentoring and support. The drug supply reduction strategy was comprehensive and incorporated a good range of measures to tackle the availability of drugs in the prison. Inspectors found good evidence that the strategy was effective. Prisoners with the greatest mental health needs were supported well, but the range of interventions and staffing resources did not meet all low-level needs.

Independent Monitoring Board

40. 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 annual report, published in October 2018 the IMB were very concerned about the levels of self-harm and violence and about the ready availability of psychoactive substances (PS).

Assessment, Care in Custody and Teamwork (ACCT)

41. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

42. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Psychoactive Substances (PS)

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

The key worker system

44. The key worker system is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

45. Mr Nathan Webster had a custodial history dating back to 2009. He had a significant history of illicit drug use, especially cannabis and PS.

46. In 2015, he was sentenced to 54 months for the offences of theft, Class B drugs, weapons and affray. He was released on licence from HMP Hull on 20 March 2018.

47. On 1 May 2018, Mr Webster was recalled to custody at HMP Lincoln for breaching his licence conditions due to drug use. He was due to be released at the end of his sentence on 29 November 2019.

HMP Lincoln

48. At his initial health screen on 1 May, Mr Webster said he had self-harmed in 2017, but had no current thoughts of self-harm or suicide. Later that evening, officers requested healthcare assistance as Mr Webster appeared under the influence of an illicit substance.

49. On 9 May, officers started ACCT monitoring because Mr Webster had made a ligature but had not used it. Mr Webster said his "head had gone", he had started to have suicidal thoughts and wanted to work with the mental health team. The ACCT was closed on 16 May, after Mr Webster said he felt better and denied any thoughts of self-harm or suicide.

50. Also in May, a nurse saw Mr Webster for a mental health assessment. Mr Webster said he had used drugs since the age of 12, and had self-harmed in the past due to his drug use. He said he was looking forward to becoming a father as his partner was due to have a baby in June. Mr Webster said he had been in and out of prison for ten years and wanted support to get himself "back on track".

51. The nurse recorded that Mr Webster was not prescribed any medication. She wrote that he had no intention of self-harm or suicide, and becoming a father was a protective factor, and that he should receive on-going support from the mental health team.

HMP Stocken

52. On 25 May, Mr Webster was transferred to HMP Stocken. At his reception health screen, Mr Webster said he had used PS three weeks previously. He was referred to the substance misuse team.

53. In June and July, Mr Webster saw members of the substance misuse team. He said that he had been using drugs since the age of 12, but was currently drug-free and wanted to remain so in order to be a good role model and father to his new-born son. He said his partner, children and home were major motivation factors for him. He agreed to be referred to the PS awareness group and to receive ongoing support from the substance misuse team.

54. In July, a mental health nurse saw Mr Webster for a mental health review. She recorded Mr Webster appeared calm and settled and had insight into his needs and was aware of the detrimental affect illicit substances could have on his

mental wellbeing. He was discharged from the care of the mental health team, and he would self-refer in the future, if he felt he needed support.

55. By the end of September, Mr Webster had completed two offender behaviour programmes and was able to start the PS awareness course. Mr Webster said his partner and his three-month old son were his main focus and that he had good support from his family. He said he was not in debt and had a job to go to when he was released.

56. On 12 October, Mr Webster was found in possession of approximately one and a half litres of 'hooch' (illicitly brewed alcohol).

57. On 16 October, Mr Webster told staff in writing he no longer wanted to do any more work on his sentence plan and wanted a transfer to another prison. Staff explained to Mr Webster that not completing his sentence plan meant he would not be released before the end of his sentence, and that he would be transferred to a prison near to his home area toward the end of his sentence.

58. On 24 October, Mr Webster set fire to the rubbish bin in his cell to protest about not being transferred. He smashed the observation panel in the cell door, pulled the bed apart and threatened the staff who responded to the incident. He was moved to the segregation unit. Mr Webster said he wanted a transfer and his poor behaviour would continue until he got what he wanted. He remained in the segregation unit until 30 November when he was transferred to HMP Hull.

HMP Hull

59. When Mr Webster arrived at Hull on 30 November, a nurse saw him in reception. Mr Webster said he had no health concerns, and no thoughts of suicide or self-harm and did not want to be referred to the mental health team, but was aware that he could seek support at any time. She recorded that Mr Webster appeared to be mentally stable and showed no outward signs of emotional distress. She noted Mr Webster had been on an ACCT before, but assessed he was not at risk at that time.

60. On 21 December, a nurse saw Mr Webster as officers suspected he was under the influence of an illicit substance. She recorded that Mr Webster was on his bed, his speech was slurred and his eyes were 'pinned'. Mr Webster said he had not taken anything. She assessed that Mr Webster was under the influence of an illicit substance, but that there was no need for any further treatment.

61. On 9 January 2019, Mr Webster told a substance misuse worker, that he wanted support from the substance misuse team because he wanted to address his drug use and be drug-free when he was released. He said he had smoked 'spice' (a type of PS) a few weeks earlier and been found under the influence and did not want to start smoking it again. He said he would like to be free from PS and cannabis in the community. Mr Webster said he had been living with his partner before he went to prison but did not plan on living with her again as they argued too much and he was keen to try and 'sort himself out' when he was released. He said his partner often visited him and brought their son in with her. Mr Webster said he had no mental health issues and no thoughts of self-harm or suicide.

62. She recorded that she discussed with Mr Webster the risks of smoking PS, its addictive properties, its effect on physical and mental health and the negative implications of being found under the influence (such as extra days on his sentence and loss of privileges). Mr Webster agreed to attend group work sessions and do in-cell work.

63. On 16 January, the substance misuse worker recorded she had spoken to a social worker for Scunthorpe Children's Services. She said that Mr Webster had been monitored by social services due to his volatile relationship with his partner, as well as his drug use in the community, but this had stopped in November 2018. There were no restrictions in place to prevent Mr Webster from having contact with his son. Social services were aware Mr Webster's partner was in regular contact him and visited him in prison.

64. She said Mr Webster's probation officer was fully aware of all the safeguarding concerns and had been actively involved in meetings about safeguarding. Any future safeguarding referral would be made to North East Lincolnshire children's services, as Mr Webster's partner had moved. On 25 January, the substance misuse worker recorded she had spoken to his probation officer. The probation officer said he would visit Mr Webster in prison before his release.

65. On 1 February, the substance misuse worker saw Mr Webster for a substance misuse review. Mr Webster said he planned to live alone when released as he did not think living with his partner would be the best thing for either of them or their son. He said he had previously been released to a hostel which had resulted in him being recalled and he believed it would be better if he remained in custody for the entire duration of his sentence. Mr Webster said he could refrain from using drugs when he was in a good frame of mind, but as soon as he and his partner argued, or something else affected his mood, he would use cannabis or PS, which would become a binge. He said he did not want to use drugs when he was released.

66. She recorded she gave Mr Webster examples of how he could adapt his thinking in stressful situations so he could cope better and not use drugs. She explained binges were dangerous, particularly because of the negative effects on mental health and the unknown substances that PS contains.

67. On 1 April, a psychosocial wellbeing practitioner saw Mr Webster on the wing. She told Mr Webster she had replaced the substance misuse worker, as his substance misuse worker. Mr Webster said was happy as he had a job as a cleaner on the wing, which kept him busy. He said he was looking forward to starting substance misuse groups and was on the waiting list. She told Mr Webster she would be on the wing most weekday mornings and if he required support he could speak to her.

68. On 16 April, the psychosocial wellbeing practitioner saw Mr Webster on the wing for a substance misuse review. Mr Webster said he had used cannabis on the wing, smoking one to two joints each evening. He said he enjoyed using cannabis as it made him feel calm. He denied any other illicit drug use, and said he had no more cannabis and wished to use the opportunity to stay drug-free.

69. She advised Mr Webster about the use of illicit drugs and the risk of overdose. She recorded that Mr Webster was on the waiting list for the substance misuse groups and was keen to attend.

70. That evening, a nurse saw Mr Webster as staff believed he was under the influence of an illicit substance. Mr Webster said he had used 'spice' as he was "fed up". She recorded that Mr Webster was under the influence of an illicit substance and that there were no other concerns.

71. On 25 April, the psychosocial wellbeing practitioner saw Mr Webster on the wing for a substance misuse review. Mr Webster said he had used 'spice' because he had no more cannabis. He admitted he had smoked two sheets of A4 paper soaked in PS in a week and he had spiralled out of control. He said he realised after he was caught that he could no longer smoke cannabis as it always led him to use other drugs. Mr Webster said he had not used any illicit substances for three days. She questioned how serious he was about being drug-free, reiterated the advice about the use of illicit drugs use on the wing and the risk of overdose. Again, Mr Webster said that he wanted to be drug-free and felt he had had a 'lightbulb' moment and wanted to "make it last this time".

72. On 30 April, the psychosocial wellbeing practitioner recorded that Mr Webster had attended the recovery group on the wing. She noted Mr Webster appeared alert, focussed and engaged well throughout the session.

May and June 2019

73. On 8 May, Mr Webster started a dirty protest. A SO recorded Mr Webster started the protest because he wanted a move and believed he was under threat on B Wing but would not elaborate any further. Mr Webster was moved to G Wing.

74. On 23 May, a CM recorded that Mr Webster had requested a move to I or J Wing as he had given staff information about the use of drugs and mobile phones by other prisoners on B Wing. The CM recorded that I and J Wings were for prisoners convicted of sex offences and therefore Mr Webster did not meet the criteria for those wings.

75. Later that day, the psychosocial wellbeing practitioner saw Mr Webster on the wing for a substance misuse review. Mr Webster said he had been moved from B Wing to G Wing as he felt unsafe after he had given information to staff about mobile phones and drugs used by other prisoners. Mr Webster said he now felt safe but wanted to be transferred to another prison. He denied any illicit substance use since the last time he saw her and said it had been "the last thing on his mind". Mr Webster said he only wanted one-to-one support from her and did not want to do any group work or in-cell work.

76. On 24 May, an officer started ACCT monitoring after she found Mr Webster with a ligature, made from torn bedding, around his neck. Mr Webster said he would harm himself because he was frustrated as he wanted a transfer.

77. A SO saw Mr Webster and completed the ACCT immediate action plan. He assessed Mr Webster as being at raised risk of self-harm, and set his level of observations at hourly throughout the day and night until the first case review.

78. On 25 May, an officer assessed Mr Webster as part of the ACCT procedures. Mr Webster said staff were corrupt and were out to get him and he did not feel safe on the wing. He said his head was all over the place and had isolated himself in his cell. Mr Webster said he did not intend to kill himself and had no current thoughts of suicide. He said he had six months left to serve in prison and he looked forward to release to be a father to his son. The officer recorded that Mr Webster appeared paranoid.

79. At 10.15am, a SO chaired the first ACCT case review with another SO, an officer, a nurse from the mental health team and Mr Webster present. Mr Webster said he felt "stitched up" by staff. He said he did not feel safe on the wing but would not say why. He said he put a ligature around his neck to get a move to I or J Wing or to another prison. Mr Webster denied he had substance misuse issues and said he did not want to take any medication. He said he looked forward to his release to be with his son.

80. The SO recorded that Mr Webster was due to be released in six months. He assessed Mr Webster as being at low risk of suicide and self-harm and closed the ACCT.

81. The SO completed the ACCT caremap, which contained one action: for Mr Webster to be transferred to another prison. The SO noted that staff were waiting for a response about Mr Webster's transfer, but he signed the caremap to say the action had been completed. A post-closure interview was set for 3 June.

82. The nurse recorded in Mr Webster's medical record that she had attended the ACCT review. She recorded that Mr Webster had a history of self-harm, was self-isolating, but had no mental health issues.

83. On 26 May, Mr Webster climbed over the railings on the wing, onto the netting, with a ligature around his neck, protesting about not being transferred. Officers got Mr Webster back over the railings and took him back to his cell. A SO re-opened the ACCT document.

84. The SO chaired an ACCT review with another SO and Mr Webster present. No-one from the healthcare team was present. Mr Webster said he wanted to be moved to the segregation unit. He said he had issues on all the wings at Hull because he was in debt. Mr Webster said if he was not moved, he would start another dirty protest.

85. The SO recorded that there was no evidence that Mr Webster was in debt and there was no reason for him to be segregated. He recorded that Mr Webster appeared very paranoid and that a member of the mental health team should be at the next review. Both SO's assessed Mr Webster as being at low risk of suicide and self-harm and set the level of observations at hourly throughout the day and night until the next case review.

86. A SO completed the ACCT caremap which contained a second action for Mr Webster: to have a mental health assessment. The SO recorded the next case review was to be held as soon as possible but did not specify a date.

87. The healthcare administration support recorded in Mr Webster's medical record that she had received a call from the SO to inform her that Mr Webster's ACCT

had been reopened as he had tried jumping off the landing with a ligature around his neck. The SO said Mr Webster presented as very paranoid. She referred Mr Webster for a mental health assessment. She did not specify a level of priority.

88. That morning, an officer recorded that Mr Webster had flooded his cell. Mr Webster said he had done this to be moved to the segregation unit.

89. On 27 May, an officer recorded that Mr Webster had started another dirty protest. Mr Webster said he wanted to be moved to the segregation unit. Later that afternoon, Mr Webster cut his left arm and was moved to the segregation unit.

90. When Mr Webster arrived in the segregation unit, a Custodial Manager (CM) chaired an ACCT review with another SO and Mr Webster. No member of the healthcare team was present or contributed. The CM recorded that Mr Webster appeared very anxious and that his behaviour had deteriorated while on G Wing. Mr Webster apologised and thanked the staff for moving him. Mr Webster said he felt much better and that any thoughts of self-harm had subsided.

91. The CM and the SO assessed Mr Webster as being at low risk of suicide and self-harm and reduced the level of observations to one conversation in the morning, one conversation in the afternoon and two observations during the night. The next review was set for 29 May.

92. That evening, the head of security, recorded the justification for segregating Mr Webster while he was on an ACCT. He recorded that Mr Webster's move to the segregation unit was appropriate after a protracted period of poor behaviour, and that it was not appropriate for him to be moved to I or J Wing as he was not convicted of sex offences.

93. On 29 May, a CM chaired an ACCT review with a SO and Mr Webster present. Again, no member of the healthcare team was present or contributed. Mr Webster said that he had no thoughts of self-harm and felt the most settled he had for a while. The CM recorded that the mental health team had been asked to assess Mr Webster, but no one was available.

94. The CM and the SO assessed Mr Webster as being at low risk of suicide and self-harm and closed the ACCT. The CM completed the ACCT caremap to say all actions had been completed, despite the fact Mr Webster had not had a mental health assessment and a transfer remained outstanding. A post-closure interview was set for 6 June.

95. On 2 June, a SO recorded that Mr Webster had flooded his cell in the segregation unit. Mr Webster said he had done this to get a transfer to another prison and did not want to go back to a wing at Hull.

96. On 3 June, at 10.50pm, an operational support grade, re-opened the ACCT as she found Mr Webster had made a ligature around the window bars. Mr Webster said he had had enough and wanted to hang himself.

97. A CM completed the immediate action plan. He assessed Mr Webster as being at raised risk of self-harm, and set his level of observations at five per hour throughout the day and night until the first case review.

98. The Head of Drug Strategy, recorded the justification for segregating Mr Webster while he was on an ACCT. He said that the segregation unit was an appropriate location for Mr Webster as he felt safe there.

99. On 4 June, a CM chaired an ACCT review with a SO, a nurse from the mental health team and Mr Webster present. Mr Webster said the previous evening was a “blip” and said he had no further thoughts of self-harm. He said he wanted a transfer to another prison and would refuse to leave the segregation unit until he got a transfer.

100. They assessed Mr Webster as being at low risk of suicide and self-harm and reduced the level of observations to hourly throughout the day and night. The next review was set for 7 June.

101. The nurse recorded in Mr Webster’s medical record that his mental state was stable and there was no evidence of any mental health problems.

102. On 7 June, a CM chaired an ACCT review with a SO, a nurse and Mr Webster present. The CM told Mr Webster that staff were doing everything possible to get him a transfer to another prison. The CM told Mr Webster he would not be forced to leave the segregation unit. Mr Webster said he was grateful and said he had no more thoughts of self-harm.

103. They assessed Mr Webster as being at low risk of suicide and self-harm and closed the ACCT. The CM updated the ACCT caremap to say all actions had been completed despite the fact Mr Webster had not had a mental health assessment and a transfer remained outstanding. A post-closure interview was set for 14 June.

104. On 11 June, the psychosocial wellbeing practitioner saw Mr Webster for a substance misuse review. Mr Webster said he felt safe in the segregation unit and was happy to be there. He said he had not used illicit substances for some time and hoped he would stay in the segregation unit until he was transferred. Mr Webster said stated he would like some in-cell work to do on substance abuse as he felt while he was in the segregation unit it would be a perfect time to "get his head down" and concentrate on himself and his recovery.

105. On 14 June, Mr Webster transferred from Hull to HMP Doncaster. The scheduled ACCT post-closure interview was not held. A nurse saw Mr Webster in reception before he was transferred. She recorded Mr Webster had an appointment with a doctor that day, however he was still transferred. The Head of Healthcare, told the investigator it was not possible to determine what Mr Webster’s appointment was for.

HMP Doncaster

106. During his initial health screen at Doncaster on 14 June, Mr Webster told a nurse that he had no thoughts of suicide or self-harm. He did not want to be referred to the substance misuse team. The nurse recorded that Mr Webster had recently been subject to ACCT monitoring and had self-harmed in the past. He referred Mr Webster to the mental health team for a full assessment.

107. Early the following morning, Mr Webster set fire to the bin his cell. Staff put out the fire and moved Mr Webster to a nearby cell. Mr Webster immediately smashed the sink off the wall and flooded the cell. He was moved to the segregation unit.

108. On 17 June, a nurse, a member of the mental health team, did a paper triage of the referral made by the nurse. She recorded that she could see from Mr Webster's medical record he had been subject to ACCT monitoring while at Hull due to increased suicidal behaviour, but had said he had no thoughts of suicide or self-harm when he arrived at Doncaster. She arranged for Mr Webster to have a full mental health assessment later that month. The nurse did not note the referral's level of priority.

109. On 18 June, a healthcare support worker recorded in Mr Webster's medical record that Mr Webster's partner had telephoned to say that she was concerned that he was showing signs of psychosis and paranoia and that she felt his mental health had deteriorated over the previous two months. She noted that Mr Webster had a full mental health assessment scheduled for 27 June, but she made the mental health team aware of concerns raised by Mr Webster's partner. No one spoke to officers about Mr Webster's partner's concerns.

110. Later that afternoon, a Prison Custody Officer (PCO) saw Mr Webster in the segregation unit and introduced himself as his 'key worker'. Mr Webster said he felt unsafe at Doncaster because he was labelled as a sex offender. He said his health was good, he had no substance misuse issues and was in contact with his family. The PCO recorded that a Custodial Operations Manager (COM) from the vulnerable prisoner unit had been to see Mr Webster with a view to him moving from the segregation unit.

111. A COM told the investigator she was asked to assess Mr Webster for Houseblock 1, the vulnerable prisoner unit, as he claimed he would be seriously under threat on a normal houseblock. The COM said she found Mr Webster to be a polite, compliant, decent young man. Mr Webster said he wanted to keep his head down and get to the end of his sentence. She agreed Mr Webster could live on Houseblock 1, provided his behaviour improved, otherwise he would be moved to a normal houseblock. Mr Webster moved to Houseblock 1 on 19 June.

112. On 27 June, a nurse saw Mr Webster for a mental health assessment. Mr Webster said he had used his poor behaviour to manipulate a transfer. He said he believed others played tricks on him. He said he had used illicit drugs in previous prisons but had not used any drugs since he had been at Doncaster. He said he had no thoughts of suicide or self-harm. He said he was in regular contact with his mother and his partner.

113. The nurse recorded that Mr Webster had a history of self-harm and substance misuse and had previously been on an ACCT. The nurse completed two mental health screening tools which indicated that Mr Webster had moderate depression, and moderate to severe anxiety. The nurse assessed that Mr Webster suffered from paranoia and persecutory ideation. There is no record that the nurse considered Mr Webster's partner's concerns. The nurse noted: 'Mr Webster should be reviewed once every three weeks to monitor relapse and acute

deterioration; be seen by the psychiatrist; and an ACCT should be opened if necessary.'

114. The nurse's assessment was the last recorded interaction with any member of healthcare staff before Mr Webster's death nearly four weeks later.

115. On 29 June, the COM recorded that Mr Webster had told her everyone on the houseblock was out to get him and staff would let them into his cell to attack him. She recorded that she had attempted to reason with Mr Webster but it was impossible due to his paranoia.

116. The next day, the COM recorded in Mr Webster's prison computer record that Mr Webster had become very paranoid and would not come out of his cell. The COM recorded that she had spoken to the nurse to get him to come and see Mr Webster and ensure that he was on the list to be seen by the psychiatrist. There is no record of this conversation in Mr Webster's medical record.

117. Prison records show that Mr Webster was in regular contact with his mother and partner, and his mother visited him. Mr Webster's last phone call was made on 4 July when he spoke to his next of kin. The investigator has listened to this call. Mr Webster asked if his next of kin still planned to visit him the next day, and whether she would bring his child. Mr Webster's next of kin said she would visit but would be on her own. Mr Webster talked about others being out to get him. His next of kin told him he was "talking nonsense", it was "far-fetched" and she told him to stop isolating himself. Prison records confirmed Mr Webster's mother visited him on 5 July.

118. On 11 July, a PCO saw Mr Webster and introduced herself as his 'key worker'. Mr Webster said he felt unsafe, but did not say why. He said he was not in debt, his health was 'ok' and he was in contact with his mother. The PCO recorded that Mr Webster was not on an ACCT and he did not mix with other prisoners.

119. On 17 July, a PCO saw Mr Webster and introduced himself as his 'secondary key worker'. The PCO explained that key workers should see their allocated prisoners on a weekly basis. Where this is not possible a member of staff is tasked as a secondary key worker to see those prisoners who have not been seen. Mr Webster said he felt safe and had no health problems or other concerns.

Wednesday 24 July

120. At 8.20am, a PCO arrived at Mr Webster's cell to let him out for education. When she opened the cell door, she saw Mr Webster hanging from the shelving unit by a ligature made from bedding. She immediately radioed an emergency code blue, which indicates a prisoner is having difficulty breathing. Staff and nurses responded within 60 seconds, cut the ligature and began cardiopulmonary resuscitation (CPR). The control room log shows the PCO called the code blue over the radio at 8.20am and an ambulance was called immediately. The On-site Paramedic pronounced Mr Webster dead at 8.33am.

Contact with Mr Webster's family

121. The Director of HMP Doncaster, and the prison's family liaison officer (FLO), visited Mr Webster's next of kin at her home address at 10.40am, to break the news of his death and offer condolences. In the days that followed, the FLO maintained contact with Mr Webster's next of kin. The prison contributed to the costs of the funeral in line with Prison Service instructions.

Post-mortem report

122. A post-mortem examination found that the cause of Mr Webster's death was hanging. Toxicology results confirmed that Mr Webster was not under the influence of any illicit drugs or alcohol at the time of his death.

Support for prisoners and staff

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

124. However, the on-site Paramedic and two nurses each told the investigator that they were not involved in the hot debrief and were not offered support.

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

Findings

Management of risk of self-harm and suicide

126. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include recall to custody, previous self-harm, mental health issues and a history of alcohol or drug abuse. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

HMP Hull

127. Mr Webster struggled with drug misuse while he was at Hull. From January 2019 onwards, he appeared to be doing well at Hull and was remaining drug-free. However, he started to use drugs again in April 2019, and in May he started to say that he was at risk from other prisoners. His behaviour deteriorated as he tried to secure a transfer to another prison. Staff described him as 'paranoid'.

128. Mr Webster presented with a number of risks, possibly compounded by his PS use, and staff at Hull appropriately opened an ACCT on 24 May after he was found with a noose round his neck. However, a SO assessed Mr Webster as being at low risk of self-harm and closed the ACCT less than 24 hours later on the morning of 25 May. We consider this was premature, particularly as the caremap action had not been completed.

129. A SO reopened the ACCT on 26 May after Mr Webster had made another ligature and jumped onto the netting. At the subsequent ACCT review Mr Webster was assessed as being at low risk of self-harm. It is hard to understand the basis for this decision given that Mr Webster had threatened suicide twice in 48 hours and was described as 'very paranoid' and requiring a mental health assessment.

130. We are also concerned that neither this review, nor the reviews on 27 and 29 May were multidisciplinary, even though Mr Webster was located in the segregation unit and described as 'paranoid'. We consider that a CM's decision to close the ACCT on 29 May was premature. We do not consider that there was evidence of a sufficient reduction in Mr Webster's risk and the caremap action that Mr Webster should have a mental health assessment was still outstanding.

131. An OSG appropriately reopened the ACCT on 3 June, when Mr Webster was found with a ligature and said he intended to hang himself. However, at the review on 4 June, the CM and a nurse, again, assessed that Mr Webster was at low risk of self-harm and reduced the level of observations. We consider that this assessment was wholly inappropriate, as this was the third time in 11 days that Mr Webster had made a ligature and, on the last occasion, he had said he wanted to hang himself.

132. On 7 June, a CM closed the ACCT, even though the caremap action that Mr Webster should have a mental health assessment remained outstanding. We do not consider that this was appropriate.

133. We are also concerned that the ACCT post closure interview was scheduled for 14 June, but this did not take place as required by the PSI.

134. We therefore make the following recommendations to the Governor at Hull.

The Governor of HMP Hull should ensure that two SO's and a CM receive further training in ACCT assessment as a priority.

The Governor of HMP Hull should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **conducting ACCT reviews as specified in the national instructions;**
- **assessing the level of risk and recording the reasons for decisions;**
- **setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;**
- **only closing an ACCT when all caremap actions have been completed; and**
- **conducting ACCT post-closure interviews as specified in the national instructions.**

HMP Doncaster

135. PSI 64/2011 includes the following mandatory action:

> "Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form."

136. We are concerned that there is no evidence that anyone considered opening an ACCT on 18 June after Mr Webster's partner contacted healthcare staff at Doncaster with serious concerns about his mental wellbeing. This is especially concerning, given Mr Webster's very recent history of self-harm and threats to kill himself.

137. We are also concerned that the information from Mr Webster's partner was not passed on to prison staff.

138. When a COM saw Mr Webster on 29 and 30 June she recorded that he had become 'very paranoid' and was self-isolating, and that she had asked a nurse from the mental health team to see him and to make sure he was seen by a psychiatrist. Again, given Mr Webster's recent history of self-harm and threats to kill himself, we consider that the COM should have considered opening an ACCT at this point.

139. We make the following recommendations:

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

- **recording, considering and sharing information received from families to determine a prisoner's risk of suicide or self-harm.**

The Head of Healthcare at HMP Doncaster should remind all healthcare staff that they should share information with prison staff where necessary to ensure prisoner's safety.

The Director of HMP Doncaster should ensure that this report is shared with a COM and arrange for a senior member of staff to discuss the Ombudsman's findings with her.

Clinical care

140. The clinical reviewer considered the care provided to Mr Webster was not equivalent to that which he could have expected to receive in the community.

141. Mr Webster presented with early symptoms suggestive of a major mental health problem. He was paranoid and suspicious and this appeared to increase.

142. While at Hull, Mr Webster was referred for a mental health assessment on 26 May, but this had not been carried out by the time he was transferred to Doncaster on 14 June. The Head of Healthcare, said prisoners referred to the mental health service should be seen within 24 hours if it is deemed urgent, or within seven days or fourteen days dependent on symptoms and presentation. We do not think that sufficient urgency was attached to the mental health referral in Mr Webster's case given that he was on an ACCT at the time, and we are concerned that the referral was not actioned within any of the required timescales. We make the following recommendation:

The Head of Healthcare at HMP Hull should ensure that the mental health service meets prisoners' needs, including timely mental health assessments and effective ongoing interventions.

143. We also agree with the clinical reviewer that Mr Webster should not have been transferred to Doncaster until the outstanding doctor's appointment at Hull had taken place. We do not know if this was the planned mental health assessment, but we consider that Mr Webster should have been subject to a medical hold given his mental health, substance misuse and self-harm issues. We recommend:

The Head of Healthcare at HMP Hull should ensure a prisoner's outstanding health appointments have taken place before any transfer, and if required a medical hold should be put in place.

144. When Mr Webster arrived at Doncaster on 14 June, a nurse appropriately referred Mr Webster for a mental health assessment. A paper triage took place on the 17 June, and on 18 June, Mr Webster's partner spoke to healthcare about her concerns about Mr Webster's deteriorating mental health. However, Mr

Webster was not seen for an assessment until 27 June. And despite three recent incidents of suicide threats, and deteriorating mental health, a nurse did not refer Mr Webster to a psychiatrist or any other secondary care mental health services.

145. The clinical reviewer considered that the assessment made by the nurse was not of the standard expected. The assessment did not take place in a private room where confidentiality, dignity and respect could be maintained. The nurse's knowledge and skills were limited and at interview he was not able to explain to the differences between thought disorder and delusional ideas.

146. We are concerned that on 30 June, when a COM asked the nurse to see Mr Webster due to his increased paranoia, the conversation was not noted in Mr Webster's medical record, and there is nothing in his medical record to show that the nurse, or any other member of the mental health team, made any attempt to see him. When interviewed, the nurse was unable to say with any certainty when Mr Webster would have been reviewed.

147. We agree with the clinical reviewer's conclusion that the care that Mr Webster received at Doncaster was not equivalent to that which he could have expected to receive in the community. It is impossible to know if Mr Webster's suicide might have been prevented if he had received appropriate mental health care. We make the following recommendation:

The Head of Healthcare at HMP Doncaster should ensure the mental health service meets prisoners' needs, including timely mental health assessments and effective ongoing interventions.

The Head of Healthcare at HMP Doncaster should arrange for the nurse's line manager to:

- **discuss this report with him;**
- **consider whether any further action is required; and**
- **provide a report to the Ombudsman.**

Psychoactive substances

148. Mr Webster had a significant history of illicit drug use in prison. He admitted he had used drugs while at Hull, and he received support and advice from the substance misuse team. However, after remaining drug-free for some months, he began to use cannabis and PS again.

149. The use of PS has the potential for precipitating or exacerbating the deterioration of mental ill health and has been linked to paranoia and increased risk of suicide or self-harm.

150. Hull has a strategy to address both the supply of and demand for illicit drugs. It includes numerous actions intended to reduce the supply of drugs into the prison and movement of drugs around the prison. Examples of this include photocopying mail to prevent paper soaked in PS entering the prison, and providing additional staff to carry out mandatory drugs tests and cell searches.

There are also measures to educate prisoners about the dangers of PS and support those known to use drugs, plus additional disciplinary measures to deter drug use.

151. We are concerned that, despite this, Mr Webster was able to obtain PS with apparent ease at Hull. It seems likely that this contributed to the sudden deterioration in his mental health from May 2019 and increased his risk of suicide or self-harm.

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

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

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

We, therefore, recommend:

The Governor of HMP Hull should ensure that the key drug issues are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

Key worker system

154. Three different key workers saw Mr Webster during his time at Doncaster on three separate occasions. We are concerned about Mr Webster's lack of weekly contact with a key worker and the inconsistency of staff completing these sessions. We do not suggest that these sessions would have prevented Mr Webster's death, but we are concerned that the key worker model was not working as effectively as it should have done. This may have been a missed opportunity to understand Mr Webster's feelings and to assess his risk of suicide and self-harm. We, therefore, recommend:

The Director of Doncaster should ensure that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

Actions following a death in custody

155. PSI 64/2011 sets out the actions that prisons should undertake after a prisoner's death, and includes a mandatory action that a 'Hot Debrief' must be held immediately after a death in custody. A senior member of staff must act as a debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. None of the healthcare staff directly involved in the emergency response were involved in the 'Hot Debrief'. We therefore make the following recommendation:

The Director of Doncaster should ensure that all prison and healthcare staff involved in an emergency response attend a hot debrief and are offered support in line with PSI 64/2011.

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