Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Shreeve, a prisoner at HMP Doncaster, on 21 February 2021

A report by the Prisons and Probation Ombudsman

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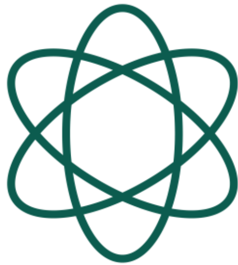
Our vision

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 Jason Shreeve was found unresponsive in his cell at HMP Doncaster on 21 February 2021. He was 43 years old. I offer my condolences to Mr Shreeve's family and friends.

Mr Shreeve died of aspiration pneumonitis (inhaling regurgitated stomach contents) caused by a codeine overdose. Neither this investigation nor post-mortem examinations could determine whether the overdose was deliberate or accidental. As Mr Shreeve was not prescribed codeine while at Doncaster, he can only have obtained the drug illicitly from another prisoner.

On 20 February (the day before he was found dead), staff began monitoring Mr Shreeve under suicide and self-harm monitoring procedures, known as ACCT, after he made deep cuts to his arms and appeared tearful and distressed. The ACCT was closed around three hours later as staff considered Mr Shreeve's mood had stabilised. We consider this was premature.

We cannot, however, say that the closure of the ACCT made a significant difference to the outcome for Mr Shreeve as staff checked on him at intervals during the night in any case because had had two epileptic seizures earlier in the day.

We consider that officers should have gone into Mr Shreeve's cell without delay when they discovered him unresponsive on the morning of 21 February. We cannot say whether the five-minute delay affected the outcome for Mr Shreeve, but it could be critical in future medical emergencies.

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 **July 2022**

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Summary

Events

1. In July 2019, Mr Jason Shreeve was remanded to HMP Hull charged with attempted murder (which was later changed to murder after the victim died in hospital). It was not his first time in prison.

2. Mr Shreeve had epilepsy and experienced frequent seizures. He had a long history of self-harm and was prescribed medication for anxiety and depression. He also suffered from post-traumatic stress disorder (PTSD) and had a history of substance misuse.

3. Mr Shreeve was transferred to HMP Doncaster on 11 October 2019. He was monitored by staff under Prison Service suicide prevention procedures, known as ACCT, on multiple occasions while at Doncaster, and was often under the care of the prison's mental health team.

4. At 5.50am on 20 February, staff opened ACCT procedures after Mr Shreeve cut his arms. Staff closed the ACCT about three hours later as they considered that he was no longer in crisis. Later that afternoon, Mr Shreeve had two seizures while having his self-harm wounds dressed by healthcare staff.

5. As Mr Shreeve had had seizures that day, night officers completed visual welfare checks on him during the night at around 12.00am, 3.00am and 4.00am. They raised no concerns.

6. At around 5.45am, the night officers found Mr Shreeve unresponsive in his cell and radioed to ask permission to go into the cell. After they entered the cell, an officer radioed a medical emergency 'code blue' (indicating a life-threatening situation). Officers and healthcare staff began cardiopulmonary resuscitation (CPR). At around 6.10am, paramedics arrived and took over CPR. They were unable to revive Mr Shreeve and confirmed that he had died at 6.32am.

7. A post-mortem examination identified the cause of Mr Shreeve's death as aspiration pneumonitis (inhaling regurgitated stomach contents) as a result of a codeine overdose. (The post-mortem report noted that it was unlikely that Mr Shreeve's epilepsy contributed to his death.)

Findings

Clinical care

58. The clinical reviewer concluded that the physical and mental healthcare Mr Shreeve received at Doncaster was of a good standard and equivalent to that which he could have expected to receive in the wider community. He made no recommendations.

Management of risk of suicide and self-harm

9. Neither this investigation nor post-mortem examinations could determine whether Mr Shreeve's codeine overdose was deliberate or accidental. Nevertheless, we consider that the decision by staff to close Mr Shreeve's ACCT on the morning of

20 February was premature, given Mr Shreeve's serious incident of self-harm only about three hours earlier.

10. However, as Mr Shreeve was monitored by staff overnight anyway (due to the two epileptic seizures he had experienced earlier that day), we cannot say that keeping the ACCT open would have prevented his death.

Substance misuse

11. Prison intelligence indicated that Mr Shreeve was swapping and selling his prescribed medication with other prisoners. As he was not prescribed codeine while at Doncaster, he can only have obtained the drug illicitly from another prisoner. Doncaster's current drug strategy, which does cover the trading of prescription medication, was only introduced in late 2020 (and Mr Shreeve died in February 2021). We appreciate that it will take time to implement and embed.

Emergency response

12. We consider that officers should have entered Mr Shreeve's cell immediately (in line with Doncaster's local 'night state' policy) when they discovered him unresponsive in his cell.

13. We are concerned that there appears to have been a delay of around five minutes from seeing him unresponsive to entering the cell and calling the code blue. Although we cannot say whether Mr Shreeve's life could have been saved if staff had gone into the cell immediately and called the code blue earlier, this could make a critical difference in other medical emergencies.

Recommendations

- The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including by:
    - ensuring that sufficient consideration and weight is given at ACCT case reviews to a prisoner's risk factors for suicide and self-harm; and
    - ensuring that a prisoner's level of observations appropriately reflect their risk.
- The Director should ensure that, subject to a personal risk assessment, staff go into cells as quickly as possible if there is reason to consider that the prisoner's life may be at risk, in line with national and local policy.

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. No one responded.

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

16. The investigator interviewed 11 members of staff at Doncaster. The interviews were completed by video link and telephone due to the restrictions imposed as a result of the COVID-19 pandemic.

17. NHS England commissioned a clinical reviewer to review Mr Shreeve's clinical care at the prison. The interviews were conducted jointly by the clinical reviewer and the investigator.

18. We informed HM Coroner for Yorkshire South East of the investigation. She provided us with a copy of the post-mortem report, and we have sent her a copy of this report.

19. The PPO's investigation was suspended on 21 April 2021 as we were waiting for the toxicology report which we were told might impact the cause of death (and therefore the course of our investigation). We reopened our investigation on 9 July following receipt of the toxicology report.

20. The Ombudsman's family liaison officer wrote to Mr Shreeve's next of kin, his mother, to explain the investigation. She asked for a copy of the report. She also asked what observations took place overnight on 20/21 February, and why Mr Shreeve was not on suicide/self-harm watch when he died. We have addressed these questions in this report.

21. Mr Shreeve's mother also said that she had seen his body at the funeral director's and saw that he had red marks down the side of his face and a mark on his nose. She asked what caused these marks. The post-mortem examination did not identify what caused these marks, although Mr Shreeve had had seizures the day before he died.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified one factual inaccuracy which we have amended.

23. Mr Shreeve's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Doncaster

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

HM Inspectorate of Prisons (HMIP)

25. HMIP carried out an unannounced inspection of Doncaster in September 2019. Inspectors were very concerned by the levels of self-harm and that there had been five self-inflicted deaths in the year leading up to the inspection and another self-inflicted death shortly after the inspection. Inspectors found that the number of prisoners on Prison Service suicide prevention procedures, known as ACCT, was consistently very high. As a result, ACCT processes had become difficult to manage and staff were sometimes prevented from focussing on individuals with the highest risk. Inspectors also noted that available data and serious acts of self-harm were not sufficiently investigated to identify underlying causes or emerging trends.

26. Inspectors also found that not all recommendations from the Prisons and Probation Ombudsman in response to the self-inflicted deaths were being regularly reviewed, and that action was not being taken to ensure that they were embedded in operational practice.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest report for the year to 30 September 2020, the Board noted it was concerned about self-harm, although it was aware of and supportive of work being done in the prison to identify men at risk, to engage with them to reduce risk, the recording of incidents (in a timely way) and work with men who have self-harmed.

28. The Board noted that there was drug use in the prison, but that routine and targeted security measures were in place and they supported the prison's drug strategy. The Board also noted that the PPO had investigated deaths in custody during the reporting year and said they would monitor action on the PPO's recommendations.

Previous deaths at HMP Doncaster

29. Mr Shreeve was the 23rd prisoner to die at Doncaster since February 2019. Of the previous deaths, 11 were from natural causes, nine were self-inflicted and two were drug-related. There were no significant similarities between Mr Shreeve's death and the previous deaths.

Assessment, Care in Custody and Teamwork (ACCT)

30. 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

31. As part of the process, a caremap (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.

Psychoactive Substance (PS)

32. Psychoactive substances (PS), previously known as 'legal highs', are an increasing 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.

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

COVID-19 restrictions

34. On 24 March 2020, in response to the COVID-19 pandemic and in line with Government advice, HM Prison and Probation Service (HMPPS) issued an instruction to all prisons to introduce social distancing and a restricted regime for staff and prisoners, wherever possible. On 27 March, HMPPS issued operational guidance to prisons on exceptional regime and service delivery, which reflected Government restrictions following the national lockdown of 23 March. This guidance resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent much of their day locked behind their cell doors.

Key Events

Background

35. Mr Jason Shreeve was first convicted of a criminal offence in 1988. He served several prison terms during his life for theft, arson, criminal damage and other offences. He had a history of substance and alcohol misuse.

36. Mr Shreeve was prescribed medication to treat epilepsy (which he had suffered from since he was 3 years old) and he experienced frequent seizures. He had a long history of self-harm and was prescribed medication for anxiety and depression. He also suffered from post-traumatic stress disorder (PTSD).

37. On 9 July 2019, Mr Shreeve was remanded to HMP Hull charged with attempted murder (his charge was later changed to murder after the victim died in hospital). When Mr Shreeve arrived at Hull, staff began monitoring him under ACCT procedures due to his self-harm and mental health history, his presentation and the nature of his alleged offence.

38. On 16 July, staff called a medical emergency ‘code blue’ over the radio, indicating a life-threatening situation, after Mr Shreeve had an epileptic seizure.

39. On 24 July, staff called another code blue after Mr Shreeve’s cellmate discovered him with a ligature around his neck. He did not lose consciousness, but he was reportedly tearful and said he had nothing to live for. He was moved to the healthcare centre so staff could monitor him more closely.

40. On 18 August, staff called a further ‘code blue’ for Mr Shreeve, after he was discovered face down in a pool of blood having a seizure.

HMP Doncaster

41. On 11 October 2019, Mr Shreeve was transferred to HMP Doncaster while still subject to ACCT monitoring. The reception nurse assessed Mr Shreeve and recorded on SystmOne (the electronic medical record) that he was finding it difficult to accept his offence. The nurse referred Mr Shreeve to the mental health team for further assessment and did not allow him to keep his medication in his cell due to concerns that he may overdose.

42. According to SystmOne, Mr Shreeve had 21 seizures between November 2019 and January 2021 while at Doncaster. Due to the severity of some of the seizures, he was transferred to Doncaster Royal Infirmary on seven occasions.

43. On 30 October, a mental health nurse completed two assessments to determine Mr Shreeve’s level of anxiety and depression. He concluded that Mr Shreeve was experiencing moderate anxiety and severe depression. As a result, he concluded that Mr Shreeve should be prescribed appropriate medication and receive ongoing support from the mental health team. He added Mr Shreeve to his caseload for follow-up work.

44. Mr Shreeve’s trial took place in November and it was noted on his Person Escort Record (PER) on 21 November that he had been assaulted with a knife by another

prisoner two days' previously. Staff also recorded on the PER that Mr Shreeve had displayed "refractory" behaviour in the past, including threats to start a fire and pretending to faint apparently in order to manipulate staff. Mr Shreeve's Cell Sharing Risk Assessment from this period notes that he was not suitable to share a cell with another prisoner due to risk of escape and assaults on staff and prisoners.

45. On 6 December, Mr Shreeve was convicted of murder and sentenced to life imprisonment with a minimum term to serve of 19 years. Following Mr Shreeve's sentence, staff continued ACCT monitoring to support him. The mental health team saw Mr Shreeve regularly in the weeks after his sentence. Although Mr Shreeve self-harmed on 20 December, he made good progress in the following days. As a result, staff closed his ACCT on 23 December.

2020

46. When the mental health nurse assessed Mr Shreeve again on 30 January 2020, he reported that he was doing well, had a job in the prison and his mood was settled. As a result, he discharged Mr Shreeve from his caseload as he was satisfied that he was making good progress.

47. However, Mr Shreeve told staff in March that he felt like self-harming as he was having difficulty accepting the length of his sentence and was having flashbacks to his offence. He also said he was struggling with the COVID-19 restrictions, which meant that he was in his cell for 23 hours a day. The mental health team continued to work with Mr Shreeve for the rest of the year. An assessment completed by the mental health nurse in June concluded that Mr Shreeve was suffering from moderate anxiety and moderate depression, and his treatment was informed accordingly. As part of Mr Shreeve's mental health care treatment, an assistant psychologist worked with him to try to address his self-harm and trauma issues.

48. The substance misuse team also saw Mr Shreeve in March after he tested positive for cannabis use. They offered him treatment to address his drug issues, but he refused it. He did, however, accept support and advice from them and was allocated a substance misuse worker to support him. Following a code blue in July (when Mr Shreeve was found under the influence of PS), he told staff that he used PS when he felt stressed. The substance misuse worker attended Mr Shreeve's ACCT reviews on several occasions. She had regular contact with him while at Doncaster and said she developed a good working relationship with him.

49. Mr Shreeve cut himself eight times between May and December, sometimes so severely that he had to be taken to hospital. Staff used the ACCT process to monitor Mr Shreeve's risk, and he was subject to constant supervision for a week in September after he told staff he could not cope with the guilt about his offence and showed them suicide notes.

50. Doctors continued to review Mr Shreeve's medication for epilepsy and anxiety and adjusted it where necessary. In September, Mr Shreeve's dose of pregabalin (used to treat epilepsy and anxiety) was decreased. This was partly because he had allegedly been swapping and selling his medication with other prisoners. (Pregabalin is a popular drug of abuse in prison because of its euphoric effects.)

51. On 30 September, Mr Shreeve had a serious seizure and was transferred to hospital where he was prescribed codeine (an opioid painkiller). When he got back to prison, Mr Shreeve asked healthcare staff to prescribe him codeine, but they decided against it due to concerns about how it might interact with other medications he was taking. (Codeine is also illicitly traded and abused in prisons.)

52. On 8 December, the mental health nurse reviewed Mr Shreeve and recorded on SystmOne that Mr Shreeve was happy with his medication, that his psychology sessions were helping and that he was aware of the support available to him in the prison. As a result, the nurse discharged Mr Shreeve from his caseload.

53. On 14 December, Mr Shreeve self-harmed by opening an old wound. He told a nurse that he did this because he had been accused by staff of taking an illicit substance. Following the incident, staff opened an ACCT for Mr Shreeve, which was closed later that day following a review. The next day, the substance misuse worker completed a psychology session with Mr Shreeve and recorded on SystmOne that he engaged well and was managing to use some of the techniques that had been discussed in their sessions.

54. On 18 December, a psychiatrist reviewed Mr Shreeve's medication and increased his dose of trazodone (an antidepressant).

55. On 30 December, Mr Shreeve went to the medication hatch and told a nurse that he felt like self-harming. He presented as very agitated and distressed. She told Mr Shreeve that she would ask one of the mental health team to see him the next day.

56. The following day, the mental health nurse went to see Mr Shreeve and felt that he engaged well. Mr Shreeve told the nurse that he wanted to be moved to another prison due to the length of his sentence. After their session, the nurse raised this issue with a one of the custodial managers. (In interview, the nurse told us that transfers to other prisons were difficult to arrange at the time due to the pandemic.)

2021

57. On 6 January 2021, a clinical psychologist wrote to Mr Shreeve explaining that the assistant psychologist had to work from home and would temporarily be unable to continue with his psychology sessions. She explained to him how to access support in the meantime.

58. On 17 January, a nurse completed a review of Mr Shreeve's healthcare needs. Although Mr Shreeve reported feeling emotional about his offence and sentence, she recorded that he engaged well with the review and said that he had a good rapport with staff and no intention of self-harming.

59. On 8 February, staff opened an ACCT for Mr Shreeve after he self-harmed by making three cuts to his right arm. Mr Shreeve told staff that that he was frustrated about not being moved to another prison. The following day, Mr Shreeve told staff at his ACCT review that he was struggling to sleep. Staff moved him to another wing due to issues he was having with other prisoners. Staff closed the ACCT, as they were satisfied that all the issues on Mr Shreeve's caremap were resolved and he appeared to be making good progress.

60. On 11 February, healthcare staff recorded in his medical records that they had received information that Mr Shreeve was diverting and selling his clonazepam medication (which is used to treat epilepsy) to other prisoners. (It is unclear what action, if any, was taken by staff as a result of this information.)

61. On 12 February, an officer completed a key worker session with Mr Shreeve. She recorded that Mr Shreeve said he had no concerns on his new wing and felt safe and well, and that he had no problems with the COVID-19 restrictions that were in place at the time. She raised no concerns about Mr Shreeve's wellbeing.

62. The officer met Mr Shreeve for another key worker session on 18 February and raised no concerns about him. In interview, she told the investigator that Mr Shreeve seemed "perfectly fine" when she spoke to him that day, although she described his mood in general as "up and down".

20 February

63. At 5.50am on 20 February, staff opened an ACCT for Mr Shreeve after he self-harmed by making deep cuts to his arm. Mr Shreeve presented to staff as very distressed and tearful. The ACCT assessor, a Custodial Operational Manager (COM), spoke to Mr Shreeve at about 8.35am and recorded on the ACCT assessment interview form that Mr Shreeve said his "head has gone" and that he wanted to speak with the mental health team. Mr Shreeve said he was struggling with having no contact with his family (as they had cut off contact with him following his offence) but said his self-harm was not a suicide attempt. He told the COM that he did not want to die, and instead wanted to progress and transfer to a more settled prison. He also said that he felt much better and more relaxed after speaking about his issues.

64. The ACCT review took place at around 8.55am and was attended by a COM, the mental health nurse, another COM (the ACCT case manager) and Mr Shreeve. At the review, the case manager told Mr Shreeve that he had emailed the Offender Management Unit (OMU) and they would see him soon to discuss a potential transfer to another prison. He also referred Mr Shreeve back to the self-harm reduction programme he had previously been on (and which he said had helped him). All staff members present were satisfied that Mr Shreeve's level of risk should be changed from 'raised' to 'low' and the ACCT should be closed.

65. In interview, the mental health nurse told the investigator that Mr Shreeve had self-harmed on this occasion because his mother had been diagnosed with cancer and he was not in contact with her. After discussing the issue with Mr Shreeve, he and the other staff members were satisfied that the crisis had been talked through and resolved as much as possible.

66. At around 3.30pm, Mr Shreeve went to the healthcare centre to have his wound properly dressed and cleaned. According to SystmOne, he told staff that he felt "funny" and then had a seizure which lasted approximately five minutes. Staff took Mr Shreeve to get his medications and he had a further seizure, which lasted around three to four minutes. Staff assisted Mr Shreeve back to his cell using a wheelchair and planned to check him later that evening. Mr Shreeve was coherent and chatting to officers when they left him.

67. At around 11.00pm, two nurses went to Mr Shreeve’s cell and took his observations, which were all within the normal range. (Mr Shreeve refused to have his blood pressure taken.) Due to Mr Shreeve’s earlier seizures, Officer A, the night officer, was tasked with checking Mr Shreeve at intervals during the night.

21 February

68. At around 12.00am, Officer A and another night officer, Officer B, completed a visual check on Mr Shreeve by looking through his cell observation panel and saw that he was sitting on the floor leaning on his bed (a position which Officer B said he was known to sleep in). In interview, Officer A told the investigator that he saw Mr Shreeve breathing and noted some hand movements.

69. At around 3.00am, both officers completed another visual check on Mr Shreeve and noted that he was breathing. They raised no concerns.

70. At 4.00am, Officer A, by himself this time, completed a further visual check on Mr Shreeve and noted that his chest was moving. He raised no concerns.

Emergency response

71. At 5.45am, Officer A and another night patrol officer, Officer C, completed a visual check on Mr Shreeve and found him sitting on the floor looking pale, with his head tilted to the right. They shouted to him, but he did not respond. At that point, Officer C shouted out to another more experienced officer, Officer D, who was nearby, and asked him to unlock the cell door. Officer D radioed the duty manager and asked permission to go into the cell, which was granted. Officer D went into the cell, followed by Officer C and Officer A. Officer D checked for a pulse but could not find one. He found that Mr Shreeve was very pale and cold to the touch.

72. Officer D radioed a code blue at around 5.50am, and the control room immediately called for an ambulance. The duty manager and other officers arrived at the cell in less than a minute. The officers carried Mr Shreeve on to the landing and assisted Officer D with cardiopulmonary resuscitation (CPR). Around a minute later, two nurses arrived at the cell and took over the CPR. They attached a defibrillator and administered oxygen to Mr Shreeve.

73. At 5.58am, paramedics arrived and took over the CPR from prison healthcare staff. They were unable to revive Mr Shreeve and at 6.32am, they confirmed that he had died.

Contact with Mr Shreeve’s family

74. The prison’s appointed family liaison officer (FLO) initially had problems finding up to date contact details for Mr Shreeve’s next of kin (his mother). As a result, Mr Shreeve’s mother was informed of the death by police later that day.

75. The FLO called Mr Shreeve’s mother at 9.13am the following day to offer her condolences and apologise for the delayed contact. She maintained contact with Mr Shreeve’s family and, in line with national instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

76. The duty manager held a debrief with prison staff involved in the emergency response. All staff were offered the support of the prison's care team.

77. The Director posted notices informing other prisoners of Mr Shreeve's death and offering support in case they had been adversely affected.

Post-mortem report

78. Post-mortem toxicology tests indicated a potentially fatal use of codeine and paracetamol. The codeine concentration found was well within the fatal range and the concentration of paracetamol is likely to have caused liver damage if taken two to three days before Mr Shreeve's death. The pathologist said that, because the autopsy was conducted digitally, it was not possible to see the liver directly or to define the presence or absence of paracetamol damage. However, overall, the evidence indicated that Mr Shreeve died as a result of aspiration pneumonitis (inhaling regurgitated gastric contents) as a result of a codeine overdose.

79. The pathologist also said that because Mr Shreeve was prescribed satisfactory levels of anti-epileptic medication, it was unlikely that Mr Shreeve's epilepsy played a major part in his death.

Findings

Clinical care

80. The clinical reviewer concluded that the standard of physical, mental health and substance misuse care received by Mr Shreeve at Doncaster was of a good standard and was equivalent to that which would have been received in the wider community.

Management of risk of suicide and self-harm

81. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.

82. Neither this investigation nor the post-mortem examinations could determine whether Mr Shreeve's codeine overdose was deliberate or accidental. However, we have still considered whether staff at Doncaster acted appropriately when they closed Mr Shreeve's ACCT on 20 February (the day before he was found dead). We appreciate that decisions on whether to close an ACCT are often finely balanced, and we understand how difficult they can be to make.

83. Mr Shreeve was monitored under the ACCT process on many occasions while at Doncaster due to his self-harming behaviour. He had two main risk factors for suicide: he had a long history of self-harm and had been sentenced to life imprisonment for a violent offence (which he was struggling to come to terms with). In interview, the mental health nurse told us that Mr Shreeve appeared settled during the ACCT review on 20 February, had all his medications, and was aware of all the prison-wide support structures available to him outside of the ACCT process. We have no reason to doubt the nurse's version of events.

84. However, we are concerned that only around three hours earlier Mr Shreeve had made deep cuts to his arms and been tearful and distressed. He had also cut himself nine times in the previous 10 months, sometimes so severely that he had to be taken to hospital and had last done so only 12 days earlier. We consider that it was too soon for staff to be satisfied that his risk of suicide or self-harm had reduced sufficiently for the ACCT to be closed. It follows that we consider the decision to close Mr Shreeve's ACCT was premature. We make the following recommendation:

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

    - **ensuring that sufficient consideration and weight is given at ACCT case reviews to a prisoner's risk factors for suicide and self-harm; and**
    - **ensuring that a prisoner's level of observations appropriately reflect their risk.**

85. However, Mr Shreeve was monitored by staff anyway during the night of 20/21 February (following the two epileptic seizures he had experienced earlier in the day). We cannot, therefore, say that closing the ACCT made any difference or that the outcome would have been different for him if the ACCT had remained open.

Substance misuse

86. Mr Shreeve had a significant history of substance misuse both in the community and in prison, and often used drugs as a way to cope with stress. Although Mr Shreeve accepted support and advice from the substance misuse team at Doncaster, he refused to engage in any treatment.

87. Prison intelligence indicated that Mr Shreeve was swapping and selling his prescribed medication with other prisoners. There is no evidence that staff acted on this intelligence, other than to record it in his healthcare record. As he was not prescribed codeine while at Doncaster, he can only have obtained the drug illicitly from another prisoner.

88. Doncaster's current drug strategy was introduced in late 2020 (a few months before Mr Shreeve died). Having reviewed the strategy, we are satisfied that it is clear in its vision to tackle the supply and trading of prescription drugs in the prison.

Emergency response

89. HMP Doncaster's Night State Policy ("8.05 Nights – Opening Cells") says that in an emergency where there is, or there appears to be, immediate danger to life, a cell may be unlocked without the authority of the Duty Manager and with only one officer present.

90. In interview, Officer A told us that when he conducted the early morning check on 21 February with Officer C, he was unsure whether Mr Shreeve was breathing. Officer C told us that Mr Shreeve looked very pale and was unresponsive. We therefore consider that this was a medical emergency and officers should have gone into the cell immediately (rather than waiting for the Duty Manager's permission), in line with Doncaster's local policy. This led to a delay of around five minutes before staff entered the cell and called the medical emergency code.

91. We cannot say whether Mr Shreeve's life could have been saved if staff had gone into the cell immediately and called the code blue earlier. However, a delay of this length could make a critical difference in other medical emergencies.

92. We make the following recommendation:

The Director should ensure that, subject to a personal risk assessment, staff enter cells as quickly as possible if there is reason to consider that the prisoner's life may be at risk, in line with national and local policy.

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