Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raycey McDonald, a prisoner at HMP High Down, on 5 November 2020

A report by the Prisons and Probation Ombudsman

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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 Raycey McDonald was found hanged in his cell at HMP High Down on 5 November 2020. He was 32 years old. I offer my condolences to Mr McDonald's family and friends.

Mr McDonald was recalled to prison in January 2020 for a violent offence against his partner. He experienced episodes of paranoia when he believed other prisoners were trying to kill him and poison his food. His paranoia increased as he approached his release date of 24 November.

Mr McDonald experienced a very restricted regime during the COVID-19 pandemic. There is no evidence that wing staff completed welfare checks or had any meaningful interactions with Mr McDonald in the seven months leading up to his death. I am concerned that prison and healthcare staff missed several opportunities to identify Mr McDonald's risk and start ACCT monitoring.

In addition, there was a three minute delay in entering Mr McDonald's cell when he was found hanged. Although this did not affect the outcome for Mr McDonald as he had been dead for some time, it could make a critical difference 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 **March 2022**

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Summary

Events

1. Mr Raycey McDonald was serving a four year sentence for a violent offence. In November 2018, he was released on licence from HMP High Down. He was recalled to High Down on 9 January 2020 after breaching his licence conditions and, on 27 February, he received a 24 week sentence for a further violent offence. His release date was 24 November.

2. Mr McDonald had a history of paranoid behaviour and believed other prisoners were trying to poison his food. On 22 January, he assaulted another prisoner who was serving food and was referred to the mental health in-reach team. The following day he was moved to the segregation unit after he refused to move to another house block.

3. Mr McDonald continued to display paranoid behaviour in the segregation unit. A psychiatrist assessed him and concluded that he did not have any symptoms of psychosis. He was discharged from the mental health in-reach team on 31 January and returned to the house block on 12 February.

4. Key working sessions were suspended in March during the COVID-19 pandemic. Mr McDonald had his last key work session on 30 March and one recorded welfare check on 2 May.

5. On 19 October, Mr McDonald told his offender supervisor he was hearing voices at night. The next day, Mr McDonald told a mental health nurse he was feeling stressed about his release from prison. He denied any thoughts of suicide or self-harm and a prison GP prescribed medication for insomnia.

6. On 3 November, an officer asked a mental health nurse to see Mr McDonald because she was concerned that his mental health was deteriorating. Mr McDonald told the nurse that he thought other prisoners were talking about him. The officer emailed the mental health in-reach team the same day because she was very concerned about Mr McDonald's mental health.

7. On 4 November, another mental health nurse saw Mr McDonald. She noted that there was no evidence that Mr McDonald was suffering from psychosis but that she would request a further assessment. Later that day, Mr McDonald told an officer he felt 'off balance'. A psychiatrist assessed him and diagnosed chronic untreated psychosis. Mr McDonald told the psychiatrist that he was hearing voices telling him to kill himself. The psychiatrist arranged that Mr McDonald would move to the prison's inpatient unit the following day.

8. At around 5.23am on 5 November, an operational support grade (OSG) conducting a roll check saw Mr Donald with a ligature around his neck and a large amount of blood in the cell. The OSG radioed an emergency code. Prison and healthcare staff responded but did not try to resuscitate Mr McDonald as it was clear he was dead. At 5.40am, ambulance paramedics confirmed that Mr McDonald had died.

Findings

9. Mr McDonald had a number of significant risk factors for suicide and self-harm.

10. We are very concerned that both prison and healthcare staff failed to identify and assess Mr McDonald's risk to himself. A psychiatrist did not begin suicide and self-harm procedures (known as ACCT) after Mr McDonald told him he was hearing voices telling him to kill himself. Officers were over reliant on Mr McDonald's assurances that he would not kill himself and they did not consider if he posed a risk to himself despite their concerns that his mental health was deteriorating.

11. We are concerned that there is no evidence that prison staff had any meaningful interaction with Mr McDonald after the prison suspended key work sessions at the end of March due to COVID-19 restrictions. Prison staff recorded only one welfare check over the next seven months before Mr McDonald's death. This was a missed opportunity to identify Mr McDonald's distress and provide him with additional support, particularly as he approached his release from prison.

12. The OSG who found Mr McDonald hanging did not enter the cell, despite being aware that he was able to do so. There was a three minute delay before officers arrived and entered the cell and cut the ligature.

13. The clinical reviewer concluded that Mr McDonald's clinical care was equivalent to that which he could have expected to receive in the community. However, she noted that healthcare staff did not request Mr McDonald's community GP records to ensure continuity of care.

Recommendations

- The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that prison and healthcare staff:
    - share all information that affects risk;
    - start ACCT monitoring procedures when a prisoner has significant risk factors, or record their reasons for not doing so; and
    - open an ACCT if a prisoner indicates that he is at risk of attempted suicide and self-harm and do not rely solely on what a prisoner says or how he presents.
- The Governor should ensure that staff conduct meaningful welfare checks during a restricted regime, in line with the Exceptional Delivery Model.
- The Governor should ensure that:
    - all prison staff are made aware of and understand their responsibilities during medical emergencies, including that night staff enter cells as quickly as possible in a life-threatening situation; and
    - the night patrol officer's form is amended to include specific instructions on entering a cell at night.

- The Head of Healthcare should ensure that healthcare staff request full GP records for newly arrived prisoners.
- The Governor should share this report with Officer B and the OSG and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Governor should share this report with the offender supervisor to ensure she is aware of the Ombudsman's comments about her good practice.
- The Head of Healthcare should share this report with Psychiatrist A and discuss the Ombudsman's findings with him.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP High Down informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

15. The investigator visited High Down on 12 November 2020. She obtained copies of relevant extracts from Mr McDonald's prison and medical records. She spoke to one prisoner.

16. NHS England commissioned a clinical reviewer to review Mr McDonald's clinical care at the prison. The investigator and clinical reviewer interviewed eight members of High Down staff on 10 December and 17 June 2021. The investigator interviewed two members of staff on 25 June and one member of staff on 4 October. We interviewed some staff in person and other interviews were conducted by telephone or video because of the restrictions in place during the COVID-19 pandemic.

17. We informed HM Coroner for Surrey of the investigation. The Coroner provided us with a copy of the post-mortem report. We have sent the Coroner a copy of this report.

18. We wrote to Mr McDonald's nominated next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr McDonald's family wanted to know:

    - Why Mr McDonald was in a cell on his own?
    - Was Mr McDonald's mental health assessed and appropriate action taken to safeguard him?
    - Why was Mr McDonald not moved to a psychiatric unit or the inpatients unit?
    - Did prison staff act on the family's concerns about Mr McDonald's mental health?
    - Why was Mr McDonald not monitored under ACCT procedures?
    - What sentence was Mr McDonald serving and did he serve over his sentence time?
    - Was Mr McDonald prepared for his release?
    - Was Mr McDonald prescribed any medication?

19. We have answered the family's questions in this report.

20. In October 2021, Mr McDonald's partner asked some questions, which will be answered in separate correspondence.

21. Mr McDonald's family received a copy of the initial report. The solicitor representing Mr McDonald's mother wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP High Down

23. HMP High Down is a local prison in Surrey which holds up to 1,150 men. Central and North-West London (CNWL) NHS Foundation Trust provides primary health services and in-reach mental health care. Anchor Health delivers GP services. The healthcare unit has inpatient facilities with 24-hour nursing cover. Substance misuse services are provided by the Forward Trust.

HM Inspectorate of Prisons

24. The most recent full inspection of HMP High Down was in May 2018. Inspectors reported that levels of self-harm had increased but were still lower than at similar prisons. There was a reasonably good strategic approach to managing prisoners at risk of suicide and self-harm, but key aspects, notably providing prisoners in crisis with activity, had yet to be delivered. Monthly safer custody meetings were informed by adequate analysis, but incidents of self-harm were not followed up to generate learning. Staff struggled to manage the number of ACCT case management documents for prisoners at risk of suicide or self-harm effectively, and outcomes were highly variable. Inspectors found some examples of inadequate support for prisoners in crisis. Health service staff rarely attended case reviews, and care maps were often weak.

25. In March/April 2021, HMIP conducted a Scrutiny Visit (a shortened inspection during the pandemic). Inspectors reported that they had found a troubled prison confronting difficult, long-term challenges. Progress had been too slow to provide prisoners with purposeful activity 12 months into COVID-19 restrictions. Most prisoners still had only one hour out of their cells each day, sometimes less when time in the open air was cancelled. Recorded levels of self-harm had reduced during the pandemic, but the number of prisoners being managed under ACCT was high and this had affected the quality of support for those at risk of suicide and self-harm. Sometimes there was no care map, and it was not clear how staff were supposed to help the individual.

26. Inspectors also reported that they were seriously concerned by the poor quality of healthcare provision. There had been a lack of consistent leadership, with four heads of healthcare in the year. There had been severe staff shortages and healthcare staff told inspectors that they felt compromised by the unmanageable demands on their time.

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 annual report, for the year to December 2020, the IMB reported that the number of hanging attempts and overdoses had both reduced, but the number of head-banging and wound aggravation incidents had increased. The Board said it was hard to draw conclusions from these figures, although they were

aware of the impact that the very limited pandemic regime might have had on the mental health of many prisoners.

Previous deaths at HMP High Down

28. Mr McDonald was the fourth prisoner to die at High Down since November 2019. Of the previous three deaths, one was self-inflicted and two were from natural causes. There has been one self-inflicted death and two natural cause deaths at High Down since Mr McDonald's death which are currently under investigation.

29. In a previous investigation into a self-inflicted death at High Down in August 2019, we found that the prisoner's risk factors were not properly assessed. We recommended that the staff concerned received refresher training in ACCT and safer custody procedures as a matter of urgency. The prison accepted our recommendation and said that the staff concerned had completed national Suicide and Self Harm (SASH) training and would receive refresher training that covered ACCT processes by July 2020.

Assessment, Care in Custody and Teamwork

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. As part of the process, a caremap (plan of care, support and intervention) is put in place. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011

The key worker scheme

31. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. Under the scheme, 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. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner. 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.

32. Key working was suspended across the prison estate on 24 March 2020 due to the COVID-19 pandemic. On 12 May, the Prison Service issued an Exceptional Delivery Model (EDM) setting out the key regime elements that establishments must operate during the pandemic. The EDM recommended that key work should continue for certain high risk groups, including prisoners at risk of suicide or self-

harm. It also recommended that regular welfare checks should be conducted on other prisoners.

Key Events

33. On 16 June 2017, Mr Raycey McDonald was sentenced to four years in prison for a violent offence and was sent to HMP High Down. On 23 November 2018, Mr McDonald was released on licence. He was recalled to High Down on 9 January 2020, after breaching the conditions of his licence. On 27 February he was sentenced to 24 weeks for a violent offence against his partner. Mr McDonald was due to be released from prison on 24 November 2020.

34. A cell sharing risk assessment (CRSA) was completed when he arrived at High Down. This recorded that Mr McDonald was a high risk for sharing a cell because of previous violent behaviour in prison. Mr McDonald was allocated a single cell on Houseblock 2.

35. A nurse completed Mr McDonald's initial health screen. She noted that Mr McDonald did not have any long-term medical conditions and was not prescribed any medication. Mr McDonald said he had no physical or mental health concerns and had no thoughts of suicide or self-harm. He gave consent for staff to obtain his community medical records, although staff did not obtain them. Mr McDonald did not attend a second health screen on 15 January.

36. On 22 January, Mr McDonald's mother left a voicemail message on the Safer Custody hotline. She said that she was concerned that Mr McDonald was displaying paranoid behaviour as he believed that his food was being tampered with by other prisoners. An officer completed a welfare check the same day. Mr McDonald was unable to say who was tampering with his food but said that he felt under threat from other prisoners.

37. Later that day, Mr McDonald assaulted another prisoner who was serving food because he believed he was poisoning his food. An officer completed a violence reduction investigation into the incident. She noted that Mr McDonald was displaying paranoid behaviour and was convinced that another prisoner was trying to poison him. Mr McDonald was placed on the basic regime under the Incentives and Earned Privileges (IEP) scheme for 14 days and referred to the mental health in-reach team.

38. On 23 January, Mr McDonald saw his probation officer. After her visit, she contacted the Safer Custody department at High Down and said that Mr McDonald had told her he was under threat from other prisoners on the house block. Staff decided to move Mr McDonald to Houseblock 5. Later that day, Mr McDonald refused to move and became uncooperative and argumentative. Mr McDonald was then moved to the segregation unit under Prison Rule 45 (for reasons of good order or discipline).

39. While he was in the segregation unit, prison and healthcare staff saw Mr McDonald daily. Prison officers expressed concern that Mr McDonald was acting in a paranoid way and believed other prisoners were trying to kill him by poisoning his food and planning to gas him in the showers. A nurse assessed Mr McDonald and noted that he denied any thoughts of suicide or self-harm.

40. On 27 January, a nurse recorded that Mr McDonald continued to present as paranoid and was adamant that he would be killed if he left his cell. The same day, a mental health nurse assessed Mr McDonald and noted that he remained paranoid and unsettled. Mr McDonald refused to give permission for prison or healthcare staff to contact his mother to discuss his mental health. Mr McDonald said he wished to remain in the segregation unit and refused to return to the houseblock.

41. On 28 January, the mental health nurse noted that Mr McDonald denied that he had said that he was under threat from other prisoners. The nurse recorded that Mr McDonald was now fit to return to the houseblock but would instead move to the prison's inpatient unit for further assessment.

42. On 29 January, Mr McDonald moved to the inpatient unit where he was assessed by a mental health nurse. Nurses created a mental health care plan. A psychiatrist assessed Mr McDonald in the inpatient unit. He recorded that Mr McDonald did not display any symptoms of psychosis and appeared burdened by his crimes. He concluded that Mr McDonald had 'adjustive disorder' resulting from his recall to prison. Mr McDonald returned to the segregation unit on 30 January and was discharged from the mental health in-reach team's caseload on 31 January.

43. On 12 February, Mr McDonald moved to Houseblock 3. A Senior Officer (SO) provided support to Mr McDonald with his transition from the segregation unit to the houseblock. Mr McDonald did not express any concerns about his return.

44. On 13 February, Mr McDonald saw his keyworker. Mr McDonald said he was happy to be back on the houseblock and did not express any concerns. The keyworker continued to see Mr McDonald weekly until 30 March, when key working was suspended because of the pandemic.

45. On 20 February, Mr McDonald asked to see a mental health nurse. Mr McDonald said that he felt mentally stable and was keen to start therapy. The nurse made a referral to the psychological therapies team.

46. On 11 March, an assistant psychologist assessed Mr McDonald. Mr McDonald said that he felt frustrated he did not have contact with his children, and that he was not allowed to speak to his partner because she was the victim of his offence. He denied having suicidal thoughts and said he was no longer suffering from paranoia. He wanted to engage in therapies to help him cope with the prison regime and to improve his relationship with his partner. Mr McDonald was placed on the waiting list for the wellbeing group.

47. On 2 May, an officer completed a welfare check and recorded that Mr McDonald did not have any concerns.

48. On 27 May, Mr McDonald spoke to his offender supervisor to discuss his Parole Board hearing in June. Mr McDonald said that he was happy to be back in contact with his partner and he felt that his mental health had improved. He said he enjoyed speaking to his children on the telephone but spent the majority of his time sitting in his cell watching television. Mr McDonald said that he hated being in prison and wanted to get to the end of his sentence in November.

49. On 11 June, the offender supervisor saw Mr McDonald again. He told her he was working towards getting to the end of his sentence and was seeing the Chaplaincy team.

50. On 16 July, Mr McDonald's offender supervisor spoke to him on the telephone about his parole hearing. She said that the hearing had been adjourned and that she was unable to recommend Mr McDonald's release because he did not have a place at an Approved Premises. Mr McDonald said that he was getting on with his partner, but they were no longer in a relationship. He told her he wanted to focus on his children as they were his priority.

51. On 24 August, the offender supervisor spoke to Mr McDonald on the telephone. She recorded on NOMIS that Mr McDonald was angry and obstructive and refused to discuss his relationship with his partner. Mr McDonald told her he did not wish to speak to her again.

52. On 16 September, the offender supervisor saw Mr McDonald. He apologised to her for his previous behaviour. Mr McDonald said that he wasn't happy that day and was not in the mood to speak about his relationship issues. She encouraged Mr McDonald to contact his offender manager to discuss his release plan. Mr McDonald said he would no longer be able to live with his mother after release and hoped to get his job back as a delivery driver. He told her he was still experiencing anxiety and recognised he would need support with his mental health after he was released.

53. On 19 October, the offender supervisor spoke to Mr McDonald on the phone. He told her he was hearing voices at night which he believed were coming from another prisoner, and that people were making threats toward him and his family. She noted that Mr McDonald appeared paranoid because one of the prisoners whose voice he said he could hear making threats had left the prison two months earlier. She submitted a security information report and contacted the mental health in-reach team.

54. A mental health nurse saw Mr McDonald on 20 October. Mr McDonald said he was feeling stressed about his release from prison in November. He denied any thoughts of suicide or self-harm and said he had reconciled with his partner and was looking forward to seeing his children.

55. The mental health nurse saw Mr McDonald again on 21 October, because he was having an acute episode of restlessness and was hearing voices which made him believe that he was under threat from other prisoners. Mr McDonald was prescribed promethazine (an antihistamine used to treat insomnia). The nurse said he would see Mr McDonald the following week. Later that day, prison staff expressed concern that Mr McDonald appeared to be fixated with a female member of staff and continued to express paranoid thoughts. The nurse noted that staff should continue to monitor Mr McDonald's behaviour and that he should be seen urgently if there was no improvement in the next 24 hours. The mental health team did not see Mr McDonald again until 3 November.

56. On 28 October, a psychologist told Mr McDonald he would not be able to complete the psychological therapies before his release and he would be told how to access support in the community. The same day, the prison agreed to facilitate a

telephone call between Mr McDonald and the social worker for his children to discuss the plan for Mr McDonald's contact with his children after his release. However, the telephone call did not take place because the social worker had recorded the wrong date and time.

57. On 2 November, the Safer Custody team rang the houseblock to say that Mr McDonald's mother was concerned because she had not heard from him for a while. An officer spoke to Mr McDonald who said he would ring his mother. That afternoon the offender supervisor messaged Mr McDonald, asking him to contact his probation officer to discuss his release plans.

Events of 3 November

58. On 3 November, Officer A was working on Houseblock 3. She told the investigator that Mr McDonald rang his cell bell and she responded with Officer B. Mr McDonald asked them if he could collect his medication, despite already having done so. Officer B told Officer A that she was concerned that Mr McDonald's mental health was deteriorating and said she had asked a member of the mental health team to see him.

59. That afternoon, a mental health nurse assessed Mr McDonald and noted that he denied any thoughts of suicide or self -harm. She described Mr McDonald as 'guarded throughout the review' and recorded that he had said he had 'thoughts of some nice things and not so nice things only when he is in his cell'. Mr McDonald thought that other prisoners were talking about him. She told Mr McDonald how to contact the mental health team, Samaritans and Listeners (prisoners trained by the Samaritans to provide support to other prisoners).

60. At 5.27pm, Officer A emailed the mental health in-reach team because she was very concerned about Mr McDonald. She said that Mr McDonald was paranoid that a prisoner had threatened him (the prisoner concerned was no longer in High Down), he had forgotten that he had taken his medication and he appeared vacant. She said prison staff were concerned that Mr McDonald's mental health had deteriorated.

Events of 4 November

61. At 9.05am, a member of the mental in-reach team replied to Officer A and said a mental health nurse had assessed Mr McDonald the previous day. Mr McDonald had denied that he was paranoid and there was no evidence that he was suffering from psychosis. She said she would request that a further assessment took place.

62. At approximately 3.00pm, Mr McDonald pressed his cell bell and asked Officer B for a chat. Officer B told the investigator that she took Mr McDonald to the Listener's suite. Mr McDonald said that he felt positive about his forthcoming release from prison and was excited to see his children. However, he told her that he felt 'off balance'. She told the investigator she did not have any concerns about Mr McDonald and for this reason she did not make an entry about their conversation in his NOMIS record.

63. At approximately 4.00pm, Psychiatrist A assessed Mr McDonald. Officer B was also present. The psychiatrist recorded that Mr McDonald continued to experience threatening hallucinations and had chronic untreated psychosis which was worsened by the prison environment and his imminent release. He considered that Mr McDonald posed a risk to others and could not be safely managed on the houseblock.

64. Psychiatrist A recorded that Mr McDonald was hearing voices telling him to 'sit down', which Mr McDonald said meant the voices were telling him to kill himself by hanging. Mr McDonald said this was what the voices wanted and was not his wish. He concluded that Mr McDonald was acutely psychotic.

65. Although Mr McDonald was hearing voices telling him to kill himself, Psychiatrist A recorded that Mr McDonald felt he was able to keep himself safe, and that he considered his risk was to other prisoners and less so to himself and was not worried that Mr McDonald was at risk of suicide or self-harm. He discussed his assessment of Mr McDonald with a consultant psychiatrist. He did not consider that Mr McDonald required emergency admission to the inpatient unit, but he made a plan to move Mr McDonald to the inpatient unit the next day for monitoring and to receive anti-psychotic medication.

66. Psychiatrist A spoke to Officer C in the wing office and told him that due to a decline in Mr McDonald's mental health, he would be moving to the inpatient unit the next day. Officer C told the investigator that he spoke to the psychiatrist about moving Mr McDonald to the inpatient unit that evening if necessary. The psychiatrist did not provide a full handover about Mr McDonald's circumstances and he left the wing shortly after. He did not ask for Mr McDonald to be moved to the inpatient unit that day.

67. Officer B told the investigator she did not hear Mr McDonald say that he was hearing voices telling him to kill himself.

68. When Mr McDonald returned to his cell, he refused to leave it to collect his evening meal. Officer C took Mr McDonald's meal to his cell door and prisoners were locked up at 6.00pm. Mr McDonald was aware that he was moving to the inpatient unit the next day and did not express any concerns.

69. CCTV shows an Operational Support Grade (OSG) completing a roll check at Mr McDonald's cell at 8.45pm. The OSG told the investigator that he asked Mr McDonald if he was alright, and Mr McDonald replied 'yes'.

Events of 5 November

70. At approximately 5.21am, the OSG completed the early morning roll check. CCTV shows him looking through the observation panel of Mr McDonald's cell and using his radio to call an emergency code blue (indicating a prisoner is unconscious or not breathing). The control room immediately called an ambulance. The OSG told the investigator that Mr McDonald was kneeling down in the centre of his cell with a ligature around his neck tied to the window, and that there was a lot of blood in the cell. He broke the seal on his pouch and removed the key so he could open the cell door when assistance arrived.

71. Two officers arrived at approximately 5.23am and the OSG opened the cell door. The officers moved Mr McDonald onto his back so they could start cardiopulmonary resuscitation (CPR). A prison paramedic and a nurse arrived. The paramedic completed routine observations and found that Mr McDonald did not have a pulse, his temperature was very low and there was rigor mortis in his jaw. He recorded that Mr McDonald was 'obviously deceased' and made the decision not to start CPR.

72. The ambulance paramedics arrived at 5.40am and confirmed that Mr McDonald had died.

73. Following Mr McDonald's death, the police found a piece of porcelain in his cell. It appears that he had used this to stab himself in the neck before he tied a ligature around his neck, and this was why there was a lot of blood in his cell.

Contact with Mr McDonald's family

74. The prison appointed an officer as the family liaison officer (FLO) and identified Mr McDonald's mother as his next of kin. At 8.40am on 5 November, the Governor telephoned Mr McDonald's mother, due to the COVID-19 restrictions, (instead of visiting her in person) and broke the news of his death.

75. The prison contributed towards the cost of Mr McDonald's funeral in line with Prison Service guidance.

Support for prisoners and staff

76. After Mr McDonald's death, the Head of Safer Custody debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

77. The prison posted notices informing other prisoners of Mr McDonald'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 McDonald's death.

Post-mortem report

78. The pathologist concluded that Mr McDonald's death was due to hanging and a venous air embolism from a stab wound to the right side of the neck.

79. The toxicology report did not detect any illicit substances in Mr McDonald's blood.

Findings

Management of Mr McDonald's risk of suicide and self-harm.

80. PSI 64/2011 lists a number of risk factors and potential triggers for suicide and self-harm. It says 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.

81. Mr McDonald had a number of significant risk factors, including a significant history of anxiety and paranoia, family history of mental illness, relationship instability and family breakdown, licence recall for a violent offence against his partner and he appeared out of touch with reality. We are concerned that prison and healthcare staff at High Down missed several opportunities to identify Mr McDonald's risk of suicide and self-harm:

- On 19 October, Mr McDonald told his offender supervisor he was hearing voices at night from another prisoner who was no longer in the prison. Mr McDonald told a mental health nurse he was feeling stressed about his release from prison.
- On 21 October, prison staff expressed concern that Mr McDonald was fixated with a female officer and was still having paranoid thoughts. A mental health nurse said he should be seen urgently if there was no improvement but did not see Mr McDonald again until 3 November.
- On 28 October, a social worker failed to telephone Mr McDonald as arranged to discuss contact arrangements with his children after his release. Prison staff did not complete a welfare check with Mr McDonald to see if this had affected him.
- On 3 November, prison officers were concerned that Mr McDonald's mental health had deteriorated. Mr McDonald told a mental health nurse he had thoughts of 'not so nice things' in his cell.
- On 4 November, Mr McDonald told a psychiatrist he was hearing voices telling him to kill himself. The psychiatrist decided that Mr McDonald should move to the inpatient unit for monitoring and receive anti-psychotic medication the next day.

82. Given these factors, it is very difficult to understand why staff did not recognise that Mr McDonald was a vulnerable man who might be at risk of suicide and why they did not monitor him under ACCT procedures.

83. We consider that Psychiatrist A should have started ACCT monitoring on 4 November. We share the clinical reviewer's concern that although Mr McDonald told the psychiatrist that he was hearing voices telling him to kill himself, the psychiatrist considered that Mr McDonald was able to keep himself safe. The psychiatrist concluded that Mr McDonald's risk was to other prisoners and the risk to himself seems to have been overlooked.

84. We are also concerned that prison staff did not start ACCT monitoring, given Mr McDonald's obvious risk factors. His potential risk should have been considered when Psychiatrist A told prison staff that Mr McDonald required admission to the inpatient unit. Officer B was present when Psychiatrist A saw Mr McDonald, although she maintained that she did not hear Mr McDonald say he had heard voices which told him to kill himself. However, she and other prison officers were concerned about Mr McDonald's mental health and this should have prompted them to consider whether Mr McDonald posed a risk to himself. There is no evidence that they did so.

85. We recommend:

The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that prison and healthcare staff:

- **share all information that affects risk;**
- **start ACCT monitoring procedures when a prisoner has significant risk factors, or record their reasons for not doing so; and**
- **open an ACCT if a prisoner indicates that he is having suicidal thoughts and do not rely solely on what a prisoner says or how he presents.**

Key worker scheme

86. Mr McDonald had a key worker session on 30 March but had no further key work sessions after that. Apart from one welfare check on 2 May (which simply recorded, 'No concerns raised'), there is no record that wing staff had any interaction with Mr McDonald in the seven months before he died. Although we recognise that welfare checks may have happened without being recorded, we would have expected any meaningful contacts to have been recorded if they took place.

87. His offender supervisor appeared to be the only member of prison staff who spoke to Mr McDonald in any depth. She saw him five times in seven months to discuss his parole report and his plans after his release, and she also telephoned him twice during this time. After the last phone call (on 19 October), she contacted the mental health in-reach team because she was concerned about his mental health. We think she should also have considered opening an ACCT.

88. The restrictions imposed in response to the COVID-19 pandemic meant that prisoners were spending long periods locked in their cells, with less interaction with staff and other prisoners than would normally have been the case. It is possible that the long periods of isolation affected Mr McDonald's mental health and influenced his decision to take his life. We cannot say whether staff might have picked up on signs of distress if they had had more contact with him.

89. We acknowledge the significant pressures faced at High Down around the time of Mr McDonald's death because of reduced staff numbers and the impact of COVID-19. However, we consider that more attention should have been given to supporting those prisoners who may have been experiencing finding the lack of social contact particularly difficult, especially at significant points in their prison time, such as when they are approaching their release.

90. We recommend:

The Governor should ensure that staff conduct meaningful welfare checks during a restricted regime, in line with the Exceptional Delivery Model.

Entering Mr McDonald's cell

91. The OSG told us that when he saw Mr McDonald with a ligature around his neck, he was aware that he was able to enter the cell alone. However, he said the shock of what he saw stopped him from doing so. He removed the key from his sealed pouch and waited until assistance arrived before he unlocked the cell door.

92. Instructions about night procedures (PSI 24/2011, *Management and Security of Nights*) and about safer custody (PSI 64/2011, *Safer Custody*) are clear that preservation of life takes precedence over the usual arrangements for opening cells. Where there appears to be immediate danger to life, prison staff can enter cells by themselves without the authority of the night manager, subject to a personal risk assessment.

93. There was a delay of around three minutes before prison officers arrived and entered Mr McDonald's cell. We appreciate that the OSG was in a state of shock when he saw Mr McDonald hanging in the cell and we are satisfied that the delay did not affect the outcome for Mr McDonald as he had been dead for some time. However, early intervention is crucial to improving the outcome in cases of hanging.

94. In response to a previous PPO recommendation about this issue in February 2019, High Down said that from March 2019, all night staff would receive a briefing on their key responsibilities at the start of their night shift. We are concerned that the prison's night patrol officer's form does not include instructions on entering a cell at night.

95. We recommend:

The Governor should ensure that:

- **all prison staff are made aware of and understand their responsibilities during medical emergencies, including that night staff enter cells as quickly as possible in a life-threatening situation; and**
- **the night patrol officer's form is amended to include specific instructions on entering a cell at night.**

Clinical care

96. The clinical reviewer concluded that Mr McDonald's clinical care was equivalent to that which he could have expected in the community.

97. The clinical reviewer commented, however, that healthcare staff did not request Mr McDonald's community GP records. This meant that staff knew nothing about his medical history while he was on licence in the community. We recommend:

The Head of Healthcare should ensure that healthcare staff request GP records for newly arrived prisoners.

Learning lessons

98. We consider it essential that staff learn the lessons from our reports. We therefore recommend that:

The Governor should share this report with Officer B and the OSG and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Governor should share this report with the offender supervisor to ensure she is aware of the Ombudsman's comments about her good practice.

The Head of Healthcare should share this report with Psychiatrist A and discuss the Ombudsman's findings with him.

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