Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Harris, a prisoner at HMP Doncaster, on 21 November 2019

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Michael Harris died on 21 November 2019, after being found hanged in his cell at HMP Doncaster. He was 35 years old. I offer my condolences to Mr Harris' family and friends.

Mr Harris had a significant history of alcohol and illicit drug use. He was managed under suicide and self-harm prevention procedures (known as ACCT) for a short period during the six days he spent at Doncaster. Our investigation found that the assessment of Mr Harris' risk and the management of the ACCT procedures was poor.

The investigation also found that the mental healthcare Mr Harris received was not equivalent to that he could have expected in the community.

I have expressed concerns about deficiencies in the management of suicide and self-harm procedures and mental health provision at Doncaster in previous investigations. I was, therefore, concerned to find poor practice again in November 2019. Following its inspection of HMP Doncaster in September 2019, HM Inspectorate of Prisons (HMIP) were concerned that not all PPO recommendations had been implemented following the unusually high number of self-inflicted deaths at the prison.

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 **February 2021**

Contents

Summary

Events

1. Mr Michael Harris had a significant history of alcohol and illicit drug use. He had been in prison before and had been released on licence on 3 September 2019. On 31 October, Mr Harris' licence was revoked for breaching his curfew. On 14 November, Mr Harris was arrested, and he was taken to HMP Doncaster the next day.

2. Mr Harris had a history of substance misuse and mental health problems and presented as unkempt and agitated. On 19 November, staff began monitoring Mr Harris under Prison Service suicide and self-harm prevention procedures (known as ACCT). He was initially checked once every 30 minutes but on the morning of 20 November, his risk to himself was assessed as low and the ACCT was closed. Mr Harris continued to behave bizarrely.

3. On 21 November, at 5.37am, an officer found Mr Harris hanged in his cell. He requested an ambulance. Officers and nurses responded and began cardiopulmonary resuscitation. The paramedics arrived at 5.50am, and took Mr Harris to Doncaster Royal Infirmary where, at 6.36am, a hospital doctor pronounced that Mr Harris had died.

Findings

Management of risk of suicide and self-harm

4. We consider that Mr Harris' risk to himself was not adequately assessed. Staff did not give sufficient weight to Mr Harris' risk factors (especially his mental health concerns and his history of alcohol and illicit drug abuse) and relied too much on his assertions that he had no intention of killing himself.

5. Although it was appropriate to open ACCT procedures when Mr Harris said he intended to kill himself, we found that the management of these procedures was poor.

6. We found that ACCT procedures were not conducted in line with mandatory national instructions. Staff did not carry out the prescribed observations and conversations were not recorded. The ACCT was closed just 24 hours after Mr Harris said he intended to kill himself, and the only caremap action remained outstanding.

Clinical care

7. The clinical reviewer concluded that the care Mr Harris received was of a mixed standard and only partially equivalent to that which he could have expected to receive in the wider community. Although the reception screens and the substance misuse care were delivered appropriately, Mr Harris' mental health treatment was not of the required standard.

Psychoactive Substances

8. Doncaster has comprehensive policies to tackle illicit substance misuse. Despite this, Mr Harris was able to access drugs with apparent ease and post-mortem analysis found that he had used synthetic cannabinoids in the hours before he died.

Recommendations

- The Executive Director of Custodial Contracts should:
  - satisfy himself that processes are in place at Doncaster to ensure that the PPO's recommendations are being implemented and embedded; and
  - report his findings to the Ombudsman.
- The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - assessing a prisoner's level of risk on the basis of recognised risk factors and not just on the prisoner's presentation or what he says;
  - recording the reasons for decisions;
  - carrying out and recording conversations and observations, as required; and
  - only closing an ACCT when all caremap actions have been completed.
- The Head of Healthcare should:
  - confirm to the Ombudsman that a revised mental health triage process is now in place;
  - ensure that all relevant information and actions from the previous day's mental health response nurse is shared at the daily handover; and
  - ensure that healthcare staff prepare for ACCT reviews by reading the prisoner's SystmOne notes.
- The Director should ensure that the key drug issues at Doncaster are identified and addressed in the prison's local drugs strategy.
- The Director should share this report with COM A and COM B and discuss the Ombudsman's findings with them.
- The Director should ensure that this report is shared with PCO A and that a senior manager discusses the Ombudsman's findings with him.
- The Head of Healthcare should share this report with Nurse A and Nurse B and discuss the Ombudsman's findings with them.

The Investigation Process

9. 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.

10. The investigator visited Doncaster on 27 November 2019. He obtained copies of relevant extracts from Mr Harris's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Harris' clinical care at the prison.

12. The investigator interviewed seventeen members of staff at Doncaster in December, 10 interviews were conducted jointly with the clinical reviewer. The investigator interviewed one member of staff in January.

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

14. One of the PPO's family liaison officers contacted Mr Harris' mother and sister, to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. Mr Harris' sister requested a copy of this report.

15. Mr Harris' family received a copy of the draft report. The solicitor representing Mr Harris family pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. The solicitor also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. We have also raised some of the family's concerns directly with the Director of HMP Doncaster through separate correspondence.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. Their action plan is annexed to this report.

Background Information

HMP Doncaster

17. 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. The prison directly employs qualified paramedics as part of their healthcare team, and they respond to emergency calls in the prison.

HM Inspectorate of Prisons

18. 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. 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, nor was action taken to ensure that they were embedded in operational practice. 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

19. 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 years 2017-2018 or 2018-2019.

Previous deaths at HMP Doncaster

20. Mr Harris' death was the seventh self-inflicted death at Doncaster since January 2017. There were also nine deaths from natural causes during the same period. There are similarities between Mr Harris' death and two of the other self-inflicted deaths where mental health was not assessed and there was inappropriate assessment of risk of suicide and self-harm.

21. Since Mr Harris' death, there have been five further deaths: two self-inflicted deaths, one from natural causes, one drug-related death and one awaiting classification.

Assessment, Care in Custody and Teamwork (ACCT)

22. 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. 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)

23. Psychoactive substances 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.

Key Events

24. Mr Michael Harris had a custodial history dating back to 2001. He was released on licence from HMP Ranby on 3 September 2019.

25. Mr Harris had a significant history of illicit drug use, specifically cannabis and psychoactive substances (PS), and intelligence suggested he had been involved in the use of illicit drugs and mobile phones and was associated with gang culture in prison.

26. On 31 October, Mr Harris' licence was revoked because he broke his curfew. He was arrested on 14 November, and police records show that Mr Harris admitted he had used alcohol and cannabis during the 24 hours before his arrest.

27. After a court appearance on 15 November, Mr Harris was taken to HMP Doncaster. During the initial health screen, a nurse noted that Mr Harris had a history of drug use and mental health issues and referred him to the substance misuse team and mental health team. Mr Harris said he had no thoughts of suicide or self-harm.

28. A Prison Custody Officer (PCO) completed a first night assessment and the Duty Key Worker contact form. The PCO recorded that there were no immediate concerns about Mr Harris' wellbeing and explained the role of the key worker. Mr Harris said he had been recalled to prison, he struggled with his mental health and had issues with drugs and alcohol. He said he felt safe and was not a member of a gang. He said he would not receive visits or support from his family. Mr Harris was allocated a shared cell.

29. Later that morning, an operational support officer (OSO) carried out a basic custody screen assessment. They discussed Mr Harris' accommodation and he said he was single, had no children and had been claiming state benefits. He said he had no contact with his parents. Mr Harris said he had issues with alcohol and drugs, suffered from depression and anxiety but was not prescribed any medication. He said he had no thoughts of suicide or self-harm.

30. That afternoon, another OSO recorded on a category classification form that Mr Harris was a category C prisoner who had breached his Home Detention Curfew (HDC). As he remained a category C prisoner, the OSO concluded that Mr Harris would be transferred from Doncaster to HMP Moorland to serve the remaining one year, two months of his sentence.

31. At an initial substance misuse assessment on 19 November, Mr Harris told the substance misuse worker that he had used cannabis from the age of 14. He said he had previously overdosed and had used crack cocaine in the week before he was recalled to prison. Mr Harris said he had used PS in previous prisons but had not used any at Doncaster. When the substance misuse worker asked about his poor personal hygiene, Mr Harris said he was not bothered about the way he looked. She recorded that Mr Harris was agitated and behaved strangely during their conversation, continually moving his head from side to side. Mr Harris said he felt anxious, paranoid and frustrated.

32. At 10.35am, the substance misuse worker started ACCT monitoring and completed the Concern and Keep Safe form. She recorded Mr Harris' erratic behaviour and that he had said, "I feel crazy", "I'm going to kill myself, but I don't know how yet."

33. At 11.00am, Custodial Operations Manager (COM) A completed the ACCT immediate action plan. She assessed Mr Harris as being at raised risk and set his level of observations at every 30 minutes throughout the day and night until the first case review, along with three quality conversations during the day.

34. According to the ACCT ongoing record, Mr Harris was checked at 11.00am, 11.35am and 12.00pm. There were no further entries made until 5.15pm and no one recorded a conversation.

35. That afternoon, COM A called the healthcare centre to ask for a member of the mental health team to see Mr Harris because he was behaving bizarrely. At 5.15pm, a nurse recorded in the ACCT ongoing record that he saw Mr Harris in his cell. Mr Harris said he had attempted suicide two years ago by taking a bowl of tablets. He said he had a history of drug abuse including heroin and PS and admitted he had used drugs since arriving at Doncaster. Mr Harris said he thought he had bipolar disorder like his father. The nurse recorded in Mr Harris' medical record that Mr Harris asked for help for his mental health because he felt something was not right. Mr Harris said he had no thoughts of suicide or self-harm. The nurse noted he was subject to ACCT monitoring and needed a full mental health assessment.

36. The ACCT ongoing record shows that Mr Harris was checked at 5.45pm, 6.15pm and 6.35pm. There were no further entries until 8.30pm, when PCO A made an entry. PCO A recorded that all observations had been carried out and Mr Harris was on his bed and chatting to his cellmate. At interview, PCO A told the investigator that he had checked and spoken to Mr Harris throughout the day, but that he did not have time to make individual entries in the ACCT document.

37. Staff checked Mr Harris every 30 minutes from 8.30pm, throughout the night and the next morning up to 11.00am.

38. At 11.23am, on 20 November, Nurse A undertook a desktop triage of Mr Harris' mental health referral. Nurse A recorded that Mr Harris had presented with suspicious and bizarre behaviour, was not prescribed any medication, had a history of cannabis, PS and alcohol misuse and was subject to ACCT monitoring. Nurse A booked an appointment for Mr Harris to have a full mental health assessment on 28 November.

39. That morning, a COM assessed Mr Harris as part of the ACCT procedures in the wing office. Mr Harris said he had no issues other than wanting to be in a single cell. He said he had no thoughts of suicide or self-harm but had attempted an overdose in the past. He said he was "all over the place" and believed this would improve once he was prescribed medication (an anti-psychotic). The COM signed and timed the assessment form at 11.40am. The COM said he left the office immediately after conducting the assessment and did not take part in the first case review.

40. COM B chaired the first ACCT case review with COM A, Nurse B from the mental health team and Mr Harris. Mr Harris said that he had no thoughts of suicide or self-harm and did not know why he was subject to ACCT monitoring. COM B recorded that Mr Harris had an appointment with the mental health team and that there were no other issues.

41. COM A, COM B and Nurse B assessed Mr Harris as being at low risk of suicide and self-harm, and closed the ACCT. COM B wrote one action on the caremap for Mr Harris: to have a mental health assessment and recorded that it had been completed. The ACCT post-closure review was set for 27 November. COM B signed and timed the first case review form at 11.30am.

42. At 4.36pm, COM A recorded in Mr Harris' prison computer record that she had authorised Mr Harris to be moved into a single cell because he displayed bizarre and erratic behaviour. COM A recorded that Mr Harris was waiting for a mental health assessment. At interview, COM A told the investigator no prisoners were willing to share a cell with Mr Harris, even though he had been provided with fresh clothing and toiletries. He had refused to shower, and he had been quite loud the previous night. COM A authorised single cell status until Mr Harris was assessed by the mental health team and his personal hygiene had improved.

43. The PCO on duty throughout the night on Mr Harris' wing told the investigator he completed the welfare checks on the wing at 10.00pm and 2.00am. The PCO said he had to speak to Mr Harris several times during the night as he was disturbing other prisoners by banging his door, shouting and talking to himself.

Thursday 21 November

44. At 5.00am, the PCO arrived at Mr Harris' cell as part of the roll check of all prisoners on the wing. The PCO said he opened the observation flap on Mr Harris' door and could not see him in the cell. He turned on the cell light and Mr Harris jumped out in front of the flap. The PCO said Mr Harris pulled a strange face and his eyes were enlarged. The PCO continued with the rest of the roll check.

45. At 5.37am, the PCO returned to Mr Harris' cell as he was concerned about his behaviour. When he opened the observation flap, the PCO saw Mr Harris hanging from the window bars with a ligature made from bedding. He immediately radioed a code blue emergency code (a medical emergency code which indicates a prisoner is unable, or having difficulty, breathing). Officers went into the cell, cut the ligature, lowered Mr Harris to the floor and began cardiopulmonary resuscitation (CPR).

46. The control room log shows the code blue emergency was radioed at 5.37am, and an emergency ambulance was called immediately. Four nurses responded within two minutes to the code blue and continued resuscitation until the paramedics arrived.

47. Yorkshire Ambulance Service records show that they received the 999 call at 5.39am. The paramedics arrived at 5.50am and, after further treatment, they took Mr Harris to Doncaster Royal Infirmary, where at 6.36am, he was pronounced dead.

Contact with Mr Harris' family

48. The Assistant Director responsible for safer custody, and the prison's family liaison officer (FLO), visited Mr Harris' sister at her work address at 10.30am, to break the news of her brother's death and offer condolences. In the days that followed, the FLO maintained contact with Mr Harris' family and in line with Prison Service instructions, the prison contributed to the costs of the funeral.

Post-mortem report

49. At the time of issuing our initial report, we have not received the report of Mr Harris' post-mortem examination.

50. The toxicology tests found that Mr Harris may have used a synthetic cannabinoid (psychoactive substance) in the hours before his death, which may have affected his cognition and motor skills. The toxicologist commented that the contents and effects of synthetic cannabinoids are unpredictable, and their use may result in serious adverse mental and physical health effects. The mental health effects may include agitation, delirium and hallucinations

51. Toxicology tests also identified "no more than a trace" of citalopram, an anti-depressant which Mr Harris was not prescribed, in Mr Harris' blood and urine.

Support for prisoners and staff

52. An 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.

53. The prison posted notices informing staff and prisoners of Mr Harris'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 Harris's death.

Findings

Management of risk of suicide and self-harm

54. 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 a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. 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.

55. As we have noted many times in individual investigation reports, thematic reports and annual reports, too often staff make decisions about risk based on their perceptions of a prisoner's presentation and statements from the prisoner that they do not have any thoughts or intention of suicide or self-harm. Known risk factors which might increase the prisoner's risk, such as a history of suicidal behaviour, or the circumstances of their offence, can often be overlooked. The lesson we have identified repeatedly is that evidence of risk should be fully considered and balanced against the prisoner's demeanour and what he says.

56. It is clear that Mr Harris had some risk factors, in particular his recall to custody, his significant history of illicit drug use and his mental health, which should have been fully explored with him.

57. We are concerned that both prison and healthcare staff assessed his risk solely on the basis of his presentation when he first arrived on 15 November, rather than also taking his risk factors into account. If they had spoken to him about his possible risk factors, they may have concluded that it was appropriate to open an ACCT.

58. The substance misuse worker appropriately opened an ACCT on 19 November when Mr Harris said he intended to kill himself. COM A appropriately assessed Mr Harris' risk of self-harm and set the level of observations accordingly.

59. However, we are concerned that the majority of the observations and required conversations during the daytime were not recorded in the ACCT ongoing record. PCO A said in interview that he was "unable to get off the wing" to complete the ongoing record because he was too busy. We do not know whether this was a particular problem that day or whether it is a recurring problem. It is important that staff complete the ongoing record, as this audit trail confirms that the observations and required conversations have taken place. It is also an important way of sharing information with other officers about a prisoner's behaviour and mood. If officers are frequently too busy to complete the ongoing record in line with national policy, the prison needs to address this as a systemic issue.

60. At the first case review on 20 November, COM A, COM B and Nurse B assessed that Mr Harris was at low risk of suicide or self-harm and closed the ACCT. We consider that this was a mistake. We are concerned that this assessment was

made only 24 hours after Mr Harris had said he intended to kill himself. We are also concerned that Mr Harris had very poor personal hygiene and a dishevelled appearance and was acting strangely. We consider that these factors (which may have indicated mental health issues and/or drug use) were not given sufficient weight during the ACCT assessment and were not even mentioned on the case review record. Instead, staff appear to have simply accepted Mr Harris' assertions - made only during his ACCT assessment and case review - that he had no thoughts of self-harm or suicide and based their decision on this alone. In response to our initial report, Mr Harris' family were concerned about the impact of the ACCT closure, in particular that Mr Harris might not have been allocated a single cell if his ACCT had remained open. While we cannot conclude with certainty what the impact of the premature ACCT closure might have been, we agree that his ongoing risk of suicide and self-harm should have been recognised and monitored.

61. We are also concerned that, although Mr Harris continued to act bizarrely for the rest of the day and overnight, staff did not consider re-opening the ACCT.

62. Mr Harris' mental health assessment, scheduled for 28 November, was identified as a protective measure for him and recorded on his caremap. Mr Harris' need for anti-psychotic medication had been mentioned in his ACCT assessment interview paperwork but was not formally identified at the ACCT review and recorded on his caremap as it should have been. Both actions were still outstanding when Mr Harris' ACCT was closed on 20 November (as he had not yet attended his mental health assessment or received his medication). PSI 64/2011 (Safer Custody) says that an ACCT should only be closed when all issues on the caremap have been resolved. In Mr Harris' case his possible mental health issues had not been resolved and we are concerned that the ACCT was closed before this was done.

63. We therefore make the following recommendations:

The Executive Director of Custodial Contracts should:

- **satisfy himself that processes are in place at Doncaster to ensure that the PPO's recommendations are being implemented and embedded; and**
- **report his findings to the Ombudsman.**

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

- **assessing a prisoner's level of risk on the basis of recognised risk factors and not just on the prisoner's presentation or what he says;**
- **recording the reasons for decisions;**
- **carrying out and recording conversations and observations, as required; and**
- **only closing an ACCT when all caremap actions have been completed.**

Clinical care

64. The clinical review concluded that that the care Mr Harris received was of a mixed standard and only partially equivalent to that which he could have expected to receive in the wider community.

65. The clinical reviewer judged that the reception screens were conducted appropriately, and the substance misuse care was delivered appropriately and was equivalent to the care Mr Harris would have received in the community.

66. However, the clinical reviewer was concerned that Mr Harris did not receive adequate mental healthcare. A nurse's reviewed Mr Harris on the evening of the 19 November, with an appropriate recommendation that he receive a full mental health assessment and remain subject to ACCT monitoring. We are concerned that this was not communicated during the morning handover.

67. In addition, Nurse A did not read a nurse's entry in the medical record when she carried out the desk top triage. As a result, she made a routine mental health referral, rather than an urgent referral, meaning Mr Harris' mental health would not have been assessed until 28 November. Nurse A told the investigator that the system of desk top triages had been reviewed and a new system was to be implemented where all prisoners referred to the mental health team would have a face to face initial assessment and a triage decision would be made following this assessment. She hoped that this would start by the end of December 2019.

68. We are also concerned that Nurse B acknowledged at interview that she had not read a nurse's entry in Mr Harris' clinical record before she attended the ACCT review. As a result, she did not know that the nurse had seen him the previous evening or that he was not prescribed any medication. She said that if she had known, she would have referred Mr Harris for an urgent full mental health assessment and would have considered that the ACCT should remain open.

69. We agree with the clinical reviewer's assessment and make the following recommendations:

The Head of Healthcare should:

- **confirm to the Ombudsman that a revised mental health triage process is now in place;**
- **ensure that all relevant information and actions from the previous day's mental health response nurse is shared at the daily handover; and**
- **ensure that healthcare staff prepare for ACCT reviews by reading the prisoner's SystmOne notes.**

Psychoactive Substances

70. Toxicology results show that Mr Harris had used PS before his death and the Home Office pathologist concluded that the cause of Mr Harris's death was "compression of the neck in the context of novel psychoactive substance use".

71. Doncaster has a strategy to address both the supply of and demand for PS and 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 resources 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 the drugs, plus additional disciplinary measures to deter drug use.

72. We are concerned that, despite this, Mr Harris was able to obtain PS with apparent ease at Doncaster. HM Inspectorate of Prisons have expressed concern about the ready availability of drugs at Doncaster and it is obviously a cause for concern that Mr Harris was able to obtain and use them.

73. 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.

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

75. "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."

76. We, therefore, recommend:

The Director should ensure that the key drug issues at Doncaster are identified and are addressed in the prison's local drugs strategy.

Learning lessons

77. It is important that staff learn from our reports. We, therefore, recommend:

The Director should share this report with COM A and COM B and discuss the Ombudsman's findings with them.

The Director should ensure that this report is shared with PCO A and that a senior manager discusses the Ombudsman's findings with him.

The Head of Healthcare should share this report with Nurse A and Nurse B and discuss the Ombudsman's findings with them.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100