

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Duggan, a prisoner at HMP Nottingham, on 18 December 2021

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Kenneth Duggan died on 18 December 2021. He was found hanged in his cell at HMP Nottingham. He was 50 years old. I offer my condolences to Mr Duggan's family and friends.

Mr Duggan had previously been in prison and had been managed under Prison Service suicide and self-harm prevention procedures. He had a number of risk factors which were considered by staff during the reception process. Despite this, I consider that the decision not to begin suicide and self-harm prevention procedures was considered by officers and appears reasonable at the time.

The clinical reviewer concluded that the care Mr Duggan received at HMP Nottingham, in the short time between being recalled to prison and his death the following day, was equivalent to that which he could have expected to receive in the community.

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

August 2022

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Summary

Events

1. On 17 December 2021, Mr Kenneth Duggan was recalled to HMP Nottingham for breaching his licence conditions. Mr Duggan had a history of self-harm.
2. Mr Duggan arrived at Nottingham at around 4.30pm. A nurse completed his reception screening and a prison officer interviewed him. The Prisoner Escort Record (PER) did not list any concerns about Mr Duggan's risk. Staff did not consider it necessary to start suicide and self-harm prevention procedures (known as ACCT).
3. At 11.35am on 18 December, Mr Duggan collected his meal and returned to his cell. At 1.43pm, an officer went to his cell and found him with a ligature around his neck. The officer called an emergency medical code and other officers and nursing staff arrived within minutes.
4. Staff began emergency first aid on Mr Duggan. At 1.57pm, paramedics arrived and tried to resuscitate him. At 2.20pm, the paramedics confirmed that Mr Duggan had died.

Findings

5. Mr Duggan arrived at Nottingham with risk factors for suicide and self-harm. Evidence suggests prison staff considered risk but did not conclude he should be monitored under ACCT procedures.
6. We were not provided with evidence that Mr Duggan was observed or checked during his first night in custody, and we were not provided with a local policy which requires these checks.
7. Healthcare staff completed Mr Duggan's first and secondary healthcare screenings on the same day which is not in line with National Institute for Health Care Excellence (NICE) guidance.
8. The clinical reviewer concluded that the care Mr Duggan received at HMP Nottingham was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that staff review all relevant information when assessing a prisoner's risk of harm to himself, in line with PSI 07/2015.
- The Governor should ensure that a policy is in place to monitor vulnerable prisoners during their first night in custody and that the process is followed.
- The Head of Healthcare should ensure that the standards of the first stage and second stage health assessments for newly detained prisoners are conducted within the timescales specified by NICE guidelines.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Nottingham informing them of the investigation and asking anyone with relevant information to contact him.
10. The investigator requested evidence from the prison on 22 December 2021. He obtained copies of relevant extracts from Mr Duggan's prison and medical records.
11. NHS England commissioned an independent clinical reviewer to review Mr Duggan's clinical care at the prison. The investigator and clinical reviewer jointly interviewed staff. The investigator interviewed five members of staff remotely on 25 January 2022.
12. We informed HM Coroner for Nottinghamshire of the investigation. The post-mortem report was not available at the time of writing this report. We have sent the Coroner a copy of this report.
13. The Ombudsman's family liaison officer contacted Mr Duggan's next of kin, his brother, to explain the investigation and to ask if he had any matters, he wanted the investigation to consider. Mr Duggan's brother asked us to consider the following, which we have addressed in this report:
 - Why and how the family learned of Mr Duggan's death from another prisoner, rather than from officials at HMP Nottingham?
 - Whether mental health risk assessments were considered?
 - Whether Mr Duggan should have been on observations?
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
15. We sent a copy of our initial report to Mr Duggan's brother. He pointed out no factual inaccuracies.

Background Information

HMP Nottingham

16. HMP Nottingham is a resettlement and local prison serving the courts of Nottinghamshire and Derbyshire. It has capacity for approximately 1,000 men. Healthcare for the prison is provided by Nottinghamshire Healthcare NHS Foundation Trust.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Nottingham was in January 2020. Inspectors reported that early day's support was reasonably good, noting that reception remained busy, but staff managed the process efficiently. Reception interviews were also conducted in private and included an appropriate focus on safety. Inspectors also found that listeners (Samaritans trained prisoners to provide support) and peer support was not available at reception.
18. Inspectors noted additional observations during the first night as a positive factor which had been introduced since their last inspection. However, there was a record number of recorded self-harm incidents, and there had been four self-inflicted deaths between inspections with not all PPO recommendations being implemented. It was also noted that while the Assessment, Care in Custody and Teamwork (ACCT) process and documentation had improved, there were still key weaknesses which needed to be addressed.

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. In its latest annual report, for the year to 2019, the IMB reported that several problems persisted from previous years, including the inexperience of staff and the closure of certain facilities.
20. In relation to the reception process, the IMB welcomed improvements such as private interviews for those arriving in the establishment to establish any risk factors. It was highlighted that there were ongoing concerns around ACCT processes, and in particular record keeping and completion of documentation.

Previous Deaths at HMP Nottingham

21. Mr Duggan's death was the first self-inflicted death at HMP Nottingham since December 2019.

Assessment, Care in Custody and Teamwork

22. ACCT is the case management approach used to support those at risk of suicide or self-harm within HM Prison Service. The purpose of ACCT is to identify risk, how to monitor and supervise the prisoner, and how to reduce risk. The prisoner is assessed when the ACCT is opened, and the level of checks and supervision are set according to the perceived risk. Regular multidisciplinary review meetings with the prisoner should be held.

Key Events

23. In November 2007, Mr Kenneth Duggan was sentenced to an Indeterminate Sentence for Public Protection for rape. He received a minimum term of four years. In October 2012, he was released into the community but was recalled to prison in July 2013 for sexual assault and received a sentence of two years in prison.
24. In October 2021, Mr Duggan was released from HMP Lincoln after serving eight years in prison. Two months later, he was recalled to HMP Nottingham for secretly entering into a relationship with a woman and relapsing into substance misuse, which was a breach of his licence conditions.
25. At 4.30pm on 17 December, Mr Duggan arrived at HMP Nottingham. His Person Escort Record (PER) did not record any concerns of suicide or self-harm. Prison staff completed his first night in custody form and cell sharing risk assessment. The first night form recorded that during his previous time in prison, Mr Duggan had been on suicide and self-harm prevention procedures (known as ACCT).
26. Mr Duggan's recall paperwork, which staff did not have access to at the time, noted a number of risk factors, including that he was a lifer recall and that the police should consider whether Mr Duggan was under the influence of alcohol or drugs when arresting him.
27. A nurse conducted Mr Duggan's initial reception screening. She said that Mr Duggan appeared agitated at the beginning of the process as he did not have access to his medication (an inhaler and dihydrocodeine), however he relaxed when these were provided to him. She asked Mr Duggan questions about suicide and self-harm and asked if he had any mental health related issues. Mr Duggan said that he did not have any intention of harming himself, did not have any suicidal thoughts and had no mental health related issues.
28. The nurse considered that there was nothing which indicated to her that he posed a risk to himself, and nothing was flagged up during his initial assessment or on his PER. During interview she told us that she did not see anything which indicated he posed a risk to himself. Further to this, a referral to the mental health team was not made.
29. The nurse told us that she did not have sight of Mr Duggan's recall paperwork, and without having a direct indication of risk she did not search his prison medical record for references to self-harm as she said she did not have time.
30. An officer conducted the first night interview with Mr Duggan. He noted on the paperwork that Mr Duggan was recalled for a sexual offence and was identified as a vulnerable person (VP).
31. The officer told us that he viewed the documentation Mr Duggan came to prison custody with before conducting the interview with him. He said that he could not recall Mr Duggan having any warning markers for self-harm, but that he had a previous incident of self-harm in April 2021. He asked Mr Duggan if he had any current thoughts of suicide and self-harm, to which he said he did not. Mr Duggan told him that he had limited family and friends support and would likely need additional support in prison.

32. The officer assessed that Mr Duggan had no current presenting risk factors, he was not in distress and his answers to his questions were clear and concise. He said that he considered all the information available to him at the time when assessing Mr Duggan, such as the PER, the National Offender Management Information System (NOMIS – a prisoner’s electronic record) and what Mr Duggan said during the interview.
33. The officer told us during interview that he recalled Mr Duggan may have told him he was suffering from depression, but he did not remember exactly, and evidence suggests he did not register this as a significant risk.
34. The officer completed the Early Days in Custody booklet which recorded that Mr Duggan had several risk factors. These were listed as his offence and his recall, but ACCT procedures were not initiated.
35. The officer made an entry on NOMIS recording that Mr Duggan had a history of suicide and self-harm but was stable at that time. He also noted that Mr Duggan had previously been supported under ACCT procedures and had said he had no mental health or substance misuse issues at that time.
36. Mr Duggan was located on the vulnerable prisoners’ unit because of his offence and recall to prison. A nurse told us during interview that after the screening Mr Duggan was taken onto the wing and placed in his cell.
37. At 5.01am on 18 December, an officer recorded on NOMIS that he conducted a welfare check on Mr Duggan and recorded no issues. HMP Nottingham provided no evidence to suggest any other checks were completed overnight.
38. At 8.36am, Mr Duggan rang his cell bell. An officer responded, and Mr Duggan asked if his medication was sorted. The officer said that it had been sorted out and said that Mr Duggan seem pleased with this.
39. At 11.36am on 18 December, CCTV shows an officer unlocking Mr Duggan’s cell and he went to collect his meal. CCTV shows that Mr Duggan did not talk to either prison officer on the landing and was wearing a face mask. He returned to his cell a few minutes later.
40. An officer was gathering prisoners for exercise when he came to Mr Duggan’s cell. At 1.43pm, he opened the observation panel of Mr Duggan’s cell door and saw him on the rear side, slumped with something tied around his neck. He immediately radioed a ‘code blue’ (a medical emergency code indicating a prisoner is unconscious or is having breathing difficulties). He entered the cell and cut the ligature from around Mr Duggan’s neck using his fish knife. He then lowered him to the floor and attempted to rouse him by saying his name.
41. Body Worn Video Camera (BWVC) footage shows that control room staff asked for more information and then called an ambulance at approximately 1.45pm.
42. The officer put Mr Duggan in the recovery position, and he was joined quickly by other prison staff. A nurse and other healthcare staff responded immediately and picked up medical equipment en route to the cell.

43. More officers attended the cell 30 seconds after the code blue was called. They asked the first officer if there was a pulse, and he said there was not. An officer moved Mr Duggan onto his back and began chest compressions, while another officer maintained his airway.
44. A nurse arrived at the cell a minute later, when other prison officers were already doing CPR on Mr Duggan. Two other nurses attended to Mr Duggan's breathing while the officers were doing chest compressions. They attached a defibrillator to Mr Duggan, but the nurse noted that 'no shock' was advised. At 1.57pm, ambulance staff arrived at Mr Duggan's cell. Officers and nursing staff left the cell and paramedics began further attempts to resuscitate Mr Duggan. At 2.19pm, the ambulance staff confirmed that Mr Duggan had died.

Contact with Mr Duggan's family

45. The prison appointed a Family Liaison Officer (FLO) to act on their behalf. The FLO contacted the police to check the correct address for Mr Duggan's next of kin prior to visiting him and this caused a slight delay in making contact. At 5.35pm, prison staff went to Mr Duggan's brother's address and informed him that Mr Duggan had died.

Support for prisoners and staff

46. After Mr Duggan's death, the duty governor 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.
47. The prison posted notices informing other prisoners of Mr Duggan's death, and offering support.

Post-mortem report

48. The post-mortem report found the cause of Mr Duggan's death was hanging. The toxicology found that Mr Duggan had used synthetic cannabinoids (Spice) prior to death, and there was evidence of prior heroin and cocaine use.

Findings

Identifying the risk of suicide and self-harm

49. 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. We have considered whether staff at HMP Nottingham should have recognised Mr Duggan as at risk and started ACCT procedures.
50. PSI 07/2015 relates to first nights in custody. It governs the requirements for a PER form to accompany each new prisoner and *'any other available information'* to be reviewed to identify any immediate risks and needs of prisoners. The policy also outlines that prisoners must be interviewed in private to identify any further risks or relevant information. It also requires new prisoners to be moved onto the first night unit, *'or other accommodation, such as the Segregation Unit or healthcare, as necessary'* where they spend their first night in the establishment. The policy specifically says new prisoners can be located on the vulnerable prisoners' unit if appropriate.
51. PSI 07/2015 also covers assessing risk of suicide and self-harm during the early days in custody. Specifically, the policy says that PERs and any other relevant information should be considered in relation to risk of suicide and self-harm *'including that held on OASys'*. It adds that those returning to custody are at greater risk of suicide and self-harm, and the risk is both with transferred prisoners as well as those going through initial reception. When locating prisoners in first night accommodation, staff are required to consider risk of suicide and self-harm.
52. Mr Duggan was in HMP Nottingham for only 20 hours before he was found hanging in his cell. He did have some risk factors for suicide and self-harm including his offending history, his fourth recall to prison and a relationship that gave the Probation Service cause for concern. He also had a history of suicide and self-harm and had been on an ACCT while at HMP Lincoln in April 2021.
53. An officer told us during interview that he considered the information on the PER and NOMIS, which did not flag an immediate risk of suicide or self-harm relating to Mr Duggan. He said that he also considered his history of suicide and self-harm, and what he was saying along with his presentation of being calm and making eye contact. Mr Duggan denied having any thoughts of suicide or self-harm, any substance issues or serious health concerns. We also note that Mr Duggan's recall paperwork identified that he had a history of substance misuse, but that this was not available to staff in Reception.
54. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. While Mr Duggan had some risk factors for suicide and self-harm, we are satisfied that an officer identified and recorded these risk factors. Although staff appear to have underestimated the extent of Mr Duggan's risk, we consider

that his risk factors were properly identified, and we do not therefore criticise the decision not to open ACCT procedures.

55. The Probation Service recorded Mr Duggan's current risks factors on his recall paperwork, which included his substance abuse and previous self-harm. Prison staff told us they did not have access to the recall paperwork while conducting Mr Duggan's initial risk assessments. Staff did not appear to have checked Mr Duggan's OASys which referenced previous attempts of self-harm, which is not in line with paragraph 2.18 of PSI 07/2015. We make the following recommendation:

The Governor should ensure that staff review all relevant information when assessing a prisoner's risk of harm to himself, in line with PSI 07/2015.

Welfare Checks

56. PSI 07/2015 also requires governors to ensure arrangements are in place for staff to monitor prisoners' safety and well-being in the first night of prison custody. HMP Nottingham did not provide, when asked, a local policy which covers first night welfare checks and monitoring.
57. There is no evidence Mr Duggan was checked or monitored overnight after he was taken to his cell.

The Governor should ensure that a policy is in place to monitor vulnerable prisoners during their first night in custody and that the process is followed.

Family Liaison

58. Mr Duggan's brother learnt of his death from another prisoner. Prison staff speculated that the prisoner contacted him on his in-cell telephone.
59. PSI 64/2011 states that time is of the essence in breaking the news of a death to the next of kin to try to ensure that they do not find out from another source. Unfortunately, another prisoner contacted Mr Duggan's brother very soon after his death before the family liaison officer could visit her to inform him in person. We acknowledge Mr Duggan's brother's distress at the way he learnt the news of his brother's death but are satisfied that prison staff acted appropriately and that there was not an unreasonable delay before they visited Mr Duggan's brother.
60. We make no recommendation.

Clinical Care

61. National Institute for Health Care Excellence (NICE) guidance sets out that the secondary health screening should take place within seven days of the first, and as a minimum should include a review of the actions and outcomes of the first screening. Healthcare staff conducted Mr Duggan's first and secondary healthcare screenings on the same date which was not in line with NICE guidance. We recommend:

The Head of Healthcare should ensure that the standards of the first stage and secondary stage health assessments for newly detained prisoners are conducted within the timescales specified by NICE guidelines.

62. The clinical reviewer concluded that the care Mr Duggan received at HMP Nottingham was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.

Inquest

63. At the inquest, held from 8 to 19 January 2024, the jury concluded that Mr Duggan died by suicide.

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