



**Investigation into the circumstances surrounding the  
death of a man  
at HMP Doncaster in April 2011**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**May 2012**

This is the report of an investigation into the death of a man who was, for a very short time, a prisoner at HMP Doncaster. In April 2011, he was found hanging in his cell at 10.20am. Staff attempted to resuscitate him, but were unsuccessful in their attempts. I offer my condolences to his family and friends for their loss.

My colleague was appointed to carry out the investigation. A review of the man's healthcare was undertaken by a clinical reviewer. I am grateful to the Director of HMP Doncaster and his staff for their co-operation during this investigation. I apologise that the report has been delayed.

The man was only in contact with the criminal justice system for a short time and passed through a number of agencies before arriving at Doncaster. The investigation examines the assessment of his risk of self-harm or suicide by these various agencies. His risk factors appear to have been significant: he faced sexual offences against members of his family, it was his first time in custody, he had a history of depression and he had made a recent attempt at suicide. However, there were weaknesses in the transmission and recognition of these factors between and within the agencies involved. It must be noted that he was not open about his feelings with either staff or his cellmate but, while various staff engaged with him, too much emphasis may have been placed on his presentation rather than other risk factors. As a result, it was only when his mother telephoned the prison that measures were put in place to safeguard him. Unfortunately, these were unsuccessful.

The report suggests a number of lessons which can be learned from his tragic case. In particular, we make recommendations about improving the transparency, transmission and recognition of risk assessments, together with better use of radio codes during an emergency. It is of concern that similar weaknesses in the sharing of information about risk between agencies were identified in a previous death in custody investigation at Doncaster. The Director needs to take steps to minimise the chances of any further repetition.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

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## SUMMARY

1. The man was arrested on a motorway bridge in April 2011, and charged with sexual offences against his stepchildren. It was not initially clear what his intention was when he was found on the bridge, but he later told to staff in Doncaster that he had planned to commit suicide.
2. He was taken to a local Magistrates' Court the following day and remanded into custody at HMP Doncaster. It was his first time in prison. It was written on the warrant (the document authorising his detention) that he had tried to kill himself (apparently referring to the incident on the bridge). Nevertheless, the escort services did not begin suicide and self-harm monitoring procedures because they did not assess him as at risk of self harm. Despite the information regarding suicide and self-harm on his documentation, reception staff at Doncaster also deemed him to be not at risk of harming himself.
3. His cellmate said that the man was unhappy at being in prison and cried through the night. He did not get up to collect his breakfast the following morning, and did not communicate much with his cellmate. He attended the usual induction meetings that morning which introduced him to the prison environment and what it could offer him.
4. His mother telephoned Doncaster at approximately 9.30am and expressed concerns about the safety of her son. The unit manager agreed to speak to the man to check on his wellbeing. Although he appeared relatively well he became visibly upset when the unit manager spoke to him of his upcoming court appearance at about 9.50am. Suicide and self-harm monitoring procedures were begun, which he was content with.
5. He declined to go out and exercise and was locked back in his cell at approximately 10.05am. At 10.20am an officer went to take him to visit the doctor. When he reached the cell, he saw that he was hanging with a ligature around his neck. He opened the cell and summoned assistance, but resuscitation was unsuccessful and he was pronounced dead at 10.56am.
6. The investigation considers the assessment of the level of risk during his short period of time in the custody of the escort, court and prison services. This report emphasises the need for all the agencies involved to be mindful of the type of risk factors that mean a prisoner is at a higher risk of harming themselves.

## THE INVESTIGATION PROCESS

7. The investigation was opened on 26 April 2011, when the investigator issued notices announcing the investigation to staff and prisoners. The investigator visited HMP Doncaster on 5 May where he met the liaison officer for the investigation. The investigator also met the prison controller (a Ministry of Justice appointee responsible for monitoring the prison's performance against their contract), and discussed the investigation with her. The investigator also visited the wing where the man was located. The investigator was provided with all documentation relating to the man.
8. The investigator visited HMP Doncaster on 10 June and 15 July to conduct interviews. Another investigator also undertook an interview on the investigator's behalf on 28 September. During these visits, interviews were conducted with five staff and one prisoner. The investigator later visited Rotherham Magistrates' Court on 8 November to interview three members of escort staff. He wrote to the Director of Doncaster providing initial feedback on the progress of the investigation.
9. The clinical reviewer was asked to review the man's clinical care and he was provided with all relevant documentation to assist this review. I thank him for the clinical review, which was received on 27 October 2011. The investigation report was delayed to a combination of the date of receipt of the clinical review and workload pressures within the office.
10. The investigator contacted Her Majesty's Coroner for South Yorkshire Eastern District, to inform her of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist her enquiries into the man's death.
11. One of the office's family liaison officers contacted the man's family to inform them of the investigation and invite them to ask questions or raise concerns about the care of the man. His mother asked what measures were taken to safeguard her son when he entered prison, and what was done following her telephone call to Doncaster. It is hoped that this report provides answers to her questions.
12. Following the publication of the draft report, his mother wrote to the office's family liaison officer. She said that she agreed with the recommendations. The National Offender Management Service also responded to the draft report, and their response to the recommendations is included at the end of this report.

## **HMP DONCASTER**

13. HMP Doncaster is a purpose built prison holding remand and sentenced adult males and young offenders. It opened in 1994 and is privately managed under contract by Serco Home Affairs. It is a local prison serving the courts of South Yorkshire and has a maximum overcrowded capacity of 1,145 prisoners.
14. Every privately operated prison has a Controller appointed by the Ministry of Justice. The Controller is responsible for monitoring the contractor's compliance with the contract. The prison is required to follow the operational guidance contained in the Prison Service Orders (PSOs) and Prison Service Instructions (PSIs) that apply to public sector prisons. In addition, private prisons have their own set of procedural Director's Rules specific to each prison.

### **Assessment, Care in Custody and Teamwork (ACCT) process**

15. When a prisoner is deemed to be suicidal or at risk of harming themselves staff can use the ACCT (Assessment, Care in Custody and Teamwork) framework to monitor and protect the prisoner concerned. Once placed on an ACCT, the prisoner is observed at irregular intervals according to the perceived level of risk. Each prisoner is assessed within 24 hours. The ACCT guidance says that, to be effective, subsequent case reviews should involve the key people who know the person at risk or are involved in their care. There is a similar system involving a 'Suicide and self-harm warning form' used by the escort services.

### **Her Majesty's Chief Inspector of Prisons**

16. An unannounced inspection by Her Majesty's Inspector of Prisons (HMCIP) took place at Doncaster from 2 to 12 November 2010. The prison was previously inspected in an unannounced follow-up inspection in February 2008. HMCIP found the arrangements to receive, settle and induct newly arriving prisoners operated well. At the time there was an average of 600 new prisoners per month. Reception was found to be well organised with staff taking steps to minimise delays during the busiest periods. HMCIP found the induction procedure to be thorough, with the appropriate involvement of specialist departments.

### **Independent Monitoring Board (IMB)**

17. Each prison has an Independent Monitoring Board (IMB) made up of members of the local community. The IMB's role is to ensure that the prison is properly run and that prisoners are treated decently. Each IMB produces an annual report for the Secretary of State. The latest available annual report of the Doncaster IMB is for 2009–10 and did not raise anything of specific relevance to this investigation.

## **Previous deaths at Doncaster**

18. There have been six self-inflicted deaths at Doncaster since the Ombudsman took responsibility for investigating deaths in custody in April 2004. There are some similarities between the man's experiences and that of a prisoner who died apparently by his own hand in 2010. These references are considered further in the body of the report.

## KEY FINDINGS

19. The man was arrested on 20 April 2011 by the police who found him on a motorway bridge. He was later charged with sexual offences against his stepchildren.
20. The Person Escort Record (PER) is a document, individual to each prisoner, agreed by all the agencies involved in the management of the transfer of prisoners to record the external movements of the prisoner between these different agencies. In the case of the man, the PER that accompanied him to Doncaster said in the box next to suicide/self-harm risk, "stated at custody desk". (The PER was begun by the police and this referred to the police custody desk.)
21. A senior custody officer (SCO) worked for G4S at the time the escort company responsible for prisoners appearing in Rotherham Magistrates' Court. Rotherham Magistrates' Court is connected to the police station by an underground tunnel. He told the investigator that he collected that morning's paperwork from the police at approximately 7.10am. He said that he asked about the reference on the man's PER and was told by police staff that it did not come from the man, but referred to something his wife had told the police. However, he was not able to recall the details of the conversation.
22. The record of events section of the PER reveals that the man was taken from police custody at approximately 9.11am on 21 April. The SCO recalled that when he escorted him from the police station to the court cell he asked if he was alright, and he responded by saying "right as rain."
23. Following the note made by the police on his PER, and prompted by a colleague, the SCO interviewed the man at 9.28am, but did not assess him to be at risk of suicide or self harm. He did not start suicide prevention monitoring procedures. After the interview, the SCO recorded on the PER that the man "denies all knowledge of self-harm history". In his statement made on 26 April, the SCO described the interview:

"I returned to the man's cell and spoke to him about the markers and if he had any thoughts of self harm and suicide. He seemed quite taken aback with the questions I had asked and stated "I don't know where you've got that from I've never done that sort of thing." He then asked again if he could have a cigarette."
24. The SCO repeated to the investigator that the man seemed genuinely surprised to have been asked such questions. The SCO described him as quiet throughout the morning and no concerns were raised by any member of staff who had contact with him.

25. He attended a court hearing from 11.15am to 11.55am and was remanded to HMP Doncaster. The investigator was told by court staff that concerns regarding his intentions when he was arrested on a motorway bridge were raised in court during bail representations. The legal advisor completed the warrant according to the wishes of the magistrates and passed it to a court usher to take it to the escort staff.
26. The warrant that authorised his detention listed the reasons he was to remain in custody until his next court hearing on 28 April:
- “1. You are likely to offend if you are given bail.
  2. If you are given bail you are likely to interfere with witnesses or the course of justice, in your own or somebody’s else case.
  3. You need to be kept in custody for your own protection.

This was because

1. The offence is a serious one and you may be afraid of a severe punishment if you are convicted.
  2. You have tried to commit suicide.”
27. The SCO wrote in his statement that the man’s legal representative denied that he had been attempting to commit suicide when he was arrested by the police. He recalled to the investigator that there did not appear to be any consensus regarding the man’s intentions on the motorway bridge. The SCO did not consider that he had attempted to kill himself while being arrested, so did not feel anything of significance needed to be added to the PER.
28. The SCO, in his statement, described the man’s behaviour as he led him out of the court hearing:
- “During his return to his cell I asked him if he was ok and he stated ‘yes fine, can I have a cigarette’ ... At no time during the morning did he cause any concern to the staff and his solicitor had no reason to raise concerns on his behalf due to his general amenable nature.”
29. The SCO said that his training taught him to check certain features of the warrant were correctly completed, such as name, date of birth and stamp. He said he would expect any significant information regarding risk on the warrant to be highlighted to ensure escort staff noticed it. The reference on the warrants relating to suicide was not highlighted, and there was nothing to draw attention to that section.
30. According to a copy of the electronic PER provided to the investigator, he was transferred back to the custody of a vehicle escort team at 12.15pm and left the court four minutes later. The electronic record shows that the vehicle arrived at Doncaster at 12.55pm, and he was

formally transferred to the custody of the prison at 1.31pm. The prisoner custody officer (PCO) told the investigator that she would have checked the man during the drive to Doncaster. She was unable to recall him particularly but said that was because he did not 'stand out' in any way. She said that, if she had concerns regarding any of the prisoners on her vehicle, she would make the prison reception staff aware of it. There is no record that any information was passed to Doncaster by the escort staff.

31. A reception officer at Doncaster explained that, when the escort van arrives, the escort staff come into reception and hand over the prisoners' documentation. At this point, there is an opportunity for prison staff to ask further information of the escort staff if any of the paperwork prompts them.
32. When prisoners arrive at a new prison they go through the reception process. The officer at the custody desk is responsible for checking the prisoner's warrant to ensure that they can be legally held in prison. In the case of the man, this was undertaken by the reception officer. He explained to an investigator what he would be looking for on the warrant:

“ ... what I'm checking for is to make sure that his name is spelt correctly, it's got a crest on from the court, because no warrant is actually, well the majority of warrants aren't legal unless they've got a crest. There're certain things in a warrant to be executed, one of them is that, the name is right, his date of birth is right, the details are right and it's signed and dated by the Clerk of the Court.”
33. The reception officer was unable to recall whether further information was shared regarding the man but thought it unlikely. He explained that he would reflect anything that escort staff tell him on the PER. In this case, the information the reception officer wrote onto the cell sharing risk assessment (CSRA) was no more than what was on the PER. (A CSRA is carried out by a prison officer to establish the level of risk a prisoner presents to a cellmate.) Therefore, he thought escort staff had not raised any concerns with him about the man:

“Chances are most probably not because what I've written is basically what that's written there. But 100% I couldn't tell you.”
34. During interview, the reception officer was unable to say whether he had noticed the reference to the suicide attempt on the warrant. He told the investigator he was not used to seeing such a reference on a warrant:

“No, I haven't seen that very often. To be honest if that was flagged up from the court we'd expect a self-harm warning form

to have been produced at court because at the end of the day they've produced this document.”

35. The personal summary sheet undertaken at the reception desk noted that this was his first time in prison and that, due to his dyslexia, he had trouble reading and writing. (Dyslexia is a broad term indicating a learning disability often related to reading and writing.) A further document, entitled 'Initial Reception', noted that he had no immediate needs or concerns.

36. A number of further interviews are undertaken to assess a prisoner's physical and mental well-being, and initial needs. In the case of the man, this was undertaken by an officer. He told the investigator that the first time he saw him, he was talking to a colleague. The officer said that he: “seemed fine, he seemed really chatty.” However, the officer also said that he was a bit 'teary' and appeared shocked by being in prison, although he was reassured once he had spoken to staff. The officer took him aside to complete the CSRA. The comment from the reception officer on the CSRA stated:

“PER – suicide/self-harm stated at custody desk.”

37. The reception officer confirmed that he copied this reference from the PER to ensure that the nurse saw it. He said to the investigator that the transfer of this information, and no more, suggested that he did not gather further information from the escort service staff:

“I have written, well as far as I can tell by what I've written there and what's written there, I've just copied what's on there.”

38. The man told the officer who assessed his physical and mental well being that he was not racist or homophobic. The officer noted that suicide and self-harm concerns had been raised at the custody desk and, due to the nature of his offences, he could be vulnerable to assault. The officer told the investigator that he asked the man directly about whether he was thinking of suicide or self-harm and he said 'no' while maintaining eye contact with the officer. The officer noted that he had no concerns regarding the risk of harming himself and recommended a shared cell.

39. The man then went to a nurse to complete the CSRA, and undergo a first reception healthscreen. This seeks to establish any health concerns a prisoner might have when they enter prison, including mental health, substance misuse and suicidal feelings. A nurse undertook section two of the CSRA and assessed him to be at 'no increased risk' and noted on the form that he “strongly denies DSH [deliberate self-harm]”. The form was then checked by another officer who authorised the man as being at standard risk of assaulting a cellmate, and wrote that he would require a further assessment the

next day. (There are two categories in the CSRA system, standard and high.)

40. An initial healthscreen is conducted with all prisoners when they enter a prison for the first time. The nurse who undertook section two of the CSRA spoke to the man and noted that no healthcare information had been received from outside the prison, such as from his GP. The nurse wrote that he had been prescribed 20mg of Citalopram (an anti-depressant medication) in the community. He raised no concerns regarding his physical health, and said that he had not used drugs in the last month. He said that he had received treatment for depression from a psychiatrist in 2010. He said that he had never attempted to harm himself, and did not feel like he would in prison. The nurse noted that he denied thoughts of self-harm “strongly”, but described his behaviour as “weepy and upset”. The nurse referred him to the doctor and to a mental health nurse.
41. The man was taken to a cell on the second landing in D wing. (D wing is the induction unit where prisoners would typically stay for a few days to complete their induction into the prison. All cells on D wing are double cells.) He was given a smokers’ pack but declined to make a telephone call. Another prisoner was already in the cell when the man arrived.
42. The prisoner told the investigator he believed it to have been about 6.00pm when the man joined him in his cell. He said that the man appeared red around the eyes and was clearly upset to be in prison. He said that he tried to make conversation with him on a number of occasions but he responded with short, one-word answers each time. He told the investigator that it became clear that he did not wish to speak so he gave up trying to make conversation. He recalled that during the night, he thought he heard him crying and rustling with a plastic bag. He suggested that he may have been trying to muffle the sound of crying with the bag. Neither of the two men went to collect their breakfast in the morning and he decided not to raise the issue of the plastic bag as he did not want to embarrass him. He told the investigator that he had no concerns that the man might harm himself and was shocked when he heard what had happened.
43. The investigator spoke to a D wing officer, who explained that prisoners are typically unlocked at 8.00am for half an hour to allow them to collect their breakfast. The officer said that prisoners do not have to do this and could remain in bed if they preferred. At 8.30am, the cells are locked again until 8.45am when staff begin to unlock the prisoners who would be attending the 9.00am induction meeting in an upstairs room. The man went to the day one induction meeting at 9.00am, and the rest of the wing was locked up again until 9.30am when exercise was available. The prisoner went out to exercise which lasted until 10.30am.

44. The man's mother telephoned the prison at approximately 9.30am. She spoke to a communications clerk and explained that she was concerned about her son as he had attempted suicide prior to his arrest, and was autistic. (Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. There is no other reference to him being autistic in the prison records.) The communications clerk spoke to the unit manager, at 9.45am and asked if he would speak to the man's mother. The unit manager wrote in his statement that he would not normally speak to a prisoner's family unless he already knew the prisoner. He explained to the investigator: "We don't normally speak to the families, certainly, with not knowing him, I'd have liked to have met him first."
45. As the unit manager did not know the man, he told the communications clerk he would speak to the man first and then ring his mother back, once he had seen how he was. The unit manager went to the induction area and took him into a private room so they could talk confidentially at about 9.50am. He explained to the investigator how the man seemed when they first met:
- " ... he was actually very upbeat and I must say that had it not been the phone call from his mother, via Comms, if I just met him on the corridor I'd probably, wouldn't have considered putting him on a watch. He seemed very, very upbeat ... "
46. The unit manager outlined his mother's concerns and he confirmed that he had tried to jump from a bridge before he was arrested. He denied having any thoughts of harming himself at the time of their conversation. However, when he spoke about his offences and his next court appearance he became teary-eyed. He said that the man would be subject to ACCT procedures (suicide prevention measures) and observed every 30 minutes. He agreed to this, and the unit manager let him back onto the wing, and he went to the office to write up the ACCT documentation at 10.05am.
47. An officer saw the man standing by his cell at 10.05am. He went over and asked him if he would like to go out to exercise or be locked in his cell. He said that he wanted to go in his cell so the officer locked him in it. It was empty as his cellmate was still out exercising.
48. At approximately 10.20am, the D Wing officer received a telephone call from the healthcare department which asked him to take the man to the healthcare department for an appointment with a doctor. (This was a result of the referral made by the nurse the previous evening.) The officer went to his cell and looked through the observation panel. He saw him hanging. He shouted to an officer to radio through a code blue (a radio alarm indicating a medical emergency concerning breathing) and then unlocked the cell and went in.

49. The statements provided by the healthcare staff say that no radio code was used, instead a response call was made over the radio. This alerted healthcare to an emergency situation, but did not make clear what type of situation they were responding to.
50. The officer who asked the man if he would like to go out to exercise came to the D Wing Officer's assistance and they cut the ligature and laid him down on the floor. The unit manager said that he ran on to the wing when he heard the emergency code being called. He realised that it was a serious situation and asked the communications room to call an ambulance. Other officers were involved in returning the prisoners to their cells.
51. The unit manager entered the cell with the nurses responding to the radio call. Two nurses began cardio pulmonary resuscitation (CPR). One of the nurses called for Hotel 1 to attend. (Hotel 1 is the call sign of a radio assigned to a nurse who should attend a medical emergency.) Shortly afterwards, the defibrillator and oxygen were brought which were attached to the man. (Defibrillators deliver a brief electric shock to the heart, which can enable the heart's natural pacemaker to regain control and establish a normal heart rhythm.) The defibrillator advised not to shock but to continue CPR, which they did until the paramedics arrived.
52. The paramedics and a prison doctor arrived and CPR continued. He was moved out of his cell to allow for easier access to him. He was provided with adrenaline but, as there was no response, the prison doctor pronounced death at 10.56am.

### **Family liaison**

53. One of Doncaster's Assistant Directors, and the prison's family liaison officer, broke the news to the man's family at their home. The prison offered a contribution towards the cost of the funeral. His family were offered the opportunity to visit the prison and see his cell, but they declined. His property was returned to his family.

### **Support for staff and prisoners**

54. The unit manager told the investigator that the services of the care and support team were offered to any staff who required further support. His cellmate and the prisoners next door were assessed with regard to their well-being and prisoners subject to ACCT monitoring procedures were reviewed again.

## ISSUES

### Clinical issues

55. The clinical reviewer assesses that the man hid his intent to commit suicide from all the staff he came into contact with. He writes that, despite this dissembling of his intentions, his mental health was reasonably supported by staff.
56. The clinical reviewer also raises the point that he did not see a doctor on his first night in custody, although he acknowledges that “it is unlikely that this omission contributed directly to his death.” As there is no requirement for prisoners to see a doctor on their first night in custody unless there is an urgent treatment need, the Ombudsman’s investigation did not have concerns in this area. Nevertheless, the Head of Healthcare will want to consider the findings of the clinical review.

### The Man’s reception procedures

57. It was only when his mother telephoned Doncaster that suicide prevention measures were put in place. None of the agencies involved in his transfer from police to court to prison considered the information they possessed to be an indication that he was at risk of suicide or self harm. Accordingly, none of the agencies implemented suicide prevention procedures. It is vital to ascertain whether this was appropriate, and whether any opportunities were missed in assessing him or information sharing.

### *The PER from police to court*

58. Prison Service Order (PSO) 1025 (Communicating information about risks on escort or transfer - The prisoner escort record) states:

“It is essential that, when a prisoner is moved from police station, court or prison to court, prison, hospital or other destination, those responsible for the prisoner are made aware of any risks or vulnerabilities. In particular it is essential that known risks of escape, assault, suicide/self harm or harassment are communicated to others into whose custody the prisoner is passed; to protect prisoners, staff and the public. It is also essential that any new risks that develop during a movement are recorded and flagged up for others.”
59. The front of the PER has an ‘X’ and “stated at custody desk” written in the box next to ‘Suicide/Self Harm’. Although the SCO believed it to be a reference to something his wife told police, it is not clear from the form what the note refers to. The remit of this investigation does not cover the actions of the police service, and this note was written by

police. What is apparent from the PER 'Record of Events' is that he was interviewed by the SCO at 9.28am:

"Prisoner interviewed and SSH [Suicide/Self-harm] warning form not commenced placed in cell on own due to nature of offence. Denies all knowledge of self-harm history."

60. The escort services acknowledged the warning on the front of the PER and asked him directly about his history of harming himself. Their view was that, at the time of their assessment, he was not at risk of harming himself. The SCO explained to the investigator that he spoke to the man on a number of occasions and each time asked him how he was.
61. The investigator spoke to the SCO who emphasised that he did not present as someone at risk of harming himself when he collected him from police custody. Despite the remarks by the police on the PER, staff were content that he was not at risk of harming himself, given his presentation. The SCO had a duty to consider the reference on the PER, which he did and we consider that his actions were reasonable given the behaviour and responses of the man.

*The inclusion of further information on the warrant*

62. According to the PER 'Record of Events', he was in court between 11.15am and 11.55am when he was remanded into custody. His warrant contained the line "You have tried to commit suicide" amongst the reasons for his detention. The investigator spoke to the Deputy Justices' Clerk for Barnsley and Rotherham Magistrates' Courts, regarding this. He provided the investigator with a copy of the Magistrates' Court manual which says:

"It is vitally important that where a risk of self harm has been indicated in the courtroom which has not been mentioned previously and is not therefore in any medical/psychiatric/presentation report a supplementary remand warrant (WTSUP) must be also provided to the PECS." [Prisoner Escort and Custody Services].

63. A supplementary remand warrant was not used in the case of the man. However, reference to his possible previous suicide attempt was included on the warrant. The Deputy Justices' Clerk told the investigator that it is the magistrates' decision as to what information is included on the warrant, but their local practice is to include anything of note. He said that, in a similar situation in the future, he would expect a supplementary remand warrant to be used but he was uncertain when the WTSUP system had started.
64. He explained that once the hearing is completed, the warrant is produced and signed by the legal advisor (formerly known as the court clerk). It is then given to a court usher who passes it to the escort staff

in the custody suite of the court. It is the usher's responsibility to pass the relevant document to the escort staff, but the escort staff's responsibility to consider the information on it.

65. The investigator spoke to the escort staff about transferring the warrant information onto the PER. The SCO explained that he was in court with the man when the incident on the motorway bridge was discussed. He said that the event was disputed and it was not clear whether he had actually sought to harm himself on the bridge. (Although, he did tell prison staff later that he had attempted to jump from the bridge.) Due to that, he did not update the PER or open a self-harm warning form. He also said that he would not have checked that section of the warrant as any warnings on warrants have previously been hand-written and highlighted to draw them to staff's attention.
66. The information on the warrant may not have been a clear reflection of the content of the discussions in court. This disparity meant that the SCO did not believe anything of significance had been raised and did not realise that the warrant included reference to a suicide attempt.
67. As PSO 1025 explains, all relevant information regarding a prisoner's level of risk should be included on the PER: "It merely, but importantly, conveys the information about the assessed risks to others who may need to know about them." This information could have been included on the PER so that all risk related information was together and easily visible to the escort staff and receiving establishment. While the actions of the escort staff are understandable, given their account of what was discussed in court, there was clearly a breakdown in communication as information was transferred on some documents and not others. It would have been preferable for the court staff to ensure that the escort staff knew what was on the warrant, so they would have been obliged to update the PER, regardless of their view of the man's level of risk. The Ombudsman's terms of reference does not include court staff prior to a prisoner's reception in prison, so the following recommendation is made to the Director:

**The Director should liaise with the Court Service to ensure the inclusion of appropriate risk information on prisoner documents, including supplementary warrants.**

*Asking for further information than that on the PER*

68. PSO 2700 (Suicide and self-harm) states:

"When receiving a prisoner with a Suicide/Self-Harm Warning Form, an open ACCT Plan, or a Prisoner Escort Record with the suicide/self-harm warning box ticked, if the reasons for the concern are not clearly documented the Reception Officer should be asking for a verbal handover (i.e. a further explanation)."

69. The information on the PER is vague, and the reference to attempted suicide on the warrant was not transferred to the PER. There is no evidence that any of the reception staff asked the escort staff about the reference on the PER. When the officer on the front desk that day, was interviewed he said that it was unlikely that he received any further information since the CSRA only had the information on the PER.
70. The PSO requires prison officers to request a verbal handover from the escorting staff. This should be encouraged in an effort to get as much information as possible and might also encourage the other agencies to include more detail on the PER. Therefore, it is recommended that:

**The Director ensures that reception staff ask escort staff about any reference relating to risks on the Prisoner Escort Record in accordance with PSO 2700.**

#### *Analysing the warrant*

71. Prison Service Instruction (PSI) 52/2010 (Early days in custody) says:

“The PER and any other available documentation including Suicide and Self Harm Warning Forms, ACCT documents and CSRA documents, must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm by the prisoner.”
72. The warrant that authorised the man’s detention explicitly mentioned his previous suicide attempt: “You have tried to commit suicide.” (Despite apparently minimising this incident in previous conversations, he later admitted to the unit manager that he had attempted to jump off a bridge prior to being arrested.)
73. The warrant is not passed to other members of staff in the reception area, but kept in the prisoner’s core prison file. Therefore, the review of it by the initial reception officer is the only opportunity for the prison to take action regarding any risk highlighted on it. The reception officer was responsible for examining the warrants on 22 April to check the legality of holding the prisoners who entered Doncaster.
74. The reception officer saw the reference on the PER and added it to the CSRA, but he said that he could not remember if he saw the warrant or not. He told the investigator that had he read the reference on the warrant: “I think I would have written more details on the risk assessment and maybe, now I would have opened a watch.” There is no evidence that he passed on the information, either verbally or in writing.
75. It is true that the mention of attempted suicide on a warrant without an accompanying suicide and self-harm warning form is unusual.

Nevertheless, reception officers are responsible for checking all information provided to them to try to ascertain a prisoner's level of risk. It is regrettable that this clear reference to recent suicidal behaviour on the part of the man was not adequately picked up at Doncaster reception. Research indicates that a significant indicator that a person will attempt to kill themselves is if they have tried to do it before. The office's recent research report analysing self-inflicted deaths from January 2007 to December 2009 found that there was a history or identified risk of self-harm or attempted suicide in 72 per cent of all cases.

76. Notwithstanding the failure of Doncaster staff to notice the information on the warrant, there was a lack of clarity between court and prison staff regarding the use of the warrant to record information about risk. The escort staff were also unused to such information being put on the warrant. As the reception officer told the investigator interviewing him:

"I don't think that's the place for stuff like that to be put in."

77. However, the Deputy Justices Clerk told the investigator that the court has a duty to include information of concern on the warrant or supplementary remand warrant. It is essential that prison staff realise that the warrant may contain important information regarding the prisoner. To this end, it is recommended that:

**The Director ensures that reception staff read the warrant in each case and any significant information should be immediately shared with all relevant staff.**

*The assessment of the man by reception staff*

78. Regardless of whether the escort staff gave Doncaster any further information about the nature of his risk or whether the information on the warrant was considered, reception staff still had a responsibility to assess the man's risk of suicide or self-harm. Prison Service Order 1025 (Communicating information about risks on escort or transfer - The prisoner escort record) instructs escort and prison staff:

"If a prisoner is received from the police with this box [suicide/self-harm] ticked staff must establish whether the risk is current or past."

79. Doncaster staff explored self harm and suicide issues with him as a result of the information on the PER (even if they were unaware of the warrant information). The officer who carried out the assessment and the nurse who undertook section 2 of the CSRA both asked him directly whether he had any thoughts of self-harm, and he said he did not. Accordingly, staff assessed that he was not at risk of suicide or self-harm.

80. The nurse also said that the reference on the PER may have been historical, and therefore she would not consider them relevant to the current circumstances of the prisoner. (This makes it more disappointing that the information on the warrant was not shared with the nurse, as it makes it clear that the suicide attempt was recent.)
81. She explained how she came to her assessment:
- “I had the gentleman, the man, in front of me adamant that he had himself to live for, his family to live for and he denied any thoughts or intentions of hurting himself.”
82. The officer told the investigator how he assessed his likelihood of harming himself:
- “My judgement call definitely I worked off of his reaction, his verbal reaction ... it was his demeanour, it was the whole personality, his body language everything was taken into account and watching how he reacted, how his eye contact was. We all know from history that anybody who tends to lie or wanted to lie, you know they are looking away, there’s no contact with you and there’s interaction with you.”
83. He consistently denied having any intention to harm himself, but it is a matter of concern that staff so readily accepted his assertions given his risk factors. In rule 18.1 of Doncaster’s Suicide and Self Harm Strategy, there is a list of factors indicating when a prisoner is at a higher risk of suicide and self-harm. The following risk factors listed in the policy applied to the man:
- “Those in prison for the first time.
  - Those on remand.
  - Severe guilt or shame over the offence.
  - First 24 hours of confinement.
  - Past self-harm or suicide attempts
  - Vulnerability.” [the officer judged him vulnerable on the CSRA.]
84. In addition, the nurse knew that the man had a history of depression. The nurse and officer in reception reflected to the investigator that they attached significant weight to his presentation, rather than other indications of risk. A prisoner’s presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff.
85. Despite this, the strength of the documentary evidence and risk indicators that applied to him should have been sufficient for ACCT procedures to have been begun when he entered Doncaster. The risk indicators listed in the suicide and self-harm strategy must be disseminated and their importance understood by all relevant staff.

**The Director should ensure relevant staff strike an appropriate balance between indicators of risk and presentation when assessing the risk of self-harm in prisoners.**

*Conclusion*

86. The clinical reviewer describes the man's state of mind in his clinical review:

“On at least three occasions over two separate days, to both discipline and healthcare staff, he denied thoughts of self-harm or suicide. It would appear that he had clear intent on suicide which he wished to keep hidden from prison staff.”

87. This report has detailed a list of oversights and missed opportunities to communicate how vulnerable he was from the time he left police custody to his death. The report has highlighted how court, escort and prison staff needed to work together consistently and successfully to transfer vital information. This work is important, and must be continued and strengthened.

88. It is disappointing that some of the significant features of this case have been pointed out in previous investigations at Doncaster. When the Ombudsman's office investigated a self-inflicted death in 2010, it was found that reception staff missed vital information on the PER that indicated the prisoner was at risk. In addition, the report highlighted concerns about staff's understanding of the factors that put a prisoner at higher risk of harming themselves. It is vital that Doncaster continues to work to improve their reception procedures and ensure that risk factors are not missed in future.

**The decision to begin ACCT procedures on 22 April 2011**

89. Following the unit manager's conversation with the man in the morning of 22 April, he began ACCT procedures. This was the correct decision given his emotional state and confession that he attempted to jump off a bridge prior to his arrest. It is highly unfortunate that he chose to take his life so soon after ACCT procedures were begun, but no fault attaches to the unit manager's actions. The ACCT was suitably completed and he took his life before the assessment interview could be completed.

**Radio codes**

90. When he was found, staff entered the cell to attempt to assist him. Doncaster uses a radio code system for staff to alert their colleagues to emergency situations. However, instead of using the code system, a generic response alarm was used. When the response alarm was made, healthcare staff responded to the alert but the lack of appropriate code meant they were unaware of the nature of the

emergency, and this impacted on the equipment they initially took with them. It is clear from the statements made by the staff involved that items such as the defibrillator and oxygen were brought to the cell by later staff and it is possible their arrival could have been expedited had the correct code been used. However, the clinical reviewer does not comment on this issue and notes that: "The efforts made to resuscitate him appeared to be within the boundaries of reasonable and acceptable primary care practice."

91. Staff responded to a difficult and stressful situation and, although using the code system would have been preferable, it is clear that they responded quickly and attempted to save him. Nevertheless, there should be clear systems in place for emergency response to ensure that appropriate staff and equipment get to the required location as soon as possible:

**The Director should ensure that staff use the appropriate code when responding to an emergency situation**

## CONCLUSION

92. The man was only in Doncaster for one night. However, there were inconsistencies in the manner that information about his potential risk of self-harm was passed to the different agencies involved in the process. When he was assessed during his brief contact with the criminal justice system, these assessments judged him not to be at risk of harming himself. It is clearly imperative that all relevant information regarding a prisoner is captured and shared in an efficient and transparent manner to inform assessments appropriately.
93. The other significant issue that arose in this investigation was the concern that some staff may have over-emphasised the importance of his presentation against other factors when assessing risk. Professional and clinical judgement must always play an important role, but so must recognition of recent relevant events – such as apparent suicidal intentions - that research makes clear places some prisoners at higher risk than others. This balance must be clearly understood by the staff involved in prisoner assessments.

## RECOMMENDATIONS

1. The Director should liaise with the Court Service to ensure the inclusion of appropriate risk information on prisoner documents, including supplementary warrants.

This recommendation was **partially accepted**:

“Whilst the prison will strive to maintain and build a positive relationship with the court services it should be their responsibility to ensure their procedures are followed correctly. This information will be discussed at the court escort meeting and passed to the MOJ PECS monitor to forward to the Court Services.”

2. The Director ensures that reception staff ask escort staff about any reference relating to risks on the Prisoner Escort Record in accordance with PSO 2700.

This recommendation was **partially accepted**:

“There should be some responsibility placed on the court staff to ascertain information placed on documents by the police and some responsibility on the court escort contractor to ensure that information placed on the warrant is placed on a the self harm warning section form.”

3. The Director ensures that reception staff read the warrant in each case and any significant information should be immediately shared with all relevant staff.

This recommendation was **partially accepted**:

“There appears to have been no investigation to establish why a self harm warning form had not been opened by court staff in line with PSO2700 Annex 3B. Had this procedure been followed there would be no reason to check the warrant. Nevertheless, staff will be reminded of the importance of reading all documentation received on reception.”

4. The Director should ensure relevant staff strike an appropriate balance between indicators of risk and presentation when assessing the risk of self-harm in prisoners.

This recommendation was **partially accepted**:

“Staff will be reminded of the importance of balancing risk indicators against how the prisoner presents when being assessed. However the sharing of risk information in this

situation was not passed to Doncaster staff in the appropriate manner.”

5. The Director should ensure that staff use the appropriate code when responding to an emergency situation  
This recommendation was **accepted**:

“Staff will again be reminded as to the appropriate code used when responding to an emergency situation. Signs will be displayed on wings, reception HCC and the reorientation unit noting the correct code to use in specific emergency situations.”