

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP Humber  
in January 2014**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Humber in January 2014. He was 21 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received while he was at HMP Doncaster and HMP Humber was undertaken. Staff at both prisons fully co-operated with the investigation.

The man was sentenced to nine years imprisonment on 30 July 2013. He had a range of vulnerabilities, including a history of mental illness and substance misuse. He spent most of his time at Doncaster and had transferred to Humber less than month before he died. He frequently harmed himself. He had attempted suicide four times at Doncaster and was managed under Prison Service suicide and self-harm prevention procedures. He began to engage well with substance misuse and therapeutic interventions including dialectal behaviour therapy, designed to help people with borderline personality disorder, especially those who self-harm. However, he wanted to move closer to his family and asked for a transfer as soon as he was 21. On 19 December, a day after his 21<sup>st</sup> birthday, he was transferred to Humber, which was further away from his family. No one had told him he was going there.

One evening in January an officer found the man hanging in his cell from a ligature, made from a towel, attached to the window. Prison officers quickly began cardiopulmonary resuscitation (CPR) but were unable to revive him. Paramedics arrived and, after further emergency treatment, pronounced him dead.

The man was supported by suicide and self-harm prevention procedures for most of his time in prison, but I do not consider that these measures always operated effectively either at Doncaster or Humber. Prison staff assessed his level of risk as low, even when he had very recently harmed himself and despite his other risk factors. Support procedures were not always started after acts of self-harm and members of the mental health team were not always present at review meetings as they should have been. While he received some good therapeutic support at Doncaster he was transferred before completing useful therapy and I must conclude that the transfer to Humber was not in his best interests.

Once at Humber, the man's care was deficient in a number of ways. I am particularly concerned that the mental health team never assessed him during his time at the prison. Suicide and self-harm prevention procedures were also poor, lacking consistency of case management and appropriate assessment of his level of risk. When he was found hanging, the officer did not use an appropriate emergency radio code and the prison did not inform his family of his death for over 12 hours.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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## SUMMARY

1. The man had been diagnosed with schizophrenia and had a history of substance misuse. On 22 January 2013, he was remanded into custody, charged with a violent offence and went to HMP and YOI Doncaster. He was released on bail on 11 April but remanded to Doncaster again on 18 July after failing to attend court. On 30 July 2013, he was sentenced to nine years imprisonment.
2. During the man's first period at Doncaster, between January and April, he had harmed himself many times and had attempted to hang himself three times. When he arrived back at Doncaster on 18 July, Prison Service suicide and self-harm prevention procedures, known as ACCT, were begun but ended the next day. He harmed himself several more times during this second period at Doncaster, usually by cutting his arms. On one occasion he tied a ligature around his neck. ACCTs were opened twice more. He was well supported by the mental health team and visiting psychiatrists and psychologists. He reported having thoughts of harming his cell mate a number of times yet his cell sharing risk assessment was not reviewed.
3. The man wanted to move nearer his family and had agreed to transfer to HMP Wealstun, near Wetherby, on 19 December, the day after his 21<sup>st</sup> birthday. However, on day before the transfer, Wealstun withdrew his place because of his history of substance misuse. He was taken to Humber instead. An ACCT was still open.
4. At Humber, the man continued to be managed under ACCT procedures. A nurse in reception referred him to the mental health team but no one from the team saw him during his time at Humber. He harmed himself twice and was found with a potential ligature in his cell. Four ACCT reviews were held but each was chaired by different managers. On the day he died no-one noted any particular concerns and he played pool with other prisoners in the afternoon.
5. One evening in January 2014, at 6.40pm, an officer found the man hanging in his cell. He called for assistance but did not use the appropriate emergency code which should have resulted in an ambulance being called immediately. A wing manager asked for an ambulance to be called two minutes later. Officers cut the ligature, and started to try to resuscitate him. Paramedics arrived and took over the emergency treatment but pronounced him dead at 7.19pm.
6. On the day that the man arrived at Doncaster in July, an ACCT was opened but, despite his history of self-harm and other risk factors, was closed the next day. This was without any input from the mental health team. On at least three occasions, he reported that he had harmed himself but ACCTs were not opened. We are concerned that when he was being managed and supported under ACCT procedures, prison staff at both Doncaster and Humber assessed his level of risk of suicide or self-harm as low although he had a range of risk factors which would suggest otherwise. Case reviews were not held frequently enough and the mental health team was often not represented at reviews. We are concerned that he was moved to Humber without any

warning and advance information. It had been difficult for his family to visit him at Doncaster, but this move took him even further away.

7. The clinical reviewer found that the man did not always receive his medication as he should have done at Doncaster and the mental health team at Humber did not assess him while he was there despite his obvious risks and mental health problems. The reception nurse at Humber did not have essential information for her assessment. Officers did not use an emergency code when he was found hanging, and there was an unacceptable delay in informing his family of his death. We make eleven recommendations about these matters.

## THE INVESTIGATION PROCESS

8. The investigator issued notices at HMP Humber inviting anyone with relevant information to contact her. No one responded.
9. The investigator visited Humber on 15 January, and met the Governor and Deputy Governor and spoke to the staff who were involved in the emergency response. She visited the wing where the man had lived and spoke to two prisoners who had known him. She obtained his prison and clinical records. She interviewed staff at Humber on 4 and 5 March and informed the Governor of the preliminary findings.
10. The investigator visited HMP Doncaster on 6 March and interviewed staff who had contact with the man while he was there.
11. NHS Humber commissioned a clinical reviewer to review the man's clinical care at Doncaster and Humber.
12. The investigator informed HM Coroner for East Riding of Yorkshire of the investigation and we have sent the Coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted the man's family to inform them of our investigation and to invite them to identify any relevant issues they wanted the investigation to take into account. They asked the investigation to consider the following:
  - What medication was he given and what assessments took place when he arrived at Humber?
  - Was he being monitored for suicide and self-harm and, if so, how often and when did it begin?
  - At what time did he take his life? (His family said that they had been given three different times.)
14. The man's family received a copy of the draft report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

## **HMP HUMBER**

15. HMP Humber is made up of two former prisons, HMP The Wolds and HMP Everthorpe. The prison currently operates separate regimes on the two sites which will eventually physically merge. The man lived on the site which was formerly HMP Everthorpe. In total the prison holds up to 1062 Category C men serving medium to long term sentences. There are seven residential units on the Everthorpe site.
16. Healthcare services are provided by Humber NHS Foundation Trust. Services are staffed during the day and there is an on call doctor at night.

## **HM Inspectorate of Prisons**

17. The combined prison of HMP Humber has not yet been inspected. HMP Everthorpe's last inspection was in March 2012, which was a follow up of a full inspection in 2009. Inspectors found that Everthorpe was generally a safe and decent establishment. They noted that consultation with prisoners about issues of self-harm had improved. As there was no definition of what constituted a serious incident of self-harm, inspectors were not fully assured that all such incidents were investigated. ACCT refresher training was not up to date. Inspectors noted that there had been no deaths at the prison since the previous inspection six years earlier. Some improvement in health services was noted.

## **Independent Monitoring Board**

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In the last IMB annual report for HMP Everthorpe, for the year to October 2013, the IMB was satisfied that the prison was well managed and that prisoners were treated with dignity and respect. The IMB noted that a shortage of healthcare staff had impacted badly on standards of care during the year but this had been addressed. The departure of the safer prisons co-ordinator had also led to some problems with the management of safer custody but towards the end of the year a new co-ordinator had been employed with the expectation that the safer custody team would return to performing at an optimum level.

## **Previous deaths**

19. There has been only one previous death at Everthorpe since the Ombudsman began investigation deaths in prison in 2004. This was in 2006 and was also self-inflicted. There were no other similarities.

## **HMP & YOI DONCASTER**

20. HMP &YOI Doncaster is a Category B local prison which can hold up to 1,145 men. The prison is managed under contract by Serco Home Affairs. Healthcare is provided by NHS Nottinghamshire Trust.

## **HM Inspectorate of Prisons**

21. The most recently published inspection report of HMP Doncaster is of an inspection in November 2010. The report of a more recent inspection in March 2014 has yet to be published, but inspectors told us that there was a robust approach to opening ACCTs for prisoners who met a number of set risk predictors when they arrived. After they were assessed, most ACCTs were then closed. Mental health referrals were described as satisfactory, and a mental health nurse saw all new arrivals in reception.

## **Independent Monitoring Board**

22. In its most recently published report for the year to September 2013, the IMB noted that NHS Nottinghamshire Trust had vastly improved its procedures and this was reflected across the prison. In particular, there had been significantly improved access to services for those with serious mental health problems such as psychotic illness and complex personality disorders. The IMB reported that the safer custody team had managed 1209 ACCT documents in the previous 12 months. The team was based on the first night centre and worked closely with the substance intervention team to provide a seamless approach to care for prisoners at risk. The IMB noted that many ACCTs were closed within 24 hours as prisoners felt safe and understood how to get support if they needed it. The IMB said that they had received positive feedback about the drug recovery wing, which offered a variety of clinical, psychosocial and alternative therapies, including structured group work.

## **Assessment, Care in Custody and Teamwork - ACCT**

23. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

## **Care Programme Approach (CPA)**

24. The Care Programme Approach –CPA- is a particular way the NHS has of assessing, planning and reviewing someone's mental health care needs if they have a severe mental health disorder or a range of other vulnerabilities such as having been detained under the Mental Health Act or having a history of violence or self-harm. Someone who needs CPA support should have a formal written plan that outlines any risks and a CPA care coordinator to organise and review the plan.

## KEY EVENTS

25. The man was remanded to HMP and YOI Doncaster on 22 January 2013, charged with a violent offence. He was 20 years old. In 2004, he had been diagnosed with schizophrenia. When he arrived at the prison, staff began ACCT procedures because he had recently harmed himself in the community and they had a number of concerns about his risk. During his stay at Doncaster between January and April 2013, he attempted to take his own life on four occasions - three times by using a ligature and once by taking an overdose. He told staff that he heard voices, which told him to harm or kill himself or others. He was considered to be a high risk of harm to himself and others.
26. The man was released on bail on 10 April 2013. On 16 July, he was remanded to Doncaster again for failing to surrender to bail. On 30 July, he sentenced to nine years imprisonment for a violent offence.
27. On 18 July, the man told a nurse at a health screen that he been diagnosed with schizophrenia and had misused a number of illegal drugs over a long period of time. He said that he was under the care of Beechwood House Mental Health Services, Halifax, and was prescribed olanzapine (an antipsychotic) and citalopram (an antidepressant), but had not taken either medication since April. He told the nurse that he had cut himself with a razor blade about a month earlier in an effort to release stress and not to kill himself. He had not been diagnosed with epilepsy, but said that he suffered from seizures and had last had one about a month earlier. After a positive test for cocaine, the nurse referred him to the substance misuse service and began a detoxification programme.
28. Staff opened an ACCT because of the man's previous self-harm at the prison and his recently reported act of self-harm in the community. The level of observations was set at twice an hour with three quality conversations each shift. The next day, 19 July, at the first ACCT review, he told staff that he felt safe and had no thoughts of self-harm. He said that while he found detoxification difficult, he felt mentally strong. The review assessed him as at low risk of harm to himself and closed the ACCT. A post-closure review was arranged for 26 July.
29. On 22 July, a cell sharing risk assessment was completed. The assessment concluded that the man was a standard risk of sharing a cell. There is no evidence that this assessment was changed while he was at Doncaster.
30. On 24 July, the man was very distressed and tearful and told a nurse and member of the mental health in-reach team that he was hearing voices which were telling him to kill his cell mate by strangling him and then cutting him to pieces. He said that he was very upset because he thought that he would soon be unable to resist the voices and would have to take his own life because he would not be able to live with himself if he killed someone. He believed that he would never be able to live a normal life because of his illness. The nurse arranged for him to go to the healthcare unit for the night because of the risks to his cell mate but did not open an ACCT.

31. The next day, 25 July, the nurse reviewed the man, who appeared more settled and agreed to take antipsychotic medication, but not olanzapine because he said it had not worked the last time that he had taken it. He said that the voices were trying to talk him into harming other people and that he would have to serve six years, six months and six days in prison and then he would end his life. He told the nurse that his psychiatric worker in the community had tried to arrange for him to be detained under the Mental Health Act, but had decided not to when he had told him that the olanzapine was working. He told the nurse that he was due in court on 30 July for sentencing. He could not stop crying and was feeling very emotional. The nurse booked a medication review and mental health assessment for 6 August. The nurse arranged to see him again on 13 August, and for another member of the mental health team to see him in the meantime.
32. The man was discharged from the healthcare unit on 26 July. Later that day, an officer completed an ACCT post-closure review but did not mention his extreme distress two days earlier and there is no evidence that he had spoken to anyone from the mental health team. The officer decided that the ACCT should remain closed. He moved to wing 3B.
33. On 29 July, a nurse prescriber prescribed the man hyoscine butylbromide (for withdrawal symptoms from drugs), olanzapine and citalopram. The substance misuse and healthcare teams agreed a care plan for him to attend harm-minimisation and overdose-awareness sessions. On 30 July, he was sentenced to nine years imprisonment. There is no note in the clinical record that he was seen by a member of the healthcare team when he returned from court. On 31 July, a nurse assessed that he should not be allowed to have his medication in his possession, as he was at high risk of taking an overdose. On 1 August, he attended a substance misuse session and told a substance misuse worker that he was fine about his sentence and that he wanted to go to the drug recovery wing and engage in group work to tackle his substance misuse problems.
34. On 7 August, a consultant forensic psychiatrist examined the man, who told him that he was still hearing voices telling him to harm himself and others. He said it was affecting his mood because he did not want to hurt anybody; he was currently able to resist the voices but he was on the verge of doing what the voices were telling him. The voices had told him how to murder his cell mate which had distressed him so much that he had pressed the cell bell. The psychiatrist replaced his olanzapine with haloperidol (another antipsychotic drug) and arranged a review for six to eight weeks later.
35. On 15 August, a nurse reviewed the man, who said that he felt better and that, although the voices were still present, they were not distressing him so much. However, the voices interfered with his sleep and he was only sleeping two to three hours each night. He discussed his sentence and said that his release date was 13 September 2017. He told the nurse that as soon as he was moved from Doncaster, he would kill himself.
36. On 20 August, the nurse prescriber re-assessed the man's risk of keeping his medication in his possession. He was now regarded as a moderate risk and was allowed to keep a weekly supply of medication in his cell.

37. On 28 August, a wing officer asked a nurse to see the man, who appeared distressed. He was tearful and told the nurse that that he could not cope in prison and he was going to kill himself. He said that the haloperidol was not working and the voices, and his ability to sleep, were getting worse. He said that he would have a breakdown which would be "a thousand times worse than the last one". The voices were continuing to tell him to hurt someone and he felt that he would follow through with the instructions. He said that was also getting flashbacks to physical and sexual abuse that he had experienced when he was younger. The nurse arranged to see him again on 2 September, but did not open an ACCT.
38. On 1 September, the man said that he had taken an overdose the day before. He wrote a letter to his family and said that he had taken paracetamol, haloperidol, citalopram, and tramadol, because everyone would be better off without him, and that he intended to die. A nurse telephoned the National Poisons Information Service, who advised that he needed to go to hospital. He was taken to hospital and returned to the prison six hours later.
39. Prison staff opened an ACCT and the man told them that he was worried about where he might be transferred from Doncaster and that he was concerned about his relationship with his ex-girlfriend, the mother of his children. He said that he would kill himself but not at Doncaster. He wanted a transfer to HMP Leeds or HMP Wealstun because that would make it easier for his family to visit. An ACCT case review on 2 September, chaired by a member of the safer custody team and attended by another wing officer and a nurse, assessed him as at low risk of harm to himself. The review agreed that staff should observe him at least once an hour. A careplan was completed with one objective - for him to engage with the mental health team.
40. On 9 September, a nurse saw the man before they attended a sentence planning meeting. He said he was still having thoughts of harming his cell mate by smothering him with a pillow and suicidal thoughts. He said he was still finding it difficult to cope with memories of sexual abuse that he had experienced as a child. He was using an elastic band around his wrist which he snapped against his skin as a distraction to prevent him from cutting himself.
41. The meeting agreed that the man should be given a single cell because of his comments about his cell mate. (It is not clear from the records whether he moved to a single cell at that point.) His offender manager (probation officer) completed a security information report (SIR) and informed the unit manager. It was agreed that the psychiatrist would review him on 11 September, and that they should get him to engage with a psychosocial interventions course, a particular type of therapy for post-traumatic stress and high anxiety. A nurse arranged to see him again on 12 September.
42. On 11 September, the man told the psychiatrist that he did not think his current medication was working. He was still finding it difficult to sleep and he felt suicidal. The psychiatrist asked him how he would kill himself and he said that he did not know but would probably just slit his throat. The psychiatrist decided to increase the dosage of haloperidol and citalopram. He considered that he was suffering from a severe and enduring mental health condition, but he should remain in prison because a hospital would not be able to offer any

other treatment and he should be able to progress in his sentence. A care plan approach (CPA) review meeting was arranged for 2 October.

43. The second ACCT case review took place on 13 September, with the same case manager again. No changes were made to the man's risk or observation levels and the careplan objective to engage with the mental health team remained the same. The record of the review states that the case manager had discussed him with the nurse, but the nurse did not attend the review, and no other healthcare staff were present.
44. On 16 September, the man told a nurse that he had not received his haloperidol. On 26 September, he told the nurse that he had tried to hang himself on 23 September, but the ligature had broken. He said that he had still not had his medication and had complained to his solicitor and to the Independent Monitoring Board. The nurse told a wing officer about his attempt to hang himself and noted this on the ACCT record but there was no review and the level of observations remained the same. He did not receive his haloperidol until 28 September.
45. On 30 September, the man harmed himself by cutting his arms. An officer noted in his prison record that the level of observations had been increased to two an hour. The next day, 1 October, a manager held another ACCT review which a wing officer and the nurse attended. The record of the case review did not refer to the man's report that he had tried to hang himself on 23 September, but the self-harm incident of 30 September was noted. Despite these recent incidents the review still assessed his risk of suicide and self-harm as low. The review made no changes to his careplan, but reduced the level of observations to one an hour again with three entries per shift. (This meant that officers did not record each check they made.)
46. On 8 October, the man cut his arms again. The nurse who treated the wounds described them as superficial. He told the nurse later that day that he had not taken his medication in the morning because he was being bullied by other prisoners and did not want to come out of his cell. He said that he did not think he would see his 21<sup>st</sup> birthday because he would have killed himself before then. The nurse did not note this in the ACCT record.
47. The man attended a substance misuse session on 8 October and told an officer that he had nothing to live for and felt vulnerable on the wing. She told wing staff about what he had said and asked for him to be moved to the recovery wing, a dedicated wing for prisoners tackling substance misuse problems.
48. On 9 October, the man attended an appointment with a specialist registrar in forensic psychiatry. He told the psychiatrist about his feelings and thoughts and that he had cut himself on a number of occasions. The psychiatrist arranged for his medication to be increased to 60mg of citalopram and 5mg of haloperidol three times a day and for him to have a psychological assessment. He was to continue to work with the nurse. On 10 October, he moved to the recovery wing.
49. On 11 October, the man told the nurse that he was not getting the increased dosage of haloperidol. The pharmacy told the nurse that the increased

dosage of citalopram was not licensed to be taken with the increased dosage of haloperidol. The psychiatrist and the pharmacy staff agreed that he should be prescribed 40mg citalopram and 10mg haloperidol a day until the Care Programme Approach review (which eventually took place on 23 October).

50. On 15 October, a manager held an ACCT review attended by a wing officer and the nurse. The man said that he felt more settled on the recovery wing but he was still hearing voices and had still not received his medication as prescribed and had not received his afternoon and night doses the day before. He said that he had had a good visit from his mother and brother and had slept better, but was still disturbed by thoughts about his experience of sexual abuse. The review increased the level of observations to two an hour, although the reason for this was not given. His risk of suicide and self-harm was still assessed as low and no changes to his careplan were made.
51. On 17 October, a psychologist assessed the man and noted that he was calm and settled, made good eye contact and engaged well. He told her about his current feelings, propensity to harm himself and his suicidal ideation. He said that he was having visual hallucinations of a person who cried in front of him and that he could feel the person's anger and rage. He told her that one of the voices he heard was of the person who had abused him when he was a child. Her assessment recommended that he should attend trauma counselling and have dialectal behaviour therapy (DBT). (DBT is a therapy that enables people to become mindful of their condition and helps them to tolerate distress better.)
52. At the next Care Programme Approach meeting on 23 October (which had been postponed twice because of scheduling difficulties), the psychiatrist suggested that the man should receive haloperidol by depot injection, continue with citalopram and continue to engage with the psychologist for dialectal behaviour therapy. On 28 October, he attended a substance misuse session.
53. On 29 October, an ACCT review reduced his level of observations to one each hour again. His risk remained assessed as low. He said that he was taking his medication and felt more settled. The ACCT record notes that he smiled and chuckled occasionally during the review. He had applied for a prison job to keep him occupied and to distract his thoughts.
54. The man attended a substance misuse meeting on 30 October, and had a follow-up appointment with the psychologist on 31 October. He said that he was happy to continue with the dialectal behaviour therapy group and to meet her every fortnight. She noted that he had been coming out of his cell more and interacting with other prisoners. On 14 November, he told a nurse that he was feeling unwell again. He said that the voices were becoming more stressful again but he could resist acting on them. He said that his sleep was becoming more unsettled but he was not feeling suicidal and he did not want to harm himself. He was looking forward to a visit from his family. The nurse did not record this information on the ACCT ongoing record.
55. On 18 November, a member of the safer custody team chaired an ACCT review. Two officers from the man's unit attended. There was no member of healthcare staff present. He had not harmed himself in the previous three

weeks and had now got a job as a wing cleaner and was enjoying working. He said that he had family support and was engaging with substance misuse services and mental health workers. He was taking his medication appropriately and said that he did not feel suicidal or want to harm himself. The review decided to close the ACCT because he was receiving support and had recently been stable. The one objective in the careplan was ongoing and he continued to engage with mental health services. At a post-closure review on 26 November, he said that he was feeling supported because he would be moving to a prison nearer to his home, so his family could visit more often.

56. On 21 November, the man attended a dialectal behaviour therapy group. He said that his job as a wing cleaner had helped distract him from the voices he heard. He engaged well in the group activities and exercises. It was subsequently agreed that he should attend the dialectal behaviour therapy group, rather than see the psychologist on a one to one basis.
57. On 25 November, the man attended a substance misuse group, and then saw a nurse for a review. He told the nurse that he had fallen out with his mother but he was trying to make it up with her. He said he was enjoying his job and that it helped to keep his mind occupied. On 1 December, he saw his offender manager to discuss the possibility of a transfer to a prison in Lancashire, nearer his family. She said that she would ask for any transfer to be put on hold until after his 21<sup>st</sup> birthday on 18 December, otherwise he would need to go to a young offenders institution and she believed that his condition should stabilise before he moved. She said that she was trying to arrange a transfer to Wealstun near Wetherby. Although not in Lancashire, he said that he was content with this as it was closer to his family.
58. On 2 December, the man made several cuts to his arms and made a ligature from bedding which he tied around his neck. An officer opened an ACCT. During an ACCT assessment interview, he said that he was feeling depressed, angry and upset because his family could not visit him as often as he would like because of the distance to the prison. He said he had not been sleeping again, was hearing voices and was under pressure on the wing to take drugs, which he did not want to do.
59. A manager chaired the first case review on 3 December. The unit manager was present, along with the ACCT assessor and a member of the mental health in-reach team. His risk was assessed as low and the level of observations set at twice an hour with three entries each shift. A careplan was completed with three objectives:
  - To continue to engage with the mental health in-reach team
  - To move wing
  - To arrange a transfer to HMP Wealstun and for staff to liaise with their mental health team
60. The man attended the dialectical behaviour therapy group on 5 December and had a meeting with a substance misuse worker on 10 December. On the evening of 10 December, at 7.15pm, he cut his arms with a broken cup. He told the nurse manager that he had not taken his medication for several days because other prisoners were asking him to bring it back for them. She suggested that healthcare staff should arrange for him to come for his

medication first or last and they would keep him safe. He agreed to this and said that he would not harm himself.

61. At 8.10pm, officers called the nurse manager back to see the man shortly after she had left the wing. When she arrived, he was sitting on the floor holding his head and looked very distressed. He told her that he was trying to read his letters and respond to his family but he could only hear voices. She gave him his medication and offered to read his letters to him to help distract him from the voices. He agreed and eventually calmed down. She arranged for a member of the mental health team to visit him the next day.
62. The man attended the dialectical behaviour therapy group on 12 December and a substance abuse session on 16 December. He engaged well with both.
63. A manager held the second ACCT review on 18 December, which was the man's 21st birthday. Two wing officers attended, but there was no input from the mental health team. His offender manager contributed a written report. He said that his risk of self-harm was low and he had been engaging with the mental health team. The offender manager had told him that he would transfer to Wealstun the next day, and he was happy about this move. His risk remained assessed as low and the level of observations remained at twice an hour.
64. On 19 December, the man believed that he was being transferred to Wealstun. Instead he was taken to HMP Humber without anyone explaining this to him. His offender manager said that the day before the planned transfer, Wealstun had refused to take him because of his history of substance misuse and instead he went to Humber. A nurse said he spoke to the healthcare team at Humber to inform them of his mental health problems and that he was subject to the care programme approach. Humber was also aware that he was on an ACCT.
65. A nurse carried out the man's routine health screen examination at 2.53pm when he arrived at Humber (Everthorpe site). She said that she could not remember if she had been given a summary of his medical notes and medication. She explained that when a prisoner transferred, she completed a health screen template on SystemOne (the electronic health record.) She said that more often than not they did not receive information from Doncaster and that she did not routinely receive information about whether the prisoner was on an ACCT, unless the prison reception team told her.
66. The nurse said that she first had to complete and save the health screen template in order to look at a newly-arrived prisoner's full clinical record on SystemOne. She said that it would be helpful to receive a hard copy of a summary of the patient's health history and copies of the ACCT document. She said that at health screens, she relied mainly on what the prisoner told her.
67. The man told her that he was subject to ACCT monitoring. He said that he was angry about being transferred as he had been due to see the doctor about changing his haloperidol from oral to depot injection. He said that he had asked for this change because other prisoners were forcing him to regurgitate his medication for them. (There was no note of this in the medical

record). The psychiatrist had recommended at the care programme approach meeting on 23 October that he should receive his haloperidol by depot injection but this does not appear to have happened. There was no note in the record about when the next review would take place.

68. The nurse decided that the man should not keep his medication in his possession because of his risk of suicide and self-harm. She completed a mental health assessment, which indicated that he was depressed and still thinking of harming himself. She was concerned about his responses, so she spoke to another nurse from the mental health in-reach team about him and referred him to be seen by the mental health team. She briefed wing staff about her concerns. He was prescribed the following medication:
- citalopram 20mg,
  - domperidone 10mg,
  - haloperidol 5mg,
  - hyoscine butylbromide 10mg, and
  - omeprazole 20mg.
69. At 6.30pm on 19 December, a Supervising Officer (SO) held an ACCT review, attended by another SO. They recorded that the man had said that he was a lot happier to be at Humber and the officers assessed him as a low risk of harm to himself. Observations were set at one in the morning and afternoon and every two hours at night. One action was added to his careplan: to obtain a prison job. The next ACCT review was scheduled for 26 December and a mental health review was arranged for 6 January 2014. A note in his clinical record indicates that he was still waiting for an assessment by the mental health in-reach team on 23 December.
70. A cell sharing risk assessment was completed when the man arrived at Humber. Because he had heard voices telling him to harm his cell mate, he was assessed as being a high risk of sharing a cell.
71. On Christmas Day at 6.48pm, the man told an officer that he had cut his arm. Humber does not have 24 hour health cover and two officers went into his cell and treated the cuts, which they described as superficial scratches, with a dressing. He told them that voices were telling him to harm himself and he was concerned because he was only getting his medication twice a day, instead of three times a day as previously. The officers told him to discuss this with healthcare staff the next day and also arranged for them to check his dressing. They checked that he knew about support systems in the prison and that he had enough tobacco for the night. They recorded this in the ongoing record and raised the level of ACCT observations to one every hour. He settled for the rest of the night.
72. A SO held an ACCT review at 10.30am on 26 December, which was attended by a wing officer. There was no healthcare representation. The man said that his thought patterns and feelings had not changed. His risk of suicide or self-harm was assessed as low. The level of observations reverted to one in the morning, one in the afternoon, one in the evening and one every two hours at night. There was no record of the incident of self-harm from the previous evening in the record of the ACCT review. It is therefore unclear if the ACCT reviewers had read this. They arranged the next review for 3 January.

73. A nurse changed the man's dressing at 1.44pm on 26 December and noted that he was calm and relaxed. She told him that the mental health in-reach team were aware of him and would visit him soon and sort out his medication. She encouraged him to ask for support if he needed it and noted that he appeared to be appreciative. The next day, a doctor changed his haloperidol dosage to 1.5mg tablets, five issued each morning and evening. It is not clear from the record that he saw him in person.
74. A SO held an ACCT review on 3 January, which was attended by an officer. There was no healthcare representative. The man said that he did not have any thoughts of suicide or self-harm. The SO noted that he was still waiting to be seen by the mental health in-reach team and he would not consider closing the ACCT until they had assessed him. His risk remained assessed as low risk and the level of observations were decreased to one quality entry a day, a recorded conversation at night and observations every two hours at night.
75. Later that afternoon, at 3.00pm, an officer recorded in the ACCT document that he had had a long conversation with the man. He said that he had come to terms with his sentence but would like a transfer nearer his home at some point. The officer wrote that he seemed very talkative and in good spirits.
76. On 4 January, at 3.40pm, a SO recorded that he had spoken to the man. He said that he was keen to see the mental health team that he had been working with at Doncaster. He said that he missed his family and asked for a transfer to HMP Wymott, which was closer to them. The record indicates that he had been out of his cell during an association period and had made some friends. There were no issues raised over the next three days and he seemed to be in good spirits.
77. At 11.36pm on 7 January, an officer checked the man and saw a piece of bedding tied to the hot water pipe in his cell. He and the duty manager removed it from the cell. The officer noted that he was chatty and seemed happy but there is no record that the officer or the duty manager had asked him about the bedding and his intentions. The officer made a note in the ACCT ongoing record for staff to check his cell for other ligatures. No changes were made to his level of observations, despite the concern about ligatures.
78. At 10.25pm on 9 January, an officer checked the man and found that he had cut his ear lobe and arm. Officers treated his cuts, which were not serious enough for him to go to hospital. He said that he was feeling anxious because his family were so far away and could not visit him. The level of observations was increased to hourly and the next ACCT review was brought forward to the next day.
79. At 8.15am on 10 January, an officer checked the man, who said that he had harmed himself because he was hearing voices. He went to collect his medication and an officer told him they would hold an ACCT review later that day. The officer encouraged him to press his cell bell to talk to staff if he felt like harming himself again. The officer said he later saw him talking to other prisoners in his cell and he had seemed in good spirits.

80. A SO held an ACCT review at 3.00pm on 10 January, which an officer attended. There was no healthcare person present but the SO said that he had contacted a nurse by telephone as part of the review. The nurse had told him that the man usually cut himself to relieve stress. (She told the investigator that when the SO called her she was unable to comment on the man's mental health because she was not qualified in that area of work.) The SO noted that he had spoken to someone from the mental health in-reach team, who had told him that the in-reach team would see the man the next week. The SO described him as happy at the review. He told the SO that he had cut himself the night before because he had not been able to speak to his mother for some time, but said that he did not want to kill himself. He said that he had heard voices but he did not listen to them. He was happy to speak to staff, would do so if he felt that way again and was no longer thinking of harming himself.
81. The SO offered the man the opportunity to call his mother from the office telephone. He said that the man tried twice but could not get an answer. However, he said that even though he could not get through to his mother he was smiling and laughing and his reaction did not suggest not indicate that he was stressed by this. The SO assessed his risk as low, even though he had harmed himself the night before, and kept his observations at one entry in the morning, one in the afternoon and every two hours at night.
82. That afternoon, the ACCT records indicate that the man played pool and joked with other prisoners. He asked for paper to write a letter and said that he was fine. (A letter was later found in his cell addressed to his girlfriend. It indicated that he was missing her and was worried about their relationship.) At 3.45pm Officer A noted that he was playing pool again. At 4.45pm, he collected his evening meal and his canteen and seemed in a good mood. An officer checked on him at 5.45pm, when he was in his cell. He recorded that the man gave him a thumbs up sign.
83. Officer A went to check on the man again at 6.40pm. When he looked through the observation hatch, he saw him suspended by a towel, tied to the cell window, facing towards him. He said that the cell light was on and he could see clearly. The officer radioed for urgent assistance but did not use an emergency code. He then went into the cell.
84. Officer A told the investigator that the man appeared to be lifeless. He took his weight and tried to cut the towel with his anti-ligature knife. A SO and another officer arrived and at 6.42pm the SO Paterson asked the communications room to call an ambulance. Together they cut the ligature and lifted him to the bed. Officer A noted that he was not breathing and he was unable to find a pulse. He said he was confident about attempting resuscitation as he had previously been an auxiliary nurse. He started chest compressions and noted that he was extremely limp and had blue mottled skin. He thought that he was dead. He continued chest compressions for approximately 15 minutes, until paramedics arrived at 6.52pm. They took over emergency care but, at 7.19pm, pronounced him dead.
85. Staff later informed the prisoners about the man's death. Prisoners who were on ACCTs were reviewed in case they had been adversely affected by the

news of his death. A debrief was held for the staff involved in the emergency response to offer support. They told the investigator that it was helpful.

86. At 8.00pm, an officer was asked to act as the prison's family liaison officer (FLO). Officers had found a letter in the man's cell asking them to contact his mother and girlfriend. The FLO collected the information about the man's death and completed a risk assessment, which he finished at 10.43pm. In conjunction with managers it was decided that it was too late at night to inform the man's family. The reasons given were that the police had said that prison staff would need to be supported by them and because of the distance they would have to travel and the time that they would arrive at the next of kin's home (early hours of the morning). They therefore arranged to tell them the next morning as soon as possible.
87. At 8.53am on 11 January, the FLO and another family liaison officer went to the man's mother's home and informed her of her son's death. While they were there, she telephoned his girlfriend and told her the sad news. The family liaison officers continued to liaise with the family and offered a financial contribution towards the cost of the funeral, in line with national guidance.

## ISSUES

### Clinical care

88. The clinical reviewer found that the man's substance misuse and mental health issues were appropriately identified when he arrived at Doncaster. He was referred to the mental health in-reach team, saw a psychiatrist and attended dialectical behaviour therapy sessions. He noted that dialectical behaviour therapy is a recognised treatment for suicidal patients, but one that was not available at Humber. Prison Service Order 3050 – Continuity of Healthcare for Prisoners - states that prisoners can be withheld from transfer for clinical reasons for a period of time. He considered that the mental health in-reach team at Doncaster should have considered placing the man on clinical hold while he continued with the dialectical behaviour therapy. While this would have affected his request to transfer to a prison nearer his family, the benefits of continuing the therapy might have outweighed that benefit. The possibility of postponing a transfer for a while until he had completed the dialectical behaviour therapy programme, or at least some initial treatment goals had been achieved, should have been discussed with him and been part of his care plan under the care programme approach. In the event, he received neither benefit and moved to a prison where he was not able to continue with his therapy and was less accessible for his family. We make the following recommendation:

**The Director of HMP Doncaster and the Head of Healthcare should ensure that where there is a clear therapeutic benefit which outweighs other factors, prisoners participating in dialectical behaviour therapy and other psychological therapies, are able to remain at Doncaster at least until initial treatment goals have been fulfilled.**

89. The man told a nurse on 26 September that he had not received his antipsychotic medication. This took two days to resolve. On 9 October a specialist registrar in forensic psychiatry changed his medication plan, increasing the dose of citalopram to 60mg a day and haloperidol to 5mg per day. The pharmacist later pointed out that the level of citalopram was unlicensed when used with haloperidol so this was not issued. Although the level of medication prescribed was inappropriate, he did not receive any of his medication at the time. We make the following recommendation:

**The Head of Healthcare at HMP Doncaster should ensure that prisoners are prescribed appropriate medication and receive it as planned.**

90. At the time of his death, three weeks after moving to Humber, the man had still not been assessed by the mental health in-reach team. The clinical reviewer commented that in the context of such serious and prolific self-harm and suicidal behaviour the mental health services at Humber should have prioritised his assessment. As the man was being managed under the care programme approach, he should have had a care co-ordinator to help ensure continuity of care and we would have expected his mental health and medication regime to have been assessed immediately he arrived at Humber. We make the following recommendation:

**The Head of Healthcare at Humber should ensure that newly-arrived vulnerable and mentally ill prisoners are identified and prioritised for assessment by the mental health in-reach team and that prisoners subject to the Care Programme Approach are assessed urgently.**

91. A nurse told us that she did not routinely have access to ACCT documents during reception health screenings, and relied on prisoners self-reporting. She also said that she could not access the man's previous medical record until she had completed her assessment.
92. It is important that nurses assessing a prisoner's health needs have access to as much information as possible. In particular, Prison Service Instruction 64/2011, which deals with safer custody issues, gives a mandatory action that the ACCT plan must travel to and from any location the prisoner moves to when he/she participates in activities (e.g. the prisoners' workplace). This does not appear to be happening in reception at Humber. It is also possible to access previous medical records on SystemOne when prisoners arrive at a new prison if the system is set up correctly. We make the following recommendation:

**The Governor and Head of Healthcare at HMP Humber should ensure that reception nurses have access to a prisoner's ACCT document and previous medical records when conducting a reception health screen.**

#### **Cell Sharing Risk Assessments (CSRA)**

93. A cell sharing risk assessment was completed on 22 July after the man arrived at Doncaster. He was assessed as being a standard risk of sharing a cell. However, he made five references to having thoughts of harming others and, on 24 July and 9 September, specifically about killing his cell mate. Nothing was done about this until a sentence planning meeting on 9 September noted that he should no longer share a cell. It is not clear from the records whether he moved to a single cell that day, but there is no other reference to him having thoughts of killing his cell mate. There is no evidence that a new cell sharing risk assessment was completed until he moved to Humber in December 2013.
94. Prison Service Instruction 9/2011 states that prisons must ensure that there is an up-to-date cell sharing risk assessment for all prisoners. Paragraph 7.1 states that standard risk assessments should be reviewed where new or additional information becomes known which indicates increased risk. The man gave specific information about the thoughts he was having which indicated that he presented an increased risk to his cell mate and which should have triggered a review of his cell sharing risk assessment. We make the following recommendation:

**The Director and Head of Healthcare at HMP Doncaster should ensure that cell sharing risk assessments are reviewed whenever there is information that a prisoner is at increased risk of violence towards a cell mate.**

## Management of risk of self-harm

95. When the man arrived at Doncaster on 18 July 2013, he was already known to the prison staff. He had a number of static risk factors - he was relatively young, suffered from mental illness, had previously tried to kill himself in prison and said that he had harmed himself in the community one month earlier. He was described as a prolific self-harmer and was due to be sentenced on 30 July. An ACCT was opened but was closed the next day. (HM Inspectorate of Prisons noted in their recent inspection that this frequently happened.) We are very concerned that with his history of mental illness, there was no member of the healthcare team present at the review when the ACCT was closed within 24 hours.

96. We consider that the decision to open the ACCT when the man arrived at Doncaster was correct given the number of risk factors he displayed. However, the ACCT was closed after one day and with no input from the mental health team. We consider that this was insufficient time to assess whether he was no longer at risk of suicide and self-harm and that such a decision should not have been made without the input of mental health services. We make the following recommendation:

**The Director of HMP Doncaster should ensure that ACCT documents are not closed for prisoners with known histories of mental illness and self-harm without input from the mental health team.**

97. We are also concerned about how the man's risk of suicide and self-harm was assessed and managed by staff at Doncaster after the ACCT opened on arrival was closed. Between 18 July and 26 July, he harmed himself twice. These incidents of self-harm were not considered at the post-closure review on 26 July, and the ACCT was not re-opened in response. On 28 August, a nurse recorded that he was depressed and tearful and had said that he could not cope in prison and felt suicidal. Despite this clear articulation of risk, the nurse did not open an ACCT. After an ACCT was opened on 1 September, his level of risk was assessed as low even though he had received hospital treatment for a suspected overdose the previous day. (The ACCT document states that a prisoner should be considered a raised risk when "suicidal ideas are frequent but generally fleeting and where there is evidence of a mental disorder and where a prisoner has recently attempted suicide and demonstrates current, self-harming behaviour".)

98. We are also concerned that ACCT observations were not recorded at the time they were made. For example when the man was subject to hourly observations on 1 October these observations were recorded only three times each shift. This is at odds with the guidance for recording observations in the ACCT document. This requires staff to follow the level of observations and conversations and record these immediately or as soon as practicable thereafter. When staff do not make entries in the ACCT document contemporaneously, it is difficult to be assured that the required level of observations is carried out.

99. On 26 September, the man told the nurse that he had tried to hang himself three days earlier. The nurse noted this in the ACCT document, but staff did not hold a review and did not alter the level of observations. On 30

September, he cut his arms. At a review the next day, his level of risk was assessed as low. There was no reference to this attempted hanging in the record of this review. On 2 December, he cut himself again and placed a ligature around his neck. At the first case review, his level of risk of suicide and self-harm was again assessed as low. ACCT reviews were usually held at two-week intervals, perhaps reflecting the assessments that he was at low risk. There was only one caremap action for much of his time at Doncaster - for him to engage with the mental health team, which he was already doing.

100. We consider that the assessments of the man's risk of suicide and self-harm were not in line with his recent history, which meant that he was not always supported appropriately under the ACCT process. ACCTs were not conducted after he harmed himself and his level of risk remained assessed as low even just after he had harmed himself which meant that reviews were held too infrequently to offer any meaningful support. However, we note that there was good consistency of case management. Most of the reviews had appropriate and consistent healthcare representation but it is a concern that there was no mental health team involvement in the review on 18 November at which the ACCT was closed. For much of his time at Doncaster, the caremap consisted only of one ongoing action, with no action in place to address his overwhelming concern, a plan to move closer to his family. We make the following recommendation:

**The Director of HMP Doncaster should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that officers:**

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including recent history of self-harm.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**
- **Assess the level of risk of suicide or self-harm appropriately and ACCT reviews at intervals to reflect the risk.**
- **Hold a review as soon as possible after an act of self-harm.**
- **Record ACCT observations immediately or as soon as possible after they are made**
- **Hold multi-disciplinary ACCT reviews.**
- **Write specific meaningful actions on ACCT caremaps aimed at reducing prisoners' risks to themselves.**

101. The man was being managed under ACCT when he arrived at Humber. He had four case reviews while there, but each review was chaired by a different manager and there was little evidence of continuity of case management. No member of the healthcare team attended any of the four reviews. His risk of suicide and self-harm was assessed as low even when he had harmed himself the day before a review (on Christmas Day and 9 January 2014). Following his self-harm on 9 January, the level of observations was reduced to every two hours from every hour.

102. As with the management of the ACCT process at Doncaster, we consider that officers at Humber did not manage the man's risk of suicide and self-harm effectively. We make the following recommendation:

**The Governor at HMP Humber should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that officers:**

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including recent history of self-harm.**
- **Ensure continuity of case management.**
- **Assess the level of risk of suicide or self-harm appropriately.**
- **Hold multi-disciplinary ACCT reviews.**

### **Transfer to Humber**

103. The man wanted to move from Doncaster because it was difficult for his family to visit him there. Ideally he wanted to go to a prison in Lancashire but was told that he would move to Wealstun. He said he was content with this as it was nearer. However, on the day before the proposed transfer, an officer at Doncaster recorded that Wealstun refused to take him because he had a history of substance misuse and the man was transferred, seemingly without his knowledge, to Humber instead.
104. While it appears that staff at Doncaster briefed Humber about the man's circumstances, we do not consider that this transfer was in his best interests. He was on an ACCT because of his risk of suicide and self-harm. He had engaged well with dialectical behaviour therapy at Doncaster but this was not available at Humber and he would not have received the level of family support at Humber that he thought he might get had he moved to Wealstun.
105. We understand that population pressures mean that prisons sometimes have to transfer prisoners, often at short notice, to fill available spaces. However, the man was a vulnerable and seriously mentally ill young man, subject to the care programme approach and being managed under suicide and self-harm prevention procedures. The move to Humber seems to have been entirely random without any thought given to his needs. It was directly contrary to one of the objectives of his ACCT caremap that he should move to Wealstun to be nearer his family for support. While it is not entirely clear why the move to Wealstun fell through, (the reasons given are hard to accept) it is difficult to see that there was any rationale for his move to Humber, other than there was a van going there that morning. Moves for prisoners with his level of vulnerabilities need to be carefully coordinated and planned to ensure their safety and meet their needs. We make the following recommendation:

**The Director of HMP Doncaster should ensure that when prisoners being managed under suicide and self-harm prevention procedures and with identified mental health problems are transferred there is a clear**

**plan to ensure that their needs, including those identified in ACCT caremaps, can be met safely at the receiving prison.**

### **Emergency Response**

106. The officer who found the man hanging in his cell radioed asking for urgent assistance but did not use a recognised emergency code. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, issued in February 2013, contains mandatory instructions for prisons to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. Humber has such a protocol, but the officer did not follow it. This meant that the staff responding did not initially know the type of incident they were attending and that there was a slight delay of two minutes or so in calling an ambulance, which should have been requested automatically as soon as an emergency code was called. We make the following recommendation:

**The Governor of Humber should ensure that all prison staff are made aware of and understand PSI 03/2013 and the local protocol and their responsibilities during medical emergencies.**

### **Family liaison**

107. The man was pronounced dead at 7.19pm. A family liaison officer was appointed at 8.00pm that evening. However, his family were not informed of his death until 8.53am the next morning. Prison Service Instruction 64/2011 states that:

“Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.”

108. While we understand that risk assessments need to be completed and prison staff should be safe when they give the news of the death of a family member, we consider that the man’s family should have been informed much earlier, in line with PSI 64/2011. We make the following recommendation:

**The Governor of Humber should ensure that a prisoner’s next of kin are notified as soon as possible after a death in custody.**

## RECOMMENDATIONS

1. The Director of HMP Doncaster and the Head of Healthcare should ensure that where there is a clear therapeutic benefit which outweighs other factors, prisoners participating in dialectical behaviour therapy and other psychological therapies, are able to remain at Doncaster at least until initial treatment goals have been fulfilled.
2. The Head of Healthcare at HMP Doncaster should ensure that prisoners are prescribed appropriate medication and receive it as planned.
3. The Head of Healthcare at Humber should ensure that newly-arrived vulnerable and mentally ill prisoners are identified and prioritised for assessment by the mental health in-reach team and that prisoners subject to the Care Programme Approach are assessed urgently.
4. The Governor and Head of Healthcare at HMP Humber should ensure that reception nurses have access to a prisoner's ACCT document and previous medical record when conducting a reception health screen.
5. The Director and Head of Healthcare at HMP Doncaster should ensure that cell sharing risk assessments are reviewed whenever there is information that a prisoner is at increased risk of violence towards a cell mate.
6. The Director at HMP Doncaster should ensure that ACCT documents are not closed for prisoners with known histories of mental illness and self-harm without input from the mental health team.
7. The Director of HMP Doncaster should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that officers:
  - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
  - Consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including recent history of self-harm.
  - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
  - Assess the level of risk of suicide or self-harm appropriately and ACCT reviews at intervals to reflect the risk.
  - Hold a review as soon as possible after an act of self-harm.
  - Record ACCT observations immediately or as soon as possible after they are made
  - Hold multi-disciplinary ACCT reviews.
  - Write specific meaningful actions on ACCT caremaps aimed at reducing prisoners' risks to themselves.
8. The Governor at HMP Humber should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that officers:

- Have a clear understanding of responsibilities and the need to share all relevant information about risk.
  - Consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including recent history of self-harm.
  - Ensure continuity of case management.
  - Assess the level of risk of suicide or self-harm appropriately.
  - Hold ACCT reviews at frequent intervals to ensure they offer appropriate support.
  - Hold multi-disciplinary ACCT reviews.
9. The Director of HMP Doncaster should ensure that when prisoners being managed under suicide and self-harm prevention procedures and with identified mental health problems are transferred there is a clear plan to ensure that their needs, including those identified in ACCT caremaps, can be met safely at the receiving prison.
10. The Governor of HMP Humber should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies.
11. The Governor of HMP Humber should ensure that a prisoner's next of kin are notified as soon as possible after a death in custody.

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Director of HMP Doncaster and the Head of Healthcare should ensure that where there is a clear therapeutic benefit which outweighs other factors, prisoners participating in dialectical behaviour therapy and other psychological therapies, are able to remain at Doncaster at least until initial treatment goals have been fulfilled.	Accepted	<p>Most prisons in the Yorkshire/East Midlands areas have mental health teams that provide equivalent care to that provided at HMP/YOI Doncaster. In many cases, therefore, a transfer is appropriate: handovers of clinical presentation and risk are undertaken on transfer, and treatment continues in the receiving prison.</p> <p>The mental health team at HMP/YOI Doncaster favours the use of dialectical behaviour therapy. Teams in other prisons favour different approaches which can be of equal value to patients.</p> <p>If our clinical judgement is that an equivalent treatment cannot be provided at other prisons, a "medical hold" will be placed on the prisoner. The healthcare team arrange such holds via the Catch 22 team (an organisation which works in partnership with Serco at HMP/YOI Doncaster and which is primarily responsible for offender management and resettlement services).</p>	Complete	
2	The Head of Healthcare at HMP Doncaster should ensure that prisoners are prescribed appropriate medication and receive it as planned.	Accepted	<p>All patients are assessed and prescribed medication appropriately according to their clinical needs. There is a process for following up those who do not collect medication, and this varies according to the type of medication.</p> <p>This is ensured by the clinical matron for mental health who audits the clinical records</p>	Complete	
3	The Head of Healthcare at Humber should ensure that newly-arrived vulnerable and mentally ill prisoners are identified and prioritised for	Accepted	An immediate internal review of current working practices was undertaken as part of the Serious	Complete	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	assessment by the mental health in-reach team and that prisoners subject to the Care Programme Approach are assessed urgently.		<p>Incident procedure:</p> <p>A Briefing report was completed and presented to the risk management team.</p> <p>The briefing report outlined an immediate action plan:</p> <ul style="list-style-type: none"> <li>• Introduction of new triage system within the Mental Health In reach team – this would include a process for prioritising referrals</li> <li>• New Triage assessment to be completed for all Prisoners currently waiting for a service from the mental health in-reach Team.</li> <li>• Review of mental health in-reach team’s involvement in the ACCT assessment process.</li> <li>• Review of primary mental health care triage assessments to be carried out by Service Manager.</li> </ul> <p>Following on from the initial action plan a number of permanent changes have been introduced in an attempt to ensure relevant information is communicated effectively to ensure the most vulnerable prisoners are assessed and offered treatment quickly, including:</p>	Complete	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			<ul style="list-style-type: none"> <li>• The MH in-reach referral process was reviewed and refers updated on the referral process - please see attached number 1 - referral process flow diagram.</li> <li>• A new MH in-reach triage process has been implemented (please see attachment number 2). This process allows for referrals to the MH In-reach team to be prioritised and assessed accordingly.</li> <li>• The new MH In-reach team Triage process includes routine checks to identify previous Prisoner contact with mental health services.</li> <li>• Representatives from the MH In-Reach Team now attend HMP Humber Safer Prison Meetings (monthly).</li> <li>• HMP Humber Safer Prison Team provides the MH In-Reach Team with a list of all Prisoners on an open ACCT document on a weekly basis. This list is reviewed by the MH In-Reach Team at the Team meeting.</li> <li>• MH In – reach staff will advise PCMH Team s and Prison staff that: All Prisoners who are under CPA should be referred to the MH In-Reach Team and will be triaged for Assessment</li> </ul>		

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			however not all prisoners under the CPA will require an urgent referral.		
4	The Governor and Head of Healthcare at HMP Humber should ensure that reception nurses have access to a prisoner's ACCT document and previous medical record when conducting a reception health screen.	Accepted	<p>All available documentation will be accessible to the nurse conducting the reception screen.</p> <ul style="list-style-type: none"> <li>An immediate internal review of current working practices was undertaken as part of the Serious Incident procedure and following on from the initial action plan a number of permanent changes have been introduced to ensure Health care staff have access to all relevant Prisoner information including ACCT documentation.</li> </ul> <p>Changes</p> <ul style="list-style-type: none"> <li>HMP Humber is in the process of moving over to the Summary care record functionality with in SystemOne</li> <li>All health care staff are in the process of gaining access to NOMIS and Quantum to ensure easier access to relevant information.</li> <li>The new MH In-reach team Triage process includes routine checks to identify previous Prisoner contact with mental health services.</li> </ul>	<p>1 August 2014 Operations</p> <p>Complete</p>	

Action Plan					
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			<ul style="list-style-type: none"> <li>Representatives from the MH In-Reach Team now attend HMP Humber Safer Prison Meetings (monthly).</li> <li>HMP Humber Safer Prison Team provides the MH In-Reach Team with a list of all Prisoners on an open ACCT document on a weekly basis. This list is reviewed by the MH In-Reach Team at the Team meeting.</li> </ul> <p>If a prisoner arrives at Reception with an ACCT document, the reception staff will ensure that this document is available to the Nurse for reference during their screening.</p>	Aug 14	
5	The Director and Head of Healthcare at HMP Doncaster should ensure that cell sharing risk assessments are reviewed whenever there is information that a prisoner is at increased risk of violence towards a cell mate.	Accepted	The healthcare manager will instruct the healthcare team to communicate to unit managers any relevant risk information identified during patient interviews or from documentation. All healthcare staff are trained in how to complete cell sharing risk assessments (CSRA) during their safer custody training and attend safer custody refresher training.	Healthcare Manager September 2014	
6	The Director at HMP Doncaster should ensure that ACCT documents are not closed for prisoners with known histories of mental illness and self-harm without input from the mental health team.	Accepted	The mental health team are involved in ACCT reviews in collaboration with the safer custody team. Attendance is not always possible but in accordance with PSI 64/2011, where they are not able to attend, a written report is given to the case manager. The residential team has been instructed not to close ACCTs for prisoners with mental health history without a contribution from the mental	Healthcare Manager Safer Custody Manager September 2014	

Action Plan					
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			health team. The safer custody manager will ensure compliance through ACCT quality checks.		
7	<p>The Director of HMP Doncaster should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that officers:</p> <ul style="list-style-type: none"> <li>• Have a clear understanding of responsibilities and the need to share all relevant information about risk.</li> <li>• Consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including recent history of self-harm.</li> <li>• Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.</li> <li>• Assess the level of risk of suicide or self-harm appropriately and ACCT reviews at intervals to reflect the risk.</li> <li>• Hold a review as soon as possible after an act of self-harm.</li> <li>• Record ACCT observations immediately or as soon as possible after they are made</li> <li>• Hold multi-disciplinary ACCT reviews.</li> <li>• Write specific meaningful actions on ACCT caremaps aimed at reducing prisoners' risks to themselves.</li> </ul>	Accepted	<p>The processes for identifying prisoners at risk of self-harm and for managing and supporting them is set out in PSI 64.2011. All officers are trained in this process as part of their initial training, and undertake refresher training.</p> <ul style="list-style-type: none"> <li>• Staff are aware of their responsibilities and the need to share information on risk.</li> <li>• All known risk factors are considered as part of the initial reception, healthcare and first night screening process. Particular attention is paid to any history of self harm and specifically to any incident within the last 6 months.</li> <li>• An ACCT document is opened whenever there is a recent history of self harm or suicidal intent.</li> <li>• The ACCT process ensures that the level of risk of suicide or self-harm is appropriately assessed and reviews are scheduled at intervals to reflect the risk.</li> <li>• Guidance has been issued to ensure that a review is held as soon as possible after any act of self-harm.</li> </ul>	<p>Learning &amp; Development</p> <p>Director</p> <p>Healthcare, Security, Residential, Discipline</p> <p>Healthcare, Security, Residential,</p> <p>Residential, Safer Custody</p> <p>Residential Managers</p>	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			<ul style="list-style-type: none"> <li>ACCT observations are recorded immediately or as soon as possible after they are made.</li> <li>All agencies are aware of the need for appropriate participation in multi-disciplinary ACCT reviews, and participate in accordance with the guidance in PSI 64/2011. This is monitored by the Safer Custody Manager and repeat non compliance is reported to the Deputy Director.</li> <li>Case managers will be reminded of the need to mitigate risks and triggers within care maps.</li> </ul> <p>A dedicated safer custody manager has been tasked with checking the quality of ACCT documents, including care maps. The outcomes of these checks will be circulated to relevant managers, through safer custody meetings and written feedback to individuals. This requirement will be particularly emphasised as part of ACCT refresher training. The safer custody manager will publish a 'Case Managers' Guide' and distribute to relevant managers.</p> <p>Performance of duties with regard to ACCT will form part of the appraisal objectives and job descriptions of relevant managers for 2015</p> <p>Risk factors will be identified by checking the NOMIS case management system, the Person Escort Record and self harm warning forms, as well as</p>	<p>Safer Custody Manager</p> <p>Healthcare, Security, Residential, Safer Custody</p> <p>Safer Custody Manager</p> <p>Deputy Director</p> <p>March 2015</p>	

Action Plan					
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			through conversations with the prisoner. The source of identified risks will be documented in the ACCT form.		
8	<p>The Governor at HMP Humber should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that officers:</p> <ul style="list-style-type: none"> <li>• Have a clear understanding of responsibilities and the need to share all relevant information about risk.</li> <li>• Consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including recent history of self-harm.</li> <li>• Ensure continuity of case management.</li> <li>• Assess the level of risk of suicide or self-harm appropriately.</li> <li>• Hold ACCT reviews at frequent intervals to ensure they offer appropriate support.</li> <li>• Hold multi-disciplinary ACCT reviews</li> </ul>	Accepted	A notice to staff was produced providing local guidance. Safer custody training is provided as part of the establishment training plan and additional sessions are starting next month to increase ACCT training. All bullet points will be addressed as part of this training.	Residence & Safety August 2014	
9	The Director of HMP Doncaster should ensure that when prisoners being managed under suicide and self-harm prevention procedures and with identified mental health problems are transferred there is a clear plan to ensure that their needs, including those identified in ACCT caremaps, can be met safely at the receiving prison.		Where there is a medical need, clinicians at HMP/YOI Doncaster speak to clinicians at the receiving prison to ensure that a plan is in place for that need to be met. In the case of more general needs, the allocation team discuss with the safer custody team and contact the receiving prison to ensure that an appropriate plan is in place.	Complete	
10	The Governor of HMP Humber should ensure that all prison staff are made aware of and understand PSI	Accepted	Briefing has been published. This will form part of the additional training which commences in	Complete	

Action Plan					
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	03/2013 and their responsibilities during medical emergencies.		September.		
11	The Governor of HMP Humber should ensure that a prisoner's next of kin are notified as soon as possible after a death in custody.	Accepted	NOK will be notified as soon as possible within the considerations of risk and decency. Sadly, this was tested very recently with a further self inflicted death.	Complete	