

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Gerrard Scahill a prisoner at HMP Doncaster on 22 April 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

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

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Gerrard Scahill was found hanged in his cell at HMP Doncaster on 22 April 2016. He was 42 years old. I offer my condolences to Mr Scahill's family and friends.

Mr Scahill did not appear to be at high or imminent risk of suicide or self-harm before his death, and I am satisfied that staff at Doncaster could not have predicted or prevented Mr Scahill's actions.

It is clear from Mr Scahill's own comments to prison staff and the post mortem report that he used new psychoactive substances (NPS). Like HM Inspectorate of Prisons and the Independent Monitoring Board, I am troubled by the high availability of and demand for NPS at Doncaster and across the prison estate.

While it might not have changed the outcome for Mr Scahill, I am concerned that staff did not respond appropriately to Mr Scahill's allegations that he felt under threat the month before his death and that they did not check on Mr Scahill's wellbeing at unlock on the day he died. I am also concerned that, while covered and screened, Mr Scahill's body was left on the landing for some hours after his death. This was disrespectful and distressing for prisoners and staff who had to walk round it.

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

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

**March 2017**

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# Summary

## Events

1. On 1 November 2014, Mr Gerrard Scahill was remanded to HMP Altcourse, charged with wounding. He had a history of alcohol and substance misuse, and anxiety. On 18 June 2015, he was sentenced to nine years in prison. Mr Scahill was transferred to HMP Lincoln on 2 October 2015, and spoke to the mental health team about his anxiety.
2. He was transferred to HMP Doncaster on 10 February 2016 where he spoke to a psychiatrist and a mental health nurse about his anxiety, depression and negative, violent thoughts about harming others. Mr Scahill hoped to transfer to HMP Dovegate's therapeutic community. In March 2016, a psychiatrist diagnosed him with antisocial personality disorder.
3. In March 2016, Mr Scahill told the psychiatrist that he smoked as much NPS as he could afford and he was twice found under the influence of NPS in prison – once at Altcourse, in April 2015, (when staff downgraded Mr Scahill to the basic level of the Incentives and Earned Privileges scheme) and once in Doncaster, in March 2016, when Mr Scahill said he had been 'spiked' and the healthcare team monitored him overnight. We have seen no evidence that Mr Scahill was referred to the substance misuse team on either occasion or that the incident in March 2016 was investigated.
4. On 29 March, Mr Scahill told his offender supervisor that he felt threatened by prisoners who called him a "nonce" (prison slang for sex offender). The wing observation book noted that he stayed in his cell on 29 and 30 March because he felt "under threat".
5. At 8.27am on 22 April, staff unlocked Mr Scahill, but did not check on him or open his cell door. It was only when staff locked prisoners up after breakfast, at 9.31am, that they found Mr Scahill hanged in his cell. The officer who found Mr Scahill radioed an emergency code blue and control room staff called an ambulance immediately. Paramedics arrived and tried to resuscitate Mr Scahill but were unsuccessful and pronounced he had died.

## Findings

6. We are concerned about the availability of and demand for drugs at Doncaster. Mr Scahill said that he had used NPS in prison, would use them as frequently as he could, and was twice found under their influence. A toxicology report found new psychoactive substances in his body.
7. When Mr Scahill told staff that he felt threatened in March 2016, they did not follow Doncaster's violence reduction policy. While we have seen no evidence that Mr Scahill continued to feel threatened after March 2016, staff did not deal appropriately with Mr Scahill allegations and this may have increased Mr Scahill's risk of suicide and self-harm.
8. Doncaster's policy on roll checks and unlocking prisoners says that officers should obtain a verbal response from prisoners at unlock. The officer unlocking

Mr Scahill did not do so on 22 April 2016 and was unaware of the policy. This meant that there was an unacceptable delay of over an hour before Mr Scahill was found. It is possible that the outcome might have been different for Mr Scahill if the officer had checked Mr Scahill when she unlocked him.

9. Paramedics asked staff to move Mr Scahill's body to the landing so that they could treat him more easily. After Mr Scahill died, his body was left on the landing for several hours. We consider that this was disrespectful for Mr Scahill and upsetting for staff and prisoners. Mr Scahill's body should have been moved back into his cell quickly.

## **Recommendations**

- The Director should ensure that all information about bullying and intimidation is fully co-ordinated and investigated; that those suspected of involvement are appropriately challenged and monitored; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.
- The Director should ensure that there is an effective strategy to reduce the supply of and demand for new psychoactive substances, and that staff are vigilant for signs of their use and are briefed about how to respond when prisoners appear to be under the influence of such substances.
- The Director should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.
- The Director should ensure that a deceased prisoner's body is treated with dignity and respect at all times.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator visited Doncaster on 4 May 2016. She obtained copies of relevant extracts from Mr Scahill's prison and medical records. She met a member of the Independent Monitoring Board, the Head of Safer Custody and a member of the Safer Custody team.
12. NHS England commissioned a clinical reviewer to review Mr Scahill's clinical care at Doncaster.
13. Another investigator interviewed staff and prisoners at Doncaster in June 2016. The investigator and clinical reviewer interviewed healthcare staff together.
14. We informed HM Coroner for Doncaster of the investigation who sent us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Scahill's father to explain the investigation. He asked us to consider why Mr Scahill was in a single cell. He said that his daughters had received letters from Mr Scahill which said he was depressed and had stopped taking his medication in December 2015.
16. The solicitor for Mr Scahill's family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

# Background Information

## HMP Doncaster

17. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men. Nottingham Healthcare provides 24 hour physical and mental health services, and substance misuse services.

## HM Inspectorate of Prisons

18. The most recent inspection of HMP Doncaster was in October 2015. Inspectors reported that levels of self-harm and assaults were high, and 44% of men said they had emotional or mental health problems. They found suicide and self-harm prevention procedures were inadequate, support was intermittent and too many prisoners in crisis were left isolated. Inspectors said Doncaster had not rigorously implemented our recommendations after previous deaths.
19. Nearly half of the prisoners interviewed during the inspection said it was easy to get drugs. Inspectors said the security department were aware of the high availability of drugs, especially NPS, but Doncaster was not tackling the problem sufficiently or strategically. Inspectors noted that there were too few staff and they were unsupported. They said that a lack of challenge from staff to poor behaviour led to a danger of collusion.

## Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to September 2015, they said that the use of Spice, a NPS, had increased and created problems for the prison. They had an average of 16 incidents involving new psychoactive substances a month and assaults had almost doubled. They said that Doncaster had done some work in response to educate prisoners about the effects of NPS. They noted that a full time violence reduction co-ordinator and a new assistant director for safer custody had implemented a revised safer custody induction package. They said that the level of mental health services offered at Doncaster was equivalent to that received in the community.

## Previous deaths at HMP Doncaster

21. Mr Scahill was the fourth prisoner to take his life at Doncaster since January 2014. Our investigation of Mr Scahill's death did not identify any similar issues to our previous investigations at Doncaster.

## New psychoactive substances

22. New psychoactive substances (NPS), previously known as 'legal highs' (although they are now illegal), are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical

health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide and self-harm.

23. In July 2015, we published a Learning Lesson Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
24. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

### **Incentives and Earned Privileges scheme**

25. Each prison has an Incentives and Earned Privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money from prison job and to wear their own clothes. There are four levels: entry, basic, standard and enhanced.

# Key Events

## HMP Altcourse

26. On 1 November 2014, Mr Gerrard Scahill was remanded to HMP Altcourse, charged with wounding. Mr Scahill had a long history of offending and drug and alcohol misuse, and had spent time in prison before.
27. At an initial health screen, Mr Scahill presented as anxious, agitated and tearful. He said that he had used heroin, had drunk alcohol excessively for many years and had alcohol related seizures. The GP prescribed him methadone and he started a detoxification programme.
28. At a mental health assessment on 17 November, Mr Scahill told a nurse that he had never self-harmed and had no thoughts of doing so. The nurse described him as anxious and unsettled. Mr Scahill agreed to attend counselling but did not participate during his first appointment and declined further help.
29. By 28 February 2015, Mr Scahill had settled into the prison regime, had a job and was an enhanced prisoner under the Incentives and Earned Privileges (IEP) scheme.
30. On 15 March, Mr Scahill told his offender supervisor that he was worried about his mental health and thought he would harm someone. She referred him to the mental health team again.
31. On 17 April, Mr Scahill was convicted of wounding and was remanded to Altcourse until sentencing. The next day, Mr Scahill told the reception nurse that he had no thoughts of suicide and that he would not harm himself because he had two children. He told her that he heard voices in his head, telling him to kill or injure someone and that he would do so if he had to share a cell. The nurse referred him to a psychiatrist and spoke to an officer, who completed an intelligence report and increased Mr Scahill's level of risk to other prisoners to high. Mr Scahill was allocated a single cell.
32. On 20 April, staff reduced Mr Scahill's IEP level to basic because he was found apparently under the influence of NPS.
33. On 18 June, Mr Scahill was sentenced to nine years in prison. Mr Scahill told a nurse at Altcourse that he had been expecting a longer sentence, and so was satisfied with the outcome.

## HMP Lincoln

34. On 2 October, Mr Scahill was transferred to HMP Lincoln. He told a nurse during his healthscreen, that he had no thoughts of suicide or self-harm. Mr Scahill had been waiting to see a psychiatrist and the nurse referred him for a mental health assessment.
35. On 8 October, Mr Scahill did not attend his mental health assessment so a mental health nurse visited him in his cell. Mr Scahill declined mental health support and said he had no thoughts of suicide and self-harm. The nurse noted that Mr Scahill was sharing a cell despite being assessed as a high risk to other

- prisoners. She noted that she would speak to the wing supervising officer about it.
36. On 27 October, Mr Scahill was moved to a single cell after staff updated his cell sharing risk assessment to high risk. That day, Mr Scahill told the mental health nurse that he heard voices in his head telling him to harm others. He maintained that he would not harm himself.
  37. On 27 November, Mr Scahill attended a mental health review with the mental health nurse. He told her that he fantasised about violence and inflicting pain on others. He said that he isolated himself from other prisoners to decrease the risk of him harming someone but this had lowered his mood. Mr Scahill denied having thoughts of suicide or self-harm.
  38. On 17 December, Mr Scahill saw a psychiatrist. He said that he did not want to talk at that time. She offered him another appointment but he declined it. She suggested that Mr Scahill make another appointment when he was ready and asked the mental health nurse to check on him.
  39. On 30 December, Mr Scahill saw the mental health nurse. He told her that medication might help reduce his violent thoughts. He denied thoughts of suicide and self-harm. She referred Mr Scahill again to a psychiatrist.
  40. On 3 February 2016, Mr Scahill told the mental health nurse that his negative thoughts had become intrusive and he was struggling to concentrate on work or education. He said that when he finished his work, he had too much time to think, which made him anxious. He asked to see the psychiatrist.

## **HMP Doncaster**

### **Mental health**

41. On 10 February, Mr Scahill was transferred to Doncaster before he saw the psychiatrist. At his reception healthscreen, Mr Scahill told the nurse that he heard voices and wanted medication for his anxiety and negative thoughts. He denied thoughts of suicide and self-harm. The nurse referred Mr Scahill to the mental health team. His cell sharing risk level remained high.
42. On 18 February, Mr Scahill did not attend his mental health appointment. A mental health nurse went to his cell but Mr Scahill had gone to the exercise yard. Wing staff told her that Mr Scahill had mixed with other prisoners during the association period and had taken his food.
43. On 19 February, the mental health nurse saw Mr Scahill. He said that he did not want the appointment that day but had no concerns, other than feeling that he was being passed around the prison system.
44. On 26 February, Mr Scahill attended a mental health appointment with the nurse. He told her that he found it difficult to handle his emotions, particularly his anger. Mr Scahill told her that he no longer wanted medication but wanted to see a psychiatrist.

45. On 29 February, the psychiatrist who saw Mr Scahill at Lincoln, saw him at Doncaster. The appointment was brief as she was called away to an emergency. Mr Scahill said that he wanted to deal with his mental health issues and would wait three weeks for a longer appointment.

### **Bullying and violence on the wing**

46. On 9 March, Mr Scahill's offender supervisor saw him. Mr Scahill told her he could not be in any prison in the North West and there was a "price on his head" for some money he stole from another prisoner. He said he feared prisoners would kill him. She completed an intelligence report about this.
47. On 21 March, Mr Scahill attended separate appointments with the mental health nurse and the psychiatrist. He told them both that he was not happy with the "chaos" and violence on the wing. He said that he had managed to avoid being violent, but if someone was aggressive to him, he would dissect them with a smashed cup. He said he needed to be occupied. He said that he would not kill himself in prison because he was not in control, but would do so when he was released.
48. Mr Scahill told the mental health nurse and the psychiatrist that he smoked as much NPS as he could afford. Mr Scahill refused medication but said that he wanted to transfer to a therapeutic community such as the one at Dovegate. The psychiatrist diagnosed Mr Scahill as having antisocial personality disorder. She completed a careplan for Mr Scahill:
- to apply to transfer to Dovegate;
  - to see her again in five weeks; and
  - to have blood tests, particularly for his liver. (His test results were in the normal range.)
49. On 23 March, Mr Scahill was found under the influence of NPS. An officer said a Supervising Officer (SO) completed an intelligence report, which said that Mr Scahill had alleged to have been "spiked" with NPS. Mr Scahill had not identified the perpetrator. Healthcare staff monitored him overnight. Other than in an intelligence report, there is no information in Mr Scahill's medical or prison records about what happened after he was found under the influence of NPS, and there is no evidence that Mr Scahill was referred to the substance misuse team.
50. On 29 March, while at an education class, Mr Scahill told his offender supervisor that he felt under threat on the wing as prisoners were calling him a "nonce" (prison slang for sex offender). She told the investigator that she telephoned the SO on the wing and asked him to come to the wing to see Mr Scahill. She said when he arrived he refused to discuss Mr Scahill's allegations with him, but instead said that Mr Scahill should speak to him when he returned to his office. She recorded Mr Scahill's concerns in his prison records.
51. We have seen no evidence that the SO spoke to Mr Scahill. The SO was unavailable for interview but emailed the investigator to say he could not recall being asked to see Mr Scahill, dealing with or speaking to Mr Scahill. He said

that he was not aware of any prisoners targeting Mr Scahill. He said in his email to the investigator that he remembered speaking to someone in the amenities department, where the offender supervisor worked and whom he presumed must have been her. He said she told him that Mr Scahill was okay and did not want to take things further.

52. Mr Scahill told his offender supervisor that he was too scared to return to the wing on his own, so she arranged for an officer to escort him back to his wing.
53. The offender supervisor completed two intelligence reports on 29 March, in which she explained Mr Scahill's concerns and what she had done about them. The Head of Professional Standards and Decency said that when an intelligence report was submitted, it went to the security department, where it was analysed alongside other intelligence. In cases of reported bullying or intimidation, he said the security department should inform wing supervising officers, who in turn should follow the prison's violence reduction policy.
54. The Security Department said they emailed the supervising officers on the wing about Mr Scahill's allegations. Other than the SO, all the recipients were on leave. Doncaster did not provide us with a copy of the email. There is no evidence that wing staff spoke to Mr Scahill. A note in the wing observation book on 29 and 30 March said that Mr Scahill was "not to be unlocked – under threat". After 30 March, there is no evidence about whether Mr Scahill remained in his cell or continued to feel threatened.

#### **Events of 22 April**

55. On 22 April at 6.31am, CCTV shows an officer completing a roll check. She opened the cell observation panels and appeared to check that each prisoner was present. She said that she did not remember checking Mr Scahill's cell.
56. At 8.27am, CCTV showed Officer A unlocking Mr Scahill's cell door. She did not open the door, nor look through the observation panel. She then continued to unlock other cell doors. She said that she did not routinely open cell doors at unlock and that there was no need to talk or see the prisoner unless they were on suicide and self-harm management procedures. When the investigator raised Doncaster's policy on unlocking with the Head of Professional Standards and Decency and a custodial manager, neither knew the policy set out an expectation that a response was required from prisoners.
57. At 9.31am, CCTV showed Officer A returning to Mr Scahill's cell and opening the door. She immediately closed it and took several steps towards Officer B, who was nearby on the landing. She then returned to Mr Scahill's cell with him and they looked through the observation panel. She appeared to talk on her radio, and they then went into Mr Scahill's cell.
58. Officer B told the investigator that Mr Scahill looked like he was sitting in his chair. He called to Mr Scahill, but he did not respond. He moved a privacy curtain near Mr Scahill's head and saw that he had used a ligature to hang himself from the window behind the curtain.
59. At 9.31am, Officer A radioed, "medical response one alpha". The communications officer interrupted her to acknowledge the message and a nurse

responded that she was on her way. She said that she radioed a “medical response, code blue” but the control room operator interrupted and spoke over her so that her code blue message was not heard. The nurse who responded asked for a code and she said it was a code blue and told her to get there quickly. Control room staff called an ambulance at 9.31am. The control room immediately alerted staff, and healthcare staff responded promptly.

60. Officer B used his anti-ligature knife to remove the ligature, made from shoelaces, from Mr Scahill’s neck. Both officers laid Mr Scahill on his back on the floor. At 9.33am, the unit manager and Officer C arrived at Mr Scahill’s cell.
61. The unit manager checked Mr Scahill’s neck for a pulse, but could not find one. He started chest compressions. He said that he thought Mr Scahill’s neck showed signs of rigor mortis. Officer C helped staff return prisoners to their cells.
62. Within seconds, a senior nurse and a healthcare assistant arrived at Mr Scahill’s cell. They had emergency equipment with them, took over resuscitation, and attached a defibrillator to Mr Scahill. They used an ambu bag (a self-inflating bag inserted into the throat to enable oxygen to be pumped into the body) but it was ineffective.
63. The nurses involved in the emergency response radioed the clinical matron about Mr Scahill and said they needed more oxygen. The matron took two oxygen cylinders to Mr Scahill’s cell and helped with resuscitation attempts. Other nurses arrived and took turns to complete chest compressions on Mr Scahill. The defibrillator did not advise them to shock him so they continued chest compressions until paramedics arrived at 9.35am.
64. The paramedics asked staff to move Mr Scahill to the landing, where they had more room to treat him. Despite their efforts, paramedics were unable to resuscitate Mr Scahill and pronounced him dead at 10.10am. Mr Scahill’s body remained on the landing until 1.47pm when it was removed. A prisoner said that staff and prisoners had to walk around Mr Scahill’s body. He said it was undignified that Mr Scahill’s feet were visible. The unit manager said that he remained with Mr Scahill’s body, which was covered and screened. He said that the police had asked staff to leave Mr Scahill’s body on the landing.
65. Mr Scahill had left a note in his cell for his daughters, which indicated his intention to take his life.
66. The day after Mr Scahill’s death, a prisoner and Mr Scahill’s friend who lived on another wing, gave a note to the English tutor. He said that during a class with Mr Scahill on 21 April, Mr Scahill had been “laughing and goofing around” with him but said that prisoners were stealing his belongings, like his tobacco and television, from his cell. He said that Mr Scahill had asked an officer if he could move wings. He said the officer had told Mr Scahill to speak to someone who regularly worked on his wing. It was not possible to interview the prisoner as he had been released when the investigator visited the prison. No one the investigator spoke to knew anything about Mr Scahill’s concerns and we have seen no evidence that Mr Scahill applied for a wing transfer.

67. Officer A told the investigator that she worked regularly on the wing, where Mr Scahill lived. She said that he was a quiet prisoner who did not mix with everyone, but he had a small group of friends. She had not noticed any problems between him and other prisoners in the days before his death.

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

68. At around 10.30am on 22 April, a manager debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. He held a second debrief at 2.40pm, with the staff who were unable to attend the earlier one. The clinical matron held a separate debrief with healthcare staff. The staff care team also offered support.
69. The prison posted notices informing other prisoners of Mr Scahill's death and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Scahill's death.

### **Contact with Mr Scahill's family**

70. At around 10.50am on 22 April, the assistant director appointed a programmes facilitator as the prison family liaison officer. As Mr Scahill's father, who was his next of kin, lived in Wales, she telephoned HMP Risley and HMP Thorncross at 12.10pm to ask whether one of their family liaison officers could inform Mr Scahill's family of his death. Both prisons said they could not help. She then called HMP Liverpool at 12.30pm. At 1.10pm, Liverpool responded to say they could not help. The police liaison officer suggested that the police notify the family as time was passing, and she contacted the police at 1.34pm. At 4.15pm, a police officer visited Mr Scahill's father and informed him of Mr Scahill's death. The prison contacted the family the next day to offer their condolences and visited them on 27 April. The prison contributed financially to the funeral in line with national instructions.

### **Post-mortem report**

71. A post-mortem examination found that Mr Scahill died from airway occlusion and circulatory obstruction (hanging). The toxicology report noted that Mr Scahill had NPS in his body which contributed to his death.

## Findings

### Assessment of Mr Scahill's risk of suicide and self-harm

72. Prison Service Instruction (PSI) 64/2011 lists a number of factors and potential triggers which increase the risk of suicide and self-harm. Mr Scahill had some of these risk factors: mental health concerns including antisocial personality disorder, depression, anxiety and hearing voices; substance and alcohol misuse and he used NPS. Apart from one occasion in March, when Mr Scahill told a nurse that he would kill himself when he left prison, he consistently denied thoughts of suicide and self-harm and there is no evidence that he self-harmed. It was therefore reasonable that staff at Doncaster did not consider that Mr Scahill needed to be monitored under suicide and self-harm prevention procedures, but appropriately referred him to the mental health team.

### NPS

73. We are concerned about the prevalence of NPS in prisons and the effect it has on the behaviours and health of those taking it, including an association with suicide and self-harm. In July 2015, we published a learning lessons bulletin about deaths in which NPS was thought to be a factor. We highlighted several lessons to be learned, including giving staff information about NPS to help them identify when prisoners are using it and having an effective drug supply reduction and violence reduction strategy.
74. Mr Scahill told staff that he used NPS in the community and in prison. He was twice found under the influence of NPS in prison (in April 2015 and once in Doncaster, in March 2016) and he told a psychiatrist that he smoked as much of it as he could afford. The toxicology report after Mr Scahill's death found NPS in his body, which contributed to his death. Doncaster has a care pathway for prisoners found using NPS. Although healthcare staff, wing staff and prisoners can refer a prisoner to the substance misuse team, it is not mandatory and a prisoner must give his permission for this to happen. There is no evidence in Mr Scahill's prison or medical records that anyone referred him to substance misuse services. We repeat HMIP's and the IMB's concerns about the prevalence of and demand for NPS at Doncaster. We make the following recommendation:

**The Director and Head of Healthcare should ensure that there is an effective strategy to reduce the supply of and demand for new psychoactive substances, and that staff are vigilant for signs of its use and are briefed how to respond when prisoners appear to be under the influence of such substances.**

### Bullying

75. Doncaster's violence reduction policy says that:

"Acts of bullying will be initially reported to the residential manager who will make initial enquiries. The details of the allegations and enquiries will be made available to the Safer Custody Manager on a Bully Incident Report Form...The Safer Custody Manager will carry out a detailed investigation if required."

76. On 29 March, Mr Scahill told his offender supervisor that he was being threatened and called a “nonce” and he felt scared to return to the wing. She appropriately asked the wing supervising officer to speak to Mr Scahill. She said that a SO refused to speak to Mr Scahill at that time but instead told her to tell Mr Scahill to speak to him in his office on the wing. She completed two intelligence reports and ensured that an officer escorted Mr Scahill back to the wing.
77. The SO could not remember speaking to Mr Scahill and said he was not aware of any prisoners targeting him. Although Mr Scahill’s prison records said that he remained in his cell on 29 and 30 March because he was “under threat”, Doncaster did not provide evidence that Mr Scahill’s allegations were dealt with effectively or in line with the violence reduction policy. We have seen no evidence that any wing staff spoke to Mr Scahill about his allegations, that they escalated his concerns appropriately to the safer custody manager, that there was an investigation, that the perpetrators were identified or that Mr Scahill was appropriately supported. We make the following recommendation.

**The Director should ensure that all information about bullying and intimidation is fully recorded, co-ordinated and investigated; that those suspected of involvement are appropriately challenged and monitored; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.**

78. A friend of Mr Scahill’s wrote that the day before his death Mr Scahill told him that prisoners were stealing Mr Scahill’s belongings from his cell. There is no record of Mr Scahill telling a member of staff about this.

### Unlocking prisoners

79. Officer A told the investigator that it was normal practice not to open cell doors or obtain a response from prisoners when unlocking them.
80. Doncaster’s policy says that staff, “must always obtain a response from the prisoner at lock up and unlock...” The officer who unlocked Mr Scahill on 22 April was unaware of the policy, as were two senior managers. The delay from unlocking Mr Scahill to finding him hanged was over an hour. Had the officer checked on Mr Scahill when she unlocked his cell, the outcome might have been different. It is unacceptable that staff did not know the correct procedures for unlocking prisoners. We make the following recommendation:

**The Director should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.**

### Maintaining the dignity of a prisoner after death

81. Mr Scahill’s body was left on the landing for some hours after his death, a decision which a unit manager said was at the request of the police. He said he stayed with Mr Scahill’s body which was covered and screened for privacy. A prisoner said that staff and prisoners had to walk around Mr Scahill’s body and that Mr Scahill’s feet were visible. We consider that it was inappropriate and disrespectful to Mr Scahill that his body was left on the landing and distressing

for staff and prisoners. Staff should have moved Mr Scahill's body back into his cell quickly and, if this was not possible, they should have ensured that Mr Scahill's body was fully screened. We make the following recommendation:

**The Director should ensure that a deceased prisoner's body is treated with dignity and respect at all times.**

### **Clinical care**

82. The clinical reviewer concluded that the standard of care that Mr Scahill received at Doncaster was equivalent to the care he would have received in the community. She did not believe that in the circumstances Mr Scahill's death could have been predicted as he had not presented as a prisoner who was "at risk".

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations