Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sadik Duba a prisoner at HMP The Mount on 29 May 2016

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

PO Box 70769
London, SE1P 4XY

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

T | 020 7633 4100
F | 020 7633 4141

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

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

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

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

Mr Sadik Duba was found hanging in his cell at HMP The Mount on 22 May 2016. He was resuscitated and taken to hospital but died on 29 May, never having regained consciousness. He was 47 years old. I offer my condolences to Mr Duba's family and friends.

Mr Duba had no history of mental illness, but in the days before he was found hanging in his cell he became extremely paranoid and believed he was being poisoned. A fellow prisoner told staff that Mr Duba had tied a ligature in his cell and had attempted suicide. I am concerned that despite this clear indication of risk and apparent rapid decline in Mr Duba's mental health, staff neither searched his cell nor started suicide and self-harm prevention measures.

Although a nurse at The Mount examined Mr Duba, he was not assessed by specialist mental health services because there is no weekend provision. The clinical reviewer concluded that Mr Duba's care was not equivalent to that which he could have expected to receive in the community. Had his mental health crisis been better managed, the outcome for Mr Duba might have been different.

I am also concerned that despite the Governor accepting previous recommendations I have made about The Mount's emergency response, I have to repeat similar concerns.

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 **July 2017**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 6
Findings 12

Summary

Events

1. When he first entered prison in June 2007, prison staff monitored Mr Duba for a short time under Prison Service suicide and self-harm prevention procedures, known as ACCT, but not subsequently.

2. Mr Duba appeared settled at The Mount. He always worked or attended education and studied for an Open University degree. Staff and other prisoners had no concerns about him, describing him as a polite and well liked prisoner.

3. On Saturday 21 May 2016, Mr Duba became distressed, claiming he was being poisoned as part of a vendetta against him. On the same day, a prisoner told staff that Mr Duba had disclosed to him that morning that he had tied a ligature and had tried to hang himself the night before.

4. A general nurse examined Mr Duba twice on 21 May. During the first examination, she contacted the out of hours doctor, who advised that Mr Duba should see the prison doctor on Monday, but to test his blood if he became physically unwell. Mr Duba told staff later the same day that he had stomach pains and felt unwell. He was examined by the same nurse who undertook blood tests as advised. The blood test results were normal.

5. Mr Duba continued to tell staff and other prisoners that he was being poisoned, and became increasingly paranoid. Staff and prisoners tried without success to reassure him. Although prison staff did not consider Mr Duba to be at an increased risk of suicide or self-harm, they completed hourly wellbeing checks.

6. At around 5.35pm on Sunday 22 May 2016, a prisoner found Mr Duba hanging in his cell. Staff and paramedics were able to resuscitate him and he was transferred to hospital. Mr Duba never regained consciousness and died at approximately 11.00am on 29 May.

Findings

7. The investigation found that, despite observing a dramatic decline in Mr Duba's mental health the day before he was discovered hanging in his cell and having been told that Mr Duba had tied a ligature and attempted suicide the night before, staff did not start ACCT procedures as they should have done. Prison staff should have also searched Mr Duba's cell for ligatures and shared this information with healthcare staff.

8. In spite of the rapid deterioration in his mental health, Mr Duba was not assessed by mental health professionals because this sudden deterioration occurred during the weekend, when no mental health staff were on duty. Healthcare staff should be able to obtain advice and support from the mental health team out of hours and at weekends if required. Not only might a mental health assessment have helped to calm Mr Duba, but it would have enabled staff to make a more informed decision about Mr Duba's risk of suicide and self-harm and appropriate risk reduction measures could have been put in

place. The clinical reviewer concluded that Mr Duba's care was not equivalent to that which he could have expected to receive in the community.

9. Prison and healthcare staff responded quickly when Mr Duba was discovered and resuscitated him. However, as in previous deaths at The Mount, staff failed to use the agreed medical emergency code, which ensures that an ambulance is requested immediately when a prisoner's condition is life-threatening.

Recommendations

- The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that all staff who assess risk:

  - Have a clear understanding of their responsibilities and the need to record relevant information about risk;
  - Consider and record all the known risk factors of prisoners when determining their risk of suicide or self-harm;
  - Open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.

- The Head of Healthcare should ensure that all healthcare staff are aware how to obtain mental health advice out of hours or at weekends, and should:

  - Publish a pathway/protocol to support the primary care team at weekends/out of hours;
  - Publish the process for escalation if they are unable to access this;
  - Ensure that all nurses use a simple psychiatric symptom rating scale, to support them in the clinical decision making process.

- The Governor and Head of Healthcare should ensure that staff use the appropriate medical emergency code when a prisoner's condition is life-threatening so that control room staff call an ambulance immediately.

The Investigation Process

10. The investigator issued notices to staff and prisoners at The Mount, informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

11. The investigator visited The Mount on 2 June and obtained copies of relevant extracts from Mr Duba's prison and medical records. She spoke to several prisoners and staff.

12. NHS England commissioned a clinical reviewer to review Mr Duba's clinical care at the prison.

13. The investigator interviewed nine members of staff and three prisoners at The Mount in July. The interviews with healthcare staff were conducted with the clinical reviewer. The investigator was unable to interview one member of staff, who has left the Prison Service.

14. We informed HM Coroner for Hertfordshire of the investigation. We suspended our investigation from July 2016 until January 2017, while we awaited the results of the post-mortem examination and toxicology tests. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Duba's family to explain the investigation. Mr Duba's family wanted to know the circumstances surrounding Mr Duba's death as they were concerned about potential threats to his life. They also wanted information about his hospital treatment but this was outside the remit of this investigation.

16. Mr Duba's family received a copy of the initial report. They did not make any comments.

17. The prison also received a copy of the report and identified no factual inaccuracies.

Background Information

HMP THE MOUNT

18. HMP The Mount is a medium security prison holding approximately 1,000 men. Hertfordshire Community NHS Trust provides primary healthcare services and GP services. There are daily GP sessions Monday to Friday, with out of hours provision at other times. There are no healthcare staff on duty between 6.30pm and 8.00am.

19. The GP, and sometimes the mental health in-reach team, support prisoners with mild and moderate mental illness. Prisoners with severe and enduring mental health problems are supported by the in-reach team with staff on duty between 8.00am and 4.00pm, Monday to Friday. There is no weekend or out of hours mental health service.

HM Inspectorate of Prisons

20. The most recent inspection of The Mount was in April 2015. Inspectors reported that care for men at risk of suicide and self-harm was generally adequate but lessons from previous deaths at the prison had not been fully implemented, in particular staff remained unclear about calling an ambulance in an emergency. Most prisoners said that staff treated them respectfully but were very busy. Inspectors found that the mental health in-reach team provided a good level of secondary mental healthcare but primary mental health services were inadequate. Not all healthcare staff had clinical supervision.

Independent Monitoring Board

21. 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 most recently published report for the year to 29 February 2016, the IMB commented that The Mount was a well run prison where staff endeavoured to provide a fair and decent service in a challenging environment.

Previous deaths at HMP The Mount

22. Mr Duba was the third prisoner to take his life at The Mount since August 2015. One prisoner died of natural causes over the same period. The findings from these investigations identified deficiencies in the emergency response.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

26. On 24 June 2007, Mr Sadik Duba, an Albanian national, was remanded to HMP Belmarsh, charged with murdering his wife. It was his first time in prison. Prison Service suicide and self-harm prevention measures, known as ACCT, were put in place for a short time.

27. On 12 September 2008, Mr Duba was sentenced to life imprisonment with a minimum of 14 years to serve before he could be considered for release. Mr Duba's first pre-tariff parole review (which considers if a prisoner's risk has reduced sufficiently to enable their transfer to an open prison) was scheduled for October 2018 and Mr Duba was eligible to be considered for release on parole from June 2021.

28. Mr Duba spent time at Belmarsh, High Down, Swaleside and Gartree prisons, before he was moved to The Mount in August 2014. Mr Duba was regularly monitored for high blood pressure, but had no other significant physical or mental health problems. Throughout his time in prison, Mr Duba was on the enhanced level of the Incentives and Earned Privileges (IEP) scheme. (The IEP scheme 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.) He successfully completed various offender behaviour programmes. In addition, he worked in prison workshops, attended education and attained numerous qualifications and taught himself to speak English.

29. Mr Duba lived in a single cell on Fowler Wing, a standard residential wing for enhanced prisoners. All the entries in his prison file were extremely positive. Mr Duba had worked hard to reduce his risk of reoffending, with a view to release, and had fully complied with the prison regime. His friends on Fowler Wing described him as a quiet, educated man who was popular with staff and prisoners.

30. On 11 March 2016, Mr Duba's new offender supervisor (responsible for his sentence planning and liaising with external probation services) introduced herself. She told Mr Duba his OASys (an assessment of risks and needs) was due to be reviewed and she would, once it had been completed, arrange a meeting with his offender manager (a probation officer) to discuss his potential release plans for his pre-tariff parole review, which was scheduled for October 2018. There were no other significant events for Mr Duba until May 2016.

31. A prisoner said Mr Duba told him that he had prostate cancer around the start of May 2016. He encouraged him to see the prison doctor. (The medical records confirm Mr Duba requested a GP appointment on 17 May. An appointment was made with the prison GP for 20 May. However, this appointment did not happen and it is unclear from the medical records if Mr Duba failed to attend, or if the GP surgery was cancelled. Another appointment was scheduled for 24 May.) There is no other mention in any of the prison or medical records that Mr Duba had concerns about his physical health.

32. Mr Duba met his offender supervisor each month. He provided her with information about his achievements while in prison and they discussed and

agreed sentence plan objectives for the next year in preparation for Mr Duba's parole review in 2018.

33. On 16 May, an officer who was working in the Education Department, submitted a security intelligence report stating that Mr Duba had disclosed that some weeks before he had experienced 'a connection' with a civilian member of staff whom he had seen coming out of a building near the workshops. Mr Duba said that he had 'felt something for her' when he looked at her but now she looked at him with hatred and he was concerned he had caused her to be upset. The security manager informed the member of staff and her department of Mr Duba's disclosure and requested they monitor the situation for any further incidents.

34. On 18 May, Mr Duba met his offender supervisor for their routine monthly discussion. Mr Duba disclosed that he had had 'feelings' for an education worker the previous summer, although had not seen her for a long time. He said he had seen her recently, and believed she and her colleague had looked 'disgusted' at him. Mr Duba said he felt ashamed and wanted to apologise to her for his actions as he did not want to upset her. She told him not to speak to the member of staff if he saw her again. She told the investigator that, while Mr Duba seemed anxious, she did not have any specific concerns and their meeting ended positively. She submitted a security intelligence report and her comments were noted, but no further action was taken.

35. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. An Albanian speaker from the Ombudsman's office listened to Mr Duba's calls made on 13 and 20 May. On both days Mr Duba spoke to his mother and niece for several minutes in separate calls. There was nothing in these conversations that suggested Mr Duba had any particular difficulties or indicated that his risk of suicide had increased. He made no other calls before he died.

36. On Saturday 21 May, Officer A told a Senior Officer (SO) that Mr Duba claimed to have been poisoned as part of a vendetta against him. He believed that his late wife's brother was seeking revenge for her murder. There was no evidence or security intelligence to suggest Mr Duba had been targeted. At 9.34am, the SO recorded in Mr Duba's prison record that he had asked to stay locked behind his door and that the officer had given him an application to request a move for his own protection. He recorded that he had referred Mr Duba to the mental health in-reach team and made an appointment for Mr Duba in the healthcare centre at 10.00am that morning. He arranged for wing staff to complete an observation record and submitted the information to the security department. He told the investigator this was an unusual situation and he was concerned about Mr Duba's mental health, but did not think he was a risk to himself. He explained that he instructed officers to complete regular wellbeing observations as the mental health in-reach team did not work at weekends.

37. Officer A escorted Mr Duba to see a nurse. The nurse recorded in Mr Duba's medical record that he believed he had been poisoned over the previous two months and he produced a salt pot which he said contained the poison. She noted Mr Duba seemed extremely anxious and upset, that he had told his family he was being poisoned, and they were going to visit him. She recorded Mr Duba

‘appears very determined to go into hospital’. She carried out basic health checks, which were all normal, although she noted he had a white coating on his tongue.

38. The nurse contacted the out of hours doctor (Hertfordshire Urgent Care) for advice, who told her to make a routine appointment for Mr Duba to see the prison doctor on Monday 23 May, as there were no signs of poisoning. She advised if Mr Duba became unwell she should organise blood tests. Mr Duba returned to Fowler Wing.

39. A prisoner who lived next door to Mr Duba told the investigator that Mr Duba had acted bizarrely that morning and kept asking him to look at his tongue, as he thought he was being poisoned. He said Mr Duba had told him he had tied a ligature using sheets the night before (Friday) and had tried to hang himself three times, but had been unable to attach the ligature properly.

40. Mr Duba told the prisoner he wanted to telephone the police. Telephone records show Mr Duba attempted to contact the police at 11.53am, but the prison system would not allow the call to be connected. The prisoner went to tell prison staff about his concerns and spoke to two officers. The prisoner said he thought Officer A was on the telephone to healthcare staff to arrange taking Mr Duba over to be examined again when he got to the office. He told the investigator that she appeared annoyed he had not told her sooner about the ligature and said she would have to start Prison Service suicide and self-harm prevention measures, known as ACCT. He told the investigator that he believed Mr Duba was having some kind of psychotic episode as he also thought there were cameras in the fire alarms. He assumed officers would open an ACCT, but this did not happen.

41. Officer A made an entry in Mr Duba’s prison record at 12.58pm. She noted Mr Duba complained of stomach pains, vomiting, headaches and a strange taste in his mouth. She also noted ‘I have since been told Mr Duba made a ligature in his cell last night but he has assured me he does not want to harm himself or commit suicide’. In her police statement she confirmed she did not search his cell for a ligature.

42. At 1.35pm, a nurse examined Mr Duba again as he had complained of stomach pains and told her it was ‘radioactive poisoning’. She recorded that Mr Duba was ‘very very keen to go to hospital’, but did not appear critically unwell. In line with the earlier advice from the out of hours doctor she took blood samples, although Mr Duba removed the needle from his arm before she could complete them all. The blood samples taken were sent to hospital for analysis and Mr Duba returned to Fowler Wing.

43. At 2.30pm, Officer B noted Mr Duba had returned to Fowler Wing having been seen in healthcare, and that he wanted to move to Howard Wing. He recorded that Mr Duba told him he had no thoughts of self-harm. He told Mr Duba a victim support plan had been started and the SO was going to consider a move to Howard Wing. The SO told the investigator that he spoke to another SO, who was in charge of Howard Wing, about moving Mr Duba as he continued to complain of feeling unwell and wanted to go to hospital. They agreed Mr Duba

would move on Monday, when a space was available and they had sufficient staff to manage the move, which Mr Duba appeared to accept.

44. The SO reviewed the victim support plan at 3pm (as part of the wider 'managing challenging behaviour' protocol at The Mount) with Officer B and Mr Duba in attendance. The plan listed one concern (that Mr Duba claimed that he was being poisoned) and noted that Mr Duba was advised to talk to staff with any concerns to make sure he felt safe. There is no mention of contact with healthcare staff or Mr Duba's request to move wings. The SO noted 'No thoughts of self-harm or suicide just wants to go to outside hospital because he is ill or dying'.

45. An officer noted on the victim support plan that Mr Duba collected his meal at 4.40pm, but looked anxious. The duty governor endorsed the wing observation book at 4.41pm and noted 'staff advised to conduct hourly obs [observations] because he may be in crisis'. The duty governor told the investigator he believed Mr Duba was in a mental health crisis, but he was unaware Mr Duba had tied a ligature the day before, despite it being recorded in the wing observation book. He said had prison staff made him aware of this information, he would have initiated the ACCT process, but accepted he should have read the earlier entries as part of his management check.

46. The hospital contacted The Mount at 5.32pm, and told the nurse Mr Duba's blood tests were normal. She asked the SO to inform Mr Duba, which he did. At 6pm, on the victim support plan, Office B noted Mr Duba was in his cell asleep. This was the last entry on the victim support plan. Staff observed Mr Duba hourly and, from 5.30pm, staff recorded their entries on an on-going record form (photocopied from an ACCT document). At 7.05pm, Mr Duba asked Officer B if he could come out of his cell to get some water from the kitchen, but was not allowed as the wing was locked up in preparation for the night state (night state is when all prisoners are locked in their cells and there are fewer staff on duty). At 8pm, Officer B recorded that Mr Duba said he could not sleep.

Sunday 22 May 2016

47. The night patrol officer, an operational support grade (OSG), completed hourly observations and noted Mr Duba appeared to have slept throughout the night from 8.45pm. Mr Duba showered at 9.05am, and stayed in his cell most of the morning. A prisoner said he had tried to encourage Mr Duba to socialise, but he chose not to. Two prisoners said Mr Duba continued to act strangely on the wing and he told them his drinking water was poisoned. A prisoner said he tried to reassure Mr Duba by drinking water from his tap, but Mr Duba maintained he was being poisoned, so he gave him a spare bottle for water and Mr Duba thanked him.

48. Mr Duba asked Officer B to fill his water bottle up from the staff tap, which he did at 4.20pm. Mr Duba was seen in the kitchen at 5.00pm and a prisoner said he had a cup of coffee with him. Closed Circuit Television (CCTV) confirms that Mr Duba left his cell with what looks like a squash bottle at 5.18pm, and he returned two minutes later, presumably having filled it with water.

49. CCTV confirms that, at 5.33pm, a prisoner looked into Mr Duba's cell to check on him, and saw him hanging by a sheet attached to the window. He called for help and pressed the general alarm. He went into the cell with three other prisoners who responded to his shout for help, and they removed the ligature. CCTV confirms staff arrived at Mr Duba's cell in less than a minute. The SO used his radio to request urgent healthcare assistance, but did not use a code blue medical emergency code. (The hand written prison communication log record notes the alarm was pressed at 5.36pm, two minutes later an officer asked for an ambulance to be called and the control room called for an ambulance at 5.40pm.) Officers started cardiopulmonary resuscitation (CPR). An operational manager responded and co-ordinated the response. Healthcare staff responded quickly to the emergency request. A portable defibrillator indicated there was no shockable rhythm, but CPR continued. At 5.50pm, nurses detected a pulse, although Mr Duba was still not breathing by himself and oxygen continued to be administered. At 6.07pm, Mr Duba started to breathe by himself, but remained unconscious.

50. East of England Ambulance Service confirmed they received a request for an emergency ambulance at 5.39pm. Paramedics arrived at The Mount at 6.12pm and spent time stabilising Mr Duba. An ambulance took Mr Duba to hospital and he was admitted to the intensive care unit at 7.12pm. He never regained consciousness and died on 29 May, at approximately 11.00am.

Contact with Mr Duba's family

51. The prison chaplain and his deputy were appointed as family liaison officers. The chaplain contacted Mr Duba's cousin in Albania and told him Mr Duba had been admitted to hospital. The chaplain and his deputy maintained contact with Mr Duba's cousin and tried to assist Mr Duba's family with obtaining a visa so they could visit Mr Duba, but he died before his family could make the arrangements. Mr Duba's body was repatriated to Albania on 19 June and the prison contributed towards the cost of his funeral in line with national instructions.

Support for prisoners and staff

52. After Mr Duba's death, the duty governor debriefed the prison staff involved in the emergency response. He offered his support and that of the staff care team. PSI 08/2010 Post Incident Care mandates that a 'hot debrief' must be held immediately after all deaths in custody for all staff directly involved, including healthcare staff. Healthcare staff were not invited to attend the debrief, and were supported by each other and the chaplain.

53. The prison posted notices informing other prisoners of Mr Duba's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Duba's death. The Mount did not consider holding a memorial service.

54. Some of the prisoners who spoke to the investigator did not feel they were given sufficient support. In addition, although not directly involved when Mr Duba was discovered, his offender supervisor, who had had very recent contact with Mr Duba, was not contacted by any member of prison management or the staff care team. She found out that Mr Duba had been admitted to hospital in a general conversation with a colleague and via the media when he died.

Post-mortem report

55. A pathologist concluded that Mr Duba had died from hanging. A toxicology report confirmed there were no illicit substances in Mr Duba's blood at the time of his death.

Findings

Identification of Mr Duba's risk of suicide and self-harm

56. Prison Service Instruction (PSI) 64/2011 about safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action to manage and support prisoners at risk. The risk factors were also listed in our thematic report on self-inflicted deaths published in April 2014.

57. Mr Duba's mental health deteriorated suddenly on 21 May, the day before he was found hanging in his cell. He displayed irrational behaviour and appeared out of touch with reality, an identified risk factor. Staff had also been told by a prisoner on the same day that Mr Duba had disclosed that he had tied a ligature in his cell and attempted suicide the night before. Despite clear risk factors being present, staff failed to start ACCT procedures. Officer A, who has since left the Prison Service, clearly was aware that this is something she should have done, yet she did not. Staff also failed to carry out a search of Mr Duba's cell to look for ligatures. Staff were clearly concerned for Mr Duba's welfare and did open a victim support plan with hourly observations, but they failed to put in place formal suicide and self-harm prevention measures as they should have done. A check of Mr Duba's records by the duty governor was not sufficiently robust and was a missed opportunity to start ACCT procedures. We make the following recommendation:

    The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that all staff who assess risk:

    - **Have a clear understanding of their responsibilities and the need to record relevant information about risk;**
    - **Consider and record all the known risk factors of prisoners when determining their risk of suicide or self-harm;**
    - **Open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.**

Management of mental health crisis

58. Mr Duba had no history of mental ill-health during his prison sentence. When he told prison staff he thought he was being poisoned, the SO, who is trained in identifying mental health issues, quickly referred Mr Duba to the healthcare centre. A general nurse concluded that Mr Duba was not under the influence of drugs and she had no concerns about his mental health. She contacted the out of hours doctor and later, on the doctor's advice, blood samples were taken and sent for urgent testing. As it was the weekend, there were no mental health nurses on duty and no facilities for an out of hours mental health assessment. The other option would have been to send Mr Duba to accident and emergency at the hospital.

59. Information recorded in the medical record by the nurse, and from interviews with prison staff, reflect the (unsupported) view that Mr Duba was keen to go to hospital outside the prison (which was seen as a security risk), rather than suffering from a possible acute psychotic episode.

60. The clinical reviewer concluded that the care Mr Duba received at The Mount was not equivalent to that which he could have expected to have received in the community and he should have been seen urgently by mental health services for an early assessment and treatment if appropriate. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff are aware how to obtain mental health advice out of hours or at weekends, and should:

- **Publish a pathway/protocol to support the primary care team at weekends/out of hours;**
- **Publish the process for escalation if they are unable to access this;**
- **Ensure that all nurses use a simple psychiatric symptom rating scale, to support them in the clinical decision making process.**

61. The clinical reviewer has made a number of additional recommendations that the Head of Healthcare will need to address.

Emergency Response

62. PSI 3/2013 requires prisons to have a medical emergency response code protocol, which sets out how staff should communicate the nature of a medical emergency, and ensures that there are no delays in calling for an ambulance if a prisoner's life is at risk. It states that when a medical emergency code (code blue or code red) is called over the radio, an ambulance must be called immediately.

63. The Mount's local protocol on medical emergency codes is confusing. While it sets out the circumstances in which a medical emergency code should be used, it also says, 'If first on scene has concern about the medical condition of the prisoner, then an ambulance should be called immediately via the Comms Room, without waiting for the attendance of Healthcare Staff'. This is unnecessary, as the use of a medical emergency code should automatically alert the control room to call an ambulance immediately. A sticker has since been added to the protocol which states, 'Control Room automatically calls an ambulance and awaits updates from the scene'. This is correct, but the original guidance that the first on the scene should arrange for an ambulance if they have concerns remains in the protocol, which could cause confusion. The protocol should be reissued so that it is clear and consistent.

64. Prisoners who found Mr Duba at 5.33pm pressed the general alarm and staff responded immediately. The SO used his radio to request urgent healthcare assistance but did not use a medical emergency code. He told the investigator he panicked. An ambulance was requested five minutes later. Healthcare staff responded immediately, arriving with the correct resuscitation equipment, and were able to resuscitate Mr Duba. However, any delay in requesting an

ambulance could be crucial. We have previously identified this as an issue at The Mount and we repeat the following recommendation:

The Governor and Head of Healthcare should ensure that staff use the appropriate medical emergency code when a prisoner’s condition is life-threatening so that control room staff call an ambulance immediately.

Prisons & Probation
Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

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

T | 020 7633 4100
F | 020 7633 4141