

**Investigation into the circumstances surrounding the
death of a prisoner at HMP & YOI Doncaster
on 21 June 2010**

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

April 2011

This report considers the circumstances of the death of a 49 year old man, a prisoner at HMP & YOI Doncaster. The man was found hanging in his cell at 5.00pm on 21 June 2010. His cellmate had discovered him when he returned from an education class and alerted staff. The staff and another prisoner removed the ligature that was round his neck and administered cardio pulmonary resuscitation (CPR). This continued until the arrival of nursing staff who had been alerted via the emergency radio, and paramedics were also called. Despite the efforts of both prison healthcare staff and paramedics, the man was pronounced dead at 5.39pm.

A senior investigator conducted the investigation on my behalf. I would like to thank the Director of HMP & YOI Doncaster and his staff for their co-operation and assistance with the investigation. A review of the medical care afforded to the man while in custody, was completed independently on behalf of my office.

The man was on remand at Doncaster and had recently been told that he was likely to face further more serious charges. He had been in prison before and was familiar with the regime. On reception, he told nursing staff that he had been previously treated for depression and he was taking antidepressants, but a referral to the mental health services was not made. Apart from treatment for a hand injury sustained during his alleged offence, he had little contact with the medical team at Doncaster. On the day of his death he told staff that he had a migraine and asked to stay in his cell during the afternoon, where he was eventually discovered by his cell mate.

I have made three recommendations. These concern referrals for mental health assessments and the absence of prescription charts and recording of medication, the other is for the Director to commend the prisoner who assisted staff in the resuscitation attempts. I conclude that staff could not have reasonably foreseen his actions and took the appropriate steps to resuscitate him once he was found, regrettably without success. All three recommendations have been accepted by HMP/YOI Doncaster.

Jane Webb
Acting Prisons and Probation Ombudsman

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CONTENTS

Summary	4
The investigation process	5
HMP Doncaster	6
Key events	8
Issues	13
Conclusion	17
Recommendations	18

SUMMARY

The man went into prison on remand at HMP & YOI Doncaster on 12 May 2010. He was 49 years old. This was not his first time in custody or indeed at Doncaster. During his initial health screen, he told the nurse that he was receiving anti-depressant medication, but denied any thoughts of self-harm or suicide. An injury to his hand sustained during his alleged offence, prompted a referral to the prison general practitioner (GP), but no further assessment of his mental well-being was completed.

While living on the residential unit, he mixed with a select group of friends, but would openly engage with staff and talk about general things. He raised no concerns during these conversations.

On 14 May, the police visited the prison in order to discuss further matters with him, but he refused to see them. He then received a letter from his solicitor telling him that he was going to be charged with further offences at his next court appearance. Neither the police nor the solicitor alerted the prison to the charges. These charges were more serious and might make him a potential target for other prisoners. He was aware of the significance of the charges, and talked about his concerns in a telephone conversation with a friend. Despite his concerns, he did not share them with staff.

On the afternoon of 21 June, he told staff that he had a migraine and asked to stay in his cell rather than go to education. There was no reason for staff to think that he had an ulterior motive for wishing to remain in his cell, and there were no requirements for him to be checked during the afternoon.

Prisoners began to arrive back from work at around 5.00pm. A Prison Custody Officer (PCO) opened the cell door to allow the man's cellmate in. When the cellmate went into the cell, he said "he's gone" and walked back out of the cell. At this point, another prisoner who had been close by went into the cell, which was dark. He immediately asked the PCO to pass her cut down tool (which is issued to every member of staff so that they can safely remove ligatures), and released the ligature attached to the man's neck. The PCO used her radio to call for medical assistance, and with the help of the prisoner and another member of staff, moved the man on to the floor of the cell. Staff, assisted by the prisoner who removed the ligature started cardio pulmonary resuscitation (CPR), which was continued by healthcare staff. Following the radio call by the PCO, an ambulance had been requested and arrived at 5.15pm. Paramedics continued to treat him and attempt to resuscitate him, but he was pronounced dead at 5.39pm.

After the man's death, a hot debrief was held and support provided for staff and prisoners. The Deputy Director and Assistant Chaplain went to the home of the man's ex-wife to break the news and answer initial questions.

THE INVESTIGATION PROCESS

1. A senior investigator was appointed as the investigator on 22 June, and made contact with the Head of Internal Affairs at the prison, who provided liaison with my office. The investigator arranged for the man's prison and medical records to be made available. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone who had information about the death to contact the investigator. No responses were received.
2. The investigator visited Doncaster on 24 June to formally open the investigation. He met senior staff and discussed the case with them. He also collected the relevant documentation.
3. During the course of the investigation, the investigator interviewed three members of staff at Doncaster and spoke to one prisoner. He also wrote to another prisoner who had been released from custody, but received no response. Following the investigation, the investigator provided feedback on his findings to the Director, both verbally and in writing.
4. The man was examined by healthcare staff at Doncaster in relation to an injury to his right hand which he had sustained before he went into custody. Apart from this, he had limited contact with healthcare staff. An independent GP undertook a complete review of the medical care afforded to the man while in custody, on behalf of my office.
5. One of my family liaison officers (FLO), wrote to the man's ex-wife and she responded by telephoning on 15 July. The FLO explained the purpose of the investigation and provided the family with the opportunity to ask questions or raise any concerns for consideration as part of my investigation. The FLO was also contacted by the man's sister regarding questions that the family wish to be answered. They are summarised as follows:
 - How did he die?
 - Was he alive when he was found by prison staff?
 - Why had he been remanded and was he facing other charges?
 - Why was he not subject to any suicide or self-harm monitoring?
6. The investigator has investigated the concerns raised by the family as well as other issues. I hope that my report provides the family with more clarity of the time he spent in prison and the events leading up to his death.
7. The investigator also contacted the Coroner to inform him of the nature and scope of the investigation. He asked for a copy of the post mortem report to be made available when completed. The Coroner provided the report which concludes that the cause of the man's death was fatal upper airway obstruction, which would be in keeping with 'hanging'.

HMP & YOI DONCASTER

8. HMP & YOI Doncaster is a privately run prison operated under contract by Serco. It opened in 1994 as a local prison, originally graded to hold the most dangerous of prisoners (category A). It was reclassified to a category B prison in May 2003. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult.
9. The Governor of a private prison is referred to as a Director. The contract between the National Offender Management Service and the prison is monitored by a controller appointed by the Ministry of Justice.
10. The prison is certified to hold up to 771 prisoners, but has recently had an operational capacity of 1,145. It consists of three houseblocks, each made up of four separate two level wings. In addition to the residential units the prison also has a two floor healthcare unit and a segregation unit.
11. At the time of Mr Johnson's death, the last inspection of the prison by HM Chief Inspector of Prisons had been carried out in February 2008. The report of this inspection said:

"... On our return for this unannounced full follow-up inspection, we found improvements in a number of areas, but also a worrying deterioration in healthcare and little progress in expanding purposeful activity ...

"... Staff prisoner relationships remained generally sound, and managers had embarked on a culture change programme among staff to reinforce expectations ...

"... Doncaster has addressed a number of the criticisms that we made on our last visit, and continued to make good progress in areas such as resettlement. However, there is much still to do, not least to ensure that safety is maintained and the serious deficits in healthcare urgently addressed ..."

A further unannounced inspection of Doncaster took place in November 2010.

12. The Independent Monitoring Board (IMB) at Doncaster also published a report in September 2009. The Prisons Act 1952 and the Immigration and Asylum Act 1999 require every prison and immigration centre to be monitored by an independent board. The members are appointed by the Secretary of State for Justice from members of the community in which the prison is situated. Doncaster IMB's report concluded:

“... The Board continues to feel that all prisoners should be engaged in purposeful, meaningful activity each day and though recognising this is difficult to achieve in what is a local prison with a high turnover of remand prisoners it remains a concern.

“The prison is fortunately a modern and flexible establishment whose physical build is advantageous and helps the process of coping with difficult situations, from incidents to overcrowding. This is in no small part due to work of its staff that has served the prison well in the period and continues to do so ...”

13. My office was given responsibility for investigating all deaths in custody in 2004. Since then there have been three previous investigations into apparent self-inflicted deaths. Recommendations made following these investigations are not repeated in this report.

KEY EVENTS

14. The man was arrested on 9 May 2010. On his arrest, he had an injury to his right hand sustained during the alleged offence of assault. Once in police custody he was seen at Barnsley District General Hospital. He was examined, but this was not concluded due to his aggressive behaviour. The police recorded that he was alcohol dependent. He had not consumed alcohol for a few days, until the day before his arrest. No concerns about self-harm were recorded.
15. The man was prescribed medication for pain relief and taken to Sheffield Northern General Hospital under police escort, where the injury to his right hand was operated on. Following the operation, he returned to the police station on 11 May. He appeared at Barnsley Magistrates Court the following day where he was remanded into custody until 18 May.
16. Following his court appearance, he was taken to HMP Doncaster. All new prisoners are given a health screening and on his arrival a nurse interviewed him. The clinical assessment forms completed while in police custody were sent to the prison and passed to the nurse. The nurse recorded that he had been in custody previously and was last released from HMP Lindholme. All the medication that he had been receiving in police custody and prescribed by the hospital was recorded. When asked about his alcohol consumption, the man said that he only drank socially, but had used cannabis in the last month.
17. As part of the health screen, the nurse asked him about his mental health history. He said that he had previously been treated for depression and prescribed the antidepressant, trazadone. The reception health screen indicates that he brought this medication into prison with him and the clinical reviewer was told that the drug was dispensed to the man while he was in custody. Traces of trazadone were found by the toxicologist following the post mortem. When asked about self-harm, he said that he had no history of trying to harm himself in prison custody, but nothing is recorded about any history outside custody. The man reiterated to the nurse that he had no feelings about harming himself while in custody.
18. Following the initial health screen, a secondary screening was completed. The secondary screening provides more depth on both previous and family medical history. Again, the man's depression was recorded, as well as no family history of chronic illness. He told the nurse that he expected to have support from his ex-wife while in custody. He was referred to the prison GP due to the injury on his right hand. He also gave consent for information to be shared with other support agencies working in the prison and for his medical notes to be obtained from his community GP. There is no documentary evidence to show that any information was requested or received from an outside GP.
19. As with all new prisoners coming into custody, a cell sharing risk assessment (CSRA) was completed. The purpose of a CSRA is to identify any potential risks that may arise from placing prisoners in shared accommodation. Homophobia, racism and unpredictable violent behaviour are some of the

indicators that staff try to identify. Once completed, the staff assign a level of risk to a prisoner based on their answers to the questions, and they decide whether the individual is suitable to share a cell or not. During the CSRA, he raised no concerns that would place him at high risk of harm to a cellmate, but he did say that he had been subject to self-harm monitoring while in prison in 2008, for 24 hours. In addition to questions asked by staff on the CSRA, staff will also access a prisoners pre-convictions from the police national computer, and any relevant information will be used in the CSRA process.

20. The prison GP, assessed the man on 13 May, recorded the injury to his right hand and arranged for the dressing to be changed frequently. The doctor also recorded that medication should continue to be prescribed as indicated in the hospital's discharge letter, there is no prescription chart and no indication when this medication was prescribed or by whom.
21. Within the medical documentation provided to the investigator, there was a referral to the community mental health team at the prison. It had been completed in February 2008, for him, during a previous sentence. The referral indicates that he was possibly suffering from depression and had been prescribed medication to treat this. However, the community mental health team did not consider the man to require their input, and he was referred back to the primary care mental health nursing staff. It is not clear whether the nurse who conducted the health screen on his most recent reception was aware of the previous referral or whether it would have made any difference to the actions taken, but it does show that concerns about depression had been raised previously at Doncaster.
22. The man began his induction (the process of introducing new or newly sentenced prisoners into custody) on 13 May, but only completed the first day due to his hand injury. On the same day, he was also seen by the CARATs (Counselling, Assessment, Referral, Advice and Throughcare services) team and an assessment completed. (Organisations specialising in the treatment of substance abuse have drugs and alcohol workers based in most prisons. CARATs workers can run programmes, offer counselling, support and referral to rehabilitation centres to prisoners and on release.) He disclosed that he had smoked a small amount of cannabis daily for the last 20 years, and hoped to be able to stop the habit. He also said that he was aware that his paranoia had increased over recent years, and that he suffered from bi-polar disorder. When he experienced episodes of mania, he would use cannabis to bring himself down. The CARATs worker explained the health risks associated with cannabis and provided Mr Johnson with leaflets detailing the risks. It was recorded that no further intervention was required.
23. After completing his induction, the man moved from the induction landing to another residential wing on 18 May. He also appeared via video link at Barnsley Magistrates Court the same day and was subsequently remanded into custody until 15 June. While on the residential wing, little is documented about him. However, he was seen by nursing staff on a number of occasions throughout the remainder of May, for his dressing to be changed and eventually

the stitches removed. No concerns about any other medical problems were recorded, and he never raised concerns with the Mental Health Team.

24. On 14 May, the police visited Doncaster in order to question him on other matters, but he refused to see them. He then appeared via video link again at Barnsley Magistrates Court on 15 June, and was further remanded until 22 June. On the wing, the man continued to cause no concern to staff who described him to the investigator as a 'model' prisoner. On 16 June, he began attending education where he participated in entry level numeracy classes.
25. His solicitor wrote to him on 18 June, to tell him that the Crown Prosecution Service (CPS) intended to charge him with further offences arising from the original offence, and they would form part of the hearing on 22 June. The letter did not detail what the new charges were, but it is understood that they were known to him. (Correspondence between prisoners and their legal representatives is confidential and so the contents of the letter would not have been known to prison staff.)
26. The investigator listened to telephone calls made by the man whilst he in prison. All calls made by prisoners are recorded, but only those of prisoners who are subject to legal restrictions are routinely monitored. The man had no such restrictions. He spoke to his friend on 19 June, and said that he had received a letter from his solicitor that indicated that he was to be charged with sexual assault. During the conversation, he told his friend that he was in the wrong place for charges like those to "come out". However, during the call he sounded in good spirits and asked about the times and channels of television programmes.
27. Staff interviewed during the investigation said that the man was quite a talkative individual who would speak to staff on the wing. He would sometimes talk about his case, but never indicated that he had any particular concerns. Over the weekend of 18/19 June, he had a visit from his friends and at lunchtime on 21 June, he made another telephone call to his friend to ask whether they had got home safely. His friend asked him whether he had cheered up, and he replied "no, not really". His friend then told him that there was light at the end of the tunnel, and he replied "what light". They then talked about what he had eaten for lunch and his friend told him that he needed to eat more as he was losing weight. The man's friend then told him to not do anything "daft", and he replied "forgive me if I do". His friend responded by telling him not to talk like that and the man said that it was "the only way he could see out of it". They also discussed the breakdown of his relationship during the calls and the fact that his ex-partner was the alleged victim.
28. After lunch, at around 3.00pm, prisoners were unlocked from their cells to attend work and education. The man approached a PCO and said that he felt unwell, and had a migraine. The PCO told the investigator that he asked the man if he was alright, and he replied "yes, I am just going to lie down in my cell". The officer said that there was nothing to indicate that he should be concerned about him.

29. The PCO added that, during each week day afternoon, staff go to every cell to deliver breakfast packs to each prisoner. Breakfast packs contain cereal, a carton of milk, tea bags and sometimes a bread roll, jam and butter. They are provided between Monday and Friday when prisoners are not unlocked for breakfast. The PCO said that, given the man had indicated that he had a migraine, staff would have tried not to disturb him. They would have opened his door slightly and placed the breakfast packs inside. The man was not subject to any special monitoring, such as suicide prevention or to prevent escapes, and as such there was no reason for him to be checked during the afternoon.
30. Prisoners returned from work and education just before 5.00pm. Another PCO was on duty on house block 3 and escorted the man's cellmate to his cell. When interviewed, the PCO said that she unlocked the cell as she normally would and noticed that it was "exceptionally dark", which was unusual. She also noticed that there was a towel hanging over the end of the bunk bed down to the floor. The PCO explained that there were curtains at the window, which prisoners are able to purchase from the prison canteen. (The prison canteen enables prisoners to purchase goods including food, toiletries and other items that have been approved by security, using money that they have earned in prison or have been sent by family or friends.)
31. The PCO said that when she opened the door the cellmate went into the cell and she heard him say something like "he's gone". At that point, another prisoner who had been standing close by, went into the cell. The PCO said that she did not go into the cell at this point, but then the prisoner who had entered called to her and asked her to pass him her cut down tool. (All prison staff carry a tool that is designed to cut ligatures.)
32. The investigator said to the PCO that it seemed unusual for a member of staff to hand a cut down tool to a prisoner, and asked her why she had done this. She explained that her first instinct when the prisoner asked for her cut down tool was to pass it to him as if he was asking for it then there was obviously a problem. She added that as the cell was dark she could not actually see the man, but could see the prisoner cutting something. He then passed the tool back to her. The PCO said that she had also radioed for medical assistance. She does not recall indicating a code, but the healthcare staff and another PCO who responded recall that a code blue emergency call was made. (Doncaster operates an emergency code system - code blue means a person is not breathing and code red means there is a blood injury).
33. In a statement written after the man's death, the prisoner who had entered the cell and cut the ligature, said that when he went into the cell the man was lying on his bed with his arms by his side. His weight was supported by a ligature around his neck that was made from torn bedding. He asked the PCO to pass her cut down tool, cut the ligature and then removed it from the man's neck. He later made an amendment to his statement in which he alleges that the PCO had frozen when she realised the man was hanging and he had to ask her for her cut down tool. The prisoner also said in his amended statement that he considered that the PCO could have acted quicker. The investigator spoke to

the prisoner when he visited Doncaster. The prisoner told him that, at the time everything happened really quickly and, on reflection, he felt that the PCO had acted appropriately. He also said that the man's death had affected him and he was now seeing medical staff at Doncaster who were providing support.

34. A fellow PCO told the investigator that he was on the wing and locking up other prisoners when he heard the emergency call over the radio. He then called to the PCO at the cell. She called back to tell him where she was and he made his way to there. He said that when he got to the cell, the man was still lying on the bed and he helped the PCO and the prisoner move the man on to the cell floor. The PCO said that, once the man was on the floor, the prisoner automatically began cardio pulmonary resuscitation (CPR) by giving mouth to mouth breaths. The PCO carried out chest compressions. They were joined by another PCO who took over from the prisoner in administering mouth-to-mouth breaths.
35. Both PCO's continued the resuscitation attempts until the medical staff arrived bringing medical equipment with them, including a defibrillator. A defibrillator is a device that can be used when a person has gone into cardiac arrest. The machine monitors for any electrical output from the heart and a voice prompt instructs medical staff whether to continue with resuscitation. If there is output the machine will deliver an electric shock to try and get the heart into a normal rhythm. However, a defibrillator will not restart a heart that has no output.
36. Nursing staff continued to deliver CPR until paramedics arrived at 5.15pm. The paramedics took over CPR and continued to administer treatment until 5.39pm, when they pronounced the man dead.

Following the man's death

37. Following the man's death, a member of the staff care team at Doncaster, was contacted at home and came into the prison. He spoke to the staff involved as well as the prisoner who had assisted. He also spoke to prisoners who were subject to suicide and self-harm monitoring.
38. A hot debrief was held with the staff who were involved in trying to resuscitate the man. Arrangements were made for his cellmate to be given support as well as the prisoner who had helped staff. Staff involved were also offered support with travelling home, and the chaplaincy team told them that they were available to give support to staff and prisoners. The Deputy Director and Assistant Chaplain, arranged to visit the man's next of kin to inform them of his death.
39. As with all deaths in custody, the police were notified and attended at 7.09pm. They visited the cell and removed what appeared to be a suicide note addressed to the man's ex-partner. A copy of the note was given to the investigator. In the note, the man addressed his personal feelings towards his ex-partner and told her that he still loved her.

40. The prison staff arrived at the home of the man's ex-wife, who he had named as his next of kin, at 8.05pm. When they broke the news, she was upset and concerned as to how she would break the news to their daughter. A neighbour was invited round to support her and the man's parents were also asked to come and help break the news to the daughter.
41. The Deputy Director told the man's ex-wife what was known about her ex-husband's death at that time and the various investigations that would take place. She declined the invitation to visit the prison and the Deputy Director told her that the offer would remain open, she also reassured her that the prison would assist with funeral costs if she wished.

ISSUES

Clinical care

42. When the man arrived at Doncaster, a reception health screen was completed. The screen recorded that he was receiving medication for depression and this continued while in custody. It was also recorded that he had been treated for depression in the community. The clinical reviewer highlighted this element of the screening in his assessment of the man's clinical care:

"... A positive answer to this question prompts a referral for a mental health assessment. There is no evidence that such a request was made to the Mental Health Team. When seen by the GP on 13 May 2010, no reference to his mental health or review of his medication was made ..."

43. The clinical reviewer goes on to say in his review that:

"It can be argued that any interaction between a clinician and a patient contains an element of mental health assessment, but there is no evidence of this having happened even at an informal level ..."

44. Within the documentation provided to the clinical reviewer and my investigator is a copy of a mental health referral for the man from a previous sentence at Doncaster in 2008. In relation to this, the clinical reviewer says:

"A copy of a Mental Health referral and assessment from 2008 is in the bundle. This raises no immediate concerns in its own right but if taken in conjunction with the current prescription of a substantial dose of anti-depressant could have prompted further assessment of the man's mental state, at primary care level if nothing else ..."

45. In view of the comments made by the clinical reviewer in relation to referrals to the mental health services and the information provided by the man on his reception, I make the following recommendation:

The Head of Healthcare should ensure that, if a prisoner discloses a mental health condition on reception, or if evidence of such a condition comes to light in the accompanying documents, staff should refer them to the appropriate agencies and ensure that a full mental health assessment is carried out.

46. The reception health screen is designed to be completed in two stages. Again, the clinical reviewer makes reference to this in his report:

"The Health Screening Tool was designed to be done in two stages. The first part on reception and the second part, two to three days later. The man's screen was all completed on the same day. This is not a criticism, merely an observation ..."

47. In concluding his review, the clinical reviewer says:

“From the records, there is nothing that flags up a high risk of suicide, but the man was receiving a substantial dose of an anti-depressant and had been referred to the prison GP. The GP focused on his hand injury, but one might respectfully suggest that a review of medication was appropriate at that time. This might have raised concerns.

“Equally the instruction that a mental health assessment should be prompted by a positive response to Q8 and Q9 was not carried through and again such a referral **might** have thrown up concerns.

“With the reservations expressed above, I have no grounds for thinking that the man’s care fell short of what was appropriate ...”

I make no formal recommendation about the absence of a medication review, but trust that the Head of Healthcare will consider whether staff need to be reminded of the potential value of such a review.

Clinical records

48. The investigator was provided with documentation relating to the man by the prison and this included his medical notes, however, no prescription chart was present. It is documented that he was to be prescribed medication, which is understood to have been pain relief for a hand injury. The clinical reviewer in his report says that he was told that he would have been continued on his anti-depressant medication, but without a prescription chart, this cannot be confirmed. In view of this I make the following recommendation:

Not recording drugs as they are prescribed is a breach of medical guidelines and The Head of Healthcare must ensure that prescription charts are completed as required and that notes are not just made in the ongoing medical record.

Additional monitoring

49. The man’s family asked why he had not been subject to closer monitoring. The facts gathered during the investigation have found that the further charges he was facing were causing him concern and he had voiced his concerns to a close friend on the telephone. However, he had not shared them with staff, and those charges would not have been known by the prison until he went to court on 22 June. It would not be normal practice for either the police or solicitors to share information about a prisoners charges with a prison, unless there was particular concern about an individual’s well-being. The man had not raised concerns with either his solicitor or the police.

Response to finding the man

50. When it became apparent that the man was hanging and in need of immediate medical attention, staff reacted quickly. However, the investigator questioned the appropriateness of the PCO passing her cut down tool, which could be used as a weapon, to a prisoner for him to release the ligature. When interviewed, it became clear that the PCO's reasons for doing this were well intentioned and instinctive. During discussion, she recognised that in hindsight this may not have been the most appropriate thing for her to do. The PCO is fully aware of why this was inappropriate, and I therefore make no recommendations on this matter.
51. The clinical reviewer considers the resuscitation attempts to have been appropriate. These situations are traumatic for everyone involved and in this instance, a prisoner initially took part in attempting to resuscitate the man. The prisoner concerned, told my investigator that since the death he had suffered some anxiety, but was now being offered support by the healthcare team at Doncaster. Prisoners are not expected, and indeed do not expect themselves to have to resuscitate a fellow prisoner, and his actions should be commended by the Director of Doncaster.

The Director of Doncaster should commend the prisoner's actions in assisting staff in trying to resuscitate the man.

CONCLUSION

52. The man had been in custody for only a few weeks when he took his own life. Despite the fact that a referral to the mental health services was overlooked when he arrived into custody, no other concerns about his well-being were raised by staff or himself while on the residential unit. He was familiar with prison routine and described by staff as a prisoner who kept himself to himself, but would happily talk to staff if he had concerns or just for a chat. The description provided by staff would indicate that no concerns were raised about him being either low or depressed, in his interactions with them.
53. The evidence is that he had suffered with depression in the past both in the community and on a previous sentence at Doncaster. The correct procedures for both following up his disclosure on reception with a referral to the Mental Health Team should have been followed, but it is understood that this is unlikely to have resulted in him being placed onto their case list.
54. The investigation has found that the charges that the man was facing would have carried with them the potential for him to be singled out by other prisoners. He was aware of them and referred to this in a telephone conversation with a friend. Undoubtedly, the charges, and potential stigma attached to them and the breakdown of his relationship would all have been weighing heavily on his mind.
55. On 21 June, he was unlocked to attend education. He told a member of staff that he was going to remain in his cell, as he had a migraine. The PCO had no reason to disbelieve him or consider that there may be an ulterior motive for him not wishing to go to education. The man was not on any special monitoring and, during the course of the afternoon, there was no reason for him to be checked.
56. The actions that unfolded after he was discovered are already detailed, but a note left by him indicated his intent to end his life, citing the reason for doing so as the breakdown of his relationship with his partner and ongoing court matters. I judge that given the information available to them and the man's general demeanour, staff could not have predicted that he would take this action and when he was found, they made every effort to resuscitate him.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that if a prisoner discloses a mental health condition on reception, or if evidence of such a condition comes to light in the accompanying documents, staff refer them to the appropriate agencies and ensure that a full mental health assessment is carried out.
2. Not recording drugs as they are prescribed is a breach of medical guidelines and The Head of Healthcare must ensure that prescription charts are completed as required and that notes are not just made in the ongoing medical record.
3. The Director of Doncaster should commend the prisoner's actions in assisting staff in trying to resuscitate the man.

The recommendations made in my report have been accepted and actioned by the Director and Acting Clinical Director at HMP/YOI Doncaster.