

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Johnstone, a prisoner at HMP Wealstun, on 7 December 2024

A report by the Prisons and Probation Ombudsman

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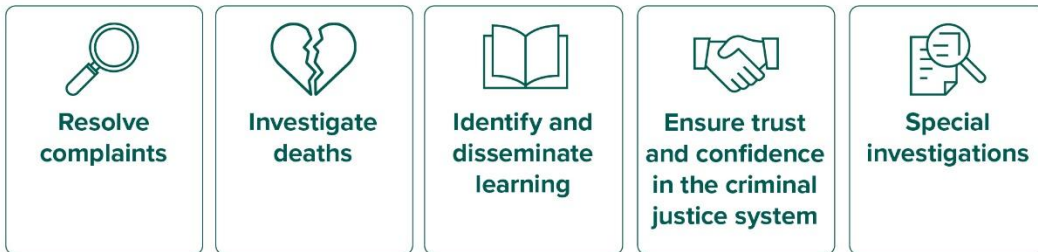
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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Steven Johnstone was found hanged in his cell on 7 December 2024 at HMP Wealstun. He was 42 years old. I offer my condolences to Mr Johnstone's family and friends.

Mr Johnstone had no history of self-harm or suicide attempts in the community or prison. Two days before he died, he was punished after being suspected of using drugs and on 7 December, his television was removed from his cell as part of that punishment. A prisoner said that Mr Johnstone told the staff involved that he would hang himself. We were unable to corroborate that.

On the afternoon of 7 December, Mr Johnstone indicated in a phone call that he felt suicidal, but staff were not aware. On balance, I consider that staff could not reasonably have foreseen his actions.

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

Adrian Usher
Prisons and Probation Ombudsman

August 2025

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings	9

Summary

Events

1. On 4 November 2024, Mr Steven Johnstone was recalled to prison for breaching his licence conditions. On 13 November, he was transferred from HMP Leeds to HMP Wealstun. He had no history of self-harm or suicide attempts in prison or in the community and had only twice before been briefly monitored under prison suicide and self-harm prevention procedures (known as ACCT) after threatening to harm himself.
2. Mr Johnstone had a history of drug and alcohol use and told his family he had deliberately breached his licence conditions so that he could return to prison to detox from alcohol. When he arrived at Wealstun, he raised no concerns and told his ex-partner he felt good as he had completed a detox period.
3. In November, Mr Johnstone told his mother in a phone conversation that he felt suicidal. Staff were not aware and had no particular concerns about him.
4. On 5 December, Mr Johnstone was suspected of having a tampered vape capsule which suggested drug use. He was found guilty at a disciplinary hearing the same day and was downgraded to a basic regime under the incentives scheme (to reward good behaviour) meaning his television would be removed from his cell. Wing staff were not aware of the punishment until 7 December and then removed the television. A prisoner said that Mr Johnstone told the staff involved that he would hang himself. The staff involved said that Mr Johnstone did not say anything about harming himself. As they did not activate their body worn cameras, we could not corroborate this.
5. On the afternoon of 7 December, Mr Johnstone spoke to his former partner on the phone and told her he felt suicidal. Again, staff were not aware.
6. During a routine check that evening, an Officer Support Grade (OSG) found Mr Johnstone hanging in his cell. Prison staff began cardiopulmonary resuscitation (CPR), and paramedics later assisted. Despite their efforts, at 9.45pm, paramedics pronounced life extinct.

Findings

7. Mr Johnstone had no history of self-harm or suicide attempts in the community or prison and few recognised risk factors. When he arrived at Wealstun, he told staff he had no thoughts of suicide or self-harm and there was no other information to indicate that he presented a heightened risk.
8. In two separate phone calls, including on the afternoon of his death, Mr Johnstone told his mother and ex-partner that he felt suicidal. Staff were not aware of the content of Mr Johnstone's conversations.
9. The lack of body worn camera footage meant it was not possible to establish whether staff should have been concerned about Mr Johnstone when they removed

his television. The prison has taken steps to ensure staff use their body-worn cameras in line with policy.

10. Staff interacted with Mr Johnstone during the afternoon and evening of 7 December and had no concerns that he was struggling or at heightened risk. On the evidence available, we are satisfied that staff could not have reasonably foreseen Mr Johnstone's actions.
11. The OSG who found Mr Johnstone did not radio a code blue immediately (but instead called for staff assistance), although this was quickly rectified. He did not go into the cell and said that he would not go into a cell without other staff in close proximity in any circumstance. The prison has taken steps to address both issues.
12. The night manager's management of the emergency was excellent, and paramedics praised the staff for the quality of CPR.
13. The clinical reviewer found that the clinical care Mr Johnstone received was of a good standard and equivalent to that which he could have expected to receive in the community.
14. We make no recommendations.

The Investigation Process

15. HMPPS notified us of Mr Johnstone's death on 7 December 2024.
16. The investigator issued notices to staff and prisoners at HMP Wealstun informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
17. The investigator visited Wealstun on 17 December 2024. She obtained copies of relevant extracts from Mr Johnstone's prison and medical records. She watched body-worn camera footage and CCTV footage from 7 December and obtained information from the Yorkshire Ambulance Service.
18. The investigator interviewed eight members of staff at Wealstun on 21 January 2025. She interviewed one prisoner on 17 December 2024.
19. NHS England commissioned a clinical reviewer to review Mr Johnstone's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed healthcare staff.
20. We informed HM Coroner for West Yorkshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
21. The Ombudsman's office contacted Mr Johnstone's mother, sister and former partner to explain the investigation and to ask if they had any matters they wanted us to consider. They asked us several questions, including:
 - Why was Mr Johnstone not monitored under suicide and self-harm monitoring procedures (known as ACCT) when he had clearly told prison staff that if they did not return his television, he would kill himself?
 - Why was he left for four hours, unobserved, when in a mental health crisis?
 - Why did he have so much 'spice' (a psychoactive substance) in his cell?

While we have tried to answer these questions in our investigation report, there is no evidence that the prison or police found illicit substances in Mr Johnstone's cell after he died.

22. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.
23. Mr Johnstone's mother, sister and former partner received a copy of the final draft report. They did not find any factual inaccuracies.

Background Information

HMP Wealstun

24. HMP Wealstun is a category C training and resettlement prison in West Yorkshire which holds adult men. Practice Plus Group provides health care services, including substance misuse services. Primary healthcare services operate daily from 7.00am to 7.30pm.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Wealstun was in October 2022. Inspectors reported that the prison had reasonably good outcomes on all the healthy prison tests, apart from purposeful activity which was not sufficiently good. These results indicated an overall improvement in the prison since the last inspection in 2019.
26. HMIP's priority concerns included the high levels of self-harm and lack of a strategy to combat the problems. Actions taken in response to Prisons and Probation Ombudsman recommendations were reviewed regularly but not all serious self-harm was investigated to identify learning.
27. Inspectors found that the number of recorded keyworker sessions was low. Fewer prisoners than in similar prisons said that they had a named officer or key worker. At the time of the inspection, the strategy for increasing the delivery of key work was under review.
28. Inspectors found that in managing behaviour, incentives to encourage positive behaviour were limited, and targets for those on the lowest level of the scheme (basic) were not tailored to individual need. There was evidence in many cases that the improvement targets were generic and did not sufficiently address the issues that had led to the prisoner's demotion. The scheme was not motivational as there was little difference between the levels.

Independent Monitoring Board

29. 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 May 2024, the IMB reported the number of ACCTs had reduced. They found the safer custody team carried out staff training on safety awareness, including for operational support grades (OSGs).

Previous deaths at HMP Wealstun

30. Mr Johnstone was the fourth person to die at Wealstun since December 2021. Of the previous deaths, one was self-inflicted and two were due to natural causes. There are no similarities between the findings in our previous investigation and those following our investigation into Mr Johnstone's death. Since Mr Johnstone's death until 1 May 2025, two prisoners have died at Wealstun. One died from natural causes and the other death was a homicide. Both remain under investigation.

Key Events

31. On 4 November 2024, Mr Steven Johnstone was recalled to HMP Leeds for breaching his licence conditions. He had been in prison before. He had a history of drug and alcohol use. He had twice been briefly monitored under prison suicide and self-harm monitoring procedures (known as ACCT) after threatening to harm himself.
32. At 8.24pm, shortly after Mr Johnstone arrived, a reception officer checked his digital person escort record which did not identify any concerns about suicide or self-harm. The officer noted Mr Johnstone had been at Leeds before and had coped well in prison. A reception nurse also saw Mr Johnstone and recorded no concerns but that he had been offered a shower, meal and welfare telephone call.
33. On 7 November, Mr Johnstone was given his recall pack and new key dates. He said he would appeal his recall.
34. On 13 November, Mr Johnstone was transferred to HMP Wealstun. At around 2.50pm, a reception nurse and officer saw him and had no concerns.
35. At around 4.30pm that afternoon, Mr Johnstone telephoned his former partner and told her he had been transferred. He said he had been given a new release date which he thought was wrong. Mr Johnstone said he had wanted to come back to prison to detox from alcohol, which he said he had now done. He told her he felt good and wanted to see her and their son.
36. Later that day, Mr Johnstone telephoned his mother and told her he had been transferred to Wealstun. He asked her to send him some money so he could buy some vapes and more telephone credit.
37. At 12.29pm on 14 November, Mr Johnstone spoke to a friend on the telephone. He told him he had deliberately breached his curfew as he wanted to come back to prison. He had thought he would be automatically re-released the following Monday (18 November) as this was when his curfew would have ended. He said he had been told this was not the case and he thought his release date was now around 18 February 2025. Mr Johnstone told his friend he would not have breached his licence if he had known that.
38. Later that day, Mr Johnstone engaged with his second induction day and no concerns were identified.
39. At 8.05pm on 16 November, Mr Johnstone telephoned his mother. He told her that he was prescribed antidepressants but had not taken them. (Mr Johnstone's medical records show that he was prescribed antidepressants which he was allowed to keep in his cell and administer himself. There is no evidence that he was not complying with taking his antidepressants).
40. On 19 November, Mr Johnstone was moved from the induction wing to B Wing.
41. During telephone calls to his brother and former partner between 19 and 23 November, Mr Johnstone told them he had bought drugs and needed money to buy more vapes and re-pay a £60 drug debt.

42. At 6.58pm on the evening of 23 November, Mr Johnstone telephoned his mother and told her he was worried as he had been unable to pay his debt and prisoners had told him that he was “going to get it in the morning”. Mr Johnstone said he could not face this and was thinking about tying a noose and pressing his emergency cell bell so staff would move him to a different wing.
43. At around 10.33pm, Mr Johnstone telephoned his mother again. He told her he had given officers a note telling them he was going to get “done in” the following morning. He said he had been put on “suicide watch” and officers were checking him every thirty minutes. Prison staff were not aware of Mr Johnstone’s telephone conversation with his mother. The wing observation book for 23 and 24 November, Mr Johnstone’s electronic prison record and security file contained no evidence of such a note or that Mr Johnstone was being supported by ACCT.
44. On 2 December, Mr Johnstone was given a negative behaviour entry in his prison electronic record for misusing his emergency cell bell to hand his canteen sheet to an officer.
45. Shortly before 5.00pm on 3 December, Officer A told the investigator that he was unlocking prisoners for evening association (when prisoners mix on the wing), when he passed Mr Johnstone’s door, Mr Johnstone asked him why he had not been unlocked. Officer A said he was not aware of any reason he should not be allowed out of his cell so unlocked him. Officer A said he later became aware that Mr Johnstone should not have been unlocked as he had refused to attend work that morning and had received a second negative behaviour entry on his electronic prison record. Officer A returned to Mr Johnstone’s cell at around 5.10pm and told him he was going to record a further negative behaviour entry on his electronic prison record for being dishonest.
46. Officer A told the investigator that he looked through Mr Johnstone’s observation panel and saw Mr Johnstone acting suspiciously with a vape. From experience, he suspected he may have been using drugs. Officer A went into his cell and challenged him. Mr Johnstone was placed on report pending a disciplinary hearing for possession of an unauthorised article (tampered vape capsule). Mr Johnstone was given his fourth negative behaviour entry of the day. Officer A said Mr Johnstone did not appear particularly bothered by this and asked if he could have the vape battery back.
47. At 9.54am on 5 December, Mr Johnstone attended a disciplinary hearing and pleaded guilty in relation to the tampered vape capsule found in his cell two days earlier. Mr Johnstone said he was struggling as he had not been released when he had expected to be. He was given fourteen days’ loss of privileges (including loss of association and television).

Events of 7 December 2024

48. On 7 December, Mr Johnstone remained on B Wing all morning. CCTV footage showed him socialising with prisoners and speaking to them through his cell door when officers locked him in his cell. At around 11.31am, he collected his meal and was locked in his cell.

49. Officer A was on B Wing all day and told the investigator he read his emails as he had been off for a few days. He read an email about the outcome of Mr Johnstone's disciplinary hearing on 5 December. Officer A was unsure if Mr Johnstone's television had been removed as it should have been and checked his cell at around 2.10pm. He noticed Mr Johnstone still had a television, so he told him he needed to remove it. Officer A told the investigator that Mr Johnstone's demeanour changed, he raised his voice and told Officer A he could not take the television.
50. At the same time, Officer B and Officer C were undertaking daily cell checks on the wing. Both told the investigator that they heard shouting and went to Mr Johnstone's cell to see what was happening. Both remembered Mr Johnstone seemed annoyed and heard him say something like "you're not going to take my TV". None of the officers turned on their body-worn cameras.
51. Mr D, a prisoner on the wing, told the investigator that at that time, he was walking along the wing with a friend and walked past Mr Johnstone and the officers. He said he saw officers come out of Mr Johnstone's cell with a television and heard Mr Johnstone say something like, "If you take my telly, I'll just lynch myself, I'll hang myself. I'll be as well just hanging myself". The CCTV footage viewed did not show Mr D walking past Mr Johnstone's cell (which can be clearly seen).
52. All three officers spoke to Mr Johnstone and explained why his television was being removed. They told the investigator that Mr Johnstone reluctantly gave them the television. All told the investigator that they did not hear Mr Johnstone say anything about harming himself.
53. At around 1.37pm, SO E reviewed Mr Johnstone's incentives status and downgraded him to a basic regime (which reduces access to various privileges including in cell television and the prison shop). She recorded this was due to him having been placed on report for being in possession of a tampered vape and was in line with the prison's zero tolerance policy around suspected drug use.
54. At around 2.18pm, Mr Johnstone telephoned his former partner. During the conversation, he indicated he felt suicidal. Prison staff were not aware of the content of their conversation. Mr Johnstone ended the call and had phone credit remaining.
55. At around 3.00pm, SO E went to Mr Johnstone's cell to give him his written incentives review and discuss it. She told the investigator that she explained to Mr Johnstone why he was being downgraded to a basic regime, review dates and gave him behavioural targets. SO E described it as a standard review. She recalled that Mr Johnstone denied drug use and told her the capsules belonged to the person in the cell before him. She said she had no concerns and was not aware of any information to suggest he was being bullied, under threat or had thoughts of suicide or self-harm.
56. At around 4.25pm, Mr Johnstone collected his evening meal and spoke to SO E on the way back to his cell. SO E told the investigator that Mr Johnstone told her he felt being placed on basic regime was unfair and he was not using drugs. SO E repeated parts of their earlier discussion and told him the date of his next review.

57. Mr Johnstone returned to his cell and was locked inside at 4.34pm. At 4.51pm, an officer conducted a routine roll check. He looked through Mr Johnstone's observation panel and checked his door was secure. This is the last time Mr Johnstone was seen alive.
58. OSG F was the night officer and had been on B Wing on night shifts all week. He told the investigator that Mr Johnstone had not been brought to his attention all week and was not discussed during the handover from day staff that night. OSG F said he began his shift as usual with a roll check of the wing.
59. At 8.46pm, OSG F came to Mr Johnstone's cell. He said he looked through the observation panel and saw a figure standing in the cell. He said something looked strange. He told the investigator that the main wing light was off, but he did not remember it being particularly dark and he used his torch. He said he noticed the ligature around Mr Johnstone's neck but could not see if his feet were in contact with the ground.
60. OSG F radioed for assistance. The communications officers asked what the problem was, and OSG F told them it was a medical emergency code blue (used when a prisoner is unconscious or not breathing). When the communications officer asked if Mr Johnstone was breathing, he told them he was unsure but did not think so. OSG F waited outside the cell for staff to arrive.
61. Officer G was working in the segregation unit and responded. CCTV showed he arrived on B Wing at 8.48pm and broke OSG F's key pouch to access a cell key. At 8.49pm, he unlocked Mr Johnstone's cell. Officer H and CM J (who was acting as the night manager) arrived at the same time. They cut the ligature and Officer G began cardiopulmonary resuscitation (CPR). CM J assisted.
62. At 9.08pm, the first ambulance arrived at the prison with two paramedics. They arrived at Mr Johnstone's cell at 9.14pm and took over resuscitation efforts. A second ambulance arrived on scene with two more paramedics at 9.18pm and assisted. Mr Johnstone was moved onto the landing, where there was more space.
63. At around 9.35pm, Mr K, a prisoner in the cell opposite Mr Johnstone's, spoke to CM J. Body-worn video camera footage captured Mr K telling CM J that Mr Johnstone had not used PS for four days and he had told the officers he was anxious as they had taken his television.
64. At 9.45pm, the paramedics pronounced life extinct.

Contact with Mr Johnstone's family

65. At around 1.00am on 8 December, the prison appointed Governor L, the duty governor, as the family liaison officer. Governor L and OSG M visited Mr Johnstone's mother, broke the news of his death and offered support. Officer N took over as family liaison officer on 9 December and attended Mr Johnstone's funeral. The prison contributed towards the cost of Mr Johnstone's funeral in line with national policy.

Support for prisoners and staff

66. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death. Wealstun implemented postvention appropriately.
67. After Mr Johnstone's death, the prison Governor and CM J debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. On 29 January 2025, the Head of Safer Custody held a second debrief with staff involved to offer a further opportunity to reflect together and access support.
68. The prison posted notices informing other prisoners of Mr Johnstone's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Johnstone's death.

Writing recovered from Mr Johnstone's cell

69. On an undated piece of paper (but which we consider was likely to have been written on 7 December) addressed to his mother, Mr Johnstone wrote that he was not coping very well. He said he just sat in his cell during association time and his television had been taken away. He wrote that that was the only thing keeping his anxiety and depression at bay. He said he would not be causing anybody any more trouble.

Post-mortem report

70. The pathologist gave Mr Johnstone's cause of death as hanging.
71. The post-mortem and toxicology reports found therapeutic levels of prescribed medication in Mr Johnstone's system. The pathologist identified the presence of synthetic cannabinoids and nortriptyline (a metabolite of amitriptyline, which he was not prescribed). Both indicated prior use which the pathologist concluded was unlikely to have directly contributed to Mr Johnstone's death. The pathologist found evidence of previous chronic intravenous drug use.

Inquest

72. At an inquest held between 27 April and 30 April 2026, the coroner concluded that Mr Johnstone died from hanging. The coroner concluded Mr Johnstone's death was suicide, contributed to by the removal of his television.

Findings

Assessment of risk

72. HMPPS' Prison Safety Policy Framework sets out the mandatory requirements for staff on identifying risks of suicide and self-harm and supporting those at risk to reduce harm. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service case management approach used to support prisoners identified as at risk of suicide or self-harm. The framework states that all staff are responsible for ensuring that an ACCT is opened if they believe a prisoner is at risk of suicide or self-harm.
73. Mr Johnstone had no history of self-harm or suicide attempts in the community or prison. He had been supported by ACCT procedures once in 2010 and once in February 2024 at HMP Holme House when he told a prison doctor that he would kill himself if he was not prescribed the dose of medication he was used to.
74. During reception and induction at Wealstun, accurate information was available to prison staff. Mr Johnstone told staff he had no thoughts of suicide or self-harm, and there was no other information that indicated he presented a heightened risk.
75. On 23 November, during a telephone conversation, Mr Johnstone told his mother he had given a note to officers and as a result, he had been placed on "suicide watch" and was being checked every thirty minutes. Our investigation found no evidence that this was the case and Mr Johnstone was not supported by an ACCT at any stage during his time at Wealstun.
76. On 7 December, following a disciplinary hearing and demotion to basic regime, Mr Johnstone's television was removed from his cell. Officers explained the reason for this and SO E comprehensively reviewed Mr Johnstone's incentive level with him later that afternoon.
77. A prisoner told the investigator that he had walked past Mr Johnstone's cell as officers were removing his television and heard him make comments about hanging himself. CCTV does not corroborate the prisoner's version of events. All three officers present said that Mr Johnstone was annoyed and reluctant to surrender his television but had not said anything about harming himself. They did not activate their body-worn video cameras and therefore we cannot verify what Mr Johnstone said. Since Mr Johnstone's death, the Head of Safety issued a notice to staff reminding them to wear body-worn video cameras and ensuring they are activated when dealing with potentially confrontational situations such as issuing incentive warnings or removing televisions.
78. During a telephone call to his former partner a short time later, Mr Johnstone indicated he was feeling suicidal. Mr Johnstone was not subject to call monitoring so staff did not hear the conversation. Wealstun has a safer custody concern line through which family and friends can log concerns about prisoners. The safer custody concern line had no records about Mr Johnstone.
79. Mr Johnstone spoke to SO E as he collected his evening meal and there is no evidence he gave any indication that he was going to kill himself. On the evidence

available, we are satisfied that staff could not have foreseen Mr Johnstone's actions or that he was at heightened risk which required support by an ACCT.

Emergency response

80. PSI 24/2011 National Security Framework, Management and Security of Nights requires night staff to be trained in local incident contingency plans. Wealstun's Night Patrol Protocol states that where there is, or appears to be, immediate danger to life, a cell may be unlocked without the authority of the night orderly officer. However, night staff must inform the control room before doing so. The protocol sets out that the preservation of life must take precedence over security concerns. However, night staff should not take action if they believe it would put themselves or others in unnecessary danger.
81. PSI 2013/03 on medical emergency response codes sets out the actions required by staff to ensure a timely, appropriate and effective response to medical emergencies. In August 2024, the Head of Safety issued a notice to staff at Wealstun, reminding them of their responsibilities. The notice set out when staff should radio an emergency code blue (including if a prisoner has chest pain, difficulty breathing or is unconscious).
82. When OSG F saw Mr Johnstone with a ligature around his neck, he radioed for assistance but did not initially radio a code blue. This was quickly rectified and the delay in calling an ambulance was minimal.
83. The OSG did not enter Mr Johnstone's cell immediately but waited for other staff to arrive. An officer arrived two minutes later and went into Mr Johnstone's cell within three minutes of OSG F raising the alarm. The OSG told us that while he could see Mr Johnstone was hanging, he could not see his feet. He also said he would never enter a cell without another member of staff present. National and local policy instructs staff in situations like this to conduct a dynamic risk assessment before entering a cell alone. OSG F might have assessed that the risk of entering Mr Johnstone's cell without other staff present was too great, but we are concerned that this was his general approach.
84. The Head of Safety told the investigator that the duty governor completes unannounced night management checks, including checking that the night patrol staff know how to respond to medical emergencies, that officers know the correct procedure for opening a cell door if a prisoner has ligatured and that they are carrying a cut-down tool (for cutting ligatures).
85. Since Mr Johnstone's death, the prison has reissued guidance to all staff on expectations about entering a cell during an emergency and the use of cut-down tools. The Head of Safety offered OSG F support and guidance. He has since agreed to undertake additional training.
86. Our investigation found no evidence of systemic issues with staff not responding appropriately to emergencies and they have not featured in previous investigations within the last three years. The prison has taken action to support OSG F and remind other staff of their responsibilities. We therefore do not make a recommendation.

Disciplinary hearing outcome

87. Mr Johnstone was found guilty at his disciplinary hearing on 5 December 2025 and given sanctions. Wing staff did not become aware of this until 7 December. Our investigation found that at the time of Mr Johnstone's death, the outcomes of disciplinary hearings were not routinely shared by a global email to all staff. This meant that managers had to run a report to obtain this information. Since Mr Johnstone's death, this issue has been rectified, and all staff receive outcomes by email to ensure sanctions are imposed immediately.

Clinical review

88. The clinical reviewer concluded that the clinical care Mr Johnstone received was of a good standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made one recommendation which was not related to Mr Johnstone's death but which the Head of Healthcare will need to address.

Good practice

89. CM J's management of the incident was excellent. She continued to manage the prison in her role as night manager while simultaneously coordinating the emergency response. Body-worn video camera footage showed she remained calm and showed care and compassion for Mr Johnstone, prisoners and staff. She ensured all prisoners in cells near Mr Johnstone were checked. For cells which were unreachable due to paramedics assisting Mr Johnstone, she ensured officers checked on prisoners through their windows and from the exercise yard. We commend her for her care and dedication to her role.
90. Paramedics commended officers for high quality CPR.
91. The day after Mr Johnstone's death, Officer B stayed after his shift into the evening to support OSG F in completing the roll check as he was aware he was feeling anxious.
92. Feedback from staff during interviews reflected a close team who felt supported by their leaders.

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