

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jayakanthan Darmaratnam a prisoner at HMP Doncaster on 10 January 2019

A report by the Prisons and Probation Ombudsman

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 2018

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 Jayakanthan Darmaratnam died after he hanged himself in his cell on 10 January 2019 at HMP Doncaster. He was 41 years old. I offer my condolences to his family and friends.

Mr Darmaratnam took his life on the morning that he was due to appear in court. He had several risk factors: he had been charged with a serious sexual offence, it was his first time in prison, and he was increasingly worried about receiving a long sentence and about being deported.

I am extremely concerned that there is no record of any meaningful contact between Mr Darmaratnam and staff at Doncaster during the four months that he was in prison. If staff had interacted with him more, they might have identified that he was at increased risk of suicide or self-harm and they might have had the opportunity to put in place measures to manage his risk.

There were procedural deficiencies in the early morning roll check on the day Mr Darmaratnam died. Even though it is highly unlikely that this failure affected the outcome for him, it is critical that prison staff carry out the roll check to required standards as early intervention can save lives.

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

Sue McAllister CB
Prisons and Probation Ombudsman

October 2019

Contents

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

Summary

Events

1. On 3 September 2018, Mr Jayakanthan Darmaratnam, who had both British and Sri Lankan citizenship, was remanded to HMP Doncaster charged with historical sexual offences. It was his first time in prison.
2. At his initial health screen, a nurse noted that Mr Darmaratnam did not have a history of mental health issues and that he denied thoughts of suicide or self-harm. However, in early January 2019, Mr Darmaratnam told another prisoner that he had taken sleeping tablets to take his life. Mr Darmaratnam also told his cellmate that he had had suicidal thoughts, was worried about his court case and that he might be deported, if convicted. However, prison staff were not told this information.
3. On 2 October, a Home Office immigration officer interviewed Mr Darmaratnam to confirm his nationality but he was not told the outcome.
4. There are no records of any staff interaction with Mr Darmaratnam after this.
5. Other prisoners said that Mr Darmaratnam became increasingly concerned about the length of his sentence and the possibility that he would be deported in the period before his court appearance on 10 January. They did not tell staff.
6. On 10 January 2019, the officer who completed the early morning roll check only looked into Mr Darmaratnam's cell for around a second before moving on.
7. At around 6.38am that morning, an officer went to Mr Darmaratnam's cell to wake him early for his court hearing. The officer found him hanged in his cell. Staff responded promptly and tried to resuscitate him, with the later assistance of paramedics. However, resuscitation efforts were unsuccessful and Mr Darmaratnam was pronounced dead shortly afterwards.

Findings

8. In the weeks leading to his death, Mr Darmaratnam's risk of suicide and self-harm increased. There is no evidence that staff interacted with him in a meaningful way which might have made them aware of his increased risk and increased the likelihood that they might have put in place measures to prevent his death.
9. The Home Office questioned Mr Darmaratnam's nationality status and the potential impact of this played on his mind. Doncaster should have confirmed to him that he was a British citizen as this might have decreased his fear of deportation.
10. The officer who completed the early morning roll check on the day Mr Darmaratnam died did not do so to the standard expected of him. It is unlikely that he had time to check on Mr Darmaratnam and his cellmate properly during his very brief look through the cell door observation panel. However, his actions are unlikely to have affected the outcome for Mr Darmaratnam.

11. The clinical care that Mr Darmaratnam received at Doncaster was equivalent to that which he would have expected to receive in the community.

Recommendations

- The Director should ensure, in line with the key worker scheme, that key workers:
 - communicate with and encourage prisoners;
 - identify their needs; and
 - make regular case history notes in the prisoner's records.
- The Director should ensure that when the Home Office reviews a prisoner's nationality status, staff confirm the outcome to prisoners and check on their wellbeing.
- The Director should ensure that staff completing roll checks satisfy themselves that there are no immediate causes for concern.
- The Director should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: the officer in the Foreign Nationals Team; the officer who carried out the early morning roll check on 10 January; and Mr Darmaratnam's key worker.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact him.
13. The investigator visited Doncaster on 22 January 2019. He obtained copies of relevant extracts from Mr Darmaratnam's prison and medical records.
14. NHS England commissioned an independent clinical reviewer to review Mr Darmaratnam's clinical care at the prison.
15. The investigator interviewed six members of staff and two prisoners.
16. We informed HM Coroner for South Yorkshire (East District) of the investigation. She gave us a copy of Mr Darmaratnam's post-mortem report. We have sent the Coroner a copy of this report.
17. We contacted Mr Darmaratnam's mother to explain the investigation and ask if she had any matters she wanted us to consider. She had no specific questions.

Background Information

HMP Doncaster

18. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 prisoners who have been remanded in custody or sentenced. Care UK provides clinical services. The prison directly employs qualified paramedics as part of their healthcare team, and they respond to emergency calls in the prison.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Doncaster in July 2017. Inspectors noted that a great deal had been achieved since their inspection two years earlier. They reported that although there were high levels of self-harm among prisoners, it was reassuring to see that previous recommendations from the Prisons and Probation Ombudsman were taken seriously and reviewed regularly to ensure ongoing compliance. Inspectors reported that contact between prisoners and officers were not always recorded. However, they noted that health services were reasonably good.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. No IMB report was produced for the reporting year 2017-2018.

Previous deaths at HMP Doncaster

21. Mr Darmaratnam was the tenth prisoner to die at Doncaster since January 2017. One of these deaths was self-inflicted and eight were from natural causes. There are no similarities between Mr Darmaratnam's death and these deaths. Since Mr Darmaratnam's death, another prisoner has died from natural causes, and we are currently investigating his death.

Assessment, Care in Custody and Teamwork (ACCT)

22. 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. 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

23. On 1 September 2018, Mr Jayakanthan Darmaratnam, who had both British and Sri Lankan citizenship, was arrested on suspicion of serious historical sexual offences and taken into police custody. (Court documents listed his nationality as Sri Lankan.)
24. On 3 September, Mr Darmaratnam was remanded to HMP Doncaster. It was his first time in prison. A nurse completed an initial health screen. The nurse noted that Mr Darmaratnam's first language was Tamil but an interpreter was not needed as he had no difficulty speaking English. Having reviewed Mr Darmaratnam's community GP records, the nurse noted that he had diabetes and had no history of mental ill health or substance misuse. Mr Darmaratnam denied thoughts of suicide or self-harm. The nurse referred Mr Darmaratnam to a prison GP to prescribe his diabetic medication.
25. On 4 September, Mr Darmaratnam was moved to the Vulnerable Prisoners' Unit, where he shared a cell with a Sri Lankan prisoner who spoke Tamil.
26. A case support officer assessed Mr Darmaratnam's needs. Mr Darmaratnam told the officer that he had been living with his partner for the past seven years, was unlikely to get support or visits while in prison and would not be able to return to her address because of his alleged offence. Mr Darmaratnam told the officer that he had some qualifications, could read and write in English and had been working full time in a shop before his arrest.
27. On 7 September, Mr Darmaratnam completed his prison induction. During this and the reception process, Mr Darmaratnam told staff that he had no thoughts of suicide or self-harm.
28. On 2 October, an officer in Doncaster's Foreign Nationals Team and a Home Office immigration officer interviewed Mr Darmaratnam briefly to confirm his nationality. The officer said that he could not recall Mr Darmaratnam raising any issues during the interview. He told the investigator that the immigration officer told Mr Darmaratnam that he might be considered for deportation if he was convicted of the serious charges against him. The Home Office later confirmed to the prison that Mr Darmaratnam was a British citizen through naturalisation. However, Mr Darmaratnam was not told about the meeting's outcome.
29. Little is known about Mr Darmaratnam during his time at Doncaster but over the following weeks, he did not come to the attention of staff and there are no records about him or any recorded concerns about him.
30. Mr Darmaratnam's cellmate told the investigator that they got on well and that although Mr Darmaratnam was quiet, he got on well with other prisoners. He said that Mr Darmaratnam would often say that his "life was finished" and that he no longer wanted to be in the United Kingdom. He said that Mr Darmaratnam was worried that his British citizenship would be taken away and that he would be deported to Sri Lanka.
31. Another prisoner on the wing told the investigator that Mr Darmaratnam always talked about his charges, feared his court hearing and what might happen, and

- asked other prisoners how long his sentence would be. The prisoner said that he tried to reassure Mr Darmaratnam that he could not be deported as he had dual nationality. He said that Mr Darmaratnam always appeared to be “feeling down”.
32. On 8 January, Mr Darmaratnam and his cellmate moved cells together to another area of the Vulnerable Prisoners’ Unit. There are no records to explain why.
 33. On 9 January, a legal visit from Mr Darmaratnam’s solicitor was cancelled after the solicitor was found in possession of a white tablet when he was searched entering the prison. Mr Darmaratnam’s cellmate told police that Mr Darmaratnam had phoned his solicitor and had been told that he could not visit him. Mr Darmaratnam told his cellmate that his solicitor had told him that he would get a 20 to 25-year sentence if he was found guilty. His cellmate said that Mr Darmaratnam told him that he would speak to a friend to persuade his alleged victim to drop the charges against him.
 34. Another prisoner on the wing told the investigator that Mr Darmaratnam did not go out for exercise in the afternoon as he usually did. He said that while he was exercising, he spoke to Mr Darmaratnam through his cell window, and although he did not mention his court case, he said that Mr Darmaratnam told him that “it was all over”, that he would be sentenced and then deported.
 35. Mr Darmaratnam’s cellmate confirmed that Mr Darmaratnam did not go to exercise that afternoon as he usually did but he put this down to him having a flu vaccination earlier in the day. He told the investigator that looking back, he thought that Mr Darmaratnam might have been planning to take his own life at that time.
 36. From around midday to 10.00pm, Mr Darmaratnam made numerous calls to a friend using the in-cell telephone. The investigator listened to recordings of the calls. During the calls, Mr Darmaratnam appeared to use his friend as a mediator between him and his ex-partner, the mother of one of his alleged victims, and asked for the allegations against him to be withdrawn. However, the friend told Mr Darmaratnam that “she” would not do this. During one call, Mr Darmaratnam told his friend that “they” had already taken the decision to “destroy his life”, and said that he would not get another chance to call him if he was sentenced at court.
 37. At 1.42pm, Mr Darmaratnam telephoned his legal representative. (Legal calls are not recorded so the contents of this call are unknown.)
 38. Mr Darmaratnam’s cellmate told the investigator that at around 6.00pm, Mr Darmaratnam was very upset because of his court hearing the following day. He was worried that he would be sentenced to around 30 years in prison. Mr Darmaratnam’s cellmate told the investigator that they played cards together and made a sandwich in the evening, as they often did.
 39. At 10.06pm, Mr Darmaratnam telephoned his friend for the last time and asked to speak to another person who was present on speaker phone. Mr Darmaratnam greeted the other person and said that he was due to appear in court the next day and only had 30 seconds of credit left on his telephone card. The person

- told Mr Darmaratnam to “go to court”. Mr Darmaratnam then said, “I have no money on my phone credit” before the telephone call was disconnected.
40. Mr Darmaratnam’s cellmate said that he went to sleep at about 11.30pm and that Mr Darmaratnam stayed up to write a letter. He said that he slept through the night and heard nothing.
 41. At 4.56am on 10 January, when an officer completed the early morning roll check, he looked into Mr Darmaratnam’s cell very briefly for around a second.
 42. At 6.32am, a different officer went to Mr Darmaratnam’s cell to wake him early as he was due to attend court that day. The officer went into the cell and told the occupants that one of them had to wake up. Neither Mr Darmaratnam nor his cellmate answered and the officer left the cell a minute later and returned to the wing office to check which prisoner she needed to wake up.
 43. At 6.38am, the officer returned to the cell to wake Mr Darmaratnam, having established that he was due to go to court. The officer went into the cell, patted Mr Darmaratnam’s bed and realised he was not there. As the officer left the cell, she saw Mr Darmaratnam hanging from a ligature, tied to the rail of the toilet’s privacy curtain. She shouted to another officer in the wing office that there was a code blue situation, indicating that a prisoner was unconscious or had difficulties breathing. She cut the ligature, laid Mr Darmaratnam on the floor and started cardiopulmonary resuscitation. She told the investigator that Mr Darmaratnam was cold and not breathing.
 44. At 6.39am, the officer in the wing office said that he heard the officer at Mr Darmaratnam’s cell shout for assistance before he radioed a code blue. When he arrived at the cell, he took Mr Darmaratnam’s cellmate out of the cell before taking over resuscitation efforts from the other officer. He checked for signs of life but could find none. He said that he could not open Mr Darmaratnam’s mouth and that he was cold. The other officer left the cell to get the wing phone and she gave the ambulance control room information about the emergency.
 45. Another officer arrived at the cell at 6.40am, and assisted with resuscitation efforts before a prison paramedic arrived at 6.44am and took charge of the incident. A defibrillator was applied but did not detect a heartbeat. At 6.53am, ambulance service paramedics arrived at the cell and assisted the prison paramedic. At 7.19am, paramedics declared that Mr Darmaratnam had died.
 46. Staff found several notes in Mr Darmaratnam’s cell after his death. They were written in English and Tamil. One note said, “My suicide is my own decision nobody told me anything to do [it] it’s my self-decision [sic].” Another letter said that the allegations made against him were lies and another asked his friend to withdraw money from his bank and give it to his wife and mother in Sri Lanka.
 47. After Mr Darmaratnam’s death, a prisoner said that he had befriended Mr Darmaratnam in around October or November 2018 when they went to the prison chapel. He said that when Mr Darmaratnam had asked what would happen to him, he had told him to ask his legal team. He said that Mr Darmaratnam asked him if he should plead guilty or not, and said that he might receive a long sentence and be deported as he had dual nationality, which would mean that he

would have to spend time in a Sri Lankan prison. He said that Mr Darmaratnam told him that he had suicidal thoughts and had tried to take his life on New Year's Eve by taking sleeping tablets that he had got from other prisoners. The prisoner did not tell staff about this.

48. Mr Darmaratnam's cellmate told police that Mr Darmaratnam had expressed suicidal thoughts for several weeks and that he wanted his ashes to be sent to his mother in Sri Lanka. His cellmate said that Mr Darmaratnam appeared happier the day before his death.

Contact with Mr Darmaratnam's family

49. The prison contacted Mr Darmaratnam's family in Sri Lanka, with the help of one of his close friends in the community. Doncaster contributed to the costs of Mr Darmaratnam's repatriation and funeral in line with national instructions.

Support for prisoners and staff

50. An Assistant Director debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered them support.
51. The Director issued notices to staff and prisoners informing them of Mr Darmaratnam's death. Staff reviewed prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Darmaratnam's death.

Post-mortem report

52. A post-mortem examination found that Mr Darmaratnam had died from hanging. Toxicology tests found no drugs in his body, other than traces of mirtazapine (an antidepressant which had not been prescribed to him) at below therapeutic levels. (There is no evidence to say where Mr Darmaratnam obtained the mirtazapine.)

Findings

Key worker scheme

53. Mr Darmaratnam arrived at Doncaster on 3 September 2018, four months before he died. Throughout his time at the prison, only two entries were made in his case history notes that evidenced any one-to-one interaction with him by staff. Neither entry referred to his personal welfare. There is no evidence that officers on his wing ever had a meaningful conversation with Mr Darmaratnam and as he was quiet and complied with the prison regime, he did not attract the attention of staff.
54. Doncaster's key worker scheme is designed to help reduce violence and self-harm by encouraging meaningful contact and positive relationships between officers and prisoners. The scheme aims to mitigate the negative effects of imprisonment by enabling prisoners to settle, feel safe and calm, progress through their sentence and to provide prisoners with a sense of hope. Each key worker has around six prisoners and will have dedicated time - on average 45 minutes a week per prisoner – and will meet each prisoner weekly. The policy requires key workers to engage with prisoners and to record their interactions at regular intervals.
55. In the months leading to Mr Darmaratnam's death, Doncaster was in the process of rolling out its key worker scheme. An officer was only assigned as Mr Darmaratnam's key worker in mid-December, once he had completed his training.
56. We are very concerned about the lack of entries in Mr Darmaratnam's prison records to show that any member of staff had had meaningful interactions or conversations with him which considered his welfare and needs. We consider that staff missed opportunities to identify Mr Darmaratnam's risk of suicide and as a result, to put in place measures to support him.
57. Mr Darmaratnam's key worker told the investigator that he tried to introduce himself in early January, although he did not record this in Mr Darmaratnam's case history notes. We also note that he and another officer we spoke to both said that they had been assigned as the key worker to prisoners who did not live on the wings, or in the areas of the prison, where they worked. This made it difficult for them to interact regularly with their allocated prisoners in the spirit of the key worker scheme.
58. We were told that, since Mr Darmaratnam's death, Doncaster has introduced new rosters for key workers which allocate prisoners to them who live on or near the wings where they work. The rosters came into effect from 20 January and enable additional officers to support prisoners under the key worker scheme. Although Doncaster told us that the full roll-out of the key worker scheme in January 2019 and the new rosters addressed our concerns, we remain dissatisfied with the lack of staff interaction with Mr Darmaratnam and we make the following recommendation:

The Director should ensure, in line with the key worker scheme, that key workers:

- **communicate with and encourage prisoners;**
- **identify their needs; and**
- **make regular case history notes in the prison records.**

Identifying risk of suicide and self-harm

59. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and manage prisoners identified as at risk under ACCT procedures. The PSI lists several risk factors and states that potential triggers should be continually assessed.
60. We have considered whether staff at Doncaster should have recognised Mr Darmaratnam as at risk of suicide and started ACCT monitoring when he first arrived and over the following weeks and months he was there. Mr Darmaratnam arrived with some risk factors: his alleged offences were sexual, they were against a family member, it was his first time in prison and he had fears of being deported. However, he had no known history of mental ill health, self-harm or attempted suicide and he denied thoughts of self-harm when asked by staff. We are satisfied that staff reasonably concluded during his first weeks at Doncaster, that Mr Darmaratnam did not need to be monitored under ACCT procedures.
61. However, in the weeks leading to his death, Mr Darmaratnam was distressed by his approaching court hearing and his fear of deportation. Staff did not identify his risks due to their lack of engagement with him, including through the prison's key worker scheme. Although he often discussed these matters with other prisoners, he did not tell staff and neither did the prisoners he spoke to about his concerns, feelings and expressions of and attempts to self-harm.
62. If staff had been more proactive in engaging with Mr Darmaratnam and if they had interacted with him in a meaningful manner, as they should have under the prison's key worker scheme, they might have been aware of his increased risk and it seems likely they would have monitored him under suicide and self-harm prevention procedures. This might have prevented him taking his life. However, as staff failed to interact with him, there was little to indicate in his outward behaviour to staff at the time that he was at risk of suicide.

Communication about nationality status

63. Mr Darmaratnam was unsure about his nationality status and how it might affect any future decision to deport him. It is clear that this played on his mind in the weeks before his death and may have been a contributory factor in his decision to take his life.
64. An officer in Doncaster's Foreign Nationals Team told the investigator that as Mr Darmaratnam was considered a British citizen, neither he nor the Foreign Nationals Team had any further contact with Mr Darmaratnam after his interview with the Home Office on 2 October. However, the officer said that no one had confirmed to Mr Darmaratnam that he was a British citizen, and therefore that he would not be deported. He said that with hindsight, either the immigration officer

from the Home Office or he should have told Mr Darmaratnam that this was the case. We make the following recommendation:

The Director should ensure that when the Home Office reviews a prisoner's nationality status, staff confirm the outcome to prisoners and check on their wellbeing.

Roll check

65. A roll check is primarily a security check to count prisoners to ensure that they are present in their cells but it is also an opportunity for any concerns about prisoners' safety to be identified and managed. The officer who was on duty on the night of 9 to 10 January, did not complete the roll check adequately. CCTV footage shows the officer looking through the cell door observation panel very briefly. It is unlikely that the officer could have seen both Mr Damaratnam and his cellmate during the second that he looked into the cell, and it is likely that Mr Darmaratnam had already hanged himself at the time.
66. Although the failure to check properly is unlikely to have altered the outcome for Mr Darmaratnam, the investigator brought the matter to the attention of the Deputy Director of Doncaster. We understand that the officer has been reminded to complete roll checks properly and the incident has been noted on his record of employment, but we make the following recommendation:

The Director should ensure that staff completing roll checks satisfy themselves that there are no immediate causes for concern.

Clinical care

67. The clinical reviewer concluded that the care that Mr Darmaratnam received at Doncaster was of a good standard and was at least equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

**Prisons &
Probation**

Ombudsman
Independent Investigations