

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Carr, a prisoner at HMP Doncaster, on 20 February 2020

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*



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

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

Mr Joseph Carr died on 20 February 2020 after he was found hanged in his cell at HMP Doncaster. He was 35 years old. I offer my condolences to Mr Carr's family and friends.

Mr Carr took his life just over two weeks after he arrived at Doncaster. I am concerned that there were deficiencies in healthcare reception procedures. In particular, healthcare staff did not consider referring Mr Carr to the mental health team despite being aware that he took antidepressants. Staff also failed to confirm some of Mr Carr's medication needs with his community GP in a timely manner. This caused him some initial anxiety.

However, I am satisfied that Mr Carr gave staff no indication that he was at imminent risk of suicide or self-harm before his death.

Mr Carr had a significant history of alcohol and illicit drug use. Post-mortem toxicology results identified that he had taken psychoactive substances (PS) before he died. We cannot say to what extent this may have affected his state of mind. He had also been physically restrained about an hour before he was found hanged and this may also have affected his state of mind.

It is unacceptable that staff failed to respond when Mr Carr rang his cell bell 45 minutes before he was discovered and that he was found hanging by another prisoner. While I cannot say whether the outcome would have been different for him, his chances of survival might have significantly improved if staff had responded to his cell bell.

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

December 2020

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Summary

Events

1. Mr Joseph Carr was released from prison on licence on 23 August 2019. On 31 January 2020, Mr Carr's licence was revoked. On 4 February, he was arrested and on 5 February, he was returned to custody at HMP Doncaster.
2. Mr Carr had a significant history of alcohol and illicit drug use. On his arrival at Doncaster, he tested positive for a number of illicit substances and was started on a detoxification programme in the prison's stabilisation unit.
3. At 2.07pm on 20 February, staff told him that he was to be moved to the Early Days Centre (EDC). Although Mr Carr initially refused to move, he agreed to do so once he had collected his belongings. However, staff said that Mr Carr quickly became aggressive and threatening and that it was necessary to use force to move him to his new cell. At 2.17pm, staff locked Mr Carr in his new cell.
4. At 2.20pm, Mr Carr pressed his emergency cell bell. Staff did not respond. At 3.05pm, a prisoner found Mr Carr hanged in his cell. He immediately alerted staff who called an emergency code and an ambulance was called. Officers and nurses responded and began cardiopulmonary resuscitation (CPR). Paramedics arrived at 3.20pm but at 3.42pm, they pronounced that Mr Carr had died.

Findings

Assessment of risk

5. When Mr Carr arrived at Doncaster, staff appropriately assessed that he was not at immediate risk of suicide and self-harm. During the two weeks that Mr Carr spent at Doncaster, he gave staff no indication that he was at risk of taking his own life.

Use of force

6. There is insufficient evidence for us to reach a view on whether the use of force on Mr Carr was justified or not.
7. Prison staff should have asked healthcare staff to examine him as soon as possible after the use of force.

Response to Mr Carr's cell bell

8. The delay in responding to Mr Carr's cell bell before he was found hanged was unacceptable. Staff should always answer cell bells as promptly as they can. HM Inspectorate of Prisons have an expectation, which we share, that they should be answered within five minutes, other than in exceptional circumstances. If staff had responded to Mr Carr's cell bell promptly, the outcome may have been different and his life might have been saved.

Clinical care

9. The clinical reviewer concluded that that the care that Mr Carr received was equivalent to that which he could have expected to receive in the community. However, staff should have referred Mr Carr to the mental health team when he arrived as they were aware that he took antidepressants. Staff also took longer than expected to confirm the medication he used in the community.

Illicit substances

10. The post-mortem toxicology results identified PS in Mr Carr's system. This may have affected his state of mind at the time of his death. The availability of illicit substances remains a problem across the prison estate and should remain a priority to address.

Recommendations

- The Director should ensure that prison staff promptly radio the healthcare team to examine a prisoner after an unplanned use of force.
- The Director should ensure that staff respond to all cell bells within five minutes, other than in exceptional circumstances.
- The Director should commission an investigation into the delay in answering Mr Carr's cell bell, with a view to considering whether disciplinary proceedings should be initiated for any managers or officers.
- The Head of Healthcare should ensure that when newly arrived prisoners are prescribed medication to support their mental health, reception healthcare staff refer them to the mental health team.
- The Head of Healthcare should ensure that the process for confirming community methadone dosages for newly arrived prisoners is effective, prompt and implemented.
- The Head of Healthcare should ensure that healthcare staff are aware of and implement the Royal College of General Practitioners' guidelines on safer prescribing in custody when discontinuing gabapentinoids.
- The Head of Healthcare should ensure that healthcare staff refer patients to pain management clinics for effective treatment when necessary.

The Investigation Process

11. 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.
12. The investigator visited Doncaster on 3 March. He obtained copies of relevant extracts from Mr Carr's prison and medical records.
13. NHS England commissioned an independent clinical reviewer to review Mr Carr's clinical care at the prison.
14. The investigator interviewed two prisoners on 3 March and three members of staff at Doncaster. The interviews were completed by telephone because of the restrictions imposed due to the COVID-19 pandemic.
15. We informed HM Coroner for South Yorkshire (East District) of the investigation. She gave us the results of the post-mortem examination and toxicology results and we have sent the Coroner a copy of this report.
16. We contacted Mr Carr's family to explain the investigation. Mr Carr's family said that an unidentified source had told them that prison staff had beaten Mr Carr up shortly before he took his life. They wanted to know what had happened.
17. Mr Carr's mother said that she did not wish to receive a copy of the report or make any comment.

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. Doncaster 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 September 2019. Inspectors were very concerned by the increased levels of self-harm, and by the fact that there had been five self-inflicted deaths in the year before the inspection. The inspectors found that Doncaster had not regularly reviewed or implemented all the recommendations that the Prisons and Probation Ombudsman had made about her findings in the investigations into these deaths.
20. Inspectors also reported that officers took too long to respond to emergency cell bells, and too many were not answered within five minutes. The prison had introduced a range of measures to address these concerns and monitor response times, but to little effect. Inspectors found the presence of illicit drugs was a real and continuing problem, and prisoners reported that they were easily available at Doncaster.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. The IMB report for the reporting year ending September 2019 noted the high rate of self-harm and the self-inflicted deaths.

Previous deaths at HMP Doncaster

22. Mr Carr's death was the eighth self-inflicted death at Doncaster since January 2018. There were no similarities between the previous deaths and Mr Carr's death.

Psychoactive substances (PS)

23. PS (formerly known as 'new psychoactive substances (NPS)' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and causing vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for PS to precipitate or exacerbate the deterioration of mental health, and they are linked to suicide and self-harm.
24. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the time NPS) and its dangers, including its close association with debt,

bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

25. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

26. Mr Joseph Carr had been in prison before. He had a significant history of misusing alcohol, crack cocaine, heroin and psychoactive substances (PS). He was convicted of theft on 23 January 2019 and after serving time in prison, he was released on licence from HMP Doncaster on 23 August 2019.
27. On 31 January 2020, Mr Carr's licence was revoked as a result of poor behaviour and failing to liaise with his probation offender supervisor in the community. On 5 February, he was returned to custody at HMP Doncaster. His licence expiry date was 22 March 2020.
28. Mr Carr's person escort record noted that he had a history of attempted suicide and self-harm and substance misuse. He had also had part of his left foot amputated and had depression and anxiety.
29. An officer completed Mr Carr's reception interview. He recorded that Mr Carr posed a high risk of harm to others and should not share a cell because of his homophobic and racist views. Mr Carr also had a history of violence. Mr Carr named his probation offender manager (probation officer), as his next of kin.
30. When he arrived at Doncaster, Mr Carr said his regular medication included mirtazapine and diazepam (for depression and anxiety), pregabalin (for nerve pain, as he had had part of his left foot amputated), zopiclone (for insomnia) and methadone (as an opiate substitute).
31. Two nurses completed an initial health screen for Mr Carr. He said that he had depression and anxiety. He told them that he had tried to hang himself several years ago but had no current thoughts of suicide or self-harm. He tested positive for methadone, opiates, cocaine, cannabinoids and benzodiazepines (sedatives). A nurse referred Mr Carr to the substance misuse team.
32. A nurse noted that Mr Carr received methadone daily in the community under the supervision of the community drugs team. She noted that healthcare staff needed to review Mr Carr's medications to check that it was safe for him to take the mix of drugs. She decided that he should not be prescribed pregabalin and zopiclone. She started Mr Carr on a detoxification programme of methadone maintenance therapy and prescribed diazepam for his benzodiazepam misuse.
33. Mr Carr lived on Houseblock 3B, the stabilisation unit, due to his dependency on drugs.
34. On 6 February, a Custodial Operations Manager (COM) saw Mr Carr and completed a key worker session with him. Mr Carr said that he felt safe on the wing. He was concerned about his medication but said that he had already raised it with the healthcare team. He said that he had taken cocaine shortly before he arrived in prison.
35. A nurse completed Mr Carr's secondary health screen that day. Mr Carr said that he had no thoughts of suicide or self-harm.
36. An Operational Support Officer (OSO) then completed a basic custody screen assessment. Mr Carr said he was single, had no dependent children and was

unemployed. He said that he had no concerns, did not need support and was not interested in working or attending classes in prison. He said he was in regular contact with his mother, who lived in a care home.

37. That day, a nurse, a non-medical prescriber, reviewed Mr Carr's medical record and updated his medication. (The healthcare team had access to an electronic summary of Mr Carr's community medical care records, including his medication history.) She noted that in line with Care UK policy, they could not prescribe Mr Carr pregabalin because of the risks of taking pregabalin and methadone in combination. She noted that Mr Carr's medication would be reviewed at the Safer Prescribing Review meeting.
38. On 10 February, a nurse completed a substance misuse assessment to review Mr Carr's progress. She noted that Mr Carr was irate, banged on the desk and demanded his medication. He then left the meeting room abruptly. Since he arrived at Doncaster, Mr Carr had been prescribed a methadone dose of 30ml, which was lower than the 60ml dose he had taken in the community. She noted that Mr Carr was not stable on 30ml and that she did not know why staff had not confirmed his usual dosage with his community pharmacy.
39. On 11 February, Mr Carr attended the medication hatch and spoke to a nurse. He demanded to see the nurse prescriber. The nurse told Mr Carr that he would have to make an appointment. Mr Carr was given paracetamol at his request. He then became verbally abusive towards the nurse and swore at her. Wing staff subsequently returned Mr Carr to his cell.
40. A resettlement officer completed the second stage of Mr Carr's basic custody screen. Mr Carr said that he was frustrated that he had been recalled to prison for 28 days as he considered it should have been 14 days. She noted that she would refer Mr Carr to Nacro (to support him in obtaining accommodation on release). She also emailed the healthcare team as Mr Carr said he should have been prescribed zopiclone and pregabalin.
41. A COM completed a key worker session with Mr Carr who said he had no immediate concerns. He said his general health was good but he had some foot pain. Mr Carr said that his family supported him and he spoke to them regularly.
42. On 12 February, a substance misuse recovery worker completed a substance misuse review for Mr Carr. He recorded a brief summary of Mr Carr's personal background and substance misuse history. He noted that Mr Carr's GP had prescribed him mirtazapine, pregabalin, diazepam and zopiclone. His diazepam detoxification was due to be completed on 15 February. Mr Carr said he was suffering emotionally because he had not yet had his community medication prescribed and he had been told that he would be reviewed in two weeks' time. The substance misuse worker checked Mr Carr's medical record and saw that a Safer Prisons Prescribing Review meeting had been scheduled for 13 February. He also noted that Mr Carr's community methadone dose was 60ml. He therefore contacted the healthcare nurse prescriber who agreed to raise Mr Carr's methadone dose from 30ml to 40ml. He discussed overdose awareness and gave Mr Carr lifestyle advice.

43. On 13 February, the nurse prescriber and a nurse discussed Mr Carr's medication with him. They noted Mr Carr was calm and pleasant. They noted that he was on a benzodiazepine dependence detoxification programme. Mr Carr said that he was not happy that his zopiclone had been stopped.
44. The two nurses attended a multidisciplinary Safer Prisons Prescribing Review meeting later that day. They recorded that Mr Carr's community GP had prescribed him pregabalin, diazepam and zopiclone. He had a burn on his left foot received over a year ago and as a result had had to have surgery in October 2019 to reshape his foot where a skin graft was completed to relieve pain he experienced and to assist his mobility. They noted that Mr Carr had not presented with any signs of pain in his foot and there was no clinical indication that he should be prescribed pregabalin. The plan was to continue Mr Carr's diazepam detoxification and that he would not be prescribed zopiclone. A letter of this decision was sent to Mr Carr and his community GP.
45. On 14 February, the substance misuse worker phoned the nurse prescriber after he spoke to Mr Carr. Mr Carr had asked for his methadone to be increased to 60ml to help stabilise him as he was no longer prescribed pregabalin. The nurse prescriber agreed to the increase, which started the following day.
46. On 18 February, Mr Carr phoned his mother. They spoke about his mother's health and Mr Carr told her that he would be released from prison in two weeks' time on 2 March.
47. On 19 February, Mr Carr discussed his methadone treatment with the substance misuse worker who offered him psychosocial support. Mr Carr asked for his methadone dose to be increased to relieve his pain. The substance misuse worker explained that methadone was not prescribed for pain relief but agreed to discuss it with the nurse prescriber. He spoke to the nurse prescriber who said that she would make an appointment for Mr Carr to see a GP about his pain management options.

Events on 20 February

48. The police investigation report says that Mr Carr phoned his mother from an illegal mobile phone between 11.30am and 12.00pm. Mr Carr was apparently in a good mood and had made plans for when he was released.
49. We were told that it is standard practice at Doncaster for prisoners to move to Houseblock 3C, the Early Days Centre, for an induction after approximately five days and once they have completed their detoxification on the stabilisation unit. A COM checked the board in the substance misuse office station (which notes which prisoners are ready to be moved from 3B). There were eight prisoners who were ready to be moved, one of whom was Mr Carr.
50. Body-worn camera (BWVC) footage shows that an officer and the COM arrived at Mr Carr's cell at 2.07pm and told him that he was to be moved to the Early Days Centre. The COM told Mr Carr that the healthcare team had said that Mr Carr no longer needed to be in the stabilisation unit. Mr Carr initially refused and said that he was still "rattling" (experiencing the physical effects of detoxing from drugs) and was only half way through his detoxification programme. He told staff

to check with his substance misuse worker. They told him that healthcare staff had considered him “fit” to be moved.

51. Mr Carr then agreed to be moved and asked staff if they would give him five minutes to pack his belongings. The COM told us that he then had to respond to a radio message so had to switch off his body-worn camera temporarily.
52. The COM said that when he returned, Mr Carr became threatening, aggressive and abusive towards the officer and him. They called for staff assistance. The COM said that it was necessary to use force on Mr Carr using control and restraint (C&R) techniques. The COM restarted his body-worn camera. Footage shows the officer and COM restraining Mr Carr. Another COM and two officers arrived in seconds and assisted. Mr Carr was handcuffed and helped to stand up. At 2.11pm, staff left Mr Carr’s cell and escorted him to the Early Days Centre. The COM said that Mr Carr continued to struggle, would not comply with instructions and remained abusive towards staff while they escorted him.
53. Body-worn camera footage shows that staff arrived with Mr Carr at his cell in the Early Days Centre at 2.14pm. He was to be a single occupant in a double cell. Staff placed Mr Carr in the prone (face down) position in the cell in a leg lock. A COM asked him whether he would comply while she removed the handcuffs. Mr Carr did not respond so an officer said he used his foot to help Mr Carr move his legs from beneath him. The officer said Mr Carr “called” out that he had hit his testicles with his foot. Afterwards, staff positioned themselves so that the COM could remove the handcuffs. The staff then left the cell one by one, and the cell door was locked at 2.17pm. Mr Carr was heard kicking and banging on the door after staff had left the cell.
54. The COM completed a prisoner injury report (Form F213) which was sent to the healthcare team and noted that there had been a “spontaneous C&R, no injuries visible when the door was secured”.
55. At 2.20pm, three minutes after he was moved to the cell, CCTV footage on the wing and the prison cell recording system show that Mr Carr pressed his emergency cell bell (as the cell bell light was flashing outside his cell door). Staff did not respond to Mr Carr’s cell bell.
56. At 2.24pm, a prisoner who lived on the Early Days Centre told the investigator that Mr Carr had shouted at him through his cell door observation panel. The prisoner was on the wing landing and went to speak to him. Mr Carr asked him for a phone and said he wanted to call his solicitor. He said that the staff had “done him in”. The prisoner said Mr Carr appeared to have blood on the right side of his face. He told Mr Carr to calm down and wait for an hour or so, but Mr Carr said that he was calm.
57. Another prisoner who lived in the Early Days Centre told the investigator that he had opened the observation panels on a number of cell doors to see the new prisoners on the wing. At about 3.05pm, he looked through Mr Carr’s observation panel and saw him hanging from the frame of the bunk bed. He said he shouted and screamed to alert staff that a prisoner was hanging. The COM, who was nearby, said she immediately radioed a medical emergency code blue (to indicate that a prisoner cannot breathe or has breathing difficulties). The

control room log shows the code blue was radioed at 3.04pm, and an emergency ambulance was called immediately.

58. Staff responded to the prisoner's shouts and arrived at Mr Carr's cell within 20 seconds. The COM and an officer unlocked Mr Carr's door and went in. The COM cut the ligature around Mr Carr's neck and he fell to the floor. She turned Mr Carr onto his side and checked him for signs of life but there were none. There was vomit coming from Mr Carr's nose and mouth. She began cardiopulmonary resuscitation (CPR) until the healthcare team arrived.
59. Two nurses and a healthcare assistant arrived at 3.07pm with a medical emergency bag. They asked staff to move Mr Carr onto the wing landing to create more space. Two COMs took turns in performing CPR and the nurses administered oxygen and used a defibrillator.
60. The control room log shows the ambulance and paramedic first responder arrived at the prison at 3.14pm and at Mr Carr's cell at 3.20pm. The paramedics took over Mr Carr's care but at 3.42pm, they pronounced that he had died.

Support for prisoners and staff

61. The Duty Director debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any issues and be supported. The staff care team and chaplaincy also offered support.
62. The prison posted notices informing staff and prisoners of Mr Carr'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 Carr's death.

Contact with Mr Carr's family

63. Mr Carr had identified his offender manager (probation officer) as his next of kin. However, prison records indicated that Mr Carr was in regular contact with his mother who lived in a care home. The Director contacted the care home manager and arranged to visit her that day. The care home arranged for Mr Carr's sister to be present as Mr Carr's mother was frail.
64. The Director and a prison family liaison officer (FLO) arrived at the care home at 5.30pm. They broke the news of Mr Carr's death to his mother and sister and offered their condolences.
65. In the days that followed, the FLO maintained contact with Mr Carr's family. Doncaster contributed to the costs of the funeral in line with national instructions.

Post-mortem report

66. A post-mortem examination concluded that Mr Carr died from hanging.
67. The report identified a considerable number of minor bruises and injuries to Mr Carr's body that the pathologist concluded had neither caused nor contributed to his death. He said that these injuries could all have been caused during the restraint. He also said that, from a purely pathological perspective, it was not possible to exclude the possibility that some of the injuries, such as a bruise to his chin and to his left outer eye, had been caused by a blow or blows.

68. A post-mortem toxicology examination found Mr Carr's prescribed medications (methadone, diazepam, mirtazapine and paracetamol) in his system, all within therapeutic levels. It also identified that Mr Carr had taken a synthetic cannabinoid (PS) shortly before his death. It was not possible to say if Mr Carr was experiencing any of the effects of PS (such as agitation, delirium or hallucinations) at the time of his death.

Findings

Management of risk of suicide and self-harm

69. Prison Service Instruction (PSI) 64/2011 on safer custody lists a number of risk factors and potential triggers for suicide and self-harm. Mr Carr had a number of these risks: he had been recalled to custody, he was in his early days in custody, and he had a history of substance misuse, attempted suicide and self-harm.
70. Despite these risk factors, Mr Carr had not been monitored under ACCT procedures since August 2019, six months before his death. During his two weeks at Doncaster in February 2020, Mr Carr did not express any thoughts of suicide or self-harm, and we are satisfied that his behaviour did not give staff any reasonable cause for concern or indicate that he was at risk of suicide or self-harm.

Use of force

71. Staff said that they used force because Mr Carr was aggressive and abusive towards them after he was told he was to be moved to another wing and that they used force because they feared for their safety.
72. Prison Service Order (PSO) 1600 sets out national instructions on the use of force and states it is justified, and therefore lawful, only if:
 - it is reasonable in the circumstances;
 - it is necessary;
 - no more force than is necessary is used; and
 - it is proportionate to the seriousness of the circumstances.
73. PSO 1600 says that staff should always try to prevent a conflict wherever possible and that the “best defensive weapon that staff have is their verbal and non-verbal communication skills”. However, the PSO also recognises that sometimes staff may “have no other option than to use force” and says that “when force has become necessary, C&R techniques are always the preferred option”.
74. After Mr Carr’s death, the Director of Doncaster suspended two members of staff who took part in the use of force. The prison’s internal investigation concluded that the staff involved in the restraint acted within the remit of the use of force guidance. The police also reviewed the incident and body-worn camera footage and decided not to pursue criminal proceedings.
75. If Mr Carr became aggressive and staff feared for their safety, as they say, the use of force would have been justified and, therefore, lawful. It is unfortunate that the COM’s BWVC was temporarily switched off during the time staff said Mr Carr became sufficiently aggressive to warrant being restrained and was not switched back on until after the use of force had begun. We cannot, therefore, say with certainty that the use of force was justified or that staff attempted to de-escalate the situation before using force.

76. The injuries Mr Carr received during the restraint could have been consistent with a lawful use of force in which only recognised C&R techniques were used, although the pathologist could not rule out the possibility that some of the injuries were caused by a blow or blows. Mr Carr shouted during the restraint that he had been kicked in the testicles, although we note that the post-mortem did not find any bruising or other injuries to Mr Carr's genitals.

Healthcare attendance at use of force incidents

77. PSO 1600 states that at the start of an unplanned use of force incident, staff should notify an "appropriately qualified healthcare professional (doctor or registered nurse)" whenever force is used to restrain a prisoner. It notes that healthcare staff should examine the prisoner as soon as possible and complete a Form F213 (on prisoner injuries) in all cases, even if the prisoner appears not to have sustained any injuries. The PSO requires that a prisoner sees an appropriately qualified healthcare professional within 24 hours of the incident.
78. Although a COM completed a Form F213 after the incident, there is no evidence in Mr Carr's medical records that healthcare staff received it until after he had died.
79. Records indicate that at least six members of staff attended the use of force incident with Mr Carr, and one of them should have radioed the healthcare team asking for a member of healthcare to come to examine Mr Carr as soon as he was located in his new cell. We make the following recommendation:

The Director should ensure that prison staff promptly radio the healthcare team to examine a prisoner after an unplanned use of force.

Response to Mr Carr's cell bell

80. The injuries Mr Carr received during the use of force were minor and did not contribute to his death in a physical sense. However, even when a use of force is entirely justified, and when only authorised C&R techniques are used, it may still be a painful and distressing experience for the prisoner. The use of force may, therefore, have exacerbated Mr Carr's distress about moving to a new unit. The PS he took before his death may also have affected his state of mind at the time he hanged himself.
81. Mr Carr pressed his emergency cell bell minutes after being moved to his new cell. He therefore had a reasonable expectation that a member of staff would come to his cell shortly to speak to him. We cannot therefore say whether Mr Carr intended therefore to take his life when he placed the ligature round his neck, or whether he expected that staff would find him – and save him - as soon as he hanged himself.
82. HMIP noted at their last inspection of Doncaster that officers took too long to respond to emergency cell call bells, with too many not answered within five minutes. The prison had introduced a range of measures to address these concerns, and were monitoring response times, but HMIP considered that this had so far had little effect.

83. Mr Carr pressed his cell bell at 2.20pm but staff had still not responded when he was found hanging by a prisoner over 45 minutes later. We recognise that staff may not always be able to respond to cell bells within five minutes at particularly busy times. However, this long delay is troubling and unacceptable. It would have been unacceptable in any circumstances but in this case, Mr Carr had just been restrained and staff could not be sure he was not injured or suffering some physical reaction. If staff had responded to Mr Carr's cell bell promptly, the outcome for Mr Carr may have been different and his life might have been saved. We make the following recommendation:

The Director should ensure that staff respond to all cell bells within five minutes, other than in exceptional circumstances.

The Director should commission an investigation into the delay in answering Mr Carr's cell bell, with a view to considering whether disciplinary proceedings should be initiated for any managers or officers.

Clinical care

84. The clinical reviewer considered that overall, the medical care that Mr Carr received was of an acceptable standard and was equivalent to that which he could have expected to receive in the community. She did, however, identify two concerns.

Mental health

85. When Mr Carr arrived at Doncaster, healthcare staff noted that Mr Carr was prescribed mirtazapine for depression and anxiety. However, he was not referred to the mental health team, and no one considered whether he needed mental health support. We therefore make the following recommendation:

The Head of Healthcare should ensure that when newly arrived prisoners are prescribed medication to support their mental health, reception healthcare staff refer them to the mental health team.

Safer medications reviews

86. When Mr Carr arrived at Doncaster, he was taking prescribed methadone and pregabalin. Healthcare staff did not establish the dosage of methadone that he was prescribed in the community during his first six days in prison. They prescribed him half the dose that he was used to taking, and this caused anxiety and withdrawal symptoms. Although the dosage information was easily accessible through his medical records, healthcare staff did not act promptly enough to lessen the impact on Mr Carr. We make the following recommendation:

The Head of Healthcare should ensure that the process for confirming community methadone dosages for newly arrived prisoners is effective, prompt and implemented.

87. Mr Carr was prescribed pregabalin, zopiclone and diazepam in combination in the community. When he arrived at Doncaster, healthcare staff identified that Mr Carr's medications needed to be reviewed to ensure that the drugs he was

prescribed were safe for him to take. Care UK's policy is that the use of gabapentinoids should be *"limited and if possible, avoided in prison"*. Healthcare staff therefore decided to discontinue Mr Carr's pregabalin and zopiclone prescriptions (both gabapentinoids) due to safety considerations.

88. The clinical reviewer notes that the Royal College of General Practitioners Safer Prescribing's guidance, published in 2019, states that if a prisoner uses Class A substances (such as heroin and cocaine) and has been prescribed gabapentinoids in the community, their dosage will be continued but then reduced gradually through multidisciplinary medication reviews, with a view to minimising withdrawal symptoms and eventually stopping the prescription.
89. Although healthcare staff at Doncaster tried to follow Care UK's policy, they did not consider Mr Carr's circumstances. He misused Class A substances and had been prescribed gabapentinoids in the community. Healthcare staff should therefore have prescribed the same dosage of gabapentinoids he received in the community and gradually reduced them, rather than stopping the prescription altogether.
90. Healthcare staff also considered that Mr Carr no longer needed pregabalin for pain because his foot surgery had taken place four months earlier. However, there is no evidence that they had fully explored his pain management during his stay at Doncaster. We make the following recommendations:

The Head of Healthcare should ensure that healthcare staff are aware of and implement the Royal College of General Practitioners' guidelines on safer prescribing in custody when discontinuing gabapentinoids.

The Head of Healthcare should ensure that healthcare staff refer patients to pain management clinics for effective treatments when necessary.

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