

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marian Pokuta, a prisoner at HMP/YOI Doncaster, on 26 August 2021

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

OGL

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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 HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Pokuta arrived at Doncaster on 23 August, after being charged with assault against his partner. It was his first time in prison. He was a foreign national and spoke little English. Violent offences against family members are recognised as potentially increasing risk factors for suicide and self-harm, as are first time in custody and detoxing from alcohol or drugs. These risk factors would have also been heightened due to the fact Mr Pokuta spoke and understood little English. Although Mr Pokuta denied any suicidal thoughts, we consider that staff should have opened suicide and self-harm monitoring (known as ACCT) while they observed how he settled in prison.

Staff used an interpreting service to communicate with him during his early days in custody. I am concerned, however, that these services were not used during his basic custody screening. I consider that this was a missed opportunity to obtain relevant information about Mr Pokuta's risk to himself and any concerns he might have had.

I am also concerned that an important letter about safeguarding restrictions was not handed to Mr Pokuta in person, nor was it translated for him so that he fully understood what was expected of him.

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

September 2023

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Summary

Events

1. On 23 August 2021, Mr Marian Pokuta was remanded to HMP Doncaster, charged with assaulting his partner. Mr Pokuta was a Slovakian national and spoke very little English. This was his first time in prison.
2. When he arrived at Doncaster, he had an initial reception screen and then further contact with staff the following day (24 August). Mr Pokuta said that he did not have any thoughts or intentions to harm himself.
3. Information that arrived with Mr Pokuta from court said that he was withdrawing from alcohol and had received medication to help manage his withdrawal symptoms. Mr Pokuta denied having any issues with alcohol. Despite this, healthcare staff decided to monitor him over the next few days for any further signs of withdrawal.
4. At 6.24am on 26 August, an Operational Support Officer (OSO) was carrying out a routine roll check and saw Mr Pokuta hanging from a radiator in his cell. The OSO immediately radioed a medical emergency code and tried to get a response from Mr Pokuta. She woke up Mr Pokuta's cell mate and asked him to try and get a response from Mr Pokuta.
5. Other staff responded quickly and entered the cell. An officer cut the ligature from around Mr Pokuta's neck, and they attempted resuscitation. Paramedics arrived at 6.38am and continued with resuscitation. At 6.56am, it was confirmed that Mr Pokuta had died.

Findings

6. Mr Pokuta had not been in prison before, he was charged with a violent offence against a close family member, and he did not speak English. Violent offences against family members are recognised as potentially increasing risk factors for suicide and self-harm, as are first time in custody and detoxing from alcohol or drugs. These risk factors would have also been heightened due to the fact Mr Pokuta spoke and understood little English. We consider that staff should have started ACCT procedures until they saw how Mr Pokuta settled in prison.
7. Mr Pokuta could not speak, read, or write in English. We are concerned that the Language Line interpreter service was not used during his Basic Custody Screening (BCS) part 1, as it should have been. We consider that this was a missed opportunity to assess his wellbeing and to identify any immediate risk concerns.
8. There is no evidence that Mr Pokuta had any further meaningful interactions after the 24 August. This was also a missed opportunity to assess his wellbeing.
9. Mr Pokuta was subject to certain safeguarding restrictions due to his offence against a family member. We are concerned that a letter from the Public Protection Unit setting out these restrictions was not translated for him so that he fully understood what was expected of him.

10. There was a three-minute delay in entering Mr Pokuta's cell when an OSO found him hanging. The OSO said that she decided not to enter the cell on her own because two prisoners occupied it, both of whom were unknown to her. We do not criticise her decision.

Recommendations

- The Director and Head of Healthcare should remind staff that they should take recognised risk factors into account when assessing a prisoner's risk of suicide and self-harm and should not rely solely on what the prisoner says or how he presents.
- The Director should remind all staff of the importance of using the translation services available to them, particularly where the prisoner is new to custody.
- The Director should share this report with the case support worker and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Director should ensure that staff have regular meaningful contact with every prisoner, particularly those new to custody which allows officers to get to know prisoners, identify their needs and make regular case history notes.
- The Director should review the way in which letters from the Public Protection Unit are issued to prisoners and ensure that:
 - letters are made available in the appropriate language;
 - a record is made to identify who issued the letter; and
 - a signature is obtained in all cases to indicate that the content of the letter has been fully explained and that the recipient has understood.

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. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Pokuta's prison and medical records. He interviewed three members of staff at Doncaster on 11 October 2021. All the interviews were conducted in person. He also obtained written statements from other staff involved in Mr Pokuta's care.
13. NHS England commissioned a clinical reviewer to review Mr Pokuta's clinical care at the prison. Due to the brief time that Mr Pokuta was in custody and his limited contact with healthcare services, the clinical reviewer completed a Level 1 (desktop) review of Mr Pokuta's medical care and did not conduct any interviews.
14. We informed HM Coroner for Yorkshire Southeast of the investigation. The coroner gave us Mr Pokuta's cause of death. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Pokuta's family to explain the investigation process and to ask if they had any matters, they wanted the investigation to consider. Mr Pokuta's family did not respond.
16. HMPPS responded to the initial report, highlighting some factual inaccuracies, and requesting clarity on a number of points made in our report. Factual inaccuracies have been amended and the report amended to add clarity where requested. HMPPS accepted all recommendations made.
17. A copy of our report was provided to Mr Pokuta's next of kin, we have received no response from them in regard to our findings.

Background Information

HMP Doncaster

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

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons carried out an unannounced inspection of Doncaster in September 2019. Inspectors were very concerned by the levels of self-harm and that there had been five self-inflicted deaths in the year leading up to the inspection. Inspectors noted that there had been another self-inflicted death shortly after their inspection.
20. Inspectors found that not all recommendations made by the Prisons and Probation Ombudsman in response to these earlier deaths were being regularly reviewed, and that action was not being taken to ensure that the recommendations were being embedded in operational practice.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In the most recent published report for the year to 30 September 2019, the Board expressed concerns about the high rate of self-harm and the self-inflicted deaths that had occurred during the reporting year. Early learning from these incidents indicated that not all Assessment Care in Custody Teamwork (ACCT) processes were being followed as expected. However, there was an ACCT improvement plan in place and the Board had seen positive work and progress, but this remained an area for the Board to continue to observe.

Previous deaths at HMP Doncaster

22. Mr Pokuta was the 24th prisoner to die at Doncaster since January 2019. Of the previous deaths, 10 were self-inflicted, 11 were from natural causes and two were drug related. There are no similarities between Mr Pokuta's death and the previous deaths.

Key Events

23. On 22 August 2021, Mr Marian Pokuta was arrested for assault and remained in police custody overnight. He was prescribed Librium (chlordiazepoxide), which is used to treat alcohol withdrawal. Mr Pokuta appeared at Sheffield Magistrates Court on 23 August and was remanded to HMP/YOI Doncaster at 6.30pm the same day.
24. Mr Pokuta was a Slovakian national and spoke little English. It was also recorded that he could not read or write in English.

23 August

25. At his reception health screen, a nurse used a Slovakian interpreter to complete the assessment. Mr Pokuta told the nurse that he had no immediate health concerns other than high blood pressure. She noted that risk information that had arrived with Mr Pokuta from court said that he was a 'problem drinker' and had been prescribed medication while in police custody to treat withdrawal symptoms. She recorded that Mr Pokuta had bloodshot eyes and a reddish complexion, associated with alcohol consumption. Mr Pokuta said that he did not have an alcohol problem. Mr Pokuta also said that he had not attempted to take his own life or self-harmed in the past and had no thoughts of self-harm at that time.
26. The nurse recorded that Mr Pokuta was alcohol dependant and completed an alcohol screening tool with him. Mr Pokuta said that he only drank two-three times per week and consumed around seven to nine units each time. Mr Pokuta declined any interventions to assist with alcohol withdrawal symptoms. Regardless of this, she placed Mr Pokuta on the night unlock list for nursing staff to monitor his observations, blood pressure and temperature during the night, and a daily review of his alcohol withdrawal symptoms.
27. During his other reception interviews on arrival at Doncaster, staff used interpreters to communicate with Mr Pokuta. Mr Pokuta named his son as his next of kin. He was unable to remember contact numbers for his son or other family members and did not make a call to his family on reception. Mr Pokuta told staff, via the interpreter, that he had no history of self-harm and that he had no current thoughts of suicide or self-harm. The only alert risk recorded in his record was that he was a perpetrator of domestic violence. He said that he felt 'okay' about being in custody and that he would receive support from his family.
28. Staff completed a cell sharing risk assessment. It identified no known issues that would prevent Mr Pokuta from sharing a cell. He was located on Bravo wing, Houseblock (HB) 3, which is a designated detoxification wing, and was allocated a shared cell.

24 August

29. On the morning of 24 August, a Prison Custody Officer (PCO) saw Mr Pokuta to complete an equality and safeguarding interview and a duty keyworker assessment with the aid of an interpreter. The PCO recorded that he had explained the role of the keyworker to Mr Pokuta and how everything that they discussed would be

recorded on Mr Pokuta's prison record. He told Mr Pokuta that he would be allocated a primary keyworker once his induction had been completed, and that they would engage with him weekly.

30. The PCO recorded that Mr Pokuta said he felt safe and had no immediate concerns. Mr Pokuta said that on his release from prison, he planned to live with his daughter and would have her support while in prison custody. As part of the equalities and safeguarding assessment, the PCO recorded that Mr Pokuta had no social care needs but referred him to education due to his limited ability to speak English.
31. The PCO told the investigator that although Mr Pokuta was able to grasp some English, the interpreter was used to ensure that information could be explained fully to him. He said that when he asked the interpreter to ask Mr Pokuta whether he had any thoughts of harming himself, even before he had finished asking the question, Mr Pokuta began shaking his head, indicating that he understood the question and had no thoughts of suicide or self-harm.
32. The PCO said that he has been working at Doncaster for 27 years, and having interviewed numerous prisoners, he said that he is aware that body language rather than just what someone says can be an indicator to how they are feeling. He said that he had no concerns either from what Mr Pokuta said or in the way he interacted that suggested he was a risk to himself.
33. Later the same day, a case support worker in the prison's Offender Management Unit (OMU) saw Mr Pokuta to complete part 1 of his Basic Custody Screening (BSC.) The purpose of the BCS assessment is to identify any immediate needs that require attention. The BCS part 1 is completed within 72 hours of a prisoner's arrival and is conducted by OMU staff. This assessment looks at areas such as accommodation, education, training employment, substance misuse/healthcare issues, relationships, and finances. During the assessment prisoners are also asked questions around current/previous suicide self-harm attempts, experiences of abuse or being in care etc. Anything flagged within this assessment, unless it is something that requires immediate attention, such as mentioning thoughts of suicide or self-harm, will be picked up at the part 2 of this assessment, completed within 5 days of arrival. The case support worker said that when he completed the screening with Mr Pokuta, there was nothing that concerned him about the way in which Mr Pokuta presented. Although the screening was an in-depth assessment, he did not use the interpreting service. He told the investigator that in his opinion, Mr Pokuta had a 'reasonable grasp' of English.
34. The case support worker said that he asked Mr Pokuta whether he had any drug or alcohol issues. And, although he could not definitely recall, he said that Mr Pokuta must have answered no. He said that he also asked Mr Pokuta about any thoughts that he might have had about harming himself. He said that he always asks prisoners directly 'do you want to hurt yourself?', 'do you want to kill yourself?' and he was satisfied that Mr Pokuta was 'ok'. He said that if he had not been happy or had any concerns about Mr Pokuta, he would have placed him on suicide and self-harm monitoring (known as ACCT).
35. The case support worker recorded that Mr Pokuta said that he intended to live with his son on his release. Mr Pokuta's son lives at the same address as Mr Pokuta's

wife, who was the victim of his offence, and therefore he would have been unable to return to that address. When the investigator asked him whether he had explained this to Mr Pokuta, he said that he thought that Mr Pokuta would have already known this, and that although he could not be certain, he thought he had mentioned this to Mr Pokuta. There is no evidence that he did.

36. Also, that day, a PCO carried out a safer custody evaluation, and a nurse carried out a secondary health screen. Both used Language Line (a telephone interpreting service) when they spoke to Mr Pokuta to conduct their assessments.
37. The nurse recorded an in-depth medical history and checked Mr Pokuta's physical observations. The PCO recorded that Mr Pokuta said that it is was his first time in prison, he had never self-harmed, and had no thoughts of suicide. The PCO also recorded that Mr Pokuta said that he had no concerns about his mental health and was prescribed medication for high blood pressure. She recorded that Mr Pokuta would like to do education while in prison and would like support with speaking English. She also recorded that Mr Pokuta would be keeping in contact with his daughter while in custody.
38. A chaplain made an entry on Mr Pokuta's record that he visited the cell on 24 August and provided Mr Pokuta with a diary but made no mention of Mr Pokuta's presentation or conversation. There was also a telephone call made to Mr Pokuta at some point during the afternoon by an officer who completed the second part of the basic custody screening with him via a translator. After the 24 August, there are no further recorded contacts with Mr Pokuta in his NOMIS record (electronic prison record). There is no evidence that staff had any further conversations with him, outside of the medical observations that continued.
39. A letter from the prison's Public Protection Unit (PPU) dated 24 August, was passed to Mr Pokuta, although we have not been able to establish exactly when this happened. The investigator was told that it had been posted under Mr Pokuta's cell door rather than passed to him in person. The letter, written in English, said that due to the offence Mr Pokuta had been charged with, he now came under the monitoring of the PPU, and any telephone calls and letters that he sent would be subject to monitoring. It also said that prisoners subject to public protection monitoring were limited to four hours use of the telephone per week.

26 August

40. On the night of 25/26 August, a Healthcare Assistant (HCA) was asked to assist nursing staff with clinical observations of prisoners because there had been many new reception prisoners that evening.
41. CCTV shows that the HCA saw Mr Pokuta at 12.10am on 26 August. She was accompanied by two PCOs. She said that when she entered Mr Pokuta's cell she completed his observations, which were normal. She said that there was a slight language barrier, but Mr Pokuta was able to communicate to her that he had a headache. She gave him two paracetamol and told him that a nurse would see him again later in the day as a matter of routine. She said that Mr Pokuta raised no other concerns and that she had no concerns about him at that time. The cell was then locked.

42. At around 6.00am, an OSO began conducting the morning welfare check. CCTV shows she reached the cell occupied by Mr Pokuta and his cell mate at 6.24am. When she looked into the cell, she could see Mr Pokuta's cell mate was in bed asleep, but she could not see Mr Pokuta in his bed.
43. The cell occupied by Mr Pokuta has two entrances. One side of the cell is the area where prisoners sleep, and an opening leads to the other half of the cell, where there is a small table, lockers, and a toilet area. There is also a separate door to enter the cell from this side.
44. When the OSO could not see Mr Pokuta, she went to the other door to see if he was in that side of the cell. When she looked into the cell, she immediately saw Mr Pokuta slumped on the floor at the back of the cell with what appeared to be a ligature around his neck. She immediately radioed a medical emergency code blue (indicating that a prisoner is unconscious or is having breathing difficulties). The radio call was timed at 6.25am.
45. The OSO began banging on the door to gain a response from Mr Pokuta. She then went back to the other door and shouted to Mr Pokuta's cell mate, who she managed to wake up. She told Mr Pokuta's cell mate that he needed to try and loosen the ligature from around Mr Pokuta's neck, which he did. She said she did not immediately enter the cell, because it was a double cell, occupied by two prisoners she did not know, and she was a female working alone.
46. CCTV shows other staff arrived onto the wing at 6.27am, and immediately entered Mr Pokuta's cell. A Custodial Operations Manager (COM) heard the 'code blue' call over his radio and as he left the office, he turned on his body-worn video camera (BWVC). He was accompanied by a PCO.
47. The COM said that the PCO entered the cell first and, using his cut down tool, released the ligature from around Mr Pokuta's neck. They moved Mr Pokuta out onto the landing outside the cell to allow them more room to administer cardiopulmonary resuscitation (CPR.) The COM said that healthcare staff arrived around a minute later. They continued with CPR while nursing staff set up their equipment and attached a defibrillator to Mr Pokuta. CCTV shows nursing staff arriving with medical equipment at 6.28am. CPR continued, with the defibrillator instructing CPR to continue, as no heart rhythm was detected.
48. Staff moved Mr Pokuta's cell mate in with other prisoners to offer him support, as he was very distressed.
49. A first responder paramedic arrived at 6.38am, and CPR continued for a further 18 minutes. Mr Pokuta did not respond to treatment and, at 6.56am, it was confirmed that Mr Pokuta had died.
50. A letter was found in Mr Pokuta's cell written in Slovakian. The letter is not dated, and it is not clear who it is addressed to, but it may be the letter to his son that Mr Pokuta told staff he had been writing on 24 August. In the letter Mr Pokuta expressed his love and asked his family to send items into him in prison, such as clothing and money to purchase vapes via the prison shop.

Contact with Mr Pokuta's family.

51. In line with Government advice on COVID-19 working practices, one of Doncaster's family liaison officers (FLOs) made several telephone calls to Mr Pokuta's son after confirming a contact number with West Yorkshire police. Mr Pokuta's son answered the phone, but quickly hung up on the FLO. The FLO tried to contact him again on a number of occasions and left voicemail messages with his contact details. The FLO contacted Mr Pokuta's wife on 31 August. The FLO explained the coroner's process and information about the process that would follow and offering support.
52. Doncaster contributed to the cost of Mr Pokuta's funeral in line with national instructions.

Support for prisoners and staff

53. The Duty Director debriefed the staff who responded when Mr Pokuta was discovered. The staff care team also offered support.
54. The prison posted notices informing other prisoners of Mr Pokuta's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Pokuta's death. Staff also ensured that Mr Pokuta's cell mate was supported by the chaplaincy and the safer custody team.

Post-mortem report

55. The pathologist gave Mr Pokuta's cause of death as suspension by ligature (hanging).
56. Toxicological tests found no illicit substances in Mr Pokuta's blood and urine.

Findings

Assessment of Mr Pokuta's risk of suicide or self-harm

57. Mr Pokuta was remanded to prison charged with a violent offence against his wife. This was also his first time in prison, and he spoke very little English. Violent offences against family members are recognised as potentially increasing risk factors for suicide and self-harm, as are first time in custody and detoxing from alcohol or drugs. These risk factors would have also been heightened by the fact Mr Pokuta spoke and understood little English.
58. There is evidence that staff considered whether he should have been placed on suicide and self-harm monitoring procedures (known as ACCT) when he first arrived at Doncaster.
59. Both prison and healthcare staff asked Mr Pokuta about his thoughts of self-harm via interpreters, but he denied any thoughts of suicide and self-harm. We have found repeatedly in our investigations that prisoners do not necessarily disclose suicidal thoughts to staff, and we have said repeatedly that staff should not therefore assess the risk of suicide and self-harm solely on the basis of what the prisoner says or how he presents but should also consider his risk factors.
60. We recognise that this is a matter of judgement but, as Mr Pokuta's alleged offence was such a clear risk factor, we think staff should have erred on the side of caution and placed him on ACCT procedures until they could see how he settled.
61. We recommend:

The Director and Head of Healthcare should remind staff that they should take recognised risk factors into account when assessing a prisoner's risk of suicide and self-harm and should not rely solely on what the prisoner says or how he presents.

Use of interpreting services

62. Prison Service Instruction (PSI) 07/2015, *Early days in custody*, says:

'Governors must ensure that all information is made available in an accessible format so that all prisoners understand the range of services that are available to them.'
63. The PSI also says:

'All new prisoners must be provided with a pack or booklet giving essential information about what will happen during their first few days in the establishment, and including information about the Samaritans, Listeners, Insiders, and any other peer supporter initiatives. This pack or booklet will contain a brief description of what the prisoner can expect from their Offender Supervisor and clarify that they will be allocated an Offender Supervisor during their period in custody who will work closely with their Offender Manager in the community. As far as possible, this information should be available in a variety

of formats (e.g., written, video, audio) and a range of languages reflecting the make-up of the local prison population.'

64. Staff who had contact with Mr Pokuta on 23 and 24 August used Language Line and a Slovakian interpreter to communicate with him and to complete each process. They made sure that Mr Pokuta was made aware of and understood the process and the questions they had asked him. This was good practice.
65. However, we are concerned that the case support worker did not use the Language Line service or a Slovakian interpreter for Mr Pokuta's Basic Custody Screening. He told the investigator that he did not use the services of an interpreter because he felt that he was able to communicate with Mr Pokuta through hand gestures.
66. The interpretation service is available to all staff to ensure that valuable information is communicated both ways and that information relevant to risk is not lost in translation. We consider that this was a missed opportunity to obtain information about Mr Pokuta's wellbeing and to identify any immediate risk concerns.
67. We recommend:

The Director should remind all staff of the importance of using the translation services available to them, particularly where the prisoner is new to custody.

The Director should share this report with the case support worker and arrange for a senior manager to discuss the Ombudsman's findings with him.

Induction

68. Staff spoke to Mr Pokuta when he first arrived at Doncaster via an interpreter and several staff saw him on 24 August, again with the aid of an interpreter. After this date there are no further documented contacts with Mr Pokuta.
69. This was Mr Pokuta's first time in custody, and we consider that this was another missed opportunity to identify any issues or concerns he might have had. Mr Pokuta's mood appears to have changed between writing the letter asking his family to send him money and clothes in prison (on 24 August) and deciding to hang himself on 26 August. If staff had been speaking to him, it is possible that they might have noticed this.
70. We make the following recommendation:
 - **The Director should ensure that staff have regular meaningful contact with every prisoner, particularly those new to custody which allows officers to get to know prisoners, identify their needs and make regular case history notes.**

Letter from the Public Protection Unit

71. Mr Pokuta received a letter from the prison's Public Protection Unit on or shortly after 24 August. The investigation was unable to establish when the letter was passed to him as it was posted under his cell door. The letter was written in English (which Mr Pokuta struggled to read). The letter set out the restrictions that he would be subject to due to the nature of his offence. There is no signature to indicate who

issued the letter and there is no signature from Mr Pokuta to indicate that he had understood the information contained within the letter or what was expected of him.

72. This was valuable information for Mr Pokuta and might be expected to stir up emotions about his relationship with his wife. We consider that information of this nature should have been handed to Mr Pokuta in person, either in a language he understood or explained to him via an interpreter. Staff should also have obtained a signature from him to confirm that he understood the contents of the letter.
73. We cannot say whether Mr Pokuta understood the contents of the letter, or if the letter had any influence on his decision to take his life.
74. We make the following recommendation:

The Director should review the way in which letters from the Public Protection Unit are issued to prisoners and ensure that;

- **letters are made available in the appropriate language;**
- **a record is made to identify who has issued the letter, and;**
- **a signature is obtained in all cases to indicate that the content of the letter has been fully explained and that the recipient has understood.**

Emergency response

75. At night, officers and OSOs have a key in a sealed pouch to enable them to enter cells in an emergency. PSI 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.
76. When the OSO found Mr Pokuta hanging there was a three-minute delay before more staff arrived and entered the cell. She assessed the situation and decided not to enter the cell because two prisoners occupied it, both of whom were unknown to her. We do not criticise her for not entering the cell on her own while awaiting support from her colleagues, which arrived promptly.
77. We make no recommendation on this issue.

Clinical care

78. The clinical reviewer concluded that the care Mr Pokuta received at Doncaster was equivalent to that which he could have expected to receive in the community. Healthcare staff continually monitored Mr Pokuta and tried to engage him in addressing his alcohol misuse despite his continual denial that he had alcohol misuse issues.
79. We make no recommendations.

**Prisons &
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