Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ben Barton, a prisoner at HMP Doncaster, on 13 January 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T l 020 7633 4100

OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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

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

Mr Ben Barton died in hospital on 13 January 2023. He died from hypoxic brain injury (lack of oxygen to the brain) after being found hanging in his cell at HMP Doncaster on 10 January. Mr Barton was 33 years old. I offer my condolences to his family and friends. Mr Barton was the seventh prisoner to take his life at Doncaster in three years.

Mr Barton was recalled to prison on 6 December 2022, so had been at Doncaster for just over one month. I am satisfied that reception staff considered his risk factors for suicide and self-harm when he arrived and that their decision not to start suicide and self-harm prevention procedures was a reasonable one. Mr Barton gave no indication that he was at risk of suicide or self-harm during the rest of his time at Doncaster.

After Mr Barton's death, information came to light that Mr Barton owed money for drugs. However, prison staff were unaware of this at the time.

HM Inspectorate of Prisons noted during their last inspection of Doncaster in 2022, that fewer prisoners than before said it was easy to obtain drugs. However, drugs clearly remain an issue at Doncaster, certainly on Mr Barton's wing. I suggest that the Director commissions a Drug Diagnostic Visit to get a greater understanding of the problem and how best to tackle it.

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 **December 2023**

Contents

Summary

Events

1. On 6 December 2022, Mr Ben Barton was recalled to prison, charged with further offences of assault, threats to kill and criminal damage. He was sent to HMP Doncaster.

2. Mr Barton had attempted suicide by taking an overdose in 2019, during a previous sentence at Doncaster. However, he told reception staff when he arrived on 6 December 2022, that he had no current thoughts of suicide or self-harm. Staff considered that suicide and self-harm prevention procedures were not necessary.

3. On 14 December, an officer saw Mr Barton for a key work session. Mr Barton told the officer that his physical health was good, but he was struggling with his mental health. The officer told Mr Barton to refer himself to the mental health team. There is no evidence that Mr Barton did so.

4. On 5 January 2023, another officer saw Mr Barton for a key work session. Mr Barton told the officer that he felt safe on the wing, his general health was good, and he had no issues with debt or housing. He said he had support from his family.

5. On 8 January, Mr Barton spent most of the money in his account on items from the prison shop, including over £15 on eight tins of mackerel. The next day, Mr Barton moved into a new cell, with a new cellmate. He called his family on several occasions asking for money to be sent into him. His sister told him she would send him money the next day.

6. At 10.09am, on 10 January, an officer unlocked Mr Barton's cell so he and his cellmate could go out for exercise. Mr Barton said he did not want to go but his cellmate left the cell. The officer locked Mr Barton back in. At 10.46am, another officer arrived to take Mr Barton's cellmate to a healthcare appointment. When he opened the cell door, he saw Mr Barton hanging from the bedframe. The officer called a medical emergency code. Other staff arrived, removed the ligature from Mr Barton's neck and started cardiopulmonary resuscitation (CPR).

7. Ambulance paramedics arrived at 10.59am and established that Mr Barton had a heartbeat. They took him to hospital, where he was sedated and put on a ventilator in intensive care.

8. On the morning of 13 January, hospital staff assessed that Mr Barton was brain dead. His life support was switched off later that day and he died at 4.30pm.

9. After Mr Barton was found hanging, prisoners reported that he had drug debts.

Findings

10. We are satisfied that reception staff at Doncaster considered Mr Barton's risk factors for suicide and self-harm, and that their decision not to start suicide and self-harm prevention procedures when he was recalled was a reasonable one. We are also satisfied that Mr Barton subsequently gave no indication that he was at risk of suicide during his month at Doncaster.

11. Although information subsequently came to light that Mr Barton had drug debts, staff would not have been aware of this prior to Mr Barton being found hanging. We note that HM Inspectorate of Prisons reported that the availability of drugs seemed to have reduced at Doncaster but there still appears to be a drug problem, certainly on the wing Mr Barton was on. We recommend a Drug Diagnostic Visit, which would involve a peer review of Doncaster's drug strategy to identify the main weaknesses and how to tackle them.

12. The clinical reviewer found that the standard of care that Mr Barton received at Doncaster was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Director should commission a Drug Diagnostic Visit to identify potential weaknesses in Doncaster's drug strategy and how best to address them.

The Investigation Process

13. HMPPS notified us of Mr Barton's death on 13 January 2023.

14. The investigator issued notices to staff and prisoners at HMP/YOI Doncaster informing them of the investigation and asking anyone with relevant information to contact him. One prisoner contacted the investigator as a result and was subsequentially interviewed.

15. The investigator visited Doncaster on 21 April 2023. He obtained copies of relevant extracts from Mr Barton's prison and medical records.

16. The investigator interviewed one member of staff, and one prisoner at Doncaster on 21 April. The remaining three interviews took place over video call on 16 March, 6 April and 3 May 2023.

17. NHS England commissioned an independent clinical reviewer to review Mr Barton's clinical care at the prison. The investigator and clinical reviewer conducted two joint interviews with healthcare staff on 16 March and 6 April.

18. We informed HM Coroner for South Yorkshire East of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's family liaison officer contacted Mr Barton's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Barton's mother said she had no specific questions but wanted to know what had happened to her son.

Background Information

HMP/YOI Doncaster

20. HMP/YOI Doncaster is a local prison, operated by Serco. It holds up to 1,145 remanded or convicted male prisoners. Practice Plus Group provides healthcare services.

HM Inspectorate of Prisons

21. HM Inspectorate of Prisons carried out an inspection of Doncaster in March 2022. There had been eight self-inflicted deaths in the year, and the level of self-harm was higher than similar prisons. Inspectors found that security arrangements were generally proportionate, the flow of intelligence was good, and fewer prisoners than at the time of their last inspection said that it was easy to get illicit drugs and alcohol.

Independent Monitoring Board

22. 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 2020, the Board expressed concerns about self-harm and the self-inflicted deaths that had occurred during the reporting year. They highlighted that there was drug use in the prison, which created acute and longer-term health issues and, at its most severe, could be an immediate risk to life. The Board said that both routine and targeted security measures were in place at the prison, and they were supportive of the prison's drug strategy.

Previous deaths at HMP Doncaster

23. Mr Barton was the 26th prisoner at HMP Doncaster to die since January 2020. Of the previous deaths, six were self-inflicted, four were drug-related and 15 were from natural causes.

24. In previous investigations, we identified issues with drug taking and bullying at Doncaster. We recommended that managers should encourage staff to identify and record signs of possible drug taking and bullying. We were told that staff would be reminded of the behaviours to look for.

Key Events

25. On 6 December 2022, Mr Ben Barton was recalled to prison, after being charged with assault, threats to kill and criminal damage. He was sent to HMP Doncaster.

26. A nurse completed Mr Barton's reception health screen. She noted that Mr Barton engaged well and made good eye contact. Mr Barton told her that he had previously attempted suicide by taking an overdose of paracetamol but had no current thoughts of suicide or self-harm. (Mr Barton's suicide attempt was at Doncaster in September 2019.)

27. The nurse noted that Mr Barton had a history of depression, and of cannabis and cocaine use. Mr Barton had epilepsy but was not on medication for it. He told her that his last seizure was two days before, and his seizures tended to be worse when he stopped drinking. Mr Barton told her that he drank as much alcohol in a day as he could get hold of, and he would start drinking as soon as he woke up. She referred Mr Barton to Doncaster's alcohol intervention service.

28. A GP at Doncaster saw Mr Barton and noted that he was suffering from alcohol withdrawal. The GP prescribed alcohol detoxification medication. Substance misuse service (SMS) staff monitored him for withdrawal symptoms over the next five days.

29. On 7 December, the GP spoke with a neurologist at Royal Hallamshire Hospital in Sheffield, and a plan was made for Mr Barton to start on an increasing dose of anti-epilepsy medication.

30. On 14 December, a Prison Custody Officer (PCO) saw Mr Barton for a key work session. Mr Barton told him that his physical health was good, but he was struggling with his mental health. The PCO told Mr Barton to refer himself to the mental health team using the wing digital kiosk. There is no evidence that Mr Barton did so.

31. On 20 December, an SMS worker tried to carry out an assessment with Mr Barton, but he declined to engage and said he did not need support with his alcohol issues.

32. On 21 December, a PCO saw Mr Barton for a key work session. Mr Barton told her that he was safe and well and had no thoughts of self-harm.

33. On 22 December, a PCO noted that Mr Barton refused to attend a video conference call with his solicitor. There was no recorded reason for his refusal.

34. On 5 January 2023, a PCO saw Mr Barton for a key work session. Mr Barton told her he felt safe, his general health was good, and he had no issues with debt or housing. He said he had family support and would speak with them on the phone but did not like them to visit him in prison.

35. Later that day, a PCO noted that Mr Barton attended Sheffield Crown Court by video link. His case was adjourned until 19 January. Mr Barton was offered support after the hearing but declined.

36. On 8 January, Mr Barton ordered items from the prison shop. He spent £15.12 on eight tins of mackerel, leaving him with only £2.19 in his prison account.

37. On the morning of 9 January, Mr Barton was moved into a new cell, with a new cellmate. Later that day, a PCO noted that Mr Barton again refused to attend a video link conference with his solicitor. The reason for his refusal was not recorded.

38. The same day, Mr Barton bought £1 of phone credit. After receiving his unemployment pay and a deduction for TV rental, he was left with £1.62 in his prison account.

39. All prisoner calls are recorded except those that are legally privileged. Prison staff do not routinely listen to the calls. The recordings of Mr Barton's calls were provided to the investigator who listened to the calls made in the lead up to his death.

40. At 3.36pm, Mr Barton telephoned his brother asking if his sister had sent him money. His brother did not know but said he would find out. Mr Barton said he would call him back.

41. At 5.59pm, Mr Barton called his mother, who told him that his sister had been having money issues but said that a parcel was being sent to him. Mr Barton told his mother that he would call his sister later to find out what was going on.

42. At 6.37pm, Mr Barton called his brother and managed to speak with his sister. She told Mr Barton that "I can send it [the money] to you or to [Mr Barton's other sister] tomorrow". Mr Barton started to sound agitated and impatient and asked her to send the money to him.

Events of 10 January

43. Shortly before 8.15am on 10 January, an officer unlocked Mr Barton's cell. Mr Barton left his cell to empty his bins. Mr Barton also used the wing kiosk to add an additional 50p credit to his PIN phone. (From the kiosk, Mr Barton would have been able to check whether his sister had sent money to his account – no money had been received.)

44. At 8.17am, Mr Barton made two telephone calls to his brother, but his brother did not answer.

45. While out on the landing, Mr Barton spoke to a PCO about his recent cell move, his court hearing being adjourned, and about getting a job on the wing. At 8.21am, the PCO locked Mr Barton and his cellmate in their cell.

46. At 10.09am, the PCO unlocked Mr Barton's cell to offer Mr Barton and his cellmate time out to exercise. Mr Barton did not want to go but his cellmate left the cell and made his way to the exercise yard. The PCO then locked Mr Barton in his cell.

47. At 10.46am, a PCO went to Mr Barton's cell to take his cellmate to the healthcare unit (although his cellmate was still on the exercise yard). When the PCO opened the door, he saw that Mr Barton had his back towards the door, and it looked like he was holding himself up on the side of the bed. After getting no response from Mr Barton, he entered the cell, and could see a ligature around Mr Barton's neck, which had been concealed by a bed sheet.

48. The PCO radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). The control room called for an ambulance.

49. A colleague responded and helped the PCO to cut the ligature around Mr Barton's neck. The colleague thought that Mr Barton was dead as he was blue in the face, was not breathing and had blood coming from his nose. He said he checked for a pulse and when he could not find one, he started cardiopulmonary resuscitation (CPR).

50. A Custodial Operations Manager (COM) arrived, and staff decided to move Mr Barton out of the cell so that they had more room to work. The COM took over CPR. Healthcare staff arrived and assisted with CPR, with the COM continuing with chest compressions.

51. At 10.59am, ambulance paramedics arrived and established that Mr Barton had a heartbeat. They took Mr Barton to Doncaster Royal Infirmary where he was sedated and placed on a ventilator.

52. On the morning of 13 January, hospital staff confirmed that Mr Barton was brain dead. That afternoon, hospital staff withdrew life support and at 4.53pm, Mr Barton died.

Contact with Mr Barton's family

53. On 10 January, the prison appointed a family liaison officer (FLO). That afternoon, she contacted Mr Barton's mother by telephone and told her that Mr Barton had been taken to hospital.

54. On 13 January, after the hospital confirmed that Mr Barton was brain dead, the FLO was instructed to inform Mr Barton's family that he had died. She called the family and told them Mr Barton had died. This was an error as Mr Barton remained on life support at that time and the hospital had asked his family to make their way to the hospital. Mr Barton's family were understandably upset. The prison sent a formal letter of apology.

55. The FLO kept in contact with Mr Barton's family over the following days, offering support and advice.

56. The prison contributed to the costs of Mr Barton's funeral in line with national policy.

Support for prisoners and staff

57. After Mr Barton's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

58. The prison posted notices informing other prisoners of Mr Barton'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 Barton's death.

Information received after Mr Barton's death

59. After Mr Barton was found hanging, staff submitted an intelligence report which suggested that Mr Barton had been making a noose for days. Mr Barton's cellmate told the investigator at interview that he had seen Mr Barton ripping up a bedsheet that morning but when he had asked what he was doing, Mr Barton told him it was to secure his pillow. He had accepted this at the time.

60. Mr Barton's cellmate told us that Mr Barton had a Subutex (an opioid) addiction, which had resulted in him getting into debt. He also owed vapes to other prisoners. He said that Mr Barton always paid his debts as he did not want to get a bad name.

61. Mr Barton's cellmate told the investigator that he did not think Mr Barton was being bullied, but that Mr Barton did not have many possessions, and to support his Subutex habit he would order a lot of goods from the prison shop, and then use all these goods to pay off his debt.

62. Mr Barton's cellmate said that Mr Barton owed 18 cans of mackerel to one prisoner and four packs of vapes to another.

63. On 8 January, Mr Barton ordered eight cans of mackerel from the prison shop, leaving him with only a couple of pounds left in his prison account. To settle his debt Mr Barton still needed to buy a further 10 cans of mackerel and four packs of vapes.

Post-mortem report

64. The post-mortem report concluded that Mr Barton died from hypoxic brain injury caused by hanging.

65. Toxicology results found no evidence of illicit drugs or alcohol in Mr Barton's system.

Findings

Assessment of Mr Barton's risk of suicide and self-harm

66. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm. It sets out the risk factors and triggers that could indicate increased risk.

67. When Mr Barton arrived at Doncaster in December 2022, he had several risk factors for suicide. He had a history of attempted suicide (overdose in 2019), a history of depression, relationship instability (alleged infidelity of his ex-partner and was not allowed to contact her) and his alleged offences were against his ex-partner. However, reception staff considered these factors, and we find that their assessment that he was not at increased risk at that time was a reasonable one.

68. Mr Barton subsequently gave no indication that he was at risk of suicide or self-harm. The only occasion Mr Barton presented to staff with any difficulties was on 14 December, when he told an officer that he was struggling with his mental health. The officer appropriately told Mr Barton to make a self-referral to the mental health team but there is no evidence he did so.

69. We are satisfied that there was no reason to put Mr Barton on suicide prevention monitoring and that staff could not have foreseen Mr Barton's death.

Drug debts

70. There is no evidence that staff at Doncaster were aware of Mr Barton's drug debts prior to finding him hanging. After the incident, information came to light that Mr Barton owed money for drugs and about prisoners on his wing who were engaged in drug dealing and collecting debts.

71. The Intelligence Manager at Doncaster told us that in terms of tackling drug supply and the associated debt issues, staff resource had been an issue in the past, but this was being looked at by management to increase the size of the security team.

72. We understand that Doncaster has not yet received a Drug Diagnostic Visit. Such a visit would assist Doncaster in identifying any weaknesses in its drug strategy and help them to use their staffing resource more effectively to tackle drug supply and demand. We recommend:

    The Director should commission a Drug Diagnostic Visit to identify potential weaknesses in Doncaster's drug strategy and how best to address them.

Clinical care

73. The clinical reviewer concluded that the care Mr Barton received at Doncaster was equivalent to that which he could have expected to receive in the community. The clinical reviewer was satisfied that Mr Barton received appropriate support with his substance misuse issues. She noted that he was not under the care of the mental health team during his time at Doncaster.

Inquest

74. The inquest, held on 30 April 2024, concluded that Mr Barton died by suicide.

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