

**Investigation into the circumstances surrounding the  
death of a man at HMP Dovegate in June 2008**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**February 2009**

The man was found hanging in his cell at HMP Dovegate in June 2008. He had used a torn bed sheet as a ligature attached to an unauthorised makeshift block he had glued to his cell wall. Staff discovered him when they began unlocking cells in the morning. The officers on the landing, and another prisoner, responded quickly but they could do nothing to save his life. My colleagues and I would like to extend our condolences to the man's family and all those affected by his loss.

The investigation was carried out on my behalf by an assistant ombudsman and two of my investigators. A review of the man's clinical care was carried out by a team, on behalf of the local Primary Care Trust (PCT). I am grateful to the clinical review lead for her assistance.

The man was in a Therapeutic Community at Dovegate where there is an ethos of group support and of talking through problems. His death was unexpected and the community, including both staff and prisoners, were shocked and upset. I thank the Director of HMP Dovegate for the co-operation of his staff and that of the residents of the man's wing.

I make five recommendations; two relate to policies, one to training, one to unauthorised items in cells, and one to sharing information. I also draw the Director's attention to the clinical review panel's recommendation regarding communication between the Therapeutic Community and Healthcare. There are also issues regarding emergency response and the return of unused medication. These latter two issues were highlighted in a report I issued into an earlier death in custody at Dovegate (published after the man's death) and I am aware that work is being taken forward to address them. I do not, therefore, make further formal recommendations but draw the matters to the Director's attention.

On the day of the man's death the Director discovered that two officers had not carried out proper roll checks. I should record here that the Director has already taken the appropriate action.

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**Prisons and Probation Ombudsman**

**February 2009**

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## SUMMARY

The man had been in prison since May 2006. In June and July 2006, before being sentenced he had attempted suicide. The reasons for his attempts appear to be a culmination of anxiety over his sentence and relationship difficulties with his wife. Several assessments show that he told staff he was disappointed in himself for getting involved in drugs and crime when he was trying to sort his life out.

The man transferred to the Therapeutic Community (TC) at HMP Dovegate on 31 December 2007. He was trying to deal with issues surrounding childhood abuse when in local authority care and was doing this by means of legal action and personal counselling. He believed that a TC could help him continue the work he had begun in personal counselling.

The man had minimal contact with the healthcare unit and the consultations he had related to an injury to his hand and chest problems. No concerns were apparently raised regarding his mental health and so there were no consultations relating to mental health for self-harm or depression. The clinical review panel felt it was likely that the disclosure of his childhood abuse would have caused him psychological distress. My investigators are now aware from the suicide notes left by the man that he believed the TC had helped him deal with these issues.

He took time to settle into the TC, but this seems to be because he was worried about his progression through the prison to be a category D prisoner. The man left a letter for one of his sisters and one for the staff of the TC unit (TCD) he lived on. In the letter to staff he told them that he had been wrong about the TC initially. It had helped him to “box” the issues he had about his childhood and he was no longer ashamed by them.

On 4 June 2008, the man received a letter from his wife ending their relationship. He was upset, but staff and residents thought he was acting more positively than he would usually deal with things. On Saturday 7 June, he appeared to have a typical day on the wing. He spoke to staff and other residents but spent most of his time in his cell. One prisoner told my investigators that the man seemed “brighter” and enjoyed some “banter”.

During the night, between 10.30pm and 11.00pm, a prisoner in the cell next to the man heard a bang but thought nothing more of it. The night officer did not check the man’s cell during the early morning roll check as he should have done. The relieving officer did not check either. After the wing day staff came on duty, officers began unlocking the cells. At approximately 8.20am, one of the officers opened the cell and found the man hanging from a makeshift wooden block glued to his wall. The officers responded quickly and cut him down, but they were aware that he had been dead for some time and there was nothing they could do. Healthcare staff were called, as was an ambulance. Healthcare staff attempted resuscitation despite the fact that he was clearly beyond revival. When the paramedics arrived, they pronounced the man’s death.

Staff and prisoners at Dovegate described him as a quiet person. Everyone said that he was difficult to interpret because he always seemed to have the same

expression on his face. Nobody appeared to have any idea that he felt low or was struggling to deal with any problems. In fact, they felt the opposite and believed he was being more positive about dealing with things. In the letter he left to his sister, the man talked about “pretending” and “putting on a brave face”. Sadly, this seemed to have worked and the people he came into contact with thought he just had a quiet personality. All of those to whom my investigators spoke said that his death was a complete shock.

## INVESTIGATION PROCESS

1. My office asked for all the relevant prison documents including the man's core prison records, medical file and recordings of monitored telephone conversations. My investigators also visited the prison with the clinical reviewer.
2. Notices to staff and prisoners were sent to the prison to be displayed. They invited anybody with information to talk to my investigators. Apart from the staff and prisoners whom my investigators identified to interview, two other prisoners asked to speak with them. Neither prisoner knew the man, but they wanted to talk about self-harm in general and mental health services on the Therapeutic Communities. There were several prisoners, including the man's closest friend on the wing, whom my investigators asked to speak to. These prisoners declined to be involved in the investigation.
3. Dovegate commissioned its own internal investigation into the events surrounding the man's death. We have seen the findings of the internal investigator, which are consistent with my own. Additionally, the internal investigator reported on some security issues which are neither related to the man's death nor within the remit of this investigation. I therefore make no comment on these other matters.
4. Two staff were suspended when it transpired that full roll checks had not been carried out by outgoing night staff and oncoming day staff. The officers were still suspended when my investigators carried out their interviews. From the written statement provided by one of the officers and the findings of the prison's internal investigation, my investigators were able to get the information they needed and have therefore not sought to further interview the two officers.
5. A review into the man's clinical care in prison was commissioned and carried out by a panel on behalf of the local PCT. The review was received by my office on 24 October 2008.
6. HM Coroner for Staffordshire was informed of my investigation. The Coroner has kindly shared the post mortem with my investigators. He will receive a copy of this report.
7. The man's wife was identified as his next of kin. One of my Family Liaison Officers has been in contact with her and three other family members to offer them the opportunity to be involved in this investigation. The issues raised by the family are as follows:
  - The man's wife would like to know why he was not checked on during the night. She feels that he was depressed and wonders why nobody picked up on this.
  - The man's brother and sister would like to know how he was able to make and hide the items used for a ligature point as well as having the tablets he took so that he felt no pain. They also asked why their brother was not checked on during the night.

## HMP DOVEGATE

8. Opened in 2001, Dovegate is a category B prison for adult male prisoners sentenced to over four years. It is managed by Serco under contract to the National Offender Management Service (NOMS). It currently holds up to 860 prisoners. This is made up of 660 in the main prison and 200 in the Therapeutic Community.
9. Healthcare services in Dovegate are provided by Serco Health. There is a relatively new healthcare management team. The healthcare manager had been appointed at the end of 2007 and the deputy at the beginning of 2008. The new managers are currently reviewing the existing policies and procedures of the healthcare department.
10. Her Majesty's Chief Inspector of Prisons has recently carried out an inspection of Dovegate but her report is not yet published. The last published inspection (unannounced) of the Therapeutic Community was August 2006. The Chief Inspector found that the TC, "remained a largely safe and well controlled place with impressive levels of peer support and self-management that distinguish successful TCs. Reception and induction were effective, bullying was under control, levels of self-harm were low, there was little evidence of drug misuse ..." The Chief Inspector also found that prisoners in therapy received, "very good support from staff, while those outside therapy had a less positive view."
11. An area of concern was the number of prisoners who had opted out of therapy but had not been returned to the sending prison or been allocated elsewhere. This put a strain on the TC and the discipline issues on the wings disproportionately involved them.
12. The Independent Monitoring Board (IMB) also has concerns about the unsettling effect caused by the number of prisoners no longer in therapy. My investigators spoke to the IMB member with TC responsibility. She reiterated the concerns about moving prisoners on. She did, however, say that the new Director (in post since February 2006) had made a large number of improvements to the prison as a whole. The IMB member acknowledged that the Chief Inspector's report for the main prison (2006) was not positive in all areas, but that since 2006 the Director had improved areas such as safety and purposeful activity.

## THERAPEUTIC COMMUNITIES

13. There are currently five democratic TCs across the prison estate (these differ from drug treatment TCs). Dovegate is the largest, comprising four units of 40 places each, a High Intensity Programme Unit (HIP) with 20 places, and an Assessment and Resettlement Unit (ARU) with 20 places.

14. The treatment model for TCs is described in the Information for Offender Managers and Offender Supervisors as follows:

“Therapeutic Communities provide group therapy and structured community living where members are encouraged to have shared responsibility for day to day decision making and problem solving. TC intervention centres on addressing the risk factors and offending behaviour needs that inevitably emerge in this environment.”

The key features include:

- “Daily group or community meetings
- Use of community activities to promote skill development and generalisation, e.g. work assignments, delegated responsibilities, organising events, involvement in prisoner/staff committees
- Staff supporting the community in democratic decision making and providing pro social role models
- Staff and prisoners challenging and giving feedback about behaviour that is anti-social or linked to offending behaviour patterns
- Opportunities to participate in additional therapies such as Art Therapy and Psychodrama.”

15. Residents<sup>1</sup> who apply for, and are accepted, are expected to remain on the TC for at least 18 months. There are set criteria for applications onto a TC. At Dovegate these include: 1) no positive mandatory drug test in the preceding six months; 2) not on a self harm monitoring form for the preceding four months.

16. All new candidates for the TC initially stay on the ARU for a period of assessment (usually 28 days). After this, if accepted, they are allocated to one of the four units.

17. If residents choose to leave the TC they need to fill out a ‘48’ form. Their decision to leave is discussed in small therapy groups, community groups and by the staff. The resident has 48 hours to think about everything that is discussed and choose whether to remain or to leave.

18. Staff elect to work on the TC and have to go through an application and training process to determine their suitability.

19. The TC differs from a main prison wing in that it is a community run in a democratic manner. The atmosphere tends to be more relaxed than on a main

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<sup>1</sup> In Therapeutic Communities, prisoners are referred to as ‘residents’.

wing. There is a higher ratio of staff to residents and, as a result, there is more interaction between everyone on the unit. The therapy process can be very intense. Residents are often reliving very traumatic experiences in their discussion groups.

### **Small therapy groups**

20. Staff on the units also act as group facilitators. The community is divided into small groups of a maximum of ten. They are used for discussing any problems or anything a resident might wish to talk about in line with the therapeutic process. This could be anything from sentence issues to childhood problems, and residents share their experiences. The community as a whole also meet for group discussions, which are usually about issues affecting life in the community rather than individual problems.

### **Family relationships course**

21. The Family Relationships Course consists of four modules. It aims to develop parenting skills and understanding of family relationships. It also covers understanding human behaviour in relationships and developing personal confidence and self-awareness. The course usually runs over 12 weeks and takes place on three days a week – Wednesdays, Thursdays and Fridays.
22. Participants are allowed one acceptable absence. In exceptional circumstances, and if the sessions can be caught up, the tutors have discretion to allow more than one absence.

## KEY FINDINGS

23. The man was remanded into custody at HMP Forest Bank on 16 May 2006. My investigator did not have the full records from Forest Bank, but they did include an ACCT<sup>2</sup> form dating initially from 16 June 2006.
24. The form showed that prison staff had opened an ACCT on the man after his cellmate had approached them and handed over a razor blade with which he said the man had tried to kill himself. The man did not want to talk to staff about it, but at a review later that day he told staff that his wife wanted a divorce. He said that he did not have any current thoughts of suicide or self harm but staff set up a support plan and continued to monitor him for the next six days.
25. The ACCT was closed on 22 June. The man said he had had contact with his wife and the situation had improved. He told staff again that he had no thoughts of harming himself. However, later that day another prisoner told staff that the man had said he was going to harm himself because he was no longer on an ACCT. A review took place and he again told staff that he was fine. Unfortunately, some of the sheets are missing from the second form, but it appears that he was monitored overnight and the book closed on 23 June.
26. He attempted to hang himself on 4 July, although there is no copy of the ACCT document in the files my investigator received. The medical record has an entry by the mental health in-reach team on 5 July, after a meeting with the man. The entry shows that he was upset about his wife wanting a divorce and was paranoid that she was seeing another man. (In a log of key events in his life, written as a therapy exercise, he said he was also upset about his imprisonment and he had heard that the victim of his crime had died (of natural causes).) He told the mental health in-reach team that his “head was done in” and that he “felt ashamed” and regretted what he had done (a reference to the suicide attempt). He said that he was “fortunate to be alive and had not thought about family. No thoughts to do so again – feels has learned a lesson.” He told staff that he believed his suicide attempt had been unsuccessful for a reason. (In various other documents through his period in custody he said the same and appeared to be looking forward and attempting to sort his life out.)
27. The man was transferred to the healthcare unit for two days on an open ACCT. He then moved back to the residential wing, still on an open ACCT. He was prescribed anti-depressants (Citalopram), but did not feel they were of benefit and so stopped taking them. The records do not show when the ACCT document was closed, but from a separate assessment form it would appear to have been on 13 July 2006.
28. After appearing in court on 8 August 2006, he was taken to HMP Manchester rather than returning to Forest Bank. (Due to population pressures within the prison estate, it is a regrettably common occurrence for prisoners to leave one

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<sup>2</sup> Assessment, Care in Custody and Teamwork (ACCT). A monitoring form and process for supporting prisoners at risk of harming themselves.

establishment to attend court in the morning and return to another in the evening.) His prison records did not immediately follow him, and on 22 August a Community Psychiatric Nurse (CPN) logged in the temporary medical file that his full notes were still unavailable. The CPN assessed the man and found no current evidence of mental illness or thoughts of self harm. The CPN waited for some further information from Forest Bank which was received two days later on 24 August 2006. This confirmed his previous suicide attempts. The CPN referred the matter to healthcare managers and was going to speak to relevant staff at Forest Bank.

29. The mental health in-reach team at Forest Bank faxed a discharge summary sheet to Manchester. The summary showed that the community counsellor had been contacted by Forest Bank and he continued to see the man in prison. The man was reported to have felt “brighter in mood and more optimistic re the future”. He had gained employment as a wing cleaner and did not feel the need to take anti-depressants at that time (at Forest Bank).
30. The mental health in-reach team at Manchester did not take him onto their caseload because, when they assessed him, he was showing no signs or symptoms of mental illness. In fact, since being at Manchester he had become a Listener<sup>3</sup> on his wing.
31. The next entry in his medical record relates to a hand injury for which he regularly took painkillers. There are several medical contacts and treatments relating to this and chest problems throughout the rest of his time in prison.
32. The man returned to court and was convicted in October 2006. On 7 November, he received an Indeterminate Public Protection sentence<sup>4</sup> with a tariff of two years and nine months.
33. The records show that the man was eager to go to a TC to help him come to terms with his childhood abuse and address his offending behaviour. The TC at Dovegate received a self-referral from him in May 2007. On the form, applicants are requested to fill out a question regarding self harm and suicide. He answered the question as follows:

“... I hung myself in July 06 at Forest Bank. It was for a number of reasons. At that time I really didn't want to be around any longer. I had messed up once again after doing so well for so long. I thought I had lost everything good in my life. And I felt a lot of guilt as the victim of my offence died and at the time I thought it could have been down to me and my co-accused. It all got too much in my head, but luckily I was found unconscious in time. I would like to stress I do not feel

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<sup>3</sup> A Listener is a prisoner trained by the Samaritans to provide a similar service within the prison.

<sup>4</sup> An indeterminate public protection sentence is one where a minimum tariff is imposed, but the prisoner must satisfy the Parole Board that he is fit for release and does not pose any threat to the community. A prisoner's risk factors are identified by psychological assessments and they are required to complete prison courses that might help to reduce their risk and improve their chances of being considered for release on licence.

suicidal anymore. It actually done a lot of good as I have come to terms with a lot and it woke me up.”

He concluded the referral by saying, “I want to be a ‘normal’ person and be there for my children, with a normal job so I can provide for them. I want to do normal family things and not be around any more rubbish.”

34. In a review of his sentence planning in October 2007 (at Manchester), the man told the assessing officer that he was “coping okay” and “far better than he had been when he first came into custody”. He told the officer that he had not coped well due his current offence, and felt that everything he had tried to do to sort his life out had been for nothing because he had re-offended. His self harm and suicide attempts were also discussed. He told the officer that, “at present there are no issues of self harm or suicide”.
35. The Director of Therapy at Dovegate told my investigators that the man was initially turned down for the TC due to security reasons involving drugs. The man wrote to Dovegate that he was confused and unsettled by their decision. He also made a complaint to Manchester in which he mentioned preparing himself for going to therapy. After some liaison with Manchester and the assurance that the security information was circumstantial, Dovegate agreed to review their decision. On 19 December 2007, Dovegate wrote to the man to let him know he had been accepted for assessment for the TC.
36. On 31 December, the man transferred to Dovegate. When he arrived he had a reception health screen. He told the nurse of problems with collapsed lungs. The nurse (a registered mental health nurse) noted no signs of mental health problems. He was a little unsure about how the TC ran, but accepted that that was normal. The nurse noted that he had no thoughts of self harm or suicide.
37. As per procedure, the man initially lived on the ARU for further assessment and suitability checks for the TC. The wing history sheets from the unit show that he settled and attended all the relevant groups. They also note that he was generally quieter than other members of the community but that his confidence was growing. In his Personal Goal Schedule (used to highlight particular problems residents will try to address) the man chose the following as his goals:
  - Short term:** “to get selected for the TC.”
  - Medium term:** “to get a better understanding of what happened to me and why.”
  - Long term:** “to be at home and be a dad to my kids with the past behind me where it belongs.”

When writing how he would achieve these goals, he cited talking, trust and being “... open and honest with the community to be able to get something from it”.

38. Nearly a month later, on 25 January 2008, the man was selected for a place on the TC. He moved to TC ‘D’ into cell number 3. This cell is a safer cell, which

should mean that there are no ligature points. There are three such cells on the unit. Due to space on the unit, the cells are not solely for anybody at risk of self harm and can be used for any prisoner on the unit. The man was given cell 3 only because it was available, not for any concerns of self harm.

39. It took him a while to settle once on the TC and, at one point early on, he wanted to transfer to another prison. A lot of his anxiety was about his progression through the prison system. He was worried about the situation for those with indeterminate sentences and believed that, as a category C prisoner going to do therapy in a category B prison, he would not follow the natural progression to a category D prison. Staff on the wing explained that this was not the case and that he could, if applicable, move from Dovegate to a category D prison.
40. The Prison Custody Officer (PCO), one of the community small group facilitators, told my investigators that the man came across as having problems with trust. He initially found it difficult to open up within the group. It was thought that this was because there were people on the unit who were from the same area outside prison as him, and because he believed that some were not taking therapy seriously. He did not, at the beginning, want to divulge the childhood abuse issues. The PCO told my investigators that the staff worked to motivate the man. He was one of the first TC residents to be referred for a job in the main prison canteen, and by this point was happy to remain at Dovegate.
41. Before getting the job in the canteen, the man attended the pottery class as part of his education timetable. The course was due to come to an end because the tutor was leaving. This was when he applied for the job in the canteen. He also enrolled on the Family Relationships Course and started it on 14 May 2008.
42. As with other courses, he underwent an assessment to determine his motivation and suitability for the programme. He told the tutors about his childhood, his family and his offending behaviour. The assessment shows that he found social interaction difficult even with family members (the exceptions being his older sister and his wife). He wanted to do the course so that he would not “find it so hard to sit and talk to people or find a way to make it easier. To help find a resolution to difficulties with mum.”
43. A tutor on the course described the man as ‘quiet’ when she assessed him and took this to be his natural demeanour. She said at interview that he worked well in small groups, and would give input when necessary, but preferred working with the quieter people rather than those who were boisterous.
44. One of the exercises on the course involved making a ‘life snake’ (like a ladder). It is a tool to record memories at different rungs (stages) through a participant’s life. The man reflected on the abuse he had suffered when in care. He told the tutor that he did not want to be specific about events and did not want to talk about it, and she said that he did not have to. He acknowledged that looking at family units would be difficult, but the tutor said that he persevered and did all the work which was required of him.

45. During his time at Dovegate, the man had contact with the healthcare unit in relation to his hand injury and chest problems, for which he received medication as necessary. At various consultations he was prescribed anti-inflammatories (Diclofenac) and painkillers. The last consultation was on 30 May following a computed tomography (CT) scan on his wrist. He was prescribed Diclofenac and Acupan (painkiller).
46. On 2 June, the man telephoned home at 8.11am. He had tried twice earlier that day but had been unable to get a response. He discussed a planned visit (his wife, children and brother) for 21 June. He telephoned one of his brothers at 12.19pm, and they also spoke about the visit which his brother said he needed to change to 22 June. At 5.00pm, he telephoned his wife again. He told her about the visit change and repeatedly asked her if something was wrong. He telephoned his wife again at 6.28pm. He told her that he had started a job in the prison canteen. This was the last conversation he had with his wife.
47. The following day (3 June 2008), the man telephoned his brother (at 2.06pm and 7.35pm) and one of his sisters (at 6.06pm). During these calls he shared his concern that his relationship with his wife might be over. He had been unable to speak to his wife or children since the previous evening. In the telephone calls to his brother, he asked if he would still bring the children to the visit on his own if there were problems with his wife.
48. The man did not attend the Family Relationships Course the next day (Wednesday 4 June). The tutor checked to see why and was told that he was sick. Later that day the man received a letter. Although the prison do not record who letters are from, by comparing the telephone list it would appear that this was the letter from his wife asking him not to contact her any more. At 5.07pm that evening, the man telephoned his sister and told her that his wife "has gone" and he explained about the letter. He also told his sister that he had been unable to get through on the telephone to his wife and children since 2 June. This was the last telephone conversation he had with anyone.
49. In interview a friend on the wing said, that he was aware that the man had received a letter from his wife earlier in the week saying that she did not want him to contact her any more. The friend spoke to him about it and suggested that it might be alright in a week or two, but the man had said it would not. The pair did not talk about it much more, although the friend said that the man was down in mood and did not want to take part in the Family Relationships Course they were both participating in.
50. The friend said that, prior to the man receiving the letter, he had regularly been on the phone during the day to his wife and children. But in the days before his death he did not use the phone as much. The records confirm that he did not make any telephone calls after 4 June. The friend remembers that, on the Saturday the man died, he had been more like his old self on the wing. The pair had shared some banter and the friend said he was glad to see the man in better spirits. He was very shocked the next morning when he heard that he

had died because he felt that his mood had picked up (and that in the TC people could be more open about their feelings and problems).

51. At interview, the tutor said that on Thursday 5 June, the man arrived at the Family Relationships Course classroom, but asked if he could be excused. She had already allowed him the absence on Wednesday. He told her that his “head wasn’t in it” and that he was finding the course difficult. He then told her that he had received a letter from his wife ending their relationship, and wanted some time off. There was some discussion about absences and remaining on the course. The man told the tutor that he probably would not attend the following day (Friday) either, and accepted that he would probably lose his place on the course. The tutor said that he was “subdued” but that that was how she had always found him to be. Another tutor took him back to the wing. (the second tutor’s email to the internal investigator gives the date as 4 June although this is then marked out in pen to 5 June but back again to 4 June.)
52. The second tutor told the therapy manager that the man would not be attending the course that day and that he had received a ‘Dear John’ letter (a phrase denoting the ending of an intimate relationship). The therapy manager went to speak to him. The man told her that he was having some problems with his wife. Although it is usual practice for a resident who does not attend a class or work through choice to remain in his cell for the day, he asked if he could go to his work. He told the therapy manager that he did not want to be behind his door and wallow in the problem; he wanted to be active and keep his mind focussed. Although aware that this would cause some friction with other parties, the therapy manager agreed that it would be best for the man and let him go to work at the canteen. Neither member of staff recorded this information in his wing history sheet.
53. My investigators asked the therapy manager about her view of the man’s mood at the time. She said that he did not seem emotional. Although she could tell he was sad, she felt that he was quite positive. She believed that, by asking to do something different rather than worry about the problem, he was acting positively. At interview, the therapy manager said that she thought it was a change because normally he would avoid problems. She believed he was being positive and proactive.
54. On Friday 6 June, a second PCO took the man across to the canteen. They had to wait for a long while at one of the gates while a roll check took place. At interview, the PCO said that the man talked about his wife and children and the problems he was having. The PCO told the man that his wife perhaps just needed some space and that she might still let him have contact with the children. The PCO said that the man smiled at that thought. He did not think that he was very sad, but that he was trying to think positively about the situation. The PCO said that, later that afternoon, the man was doing what he usually did: listening to music in his cell.
55. Later that day, a researcher (who the prison had contracted) was on TCD asking residents a variety of questions about life on a TC. The therapy manager sat in on one of the sessions where the man was present, and recalls

him being forward thinking in his responses and that there was no indication at all of the events to come.

56. My investigators asked the therapy manager what the normal procedure would be if somebody received something like the letter the man had from his wife. The therapy manager said that staff would speak to the person and also encourage him to use their small group as a support network as well as staff. She confirmed that it would not automatically mean that somebody was put on an ACCT, that the person would be assessed in terms of how they seemed to be coping and their behaviour: for example, withdrawing etc. She said that, in the man's case, there were no signals and everyone felt that he was trying to deal with his problems in a different way than he normally would i.e. forward thinking and being positive.
57. A third PCO who has worked on the TC for three and a half years, remembers speaking to the man quite a lot during the week before he died. She was unaware of the letter but knew that he was having relationship troubles. He had told her that his wife had "done a runner" and that he had not had contact with her. He also told the PCO that another woman he had had a child with was back "on the scene," and this was causing problems in his relationship with his wife. The PCO had offered to help or to contact his wife for him, but he declined the offer. He told her that he was going to ask his brother to go around and see his wife.
58. Nevertheless, the man did ask the third PCO to see if she could sort something out to enable him to return to the Family Relationships Course the following Monday. The PCO said she would try. When my investigators asked her for her view of the man's mood that week, she reiterated what others had said in that he "stayed the same". There did not seem to be any noticeable difference in his behaviour.
59. On Saturday 7 June, the first PCO made a retrospective entry in the man's wing history sheet. He realised that nobody had recorded that he had been working in the canteen shop that week. The PCO added this to the history sheet, as well as noting that he had told him about "personal problems with his wife". At interview, the first PCO said he could not remember exactly what the man had said but that he was unaware of the letter he had received from his wife.
60. The second PCO was also on duty that Saturday. He signed that he had carried out the fabric checks (check of the cell) which took place during the day. He did not report seeing a wooden block/hook in the man's cell. The PCO said at interview that he must have missed it when he made the checks. He remembers seeing the man throughout the day. He did not notice anything out of character, and he queued up as usual for his meal at around 4.30pm. He then stayed in his cell for most of the time until 'lock up' which was at approximately 5.45pm (which is earlier on weekends than during the week).
61. Another resident on TCD, told my investigators that the man had told him he had received two letters, the last being a couple of days before his death (my

investigators have only been given one letter). He said that the man still participated on the TCD, and that the night before he was found dead he had seemed no different to usual.

62. Between 5.40pm – 5.50pm, the third PCO locked the man's door. She remembers seeing him sitting on his bed and she said, "I'll see you in the morning." She told my investigators that he said, "Yes [PCO's name] I'll see you in the morning," and smiled and gave her the thumbs up sign. She then finished her shift about 6.00pm.
63. The second PCO was still on duty and not due to finish until 8.45pm. Between 7.00pm and 7.30pm he carried out the roll check. He remembers seeing the man laying on his bed, having a cigarette. His television was on. He waved and gave the PCO the thumbs up sign. He is certain that there was nothing obstructing the observation panel in the cell door at the time and, if there had been, says he would have made sure it was taken down.
64. The officer on night duty on 7 June came on to the wing at about 8.45pm. He would have been required to carry out another roll check (for TCC and TCD) and report the numbers before any of the day staff could leave the prison. The handover from the second PCO was reportedly straightforward and he had no issues to highlight.
65. During the night, the night duty PCO would have had to patrol TCC and TCD and 'peg'. (This involves 'checking in' at random points across the wings through the night. It is not designed so that each cell is checked. There is no requirement to check on residents during the night unless they are on an ACCT or there are particular concerns.) A second resident on TCD, was on an ACCT so the night duty PCO would have been checking on him. To get to the second residents cell from the office he would have had to pass the man's cell, albeit possibly walking on the opposite side of the corridor.
66. The resident in the cell next door to the man told my investigators that all the prisoners were locked up around 5.45pm on Saturday 7 June, as is customary on a weekend evening. He said that the TC residents watch television, listen to music or read books in the evening. He said that residents do not generally speak to each other out of the windows when they are locked up, and that he did not speak to the man that evening.
67. The resident next door said that around 10.30pm – 11.00pm he heard a banging noise from the man's cell, but thought nothing of it at the time. He felt that with hindsight there might have been signs in his mood or state of mind, but because residents are engaged in therapy they can sometimes be down and upset.
68. At 11.15pm and 4.30am, the Night Orderly Officer (NOO)<sup>5</sup> visited the TC as part of the routine night checks. She remembers one resident on TCD being

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<sup>5</sup> The NOO is responsible for the prison at night and is in charge of any incidents or problems. During their rounds they check prisoners on ACCTs and ask officers if there are any other concerns on the

on an ACCT, but said at interview that no other concerns were raised when she visited the officer on the wing.

69. The Command Suite incident log shows that the night duty PCO called his roll count (39 residents) in at 6.35am on 8 June. This would have been entered on the log retrospectively. The night patrol log was also completed with 39, although there is nowhere to fill in the time of the check. However, the night duty PCO told the internal investigator that he started the count at 5.15am. He told the internal investigator that the man's cell was obscured and he had decided not to wake him.
70. At approximately 7.00am, a fourth PCO came on duty. He took over from the night duty who then left the prison. In his statement to the internal investigator the fourth PCO said that he did not carry out a separate roll check at 7.00am (as per the local policy) because in all the time he had worked at Dovegate, oncoming staff generally accepted the word of their outgoing colleagues. The second PCO arrived about 50 minutes later, shortly followed by two other PCOs.
71. At just after 8.15am, the three PCOs began unlocking the cells on TCD. A few minutes later, the third PCO opened the man's door. She could not see him in his bed or in the shower room and so opened the door a bit wider. She then realised that he was sitting on the floor at the bottom of his bed, fully dressed. The third PCO thought that the man had fainted and said, "[the man's name] what are you playing at?" She then noticed something like a sheet hanging from a hook and realised it was around his neck. The third PCO screamed for her colleague to bring the fishknife (used for cutting ligatures). She then tried to lift the man to get the weight off his neck.
72. All three officers pressed their personal alarm bells, although only two registered in the communications room (at 8.20am). The communications room log shows that radio call signs Oscar 1 (NOO) and Hotel 4 (Healthcare) were alerted to the call for assistance. The second resident, who had already been unlocked, heard the third PCO scream and went to help. A fifth PCO had also arrived at the cell and the second resident tried to help by getting the ligature off. The second PCO entered the cell shortly afterwards and used his fishknife to cut the ligature. The second resident returned to his cell. The officers lay the man on the floor with his head in the third PCO's lap. The fifth PCO checked for a pulse even though the officers realised that he had been dead for some time. The third PCO held him in her lap until the medical staff arrived.
73. At approximately 8.15am, two Registered General Nurse's (RGN) were preparing to hand out medication on the main wings. One RGN remembers that, just as the cells were being unlocked on the wing, an alarm came over the radio (at 8.20am). She said that the message from the communications room was not clear, and the nurses did not know the location or if they were needed

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wing; they also make sure that the officers have filled out the forms relevant to night duties. The NOO does not check individual cells.

immediately. When she was sure that it was a medical emergency and knew the location, she picked up an emergency 'grab bag' (medical equipment) and oxygen (although not a defibrillator) and started running to TCD. When she arrived at the security gates, her colleague, also running, had just arrived.

74. At this point, neither nurse knew exactly what they were responding to. In interview, one of the RGN's said that it took them a couple of minutes to get to the unit and that they walked at a fast pace from the gates (after running to the gates). She said that there are usually three nurses on duty on a Sunday, one for the TC and two for the main prison. On the day that the man died they were short staffed. There were only two nurses on duty, both in the main prison at the time he was found.
75. The incident log kept by the Unit Manager, shows that at 8.24am she had called for healthcare assistance again. However, this is not recorded in the communications log. When the nurses arrived at the man's cell (at 8.24am), officers had already cut him down and laid him on the floor. One RGN said that, from her medical experience, she could see that he was dead but she is not authorised to pronounce death. Both nurses assessed him to see if he had a pulse or blood pressure reading but could not find any. His pupils were fixed and dilated. The nurses were of the opinion that rigor mortis had set in. However, both nurses believed that, because they could not pronounce death, they had to commence cardio pulmonary resuscitation (CPR). Neither nurse was aware of the prison's 'death in custody' contingency plans and PSO 2700, Annex 13<sup>6</sup>, which state that CPR does not have to be attempted if rigor mortis has clearly set in. The log kept by the Duty Director records that CPR was not attempted by the officers, but does not record that CPR was attempted by the nursing staff. At interview, it was discovered that that neither nurse had up to date training in CPR.
76. Several incident logs were kept but none captures all the information and the timings differ. The communications log does not record the emergency services response. The timings which follow are taken from the incident logs recorded by the Unit Manager, Duty Director and the officers stationed outside of the man's cell. Oscar 1 completed a log in the contingency plans but the timings are all different to the other logs and do not correspond to other evidence available.
77. An ambulance had been called at 8.32am by Oscar 1 following a request by the first RGN on scene. The Duty Director's log records the paramedic first response arriving on TCD at 8.43am. The officers at the cell record the time as 8.48am. The officers' log shows the subsequent ambulance arriving at TCD at 8.57am and the man being pronounced dead at 9.00am, whereas the Duty Director's log does not record the ambulance arriving and says that he was pronounced dead at 8.45am by paramedics. The contingency plans record 8.49am as the time of death. The CCTV shows the first response paramedic arriving onto the TC yard at 8.44am and the ambulance at 8.52am. (When my investigators viewed the CCTV they were made aware that the clock ran four

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<sup>6</sup> Prison Service Order (PSO) 2700, Suicide Prevention and Self-Harm Management.

minutes faster than real time and the times above are four minutes less than the time shown.)

78. The Reverend (the Anglican chaplain) had also been called to the prison. He arrived while the paramedics were still in the cell. He determined that the man was Roman Catholic and so he prayed the prayer of the dead. He then spent some time with staff before holding the Sunday service. He returned after the service to provide support for any of the residents on the TC who wished it.
79. A 'hot debrief' took place at 1.30pm on Sunday 8 June. With the exception of the third PCO, who had to seek medical treatment after hurting her hand trying to lift the man, all relevant staff attended. Support was made available to staff and prisoners, and the man's death was discussed in the small therapy groups by the community.
80. The news of the man's death was broken to his wife by police from the Manchester area. Additionally, the Duty Director and the Reverend travelled to Manchester to visit the man's wife that afternoon. The Reverend told my investigators that the prison had offered continued support to the man's next of kin. The family did not wish to visit the prison. His possessions have been returned including a budgie which he kept. They have asked the family how they wish to keep in contact, if at all, and have left it to them to decide what support they would like from the prison.

## Events after the man's death

81. One of the residents my investigators interviewed said that the healthcare staff who responded to the call for medical assistance were walking over from the main prison. He said that they were laughing and joking and that other residents had been shouting at them through their windows. My investigators have tried to look on CCTV at the route the nurses took, but there were no cameras focussed in that direction. I can confirm that the initial call for assistance went over the radio at 8.20am and the second at 8.24am. The CCTV does show the nurses entering the unit at 8.24am.
82. One of the RGN's made an entry in the man's medical record regarding the call to his cell. Neither nurse gave, or was aware of the necessity to provide a written statement to the Director detailing their involvement. However, a copy of the sheet she wrote on was collected with all the officers' statements.
83. The second resident, who tried to assist the PCOs on scene, told my investigators that he was very shocked when he returned to his cell. He said that he had acted on instinct, but that he was upset and shocked at finding the man dead. He also said that it was difficult to know how the man was feeling because he showed nothing. The second resident had been put on an ACCT the day before the man died. His view is that staff give a high standard of care. He said that he approached them to say how he had been feeling the day before the man died and they put him on an ACCT straightaway. He believes there was little staff could do unless someone came forward and told them how they were feeling. He said that the man told him not to self harm, so he was the more surprised by his actions.
84. The man had hanged himself using a bed sheet attached to a block of wood that had been glued to the wall and painted over. It is not known how he got the block of wood, but he most likely obtained the glue and paint from the pottery classes he attended.
85. My investigators asked some of the officers on the wing what they would do if they saw an item such as this in a cell. The officers said that they would remove any unauthorised items. The officers were also asked about obstructions on a resident's observation panel. Each officer said that they would get them removed. The third PCO said that, if necessary at night, she would ask the NOO to come to the wing and open the cell door.
86. Wing staff were also asked if they were aware of the man's previous suicide attempt. No staff interviewed had any knowledge of this prior to his taking his life. It appears that wing staff receive minimal history records when a resident takes his place on a wing.
87. Various items were taken from the man's cell after his death. There were two letters that he had written (one to one of his sisters and the other to the staff of TCD). The letters go some way to explain his state of mind shortly before his death. In the letter to staff, he thanked them for how they had been with him and how they had helped him work through the issues of his childhood abuse

so that he was no longer ashamed of himself. He wrote that the staff might find it “silly” that he was taking his life because his wife had left him, but he explained that it was more than that. He did not want to live without his children and, because he had had a vasectomy, he did not consider a new life with a new partner to be a possibility. He explained that he could not handle the thought of “existing” in prison and then being on his own when he was released. He left instructions for who he wanted contacted (his brother and sister) and messages to be passed to his friends on the wing. He also asked that his budgie be given to his stepdaughters.

88. The man wrote that he had taken some illicit drugs on the Wednesday before his death because he had planned to take his life then. He explained that he had felt horrible (possibly meaning the effect of the drugs,) and was going to speak to staff, but when his door opened he was taken for a drug test. He felt that if he told staff then it would look like he was trying to cover up for taking drugs. He wrote that the night he took his life he had taken “plenty of tablets” (these appear to refer to prescription tablets rather than an illegal substance). He reiterated that he had dealt with his childhood issues, but felt guilt that the victim of his crime had since died and that he could no longer handle being in prison. He wrote that all he wanted was a family and to be a proper father. He felt that he had lost all that and would not even get a Father’s Day card. The man did not want anyone to blame his wife because she had “stuck by” him for years.
89. In his letter to his sister, he repeated how he felt about his family and his future. He added that he was “sick of pretending everything is ok and putting on a brave face when inside I’m in bits.” He wrote that he had planned to take his life for a while, and that he had obtained the “thing to put on me wall months ago and grafted to get it up. I’ve grafted tablets to put me out of it.”
90. Other items found in the man’s cell included the following medication:
- One paracetamol tablet. There is no log of this in his medical record at Dovegate, and the last prescription was at Manchester. It is possible he obtained it from another resident or it was not recorded by healthcare staff.
  - Three aspirin tablets. There is no log of these tablets in his medical record. As before, it is possible that he obtained them from another resident or it was simply not recorded.
  - One bottle of Omeprazole (used to reduce stomach acid) containing 11 capsules, issued on 6 March 2008.
  - One box of Diclofenac (anti-inflammatory) tablets containing 84 tablets. A 14 day supply was prescribed on 30 May for the wrist injury and issued on 2 June 2008. The dosage is not logged but a previous prescription (March 2008) showed that one tablet was to be taken twice a day.

- One bag of Nefopam (Acupan) (a painkiller) containing 16 tablets. A seven day supply was prescribed for the man's wrist injury and issued on 3 June 2008.

91. The toxicology report showed that the man had codeine in his urine screen, but this would be consistent with a therapeutic dose and was unlikely to have been associated with his death. It is not known where he obtained the codeine because he had not been prescribed any codeine based medication whilst at Dovegate. In contrast to what he wrote in his suicide note, the toxicology report does not suggest that the man had taken a lot of medication before he died.

## ISSUES CONSIDERED

### Emergency response

92. In Dovegate's local policy - Director's Rule PROG016 - ACCT "The management and prevention of Suicide and Self Harm" - chapter 3 advises on "required actions following incidents of self-injury". The following is instructed if a prisoner is found hanging:
- support the body to reduce constriction,
  - cut the prisoner down – using the fish cutter provided,
  - cut and then release the ligature,
  - place the prisoner on his back on a flat, solid surface,
  - check for signs of life, if none present, clear airway and attempt resuscitation using a face mask with a non return valve *unless rigor mortis of the limbs has clearly set in*. (The national Prison Service Order (PSO) 2700 in relation to self-harm and suicide gives the same instructions in relation to hanging.)
93. Dovegate's contingency plans for "Death in Custody" however, instruct those first on scene to "... *always attempt resuscitation using your airway mask, do not assume death.*" The plans also give instructions to use a colour code to alert staff to the problem, for example "code blue for hanging".
94. The emergency call for assistance on 8 June did not provide healthcare staff with enough information. The two nurses on duty were in different areas of the prison from each other and the TC. Neither nurse was aware of what they were responding to, or initially where they needed to go. One nurse took an emergency bag, but did not take a defibrillator.
95. It appears that the man died some time between 10.00pm and midnight the night before, and therefore the emergency response and equipment would not have made any difference to the outcome. However, this will not always be the case.
96. In another recent death at Dovegate, I made a recommendation that the emergency response system should be reviewed and clarified. This recommendation was made after the man's death. I am pleased to note that in response to that recommendation a review is taking place.
97. The officers who found the man did not attempt CPR. They believed that he had been dead for a long while and that rigor mortis had set in. In accordance with PSO 2700, staff are not expected to carry out CPR in this circumstance. However, the nursing staff were unaware and, even though they believed him to be dead, thought they had to attempt CPR. .
98. My investigator has compared the local and national policies for responding to somebody found hanging. There are discrepancies between Dovegate's 'Death in Custody' contingency plans, their 'Management and Prevention of Suicide and Self Harm policy' and PSO 2700 in relation to the same. It would

seem that these discrepancies led to the nurses attempting CPR on someone who was clearly dead. This was not respectful to the memory of the man and must have been traumatic for the nurses themselves.

99. In the Key Findings section of my report, I have indicated that several logs were kept by various members of staff after the man was found dead. I appreciate that there may be small differences in times recorded on a clock or according to an individual's watch. However, at two points the officer at the cell's log differed from other logs by up to 15 minutes.
100. Not all relevant information was recorded in the appropriate logs either. For instance, the arrival of the paramedic and ambulance is not in the communications log. Additionally, the communications log has "approximate" timings. These examples can cause confusion and doubt, particularly if CCTV of particular areas is not available.
101. Although one of the RGN's made an entry in the man's medical file regarding the medical response, neither nurse provided a written statement as per the requirements of the contingency plans. Additionally, as I have said, the nurses were not aware that they did not need to attempt resuscitation if rigor mortis had clearly set in.

**I recommend that the Director revises the local policies at Dovegate relating to 'Deaths in Custody' and the 'Management and Prevention of Suicide and Self Harm' to ensure that they are consistent with each other and national policy. The Director should also ensure that the agreed policies are made clear to all staff. This should include emergency response codes, and a first on scene protocol.**

102. The nursing staff who responded to the man had not received an annual update for resuscitation and emergency life saving techniques. The training records of the wing staff were not checked for this investigation. However, any first aid trained staff, whether medical or operational, should have the regular refresher training.

**I recommend that the Director and Head of Healthcare ensure that all relevant staff receive refresher training in life support as soon as possible. This should be monitored annually.**

### **Medicine Management**

103. A quantity of medication was found in the man's cell after his death. With the exception of paracetamol and aspirin, the medication was prescribed to him. None of that which was prescribed is codeine based and it is not known where he obtained the codeine based medication which was in his system.
104. In relation to the type of medication he had in his cell, all were within the 'in possession' guidelines. This said, he should not have had this quantity in his cell. In my investigation into the previous death at Dovegate to which I referred, in-possession medication was also an issue. I recommended that a

review of in-possession medication should take place. I am pleased to report that this policy is being reviewed and the return of unused medication will be incorporated into the review.

### **Ligature points**

105. The man was in a safer cell although, as previously mentioned, this was not because staff felt he was at risk of self harm. Nevertheless, this cell should have reduced ligature points.
106. My investigator received minutes of three Prisoner Information and Activities Committee (PIAC)<sup>7</sup> meetings, these being from September and October 2007. A concern across the prison was lack of space to hang clothes. The prison were looking at ways of dealing with the matter, but it was made quite explicit at the meeting on 20 September 2007 that wall hooks were only to be stuck down with an adhesive sticker. The reason that hooks and hangers (other than those authorised) had previously been removed was because the Director thought that they could be used as a ligature point.
107. It is tragic that this risk had been raised - and some makeshift hooks had already been removed across the prison several months prior to the man's death - yet he was able to use this very method. He told his sister he had planned it and had obtained the block "months ago". He appears to have used glue and paint available in the pottery class to attach the block to the wall. I am aware that the pottery class had ended some time before he took his life.
108. It is difficult to comment whether he had these items expressly for the intention of making a ligature point or where he obtained the wooden block from. If he had been collecting items as he said, including the block and medication not prescribed to him, it might suggest there were reasons other than the 'Dear John' letter that led to him taking his life.
109. Fabric checks of the cells are carried out daily. None of the officers said they noticed the block during the fabric checks. Again, it is not possible to confirm when exactly the man stuck the block to the wall. The police suggest that it must have been before the night of his death because it took a degree of force to remove it.
110. The Director and prison managers are already aware of the risks of such makeshift hooks. Albeit that some unauthorised hooks or shelves are put up for legitimate storage solutions, they remain unauthorised.

**I recommend that the Director reinforces the message that unauthorised items must be removed without delay, and ensures that officers do not become complacent but more vigilant when carrying out cell fabric checks.**

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<sup>7</sup> These meetings discuss residential matters, usually one subject per wing. The IMB report that the mood and atmosphere of the prison is well measured at these meetings. Staff/Prisoner relationships had also improved as a result. They are held on the TC as RIAC – the 'R' being for 'residents'.

## Roll checks

111. Roll checks are carried out four times a day at Dovegate. It is also routine practice nationally for night staff to carry out their own roll check when they start duty and before going off duty. Oncoming day staff are expected to do their own count. From the reports of staff, it appears that this is the way it should also be done at Dovegate. However, this is not explicit in Director's Rule SEC061 (Roll Checks), nor are the instructions clear in Director's Rule SEC002 (Night Procedures).

### ***Director's Rule SEC061 – 'Roll Checks'***

112. Paragraph 1.1 in the policy states: "HMP Dovegate will perform at least four complete counts per day, during which every prisoner will be accounted for." At paragraph 2.1 times are given when routine checks should be carried out. They are as follows:

<b>Roll check times</b>	<b>Monday-Friday</b>	<b>Weekends</b>
Before morning unlock	0600hrs	0700hrs
At lunch time	1245hrs	1300hrs
At teatime	1800hrs	1800hrs
After lock up at night	2045hrs	2045hrs

The policy does not incorporate Night Officers' roll checks.

### ***Director's Rule SEC002 – 'Night Procedures'***

113. At paragraph 4.2.4, instructions are given for the Night Officer to do the following once s/he has arrived on duty:

"The Night Officer must ensure that they check that all the prisoners are accounted for by actually seeing the prisoner in his cell, or confirming that a person is present by gaining a verbal response from the prisoner if required. This procedure is normally carried out at the same time as the cell doors are checked."

The procedures do not give any instructions for carrying out the same check at the end of a shift.

114. The second PCO carried out a roll check between 7.00pm and 7.30pm on 7 June before the end of his shift. The night duty PCO signed that he started duty at 8.45pm and for the roll at the beginning of his shift and the end of his shift. The end of shift roll is not timed but, in his interview with the internal investigator, the night duty PCO said he did this at 5.15am.
115. The rules are explicit in respect that a roll check should mean seeing every prisoner clearly and gaining a response where necessary. The night duty PCO confirmed to the internal investigator that he had not looked into the man's cell.

He had seen the obstruction over the observation panel and had decided not to wake the man. The night duty PCO realises that he should have done this.

116. The fourth PCO, who relieved the night duty PCO from his night shift at 7.00am, took his word that the roll check was complete and did not make his own roll count. He told the internal investigator that in the four years he had been at Dovegate staff generally took the word of their colleagues. He had only seen one officer carry out a separate roll check after a handover. He went on to say that staff would not wake residents at 7.00am and would wait until 8.15am unlock to get a response from them.
117. I do not believe that the failure by the night duty PCO and the fourth PCO to carry out proper roll checks resulted in or affected the man's death. However, it is very poor practice. The prison's internal investigation has already recommended the night patrol log should make clear the duties and expectations of night staff. I support this recommendation.
118. Additionally, the policies outlining duties and protocols should give the same consistent message. Currently they do not adequately cover the duties and there are discrepancies between the 'Roll Check' policy and the 'Night Procedures' policy.

**I recommend that the Director reviews the policies on 'Roll Checks' and 'Night Procedures' to ensure they are consistent with each other and national guidelines and adequately explain the duties and expectations of staff.**

119. The night duty and fourth PCO were both suspended from duty pending the prison's internal investigation. Both officers were disciplined. The fourth PCO has undergone retraining in his officer duties and the night duty PCO has resigned. Therefore, I make no recommendations in addition to the actions already taken by the Director.

### **Communication and Recordkeeping**

120. The clinical review panel made a recommendation regarding the sharing of information between the TC and the healthcare team, specifically in relation to psychological assessments which may improve risk assessment within the unit. The panel also recommended that better communication takes place between staff to ensure additional monitoring of a prisoner known for impulsive actions when s/he receives bad news.
121. My investigators found that wing staff were not aware of the man's previous suicide attempt at Forest Bank. They also found that, with the exception of the first PCO's entry in the wing history sheet relating to the man's problems with his wife, no entry was made with regard to him receiving a letter from his wife ending their relationship. As a result, at least two members of staff did not know that he had received such a letter.

122. Whilst the ethos of the TC is about therapeutic discussion and peer support, important information such as a letter with bad news should be recorded in a resident's wing history sheet. All staff should be aware of an issue such as this so that support can be made available within the small groups or the community, even if an ACCT is not opened. The man's family has questioned why he was not monitored more closely after receiving the letter, given his history in Forest Bank. I have tried to answer their questions within the Key Findings section and below.
123. Unless a prisoner is on an ACCT there is no mandatory requirement to check on him/her through the night. The officers on TCD did not know about the man's suicide attempt at Forest Bank. In practice, it is not possible for staff to know the histories of all the prisoners they look after, especially events that have taken place two years earlier and in a different prison. I appreciate that this will probably not offer much comfort to his family. However, I am satisfied that the staff on TCD (as well as other residents) had no indication of the man's real feelings or intentions after receiving the letter ending his marriage. I am also satisfied that, had the staff believed he was at risk, they would have ensured he was monitored and given additional support.

**I recommend that the Director of Therapy ensures that the TC officers receive full wing history sheets from sending prisons. The Director of Therapy should also remind staff to log any significant events in a resident's wing history sheet so that all staff are aware of relevant information.**

124. Because there was no indication and, therefore, no identified need to share information between the TC and healthcare, I do not make a formal recommendation as per the clinical review. However, this might not always be the situation and the clinical review panel make a valid point. The Director and Head of Healthcare will wish to satisfy themselves that communication between the TC and all aspects of healthcare takes place, and is open and not inhibited by the TC criteria or medical in confidence (where possible).

### **Suicide and Self Harm Management**

125. The man had a history of self-harm. With hindsight it could be argued that he should have been considered for ACCT when he received the letter from his wife. However, even when a prisoner is on an open ACCT, observation levels vary. Unless someone is on constant observations, there is still a possibility of self harm or suicide. Even with hindsight, I do not believe that it could be argued that the man should have been on constant observations.
126. All of the officers who came into contact with the man and worked closely with him during therapy, firmly believed that he was trying to work through the separation from his wife in a more positive manner than he usually dealt with problems. This belief was also held by the prisoners who spoke to my investigators. There appears to have been no indication that he was going to take his life.

127. As I have mentioned, although the ethos of the TC is for community discussions and support to deal with problems, it does not preclude the use of extra monitoring on ACCT. The second resident was placed on ACCT when he alerted staff to his feelings. I am confident that, had staff sensed that he was not coping or if he had sought help, he would also have been placed on an ACCT.

## RECOMMENDATIONS

- 1. I recommend that the Director revises the local policies at Dovegate relating to 'Deaths in Custody' and the 'Management and Prevention of Suicide and Self Harm' to ensure that they are consistent with each other and national policy. The Director should also ensure that the agreed policies are made clear to all staff. This should include emergency response codes, and a first on scene protocol.**

Dovegate has accepted this recommendation.

- 2. I recommend that the Director and Head of Healthcare ensure that all relevant staff receive refresher training in life support as soon as possible. This should be monitored annually.**

Dovegate has accepted this recommendation.

- 3. I recommend that the Director reinforces the message that unauthorised items must be removed without delay, and ensures that officers do not become complacent but more vigilant when carrying out cell fabric checks.**

Dovegate has accepted this recommendation.

- 4. I recommend that the Director reviews the policies on 'Roll Checks' and 'Night Procedures' to ensure they are consistent with each other and national guidelines and adequately explain the duties and expectations of staff.**

Dovegate has accepted this recommendation.

- 5. I recommend that the Director of Therapy ensures that the TC officers receive full wing history sheets from sending prisons. The Director of Therapy should also remind staff to log any significant events in a resident's wing history sheet so that all staff are aware of relevant information.**

In addition to these recommendations, I draw the Director's attention to paragraphs 101 and 109 to ensure these reviews cover the issues in this and my previous death in custody report. I also draw his attention to paragraph 129 in relation to communication between the TC and Healthcare.