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**A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE**

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**Investigation into the death of a man at HMP Dovegate in June  
2013**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man, who was found hanging in his cell at Dovegate in June 2013. He was 30 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in prison was undertaken.

Between November 2012 and May 2013, the man was remanded to prison three times, interspersed with periods of bail. On each occasion, he received an initial health screen within the prescribed timescale, where he disclosed previous episodes of depression, psychiatric treatment and that he had been prescribed anti-depressants. His health needs were not followed up at any time during his stay at Dovegate.

The man was involved in a lengthy trial and had to attend court daily, which presented an increased risk of suicide and self-harm. Assessing the risk a prisoner poses to himself involves balancing the prisoner's demeanour and behaviour against known risk factors. It requires some discussion with prisoners about how they are coping. Understandably, prison staff had little contact with him during the day time on weekdays, but I am concerned that no effort seems to have been made to engage with him or to assess his health needs in the evening or at weekends. Although he had an allocated personal officer, he had no contact with her. It appears that due to his circumstances, he was forgotten and no one discussed with him or assessed the impact his trial and other events in his life might be having. No checks were made with his community GP and he never received the medication he said his GP had prescribed for depression.

The investigation also found a worrying lack of understanding about appropriate emergency procedures at Dovegate. Initially there was no attempt to cut the ligature from around the man's neck and it took too long to call an ambulance and then to get paramedics to the cell. Dovegate did not have an up to date protocol, as they were required to do, giving guidance to staff about the use of emergency codes and ensuring an ambulance is called automatically in a life threatening situation. Sadly, in this case it seems unlikely that a swifter response would have saved him, but in other incidents this could be crucial.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**February 2014**

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## SUMMARY

1. The man was remanded to HMP Dovegate on 8 May 2013. At his initial healthscreen, he disclosed that he had previously suffered from depression and had been treated by a psychiatrist in the community. However, he had stopped taking the anti-depressants he had been prescribed.
2. The man was bailed from court on 24 May but remanded back to Dovegate after a court appearance on 30 May. He told a nurse in reception that he had been prescribed an anti-depressant and other medication while he was bailed but had not brought it with him. He said he did not feel suicidal, but he was anxious and stressed about problems at home and asked to speak to someone from the mental health team. The nurse made a referral, but he did not get an appointment before his death. Healthcare staff did not obtain his community medical records confirm his medication with his doctor or conduct a secondary health screen. He was never prescribed any anti-depressant medication during his time at Dovegate.
3. The man was involved in a lengthy trial and records showed that he had to attend court each weekday and had little meaningful contact with prison staff. No attempts were made to engage with him in the evening or at the weekend to take forward the outstanding medical issues or otherwise check his welfare.
4. The man had a double cell to himself. One morning in June, an officer conducting a routine roll check discovered him hanging from the bunk bed in his cell by a belt tied around his neck. The officer radioed for emergency assistance. He went into the cell but he did not check him for any signs of life and made no attempt to remove the belt from around his neck and neither did other officers who arrived shortly after. When the unit manager arrived several minutes later, he instructed the officers to cut the belt and lay him on the floor. He telephoned the control room to request an ambulance while a nurse led attempts at cardiopulmonary resuscitation. Paramedics arrived at 5.57am and pronounced him dead at 6.00am.
5. The investigation found that the prison did not follow national guidelines to ensure continuity of healthcare. The man was not offered a full health assessment as part of the standard screening procedure. Healthcare staff did not obtain information from his GP to follow up his existing health conditions and check what medication he had been prescribed. He had no induction to the prison. His allocated personal officer did not meet him at any time during his stay at Dovegate and there is no evidence that anyone ever asked how he was feeling or how his trial might be impacting on his well-being.
6. When the man was found hanging, staff did not follow the guidance for medical emergencies. While it does not seem that it would have altered the outcome in this case, there was a delay in calling an ambulance and ensuring the first responder paramedic got to the cell quickly after arrival at the prison. We make six recommendations in relation to healthcare provision, induction, emergency procedures and interactions with personal officers.

## THE INVESTIGATION PROCESS

7. On 25 June 2013, the investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and inviting anyone with relevant information to contact him. There was no response.
8. The investigator visited Dovegate on 26 June and obtained copies of the man's prison and healthcare records. NHS England, Shropshire and Staffordshire appointed a clinical reviewer to carry out a review of his clinical care.
9. The investigator and clinical reviewer interviewed 13 members of staff at Dovegate between 19–21 August. After the interviews, the investigator gave the Director verbal and written feedback about the initial findings of the investigation.
10. The local coroner was informed of the investigation and a copy of the investigation report has been sent to him.
11. One of our family liaison officers contacted the man's partner to explain the purpose of the investigation and gave her the opportunity to raise any matters she wished the investigation to address. His partner wanted to know:
  - Why he had not been given any medication while in custody.
  - Whether his GP records had been requested and received.
  - If he had been seen or assessed by the mental health services.
  - Whether he had been bullied by staff.
12. The man's family received a copy of the draft report. The solicitor representing the family wrote to us pointing out some factual inaccuracies and omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

## **HMP DOVEGATE**

13. HMP Dovegate, which is near Uttoxeter, is privately run by Serco. It holds over 1,100 adult male prisoners, both on remand and sentenced. Healthcare services are provided by Serco Health.

## **Her Majesty's Inspectorate of Prisons**

14. HM Inspectorate of Prisons (HMIP) last inspection of Dovegate was in October 2011. Inspectors noted that self-harm monitoring was of a good standard, with multi-disciplinary and meaningful reviews for those at risk of self-harm. HMIP found good relationships between the prison and the healthcare department, and that relationships between staff and prisoners had improved since their previous inspection.

## **Independent Monitoring Board**

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their most recent annual report for the year to the end of September 2012, the IMB commented that the prison continued to be safe, calm and well run. The IMB was positive about procedures to monitor those who were either a danger to themselves or others.

## **Previous deaths**

16. Since January 2013, there have been three self-inflicted deaths at Dovegate. The previous death took place only four weeks before that of the man's. All three men died from hanging, although there are no other similarities between these cases.

## KEY EVENTS

17. The man was a 30 year old Lithuanian national who had lived in Belfast, Northern Ireland, for a number of years. He was remanded to HMP Birmingham on 8 November 2012, after being charged with conspiracy to cause explosions.
18. During an initial health screen with a prison nurse and subsequent consultation with the prison GP, the man was tearful and concerned about personal problems. Initially he said he had no previous history or thoughts of self-harm, but later told the GP that he had attempted suicide by overdose five years before. He said that he had never seen a psychiatrist or received any medication for mental health problems. The doctor prescribed a five-day course of medication to help him sleep. He had no further contact with the healthcare team at Birmingham and was bailed at court on 21 December 2012.
19. On 8 May 2013, the man appeared at Crown Court and was remanded to HMP Dovegate. At an initial health screen with a nurse, he gave details of his community GP in Belfast. She recorded that he had a history of depression and had received treatment from a psychiatrist in Belfast, two to three months earlier. He told the nurse that he had stopped taking the anti-depressant medication prescribed by his doctor as he did not like how it made him feel. He said that he had no thoughts of suicide or self-harm, but if this changed he would speak to staff.
20. The nurse told the investigator that she could recall very little about her contact with the man, other than that he had lived in Ireland. She did not contact his community GP as he said he had stopped taking the anti-depressants. She said she had expected that his medical history and the reasons that he had been prescribed anti-depressants would be explored in depth at a secondary health screen, which usually takes place a few days after a prisoner arrives. The secondary health screen is a full assessment of past and current medical issues, including family history and prescribed medications.
21. After completing the reception procedures, the man was taken to Houseblock 3, where a Prison Custody Officer introduced herself and showed him to his cell. The officer then explained the emergency procedures, how to use the telephone and gave him general information about the regime on the houseblock. She recalled that he was polite and respectful but appeared a little nervous as it was his first time at Dovegate. He spoke good English and she had no problems communicating with him.
22. The man returned to Crown Court the next day and attended court each weekday until 24 May.
23. The officer explained to the investigator that the induction process takes place over five weekdays and covers all aspects of the prison regime and the services available. She believed that, when prisoners attend court for one or two days immediately after arrival, they would still be likely to complete the induction programme. However, there was no provision at weekends or

evenings for prisoners like the man, who have to attend daily at lengthy court hearings.

24. On 9 May, a Healthcare Assistant recorded that she was unable to complete the man's secondary health screen as he was at court. She told the investigator that she had not been asked to contact his community GP for information as he was no longer taking any medication. She said that there was no standard process to identify prisoners who had missed secondary health screens because they were attending court, although she kept her own list of those outstanding. There was no arrangement for reception nurses to complete secondary screens when prisoners returned from court in the evening.
25. Many prisons operate a personal officer scheme to allow the appointed officer to develop more effective relationships with individual prisoners to help address their needs and act as a point of contact for advice and assistance. On 15 May, one of the unit managers, a Senior Prison Custody Officer (SPCO), noted on the man's computerised wing record, "recently moved to C wing and allocated a new personal officer. Attending court this week however personal officer to ensure weekly entries and to update on court case and concerns he may have". She told the investigator that officers at Dovegate are expected to make quality weekly entries. She said that all staff are fully aware of this requirement as they are informed about the importance of doing so at morning briefings and they sign to confirm that they understand.
26. A Prison Custody Officer was the man's personal officer. On 22 May, she recorded:

"I am his personal officer however, I have not introduced myself to him yet as he is currently on trial and has left the wing before unlock and when he returns I have not been on shift. I am hoping to talk with him this coming weekend."
27. There are no entries by any other wing staff to indicate that they had any contact with the man.
28. The man was bailed from Crown Court on 24 May. He went back to his home in Belfast and returned to court on 30 May, where he was again remanded to Dovegate.
29. At the initial health screen when he returned to Dovegate on 30 May, the man told a nurse that his community doctor had prescribed 30mg Mirtazepine (an antidepressant) and 25mg Phenergan (also known as promethazine, an antihistamine which is sometimes prescribed as a sedative to aid sleep) but he had not brought the medication with him.
30. The man also told the nurse that he had been under the care of community mental health services. During their discussion, he did not expand on this so she did not know whether this contact had been in the previous six days or an earlier period. He said he had no thoughts of self-harm or suicide, but that he

was anxious and stressed about personal issues and wanted to see someone from the mental health team. She agreed he would benefit from a referral to the team for help with coping strategies. She completed a Threshold Assessment Grid (TAG)<sup>1</sup> and referred him to the primary mental health team. She recorded that his medication would need to be confirmed with his GP the next day and entered the GP's details on the electronic medical record, with a task for this to be followed up.

31. The man attended court the next day, Friday 31 May (and every week day up to 24 June). That day, a nurse went to his wing to see him to confirm his GP's details but found that he was at court. She noted, "medication could not be confirmed as no recorded GP details". She had not noted that this information had been recorded in his medical record, so she sent another 'task' on the electronic record for this to be followed up with him.
32. In the week after the man returned to Dovegate his partner told the investigator that she had telephoned the prison as she had not heard from him and was worried. The prison allowed him to speak with her briefly using the internal telephone and she said that he told her he had been unable to purchase telephone credit due to attending court daily. The investigator has seen no evidence of the call made by his partner, but given that he attended court daily it would be reasonable to assume that he had not been given access to canteen, and this should have been picked up by wing staff.
33. On Monday 3 June, a Healthcare Assistant went to the wing to clarify his medication with the man, but found that he was at court again. When she returned to the office, she read his medical record and realised that his GP's address had already been recorded. She told the investigator that at this point, she should have confirmed the medication, but did not have the time.
34. As previously, because he was attending court daily, the man did not have a secondary health screen. Some of the nurses interviewed told the investigator that prisoners returning from court with a change of status or those such as him, who were involved in long trials with daily hearings would not routinely receive a check on their well-being at reception. However, there had been recent changes to ensure that this now happened more frequently.
35. Healthcare staff made no further attempts to contact the man, obtain his GP or psychiatric records, or confirm his medication. He received no prescribed medication at Dovegate. The primary mental health team discussed his referral at a meeting on 4 June and placed him on their routine waiting list but he died before receiving an appointment. A Registered Mental Health Nurse (RMN), said that the initial referral indicated that he had problems sleeping and a TAG score of three, which would usually result in an appointment in around four

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<sup>1</sup> A TAG (Threshold Assessment Grid) is designed to assess the severity of patients' mental health problems. It can be used in a variety of ways, but one use is when a health professional believes that someone has mental health problems and wants to refer to a specialist mental health team - by appending a TAG to their referral letter, specialist mental health services will be helped to prioritise those most in need of help.

weeks. She was aware that he had been prescribed anti-depressants in the community and assumed that he had received this medication at Dovegate. The fact that he had seen a psychiatrist in the community had not been noted in the referral. She said that had the mental health team been aware of this, they would normally have followed it up and obtained the relevant community notes.

36. The man returned to the prison around 6.00pm after his court appearance on 24 June. He was processed in the reception area and, as on other occasions, he was not seen by a nurse in reception. He was taken back to N wing and locked in his cell between 6.30-7.00pm. He was in a cell on his own and he was not required to be observed any more frequently than other prisoners at night.
37. At approximately 5.15am, a Prison Custody Officer began the early morning roll count of prisoners. It was his first night shift at the prison. When he looked through the observation panel of the man's cell, he saw him hanging from the top of the ladder of the bunk bed by a belt tied around his neck.
38. Officer A immediately radioed for medical assistance but, when interviewed, could not recall exactly what he had said. He then opened his sealed key pouch, which contains a cell key for emergency use, opened the cell door and went inside. He called out to the man but he did not respond. He did not check for any signs of life or attempt to move him and left the cell to wait for other staff to arrive. The first to arrive was the Night Security Officer, who had been on one of the other landings on the same wing. The officer told the investigator that he did not cut the belt from around the man's neck as he was sure he was dead and it would have been difficult without moving his body.
39. Two officers were patrolling the prison grounds when they said they heard a radio call for a code blue medical emergency and joined Officer A within three minutes. (A code blue indicates a range of symptoms such as a prisoner who has difficulty breathing or is unconscious.) Officer B said that he was surprised that Officer A had not cut the ligature from around the man's neck. He said he discussed this with him but they were uncertain what to do so they waited for the unit manager, a SPCO, who was in charge of the prison that night. Officer B acknowledged that they all carried cut-down tools to be used in these circumstances.
40. The SPCO said that at around 5.00am he had gone to the gate lodge to check the keys and prepare for the arrival of day staff. Just after 5.00am, he heard a call over his radio for a nurse to attend N wing. There did not seem to be much urgency in the request and he did not hear a request for him to attend or any emergency medical code. However, as it was unusual for a nurse to be requested, he realised that something was wrong so he went to the unit. (He estimated that this took around six minutes.) He found three officers standing outside the man's cell. The door was open and he saw that he was hanging from the bed with a belt around his neck.
41. The SPCO immediately instructed Officer A to cut the belt from around the man's neck and, with the assistance of others, lowered him to the floor. He

then went to the wing office and telephoned the control room to request an ambulance rather than using his radio which might be overheard by prisoners. As he went to the office, a nurse arrived on the wing. By then, ten minutes had passed since Officer A's initial call. During his interview, the SPCO said he was unaware of the most recent national prison guidance about the procedures for requesting an emergency ambulance or any local instructions. The same question was put to all other staff involved and all said that they were unaware of the current guidance and were uncertain of the actions that should be taken on the discovery of a prisoner in such circumstances.

42. Officer B said that the nurse was accompanied by another nurse or a healthcare assistant, but this was an agency worker and staff were unable to recall their name. One of them had an oxygen cylinder and he told them they needed a defibrillator, not oxygen. He then realized that they must have had a defibrillator as the nurse used one shortly afterwards. The nurse, who no longer works at Dovegate and has not been interviewed, was based on houseblock 3, close to the incident and we do not know why it took her 10 to 15 minutes to get to the cell.
43. When the SPCO returned to the cell, Officer B and the nurse were performing cardiopulmonary resuscitation which continued until the paramedics arrived. The paramedics reached the cell at 5.57am, between 12 to 15 minutes after arriving at the prison gate and nearly 45 minutes after the man had been found hanging. After carrying out their own observations and checks, the paramedics pronounced him dead at 6.00am.

#### **Actions after the man's death**

44. All staff immediately involved in the emergency attended a debrief before leaving the prison that morning and were offered the support of the staff care team. All prisoners who were subject to suicide and self-harm monitoring were reviewed and supported as required in case they had been adversely affected by the death.
45. A family liaison officer (FLO) was appointed. As the man's partner, who was his nominated next of kin, lived in Northern Ireland, the FLO arranged for the Police Service of Northern Ireland to notify her of his death and she then telephoned her later that day. The man's partner told the investigator that the day after her partner's death she had attempted to contact the FLO at Dovegate on five separate occasions, but was told that she was unavailable and was not provided with an alternative contact or telephone number. His partner said that she felt this caused her unnecessary upset at an already distressing time.
46. Once the FLO returned to work she remained in contact with the man's partner and helped to arrange his repatriation to Lithuania for burial. His funeral took place on 6 July 2013. The prison contributed to the costs of both the repatriation and the funeral. The family subsequently raised questions about the payment with our family liaison officer. The prison confirmed they had settled all the invoices presented from funeral directors in the UK and abroad.

## ISSUES

### Medical care

47. A clinical reviewer completed a review of the man's clinical care at Dovegate. He was concerned that health services at Dovegate were not well organised to ensure that prisoners' health needs were appropriately met and reviewed. He made a number of recommendations and we repeat those directly relevant to his death in this report.

### *Continuity of care*

#### Reception and secondary health assessments

48. Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners, gives guidance on the clinical management of prisoners from reception through to discharge, with a focus on those with ongoing health needs. Prisons are required to carry out an initial assessment of healthcare needs of all newly-received prisoners within 24 hours of first reception, to identify any existing health conditions and plan relevant care. The man was first remanded to HMP Birmingham on 8 November until 21 December. After several months on bail, he was further remanded to Dovegate from 8 to 24 May and again on 30 May until his death on 25 June. On each occasion, he received an initial health screen within the prescribed timescale.
49. Another mandatory requirement is that, "[I]n the week following first reception, every prisoner must be offered a general health assessment" to gather and provide further information and check how the prisoner is settling in. The man was not offered and did not receive a secondary health screen at any time at Dovegate. We were told that this was because he attended court each day during the week and there was no provision for the health screens to be completed during the evening or at weekends. Each day, his medical record was simply annotated to indicate he was at court. Therefore, healthcare staff did not get a full understanding of any existing medical requirements or check his well-being as a new prisoner.
50. The clinical reviewer said that healthcare staff appeared to assume that every new prisoner would be given a secondary health screen. However, there was no auditable process to ensure that these took place in a timely manner or at all. He added that it is foreseeable that a prisoner will attend court and there is a requirement for a second health screen to be offered. He considers it is unacceptable that one should preclude the other. We agree that, as a number of prisoners could be involved in long trials, there should be a process to ensure that secondary health screens are offered and conducted as required.

#### Obtaining information from the man's community GP

51. During his reception health screen on 8 May, the man gave the nurse the contact details of his GP. He reported a history of depression and said he had seen a psychiatrist but he had stopped taking prescribed anti-depressants. The

nurse said that she did not consider it necessary to contact the GP to confirm the information given as he was no longer taking his medication.

52. The clinical reviewer noted that healthcare staff appeared to have discretion as to whether to contact a prisoner's GP. This seemed to be guided by whether a prisoner was in receipt of prescribed medication and staff rely on the prisoner to provide accurate information during a brief assessment in reception. He considers that, with each member of staff adopting their own approach, there is an increasing likelihood that information and continuity of treatment will be lost.
53. After his further remand to Dovegate on 30 May, the man had another reception health screen, when he said that he had been prescribed anti-depressants and other medication but had not brought it to prison with him. He also disclosed he had been under the care of the community mental health services and that he felt anxious and stressed because of personal problems. A nurse did not explore his comments in any depth but completed a Threshold Assessment Grid TAG to determine the severity of any mental health problems and, as a result, referred him to the mental health team as a routine referral. She also sent a request on the electronic medical record system for healthcare staff to confirm his medication with his doctor the next day.
54. The nurse who initially tried to follow up the task had not read the man's medical record and mistakenly thought that his GP's details were not available. She attempted to confirm the details with him but he was at court and then noticed that the GP's details had been recorded after all. A healthcare assistant tried to see him the next working day while he was at court. She had seen the GP's details but said she had been too busy to contact the surgery. There is no record of any actual attempts to contact the GP's surgery.
55. PSO 3050 expects that healthcare staff should make efforts to obtain information from a prisoner's GP or any other relevant service with which he has had recent contact. The man had reported that he had a medical condition for which he had been prescribed medication. We are concerned that staff failed to verify this information to determine what, if any, continuing care he needed.

#### Provision of medication

56. The medical record was unclear about whether the man had brought medication with him when he arrived at the prison but it was later established at interview that he had not. The clinical reviewer points out that some newly-remanded prisoners will have medication with them. Some of this will have been correctly prescribed while others might be from illegitimate or illegal sources. It is therefore important to clarify these at the earliest opportunity to avoid, or at least minimise, any discontinuity of treatment. The clinical reviewer and the investigator explored with staff at Dovegate the process for confirming this and providing further prescriptions. A nurse explained that any medication that could not be checked would be left in reception for a member of staff on a later shift to verify and ensure that it was re-prescribed.

57. The clinical reviewer points out that if a prisoner has received a legal prescription in the community from an appropriately qualified healthcare professional, it is a breach of duty to withhold or unnecessarily delay the ongoing administration of that medication. He adds that hospital staff face the same difficulties when patients are admitted to hospital as those experienced by the prison healthcare team and there is no justification for lowering the expectation in a prison.
58. The absence of secondary health screens and community medical records meant that the man did not have an accurate and detailed health assessment or any follow up of his existing medical conditions at Dovegate. We share the clinical reviewer's view that continuity of medical care is very important. We are particularly concerned that in this case staff failed to follow up previous mental health issues and treatment which by their nature, could have been exacerbated by his imprisonment and impacted adversely on his well-being. We therefore make the following recommendation:

**The Director of Healthcare should ensure that there are auditable procedures for continuity of healthcare, consistent with the requirements of PSO 3050 and that healthcare staff:**

- **Routinely request prisoners' community medical records.**
- **Offer a full general health assessment to every prisoner within a week of their arrival at Dovegate and**
- **Hold medication reviews promptly and ensure there are no avoidable delays in providing medication for new arrivals.**

### ***Assessment of mental health***

59. The man asked to be referred to the mental health team for assessment, during an initial health screen on 30 May. A nurse completed a Threshold Assessment Grid (TAG) and made a routine referral. The TAG forms are primarily for the use of mental health staff and the nurse, a newly-qualified nurse, said she had been given no training or guidance on completing them. During the investigation, the clinical reviewer and the investigator established that priority is not given on the basis of the overall TAG score, but is dependent on the risks identified by the person who completes the form.
60. The clinical reviewer says that the initial health screen in reception is the first opportunity for staff to assess mental health and risk of self-harm. Often these assessments are undertaken in very busy reception environments and are dependent on the veracity of the information provided by the prisoner as well as the subjective assessment by the healthcare professional. He considers that, as the man had previously received care from a community psychiatric team, there should have been an alternative process for him to access mental health services within the prison. At present, the mental health team relies entirely on the opinion of a busy nurse seeing a prisoner for a relatively brief time in reception and there was no evidence available to demonstrate that these assessments are reliable. We agree that there is a need for this process to be improved and make the following recommendation:

**The Director of Healthcare should ensure that healthcare staff provide in-depth assessments and appropriate prioritisation of prisoners with a history of depression and psychiatric treatment and that the screening process is audited.**

## **Induction**

61. Prison Service Instruction (PSI) 74/2011 gives guidance on early days in custody, including induction. It sets out a mandatory requirement for all new prisoners to be given a pack or booklet giving essential information such as access to Samaritans, Listeners and peer support initiatives. A further mandatory requirement is that, “prisoners must be placed on an appropriate induction programme ... arrangements must be made for those whose induction is delayed to be able to obtain information in the interim”.
62. The induction process enables prisoners to understand their entitlements, responsibilities, what is available to them and how to access facilities. Induction at Dovegate takes place over five weekdays. The man received no induction as he was at court each weekday. Without the benefit of this, it is possible that he was unaware of what help was available in a crisis or how to progress outstanding medical issues such as his medication and request to see the mental health team. We believe that Dovegate should put in place arrangements to induct prisoners such as he who are at court or otherwise unavailable. We make the following recommendation:

**The Director should ensure that all prisoners receive essential induction information quickly after their arrival, in line with PSI 74/2011.**

## **Emergency response**

63. The investigator reviewed Dovegate’s Death in Custody and Management of prisoners at risk of self-harm and suicide (Safer Custody) policies. The Death in Custody policy lists seven objectives of which the first three are:
- “To ensure all staff are aware of and understand their responsibility on discovering the apparent death of a prisoner.
  - To compile local instructions that complies with national policy and is published for all staff.
  - To develop contingency plans containing the relevant Prison Service Orders that is clearly understood by all staff.”
64. As well as the management and support of those at risk of self-harm, the safer custody policy gives guidance on the actions that staff should take after incidents of self-harm. In response to a prisoner discovered hanging, the policy says:
- “Support the body to reduce constriction.

- Cut the prisoner down using fish knife.
  - Cut and then release the ligature immediately the prisoner has been cut down.
  - Check for signs of life, i.e. breathing, pulse, any movement of the body.
  - If not breathing and/or no pulse is present, clear airway and attempt resuscitation, unless rigor mortis of the limbs has clearly set in.”
65. When Officer A discovered the man, he immediately radioed for assistance. Although he could not recall using an emergency code, the control room recorded it as a code blue and some other staff who attended said that they had heard a code blue call. He then opened his sealed key pouch and entered the cell but apart from calling out to him, he did not check for any signs of life. None of the staff who attended removed the belt from around his neck until instructed to do so by the unit manager, a SPCO, who arrived later.
66. The officer thought that the man was “past the point of no return”. The post-mortem report indicates it is unlikely that he could have been successfully resuscitated. Nevertheless, the officer was not medically qualified to make such a judgement, particularly as he had not checked for any signs of life.
67. When the SPCO arrived, he immediately instructed staff to cut the man down. By that time, staff had been standing outside the open cell for at least seven minutes. Irrespective of whether resuscitation is possible, it is a reasonable expectation that staff should cut a ligature from a prisoner as soon as possible. The staff who attended the incident did not follow the procedures in the safer custody policy and appeared to have little knowledge of what to do in such a situation.
68. The SPCO went to the wing office to telephone the control room to request an ambulance, as he did not want to be overheard by other prisoners. By that time at least 10 minutes had passed since the man had been discovered. At interview, none of the staff were aware of the correct procedures for calling an ambulance or PSI 03/2013, which states:
- ”Local procedures must ensure that staff understand that they should not delay summoning emergency assistance. For example, it must not be a requirement for a member of the prison healthcare team or duty manager to attend the scene before emergency services are called.”
69. Once the ambulance arrived, it took around 15 minutes for the paramedic to be taken to the cell, some 45 minutes after the man had been found. No specific reason was given for the delay but the SPCO and others involved referred to having a skeleton staff at night and that the houseblock was on the opposite side of the prison to the gate. PSI 03/2013 also states the need for measures to prevent any unnecessary delay in escorting ambulances and paramedics, including admitting and discharging ambulances during the night state.
70. In the man’s case, it is unlikely that the delays in the emergency procedures impacted on the outcome but such failures could have significant impact in future incidents, particularly where a prisoner is clearly unconscious. PSI

03/2013 was issued at the beginning of February 2013 and prisons were required to have a medical emergency response code protocol based on the instruction by 28 February 2013. The investigator reviewed Dovegate's policies on emergency response and noted that they were due to be reviewed in September 2013 and November 2013. There was no up to date protocol in line with the PSI. We therefore make the following recommendations:

**The Director should ensure that all frontline staff are adequately trained to ensure that they are able to take appropriate action on discovery of an unresponsive prisoner or an apparent death and initiate basic life support as needed until medical professionals arrive.**

**The Director should ensure that Dovegate's emergency response procedures are consistent with Prison Service Instruction 03/2013 and that all staff are aware of their responsibilities during a medical emergency through an emergency response protocol which:**

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

#### **Interaction with personal officer and other staff**

71. One of the unit managers noted in the man's record on 15 May that his personal officer should complete weekly entries and updates on his ongoing court case. At interview, the unit manager acknowledged that it is unacceptable that some prisoners have very few entries. On 22 May, the man's personal officer recorded that she had been unable to speak to him as he had been at court daily, but that she hoped to speak to him over the weekend. There were no other entries about him during his time at Dovegate by any other member of staff.
72. The man's partner was concerned that he had said that staff woke him up early and completed administration for him to attend court even when he was not required which he regarded as bullying. We found no evidence of these events but, as noted, there was little in his record. From the documentation provided he was required to attend court daily apart from weekends and had little contact with prison staff.
73. HMP Dovegate expects personal officers to submit quality entries at least once each week on each of the prisoners allocated to them. The investigation found that, although staff are reminded daily of this, there were no procedures in place to ensure that it actually happened. We therefore make the following recommendation:

**The Director should ensure that personal officers have regular, meaningful contact with the prisoners allocated to them and that all staff record their interactions on P-NOMIS.**

## RECOMMENDATIONS

1. The Director of Healthcare should ensure that there are auditable procedures for continuity of healthcare, consistent with the requirements of PSO 3050 and that healthcare staff:
  - Routinely request prisoners' community medical records.
  - Offer a full general health assessment to every prisoner within a week of their arrival at Dovegate and
  - Hold medication reviews promptly and ensure there are no avoidable delays in providing medication for new arrivals.
2. The Director of Healthcare should ensure that healthcare staff provide in-depth assessments and appropriate prioritisation of prisoners with a history of depression and psychiatric treatment and that the screening process is audited.
3. The Director should ensure that all prisoners receive essential induction information quickly after their arrival, in line with PSI 74/2011.
4. The Director should ensure that all frontline staff are adequately trained to ensure that they are able to take appropriate action on discovery of an unresponsive prisoner or an apparent death.
5. The Director should ensure that Dovegate's emergency response procedures are consistent with Prison Service Instruction 03/2013 and that all staff are aware of their responsibilities during a medical emergency through an emergency response protocol which:
  - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
  - Ensures staff called to the scene bring the relevant equipment; and
  - Ensures there are no delays in calling, directing or discharging ambulances
6. The Director should ensure that personal officers have regular, meaningful contact with the prisoners allocated to them and that all staff record their interactions on P-NOMIS.

**ACTION PLAN: The Man - HMP Dovegate – June 2013**

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p>The Director of Healthcare should ensure that there are auditable procedures for continuity of healthcare, consistent with the requirements of PSO 3050 and that healthcare staff:</p> <p>A - Routinely request prisoners' community medical records.</p> <p>B - Offer a full general health assessment to every prisoner within a week of their arrival at Dovegate and;</p> <p>C - Hold medication reviews promptly and ensure there are no avoidable delays in</p>	Accepted	<p>A – Staff are requested to take all reasonable steps to obtain community medical records for the patient.</p> <p>B – Prisoners receive a reception screening on arrival followed by a second screening within 72 hours. They will have seen 2 healthcare professionals at this point and if a referral to a further clinician is required this will be arranged.</p> <p>C – Medication is recorded during the reception screen process and the GP followed up to confirm current prescription within 24 hours, this is also revisited during the second screening process to ensure that the prisoner is now receiving prescribed medication.</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p>	

	providing medication for new arrivals				
2	The Director of Healthcare should ensure that healthcare staff provide in-depth assessments and appropriate prioritisation of prisoners with a history of depression and psychiatric treatment and that the screening process is audited.	Accepted	<p>Gateway meetings are held weekly, where patients are discussed and prioritised. A further referral to secondary mental health will be made if required. Caseloads are managed by named mental health nurses.</p> <p>The importance of ensuring health screens are undertaken for court returning prisoners is recognised. Priority is not simply dependent upon the TAG score. Presentations recorded in the IMR are also important for informing referral criteria.</p>	Completed	
3	The Director should ensure that all prisoners receive essential induction information quickly after their arrival, in line with PSI 74/2011.	Accepted	<p>Reception to identify and inform both the Resettlement Department and the Wing staff/Personal Officer of the prisoners future court dates, next appearance, trial, appeals, JIC etc or any instances that will required the prisoner to be produced outside of the establishment.</p> <p>This will be done as part of the first night reception notification email document, or direct /telephone contact.</p> <p>Once identified and informed, a Resettlement Rep / LSA can be deployed to supply relevant information, induction</p>	31 <sup>st</sup> December 2013	

			<p>handbook, view the induction DVD together and respond to any questions that may arise.</p> <p>This intervention will take place within 48 hrs of initial reception, following the prisoners return to the establishment, and take place in the reception area.</p> <p>Allocated Personal Officer / Wing Staff to then interview and monitor prisoner to ensure that the information is received and understood.</p>		
4	The Director should ensure that all frontline staff are adequately trained to ensure that they are able to take appropriate action on discovery of an unresponsive prisoner or an apparent death.	Accepted	<p>Line Managers will brief existing PCO badged staff of the processes required when faced with an unresponsive prisoner or an apparent death.</p> <p>The Training Manager will review existing all new staff training to ensure it is fit for purpose and, where necessary, amend the training materials</p>	16/12/13  16/12/13	
5	The Director should ensure that Dovegate's emergency response procedures are consistent with Prison Service Instruction 03/2013 and that all staff are aware of their	Accepted	The emergency response procedures have now been updated in line with PSI03/2013. This policy will be issued to all staff and managers will be required to brief staff with details of their responsibilities.	31 <sup>st</sup> December 2013	

	<p>responsibilities during a medical emergency through an emergency response protocol which:</p> <p>A - Provides guidance to staff on efficiently communicating the nature of a medical emergency;</p> <ul style="list-style-type: none"> <li>•</li> </ul> <p>B - Ensures staff called to the scene bring the relevant equipment; and</p> <p>C - Ensures there are no delays in calling, directing or discharging ambulances.</p>		<p>The training manager will also ensure that all new staff is briefed with regards to their responsibilities in the case of an emergency.</p> <p>The new policy will include guidance on efficiently communicating the nature of a medical response. It will advise staff about ensuring that the correct and relevant equipment is available at the scene and also ensure that emergency services are summonsed when the need has been identified and that that the emergency services are provided with accurate information with regards to the incident.</p>		
6	<p>The Director should ensure that personal officers have regular, meaningful contact with the prisoners allocated to them and that all staff record their interactions on P-NOMIS.</p>	Accepted	<p>All personal officers are briefed with regards to making entries onto PNOMIS relating to prisoners for whom they are responsible for. A management system has been introduced to monitor staff with regards to the quantity and quality of interventions held and feedback will be given to staff as required via the bi-lateral process. Staff who fails to comply will be performance managed in line with company policy.</p>	31 <sup>st</sup> December 2013	

