

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Jason Doughty, a prisoner at HMP Dovegate, on 27 April 2015

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

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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

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

Mr Jason Doughty was found hanged in his cell at HMP Dovegate on 27 April 2015. He was 43 years old. I offer my condolences to his family and friends.

After spending 18 years in prison, Mr Doughty had been released on life license in October 2013. On 23 April 2015 he was arrested and charged with assaulting his partner and two police officers. He was remanded to Dovegate and his licence was revoked. A nurse (and a doctor the next day) noted that Mr Doughty was depressed. However, neither they nor the other staff who assessed Mr Doughty when he arrived at Dovegate identified the extent of his risk. This meant that no one began suicide and self-harm procedures to support Mr Doughty, who killed himself just days later. I have previously made recommendations to Dovegate about the need to consider all risk factors when assessing risk of suicide and self-harm rather than relying on what a prisoner says about his intentions. While we cannot know whether additional support would have prevented Mr Doughty's actions, it is important that there is a structured assessment of risk factors for all new arrivals.

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

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

**January 2016**

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# Summary

## Events

1. Mr Doughty had been released from prison in October 2013, on life licence, after serving 18 years for murder. On 23 April 2015, he was arrested and charged with assaulting his partner and two police officers and causing criminal damage. Mr Doughty was remanded to Dovegate and was due to appear in court again on 28 April. His life licence was revoked.
2. At an initial health screen at Dovegate, Mr Doughty told a nurse that he suffered from depression and had pain from a back injury. He said that he did not have any thoughts of suicide or self-harm. The nurse referred Mr Doughty to a doctor because she was concerned about him being depressed. She recognised that being recalled to prison increased his risk, but did not begin Prison Service suicide and self-harm prevention procedures, known as ACCT. None of the other staff who assessed Mr Doughty when he arrived assessed him as a risk of suicide and self-harm and relied on him saying he did not intend to harm himself.
3. The next morning, a doctor prescribed his medication, including an antidepressant. Mr Doughty told her he did not have any thoughts of suicide and self-harm but the doctor noted his low mood and told officers she was concerned about him. She did not begin ACCT procedures and neither did any of the officers. She arranged to review Mr Doughty a week later. No one noted any further concerns about Mr Doughty.
4. On the evening of 26 April, another prisoner, who was a friend of Mr Doughty's, spoke to him and gave him some tobacco. His friend said that Mr Doughty seemed fine but was worried about his partner giving evidence to the police. That evening, Mr Doughty spoke to his mother a number of times from the telephone in his cell. He then spoke to his partner in the early hours of the morning, the last time at 2.26am on 27 April. Mr Doughty indicated that he was hanging himself as he spoke to her. At around 5.10am, an officer checking prisoners found Mr Doughty had hanged himself. Staff tried to resuscitate Mr Doughty, but it was apparent from the presence of rigor mortis that he had been dead for some time. At 5.52am, shortly after paramedics arrived, they pronounced him dead.

## Findings

5. Mr Doughty had a number of known risk factors for suicide and self-harm when he arrived at Dovegate, including an alleged violent offence against a family member, his relationship difficulties and history of depression. His life licence had been revoked, which meant he was possibly facing a long further indeterminate period in prison, after previously serving 18 years. We are concerned that there was little evidence of a structured assessment of his risk when he arrived and the staff seemed to rely on his statements that he did not intend to harm himself rather than his known risk factors. This is an issue we have raised with Dovegate before and in a number of PPO publications, including a thematic review of risk factors in self-inflicted deaths in prisons, published in

April 2014. While we cannot know that identifying his risk would have prevented Mr Doughty's death, it would have resulted in ACCT procedures to support him.

6. The officer who found Mr Doughty hanged radioed for medical help but did not use a medical emergency code, which would have alerted other staff to the nature of the emergency and prompted the control room to call an ambulance immediately. This would not have affected the outcome for Mr Doughty but it could be critical in other circumstances. As it was apparent that Mr Doughty had died we do not consider it was necessary for staff to have attempted resuscitation.

## Recommendations

- The Director should ensure that there are effective operating procedures in reception and that all staff understand their responsibilities for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:
  - Consider and record all the known risk factors of newly-arrived prisoners when determining risk of suicide or self-harm, including information from all available sources.
  - Record the reasons for decisions and open an ACCT whenever a prisoner has significant risk factors or they observe behaviour which might indicate a risk of suicide and self-harm.
- The Director should ensure that that all prison staff understand the need to use the appropriate emergency medical code in a life threatening situation and that that control room staff request an ambulance immediately an emergency medical code is broadcast.
- The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not necessary or appropriate.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator visited Dovegate on 30 April. She obtained copies of relevant extracts from Mr Doughty's prison and medical records. She interviewed a prisoner who was a friend of Mr Doughty.
9. NHS England commissioned a clinical reviewer to review Mr Doughty's clinical care at the prison. The clinical reviewer and the investigator jointly interviewed healthcare staff at Dovegate on 26 May. The investigator interviewed other staff on 27 May.
10. We informed HM Coroner for Staffordshire (South) of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers, contacted Mr Doughty's son to explain the investigation and to ask if he had any matters the family wanted the investigation to consider. Mr Doughty's son asked why his father had not been monitored more closely, as he had been recalled to prison and would have been very anxious about having to spend a long time in prison again. She wrote to Mr Doughty's partner, but she did not respond.
12. Mr Doughty's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

## Background Information

### HMP Dovegate

13. HMP Dovegate is privately run by Serco. The main prison holds around 933 remanded and sentenced men. There is also a therapeutic community, separate from the main prison, which holds up to 200 men. Healthcare services are provided by Care UK.

### HM Inspectorate of Prisons

14. The most recent inspection of HMP Dovegate was in January 2015. Inspectors reported that support for prisoners during their early days in prison suffered because there was no dedicated first night or early days unit and newly arrived prisoners were not always located on the most suitable wing. This meant that work to ensure their safety lacked consistency. Inspectors found that prisoners who were being managed under the suicide and self-harm management procedures (ACCT) were positive about the support they received and documents demonstrated that reviews were multidisciplinary.
15. While action plans from previous PPO investigations into deaths had been developed, inspectors noted they had not been reviewed to ensure that any changes had been sustained. They found examples where there was no evidence of a change in practice. Drugs, particularly new psychoactive substances (NPS), were widely available in the prison and most illicit substances found during searches were NPS and subutex. Inspectors noted that the prison was taking steps to help address this problem.

### Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to September 2014, the IMB said that the previous year had been difficult because of an increase of prisoners with challenging behaviour. The IMB said that staff shortages had impacted negatively on the time officers could spend supporting prisoners.

### Previous deaths at HMP Isle of Wight

17. There have been five apparently self-inflicted deaths, including that of Mr Doughty, since the beginning of 2013. Four of these were in 2013. In two of these cases we made recommendations about the need to ensure that all known risk factors are considered and recorded when assessing the risk of suicide and self-harm for newly arrived prisoners. One of the cases involved a recall. We made recommendations in two of the cases about the need to call an ambulance immediately in an emergency.

### Assessment, Care in Custody and Teamwork (ACCT)

18. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to



reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

19. On 24 March 1997, Mr Jason Doughty was convicted of murder and sentenced to life imprisonment. On 10 October 2013, he was released on life licence. On 23 April 2015, Mr Doughty was arrested and charged with assaulting his partner and two police officers. He was also charged with causing criminal damage. He appeared in court and was remanded to HMP Dovegate to appear in court again on 28 April. His life licence was revoked.
20. Officer A, who worked in reception, told the investigator that an official from Burton Magistrates' Court had telephoned the prison before Mr Doughty arrived to let them know that he had been recalled to prison, as his life licence had been revoked. The officer said that he knew Mr Doughty from his previous stay at Dovegate and when he arrived, he had asked him several times if he was all right. Mr Doughty told the officer that one of his charges was for a violent offence against his partner. Mr Doughty asked to speak to his partner but the officer said that he would not be able to call her as she was the victim of his offence. The officer told the investigator that he had asked Mr Doughty if he was going to harm himself and he replied firmly that he was not.
21. Officer B completed the reception process with Mr Doughty. As part of the reception process, Dovegate has a questionnaire with specific questions about risk of suicide and self-harm but the officer did not complete this. He noted that Mr Doughty said he did not have any thoughts of suicide or self-harm. The officer assessed Mr Doughty as suitable to share a cell.
22. At an initial health screen, Nurse A recorded that Mr Doughty suffered from depression and took painkillers for a back injury. He said that he had used cannabis but did not drink alcohol. He told the nurse that he had no thoughts of suicide or self-harm. The nurse noticed that Mr Doughty had previously served 18 years in prison and had had his life licence revoked. She noted that licence recall was a risk factor for suicide and self-harm but did not record any other risk factors. She did not begin ACCT procedures. As Mr Doughty said that he had suffered from depression and he appeared low in mood, she referred him to the doctor.
23. Mr Doughty went to M Wing and had a double cell by himself. At 9.00am on 24 April, unit manager, A, as a routine procedure, checked all prisoners on the unit who had arrived at Dovegate the day before. He told the investigator that he did not remember anything specific about Mr Doughty, other than that he had been in the therapeutic community at Dovegate before. He completed a form entitled "First Morning Interview", which has a question about thoughts of suicide or self-harm. He circled "No" to indicate that Mr Doughty did not have any such thoughts. He did not consider whether Mr Doughty had any other risk factors for suicide and self-harm.
24. Later on the morning of 24 April, the lead GP, Dr A, at Dovegate, examined Mr Doughty. The doctor prescribed Mr Doughty with co-codamol for back pain, fluoxetine for depression and propranolol for anxiety. This was in line with his community prescription, except that she substituted co-codamol for tramadol because of the high risk of misuse of tramadol in prisons.

25. Dr A said that Mr Doughty did not look her in the eye, was withdrawn, and in a low mood. His speech was not spontaneous. However, he said he had no thoughts of suicide or self-harm. The doctor was aware that licence recall and a charge of violence against a partner increased the risk of suicide or self-harm but she did not open an ACCT. She told wing officers about his low mood and said she had assumed that officers would begin ACCT procedures if Mr Doughty felt worse.
26. Officers did not open an ACCT and there is no formal record of any staff intervention with Mr Doughty on 25 and 26 April. On the evening of 26 April, Mr Doughty phoned his mother. He told her that he had felt suicidal coming back to prison but he would not do anything stupid. He said he had not eaten since he had arrived at the prison.
27. Prisoner, A, a friend of Mr Doughty's, was a prisoner at Dovegate, also on M Wing. He told the investigator that they had known each other for about 25 years. He said that they had spoken on the evening of 26 April and did not consider that Mr Doughty appeared depressed, although he was worried about the evidence his partner might give to the police. He said he gave Mr Doughty some tobacco before the cells were locked for the night.
28. Dovegate has phones for prisoners to use in their cells. Prisoners can only call numbers which have been agreed in advance, otherwise the number is blocked. Prisoners submit the numbers of their family and friends, which are checked against a list, in case there are any public protection concerns. If no concerns have been identified, then the number is added to the prisoner's authorised numbers. Mr Doughty's cleared list included his mother and partner. (Although Mr Doughty's partner was one of his alleged victims, no formal public protection issues had been identified to prevent him calling his partner and his partner agreed to accept calls from him when he rang.)
29. On the evening of 26 April, Mr Doughty telephoned his mother eight times between 9.00pm and 11.26pm. The last call was for one hour and 41 minutes and ended at 1.08am. He talked about his relationship with his partner, which he thought was over, although said he still loved her. He ended by saying good bye to his mother and said he loved her.
30. Mr Doughty then tried to call his partner three times, but did not get an answer until 2.12am. That call lasted one minute and 41 seconds. The police made a transcript of the telephone calls and Mr Doughty asked his partner if she would answer another call from him in a few minutes and she agreed. He then phoned her at 2.26am in a call which lasted for four minutes and 20 seconds. During the call, he told her that he was sorry for everything that had happened and said he had told her he could not do it. His partner asked him what he meant and what he was doing. He said he just had to slide off the chair, told her he loved her and that he hoped they would meet again in another life. It appears that he hanged himself then.
31. In a statement for the police, Officer C, who was on duty on M Wing on the night of 26/27 April said that she had started a roll count, at 5.10am, to check all prisoners were present in their cells. She said that when she looked through the observation flap of Mr Doughty's cell, he was sitting cross-legged near the bunk

bed ladder with a ligature, made of torn bedding around his neck. She immediately radioed for help. The control room log indicates that the officer radioed “medical response required” at 5.11am.

32. According to the control room log, staff called an ambulance at 5.15am. The West Midlands Ambulance Service logged the call as received at 5.20am. The reason for the discrepancy is not clear. (It is possible the timepiece used for the control room times was five minutes slow.)
33. Officer D and Officer E went to assist Officer C. For security reasons, officers on wings at night do not carry standard prison keys, but have a cell key in a sealed pouch for use in an emergency. Officer C used her emergency cell key to open the cell and she and Officer D went in. They found that Mr Doughty had used torn bedding to tie his hands and feet and had hanged himself from the top rung of the bunk bed ladder. He had also made cuts to both arms and the inside of each ankle. Officer C cut the ligature from the ladder and Officer D cut the bedding from around Mr Doughty’s neck, hands and feet. They laid him on the cell floor and began cardiopulmonary resuscitation.
34. Officer D told the investigator that he thought Mr Doughty was dead. His tongue was protruding and his body had signs of rigor mortis and pooling of blood, which are signs of death. At 5.20am, Nurse B arrived with the emergency bags. She administered oxygen while Officer C continued to give chest compressions. The nurse attached a defibrillator to Mr Doughty, but this found no shockable heart rhythm.
35. According to the West Midlands Ambulance Service report, the first responder arrived at the prison at 5.36am. Another ambulance arrived at 5.44am. At 5.52am, paramedics pronounced Mr Doughty dead. Paramedics noted that there was rigor mortis in his jaws and his mouth and it was beginning to form in his spine.
36. Mr Doughty had left a number of letters addressed to his mother and his partner, in which he stated his intention to take his life. Mr Doughty wrote that he had taken subutex (an opiate substitute used to treat drug addiction) and black mamba (a synthetic cannabinoid or new psychoactive substance) to calm himself before his death and to help ensure he did not make any noise. We do not know how, or from where, Mr Doughty obtained the drugs but note that at the inspection of Dovegate in January 2015, HM Inspectorate of Prisons found that the presence of drugs, including new psychoactive substances, was a significant problem and the most prevalent drugs found during searches were subutex and new psychoactive substances. The Inspectorate was satisfied that the prison had recognised the problem and was taking steps to address it.

### **Contact with Mr Doughty’s family**

37. At 7.30am on 27 April, Officer F and Officer G, the prison family liaison officers, were told of Mr Doughty’s death. They left the prison at 8.00am, to inform Mr Doughty’s partner. They arrived at her home at 9.05am and later informed Mr Doughty’s mother.

38. Mr Doughty's funeral was held on 18 May 2015. The prison contributed to the costs of the funeral, in line with Prison Service instructions.

### **Support for prisoners and staff**

39. After Mr Doughty's death, the assistant director debriefed the staff involved in the emergency response to allow staff to discuss any issues arising and to offer her support and that of the staff care team.
40. Prison staff checked each prisoner on the wing that morning and informed them of Mr Doughty's death and offered support. They later posted notices informing all other prisoners of Mr Doughty's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Doughty's death.

### **Post-mortem report**

41. A post-mortem examination found that Mr Doughty had died as a result of hanging. A toxicology report found traces of cannabinoids, subutex, fluoxetine, codeine and paracetamol.

# Findings

## Assessment of risk of suicide and self-harm (ACCT)

42. Staff judgement is fundamental to the ACCT system. It relies on staff to use their experience and skills, as well as local and national risk assessment tools, to determine risk. This must include the prisoner's known risk factors and their presentation. PSI 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action."
43. We have highlighted the risk factors and triggers for suicide and self-harm in our thematic report on risk in self-inflicted deaths (2014). Triggers and factors increasing risk of suicide and self-harm are also included in PSI 07/2015 – (Early Days in Custody). The following risk factors were relevant to Mr Doughty, who was also in a visibly very low mood when he saw Dr A the day after he arrived:
  1. He was a life sentence prisoner who had been recalled.
  2. He had allegedly committed a violent offence against a family member.
  3. He had relationship problems.
  4. He had a history of depression.
  5. He was in the early days of custody.
  6. He was likely to be facing a long stay in prison.
  7. He had a further court hearing on 28 April.
44. After Mr Doughty's death, the Director of Dovegate issued an instruction that officers should open an ACCT for all prisoners who are recalled from licence, and that the ACCT should remain open at least until there has been a multidisciplinary meeting. However, recall to prison was not the only risk factor that staff missed when he arrived at Dovegate and not all people who are recalled to prison are necessarily at higher risk of suicide. It is important that all risk factors are identified and considered together and balanced against how the prisoner presents. It is apparent that staff placed too much emphasis on Mr Doughty's statements that he did not intend to kill himself rather than on his known risk factors and there is little evidence that they were aware of them or took them into account.
45. After two self-inflicted deaths at Dovegate in 2013, we made recommendations about risk assessments, including that reception staff should document and record all the relevant risk factors of newly arrived prisoners and the reasons for their decisions. The prison accepted these recommendations, yet there is no evidence this was done when Mr Doughty arrived. We are concerned that there was no clear procedure for prison and healthcare staff in reception to actively identify risk factors together, taking into account all sources of information. Only the reception nurse appears to have actively considered his risk; other staff simply noted that Mr Doughty said he had no thoughts of suicide or self-harm.
46. In our thematic report on risk factors we noted that a third of the prisoners who died had seen a member of healthcare staff in the 72 hours before their death and this was a key opportunity to intervene. One of the key lessons was that healthcare staff need to be confident about initiating and using ACCT monitoring



and be clear about when to share concerns about prisoners more widely. Dr A told the investigator that, with hindsight, she thought she should have opened an ACCT. When Dr A saw Mr Doughty on 24 April, she was concerned about him and shared those concerns with wing staff. However, neither she nor any of the wing staff began ACCT procedures. This was another missed chance for staff at Dovegate to make a positive intervention and allow a multidisciplinary team to assess Mr Doughty's risk more thoroughly

47. We cannot know whether opening an ACCT would have prevented Mr Doughty's death. Ultimately it is very difficult to prevent someone who makes a determined decision to kill himself from carrying out that plan. However, managing Mr Doughty under ACCT procedures would have given staff greater opportunity to monitor him more closely in his early days at the prison and offer him support. We make the following recommendation:

**The Director and the Head of Healthcare should ensure that there are effective operating procedures in reception and that all staff understand their responsibilities for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:**

- **Consider and record all the known risk factors of newly-arrived prisoners when determining risk of suicide or self-harm, including information from all available sources.**
- **Record the reasons for decisions and open an ACCT whenever a prisoner has significant risk factors or they observe behaviour which might indicate a risk of suicide and self-harm. Managing the risk of suicide and self-harm.**

### **Emergency response**

48. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system based on the instruction. As is usual, Dovegate's local policy uses code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties. Calling an emergency medical code should automatically trigger the control room to call an ambulance
49. Officer C did not use a code blue when she found Mr Doughty unresponsive in his cell. Instead, she radioed "medical response required", which is not the correct message for a life-threatening emergency. Although officers and nurses responded immediately, which meant there was no internal delay in attending to Mr Doughty, this did not prompt the control room to call an ambulance immediately. It was some minutes later before one was called. While it is clear that this did not affect the outcome for Mr Doughty, who had already died, in other emergencies such a delay could be crucial. We make the following recommendation:

**The Director should ensure that that all prison staff understand the need to use the appropriate emergency medical code in a life threatening situation and that that control room staff request an ambulance immediately an emergency medical code is broadcast.**

50. Officer D said that when he arrived at Mr Doughty's cell, there was evidence of rigor mortis and blood was pooling in his body. He thought that Mr Doughty was dead. When paramedics arrived they also noted signs of rigor mortis. In such circumstances, it was not necessary to attempt to resuscitate Mr Doughty. European Resuscitation Council Guidelines 2010 state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...". The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. Decisions should never be dictated by 'blanket' policies.
51. The staff involved in the emergency response were commendably motivated by their duty of care towards Mr Doughty in attempting resuscitation. We do not criticise their actions and resuscitation should be attempted unless there are clear signs of death. However, we consider that the staff need guidance and reassurance that it is acceptable not to attempt resuscitation when someone is clearly dead, which is distressing for staff and undignified for the deceased. We make the following recommendation:

**The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not necessary or appropriate.**



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