Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Phillips, a prisoner at HMP Dartmoor, on 29 October 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

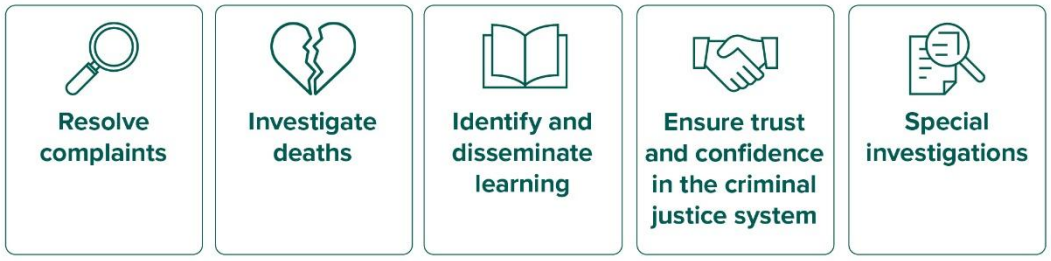
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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

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

Mr John Phillips died on 29 October 2022 after being found hanged in his cell at HMP Dartmoor. He was 37 years old. I offer my condolences to Mr Phillips' family and friends. There were two self-inflicted deaths at HMP Dartmoor in the three years leading up to the death of Mr Phillips.

The clinical reviewer found that the clinical care provided to Mr Phillips was not equivalent to that which he could have expected to receive in the community based on the delay in his mental health assessment.

I found that the non-clinical care provided to Mr Phillips was generally of a good standard. There were no clear signs that Mr Phillips was in crisis in the period leading up to his death, which came as a shock to those around him.

I am also concerned that the current HMPPS emergency response policy is not fit for purpose and have made a recommendation to the Director General.

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

Adrian Usher
Prisons and Probation Ombudsman **May 2024**

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

Contents

Summary

Events

1. In 2006, Mr John Phillips received an Imprisonment for Public Protection (IPP) sentence for robbery with a four year minimum tariff. Following the expiry of his tariff, Mr Phillips was released by the Parole Board on three occasions between 2015 and 2019 but was recalled for further offences and threatening his ex-partner. His next review by the Parole Board was due in 2025.

2. On 22 July 2022, Mr Phillips transferred to HMP Dartmoor. He consistently denied having any thoughts of suicide or self-harm while there. Staff identified that Mr Phillips was experiencing anxiety and paranoia and referred him to the mental health team. However, due to an administrative error, he was not assessed by the team until October, after which he was referred for therapeutic groups and prescribed antidepressants.

3. Both prisoners and staff said that they had no concerns about Mr Phillips and that he seemed his usual self when he was locked up the day before his death. His last telephone calls to his family did not indicate any significant distress.

4. On 29 October around 8.45am, prisoners looked into Mr Phillips' cell and realised that he was sat in his chair with bedding tied around his neck and to the window bars. They alerted staff who responded, cut the ligature and tried to resuscitate Mr Phillips. Paramedics attended and took over Mr Phillips' treatment. They confirmed that he had died at 9.10am. Police found a note in Mr Phillips' cell indicating his intention to take his own life.

Findings

5. During Mr Phillips' time at Dartmoor, he consistently denied having any thoughts of suicide or self-harm and both staff and prisoners did not observe any obvious signs he was in crisis. His death was a shock to those who knew him. Mr Phillips had been serving an IPP sentence since 2006 and had spent the vast majority of his time in prison since then. It is clear from the note that Mr Phillips left that the amount of time he had spent in prison had deeply affected him, such that he could no longer see a future. However, we have concluded that he hid his distress and it was reasonable that staff did not identify an imminent risk of suicide.

6. The clinical reviewer concluded that Mr Phillips' healthcare was not equivalent to that he could have expected to receive in the community based on the delay in his assessment by the mental health team and provision of healthcare reviews and medication. This was partly due to Mr Phillips' medical record being incorrectly transferred to another prison.

7. We are concerned that the current HMPPS emergency response policy is not fit for purpose and causes an unnecessary delay in ambulances being despatched. We make a recommendation to the Director General of HMPPS in this regard.

Recommendation

- The Director General of HMPPS must review the current emergency response policy to eliminate the conflict between calling an ambulance immediately and providing the 999 operator details about the nature of the emergency.

The Investigation Process

8. We were notified of Mr Phillips' death on 31 October 2022. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact her. Several prisoners responded.

9. The investigator obtained copies of relevant extracts from Mr Phillips' prison and medical records. There is no CCTV on the wing where Mr Phillips died. Dartmoor lost the body worn camera footage of the emergency response during a system update before they had been able to save a copy for the investigation.

10. NHS England (NHSE) commissioned a clinical reviewer to review Mr Phillips' clinical care at the prison. The investigator and clinical reviewer interviewed five members of staff and three prisoners at HMP Dartmoor in February 2023.

11. We informed HM Coroner for Exeter and Greater Devon of the investigation. The results of the post-mortem examination were not available at the time of writing. We have sent the Coroner a copy of this report.

12. The Ombudsman's family liaison officer contacted Mr Phillips' mother to explain the investigation and to ask if she had any matters she wanted us to consider. She asked how Mr Phillips had been able to take his own life, which we have addressed in this report, based on the evidence available to us.

13. Mr Phillips' mother received a copy of the draft report. She did not make any comments.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. NHSE also pointed out a factual inaccuracy in the clinical review which a recommendation was based on. We have therefore removed this recommendation.

Background Information

HMP Dartmoor

15. HMP Dartmoor is a training prison holding up to 689 adult male prisoners. Primary healthcare services are provided by Practice Plus Group (PPG) and mental health services by Devon Partnership NHS Trust.

HM Inspectorate of Prisons (HMIP)

16. The most recent HMIP inspection was a short scrutiny visit in September 2020. The visit took place while the prison was subject to COVID-19 restrictions. Inspectors found that relationships between prisoners and staff were generally good. The key work scheme had been suspended at the time due to COVID-19 restrictions. The prison was also subject to a closure notice at the time which was cancelled in December 2021.

Independent Monitoring Board

17. 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 2022, the IMB noted that, following the decision to stay open, the essential investment then needed in Dartmoor did not take place. They found that there were staff shortages in several areas, with high numbers of staff required to escort prisoners during hospital stays due to an older prison population. Prisoners were often locked up for 23 hours a day. There was reduced access to activities and education, daily communications, showers and association. The IMB concluded that prisoners' experience at Dartmoor was unacceptable though they noted that it had begun to improve towards the end of the reporting year.

Previous deaths at HMP Dartmoor

18. Since October 2019, Mr Phillips was the twelfth prisoner to die at Dartmoor. Nine of these previous deaths were due to natural causes and two were self-inflicted. Four prisoners have died of natural causes since Mr Phillips. None of our investigations into these previous deaths raised issues relevant to this investigation.

Imprisonment for Public Protection (IPP)

19. IPP sentences are indeterminate, which means that when the minimum tariff has expired, individuals are required to demonstrate to the Parole Board that their risk has reduced enough to be managed in the community. IPP sentences were introduced in 2005 and abolished in 2012, but the abolition did not apply retrospectively to those who had already received the sentence.

20. In September 2023, the PPO published a learning lessons bulletin on the self-inflicted deaths of IPP prisoners. This was due to an increase in self-inflicted deaths among IPP prisoners in 2022. We concluded that more needed to be done by

HMPPS to ensure that the high levels of deaths did not continue. We noted that an IPP sentence should be considered as a potential risk factor for suicide and self-harm. IPP prisoners can often struggle with their uncertain status leading to feelings of hopelessness and frustration. We found that this can cause a lack of engagement with the parole process and sentence planning and create a lack of trust in the system.

Assessment, Care in Custody and Teamwork (ACCT)

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

22. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key worker scheme

23. The key worker scheme was introduced in the men's prison estate in 2018. It provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

24. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

Background

25. On 24 March 2006, Mr Phillips received an Imprisonment for Public Protection (IPP) sentence, with a minimum tariff of four years imprisonment. In 2015, Mr Phillips was released for the first time. He was recalled to custody two years later. In January 2019, Mr Phillips was released again but was recalled three weeks later. In December 2019, Mr Phillips was released for the third time. In July 2020, probation staff recalled him due to allegedly threatening his ex-partner. During this last period on release he also committed further offences of robbery and handling stolen goods. He was taken to HMP Swansea.

26. On 23 July 2020, Mr Phillips transferred to HMP Parc. He said he had no thoughts of suicide or self-harm. During his time at Parc, Mr Phillips engaged with his key workers, was employed as a barber and did not raise any significant issues. He hoped to be transferred to a category D open prison as part of his sentence progression.

27. On 26 November 2021, Mr Phillips was given an 87 month extended sentence for offences of robbery and handling stolen goods. May 2025 was listed as the earliest point at which the Parole Board would consider release.

HMP Dartmoor

28. On 22 July 2022, Mr Phillips transferred to HMP Dartmoor. During his reception healthscreen with a nurse, he said that he had no problem with being at Dartmoor and had been there before. He said that he had no thoughts of suicide or self-harm. Mr Phillips' reception healthscreen noted that he had newly diagnosed type II diabetes, a history of substance misuse, had detoxed from methadone (an opiate substitute) at Parc and suffered from anxiety and paranoia. Staff referred him to the mental health team. This was a routine referral and meant that Mr Phillips should have been seen within five working days. He was prescribed metformin (for diabetes) and cetirizine (an antihistamine).

29. On 23 July, a chaplain from the chaplaincy department spoke to Mr Phillips. He told her that he was happy to be back at Dartmoor and she noted that he seemed cheerful. He said that he did not expect to receive any visits but would keep in contact with his friends and family via the telephone and was happy with this.

30. On 24 July, Mr Phillips had a secondary healthscreen with a nurse. He said that he would like to see the mental health team and the nurse told Mr Phillips that he had already been referred.

31. On 25 July, a member of staff at Parc re-registered Mr Phillips at HMP Parc. It was not possible to establish why, as the person who did so no longer worked at the prison. However, when this happened, Mr Phillips' records transferred to Parc and his appointments and referrals at Dartmoor were automatically cancelled by the system, without staff at Dartmoor being notified. On 26 July, Mr Phillips' record was transferred back to Dartmoor but his previous appointments and referrals were not reactivated.

32. On 27 July, Mr Phillips had an induction meeting with the substance misuse service. He said that he would like to be prescribed methadone again (he had successfully withdrawn from methadone around two months earlier). He was advised to apply to the substance misuse clinical lead prescriber. Mr Phillips said he did not want to engage with the substance misuse service and did nothing more to pursue a methadone prescription.

33. On 26 September, the Prison Offender Manager (POM) met Mr Phillips. He said that he was well and felt settled at Dartmoor. He said he would like to be employed to use his time productively. They spoke about Mr Phillips' offending history and Mr Phillips said that he was slowly accepting that he would not be eligible for consideration for release until 2025. He said that he was still motivated to address his offending behaviour. Mr Phillips also said that he was finding it hard to cope after his methadone prescription had been stopped at Parc. The POM noted that he would contact the substance misuse and mental health teams.

34. On 29 September, the POM emailed the mental health team to say that he had spoken with Mr Phillips who said he had applied to see them. Mr Phillips had said that his mental health was relatively stable at present but he wanted to see if any support was available as a preventative measure. There is no evidence that this email was actioned by the mental health team.

35. The POM also emailed substance misuse services. He wrote that Mr Phillips had told him that he wanted to see someone from the team about being prescribed methadone as he felt it had been withdrawn without justification at Parc and was impacting his physical and mental health.

36. On 5 October, the POM emailed the mental health team again, asking when Mr Phillips was going to be assessed. As a result of this email, on 10 October, a nurse assessed Mr Phillips. He said he had no suicidal thoughts but was low in mood. He rated his mood four out of ten but said he had been down to one out of ten in the last week. He said that he struggled with motivation and spent much time standing on the landings or watching television and felt anxious and paranoid.

37. Mr Phillips told the nurse that he had attempted suicide in the past, most recently in 2018 when he had taken a heroin overdose. He said that he had had thoughts of suicide since then, mainly when he was paranoid. Mr Phillips said that he had no current thoughts of suicide or self-harm. The nurse sent the GP an electronic task requesting that they consider prescribing Mr Phillips antidepressants and review him in four to six weeks. He also noted that Mr Phillips should be discussed in the multidisciplinary team meeting, and he would recommend two group courses for anxiety and emotional management. The nurse documented that he did not assess Mr Phillips needed suicide and self-harm prevention procedures (known as ACCT) support at the time.

38. Mr Phillips called his father at 3.05pm. They had a general conversation and Mr Phillips asked his father to research potential changes to IPP sentences as he had heard that prisoners on IPP sentences were going to be resentenced and he hoped that this was true.

39. On 11 October, an officer introduced himself to Mr Phillips as his key worker. He had recently been allocated to him. He noted that Mr Phillips was a quiet prisoner

who had been in contact with his POM and discussed his progression. Mr Phillips said that he was waiting for a psychological assessment and also needed to undertake mental health courses, though he was unsure what these were. He was due to start education on 18 October. Mr Phillips said that he had no issues that he wanted to raise with him. The officer told the investigator that Mr Phillips socialised well with other prisoners on the wing. He said that he never had any concerns that Mr Phillips was a risk to himself.

40. On 13 October, a substance misuse worker assessed Mr Phillips. He said he wanted to be prescribed methadone. He encouraged Mr Phillips to use alternative coping strategies such as attending a relapse prevention group. Mr Phillips said he had no current thoughts of suicide or self-harm.

41. On 18 October, Mr Phillips did not attend the relapse prevention group. The mental health multi-disciplinary team discussed Mr Phillips and added him to the waiting list to attend therapy groups. At the time, the waiting list for these groups was around five months although it is unclear whether Mr Phillips was told this because there is no record of contact. On 21 October, a prison GP prescribed Mr Phillips sertraline (an antidepressant) which he started taking two days later.

42. On 23 October, Mr Phillips saw a nurse due to a medical issue. They gave him advice and topical treatment. The next day, he received treatment in hospital for the condition. On return to prison, he was prescribed antibiotics as directed by the hospital.

43. On 26 October, Mr Phillips called his father. They had a general conversation and spoke about what had happened at the hospital. On 28 October at 3.10pm, Mr Phillips telephoned his father again, who asked if the antibiotics had worked, to which Mr Phillips replied that there had been no change and he would see a GP when he had finished the course. His father asked how Mr Phillips' job in the servery was going and Mr Phillips replied that it was okay and they got extra time out of their cell though the pay was bad. Mr Phillips said he would call his parents in a couple of days and he loved them both. Mr Phillips did not attend a substance misuse group session that day.

44. Prisoner A told the investigator that he was friends with Mr Phillips, and they drank coffee together most mornings. He said that Mr Phillips seemed happy and he never had any concerns that he was a risk to himself. Mr Phillips went to his cell just before they were locked up that evening and asked for some coffee and sugar. He said that it was normal for them to share things. He said that Mr Phillips seemed his usual self, was laughing and they shared some banter. He had no concerns about his safety. Prisoner B was also good friends with Mr Phillips. He said that Mr Phillips had also come to his cell before they were locked up and asked for some tea bags and sugar. He said that he seemed his "normal self".

45. An Operational Support Grade (OSG) checked prisoners were in their cells on the wing around 8.00pm that evening. She could not remember specifically checking Mr Phillips but said that there must have been nothing exceptional during the check as she would have reported it if there was.

Events of 29 October

46. On 29 October between 5.20am and 5.50am, the OSG checked all the prisoners on the wing. She estimated that she would have checked Mr Phillips' landing at around 5.40am. Again she could not specifically remember checking Mr Phillips but knows that she did and there was nothing which gave her cause for concern.

47. Around 8.30am, staff unlocked three prisoners. They were unlocked before other prisoners as they were employed on the wing. Five minutes later, Prisoner A wondered why Mr Phillips had not been unlocked as he had a job on the servery. An officer told the investigator that only cleaners were unlocked before the other prisoners, which is why Mr Phillips had not been unlocked.

48. Prisoner A went to Mr Phillips' cell and looked through his observation panel. He said there was limited light but Mr Phillips was sat in his chair and looked as if he was asleep. He asked Prisoner B to look through the flap, and he also thought that Mr Phillips was asleep. At 8.45am, Prisoner A thought something was not right and returned to Mr Phillips' cell with Prisoner C. They looked through the observation panel, turned the night light on and realised there was a strip of material attaching Mr Phillips to the window bars. The prisoners shouted for an officer, who was nearby, to check Mr Phillips.

49. The officer went straight to the cell and looked through the observation panel. He thought Mr Phillips looked slumped in his chair so he opened his cell door. He then realised that Mr Phillips was suspended by a ligature made from a bed sheet attached to the window bars. He shouted a code blue and ran down the wing stairs to alert staff. (Code blue is an emergency code indicating that a prisoner is not breathing or is having difficulty breathing.)

50. A Supervising Officer (SO) was in the wing office when he heard the officer's shout. He ran towards the officer, who said there was a code blue, which the SO radioed. Control room staff requested an ambulance immediately. The SO and officer accidentally went to the wrong landing. Two other officers had already reached Mr Phillips' cell in response to the call. They went straight in, supported Mr Phillips' body and cut the material. They then removed the ligature from his neck, checked for signs of life and began chest compressions. Healthcare staff arrived at the cell soon after and assessed Mr Phillips. They inserted an airway and administered oxygen. At 9.10am, paramedics arrived at the wing. At 9.39am, the paramedics confirmed that Mr Phillips had died.

51. Police found a note in Mr Phillips' cell after he died. He apologised for his behaviour, stated that he could not go on and regretted how he had lived his life and the amount of time he had spent in prison. Mr Phillips wrote that he had no life or future. He apologised to the person who found him.

Contact with Mr Phillips' family

52. On 29 October, the Deputy Governor travelled to Mr Phillips' mother's address to break the news of his death, but found she no longer lived there. Through speaking to a neighbour, Mr Phillips' aunt, he obtained Mr Phillips' mother's address nearby. At 1.00pm, he arrived at the address and told Mr Phillips' mother that he had died.

He offered his condolences. Mr Phillips' mother fetched Mr Phillips' father from another address nearby and he spoke to both of them together.

53. Mr Phillips' mother lived over three hours away from Dartmoor, which took the Deputy Governor away from the establishment for some time. There was a shortage of available family liaison officers (FLOs) at Dartmoor which meant longer term support for the family would be difficult.

54. On 1 November, staff at Dartmoor asked staff at HMP Channings Wood if they could assist with the family liaison. An officer at Channings Wood was allocated as the FLO for Mr Phillips' family. On 2 November, she was given Mr Phillips' mother's contact details. As she knew Mr Phillips' mother had already been informed of her son's death, she waited until she had received more information from Dartmoor before phoning her. On 5 November and 6 November, she tried to ring Mr Phillips' mother several times but could not get through. On 7 November, the Head of Safety wrote to Mr Phillips' mother explaining that staff had been unable to get through to her on the telephone. She asked that Mr Phillips' mother contact the family liaison officer and gave her their contact details.

55. On 8 November, the family liaison officer spoke to Mr Phillips' mother and offered her condolences. She offered her a contribution to funeral expenses in line with HMPPS' policy. She remained in contact with Mr Phillips' family.

Support for prisoners and staff

56. After Mr Phillips' death, the Head of Offender Management debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

57. The prison posted notices informing other prisoners of Mr Phillips' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Phillips' death.

Post-mortem report

58. The post-mortem report was not available at the time of writing. However, the coroner recorded the preliminary cause of death as hanging.

Findings

Assessment and management of risk

59. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

60. Mr Phillips had been at Dartmoor for about three months when he took his own life. During that time he had consistently denied having any thoughts of suicide or self-harm. Staff did not identify any signs that he was a risk to himself. His friends on the wing shared this view and said that he seemed his usual self just before he was last locked in his cell. We listened to the calls Mr Phillips made to family in the period before his death and none of these conversations suggested he was in crisis.

61. Mr Phillips had spent the vast majority of his time in prison since 2006, whilst serving an IPP sentence. He had been released by the Parole Board on a few occasions, but was recalled due to suspected threatening behaviour towards his ex-partner and committing further offences. Mr Phillips received a further prison sentence and was not eligible for release until 2025. Although Mr Phillips appeared to be engaged with his sentence progression at his recent meeting with his POM, it is clear from the note that he left in his cell that the amount of time he had spent in prison had deeply affected him and he no longer felt there was a point to continuing with his life. Mr Phillips spoke to his dad on 10 October about possible changes to IPP sentences but did not appear to be in immediate distress.

62. Overall, the investigator and clinical reviewer found that Mr Phillips' outward presentation did not indicate any significant risks to himself. We know that suicidal ideation is often a private process. Even had staff recognised Mr Phillips' IPP sentence as a risk factor for suicide, we conclude that staff could not reasonably have foreseen an imminent risk of suicide in the days leading to his death.

Welfare checks

63. At Dartmoor, there is no expectation that staff check prisoners when they start their shift in the morning. This is in accordance with Dartmoor's Local Security Strategy. However, in Mr Phillips' case, this meant that there was a long period during which he was not checked. A prison governor told the investigator that Dartmoor was going to introduce a routine check when day staff started their shift as an extra precaution for prisoner safety and security, we therefore do not make a recommendation.

Family Liaison

64. When Mr Phillips died, there were no family liaison officers (FLOs) available to appoint and the Deputy Governor travelled to Mr Phillips' family home to deliver the news and offer support. This was good practice to cover a gap in provision. Neighbouring HMP Channings Wood provided a trained FLO who followed up the initial visit and provided ongoing support.

65. The Head of Safety told the investigator that Dartmoor had since trained three FLOs, and another was hoping to be trained soon. We therefore do not make a recommendation.

Clinical care

66. Overall, the clinical reviewer concluded that Mr Phillips' healthcare was not equivalent to that he could have expected to receive in the community.

Mental health

67. Mr Phillips was struggling with low mood so the GP at Dartmoor prescribed antidepressants and put him on the waiting list for therapeutic groups. The clinical reviewer concluded that this approach was comparable to community services.

68. In June 2022, Mr Phillips asked to see the mental health team. A referral was made but due to Parc, his previous prison, transferring his records this referral was automatically cancelled by the system. Since Mr Phillips' death, Dartmoor have made changes to the administrative process to identify if prisoners have been incorrectly recorded as transferring to another prison. The clinical reviewer is satisfied that this has been appropriately addressed but is concerned how Parc incorrectly registered him back there. They have made a recommendation to Parc to investigate why this occurred which the Head of Healthcare will want to address.

69. In September, Mr Phillips' POM emailed the mental health team twice to request an assessment after he had spoken to Mr Phillips. The first email was not actioned. The Mental Health Team Manager was unable to check why, as the mental health team had been taken over by a different Trust since then, so they no longer had access to the old email account.

70. The second email resulted in Mr Phillips being assessed by the team. The clinical reviewer noted that the delay in Mr Phillips being assessed was a missed opportunity for the team to engage with Mr Phillips, for him to understand what support was available at Dartmoor and to address his mental ill-health. However, the reviewer concluded that the omission was unlikely to have contributed to Mr Phillips' overall wellbeing as when he was eventually assessed he said he was low in mood but his mental health was generally stable.

71. Mr Phillips was prescribed antidepressants on 23 October but the clinical reviewer notes that no review was booked with the GP. This should have taken place one to two weeks after he started antidepressants, in accordance with national guidelines.

Contact with emergency services

72. PSI 03/2013, *Medical emergency response codes,* instructs that staff radio a code blue when a prisoner is in chest pain, having difficulty breathing, unconscious, choking, having a fit, having a severe allergic reaction or having a stroke. Control room staff must then immediately call an ambulance and "await updates from the scene". Staff with the prisoner must provide relevant information about the condition of the prisoner to control room staff so that they can pass is on to the ambulance service. 999 operators require certain information in order to despatch and prioritise emergency ambulances, including the location of the emergency, and whether the patient is breathing.

73. We listened to the recording of the 999 call staff in the control room made when they received the code blue emergency alert. The information given to the operator was confused and failed to pass on basic information about the nature of the emergency. It took two minutes for the operator to establish that staff were calling from Dartmoor and Mr Phillips was not breathing (and therefore for the ambulance to be despatched), and four minutes for them to be transferred to the wing when they were given full details of what had happened.

74. We have not reviewed any evidence that suggests this impacted on the outcome for Mr Phillips. However, we have investigated a number of deaths, particularly self-inflicted deaths, where the instructions in PSI 13/2013 are not compatible with the efficient despatching of ambulances by 999 operators. We make the following recommendation:

    The Director General of HMPPS must review the current emergency response policy to eliminate the conflict between calling an ambulance immediately and providing the 999 operator details about the nature of the emergency.

Governor to note

Key work

75. Mr Phillips had only one key work session in the three months he spent at Dartmoor. This was with his key worker on 11 October. The key worker explained that Mr Phillips was allocated to him briefly as he was then temporarily promoted.

76. The Head of Re-offending said that since Covid-19, Dartmoor had been struggling to successfully reinstate the key work model in full. He said that some officers did not deliver key work for months due to poor wing management. In January 2023, out of 600 prisoners who should have been receiving one session a week, 278 key work sessions took place in. In February 2023, 48 key work sessions took place.

77. The Head of Re-offending said that at the time Mr Phillips was at Dartmoor, key work was being allocated on a daily basis, dependant on staffing resource and other pressures. He said that staffing levels were reasonable but Dartmoor's ageing population meant officers were frequently redeployed for hospital escorts, creating staff shortages on the wings. If prisoners were in crisis, they would be prioritised for key work. In August 2023, we asked him for an update. He said that key work delivery was still being impacted by resourcing pressures, which the regional Prison

Group Director (PGD) was aware of but had little power to support while officers were being sent on detached duty to establishments experiencing other staffing pressures. Both the PGD and the Head of Re-offending acknowledged the need for increased key work at Dartmoor, to ensure meaningful contact for prisoners.

78. It is difficult to measure the impact on Mr Phillips. During his time at Dartmoor, Mr Phillips engaged with various members of staff including his POM and chaplaincy. He also had regular contact with his family and had friends on the wing. Mr Phillips showed no obvious signs of distress or isolation. Our recent learning bulletin on IPP sentenced prisoners identified that they should be prioritised for key work. This is something the Governor will wish to consider.

79. We found no clear plan in place to improve key work delivery at Dartmoor by the Governor and PGD, despite the clear benefits for prisoners. Specifically, we found no plan to address the impact of staff redeployment to other prisons and the impact of the ageing population on resources. We do not make a recommendation but suggest the Governor and PGD consider this in light of the National Regime Model.

Inquest

80. The inquest into Mr Phillips' death ended on 15 June 2026 and concluded that Mr Phillips died as a result of suicide.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100