Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Williams, a prisoner at HMP Dovegate, on 12 July 2021

A report by the Prisons and Probation Ombudsman

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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.

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 Keith Williams died on 11 July 2021 after he cut his neck in his cell at HMP Dovegate. He was 46 was years old. I offer my condolences to his family and friends.

Mr Williams initially complained about an infected hair follicle, which progressed to bizarre and distressing beliefs about an infection running through his body and excruciating pain. Although there was no evidence of a physical health problem, Mr Williams was convinced that something was wrong and cut himself on several occasions to stop the pain.

Staff monitored Mr Williams under suicide and self-harm prevention procedures, known as ACCT, six times at Dovegate. While there was some good practice, I am concerned that staff did not fully address his risks or consider the possibility of accidental death. It is not the first time that I have identified deficiencies in Dovegate's ACCT procedures.

The clinical reviewer concluded that although elements of Mr Williams' clinical care at Dovegate were satisfactory, his mental health care was not equivalent to that which he could have expected in the community. Our investigation found that mental health staff focussed too heavily on his reported physical health problems and apparent substance misuse and missed several opportunities to arrange a follow-up psychiatric assessment.

I am also concerned that healthcare staff did not hold a complex case review, did not inform Mr Williams of his hospital scan result and did not always complete the ACCT document. We have previously made a recommendation about this and are disappointed that we need to do so again.

I am also concerned that the prison did not inform Mr Williams' next of kin of his death promptly in line with Prison Service instructions.

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

Sue McAllister CB
Prisons and Probation Ombudsman **July 2022**

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Summary

Events

1. In March 2017, Mr Keith Williams was sentenced to eight years in prison for robbery and sent to HMP Birmingham. (He was subsequently sentenced to an additional four years in prison in March 2019.) Mr Williams had a history of substance misuse problems and was prescribed methadone to treat opioid dependence.

2. On 16 January 2020, Mr Williams was moved to HMP Dovegate. In August, a prison GP recorded that Mr Williams had several sores on his scalp and prescribed an antibiotic.

3. In December, a prison GP, a consultant psychiatrist and a mental health nurse jointly reviewed Mr Williams after he made a cut to his neck. Mr Williams denied hallucinations or substance misuse and the psychiatrist concluded that there was no evidence of severe mental illness. That day, prison staff started ACCT procedures.

4. Over the next seven months, Mr Williams frequently reported pain and various sensations throughout his body that he felt were linked to an infected hair follicle. He sometimes said he believed there were insects in his body. Prison staff started ACCT procedures on four occasions, twice after Mr Williams cut himself to stop the physical pain he said he felt.

5. On 8 July 2021, a Prison Custody Officer (PCO) found Mr Williams in his cell, covered in blood, and radioed an emergency medical code. Prison and healthcare staff attended to Mr Williams and noted that he presented as under the influence of psychoactive substances (PS). Prison staff started ACCT procedures and removed potentially dangerous items from his cell, such as razors.

6. On 9 July, Mr Williams told staff at an ACCT case review that he did not have any suicidal thoughts but was still in agony and felt like cutting to stop the pain. They reduced his ACCT observation requirement to two an hour but did not indicate whether any items had been removed or were restricted.

7. At 11.38pm on 11 July, a night support officer (NSO) saw Mr Williams lying face down on the floor of his cell, which was covered in blood. She radioed a medical emergency code and a PCO arrived immediately. A Custodial Operations Manager (COM) asked them by radio if Mr Williams was responsive and they said that they had seen him breathing. She therefore told them not to enter the cell, unless necessary.

8. At 11.40pm, the COM arrived with a PCO and a nurse and had to force entry to the cell as Mr Williams had put a chair behind the door. Staff began cardiopulmonary resuscitation (CPR), but at 12.05am on 12 July, the nurse asked them to stop CPR as it was clear that Mr Williams had died. Paramedics arrived at 12.20am and at 12.24am, confirmed that Mr Williams was dead.

Findings

9. We cannot say if Mr Williams intended to kill himself when he cut his neck.

Risk management

10. Mr Williams repeatedly reported pain and bizarre and distressing beliefs about an infection running through his body. We are satisfied that staff showed concern and appropriately started ACCT procedures following incidents of self-harm and associated thoughts.

11. While there was some good practice, we are concerned that staff failed to fully consider Mr Williams' risk factors as part of their ongoing assessment and placed too much emphasis on the fact that he denied having suicidal thoughts.

12. We are particularly concerned that staff misinterpreted Mr Williams' risk the day before he died. They failed to consider his risk of accidental death and his access to razors and inappropriately reduced his ACCT observations. We have raised concerns about ACCT management at Dovegate before and urgent action is now required.

Clinical care

13. The clinical reviewer concluded that although elements of Mr Williams' clinical care at Dovegate were satisfactory, his mental health care was not equivalent to that which he could have expected in the community.

14. Mr Williams was referred to the mental health in reach team several times, but they repeatedly declined to provide intervention and, particularly from March 2021 onwards, appeared to focus on his PS use and reports of physical pain. These were missed opportunities to fully assess him and to request another psychiatric review.

15. We are concerned that healthcare staff did not hold a complex case review and that services often acted in isolation, with minimal communication. We are also concerned that nobody informed Mr Williams of the result of his MRI scan and that healthcare staff did not always complete ACCT records. We have previously made a recommendation about this and are disappointed to need to do so again.

Emergency response

16. The two staff who saw Mr Williams bleeding on the floor on 11 July, did not immediately enter the cell. They considered it was unsafe as Mr Williams might have a blade. We cannot say their fears were unreasonable and we do not criticise them. However, this caused a delay of around two minutes before CPR began. We cannot say whether this affected the outcome for Mr Williams.

Contact with Mr Williams' family

17. We are concerned that the prison did not inform Mr Williams' next of kin of his death promptly in line with Prison Service instructions.

Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:
    - set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review;

- encourage family engagement in the ACCT process, where appropriate, to assist in managing and reducing the risk of prisoners who self-harm;
- consider all relevant information when identifying a prisoner's risk factors and do not rely solely on his behaviour and comments;
- remove or restrict prisoners' access to items such as razors, when they present a risk of harm by cutting;
- engage prisoners in meaningful conversation and record the outcome of the discussion in the ACCT ongoing record; and
- complete all aspects of the ACCT document, including the daily supervisor check in the ongoing record.

- The Director of Custodial contracts should write to the Ombudsman setting out what is being done to ensure that ACCT procedures at Dovegate improve.

- The Head of Healthcare should:
  - ensure that there is a robust system in place for conducting complex case reviews and that the process is communicated effectively to all relevant members of healthcare staff;
  - improve communication between healthcare and mental health services and ensure that feedback and advice on how to manage complex cases is provided to those who make referrals;
  - conduct a review of the mental health risk assessment process for identifying prisoners at risk of death by self-harm to ensure that it is fit for purpose; and
  - ensure that the results of hospital investigations are promptly communicated to prisoners.
- The Head of Healthcare should ensure that all staff make an entry in the ACCT record after intervention with a prisoner to ensure continuity of care.
- The Director should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death promptly, in line with national guidance.
- The Director should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

19. The investigator obtained copies of relevant extracts from Mr Williams' prison and medical records.

20. The investigator interviewed 12 members of staff from Dovegate by video-link between 2 and 10 September. NHS England commissioned a clinical reviewer to review Mr Williams' clinical care at the prison. The investigator and clinical reviewer jointly interviewed 11 members of staff.

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

22. The Ombudsman's family liaison officer contacted Mr Williams' family to explain the investigation and to ask if they had any matters they wanted us to consider. His family wanted to know why no one told them that Mr Williams was subject to ACCT monitoring.

23. Mr Williams' family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

24. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background information

25. HMP Dovegate is a Category B prison in Staffordshire, managed by Serco. The main prison holds around 930 remanded and sentenced adult prisoners. There is also a therapeutic community, separate to the main prison, which holds up to 220 prisoners. Practice Plus Group provides 24-hour healthcare services. South Staffordshire and Shropshire Foundation Trust provides mental health services.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Dovegate was in September/October 2019. Inspectors found that despite recent staffing challenges, mental health practitioners responded promptly to prisoners' needs and the range of therapeutic options was limited but growing. Inspectors also found that a comprehensive and joined-up approach to combating the misuse of drugs was now in place, but that drug availability remained a key concern.

Independent Monitoring Board

27. 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 2020, the IMB reported that incidents of self-harm and the number of prisoners subject to ACCT procedures had increased.

Previous deaths at HMP Dovegate

28. Mr Williams was the ninth prisoner to die at Dovegate since July 2019. Of the previous deaths, one was self-inflicted, one was drug-related and six were from natural causes. There have since been two deaths from natural causes.

29. In a previous investigation into a death at Dovegate in November 2019, we found deficiencies in the operation of ACCT procedures. We also expressed concern about staff not immediately entering cells in potentially life-threatening situations and the importance of healthcare staff making entries in the ACCT record.

Assessment, Care in Custody and Teamwork

30. ACCT is the Prison Service procedure used to support prisoners at risk of self-harm or suicide. 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 multi-disciplinary review meetings involving the prisoner.

31. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive Substances (PS)

32. Psychoactive substances (formerly known as ‘new psychoactive substances’ or ‘legal highs’) are a significant problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health, with links to suicide or self-harm.

33. There are many types of PS, including synthetic cannabinoids, often referred to as “Spice”.

Key Events

2017 to 2019

34. On 8 March 2017, Mr Keith Williams was sentenced to eight years in prison for robbery and sent HMP Birmingham.

35. Mr Williams had a history of substance misuse problems and was prescribed methadone to treat opioid dependence. He occasionally harmed himself in prison and was referred to mental health services, but the consensus was that he did not have a mental illness.

36. Mr Williams also suffered from recurring dry skin and folliculitis (an infection and inflammation of the hair follicles), which healthcare staff treated with various creams and antibiotics.

37. On 7 March 2019, Mr Williams was sentenced to an additional four years in prison for robbery. Over the next nine months, he failed a mandatory drug test and was found in possession of prison-brewed alcohol (known as hooch).

2020

38. On 16 January 2020, Mr Williams was moved to HMP Dovegate as part of his sentence progression. A nurse conducted an initial health screen and made a mental health referral as Mr Williams reported a history of self-harm and asked for support. A substance misuse nurse reviewed Mr Williams and recorded that he was prescribed several medications, including methadone and mirtazapine (an antidepressant). The next day, a substance misuse worker visited Mr Williams and agreed a care plan with him.

39. On 19 January, a mental health nurse conducted an initial assessment and recorded that Mr Williams reported a history of substance misuse and depression and said that he thought he had "something growing inside his head". However, he failed to elaborate further. The following day, the mental health team discussed Mr Williams at a multidisciplinary team meeting (MDT), after which they discharged him from their care as they concluded that there was no evidence of mental illness.

40. On 30 January, a Prison Custody Officer (PCO) introduced himself to Mr Williams as his keyworker and recorded that they discussed the prospect of him attending group education. Over the next seven months, officers conducted 12 keywork sessions and records indicate that Mr Williams engaged well with the restricted regime that was imposed in response to the COVID-19 pandemic.

41. On 27 August, a prison GP reviewed Mr Williams and noted that he had several sores on his scalp that had not responded to treatment with flucloxacillin (an antibiotic). He took a swab and prescribed doxycycline (another antibiotic). Over the next three months, Mr Williams' sores persisted, and healthcare staff prescribed additional antibiotics and creams.

42. On 25 November, a nurse associate practitioner reviewed Mr Williams and noted that he was very distressed about his sores and felt that he was breathing through

the wounds. She made a mental health referral and requested a hospital referral to the dermatology team.

43. On 27 November, a mental health nurse visited Mr Williams to conduct an initial assessment and recorded that his focus was on his physical wounds and that he did not want to engage with mental health services.

44. On 29 November, Mr Williams was moved to the prison's inpatient healthcare unit for a period of assessment as he continued to display bizarre behaviour. A nurse noted that he reported parasites in his wounds, trying to get out through his stomach, and refused to have his wounds dressed for fear of not being able to breath.

45. On 1 December, the mental health team discussed Mr Williams at a clinical team meeting, and a consultant psychiatrist requested a full physical health check to rule out an infection. Attendees agreed that, in the meantime, Mr Williams would be added to a mental health nurse's caseload.

46. On the morning of 8 December, prison staff noticed that Mr Williams had cut the back of his neck using a pair of nail clippers and started ACCT procedures. A medical team jointly reviewed Mr Williams who reported a tight feeling across the skin on his back. A doctor recorded that there was no sign of infection, but he would try a short course of prednisolone (a steroid). He noted that Mr Williams denied hallucinating or taking illicit drugs and said, "It isn't in my mind" several times. He concluded that there was no evidence of psychotic or severe mental illness and suggested a psychiatric assessment once Mr Williams' physical health issues had been resolved.

47. On 9 December, a Custodial Operations Manager (COM) chaired a first ACCT case review which two members of prison staff and a mental health nurse attended. She noted that healthcare staff had prescribed diazepam (a sedative) to help with Mr Williams' anxiety and that he said he did not want to harm himself but found the pain from his sores too much to manage. Attendees assessed his risk of suicide or self-harm as low and stopped ACCT monitoring.

48. On 15 December, a consultant dermatologist reviewed Mr Williams by video link and noted that he had some inflammation on his scalp and sores on his back that appeared to have been picked. The dermatologist concluded that there was no clear diagnosis to go against a clinical diagnosis of recurrent bacterial sores with excoriation (a disorder where a person cannot stop picking at their skin) and suggested specialised shampoo and cream, with the addition of limacine (an antibacterial medication) if his condition did not improve.

49. On 21 December, a multidisciplinary team meeting (MDT) agreed that Mr Williams' presentation had improved and that he could return to the wing. Later that day, a mental health nurse reviewed Mr Williams and noted that he displayed no evidence of acute mental illness.

50. On 22 December, prison staff started ACCT procedures after Mr Williams made a superficial cut to his neck using a razor. At a first case review the next day, Mr Williams told attendees that he was struggling with his physical health and it was impacting on his mental health.

51. On 29 December, prison staff decided not to proceed with an ACCT case review as Mr Williams appeared to be under the influence of an illicit substance. On 31 December, a COM chaired an ACCT case review and recorded that Mr Williams had spoken to his father who was supportive and had encouraged him to engage with the wing regime. Attendees assessed his risk of suicide or self-harm as low and stopped ACCT monitoring.

2021

52. On 5 January 2021, a substance misuse worker visited Mr Williams on the wing for a review. He recorded that before the meeting, prison staff told him that Mr Williams had presented as under the influence of an illicit substance on several occasions. Mr Williams told him that he felt stable on his current dose of methadone and he provided harm minimisation advice about not mixing prescribed and non-prescribed medication. However, Mr Williams denied that he had taken any illicit substances.

53. On 20 January, prison staff started ACCT procedures after Mr Williams reported thoughts of self-harm. On 21 January, a COM conducted a first ACCT case review which prison and healthcare staff attended. Mr Williams refused to attend due to pain in his back. The COM noted that healthcare staff said that Mr Williams continued to complain about an infection although there was no evidence of anything abnormal.

54. On 15 February, a COM chaired an ACCT case review, which prison and healthcare staff attended. Mr Williams told attendees that he had been using psychoactive substances (PS) but had since stopped and his mental health had improved. He did not report any thoughts of suicide or self-harm and attendees stopped ACCT monitoring.

55. On 19 February, an officer saw Mr Williams for a keywork session and recorded that although he said he was fed up with the COVID-19 regime, he had regular contact with his family and did not have any issues on the wing. Mr Williams had a further eight keywork sessions before his death and officers recorded that he was happy on the wing and mostly spoke about his physical health concerns.

56. On 23 March, a doctor visited Mr Williams to conduct a follow-up review with an assistant psychologist. Mr Williams reported pains throughout his body that he felt resulted from an infected hair follicle in his neck. The doctor noted that Mr Williams had used PS within the last two weeks and had a history of mental health assessments dating back to 2011 which found no evidence of mental illness. He concluded that there was no evidence of a severe or enduring mental disorder and requested a GP review to consider a neurology referral (a branch of medicine that focuses on the nervous system). He also noted that he started ACCT procedures as Mr Williams said that he would “hang himself” if his pain continued.

57. Later that day, the mental health team discussed Mr Williams at a clinical meeting and discharged him from their care. However, they noted that staff could re-refer him following his physical investigations, if necessary.

58. On 24 March, a COM chaired a first ACCT case review which prison and mental health staff attended. She noted that Mr Williams reported a constant dripping

feeling in his back and said that his body was swelling up overnight. He said that although the pain made him want to end his life, he did not act on it as he had his father and sister for support. Attendees assessed his risk of suicide and self-harm as low and added an action to the caremap for Mr Williams to have a GP review.

59. On 26 March, a prison GP reviewed Mr Williams and recorded that he reported a headache and back pain. He noted the outcome of the mental health team's recent review and requested a Magnetic Resonance Imaging (MRI) scan of his head, spine and hips. Later that day, a COM chaired an ACCT case review and noted that Mr Williams said he was happy about being referred for an MRI scan and did not report thoughts of self-harm or suicide. Attendees assessed his risk as low and decided to stop ACCT monitoring.

60. On 29 March, a substance misuse worker visited Mr Williams to conduct a welfare check and noted that he felt stable on his methadone dose but continued to report pain in his back that he said was due to an infection that had spread through his body. He also noted that Mr Williams said that he had not been taking illicit drugs and was not imagining the pain.

61. On 2 April, a COM visited Mr Williams for an ACCT post-closure review and noted that healthcare staff were looking into his physical health concerns and that he had support from his father.

62. Between 12 and 20 April, Mr Williams' sister contacted Dovegate on several occasions to express concerns about the quality of the healthcare he was receiving. On 29 April, the Head of Healthcare sent a written response to Mr Williams' sister, addressing her concerns in detail by referring to his medical record (with Mr Williams' consent).

63. At 6.00am on 12 May, prison staff called a medical emergency code red (which indicates that a prisoner has serious blood loss or burns) after they found Mr Williams with cuts to his neck. A nurse reviewed him and noted that he said the holes in his back were causing him pain and "ripping him apart". She made a mental health referral as, on examination, she could only see scars.

64. Later that morning, a COM chaired an ACCT case review which prison and mental health staff attended. He noted that Mr Williams said that he was in such pain that he had to cut himself to stop it. Attendees assessed him as a low risk of suicide or self-harm and added two actions to the caremap: for healthcare staff to conduct a review and for an MRI scan to be arranged.

65. A mental health nurse then conducted a mental health assessment and recorded that Mr Williams' engagement was limited due to him reporting severe pain. She noted that he had a long history of substance misuse but had poor insight into the impact of his drug use. She concluded that although he potentially had delusional beliefs about the patches on his skin, he did not display disordered or paranoid thoughts and that no mental health follow-up was required. In the afternoon, mental health staff discussed Mr Williams at a team meeting and decided not to add him to their caseload.

66. On 14 May, a COM chaired an ACCT case review, which another COM attended. He noted that although Mr Williams reported pain and difficulty walking, his

presentation on the wing did not reflect this and he became irate when questioned about it. Attendees assessed his risk of suicide or self-harm as low and stopped ACCT monitoring.

67. Later that day, the Head of Healthcare wrote another letter to Mr Williams' sister to assure her that staff were doing everything necessary to care for him. She said healthcare staff would continue to monitor him frequently while he waited for a hospital scan and that she would arrange for a member of staff to provide her with monthly updates.

68. On 7 June, a COM completed an ACCT post-closure review and noted that healthcare staff were aware of Mr Williams' issues and that his appointments had been completed. (The review should have taken place on or before 21 May.)

69. On 14 June, the prison received the result of Mr Williams' MRI scan which did not show any significant abnormalities. On 23 June, a substance misuse nurse reviewed Mr Williams and recorded that he continued to report pain caused by a skin infection. Mr Williams said he had not had the results of his MRI scan, so she sent an electronic task to healthcare staff. On 25 June, a prison GP booked an appointment to discuss the results with Mr Williams on 23 July.

Events of 8 July

70. At around 12.45am on 8 July, a PCO responded to a prisoner's cell bell. At interview, she told us that as she walked past Mr Williams' cell, the light was on and she saw what she thought was a red carpet through the gap in the door before realising that it was blood. After responding to the cell bell, she returned to Mr Williams' cell, where she tried to look through the cell door observation panel but found that it was covered from inside. She radioed a medical emergency code red and the Night Security Officer (NSO), who was present on the wing, arrived straight away. The PCO said that that they could hear Mr Williams groaning and could see him moving his left arm so waited for additional staff to arrive.

71. A COM and a mental health nurse arrived shortly afterwards and entered the cell. The nurse noted that Mr Williams had cut one arm and that his cell and body were smeared with blood. He took his clinical observations and gave him oxygen, but Mr Williams refused to comply with treatment. He recorded that Mr Williams presented as under the influence and that officers found evidence of PS use in his cell (modified vapes). He noted that he washed most of the blood off Mr Williams' body but there were no other cells available to which to move him. He also made a mental health referral.

72. The PCO started ACCT procedures and the COM completed an immediate action plan. (The ACCT document started was the newer version six, known as "ACCT v6," which Dovegate began using on 5 July.) The COM set Mr Williams' observation requirement at four an hour, with three quality conversations. She also noted that staff removed items such as plastics, razors and hair clippers from Mr Williams' cell for his own safety.

73. At 5.15am, the PCO noted that Mr Williams spent the night awake, crying out in pain and picking at his cuts. She recorded that his property and cell chair were on the landing and that his bedding and clothes appeared to have blood on them. She

added that Mr Williams had not tried to clean his cell and that blood had spread out onto the landing.

74. At 7.50am, a PCO completed an ACCT assessment and recorded that Mr Williams said that he had had conflicting opinions about the pains in his body from mental and physical healthcare staff. He noted that Mr Williams showed signs of helplessness and anxiety and said that he had harmed himself to mask his physical pain as his prescribed medication was not working. He said that he had previously used illicit substances but would be willing to have a drug test to convince staff that he was self-harming because of physical pain not drugs.

75. At 10.00am, a COM chaired a first ACCT case review which several members of prison staff and a mental health nurse attended. She recorded that Mr Williams said that he had an infection running through his body that was causing him severe pain and that he was under threat from prisoners on the wing. He said that he was intent on killing himself because he wanted the pain to stop but had no razors or other plans on how he would kill himself. Attendees agreed that his observations should remain the same and two support actions were added to the care plan: for physical healthcare staff to attend the next ACCT review and for prison staff to find out who was said to be threatening Mr Williams. They also indicated that a safety intervention meeting (a multidisciplinary, safety risk management meeting chaired by the senior management team) was required but there is no record that this took place.

76. At 10.30am, the mental health nurse recorded that she had attended an ACCT case review and conducted a mental health assessment. She noted that although Mr Williams continued to report pain, recent tests and scans had not identified an underlying cause. She concluded that his presentation was most likely due to his PS use. That afternoon, the mental health team discussed Mr Williams and decided that no further input was required.

77. A substance misuse worker reviewed Mr Williams and asked him about his use of PS. Mr Williams denied taking illicit substances and said that another prisoner had broken one of his vapes and left it in his cell.

Events between 9 and 10 July

78. At 1.30am on 9 July, a NSO recorded that she had responded to Mr Williams' cell bell and that he reported burning everywhere. She contacted a nurse, who informed her that all of Mr Williams' recent tests had come back negative and that a doctor had said there was nothing wrong with him.

79. In the morning, a nurse visited Mr Williams to change his dressings, but he refused. The nurse noted that Mr Williams displayed bizarre behaviour throughout the appointment and said that he was being treated for an infected hair follicle in his head, but the infection had travelled down his back and was trying to reunite with a 'worm' behind his ear. He made a mental health referral but did not record this contact in the ACCT document.

80. In the afternoon, a COM chaired an ACCT case review, which a nurse and a substance misuse worker attended. She noted that she invited physical healthcare staff, but they did not attend. She told the investigator that she phoned the

healthcare team and was informed that Mr Williams' tests had come back negative. She said that he presented 'brighter' but did not take the news well and remained convinced that something was wrong. Mr Williams told attendees that he was still in absolute agony and felt like cutting to stop the pain but did not have any suicidal thoughts. The ACCT record shows that they did not consider that he presented a high risk of suicide or that any items, such as razors, needed removing. It also shows that they decided to reduce his ACCT observation requirement to two an hour.

81. Mental health staff discussed Mr Williams at a team meeting that afternoon and noted that prison staff had reduced his ACCT observations. However, there is no recorded outcome in response to the mental health referral.

82. On 10 July, a PCO made two entries in Mr Williams' ACCT record, one at 12.00pm, and one at 17.15pm. Both entries indicate that he had spoken to Mr Williams and that he seemed OK.

Events between 11 and 12 July

83. At midday on 11 July, PCO A noted in the ACCT record that Mr Williams had asked to see a nurse at medication time. That afternoon, a pharmacy technician gave Mr Williams paracetamol. At 5.00pm, PCO A made an entry in the ACCT record that Mr Williams seemed OK and had engaged in the regime.

84. At 7.08pm, PCO B looked through the observation panel on Mr Williams' cell door to conduct an ACCT check and recorded that she did not see any sign of self-harm or distress. At 11.00pm, a NSO looked through the cell door observation panel to conduct an ACCT check, and saw Mr Williams standing by his TV. She told the investigator that she asked Mr Williams if he was OK and that he nodded.

85. At 11.38pm, the NSO looked through Mr Williams' cell observation panel to conduct an ACCT check and saw that he was lying face down behind the door and that the floor was covered in blood. She immediately radioed a medical emergency code red and tried to get a response from Mr Williams. PCO C arrived shortly afterwards and looked through the observation panel. In her prison statement, she said that the colour of the blood was a much deeper red than it was on 9 July and that she nervously said, "I'm not going in again and getting blood on my shoes for a second time this week". She then looked to see if Mr Williams was breathing, thought that she saw movement on the right side of his back and tried to get a response from him by calling out his name and kicking the cell door.

86. In the meantime, a COM radioed PCO C and the NSO in response to the code red and asked if Mr Williams was responsive. They told the COM that they had seen Mr Williams breathing and she advised them not to enter the cell, unless necessary.

87. At 11.40pm, staff arrived at the cell. The COM looked through the observation panel and unlocked the door but had difficulty getting into the cell due to Mr Williams' position and the fact that he had placed a chair behind the door. She and a PCO forced entry into the cell. The COM checked Mr Williams for a pulse and moved him onto his back in the centre of the cell. A nurse assessed Mr Williams and found that he had fixed pupils, blue lips and a clammy body.

88. At 11.43pm, the COM radioed the control room to advise that the medical emergency code red had changed to a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing problems). She started cardiopulmonary resuscitation (CPR) while the nurse attached a defibrillator, but no shock was advised.

89. At 12.05am on 12 July, the nurse asked staff to stop CPR as it was clear that Mr Williams had died. The first paramedics arrived at the prison at 12.12am and at the cell at 12.20am. They conducted an assessment and pronounced at 12.24am that Mr Williams had died.

Contact with Mr Williams' family

90. At 7.40am on 12 July, an assistant Director phoned Mr Williams' father, his named next of kin, to break the news of his son's death. At 8.00am, the prison appointed a family liaison officer (FLO) and a PCO as her deputy. At 10.00am, the FLO phoned Mr Williams' father to introduce herself and to offer support. She also offered to visit him at home, but he declined.

91. Over the next seven days, the FLO made several calls to Mr Williams' father and spoke to him once. On 20 July, she phoned Mr Williams' father, and he told her that Mr Williams' mother was taking over as the main point of contact. Later that day, she contacted his mother by phone to introduce herself and explain her role.

92. The FLO continued to provide ongoing support to Mr Williams' mother and father until his funeral, which took place on 12 August. The prison offered a contribution towards the cost, in line with national policy.

Support for prisoners and staff

93. After Mr Williams' death, an assistant Director debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

94. The prison posted notices informing other prisoners of Mr Williams' 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 Williams' death.

Post-mortem report

95. The post-mortem report established that Mr Williams died from an incised wound (a cut) to the neck. Toxicology tests detected a type of PS in his blood and urine, which suggested recent drug use. The pathologist did not consider the PS was the cause of Mr Williams' death.

Findings

Management of Mr Williams' risk of suicide and self-harm

96. Mr Williams' presented with unusual and challenging issues. Although he strongly believed that he had physical health problems, it gradually became clear that this was unlikely to be the case and that something else was going on. Whatever the cause, it is clear that Mr Williams experienced real and severe distress which led him to self-harm, although we cannot say if he intended to kill himself on 12 July.

97. Prison staff responded appropriately to Mr Williams' self-harm and monitored him under ACCT procedures on six occasions at Dovegate. There was some good practice. Case reviews indicate that staff were aware of his physical health concerns and how these impacted on his risk of suicide or self-harm. They demonstrated understanding and healthcare staff were frequently involved in the process. However, we had some concerns about the management of the ACCT process.

Caremaps and care plans

98. Prison Service Instruction (PSI) 64/2011 on safer custody states that completing a caremap is an integral part of the ACCT process and that it must reflect the prisoner's needs, level of risk and the triggers of their distress. The caremap should set time-bounded actions and be aimed at reducing the risk prisoners present to themselves. The policy guidance annex to PSI 64/2011, which covers the changes introduced by ACCT v6, states that support actions should be set to mitigate and lower risks.

99. All the caremap actions set at ACCT case reviews between 8 December and 15 May were for healthcare staff. There was one care plan support action for prison staff on 8 July relating to potential threats from prisoners but the other was for healthcare staff. While we appreciate that Mr Williams told staff that his self-harm was due to an inability to cope with physical pain, we consider that prison staff could have done more to mitigate and lower his risk by setting out how they planned to support him.

100. For example, prison staff did not consider a caremap or support action to involve Mr Williams' family in the ACCT process. The annex to PSI 64/2011 states that case coordinators should identify and discuss potential sources of support for the prisoner at case reviews. Mr Williams told staff that he had a supportive family on several occasions and his sister wrote to the Head of Healthcare with concerns about his wellbeing. However, there is no record that ACCT case coordinators knew about his sister's communication with the healthcare team or discussed the possibility of involving his family in the ACCT process. We consider that family involvement, which would have required Mr Williams' consent, may have added an extra layer of support for Mr Williams and should have at least been explored.

Assessing the level of risk and setting observations

101. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and

take appropriate action. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in assessing risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.

102. Staff appropriately assessed Mr Williams as a high risk of suicide on 8 July and asked for his case to be escalated to a senior manager for consideration at a safety intervention meeting. However, we are concerned that there is no evidence that a safety intervention meeting took place and that at the case review on 9 July, attendees recorded that such a meeting was not required as Mr Williams did not present a high risk of suicide or self-harm. We consider that there was no significant change to suggest that Mr Williams' level of risk had changed and that therefore, a safety intervention meeting should have been arranged.

103. We are concerned that despite Mr Williams telling staff on 9 July that he was in absolute agony and felt like cutting to stop the pain, they did not place more emphasis on restricting his access to razors. A COM told us that when she asked Mr Williams what he would do if he was to end his life, he said that in the past, it had always been cutting. She said that she spoke to wing staff about not allowing Mr Williams access to razors but that there was no formal restriction. With hindsight, she said that she should have recorded it in the ACCT document and wing observation book.

104. We consider that access to razors was a significant risk factor and that staff should have put more stringent measures in place to restrict his access to them. While we cannot say whether it would have prevented Mr Williams' death, it would have made it more difficult for him to self-harm.

105. The COM told us that they decided to reduce Mr Williams' observations on 9 July as he was engaging in the regime, seemed much calmer and had spoken to his father. We consider that staff placed too much emphasis on Mr Williams' improved presentation and assurances that he had no thoughts of suicide. Mr Williams had been displaying bizarre behaviour for several months and was convinced that there was something physically wrong with him. He continued to report considerable pain and said that he still might harm himself. However, there is no record that staff took account of this, or the possibility of accidental death, when assessing his risk. We are concerned that staff did not fully consider all Mr Williams' risk factors and, consequently, underestimated his risk of serious injury or death.

Recording conversations

106. PSI 64/2011 states that staff must follow the level of conversations stated on the ACCT document and must record these immediately or as soon as is practical. The ACCT annex to PSI 64/2011 states that conversations with prisoners should be meaningful and that staff must be aware of what is on a prisoner's care plan in order to understand the context of any conversation. It also notes that the written summaries also need to be meaningful and sufficiently detailed to convey the key details of what was discussed.

107. There is no evidence that staff held good quality conversations with Mr Williams, and most of their recorded interactions with him were brief. PCO A told the investigator that on 10 and 11 July, he was redeployed from his normal position in the security department to work on a wing due to low staffing levels. He said that Mr Williams did not say much to him and that he felt it was because security staff wear an all-black uniform, and that Mr Williams might have worried that it would look to other prisoners as though he was providing information. We are also concerned that the supervisor daily check section of the ACCT was never completed.

108. While we appreciate that there may be challenges in engaging prisoners in meaningful conversations, it is an essential part of the ACCT process and will help staff to better understand and mitigate a prisoner's risk. We also consider that supervisor daily checks are vital in assuring that ACCT records are properly completed and must be undertaken.

109. We make the following recommendations:

The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:

- **set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review;**
- **encourage family engagement in the ACCT process, where appropriate, to assist in managing and reducing the risk of prisoners who self-harm;**
- **consider all relevant information when identifying a prisoner's risk factors and not rely solely on his behaviour and comments;**
- **remove or restrict prisoners' access to items such as razors, when they present a risk of harm by cutting;**
- **engage prisoners in meaningful conversation and record the outcome of the discussion in the ACCT ongoing record; and**
- **complete all aspects of the ACCT document, including the daily supervisor check in the ongoing record.**

110. Dovegate have accepted our previous recommendations intended to address the quality of ACCT procedures. In response to a previous investigation, the prison told us in March 2021 that over 90% of operational staff had received suicide and self-harm training and that prompt sheets had been sent to all ACCT case managers as a reminder of risk factors to consider when setting actions and observation requirements. They also said that quality assurance checks would be carried out monthly.

111. While we recognise that Dovegate has made positive steps to improve ACCT management, we are concerned that despite having implemented these changes, our investigation of Mr Williams' death shows that assessment of risk and setting of observation requirements continued to be inadequate. We therefore consider that urgent action is now required to ensure that ACCT procedures improve. We make the following recommendation:

The Director of Custodial contracts should write to the Ombudsman setting out what is being done to ensure that ACCT procedures at Dovegate improve.

Clinical care

112. The clinical reviewer concluded that although elements of Mr Williams' clinical care at Dovegate were of a satisfactory standard, some fell below expectations and his mental health care was not equivalent to that which he could have expected to have received in the community.

Mental health care

113. Mr Williams was referred to the mental health team seven times but was only accepted onto their caseload once, in November 2020. A doctor told the investigator that on the two occasions he assessed Mr Williams, there was no evidence of acute mental illness or delusional parasitosis (a mistaken belief that parasites have entered the body). He said that he concluded that Mr Williams' unmet physical needs required investigating further on 23 March, as he had active dermatological lesions with associated pain, and no signs of mental illness.

114. Mental health staff did not re-refer Mr Williams to the doctor or accept him onto their caseload despite an escalation of his belief that there was something wrong with him and the fact that physical investigations failed to identify an underlying condition. The doctor told us that he was not involved in clinical discussion about Mr Williams beyond 23 March but would have reviewed him again based on the neurological investigations.

115. The clinical reviewer considered that the focus of mental health staff appeared to be based on a belief that Mr Williams' bizarre behaviour and fixed ideas about an infection running through his body could be attributed to his PS use, which is something he denied, even when he was seen under the influence. However, a doctor told us that although Mr Williams did not appear under the influence at any of his reviews, he continued to present as delusional and report things crawling inside him. We therefore agree with the clinical reviewer that there was clearly something happening to Mr Williams that could not be fully explained by his use of PS.

116. The primary care team appear to have been frustrated by what they perceived to be inaction by the mental health team. A doctor told us his impression of Mr Williams based on the results of investigations, including blood tests, was significant anxiety issues manifesting themselves in physical health symptoms. He said that the primary care team's concerns centred on Mr Williams' mental health and that he was not sure they would have referred him for an MRI had he not requested it.

117. We are concerned that the mental health team did not accept Mr Williams onto their caseload or consider that they should have referred him for another psychiatric assessment.

118. The clinical reviewer also considered that as Mr Williams repeatedly harmed himself by cutting, his risk of accidental death was increased. She noted that although staff recognised the risk posed by Mr Williams' actions, the mental health team's risk assessment process for identifying prisoners at risk of accidental death due to persistent self-harm required improvement.

Communication and multi-disciplinary meetings

119. Although mental health staff discussed Mr Williams at MDTs, the clinical reviewer considered that these meetings were not truly multidisciplinary as input from primary care and substance misuse staff was minimal. The mental health team leader told the clinical reviewer that every mental health referral resulted in a face-to face assessment and discussion at the daily team meeting. However, there was no process in place for providing feedback to those making referrals or for explaining the reason for their decisions. A doctor told us that primary care staff discussed cases at a daily 'buzz meeting', but again, these meetings do not appear to have been multidisciplinary.

120. The Head of Healthcare told us that there was a process for facilitating multidisciplinary complex case reviews at Dovegate and that arranging it would have been the responsibility of the mental health team. However, a doctor told us that there was no such process in place.

121. The clinical reviewer found that the lack of communication between services was a significant issue and that by acting in isolation, staff missed the opportunity to formulate a multidisciplinary plan for Mr Williams. We therefore consider that urgent action is required to ensure that there is a process in place for holding multi-agency complex case reviews and that all staff are aware of the process and their individual responsibilities.

Informing prisoners of hospital test results

122. The clinical reviewer considered that healthcare staff should have prioritised discussing the result of Mr Williams' MRI scan with him in an attempt to reduce his anxiety. The prison received the scan result on 14 June, but there is no record that anyone spoke to him about it. While we are satisfied that a doctor responded appropriately to the task sent by a nurse on 25 June, we are concerned that the appointment he booked to speak to Mr Williams was four weeks away. We consider that as Mr Williams appeared fixated by the idea that there was something physically wrong with him, he should have received the results sooner. As it was, prison staff had to tell him, which we consider was inappropriate.

Recording healthcare interventions in ACCT records

123. The ACCT v6 record states that it is mandatory for staff other than prison officers, such as those from healthcare and education, to complete the relevant summary section of the ACCT document if they have engaged with a prisoner.

124. When a nurse saw Mr Williams on 9 July, he did not record his interaction in his ACCT record. This meant there was no record of the bizarre behaviour that Mr Williams showed throughout the review, that Mr Williams said his infection was trying to reunite with a 'worm', or that the nurse had made a mental health referral. We consider it crucial that such information is recorded as it may help staff at the case review to better assess and manage any associated risks. We make the following recommendation:

The Head of Healthcare should:

- **ensure there is a robust system in place for completing complex case reviews and that the process is communicated effectively to all relevant members of healthcare staff;**
- **improve communication between healthcare and mental health services and ensure that feedback and advice on how to manage complex cases is provided to those who make referrals;**
- **conduct a review of the mental health risk assessment process for identifying prisoners at risk of death by self-harm to ensure that it is fit for purpose; and**
- **ensure that the results of hospital investigations are promptly communicated to prisoners.**

125. Dovegate has previously accepted a recommendation intended to address the lack of healthcare entries in ACCT records. In response to the investigation published in March 2021, the prison told us that the Head of Healthcare had advised all healthcare staff by daily meetings and email of the requirement to document entries in a prisoner ACCT record following intervention. However, we are concerned that this does not appear to have resulted in any improvement. We therefore consider that further action is required to ensure that ACCT records are updated. We make the following recommendation:

The Head of Healthcare should ensure that all staff make an entry in the ACCT record after intervention with a prisoner to ensure continuity of care.

Emergency response

126. Prison Service Instruction (PSI) 03/2013 on medical response codes requires prisons to have a two-code medical emergency response system. Dovegate's local policy instructs staff to use a medical code blue to indicate an emergency when a prisoner is unconscious or has breathing difficulties, and a code red when a prisoner is bleeding or has severe burn injuries. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate equipment.

127. PSI 24/2011 on the management and security of nights states that staff have a duty of care to prisoners, to themselves, and to other staff, and that preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be immediate danger to life, a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.

128. The NSO responded promptly when she found Mr Williams collapsed on the floor of his cell, having lost a lot of blood, and called the correct medical code.

129. However, the NSO and PCO C did not enter the cell and waited for other staff to arrive. The COM said that from the information they provided, she believed that Mr Williams was alive and could wait for her to arrive with a nurse.

130. PCO C told the investigator that she did not enter the cell with the NSO because she was concerned that Mr Williams could have had a blade on him. She also said that they thought they could see Mr Williams breathing.

131. At the time, PCO C made a comment about not wanting to enter the cell and get blood on her shoes for the second time in a week. She told the investigator that it was "stupid comment", that she "said it without thinking" and that she "did not know where it came from".

132. Although we consider that the comment was inappropriate, we are satisfied that it was not the reason for staff deciding not to enter the cell. Mr Williams had clearly cut himself and may have been in an agitated state. We accept that it was not unreasonable in the circumstances for PCO C and the NSO to be concerned that he might have a blade. We do not, therefore, criticise them for not entering the cell immediately, although we think that other staff might have made a different decision in the same circumstances. Nor do we criticise the COM for advising them to wait, given they had told her that Mr Williams was breathing.

133. We cannot say whether the two minute delay entering the cell and starting CPR may have affected the outcome for Mr Williams.

Contact with Mr Williams' family

134. Prison Rule 22 requires that the Governor should inform families at once when a prisoner dies. PSI 64/2011 requires that wherever possible, the family liaison officer and another member of staff visit the next of kin or nominated person to break the news of the death. It notes that time will be of the essence in order to try to ensure that the family do not find out about the death from another source. If the next of kin lives a long distance away, consideration must be given to requesting the assistance of a family liaison officer from the nearest prison.

135. We are concerned that prison staff did not contact Mr Williams' father until seven hours after he had died. The FLO told the investigator that she did not phone Mr Williams straight away as he was in his late 70s and she did not know if he lived with anyone. She said that she considered asking a family liaison officer to break the news in person and that she tried to contact a family liaison officer several times overnight but was unsuccessful. She added that while staff were waiting for a family liaison officer to arrive at the prison, it reached a stage where she was concerned that his father would find out of his death by other means. It was at that point that the Deputy Director advised her to phone Mr Williams' father.

136. While we appreciate that Mr Williams' father was elderly and that staff phoned him before he found out by other means, we consider that they should have notified him sooner. Mr Williams' father lived approximately 44 miles from the prison, which we do not consider was far enough away to warrant them contacting another prison. We therefore consider that Dovegate should have sent an officer and/or prisoner manager as soon as possible that morning, rather than waiting for a family liaison officer. We make the following recommendation:

The Director should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death promptly, in line with national guidance.

Psychoactive substances

137. Post-mortem toxicology results found evidence of PS in Mr Williams' system, but the pathologist did not consider it caused Mr Williams' death. We are satisfied that

the substance misuse team at Dovegate reviewed Mr Williams frequently, created a care plan, provided appropriate harm minimisation advice about PS and attended ACCT reviews. We are also satisfied that Dovegate has a comprehensive local drug strategy.

Learning Lessons

138. We have identified a number of concerns in this report. We consider it is important that staff learn from our findings. We recommend the following:

The Director and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Inquest

139. At the inquest, which took place on 15 April 2024, the Coroner concluded that Mr Williams died of misadventure.

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