Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Dunn, a prisoner at HMP Garth, on 26 September 2024

A report by the Prisons and Probation Ombudsman

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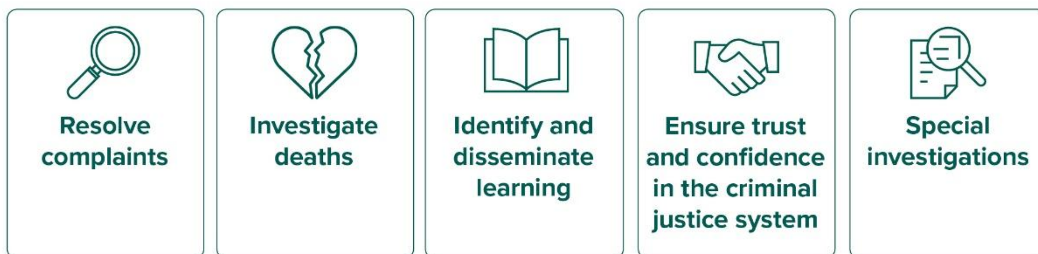
OUR VISION

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

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

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 Simon Dunn was found dead in his cell on 26 September at HMP Garth. A cause of death has not yet been established, although toxicology tests showed that Mr Dunn had taken elevated levels of some of his prescription medication, and he left a note in which he indicated that he intended to take his life. He was 55 years old. I offer my condolences to Mr Dunn’s family and friends.

Mr Dunn was the sixth prisoner to take his own life at Garth since September 2021.

Mr Dunn had several risk factors for suicide and self-harm, including a history of attempted suicide by overdose. In the time before his death, new potential triggers emerged which were not properly addressed. While Garth has struggled to provide a consistent regime in the face of considerable staff shortages, without regular proper engagement with prisoners, staff are unlikely to be able to pick up on changes in mood and behaviour that may indicate increased risk.

Mr Dunn left a note in his cell indicating that bullying contributed to him taking his life. There were not sufficiently robust processes in place to ensure that bullying concerns were being properly documented and addressed.

Around two months before he died, healthcare staff assessed and allowed Mr Dunn to keep a supply of his medication in his cell to take as prescribed. The clinical reviewer found that his history of overdose should have prompted this to have been considered through wider multidisciplinary discussion.

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 **July 2025**

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Summary

Events

1. On 13 August 2019, Mr Simon Dunn was remanded to HMP Durham for sentencing, having been convicted of sexual offences. On 10 September, he was sentenced to 16 years in prison. This was his first time in prison.

2. Mr Dunn had a number of physical and mental health diagnoses, including emotionally unstable personality disorder, depression and anxiety. He was prescribed medication for both his physical and mental health. Mr Dunn had an extensive history of self-harm and attempted suicide, including a number of serious overdoses of prescription medications in the community.

3. On 14 November 2019, Mr Dunn transferred to HMP Garth. While at Garth, staff monitored Mr Dunn under suicide and self-harm prevention procedures (known as ACCT) on nine occasions, with his most recent ACCT closed in January 2024.

4. For most of his time in prison, Mr Dunn had to collect his medication each day from the medication hatch. In July 2024, healthcare staff undertook a risk assessment and decided that Mr Dunn was now able to hold a supply of his medication in his possession.

5. In August 2024, Mr Dunn plead guilty to additional charges and was committed to the crown court for sentencing. Mr Dunn attended a court video hearing on 17 September, which was adjourned to 2 October.

6. On 19 September, Mr Dunn approached his key worker and said he needed to speak to her and that he was not okay. His key worker was not able to speak to him in detail but asked him if he had any thoughts of suicide or self-harm, which he said he did not. She was then absent from work so did not return to speak to Mr Dunn.

7. A prisoner told us that, on 24 September, Mr Dunn explained, in the presence of an officer, that he was having issues on the wing and that four people were “out to get him”. This prisoner said that Mr Dunn said that he could not cope with this and it was affecting his health. The officer told us that Mr Dunn only shared that he was having issues on the wing and did not elaborate any further.

8. At around 11.36am on 26 September, staff found Mr Dunn unresponsive in his cell. At 12.10pm, a doctor pronounced life extinct.

9. Staff found a number of empty medication packets in Mr Dunn’s cell along with a note in which he indicated that he was being bullied and that he intended to take his life.

Findings

10. Mr Dunn had several risk factors for suicide and self-harm, and in the time before his death two potential triggers emerged: his impending sentencing for further offences and concerns that he was being bullied. While it would not necessarily have led to staff starting ACCT procedures, these potential risks and triggers were

not explored as well as they might have been. Staff did not check Mr Dunn's welfare following important court appearances in the time before his death, as local and national policy expects. Some staff were not aware of how to implement local violence reduction procedures and there was a lack of evidence that incidents of low-level bullying were properly recorded.

11. The clinical reviewer concluded that the physical and mental healthcare provided to Mr Dunn was partially equivalent to that which would have been received in the wider community. She found that the decision to give Mr Dunn his medication in possession should have been discussed as part of a multi-disciplinary team, given his personality disorder and extensive history of overdose.

12. Garth informed Mr Dunn's next of kin of his death five days after he died. Initially there were challenges in obtaining the correct address for the next of kin. However, once the prison had obtained an updated address it took too long to attend the address and break the news.

Recommendations

- The Governor should ensure that staff understand their responsibilities to challenge and manage bullying and verbal abuse towards prisoners, including by:
  - Reviewing the local Safer Custody Policy to ensure there are clear expectations about what staff should do in response to bullying concerns where a perpetrator may not be disclosed.
  - Ensuring that staff receive training on CSIP and understand the referral process and expectations of their role.
- The Governor should introduce a robust quality assurance process to ensure that staff complete a welfare check on prisoners following a court appearance, including those by video link, in line with local and national policy.
- The Head of Healthcare should review the Medication in Possession policy to ensure there is a multidisciplinary approach where the prisoner has a significant overdose history.
- The Governor should ensure that there are appropriate processes in place to inform the next of kin at the earliest opportunity, including when the assigned family liaison officers are off duty.

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The Investigation Process

13. HMPPS notified us of Mr Dunn's death on 26 September 2024.

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

15. The investigator obtained copies of relevant extracts from Mr Dunn's prison and medical records. She also obtained CCTV, the Ambulance Service Records as well as the HMPPS Early Learning Review.

16. NHS England commissioned a clinical reviewer to review Mr Dunn's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed twelve members of staff in November 2024.

17. The investigator interviewed an additional three members of staff and four prisoners between November and December 2024.

18. We informed HM Coroner for Lancashire and Blackburn of the investigation. The Coroner gave us the results of the post-mortem examination and toxicology report. However, the cause of death will be determined at inquest. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Dunn's daughter to explain the investigation and ask if she had any matters she wanted us to consider. Mr Dunn's daughter wanted to know the following:

    - What physical and mental healthcare Mr Dunn had received?
    - What drugs were in Mr Dunn's system when he died and whether these were prescribed or not?
    - Whether Mr Dunn had his medication in possession and, if so, why this was the case given that he had tried to overdose with medication the previous year?
    - Whether Mr Dunn was located correctly within the prison, as his note indicated that he felt he was targeted by other prisoners?

20. We shared the initial report with HM Prison and Probation Services (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.

21. We also shared the initial report with Mr Dunn's daughter. She did not make any comments.

Background Information

HMP Garth

22. HMP Garth is a category B training prison and holds long-term and life-sentenced prisoners. At the time of Mr Dunn's death, Greater Manchester Mental Health NHS Foundation Trust provided physical health, mental health, social care and clinical substance misuse treatment at Garth. (From April 2025, Practice Plus Group will provide healthcare services.) Healthcare staff are on duty 24-hours a day and seven days a week. Delphi are subcontracted to provide psychosocial substance misuse services. Most prisoners live in single cells.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Garth was in July and August 2024. Inspectors reported that the prison had become noticeably less safe since their last visit. They noted that without better support from the regional team and HM Prison and Probation Service (HMPPS), Garth would continue to be a prison of real concern. They found that the ingress of drugs continued to be a major challenge.

24. Inspectors noted that very high levels of sickness among officers were affecting the ability of the prison to operate effectively in many areas. The Governor had implemented a part-time regime to reduce levels of violence, meaning that too many prisoners were locked behind their doors for hours. There were many inexperienced officers who had not had sufficient training or support in the role. They reported that they saw few custodial managers or other middle managers out on the wings.

25. Inspectors also reported that Challenge, Support and Intervention Plans (CSIPs, a tool to help manage violence in prisons) were poor. Prisoners told inspectors of bullying and anti-social behaviour which was either unnoticed or unchallenged by staff. They noted that many prisoners had insufficient contact with their prison offender managers, leave them feeling unsupported in progressing through their sentences. Inspectors found that this was exacerbated by the lack of regular key work sessions.

Independent Monitoring Board

26. 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 November 2023, the IMB reported that constant changes to the regime had caused unrest amongst prisoners. The Board also found that the key worker scheme was disrupted by staff shortages and constant redeployment.

Previous deaths at HMP Garth

27. Mr Dunn was the 15th prisoner to die at Garth since September 2021, and the sixth to take his life. Up to the end of February 2025, there have been three further deaths from natural causes. We have previously made a recommendation about

informing next of kin as soon as possible. Garth responded that they would brief duty governors that the next of kin should be informed as soon as possible.

Assessment, Care in Custody and Teamwork

28. 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.

29. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the actions of the support actions 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. When Mr Dunn was at Garth, guidance on ACCT procedures was set out in the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). From January 2025, this was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.

Key Events

30. On 13 August 2019, Mr Simon Dunn was remanded to HMP Durham for sexual offences. This was his first time in prison. On 10 September 2019, he was sentenced to 16 years in prison.

31. Mr Dunn had diagnoses of emotionally unstable personality disorder, depression and anxiety. He also had numerous physical health conditions. Mr Dunn was prescribed a large amount of medication for both his physical and mental health. (At the time of his death, Mr Dunn was prescribed 20 different types of medication for his mental and physical health. This included amitriptyline (an antidepressant) and aripiprazole (an antipsychotic medication).)

32. Mr Dunn had an extensive history of self-harm and attempted suicide in the community, including a number of serious overdoses of prescribed medication. Mr Dunn had voluntarily admitted himself to psychiatric hospitals on several occasions before coming into prison.

33. Before transferring to HMP Garth, staff monitored Mr Dunn under ACCT procedures on three occasions when Mr Dunn disclosed thoughts of harming himself or others.

HMP Garth

34. On 14 November 2019, Mr Dunn transferred to Garth. Staff allocated him a cell on F Wing. (F and G Wings at Garth are for vulnerable prisoners, including sex offenders.)

35. During his reception health screen, a nurse noted that Mr Dunn had mental health needs and had previously seen a psychiatrist. Mr Dunn denied any thoughts of suicide or self-harm. The reception nurse completed a medicine in-possession risk assessment and decided, based on the score, that they would not allow Mr Dunn to keep his medication in his possession and that he would need to collect this daily. (A medication in-possession risk assessment considers the risk of a prisoner holding their medication in their cell to take as prescribed. It considers factors such as their history of suicide and self-harm and whether the prisoner has been bullied for or known to have traded medication. Prisoners who do not keep medication in their cell are required to collect it each day, usually from a dispensary on their wing, and take it in front of a healthcare professional. A prison officer usually supervises the queue and dispensing.)

36. On 22 November, a mental health nurse completed a mental health assessment. In December, staff added Mr Dunn to the mental health case load.

37. Over the next few years, Mr Dunn was monitored under ACCT procedures on six occasions. Staff started these due to statements that Mr Dunn made to staff, including that he was having thoughts of suicide and self-harm, he was feeling down and that he was hearing voices. On one of these occasions Mr Dunn made a superficial cut to his wrist, saying he was fed up with hearing voices.

38. In January 2022, Mr Dunn reported that he was being bullied for vapes by four other prisoners. In March, as part of an ACCT case review, Mr Dunn reported that he was

being bullied, that people were calling him "smelly" and refusing to shower after him. Mr Dunn did not want to disclose the names of the prisoners. In April, he reported to the ACCT case review team that the bullying had subsided.

39. On 24 June, Mr Dunn told his mental health care coordinator that he had attempted to drown himself a few days before. There is no mention of this in Mr Dunn's prison records and staff did not start ACCT procedures. Mr Dunn explained that he had still not heard from the police (about further possible charges) and this was causing him some anxiety.

40. On 20 January 2023, a member of healthcare staff, Ms A, completed a medication in-possession risk assessment for Mr Dunn. She noted that he had not harmed himself or attempted suicide in the last 12 months. (This was incorrect as Mr Dunn had attempted to drown himself.) Ms A decided that Mr Dunn was able to hold seven days' worth of his medication in his possession. During this conversation, Mr Dunn shared that he had previously had issues with bullying over his medication, but he had since moved wings and there was no longer a risk of this happening. (Mr Dunn moved from F Wing to G Wing in December 2022.)

41. On 31 March, Mr Dunn told an officer that he had taken all or most of his in-possession medication in an attempt to take his life. He later told staff that he took the overdose because of recent further charges against him.

42. Staff took Mr Dunn to hospital where he stayed for four days and was treated in intensive care. Staff started monitoring Mr Dunn under ACCT procedures.

43. On 2 April, Ms B, a pharmacy technician, conducted a medication in-possession risk assessment and decided that Mr Dunn should not keep his medication in-cell due to his recent overdose. On 16 May, staff stopped monitoring Mr Dunn under ACCT procedures.

44. In June, Mr Dunn started working with Survivors Manchester (a subcontracted service at Garth who provide psychological therapy to men who are survivors of sexual abuse).

45. In the same month, Mr Dunn told staff that other prisoners were harassing him for his vapes. He explained to staff that this was affecting his mental health and he was struggling to cope. A staff member submitted an intelligence report but there is no evidence that any further action was taken.

46. In July, staff started monitoring Mr Dunn under ACCT procedures. There is a discrepancy about the reasons for this. Prison staff noted that they received a phone call from the mental health team saying that Mr Dunn said he felt like taking an overdose. In Mr Dunn's medical records, it notes that he had tried to take his life by making a ligature with his laptop charger. On 30 August, staff stopped monitoring Mr Dunn under ACCT procedures.

47. In October, Mr Dunn told his key worker that he was struggling and that he got urges to take lots of spice (a psychoactive substance). Staff began monitoring Mr Dunn under ACCT procedures. (There is no record that Mr Dunn ever used illicit substances in prison.)

48. At the end of October, Mr Dunn told the ACCT case review team that some prisoners had moved onto his wing and were hassling him for vapes. Staff suggested and facilitated a cell move so that his cell was in sight of the staff on the landing. There is no evidence that any further investigation took place.

49. On 15 November, staff closed the ACCT procedures as Mr Dunn said that he felt good and had no thoughts of self-harm. He told the case review team that he was fine now that he had moved cell and was away from the prisoners who were bullying him.

50. On 5 January 2024, staff starting monitoring Mr Dunn under ACCT procedures due to him saying that he felt suicidal after a therapy session and because of issues he was having with his medication. On 30 January, staff stopped monitoring him under ACCT procedures as he explained he felt better, was receiving good support from Survivors Manchester and had no thoughts of self-harm.

51. On 30 January, a psychiatrist reviewed Mr Dunn with Nurse A, Mr Dunn's care coordinator. The psychiatrist recorded that Mr Dunn needed more specialised psychological input. She noted that once he had finished work with psychology, he should be discussed at a multi-disciplinary meeting with a plan to re-refer Mr Dunn to the mental health team. (Mr Dunn was not discussed at a multi-disciplinary meeting as planned and there was no further consideration for psychological work once he had finished his sessions with Survivors Manchester.) On 13 February, healthcare staff closed Mr Dunn's case to the mental health team.

52. On 19 February, Mr Dunn had a key worker session with Officer A. He shared his concerns about an upcoming court case. He discussed that he could be "next in line" on G Wing to be bullied but did not give further information. Officer A told Mr Dunn to speak to her if he had issues on the wing.

53. Over the next few months, Mr Dunn continued to have sessions with Survivors Manchester, which he completed at the end of April. Mr Dunn also had monthly sessions with his key worker until July. Staff and prisoners told us that Mr Dunn generally spent a lot of time on his own and did not often socialise with peers.

54. In April, Mr Dunn signed up to have a buddy on the wing. (The Buddy Programme, managed by Recoop, is a peer support programme. Prisoners on the wing act as buddy support workers and provide additional support for prisoners with health and social care needs.)

55. On 25 May, Mr Dunn sent an application to the mental health team setting out that he was struggling with his mental health due to recent events. Nurse A visited Mr Dunn, who raised concerns about inaccuracies in his OASYS report (a tool used by probation and prison services to assess the needs and risks of offenders). She encouraged him to speak to his key worker about these concerns.

56. On 29 May, Mr Dunn approached his keyworker, Officer A, and said that he felt worried about things on the wing and was paranoid about what his peers thought. Officer A noted down that she had contacted the mental health team. (Officer A said at interview that she generally contacted the mental health team by phone but there is no record of this in Mr Dunn's medical records and no-one went to see him.)

57. On 29 June, Mr Dunn approached Ms C, a healthcare assistant, and explained that he wanted to get a job in the workshops and asked if this would be possible given that he was on sick leave from his current role (due to his physical health conditions). He also asked whether staff would allow him to have his medication in-possession. Mr Dunn explained that he had no thoughts of suicide or self-harm and said that he was confident that if he felt in crisis he would reach out to the appropriate people.

58. Ms C sent a message to Nurse A explaining that Mr Dunn wanted to review some parts of his care plan and asked her to look at the entry she had made. Nurse A responded explaining that the mental health team had discharged Mr Dunn a few months before but that he was still under the care of the psychiatrist so any concerns should be discussed with her. (The psychiatrist did not see Mr Dunn from January 2024 onwards. We understand that Mr Dunn remained open to the psychiatrist for an annual medication review.)

59. On 10 July, Officer A held a key worker session with Mr Dunn. She recorded that he sometimes got paranoid about his surroundings on the wing and spent most, if not all, of his time in his cell. She noted that Mr Dunn was progressing well and engaging with the mental health team. (Mr Dunn was no longer on the mental health case load at this time.)

60. That day, Mr Dunn sent an application on his prison laptop to healthcare saying that he wanted to have his medication in possession as he wanted to go back to work.

61. On 22 July, in response to Mr Dunn's application, Ms B reviewed Mr Dunn's medication in-possession risk assessment. She noted that he was settled and did not have any thoughts of suicide or self-harm. Ms B assessed that Mr Dunn was at low risk and decided to allow him to hold seven days' worth of his medication in-possession. She set an appointment to review this in early October.

62. At interview, Ms B told the investigator that she discussed the decision to allow Mr Dunn to have his medication in-possession with Nurse A. (Nurse A did not recall this conversation and there is no entry about it in Mr Dunn's medical records.)

63. On 26 July, a staff member from the offender management unit, visited Mr Dunn. They discussed that Mr Dunn had been charged with further offences. He expressed concerns that he may have to move prison for his court appearance and that his mental health would decline. Mr Dunn explained that he intended to plead not guilty to these charges.

64. There are no case notes, except for one concerning a move to an accessible cell, recorded for Mr Dunn on his prison record for the entirety of August and September.

65. On 19 August, Mr Dunn attended a video court hearing for additional charges. Mr Dunn pleaded guilty and the case was transferred to crown court for sentencing in September.

66. On 26 August, Prisoner A, a prisoner on G Wing, took over as Mr Dunn's buddy. He told us that Mr Dunn's friends on the wing had noticed that he was retreating more into his cell and not coming out. Prisoner A said that he spent a lot of time in Mr Dunn's cell talking to him and helping him with different things. He told us that,

following his court appearance, Mr Dunn said that he was facing more charges and that he noticed a change in his demeanour. Prisoner A explained that when Mr Dunn came back from his court appearance, he said he had now decided to plead not guilty. Around that time, Mr Dunn asked Prisoner A to help him write a letter to his solicitor. (There is no evidence that Mr Dunn formally changed his plea before he died.)

67. That day, Mr Dunn wrote to his prison offender manager, explaining that he had pleaded guilty. He asked to attend his next court appearance by video link as he was very worried about it upsetting his routine.

68. Officer A told the investigator that there would be times where Mr Dunn would stay in his cell and lock his door as he explained that he did not feel safe on the wing. There is no record of this in Mr Dunn's prison record.

September 2024

69. On 4 September, Mr Dunn told his buddy that he was worried about his upcoming court date. (Mr Dunn was next due in court on 17 September.)

70. Officer A said that at some point in the weeks before he died, Mr Dunn told her that he was worried about his upcoming court case. She said that his worries were mainly about being transferred to a prison other than Garth, rather than the outcome of his court case. Mr Dunn asked her to contact his community offender manager as he wanted to change his plea. She told us that she did not have time to do this and that she told Mr Dunn that she had not been able to. (There is no evidence that Mr Dunn submitted an application to speak to his community offender manager or anyone else in HMPPS about wishing to change his plea.)

71. On 10 September, his prison offender manager responded to Mr Dunn's application explaining that they were looking into whether his court appearance would be in person or via video link and would keep him updated. Two days later, Mr Dunn followed this up with another application saying he was getting very anxious about next week and his "mental" was getting worse. He said he needed to know if he could attend court via video link as he had already pleaded guilty. (On 17 September, Mr Dunn rejected this application himself before it was answered.)

72. On 17 September, Mr Dunn attended a court hearing by video link where the case was adjourned to 2 October.

73. On 18 September, Mr Dunn told Prisoner A that he was still worried about court.

74. Prisoner B, a prisoner on the wing, explained that in the lead up to his death, Mr Dunn had told him that he was looking at more charges and another 12 years or more in prison for historical crimes.

75. On 19 September, Mr Dunn approached Officer A and asked her for a key work session. She explained that she could not do this as she was going home. She asked him if there was anything she could do right then to which he replied that there was not but that he really needed to talk to her at some point. She explained that he could speak to other staff on the landing. Officer A told the investigator that

Mr Dunn denied any thoughts of suicide or self-harm. (Officer A was then away from work until after Mr Dunn had died.)

76. On the same day, Nurse B, head of the long-term conditions team, saw Mr Dunn. Nurse B recorded that Mr Dunn said that he was well in himself but struggling with breathlessness.

77. On 20 September, Prisoner A recorded (in a buddy support form) that he had helped Mr Dunn respond to his solicitor's letter and that they had posted the letter.

78. On 21 September, Prisoner A recorded that Mr Dunn had spoken to a Listener. There is no record of this in Mr Dunn's prison record.

79. On 24 September, Mr Dunn moved into an accessible cell on G Wing. (Mr Dunn used a wheelchair and staff moved him into an accessible cell when this became available.) Staff gave him his medication for the next seven days.

80. Prisoner B told the investigator that, on 24 September, he, Prisoner A and Officer B were in Mr Dunn's cell. He explained that Mr Dunn said that four people were "after him" and were "going to kill him". Mr Dunn said that he could not cope with this and that it was affecting his heart and health. Prisoner B said that Mr Dunn did not know who the four people were. Prisoner B described Mr Dunn as being distraught during this conversation.

81. Prisoner B said that he told Mr Dunn that he did not need to isolate and that officers would keep an eye on him. Prisoner B said that Officer B responded saying, "You'll be alright, don't worry about it, [the officers are] only down there".

82. Prisoner B explained that he said to the officer that he thought an ACCT document needed to be opened and that Officer B said that Prisoner B did not need to tell him what to do. Prisoner A recalled Mr Dunn saying that he thought people were after him and picking on him and that he wanted to self-isolate. Prisoner A recorded that Mr Dunn had spoken to an officer regarding his concern about bullying on the wing and that he wanted to self-isolate.

83. Officer B recalled a very short conversation in which Mr Dunn said he was having issues on the wing. Officer B told the investigator that Mr Dunn would not elaborate any further on this. He explained that he asked him questions about the issues and that Mr Dunn would not open up any further. He said that Mr Dunn did not say that he was having issues with four prisoners. Officer B said that if he had known this he would have asked everyone in that cell to leave and had a longer conversation. He said that Mr Dunn did not say that he wanted to self-isolate.

84. Officer C said that she spoke to Mr Dunn after he moved cell and he seemed happy with his new cell and did not raise any concerns.

85. CCTV shows that at around 8.15am on 25 September, Mr Dunn came to the doorway of his cell. He did not leave his cell all day. Prisoner A told the investigator that he collected food for Mr Dunn and explained that he seemed positive and told him he had had a good night's sleep.

86. That morning, Officer D went to Mr Dunn's cell for 20 seconds. He said that he had asked Mr Dunn about his new cell and that Mr Dunn had smiled. Mr Dunn did not raise any concerns with him.

87. At 5.23pm, Mr Dunn sent an application to F/G Wing saying that he wished to talk to his key worker urgently about locking himself behind his door. At 8.57pm, Mr Dunn rejected this application himself before it was answered.

26 September

88. The following account has been drawn from CCTV footage, staff statements, interviews, and ambulance service records. (None of the initial responding officers switched on their body worn video cameras.)

89. At around 5.00am on 26 September, the night patrol officer, conducted a routine check of all prisoners. At around 6.45am, Officer E conducted another routine check. They did not note anything of concern.

90. At 8.09am, Officer C conducted welfare checks on the wing. She opened Mr Dunn's observation panel and looked into the cell for around a second. She could not remember what she saw when she looked into Mr Dunn's cell.

91. At around 11.30am, Officer F began unlocking prisoners to come out for food. At around 11.35am, Officer F opened Mr Dunn's observation panel and saw him laid on his bed without a cover over him. She could not see any movement and therefore opened his door and attempted to get a response.

92. Officer F then shouted to Supervising Officer (SO) A for assistance and, at 11.36am radioed an emergency code blue (used to indicate when someone is unresponsive or not breathing). Officer F found that Mr Dunn's body was cold and started CPR.

93. Around a minute later, Nurse C arrived at the cell. She instructed Officer F to stop CPR while she completed her observations. She noted that there were no signs of life and that rigor mortis had started to set in. (Rigor mortis is a condition which is unequivocally associated with death.) Additional healthcare staff arrived shortly after and agreed with the decision not to re-commence CPR.

94. At around 11.55am, paramedics arrived at the cell and noted that rigor mortis and hypostasis (when the blood stops circulating and falls to its lowest point) were present. At 12.10, Dr B pronounced life extinct.

95. Mr Dunn left a note in his cell. He wrote that two prisoners knew who the bullies were. He explained that he could hear wing cleaners and laundry workers laughing at him. He noted that wing staff had not seen his cry for help or did not understand his mental health or had just turned the other cheek. He wrote that bullies had "helped him in his quest" and that they had won.

96. Nurse D found a bag which had 15 empty medication packets in Mr Dunn's cupboard. All were dated 20 September or later. (All were medications prescribed to Mr Dunn.)

Contact with Mr Dunn's family

97. The prison appointed two family liaison officers (FLO). At 1.45pm, they contacted HMP Northumberland to ask them to attend Mr Dunn's daughter's address (due to the distance that she lived from Garth). Northumberland did not have any trained FLOs on duty. They then contacted staff at HMP Durham, who attended the address but found that this was not Mr Dunn's daughter's current address.

98. CM A and Ms F then contacted Mr Dunn's community offender manager, solicitor and the police to find an updated address. CM A explained in interview that the police provided an updated address on the Friday afternoon (27 September) but he was not aware of this until the following Monday (30 September) when he returned to duty. Ms F also said that she was not aware of the new information until the Monday.

99. CM A and Ms F then decided to attend the address themselves in person the following day. CM A explained that they were not able to attend on 30 September due to adverse weather conditions and it being too late in the day.

100. On 1 October, CM A and Ms F attended Mr Dunn's daughter's address and delivered the news of his death.

101. The prison contributed toward the cost of Mr Dunn's funeral in line with national policy.

Support for prisoners and staff

102. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

103. After Mr Dunn's death, an operational manager, debriefed the prison and healthcare 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. One of the initial responding officers told us that she did not feel supported in the first few days following the incident as no one contacted her until the following week. Another responding officer told us that the TRiM team were at the debrief and said they would reach out the following week but had not done so.

104. Garth posted notices informing other prisoners of Mr Dunn's 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 Dunn's death. Listeners were deployed the following morning on the wing. A few prisoners we spoke to told the investigator that they were not offered any support following Mr Dunn's death. Mr Dunn's buddy told the investigator that he was offered sufficient support.

Post-mortem report

105. Mr Dunn was subject to a digital autopsy (when the autopsy is conducted by a scan rather than the physical examination of the body). The post-mortem author did not have the results of the toxicology tests at the time of writing but concluded that given the circumstances surrounding Mr Dunn's death, the most likely cause of death was drug overdose.

106. The toxicology identified the following above the therapeutic range: amitriptyline, metformin, diltiazem and paracetamol (although the latter may have been due to re-distribution post-mortem). The toxicology also identified use of aripiprazole, atorvastatin, omeprazole and ranolazine in the hours prior to death but it notes that these have low or no association with acute toxicity. Mr Dunn was prescribed all of these medications.

107. Mr Dunn left a note which suggested he intended to take his life.

108. The cause of Mr Dunn's death will be established by the Coroner at inquest.

Findings

Identifying risk of suicide and self-harm

109. Prison Service Instruction (PSI) 64/2011, on safer custody, which was in place at the time of Mr Dunn's death, required staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under suicide and self-harm procedures (known as ACCT). From January 2025, PSI 64/2011 was superseded by the Prison Safety Policy Framework, in which the principles of how risk is identified and the action that should be taken as a result remain largely unchanged.

110. Mr Dunn had a number of risk factors for suicide and self-harm: he had a mental health diagnosis and an extensive history of self-harm and suicidal behaviour. In the time before his death, Mr Dunn expressed concerns about his impending court appearance and the additional charges he was facing. He also said that he was being bullied by other prisoners.

111. While he had these risk factors and potential triggers, we are satisfied that there is not any compelling evidence that staff should have started ACCT procedures in the time before Mr Dunn's death. However, there were some potential risks and triggers that were not explored as well as they might have been.

Bullying

112. There is minimal evidence that prison staff had meaningful contact with Mr Dunn for the last two months of his life. From the note that Mr Dunn left in his cell, it is apparent that there was more going on for him at the time of his death than officers were aware of and that one of the drivers for taking his life was that he perceived that he was being bullied.

113. A PPO publication in October 2011, *Violence reduction, bullying and safety*, noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013 - 2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and responded to robustly.

114. The Garth Safer Custody Policy notes that the Challenge, Support and Intervention Plan (CSIP, a tool used to investigate and manage violence in prisons) process can be used to support vulnerable individuals. The strategy notes that actions to take following a verbal and physical incident of violence include: (i) reporting this on a prisoner's record (ii) submitting an intelligence report (iii) including an entry in the observations book and (iv) completing a CSIP referral.

115. Mr Dunn's key worker said that she thought Mr Dunn had a couple of issues on the wing but that he was always vague about the details. On occasions, she heard people making "snarky" comments to him on the landing. She explained she did not record these instances and challenged prisoners about this in the moment.

116. Two days before he died, a prisoner told us that he had a conversation with Mr Dunn with Officer B present. The prisoner explained that Mr Dunn said that people were out to get him, that he could not cope and that this was affecting his heart and health. Officer B recalled Mr Dunn saying that he was having issues on the wing but that he would not elaborate any further on this.

117. A number of staff members told the investigator that they were aware of wider bullying which occurred on the wing. (Except for Mr Dunn's keyworker, none had witnessed any evidence of him being bullied.) SO A said he would expect staff members to submit an intelligence report, do a referral for CSIP, record this in the observations book and put this in a prisoner's record.

118. Most of the staff we spoke to explained that they would challenge bullying in the moment, but we found a lack of evidence that they would properly record this. A prisoner told us that he sometimes raised bullying with staff members but they did not do anything "because of the paperwork". An officer told the investigator that the reason for not referring anyone to CSIP was that he did not have anyone to show him how to do it and was just told to keep an eye on prisoners when there were bullying concerns.

119. In their most recent inspection, HMIP found that CSIP was poorly used. They highlighted concerns from prisoners that bullying and anti-social behaviour was unnoticed or unchallenged by staff.

120. We found that more should be done to ensure that staff are recording and investigating suspicions of bullying, however low level they may perceive them to be. In addition, we found that there was little understanding from some officers on CSIP and the associated processes.

We make the following recommendation:

The Governor should ensure that staff understand their responsibilities to challenge and manage bullying and verbal abuse towards prisoners, including by:

- **Reviewing the local Safer Custody Policy to ensure there are clear expectations about what staff should do in response to bullying concerns where a perpetrator may not be disclosed.**
- **Ensuring that staff receive training on CSIP and understand the referral process and expectations of their role.**

Key work

121. Mr Dunn had a key worker and until July 2024 had almost monthly sessions with them. These entries were generally detailed and suggested that Mr Dunn was able to share any concerns he had. However, from July onwards, Mr Dunn did not receive any recorded sessions. Mr Dunn's key worker told the investigator that he would often approach her but that she would not always record the conversations in his prison record. She said she was not aware of his history of suicide attempts and self-harm.

122. Several officers told us that, while they are scheduled to have key worker sessions, because of staffing levels or being cross-deployed to other areas in the prison, they are often not able to complete these. We understand from one officer that most key work sessions are done on the landing, rather than in a private space.

123. Around a week before Mr Dunn died, he approached his key worker and explained that he really needed to speak to her at some point. (We know from a number of prison and healthcare staff that Mr Dunn was generally good at asking when he needed help.) He told his key worker that he was not okay but denied having thoughts of suicide or self-harm. Mr Dunn's key worker did not have the time to speak to him before she went home but said that he could speak to another member of staff on the landing. We consider that she should have asked wing staff to check on him or noted this down in the observation book.

124. Key work is important and gives an opportunity for prisoners to speak about concerns. We understand that to run key work successfully, prisons need to be properly staffed. The Head of Safety, explained that in August 2024, due to staffing levels, Garth introduced an emergency regime which impacted the ability to deliver key work.

125. We acknowledge that Garth is planning to introduce key work for priority prisoners. Mr Dunn would not have fallen into the category of "priority prisoner" according to Garth's criteria (which includes IPP prisoners, those on ACCT documents, isolators and those in debt). The Governor will want to consider how prisoners who do not meet these criteria have the opportunity for regular meaningful interactions.

Video link court appearances

126. Shortly before he died, Mr Dunn attended two video link court hearings. We understand that during the first hearing, in August 2024, he pleaded guilty to additional charges. In the second, on 17 September, his case was adjourned to 2 October.

127. PSI 64/2011 lists a number of triggers which may increase risk of suicide and self-harm. This includes court appearances, especially the start of a trial and sentencing. The Prison Safety Policy Framework sets out that there are times in a prisoner's experience of custody when they are likely to be at increased risk of suicide and self-harm. One of these is a court hearing (including a family court or video link court hearing). It notes that it is important that prisons identify and manage the risks to self and others during these times and put appropriate support in place to manage any identified risk.

128. Garth's Safer Custody Policy sets out that as court appearances, further charges and change in status can all be potential triggers, when an individual returns from court they should be spoken to ensuring any increased risk is noted and any necessary action taken. It sets out that there is an expectation that key workers are aware of when their prisoners appear at court and should discuss this with them prior to and after appearing at court. It notes that it is important such conversations are recorded on a prisoner's record.

129. Mr Dunn's key worker told the investigator that she is not informed when one of her caseload appears at court. She was not aware that there was an expectation to

have a conversation after someone has appeared at court. There is no evidence that anyone else checked Mr Dunn's welfare following the court appearances in the time before his death. We make the following recommendation:

The Governor should introduce a robust quality assurance process to ensure that staff complete a welfare check on prisoners following a court appearance, including those by video link, in line local and national policy.

Clinical care

130. The clinical reviewer concluded that the clinical care Mr Dunn received at Garth was partially equivalent to that which he could have expected to receive in the community.

131. The clinical reviewer found that Mr Dunn had timely mental health assessments and allocated case managers to oversee and monitor his mental health up until he was discharged from the team in February 2024. Staff did not discuss him again at a multi-disciplinary meeting to determine his care pathway, as they had planned to do.

132. Mr Dunn was provided with his own medication in possession in July 2024 and was dispensed seven days medication at a time. (There is no evidence that Mr Dunn had hoarded previously prescribed medication. The empty medication packets in his cell were all dated from the week before he died.) While this decision was made in line with the Greater Manchester Mental Health Foundation Trust (GMMH) operating procedure, the clinical reviewer found that it would have been worthwhile to discuss this decision as part of a multidisciplinary team, given Mr Dunn's long history of overdose and his last overdose when awarded IP status.

133. We make the following recommendation:

The Head of Healthcare should review the Medication in Possession policy to ensure there is a multidisciplinary approach where the prisoner has a significant overdose history.

Emergency response

Welfare checks

134. PSI 75/2011, on Residential Services, requires all prisons to have a clearly understood system in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock.

135. In January 2024, the Governor issued an order on welfare checks. This instructed that a welfare check should involve staff members opening the observation panel and satisfying themselves of the individual's wellbeing, giving the prisoner the opportunity to report any concerns. It went on to say that best practice during a welfare check was for staff to ensure they have full sight of the prisoner and gain a verbal response from them.

136. Officer C conducted the welfare check at around 8.00am on the morning of 26 September. Given that Mr Dunn had rigor mortis when found at 11.30am, it is unlikely that he was well when Officer C checked him. She could not remember what she saw but told the investigator that if she had thought anything was wrong she would have gone into the cell. Garth has conducted a local investigation into this incident and gave Officer C a 12-month written warning.

137. Officer C told the investigator that she had not seen the Governor's Order at the time. She explained that now she makes sure that, when conducting welfare checks, she gets a verbal response. She told us that Governor's Orders were often sent by email and that many people do not check their emails. SO A was not able to remember whether he had seen the Governor's Order and said these were only sent by email.

138. Garth have revised the Governor's Order to make it clear that staff *must* receive a response, rather than this being best practice. The Governor re-issued this in December 2024. The Governor will want to ensure that Governor's Orders are appropriately disseminated, in a variety of means, so that all staff are aware of the content of these. He will also wish to consider the need for a robust quality assurance process to ensure that this measure has been embedded.

Body worn video cameras (BWVC)

139. The Prison Service Body Worn Video Cameras Policy Framework states that staff responding to an incident should start recording at the earliest opportunity. This includes incidents involving injury or illness to a prisoner.

140. None of the initial responding officers switched on their body worn video cameras. This means that we have not been able to accurately confirm what happened upon finding Mr Dunn. The first responding officer explained in interview that she had "tunnel vision". She explained that this was not her regular wing and at that point needed another officer to go in and help her. The second responding officer explained that he forgot to switch his BWVC on.

141. The Governor will wish to assure himself that staff are reminded of the importance of activating body worn video cameras, in line with national policy.

Informing Mr Dunn's family of his death

142. PSI 64/2011 says that, wherever possible, the family liaison officer (FLO) and another member of staff must visit in person 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. It sets out that where the prisoner is a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison.

143. Mr Dunn's next of kin was not informed until five days after he died. We understand that the address noted in Mr Dunn's prison record was not correct and the FLOs therefore sought assistance from the police to find an up-to-date address. This was given to them the following afternoon (Friday 27 September).

144. In interview, one of the FLOs told the investigator that they had not received this address until the following Monday, as he and the other FLO were not on duty over the weekend. On the Monday, they decided to attend the address the following day due to extreme weather conditions and the fact that it was already late in the day. The lead FLO told the investigator that this decision was supported by the duty governor.

145. It is important that the news of a death is broken to a prisoner's family at the earliest opportunity. There should have been a process in place to ensure that action was taken on receipt of Mr Dunn's correct family address details in the absence of the lead and deputy FLO and it is disappointing that senior leaders did not consider how to prioritise this over the weekend and, indeed, on the Monday when the address was available. It would also be sensible to appoint a lead and deputy FLO who are not expected to be absent from work at the same time in the days after a death.

146. We make the following recommendation:

The Governor should ensure that there are appropriate processes in place to inform the next of kin at the earliest opportunity, including when the assigned family liaison officers are off duty.

Inquest

147. The inquest into Mr Dunn's death concluded on 22 May 2026, and recorded a verdict of suicide.

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