

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

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

Our Vision

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

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

A review was conducted into the clinical care the man received in custody.

The man was serving an indeterminate prison sentence and had been at Sudbury open prison for nine months as part of his preparation for release. He was reported to be doing well and had a parole review hearing scheduled for April 2013, at which he might reasonably have expected the Parole Board to direct his release. However, on 24 February, another prisoner at Sudbury alleged the man had assaulted him. He was segregated at Sudbury that day and moved to Dovegate, a closed prison nearby, pending a police investigation into the alleged assault. He had no history of self-harm and staff at Sudbury did not consider he was a risk.

When the man arrived at Dovegate, he was assessed by healthcare and prison staff who all concluded that he was not at risk of suicide. During the morning roll check in February, an officer discovered him hanging in his cell. Officers and healthcare staff tried to resuscitate him, but when paramedics arrived they pronounced him dead. Although staff acted swiftly in this case and it did not affect the outcome for him, the investigation has identified a need for some improvements in emergency arrangements at Dovegate.

The man gave staff no obvious indication of being at risk of suicide, but an individual's personal presentation is only part of the picture when considering risk and I am concerned that there was no apparent consideration of the circumstances of his transfer and how this might impact on him, particularly given his imminent parole review. Nevertheless, even if this risk had been acknowledged, I accept it would have been very difficult to predict his action that night and prevent his death.

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

CONTENTS

Summary

The investigation process

HMP Dovegate

HMP Sudbury

Key events

Issues

Recommendations

SUMMARY

1. The man received an indeterminate sentence for public protection in October 2005 with a minimum period to serve of three years before he could be considered for release. He spent time at a number of different prisons. In January 2012, the Parole Board recommended that he should transfer to open conditions to prepare for release. He moved from HMP Ranby to HMP Sudbury, an open prison, on 25 May 2012.
2. After his transfer to Sudbury, the man progressed well. He was allowed a number of home and town visits and got a job in the community to help his preparation for release. In December 2012, there was an investigation into a disagreement between him and another prisoner, who claimed that the man had been the author of a malicious and unfounded anonymous note accusing him of bringing unauthorised goods into the prison. There was no evidence that he had written the note and the investigation concluded that no special monitoring was necessary. Both men were reminded of the standard of conduct expected of them at Sudbury.
3. On 24 February, the prisoner involved in the December incident alleged the man had assaulted him. He had hospital treatment for injuries to his face and neck. The man was segregated at Sudbury and transferred to HMP Dovegate, a closed prison, the next afternoon, pending a police investigation. His next parole hearing was in April. At Dovegate, prison and healthcare staff in reception assessed him and did not consider he was at risk of suicide or self-harm. He raised no issues and gave staff no apparent cause for concern. He telephoned his father and explained the situation. He said he might have to go back to Ranby and it could mean he would have to serve more years in prison.
4. The next morning a prison custody officer (PCO) carried out a roll check and found the observation panel on the man's cell door had been obscured by paper. Through a gap the officer could see him hanging by bed clothes attached to the bed and radioed for emergency assistance. The radio signal was poor, so he went to get healthcare staff from a nearby office and waited for the duty manager to give permission before he opened the cell. This meant there was a few minutes delay going into the cell about which we have made a recommendation. An ambulance was called immediately and officers and nurses started cardiopulmonary resuscitation (CPR). CPR continued but paramedics assessed that he had been dead for some time and pronounced his death at 5.22 am.
5. In light of the clinical reviewer's findings, we are satisfied that the clinical care the man received at Dovegate and Sudbury was comparable to that which he could have expected in the community. However, the circumstances leading to his return to closed conditions could have been managed better. Although it would have been very difficult to predict his actions or prevent his death, more consideration should have been given to how the circumstances of his transfer affected his risk.

THE INVESTIGATION PROCESS

6. The original investigator issued notices informing staff and prisoners at HMP Dovegate and HMP Sudbury of the investigation and asking anyone who had relevant information to contact her. No one responded.
7. The investigator reviewed all relevant prison documents from Dovegate and obtained additional records from Sudbury.
8. The local PCT appointed a clinical reviewer to review the man's clinical care. The clinical reviewer and investigator carried out six joint interviews on 21 March at HMP Dovegate and the investigator provided initial feedback to the Director. Another investigator visited HMP Sudbury on 2 May and interviewed three members of staff.
9. The investigator informed Her Majesty's Coroner for South Staffordshire District about the investigation. The Coroner has been sent a copy of the report.
10. Another investigator subsequently became responsible for the investigation and obtained information from the Ambulance Service about the contact they had with Dovegate in February.
11. One of the Ombudsman's family liaison officers spoke to the man's family on 27 March to explain the purpose of the investigation. They asked for a number of questions to be considered during the investigation which are considered in the report:
 - Why did he transfer prisons and why did he go to Dovegate when he had been told he was returning to Ranby?
 - Why was he not on suicide watch?
 - Did the prisoners in the cells near him hear anything?
 - What clothing did he use to hang himself?
 - How did he hang himself when there was a deep cut on his right arm?
12. The family received a copy of the draft report. They raised one point which resulted in an amendment. They also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP DOVEGATE

13. HMP Dovegate is a category B prison, privately run by Serco. The prison holds over 1,100 adult male prisoners, both on remand or convicted. Primary healthcare at Dovegate is provided by Serco Health.

HM Inspectorate of Prisons

14. HM Inspectorate of Prisons (HMIP) last inspected Dovegate in October 2011. The HMIP report noted the lack of designated first night accommodation, which was inappropriate as the prison now held remand prisoners. New arrivals were located across a range of residential units, none of which offered assurance that the needs and vulnerabilities of new arrivals were fully considered, addressed or managed appropriately.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. The IMB annual report for the year to 30 September 2012 noted that the prison was safe, calm and well run. In respect of new receptions, the IMB noted that the introduction of dedicated first night accommodation would make arrival at Dovegate a less threatening experience and provide consistency.

Previous deaths at Dovegate

16. There have been three self-inflicted deaths at Dovegate since 2009, one of which was also through hanging. The investigator reviewed these reports and there were no similarities.

HMP SUDBURY

17. HMP Sudbury is a category D open prison holding more than 550 adult male prisoners, including a number of men serving life and other indeterminate sentences.

HM Inspectorate of Prisons

18. The last inspection of Sudbury was in April 2010. HMIP noted that Sudbury provided a reasonably safe, respectful and purposeful environment, with an effective focus on resettlement. There was an increased population since the last inspection, including many more indeterminate-sentenced prisoners. Inspectors found little evidence of action being taken about allegations and suspicions of bullying, and inconsistencies in the recategorisation of prisoners returned to closed conditions. Some segregation unit documentation was poorly completed. Records of adjudications (disciplinary hearings for breaches of Prison Rules – often referred to as being placed on report) were regarded as poor, with many showing no details of investigation into charges.

Independent Monitoring Board

19. The IMB annual report for Sudbury for the year to May 2012 noted an increased use of the segregation unit.

Open prisons

20. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. Prisons with a physically secure wall or fence are known as closed prisons. Prisons without secure physical barriers are known as open. Open prisons are for the lowest category of prisoner (D) and are used as part of prisoner's sentence progression before a prisoner is released back into the community.

Indeterminate sentence prisoners

21. Prisoners subject to indeterminate sentences for public protection are set a minimum period to serve by the trial judge (often known as 'the tariff'). After that, release is determined by the Parole Board for England and Wales, an independent public body. The Parole Board also assesses risk and makes recommendations to the Secretary of State about the suitability of indeterminate sentenced prisoners for open conditions. Once the tariff is served the Parole Board can direct release when it is satisfied that the risk is such that it is no longer necessary for the prisoner to be detained for the protection of the public. The Parole Board usually requires prisoners to have a period of testing in open conditions before it will direct release.

KEY EVENTS

22. In September 2005, the man was convicted of robbery and given an indeterminate sentence for public protection (IPP) at Crown Court on 19 October, with a minimum period to serve of three years and seven days (the tariff). He originally went to HMP Nottingham. It was not his first time in prison. He later moved to prisons at Blakenhurst, Lincoln, Lowdham Grange, Lindholme and eventually HMP Ranby. He was assessed by prison and healthcare staff each time he transferred. He did not self-harm and there was no record of him having suicidal thoughts throughout his time in custody.
23. In 2011, the man completed an offending behaviour programme designed to help prisoners manage their thoughts and feelings linked to violent behaviour. In a post-programme review on 24 May 2011, he said he had learned a lot. He had very positive reports from tutors.
24. The Parole Board considered the man's application for release in December 2011. The Board did not direct release but, in January 2012, recommended a transfer to open conditions to practice the skills he had learned during offending behaviour work. At the time, his next parole hearing was scheduled for March 2013. (It was later arranged for April.)

HMP Sudbury

25. On 25 May 2012, the man was re-categorised to D and transferred to Sudbury open prison. He said he was looking forward to proving himself and working towards his release.
26. On 29 September 2012, the man was placed on report for returning slightly late from a day release visit. He was found guilty at the subsequent adjudication and his privileges were suspended and his pay cut by 50 per cent for seven days. This was the only adjudication recorded against him during his time at Sudbury. He was noted to be polite and engaged well in his offending behaviour programme over the next few months.
27. On 7 December, prison staff received an anonymous note alleging that a named prisoner was bringing contraband (unauthorised goods) into the prison. Nothing was found when the prisoner's cell was searched. The prisoner claimed that the man had written the note maliciously. An officer completed a Violence Reduction Strategy action plan and interviewed the prisoner and the man. The other prisoner said that the man had made this allegation because he had started a relationship with the man's cousin and the man had made threats to ensure the relationship ended. The man denied any involvement and said he had no issues with the other prisoner. There was no evidence that he had written the note and no further action was taken. Both prisoners were reminded that high standards of behaviour were expected at Sudbury.
28. On 24 December, the man was approved to begin community work. A risk assessment for his release on temporary licence (ROTL) noted that he had made eight unescorted visits to Derby, that he was an enhanced status prisoner (prisoners move between levels basic, standard and enhanced,

according to their behaviour and performance) and had completed required offending behaviour courses.

29. On 22 January 2013, the man started working at a charity shop in Derby, but he was not suited to the work, so officers began seeking alternative employment for him.
30. A Parole Board oral hearing had been arranged for 30 April 2013, when a decision would have been made about the man's release on licence. His offender supervisor had completed a Parole Assessment Report in November 2012. At that stage he had made no clear recommendation about whether he should be released, intending to submit an addendum report about with a recommendation about his release nearer the time of his hearing. However, he was regarded as having made good progress.

Events from 24 February 2013

31. On 24 February, the prisoner who had claimed the man had accused him of bringing contraband into the prison was making a telephone call at 11.32am on his wing which was some distance from the man's wing. The prisoner subsequently told a member of staff that he had assaulted him with a broken pen while he was on the telephone. He was taken to hospital and treated for cuts to his face and neck.
32. Not all telephone calls are routinely monitored, but for security reasons all are recorded. The investigator listened to the telephone call and there are noises that could have been an assault. The man was not mentioned by name. The prisoner then called his family at 11.45am and 12.00pm, and said he had been jumped from behind and had hurt his face. He did not say his assailant was the man. At 12.10pm, the prisoner went to the gate and told an Officer Support Grade (OSG) that he had been attacked by the man. The OSG contacted healthcare staff and reported the allegation to the duty governor.
33. An operational manager at Sudbury explained to the man that another prisoner had made an allegation of assault against him. At 1.15pm, he was moved to the segregation unit (known as the Separate Accommodation Unit at Sudbury) because he was under investigation as a result of the allegation. It was noted that he would be located in the segregation unit until he could be transferred to another prison.
34. A nurse completed an initial segregation safety screen (used to highlight any medical concerns) and assessed that the man was fit to be segregated. The security and operations manager authorised his segregation. While he was in the segregation unit, he said he was fine and made no complaints. At 1.55pm, he asked for some religious books which he had left in his cell. He was given the books at 3.05pm. For the rest of the afternoon, he was recorded as lying on the bed watching television.
35. The man was checked throughout the night, as is routine for prisoners in segregation. A nurse saw him at 7.50am in the segregation unit the next morning. He did not raise any concerns.

36. A duty manager visited the man at 9.41am. He recorded that he seemed in good spirits and had told him about the allegation against him. He spent the rest of the day reading and watching television. At 4.00pm, the security and operations manager told him that he would be transferred to Dovegate. He said that the man said that he had no issue about moving there. Half an hour later, the operations manager gave him the following written reasons for his transfer:

“It is alleged you assaulted another offender. You are to be moved to closed conditions pending police investigation.”

He said he understood the reasons for transfer. The operations manager recorded that he ‘took the news well’.

37. At first, it was recorded that the man was re-categorised to C but this was amended before his move as such changes for indeterminate sentenced prisoners have to be agreed by the Public Protection Casework Section at National Offender Management Service headquarters which might also refer to the Parole Board for advice. He therefore remained category D. The escort risk assessment and the Person Escort Record (PER - a form that accompanies prisoners on all journeys and serves as a communication tool about a prisoner’s risks) contained contradictory information about risk, including that he was a high risk to the public, despite being a category D prisoner. There was no indication that he was at risk of suicide and self-harm.

38. The man arrived at Dovegate at 5.42pm. At his initial health screen, he told a nurse that he had not self-harmed and did not have a history of depression. The nurse noted that he interacted well throughout the assessment, and that he had no history of harming himself or thoughts of suicide. He told her that he had the support of his family and was not worried about being at Dovegate. No other staff in reception considered him at risk of suicide. No one referred to the circumstances of his move and whether this had increased his risk.

39. The man rang his father from reception at 6.40pm. A transcript of the telephone call shows that he told his father that he had been transferred as he had been accused of an assault and that he thought he might be at Dovegate for about three months. He thought he might go back to Ranby and it was possible he could serve another few months or years. He said:

“Yes I’m all right physically. I’m all right man it’s just um bit of a sore throat, know what I mean. All right man, it’s coming back here and all that going through the same procedure again, feel like proper locked up again not even getting up”.

His father advised him to stay calm and keep control of himself. He asked his father to tell the rest of his family that he had been transferred.

40. The man was allocated a single cell on the induction unit, given a toiletry pack and tea pack and took a shower. A Prison Custody Officer (PCO) introduced herself as his personal officer. She explained the cell bell system (for a prisoner to alert staff if he needs urgent attention) and about the phone

system. He pressed his cell bell twice that evening, at 7.34pm and 8.17pm, first to ask to use the phone and the second time to ask for toilet paper. A PCO gave him his PIN number to access the telephone system but told him that it would not work until the next day when the system had been updated. His personal officer brought him toilet paper. He was not on special monitoring measures as he was not assessed to be at increased risk, so this was the last time anyone spoke to him.

Events of the Incident

41. A PCO started the morning roll check. At 5.00am, when he tried to look through the man's observation panel, he noticed that it was covered by some paper. The PCO called his name but did not get a response. He saw through a small gap between the paper and the observation panel that he was hanging with jogging bottoms tied around his neck attached to the ladder on his bunk bed. He radioed a code blue alarm (used for medical emergencies). The communications room and duty manager acknowledged the request for assistance by radio. As healthcare staff had not responded, he ran up the stairs to alert some nearby nurses. An ambulance was called at 5.02am.
42. The PCO told a nurse that the man appeared to have hanged himself. They took emergency equipment to the cell and the PCO contacted a Senior PCO (SPCO) (who was managing the prison during the night) and got permission to break his sealed pouch and go into the cell. (At night staff do not carry keys but have a sealed pouch with a cell key for emergencies.) The PCO said he then had some difficulty opening the pouch in the dark to get the key as there was a zip and a seal to break. He estimated that this caused a short delay of less than a minute in opening the door.
43. Two more PCOs had arrived at the cell in response to the emergency call. They supported the man's weight while the first PCO used his anti-ligature knife to cut through the clothing around his neck. The nurse told the investigator that there were no signs of life and she asked for an emergency ambulance at 5.07am (although one had already been called). The first PCO started cardiopulmonary resuscitation (CPR), while the nurse attached an automated external defibrillator (AED) to the man. (An AED is a portable electronic device that detects activity in the heart and advises whether an electric shock can be used to restart the heart rhythm.) The AED advised that there was no shockable heartbeat and CPR was continued. The other two PCOs assisted with CPR until paramedics arrived.
44. Paramedics arrived at the prison at 5.12am and reached the man's cell at 5.17am. While CPR was continued, they assessed him and noted there was significant rigor mortis around his jaw, indicating that he had been dead for some time. He was pronounced dead at 5.22am.
45. A note was found in the man's cell addressed to his family which indicated his intention to kill himself but gave no reasons.
46. The prisoners in the adjacent cells said that they did not hear anything before staff entered the man's cell. One prisoner wrote in a statement taken

by the prison that he had been in reception at the same time as the man and he had seemed fine then.

Support for prisoners

47. A note from the Director was posted on the wing informing them of the man's death. All prisoners subject to suicide prevention measures were reviewed in case they had been adversely affected by his death. Prisoners were reminded of the support available from the Samaritans and Listeners (prisoners trained by the Samaritans to support other prisoners).

Liaison with the man's family

48. The man had nominated his mother as his next of kin when he first arrived in prison. A prison family liaison officer (FLO) was appointed and, at 7.45am, she left the prison with her colleague to break the news of his death in person. There was no answer at his mother's home, so the FLO telephoned his sister, who explained that her mother was at work but she would contact her and ask her to return home. The FLO eventually saw his mother at 10.20am and explained the circumstances of her son's death. The funeral was held on 22 March, and Dovegate contributed to the costs in line with national guidance.

Support for staff

49. The care team (staff trained to support other staff following an incident) were present on the wing to talk to any staff who required immediate support. The operations manager held a hot debrief to support the staff involved in the emergency response.

Cause of death

50. The post-mortem examination concluded that the cause of the man's death was cerebral anoxia (reduced oxygen supply) due to hanging. There were no traces of any illicit or prescribed drugs. There was a puncture wound in his left arm and small cuts around his nostrils as a result of resuscitation attempts. There was no recorded injury or deep cut to his arm.

ISSUES

Assessing risk of suicide

51. Throughout his sentence, the man was never assessed to be at risk of deliberate self-harm or suicide. A nurse assessed him when he was segregated at Sudbury on 24 February and indicated that he was not at risk of suicide. The next morning, a nurse saw him in his cell and she recorded that there were no concerns. However, neither recorded that they had specifically considered whether they had considered how or whether the circumstances he was facing had increased his risk and neither did any other staff at Sudbury. The assessment was based on how he appeared at the time.
52. When he arrived at Dovegate, the man went through the standard reception process which includes an assessment of the risk of suicide and self-harm. A registered mental health nurse concluded from his responses and her observations that he was not at risk of suicide. No other reception staff assessed him as at risk of suicide and self-harm, but there is no evidence that they had taken into account the circumstances of his transfer, which he noted in his telephone call to his father shortly after arrival, might have added years to the time he had to spend in prison. During interview, wing staff said they were aware through general conversation with him that he had been sent from open conditions, but they were not aware of the exact circumstances. There is no record of any specific conversations and officers on the wing had no concerns about his risk to himself.
53. The clinical reviewer concluded:

“There appears at no time during the man’s custody, to be any recorded or observed indications of suicidal ideation or intention to self-harm.”
54. However, Prison Service Instruction (PSI) 64/2011 (Safer Custody), Chapter 3 Risks & Triggers, notes that arrival in prison and transfer between establishment is a risk factor for suicide:

“The existence of a trigger may not necessarily increase a prisoner’s risk. However, it is vital that staff remain alert to the changes in a prisoner’s risk and act when appropriate.”
55. We accept that it would have been extremely difficult for prison staff either at Sudbury or Dovegate to have predicted or prevented the man’s death. However, we are concerned that staff appeared to rely so heavily on his personal presentation, with little evidence that they took into account the specific risk of his transfer. A prisoner’s presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. It is not apparent that full account was taken of the likely impact of an indeterminate sentenced prisoner being returned to closed

conditions or that reception staff at Dovegate were sufficiently briefed about the circumstances of the transfer and its potential implications.

56. The man had been making good progress at Sudbury and was shortly due to have a parole hearing from which he had a reasonable prospect of release. The effect of such a transfer could have added significantly to the time he had to spend in prison when he was already some years past his tariff expiry. He had recognised this possibility. Even if he did not articulate this to staff, a return to closed conditions at that stage must, objectively viewed, have been devastating to him. Ultimately, it is possible that prison staff would have reached the same conclusions about risk if they taken all these factors into account, but we consider that there are some lessons to be learned and that it is important to demonstrate that all risk factors have been considered. We make the following recommendations:

The Governor of Sudbury should ensure when transferring an indeterminate sentenced prisoner back to closed conditions that the receiving prison is fully briefed about the reasons for the transfer, the possible impact on the prisoner's sentence progression and the effect this might have on his risk of suicide and self-harm.

The Director of Dovegate should ensure that all the known risk factors of a newly-arrived prisoner, including a transfer back from open conditions, are fully considered and documented when determining his risk of suicide or self-harm.

Transfer to Dovegate

57. PSO 4700 (Indeterminate Sentence Manual) Chapter 4 Re-categorisation to a higher security category, sets out the criteria for returning an indeterminate sentenced prisoner (IPP) to closed conditions, including "Behaviour which may threaten the good order and control of the establishment". Staff at Sudbury assessed that the man's alleged assault on the prisoner needed to be investigated by the police. The security and operations manager decided to return him to closed conditions.
58. The man was notified in writing, in line with Prison Service policy, about his transfer, but all he was told was that he was accused of assaulting another unnamed offender. Indeterminate sentenced prisoners notionally maintain their security category when transferred to closed conditions until they are able to make representations about the decision. PSO 4700 requires the prisoner to be notified in writing of the reasons and the evidence. The PSO says that "if being transferred, they must receive this information prior to the transfer and that evidence can only be withheld on security grounds or to protect the safety of a third party". While it was unclear whether or not it was intended to raise his security category we consider the same principles should have applied. We do not think there were sufficient security or safety reasons to make it necessary to withhold from him the details of the allegation against him. We note that when informed he was going to be moved he did not appear to challenge the decision which could be construed to suggest he was aware of the reasons, but we cannot know that and it remained necessary to provide adequate written reasons.

59. Section 4.8.8 of PSO 4700 states that when a prisoner is removed from open conditions they should be returned to the prison which initially transferred them to the open estate (Ranby in the man's case). When interviewed, an operations manager explained that he was only likely to be at Dovegate, which acts as a holding establishment, until the police had completed their enquiries. Transport would then have been arranged to take him back to Ranby. The investigator was unable to verify what he had been told about what was going to happen. The transcript of his telephone call to his father on arrival at Dovegate indicated that he was unsure about how long he would be at Dovegate, but suggested that he understood that a return to Ranby was a possibility.
60. We are satisfied that there were appropriate reasons to transfer the man to Dovegate, pending a move to Ranby, but we consider he should have been given clearer information about the reasons.

The Governor of Sudbury should ensure that prisoners returned to closed conditions are given full written reasons and an explanation of what will happen afterwards.

Entering a cell at night

61. The PCO did not immediately enter the cell when he saw the man hanging. He radioed a code blue emergency and then went to get assistance from healthcare. On his way back to the cell, he sought and obtained permission from a SPCO. The PCO said that he did not believe he could assist him on his own.
62. Prison Service Instruction (PSI) 24/2011, management and security of nights states:
- 5.17 Under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and no cell will be opened unless a minimum of two/three (subject to local risk assessment procedures) members of staff are present one of whom should be the NOO.*
- 5.18 Staff have a duty of care to prisoners, to themselves and to other staff. The **preservation of life** must take precedence over the directions at 5.17*
63. In the local night procedures policy (SEC002), 4.3.5 it states:
- "The Night Officer will carry a "cut down" knife in case a prisoner is discovered hanging in a cell during the shift. The night officer has been given the authority to open any prisoner's cell on his or her own. This can only be done in an attempt to preserve the life of a prisoner if they consider that there is a genuine need to do so. Emergency procedures are supplied to all night patrols in their night watch packs."**
64. Earlier intervention would not have changed the outcome for the man. However, officers should be aware of the instructions in a life-threatening emergency and it should not be necessary to seek permission to enter a cell

in a life-threatening situation. Individual members of staff have to make their own decisions and risk assessments about entering a cell in an emergency but should understand their responsibilities to enter a cell as soon as possible, particularly when they see a prisoner hanging.

The Director of HMP Dovegate should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell immediately during the night state when there is potentially a risk to life.

Radio reception

65. All prisons are now required to have an emergency code system for calling an emergency over the radio network, usually 'Code Red' (for blood loss/ burns/fractures) and 'Code Blue' (for chest pain/, breathing difficulties/ unconsciousness). The advantage of a code system is that each code can alert staff to the specific type of emergency, enabling the appropriate equipment to be brought to the emergency. When an emergency code is called the control room should call an ambulance automatically. PSI 03/2013 Medical Emergency Response Codes which was introduced on 1 February and became mandatory on 28 February, just after the man's death states:

Governors/Directors of all prisons must ensure that a Medical Emergency Response Code protocol exists that enables staff discovering a prisoner who is exhibiting any of the symptoms listed in annex A, to clearly and concisely convey the nature of the medical emergency simultaneously to all interested parties and contact the communication or control room.

66. We are satisfied that Dovegate had an appropriate emergency code in operation and this resulted in an emergency ambulance being called automatically as the new PSI requires. This ensured there was no delay with paramedics arriving. The PCO called an emergency code blue in line with the policy, but he thought that healthcare staff had not heard the radio message, so went in person to summon help. Both officers and healthcare staff stated that the poor radio signal was a common problem. The healthcare staff were located a short distance away up one flight of stairs so in this case there was no significant delay in healthcare's ability to respond, but there needs to be reliable radio contact for the most effective emergency response. While the poor radio signal caused no real delay in healthcare staff attendance on this occasion, in other emergencies significant problems could occur if it was assumed that healthcare staff had heard a radioed emergency code.

The Director of HMP Dovegate should ensure that the radio system in the prison is capable of allowing effective and clear communication in an emergency.

RECOMMENDATIONS

1. The Governor of Sudbury should ensure when transferring an indeterminate sentenced prisoner back to closed conditions that the receiving prison is fully briefed about the reasons for the transfer, the possible impact on the prisoner's sentence progression and the effect this might have on his risk of suicide and self-harm.
2. The Director of Dovegate should ensure that all the known risk factors of a newly-arrived prisoner, including a transfer back from open conditions, are fully considered and documented when determining his risk of suicide or self-harm.
3. The Governor of Sudbury should ensure that prisoners returned to closed conditions are given full written reasons and an explanation of what will happen afterwards.
4. The Director of HMP Dovegate should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell immediately during the night state when there is potentially a risk to life.
5. The Director of HMP Dovegate should ensure that the radio system in the prison is capable of allowing effective and clear communication in an emergency.

ACTION PLAN: The Man - HMP Dovegate and HMP Sudbury

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p><u>HMP Sudbury</u></p> <p>The Governor of Sudbury should ensure when transferring an indeterminate sentenced prisoner back to closed conditions that the receiving prison is fully briefed about the reasons for the transfer, the possible impact on the prisoner's sentence progression and the effect this might have on his risk of suicide and self-harm.</p>	Accepted	<p>All duty Governors and Orderly Officers will be sent an instruction to ensure that they detail reasons for transfer on both the PER and in the 'reasons for transfer' form to the prisoner in as much detail as possible.</p> <p>This will be monitored for compliance via the Security and Operations dept who hold copies of the reasons for transfer centrally for HMP Sudbury</p>	31/08/2013	
2	<p><u>HMP Dovegate</u></p> <p>The Director of Dovegate should ensure that all the known risk factors of a newly-arrived prisoner, including a transfer back from open conditions, are fully considered and documented when determining his risk of suicide or self-harm.</p>	Accepted	<p>A review of the risk assessment documentation used at HMP Dovegate will be carried out. The documentation will be revised to ensure that the needs of prisoners who have been transferred from a less secure environment to HMP Dovegate are identified and addressed and an appropriate record made of all relevant details</p>	September 2013	

3	<p><u>HMP Sudbury</u></p> <p>The Governor of Sudbury should ensure that prisoners returned to closed conditions are given full written reasons and an explanation of what will happen afterwards.</p>	Accepted	<p>All duty Governors and Orderly Officers will be sent an instruction to ensure that they detail reasons for transfer on the 'reasons for transfer' form to the prisoner in as much detail as possible. A copy of the form will be issued to the prisoner. This will be monitored for compliance via the Security and Operations department who hold copies of the reasons for transfer centrally for HMP Sudbury.</p>	30.08.2013	
4	<p><u>HMP Dovegate</u></p> <p>The Director of HMP Dovegate should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell immediately during the night state when there is potentially a risk to life.</p>	Accepted	<p>The Directors Rule and operational instructions relating to incidents during night state and staff entering cells will be re-issued to all staff. Line managers will confirm that these instructions have been read and understood.</p>	September 2013	
5	<p><u>HMP Dovegate</u></p> <p>The Director of HMP Dovegate should ensure that the radio system in the prison is capable of allowing effective and clear communication in an emergency.</p>	Accepted	<p>HMP Dovegate will conduct a review with the current communications supplier in order to ascertain the issues relating to radio communications and to identify any potential alternatives that will negate black spot areas.</p>	September 2013	