Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Scott, a prisoner at HMP Dovegate, on 27 May 2019

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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

Mr Carl Scott died in hospital on 27 May 2019 after he was found hanging in his cell at HMP Dovegate earlier that evening. He was 46 years old. I offer my condolences to Mr Scott's family and friends.

Mr Scott took his life within a few hours of being sent to prison for the first time. Prison staff appropriately started suicide and self-harm prevention procedures when Mr Scott arrived at Dovegate. However, decisions about his level of risk and the frequency with which he should be observed were poor, and some key information was not properly shared between staff. I am also concerned that because he arrived on a Bank Holiday, Mr Scott did not receive the peer support that a newly arrived prisoner should expect.

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

Sue McAllister CB
Prisons and Probation Ombudsman **May 2020**

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Summary

Events

1. On 27 May 2019, Mr Carl Scott was remanded in custody to HMP Dovegate, charged with the murder of his former partner. He had been arrested three days earlier while apparently trying to take his life by jumping from a bridge. At 3.00pm, when Mr Scott arrived at Dovegate, prison staff immediately started suicide and self-harm prevention procedures (known as ACCT). Mr Scott told the officer who started ACCT procedures that he had no current thoughts of self-harm.

2. A prison nurse then assessed Mr Scott. She recorded that he said that he had also tried to take his life two weeks earlier, and she took the view from his answers and body language that he might have current suicidal intent. She did not share this information with the prison manager who completed the immediate action plan shortly afterwards and who set ACCT observations at a minimum of one per hour. The nurse recommended that Mr Scott should have a single cell.

3. At around 5.00pm, Mr Scott arrived in the first night centre and was allocated a single cell. As it was a Bank Holiday, Mr Scott did not speak to an experienced prisoner (known as an Insider) before he was locked in his cell, as was usually the case for newly arrived prisoners.

4. At around 5.50pm, a prison nurse and officers took Mr Scott's medication to his cell. Around 20 minutes later, the officer who completed the required hourly checks on all prisoners on their first night omitted Mr Scott. He said that it was because he had only recently seen him.

5. At around 6.50pm, the officer returned to Mr Scott's cell and found that he had obscured the cell observation panel. The officer left to fetch colleagues and, when they returned, they opened the cell and found Mr Scott hanging. Prison staff began cardiopulmonary resuscitation and paramedics took him to hospital, where doctors later confirmed he had died.

Findings

Management of risk of suicide and self-harm

6. Reception staff appropriately started ACCT procedures when Mr Scott arrived at Dovegate. However, there was a focus on how he presented at the expense of his risk factors for suicide. There was also poor information sharing which meant that decisions about his level of risk and frequency of observations were made without the full knowledge of Mr Scott's circumstances.

7. Mr Scott was allocated a single cell, rather than a shared cell in which a cellmate might have provided valuable peer support.

8. There was a lack of clarity among staff about how ACCT observations should be carried out alongside the welfare checks that all first night prisoners receive, and poor practice meant that there was a missed opportunity to check on Mr Scott's welfare before his death.

First night regime

9. As he arrived on a Bank Holiday, which meant there was a curtailed regime on the first night centre, Mr Scott did not speak to an Insider before he was locked in his cell for the night. This was a missed opportunity to provide invaluable peer support and advice on his first night in prison.

Emergency response

10. The officer who found that Mr Scott had obscured his cell observation panel did not radio for assistance, which would have been the quickest means of summoning support. He did not consider whether Mr Scott's identified risk of suicide and self-harm meant that he should open the cell immediately.

Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
  - Prison and healthcare staff share all information that affects risk, and make appropriate entries in the ACCT ongoing record.
  - Managers consider all relevant information that affects risk when completing the immediate action plan, and set appropriate levels of observations.
  - All newly arrived prisoners who are managed under ACCT procedures and assessed as standard risk on their Cell Sharing Risk Assessment (CSRA) are allocated a shared cell, whenever possible.
  - First night and ACCT observations are carried out as directed, with ACCT observations carried out at unpredictable intervals.
- The Director should ensure that COM A receives refresher training in ACCT procedures.
- The Director should ensure that all prisoners are given the opportunity to speak to an Insider on their first night in custody.
- The Director should ensure that a local protocol is developed and shared with staff to instruct them on what to do if they find a cell observation panel obscured.
- The Director should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that the prisoner may be at risk.
- The Director and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: COM A, Nurse A and PCO C.

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Scott's prison and medical records. He interviewed six members of staff at Dovegate on 3 July 2019.

13. NHS England commissioned a clinical reviewer to review Mr Scott's clinical care at the prison. The clinical reviewer joined the investigator for interviews with staff.

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

15. The Ombudsman's family liaison officer contacted Mr Scott's sister, to explain the investigation and to ask if she had any matters that she wanted us to consider. She told us that she understood that prison staff had identified her brother as at risk of suicide and asked whether he should have been assessed as at a higher risk and observed more frequently.

16. We have addressed those questions in this report.

17. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies and their action plan is annexed to this report.

18. We also shared the report with Mr Scott's sister. She did not make any comments.

Background Information

HMP Dovegate

19. HMP Dovegate is a Category B prison in Staffordshire, managed by Serco. The main prison holds around 930 remanded and sentenced adult men. There is also a therapeutic community, separate to the main prison, which holds up to 200 men. Care UK provides 24-hour healthcare services. South Staffordshire and Shropshire Foundation Trust provides mental health services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Dovegate was in May-June 2017. Inspectors reported that early days and induction processes were generally good. They found that a team of well-trained Insiders (prisoners who introduce new arrivals to prison life) greeted all newly arrived prisoners on the first night wing and gave them valuable advice before they were locked up for their first night in prison.

21. Inspectors also reported that levels of self-harm were much higher than at similar prisons, but that the quality of ACCT case management (to support prisoners at risk) had improved.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to September 2018, the IMB reported that incidents of self-harm had fallen by around 8% during the year.

Previous deaths at HMP Dovegate

23. Mr Scott was the ninth prisoner from Dovegate to die since May 2017, and the second to take his own life. There are no significant similarities between the circumstances of these recent deaths and that of Mr Scott.

Assessment, Care in Custody and Teamwork

24. 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 multi-disciplinary review meetings involving the prisoner.

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

Key Events

26. On 24 May 2019, Mr Carl Scott was arrested on suspicion of murdering his former partner. He was arrested on a bridge where he said he had intended to jump off. The next day, he told a police medical examiner that he felt suicidal, anxious and depressed and had also tried to jump from a bridge two weeks earlier.

27. At around 8.00am on 27 May (a Bank Holiday), Mr Scott attended court, where Prison Custody Officer (PCO) A immediately completed a suicide and self-harm warning form. He recorded that Mr Scott had tried to jump from a bridge three days earlier and noted his intent to kill or harm himself.

28. At around 11.00am, Mr Scott was remanded into custody. A member of court staff (their name is not recorded) telephoned HMP Dovegate and told PCO B in Reception that Mr Scott had been remanded for murder and would arrive with a suicide and self-harm warning form after a recent suicide attempt.

29. Court staff completed a person escort record (a form that accompanies prisoners on all journeys to communicate information, including about risk factors) and recorded that Mr Scott had tried jumping from a bridge and possibly had depression. Mr Scott left court at 1.45pm and arrived at Dovegate at 3.00pm. It was his first time in prison.

HMP Dovegate

30. PCO B spoke to Mr Scott when he arrived at Dovegate. He recorded that Mr Scott appeared withdrawn, quiet and in a low mood. PCO B told us that he initially had to work hard to get any response from Mr Scott but after around half an hour, he appeared more relaxed and willing to talk. The PCO recorded that Mr Scott showed signs of shame and guilt at the nature of his offence. Mr Scott told the PCO that he had intended to take his life a few days earlier by jumping from a bridge. He said that this was the first time that he had thought about harming himself and that he had no current thoughts of doing so. The PCO started ACCT procedures.

31. PCO B completed the operational assessment of the Cell Sharing Risk Assessment (CSRA, a form designed to assess a prisoner's risk of violence to a cellmate). He concluded that Mr Scott presented a standard risk (on a scale of standard or high).

32. Newly arrived prisoners are given the opportunity to make a telephone call to their family on their first night in custody. Mr Scott told PCO B that his mother was his next of kin but that he did not know her telephone number or address. He did not therefore make a telephone call in Reception.

33. Nurse A then assessed Mr Scott. She told us that she knew that PCO B had started ACCT procedures but she did not see the ACCT document. The nurse recorded that Mr Scott had been diagnosed with the human immunodeficiency virus (HIV, a virus that attacks the immune system and affects the body's ability

to fight disease and infection) and had brought medication for this with him. Mr Scott told the nurse about the incident on the bridge and added that he had also tried to take his life two weeks earlier. The nurse said that Mr Scott did not expand on this when she asked him about it. She recorded that Mr Scott had current thoughts of suicide. She told us that he did not say this directly but instead shrugged when asked the question and his body language failed to convince her that he did not have suicidal thoughts. The nurse noted that Mr Scott did not want to talk about his mental health, although he said that he had not previously had any contact with mental health services. She referred Mr Scott to the mental health team.

34. Nurse A recorded in the healthcare section of the CSRA that Mr Scott should have a single cell "due to mental health". She told us that she thought that this would be beneficial for Mr Scott in his first days in custody, given the high-profile nature of his offence in the local area, the mental health issues he appeared to have, his HIV diagnosis and his concerns about other prisoners finding out.

35. At around 4.00pm, Custodial Operations Manager (COM) A completed the immediate action plan. (This is used to consider the most appropriate environment and regime to support the prisoner before the first case review, and must be completed within one hour of ACCT procedures starting.) COM A told us that Mr Scott engaged well with her. She said that he appeared to be in a low mood but not in crisis. The COM told us that Mr Scott said that he had never previously tried to harm himself or take his life, and he appeared confused when she asked him about the incident on the bridge when he was arrested. She did not speak to Nurse A about her conversation with Mr Scott.

36. COM A concluded that Mr Scott was at low risk of suicide or self-harm. She said that this was because he gave no indication that he intended to harm himself. She set ACCT observations at a minimum of one per hour.

N Wing

37. At around 5.00pm, PCO B escorted Mr Scott to N Wing, the first night centre. (N Wing is one of four wings that make up Houseblock 3.) CCTV footage shows that they arrived on the wing at 5.01pm. PCO B spoke to PCO C about why Mr Scott was being monitored under ACCT procedures and the level of observations required.

38. At 5.02pm, PCO C escorted Mr Scott to his cell, which was a double cell that he would live in by himself. Staff were now locking other prisoners in their cells for the night.

39. At 5.06pm, Mr Scott left his cell and stood on the landing near to his door. At 5.11pm, PCO C returned and locked him in his cell.

40. Staff on N Wing are required to complete an hourly welfare check on all newly arrived prisoners during their first night in custody. PCO D conducted the first welfare check at 5.18pm.

41. At 5.54pm, Nurse B took Mr Scott's medication to his cell. PCO C, PCO E and PCO F accompanied her. PCO C said that Mr Scott was using the shower when they arrived, so they waited outside the cell until he had finished. Nurse B then

gave Mr Scott his medication, and she and the officers left the cell at 5.57pm. PCO C told us that Mr Scott seemed pleased to have been given his medication, and otherwise seemed fine and no different to earlier.

42. On a normal week night, N Wing prisoners are unlocked at around 6.00pm for an association period (when they can mix with other prisoners). Experienced prisoners, known as Insiders, live on the wing and usually speak to all prisoners on their first night in custody to give advice on the wing regime and answer any questions. However, on weekends and Bank Holidays there is no evening association period which means that new prisoners do not have the opportunity to speak to an Insider on their first night in custody. This was the case for Mr Scott.

43. At 6.11pm, PCO C checked on all first night prisoners except Mr Scott, whose cell he walked past without looking in. The PCO told us that he did not check Mr Scott as he had only recently seen him when they delivered his medication.

44. At 6.55pm, PCO C began a welfare check of first night prisoners. He arrived at Mr Scott's cell at 6.56pm, and found that he had blocked the cell observation panel. He knocked on the door but Mr Scott did not respond. After 20 seconds, the PCO left the wing to find colleagues to assist him. He told us that he understood that there should always be three officers present before a cell with a blocked observation panel is unlocked.

45. At 6.57pm, PCO c returned to N Wing with PCO and PCO G, who were working elsewhere on Houseblock 3. At 6.58pm, PCO C opened the cell and found Mr Scott hanging from a ligature made from a jumper which he had tied to the bedframe. PCO C removed the ligature and PCO G radioed a medical emergency code blue, indicating a life-threatening situation.

46. PCO C examined Mr Scott and found that he had no pulse and was not breathing. PCO H and PCO I (both of whom had arrived at the cell around 40 seconds after it was opened) began cardiopulmonary resuscitation (CPR). At 7.01pm, Nurse C arrived, followed a minute later by Nurse D, and took over resuscitation attempts. They attached a defibrillator, which instructed not to apply a shock and to continue CPR.

47. At 7.13pm, paramedics arrived at Mr Scott's cell. They continued resuscitation efforts and at 8.10pm, took Mr Scott by ambulance to Burton Queen's Hospital. At 8.40pm, hospital staff confirmed that he had died.

Contact with Mr Scott's family

48. Mr Scott named his mother as next of kin when he arrived at Dovegate, but did not know her address or telephone number. On the evening of 27 May, prison staff contacted West Midlands police and asked them to help identify Mr Scott's mother's address. They were unable to locate her.

49. The next morning, a friend of Mr Scott telephoned Dovegate and said that he had heard that there had been an incident. He gave prison staff Mr Scott's mother's address. Operational manager A and a family liaison officer visited her that afternoon and told her of his death. Dovegate contributed to the costs of Mr Scott's funeral in line with Prison Service instructions.

Support for prisoners and staff

50. After Mr Scott's death, operational manager B debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

52. A post-mortem examination identified the cause of death as hanging.

Findings

Management of risk of suicide and self-harm

53. Reception staff appropriately identified that Mr Scott was at risk of suicide and self-harm when he arrived at HMP Dovegate, and started ACCT procedures. It is apparent that they were concerned for his wellbeing and considered ways of supporting him in his first days in custody. However, we have identified some areas of local practice that might be improved and some areas where ACCT procedures were not managed in line with Prison Service policy.

Information sharing

54. Nurse A recorded two pieces of information that Mr Scott did not disclose to PCO B or COM A: that he had tried to take his life twice in recent weeks, rather than once, and that she believed that he had current thoughts of suicide. Nurse A did not share this information with other Reception staff, either verbally or by recording it in the ACCT document.

55. The National Institute for Health and Care Excellence (NICE) guidelines about the healthcare of people in prisons (NG57) instructs that healthcare staff should share with prison staff relevant information about people at risk of self-harm. We note that Nurse A did not see Mr Scott's ACCT document and did not therefore make an entry in it to communicate her findings. PSI 64/2011, which contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm, instructs that the ACCT document should travel around the prison with the person at risk to ensure that all staff receiving them are aware of the risks and are able to update the document.

Assessing risk and setting observations

56. PSI 64/2011 lists a number of risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns.

57. The ACCT document also provides guidance on how to assess the level of risk of suicide and self-harm. It says that risk is high, for example, when the prisoner has frequent suicidal ideas which are not easily dismissed. Risk is raised when suicidal ideas are frequent but generally fleeting, or there are recent suicide attempts. Risk is low when suicidal thoughts are soon dismissed and there is no self-harming behaviour.

58. COM A told us that she assessed Mr Scott's risk as low when she completed the immediate action plan because he gave no indication that he intended to harm himself. We appreciate that she did not know all the information that Mr Scott had told Nurse A. Nevertheless, she was aware that Mr Scott had a number of known risk factors: he had apparently been close to taking his life shortly before he was taken into custody, it was his first time in prison and he was charged with committing a very serious offence against a family member.

59. Many prisoners who kill themselves do not indicate to staff that this is their intention beforehand. Indeed, many take care to hide their intentions. For this reason, as we have said repeatedly, staff must take a prisoner's risk factors into account when assessing risk and should not focus exclusively on the way a prisoner presents or what he says. Given Mr Scott's clear risk factors, our view is that his risk should have been considered as at least raised. If COM A had assessed Mr Scott's risk as raised or high, she might have set more frequent ACCT observations.

60. We are also concerned at the lack of clarity at Dovegate about what one ACCT observation per hour means on the first night in custody. COM A told us that her expectation was that the first night and ACCT observations would be completed together, although she understood that some staff completed them separately and therefore made two observations per hour. Nurse A said that she understood that the first night and ACCT observations should be completed separately, whereas PCO C combined the observations. Our view is that conducting one ACCT observation per hour, at the same time as the first night observation, provides little additional support to that which the prisoner might normally expect, and meant in Mr Scott's case that he would not be observed any more frequently than a prisoner who was not on an ACCT.

Cell sharing

61. PSI 20/2015 instructs staff on how to complete the Cell Sharing Risk Assessment. It highlights indicators that a prisoner might pose a heightened risk of violence to a cellmate. One of these indicators is a healthcare assessment of risk, such as severe mental ill health. While Nurse A was concerned about Mr Scott's mental health, and appropriately referred him for an assessment, he did not have a diagnosis or any history of treatment and had not presented exaggerated symptoms of mental ill-health in police custody, at court, or in prison. In the absence of any other indicators or increased risk, we do not think that Mr Scott met the criteria of PSI 20/2015 that would prohibit him from sharing a cell.

62. Instead, Nurse A recommended that Mr Scott should have a single cell as she thought it would be beneficial to him in his first days in custody. We appreciate that the nurse reached this conclusion with the best of intentions, but it is usually best for a prisoner judged at risk of harming themselves to share a cell. This provides a measure of peer support, which is particularly important when it is someone's first time in prison and which, as we address later, Mr Scott did not receive elsewhere.

Completing ACCT observations

63. PSI 64/2011 states that staff must follow the level of observations noted on the ACCT document. It instructs that observations must be completed at unpredictable intervals, so that prisoners cannot predict when they will be checked and plan around this. Mr Scott's ACCT observations were set at a minimum of one per hour.

64. At 5.57pm, PCO C and other staff left Mr Scott's cell after taking him his medication. At 6.11pm, he observed all first night prisoners except for Mr Scott, despite walking directly past his cell. The PCO told us that he did not check Mr

Scott then as he had recently seen him. He returned to Mr Scott's cell at 6.56pm, at which time he found his cell observation panel blocked.

65. We are concerned that PCO C did not observe Mr Scott at the same time as the other first night prisoners. Mr Scott was subject to ACCT monitoring and had been judged as at risk of suicide and self-harm. While the PCO conducted the ACCT observations within the required timeframe, it is unfortunate that he chose not also to check Mr Scott's welfare. We make the following recommendations:

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

- **Prison and healthcare staff share all information that affects risk, and make appropriate entries in the ACCT ongoing record.**
- **Managers consider all relevant information that affects risk when completing the immediate action plan, and set appropriate levels of observations.**
- **All newly arrived prisoners who are managed under ACCT procedures and assessed as standard risk on their CSRA are allocated a shared cell whenever possible.**
- **First night and ACCT observations are carried out as directed, with ACCT observations carried out at unpredictable intervals.**

The Director should ensure that COM A receives refresher training in ACCT procedures.

First night regime

66. In their latest inspection, HM Inspectorate of Prisons (HMIP) found that Insiders were well-trained and provided valuable advice to all new arrivals at Dovegate before they were locked up for their first night in prison.

67. On a normal weeknight, all new arrivals on N Wing can speak to an Insider, either before 5.00pm lock up, or later during evening association. However, on a Bank Holiday or weekend, only those who arrive before 5.00pm have this opportunity. As Mr Scott arrived on N Wing shortly after 5.00pm, he was locked in his cell for his first night without speaking to an Insider. We agree with HMIP that Insiders provide a valuable service. This is particularly the case for men, such as Mr Scott, who have not been to prison before. We make the following recommendation:

The Director should ensure that all prisoners are given the opportunity to speak to an Insider on their first night in custody.

Emergency response

68. Dovegate does not have a local policy to tell staff what to do if they find a cell observation panel obscured. In such circumstances, we would usually expect staff who cannot see or speak to a prisoner to radio for help from other staff and remain at the cell door. If they believe the prisoner may be at risk, they should

assess the risk of opening the cell door before help arrives, particularly if the prisoner is subject to ACCT monitoring.

69. When PCO C found that Mr Scott had blocked his observation panel and could not get a response from him, he left the wing to get assistance from colleagues. We consider that he should have acted with more urgency, especially as he knew Mr Scott was on an ACCT. PCO C told us he understood that there should always be three officers present before a cell with a blocked observation panel is unlocked. Our view is that he should have radioed for assistance and considered immediately trying to open Mr Scott's cell. We make the following recommendations:

The Director should ensure that a local protocol is developed and shared with staff to instruct them on what to do if they find a cell observation panel obscured.

The Director should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that the prisoner may be at risk.

The Director and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: COM A, Nurse A and PCO C.

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