

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daley Thomas, a prisoner at HMP Dovegate, on 20 July 2020

A report by the Prisons and Probation Ombudsman

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*



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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.

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 Daley Thomas died on 20 July 2020 at HMP Dovegate from drug toxicity. He was 27 years old. I offer my condolences to Mr Thomas's family and friends.

Mr Thomas had a history of using psychoactive substances (PS) and appeared to be under the influence of drugs on numerous occasions during his time at Dovegate. He denied using illicit drugs and refused all intervention and support offered to him.

I am satisfied that staff encouraged Mr Thomas to address his drug taking and offered structured support. However, the apparent ease with which he appeared to obtain drugs suggests that more needs to be done at Dovegate to stop the flow of drugs into the prison.

Our investigation found that healthcare staff did not start suicide and self-harm monitoring procedures (known as ACCT) when Mr Thomas said he was having suicidal thoughts a few weeks before his death and that his mental health was not followed up.

I am also concerned about the quality of welfare checks conducted by prison staff.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

March 2021

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Summary

Events

1. On 28 March 2018, Mr Daley Thomas was sentenced to 11 years, six months for drug, blackmail, and kidnap offences. He transferred from HMP Bristol to HMP Dovegate on 21 November 2019.
2. Mr Thomas had a long history of illicit drug misuse and staff saw him under the influence of drugs on numerous occasions, but he refused to engage with substance misuse services in prison.
3. On 16 December, prison staff called an emergency medical code because Mr Thomas appeared to be under the influence of PS. He had passed out and banged his head. A prison nurse assessed and treated Mr Thomas, but he refused to disclose what substance he had taken.
4. On 3 June 2020, Mr Thomas was treated by a prison nurse for burns to his fingers. He said that they were from smoking drugs. Mr Thomas told the nurse he was having 'silly' thoughts about suicide. The nurse referred Mr Thomas to the prison's mental health team and the prison GP, but the former did not happen because of an administrative error.
5. At the request of wing staff Mr Thomas was seen by safer custody staff on 4 June. Mr Thomas said that he had a drug debt of £130, which he was unable to pay, and requested a wing move. He was placed in the prison's segregation unit after making threats to take a member of staff hostage. On 10 July, Mr Thomas was moved from the segregation unit to a new wing.
6. Early morning on the morning of 20 July, a night security officer carried out a routine roll count on Mr Thomas's wing. He looked into Mr Thomas's cell and saw nothing of concern.
7. At 7.40am, a prison custody officer (PCO) carried out a routine welfare check on Mr Thomas. She opened the cell door and saw Mr Thomas on the floor. She said she thought he was asleep and did not try to wake him.
8. At 9.22am, another PCO opened Mr Thomas's cell door to allow him to come out for a shower. He found Mr Thomas unresponsive on the floor. He radioed an emergency medical code and other prison staff responded and began cardiopulmonary resuscitation (CPR). At 9.26am two prison nurses took over the CPR. They stopped CPR at 9.30am, because it was clear that Mr Thomas had been dead for some time. At 9.52am paramedics confirmed that Mr Thomas had died.

Findings

Mr Thomas's substance misuse

9. Mr Thomas had a long history of using illicit drugs, including psychoactive substances (PS.) Staff made numerous attempts to try to help Mr Thomas

address his substance misuse, but he refused to engage with the interventions and support offered to him.

Drug strategy at HMP Dovegate

10. We remain concerned about the availability of PS in Dovegate. Dovegate has a comprehensive drug strategy but, despite this, Mr Thomas is the third prisoner to die at Dovegate as a result of PS use since December 2017.

Management of Mr Thomas's risk of suicide and self-harm

11. We found that staff failed to identify and assess Mr Thomas's risk to himself. A prison nurse did not start ACCT monitoring on 3 June when Mr Thomas told her that he was having suicidal thoughts.

Welfare checks

12. The PCO carrying out the welfare check on 20 July, found Mr Thomas on the floor of his cell and assumed he was sleeping. She did not attempt to get a response from Mr Thomas or check his wellbeing. Although this would not have changed the outcome for him because he had clearly been dead for some time, it could make a critical difference in other cases.

Emergency response

13. Despite clear signs that Mr Thomas had died, staff attempted CPR which is not in line with national guidance.

Clinical care

14. The clinical reviewer concluded that the clinical care Mr Thomas received at Dovegate was not of the required standard in the last few weeks of Mr Thomas's life, including the day of his death, and therefore not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Director should ensure that the prison's local drugs strategy is reviewed to ensure that the key issues are regularly being addressed.
- The Director should ensure that staff conducting welfare checks obtain a response from the prisoner if they cannot be sure he is alive and breathing.
- The Director and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that prison and healthcare staff:
 - share all information that affects risk;
 - start ACCT monitoring procedures when a prisoner discloses suicidal thoughts or self-harms; and
 - review the prisoner's level of risk whenever there is an event or change of circumstances that could impact on risk.

- The Head of Healthcare should ensure that all staff understand the administrative process to refer a prisoner to mental health services.
- The Head of Healthcare should continue to share updated PHE guidance on use of PPE during the COVID-19 pandemic and assure herself that all staff have access to appropriate PPE.
- The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate, in line with national and European guidelines.

The Investigation Process

15. The investigator issued notices to staff and prisoners at Dovegate informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
16. Due to restrictions in response to the COVID-19 pandemic, the investigator was unable to visit Dovegate. She obtained copies of relevant extracts from Mr Thomas's prison and medical records by post.
17. NHS England commissioned a clinical reviewer to review Mr Thomas's clinical care at the prison. The investigator and clinical reviewer jointly interviewed eight members of staff using Microsoft Teams on 18 September, 21 September, 1 October, 7 October, and 9 October 2020. The investigator also interviewed two members of staff by telephone on 13 and 16 November.
18. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. The Ombudsman's family liaison officer contacted Mr Thomas's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not raise any issues.

Background Information

HMP Dovegate

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

HM Inspectorate of Prisons

21. The most recent inspection of HMP Dovegate was in September–October 2019. Inspectors reported that there were some notable improvements since their last inspection in 2017. Inspectors found that despite recent challenges in staffing, mental health practitioners responded promptly to prisoners' needs and the range of therapeutic options were limited but growing. The Inspectors also found that comprehensive and joined-up approach to combating the misuse of drugs was now in place but despite this, drug availability remained a key concern.

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 Thomas was the ninth prisoner to die at Dovegate since July 2018. Of the previous deaths, three were self-inflicted deaths, two were drug-related deaths and three were from natural causes. There have been two more natural causes deaths since Mr Thomas's death.
24. In a previous investigation into a death at Dovegate in December 2018, we found that decisions about the prisoner's level of risk and some key information were not properly shared between healthcare staff and prison staff. We also expressed concern about the availability of drugs at the prison and the Director undertook to ensure that the key drug issues were identified, and that the prison's local drugs strategy was revised by September 2019.

Assessment, Care in Custody and Teamwork

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

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

Psychoactive Substances (PS)

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

Incentives and Earned Privileges (IEP) Scheme

29. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Key Events

30. On 28 March 2018, Mr Daley Thomas was sentenced to 11 years, six months in prison for drug, blackmail and kidnap offences. He transferred between various prisons before transferring to HMP Dovegate on 21 November 2019.
31. Mr Thomas had a long history of illicit drug misuse and was found by staff to be under the influence of drugs on numerous occasions. Staff managed this under the prison's incentive and earned privileges procedure and with disciplinary charges. Mr Thomas said that he used drugs as a coping mechanism due to the pressure of being in prison. He refused support and interventions offered to him and he failed to attend appointments because he said he wanted to self-manage his drug misuse.
32. On 16 December, staff called an emergency code blue (indicating a prisoner is unconscious or having breathing difficulties) because Mr Thomas was apparently under the influence of illicit drugs and had passed out and banged his head. A prison nurse assessed and treated him, but he refused to say what drugs he had taken. The nurse assessed that he did not need to go to hospital for further treatment.
33. On 3 June 2020, Mr Thomas was treated by a nurse for burns to his fingers which he said he received from smoking drugs. Mr Thomas told her that he was having "silly" thoughts and was suffering from depression. She recorded that Mr Thomas was having suicidal thoughts but that he said he had no intention of acting on them. She told the investigator that she decided not to start ACCT monitoring as she considered that he was not at risk of suicide or self-harm. She referred him to the prison's mental health team and a prison GP for extra support. However, due to an administrative error the referral to the mental health team was not made.
34. On 4 June, staff from the prison safer custody team went to see Mr Thomas at the request of wing staff. Mr Thomas said that he had drug debts of £130, which he was unable to pay. He asked to be moved to another wing. Mr Thomas refused to provide the names of the prisoners who were demanding payment. He said that he had weapons and would hurt someone. Staff refused his request to move to a different wing because he refused to provide the names. Mr Thomas made threats to take a member of staff hostage. As a result, he was moved to the segregation unit. A few days later, on 10 July, he moved to a different wing where he appeared to settle.
35. Due to COVID-19 regime restrictions, Mr Thomas had limited time out of his cell and associated only with a core group of other prisoners. Staff said he was frustrated about the limited regime but understood the reasons for it.
36. On 16 June, a prison GP spoke to Mr Thomas over the telephone and assessed him. Mr Thomas said that he was having "silly thoughts" but these were to harm others and not himself. Mr Thomas also said that the negative thoughts had gone, so the GP concluded that no further support was needed.
37. A PCO told the investigator that he saw Mr Thomas on 19 July. He said that Mr Thomas had collected his evening meal and returned to his cell. Later that

evening, Mr Thomas made a call to a female friend from his in-cell telephone. During the call he said that he had just woken up and was tired. Mr Thomas raised no issues or concerns about his wellbeing during the call.

38. At 7.45pm, the Night Security Officer (NSO) carried out a routine roll check and welfare check on all prisoners on Mr Thomas's wing. He said he looked into every cell and checked prisoners for any issues or those needing assistance or intervention. He said that he did not recall Mr Thomas raising any issues or concerns.

Events of 20 July

39. In the early hours of the morning on 20 July, the NSO carried out a routine roll count. He can be seen on CCTV using a torch when looking through the observation panel of Mr Thomas's cell door. He told the investigator that it was not unusual to find prisoners sleeping on the floor, but he did not recall seeing Mr Thomas asleep on the floor.
40. At 7.40am, a PCO opened Mr Thomas's cell door to carry out a routine welfare check and saw him lying face down on the cell floor. She said that she observed Mr Thomas for a few seconds and, on seeing what she thought was the back of his chest rise and fall, she considered he was breathing and still asleep. She did not attempt to wake him or enter the cell. She locked Mr Thomas's cell door and continued with her duties.
41. Due to restrictions in response to the COVID-19 pandemic, only a few prisoners were allowed out of their cell at any one time. At 9.22am, a PCO opened Mr Thomas's door to allow him to come out for a shower. The PCO told the investigator that he found Mr Thomas lying face down on the floor in an unusual position. He said it was dark in the cell and, on touching Mr Thomas, he was cold to the touch and had rigor mortis. The PCO said that he was initially shocked but shouted for assistance. Another PCO attended and radioed an emergency code blue. Staff responded quickly and started CPR on Mr Thomas. An emergency ambulance was called immediately.
42. At 9.26am, two nurses responded to the emergency call and took over CPR. One nurse told the investigator that Mr Thomas was cold and had signs of rigor mortis, however, they continued with CPR.
43. At 9.30am, the Deputy Head of Healthcare arrived and instructed staff to stop CPR as it was clear that Mr Thomas had rigor mortis and had been dead for some time.
44. At 9.52am paramedics confirmed that Mr Thomas had died.

Contact with Mr Thomas's family

45. At 10.40am on 20 July, a prison Family Liaison Officer (FLO) contacted Mr Thomas's next of kin, his mother, to inform her of her son's death. Due to restrictions in response to the COVID-19 pandemic, the FLO contacted Mr Thomas's mother by telephone instead of visiting her home in person.

46. The FLO remained the point of contact for Mr Thomas's mother, providing support. The prison contributed to the cost of Mr Thomas's funeral in line with national policy.

Support for prisoners and staff

47. The Governor conducted a debrief with the staff closely involved in the emergency response. The staff care team offered support.
48. The prison posted notices informing other prisoners of Mr Thomas'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 Thomas's death.

Post-mortem report

49. The Coroner gave Mr Thomas's cause of death as a drug induced death caused by the use of a synthetic cannabinoid (PS) also known as "Spice".

Findings

Mr Thomas's PS use

50. Mr Thomas had a long history of drug misuse. He was seen to be under the influence of PS on numerous occasions and staff made several attempts to engage him with interventions and support at Dovegate. However, Mr Thomas repeatedly declined support and did not want to engage or attend appointments as he said he wanted to self-manage his drug misuse. We are satisfied that Dovegate offered Mr Thomas support for substance misuse issues, but he declined help. We make no recommendation.

Drug strategy at HMP Dovegate

51. The use of PS is a concern across the prison estate and has a profoundly negative impact on the physical and mental health of prisoners, as well as being associated with debt and bullying. Mr Thomas's death is an example of the dangers of PS and illustrates why prisons must do all they can to eradicate its use.
52. HM Inspectorate of Prisons (HMIP) reported in September-October 2019 that a comprehensive and joined-up approach to combating the misuse of drugs was now in place at Dovegate. There was a good drug supply reduction strategy and there had been a significant reduction in the number of positive mandatory drug testing results. However, despite this, the availability of drugs remained a key concern and Inspectors found that much of the violence in the prison was linked to drugs and debt.
53. In April 2019, HM Prison and Probation Service published the National Drug Strategy. It set out their plans to reduce substance misuse in prisons by providing detailed guidance for prisons to help them identify issues and share best practice. It emphasised that each prison is different and needs to identify and tackle its own specific drug-related issues.
54. In 2019, Dovegate implemented a new drugs strategy for 2019-2021 which acknowledged the difficulties of preventing drugs getting into the prison and set out a process for drug detection and drug testing.
55. In a previous investigation into the death of a prisoner who died as a result of PS use at Dovegate in December 2018, we recommended that the Director should ensure that the key drug issues at the prison were identified and that the prison's local drugs strategy was reviewed regularly to ensure that the key issues were being addressed. Dovegate accepted our recommendation and said that they had reviewed and rewritten the local drug strategy policy. They said that they would continue to review the key drug issues at the prison to ensure that those issues were being addressed. They also said that they were continuing to conduct regular reviews to ensure that staff were aware of the aims and objectives of their local drug strategy and that the policy was understood by all.
56. We are concerned that although Dovegate has a comprehensive strategy and several processes in place to tackle both supply and demand, Mr Thomas was

still able to obtain illicit drugs at Dovegate with apparent ease. We make the following recommendation:

The Director should ensure that the prison's local drugs strategy is reviewed regularly to ensure that the key issues are being addressed.

Management of Mr Thomas's risk of suicide and self-harm

57. Although Mr Thomas died as a result of drugs not suicide, we are concerned that staff did not act on signs that he might be at risk of suicide.
58. 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.
59. Mr Thomas had no history of suicide and self-harm in prison but had a number of risk factors including debt, a history of depression and drug misuse. We consider that the nurse should have started ACCT monitoring on 3 June when Mr Thomas told her he was depressed and was having suicidal thoughts. We consider that staff should be especially responsive to suicidal thoughts during the pandemic when prisoners are spending so long locked in their cells. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that prison and healthcare staff:

- **share all information that affects risk;**
- **start ACCT monitoring procedures when a prisoner discloses suicidal thoughts or self-harms; and**
- **review the prisoner's level of risk whenever there is an event or change of circumstances that could impact on risk.**

Welfare Checks

60. When an officer carried out a routine welfare check on Mr Thomas at 7.40am on 20 July, she saw him lying face down on the cell floor. She told us that she thought she saw him breathing and therefore considered he was asleep, and she did not try to wake him. Prison guidance says that staff should check on a prisoner's welfare by getting a response from them, but she did not do this.
61. Paramedics disputed the officer's account that she saw Mr Thomas breathing, because rigor mortis was present when Mr Thomas was found dead less than an hour and a half later, indicating that he had been dead for some time. We consider that the officer should have gained a response from Mr Thomas before leaving the cell. Although this would not have changed the outcome for Mr Thomas, it could make the difference between life and death in other cases.
62. The prison conducted an internal investigation into the officer's actions. As a result, it was decided that she should complete the full initial officer training course again and complete a personal development plan with line management oversight.

63. While we welcome the steps the prison has taken, we make the following recommendation.

The Director should ensure that staff conducting welfare checks obtain a response from the prisoner if they cannot be sure he is alive and breathing.

Emergency response

64. Prison guidance on resuscitation says that resuscitation must be started on all patients who are found not breathing and/or pulseless unless certain conditions (such as the presence of rigor mortis) exist. The European Resuscitation Council Guidelines for Resuscitation 2015, *Section 11: The ethics of resuscitation and end-of-life decisions*, says that 'Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile'.
65. Two nurses continued with CPR, despite there being clear signs that Mr Thomas had died. Mr Thomas was described as being cold, rigor mortis present and no signs of life. To continue CPR in such circumstances is distressing for staff and undignified for the deceased. The Head of Healthcare told us that they have re-issued a notice to staff and provided additional training. However, we make the following recommendation:

The Director and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate, in line with national and European guidelines.

Clinical care

66. The clinical reviewer concluded the clinical care Mr Thomas received at Dovegate was not of the required standard in the last few weeks of his life, including the day of his death, and not equivalent to that which he could have expected to receive in the community.
67. The clinical reviewer was concerned that when Mr Thomas expressed suicidal thoughts on 3 June, an ACCT was not opened, he was not referred to the mental health team because of an administrative error, and healthcare staff subsequently failed to revisit his mental health, suicide risk and substance misuse. In addition, CPR was performed inappropriately, and nurses did not wear appropriate PPE during the emergency response.
68. We recommend:

The Head of Healthcare should ensure that all staff understand the administrative process to refer a prisoner to mental health services.

The Head of Healthcare should continue to share updated PHE guidance on use of PPE during the COVID-19 pandemic and assure herself that all staff have access to appropriate PPE.

69. The clinical reviewer has made other recommendations which the Head of Healthcare will need to address.

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