Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Dimmock, a prisoner at HMP Hewell, on 25 June 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Richard Dimmock was found hanged in his cell at HMP Hewell on 25 June 2019. He was 37 years old. I offer my condolences to his family and friends.

Mr Dimmock hanged himself after receiving a long prison sentence. Staff missed a number of opportunities to identify Mr Dimmock's risk of suicide and support him appropriately.

I am concerned that reception staff failed to consider starting suicide and self-harm prevention procedures, known as ACCT, when Mr Dimmock arrived from court with a suicide and self-harm warning form.

When ACCT procedures were begun a week later, there were deficiencies in the way staff managed Mr Dimmock for the short period that he was monitored. Despite Mr Dimmock's recognised mental health problems, healthcare staff played no part in the ACCT process and did not communicate important information about his mood and potential risk of suicide to prison staff.

I am also concerned that staff failed to address Mr Dimmock's significant concerns about his court hearing and the sentence he might receive. I consider that support should have been put in place for him when he returned from court after being sentenced on 24 June.

I am also concerned that healthcare staff inappropriately tried to resuscitate Mr Dimmock when he was found in his cell, even though he was clearly dead.

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 2020**

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Summary

Events

1. On 14 March 2019, Mr Richard Dimmock was remanded to HMP Hewell charged with historic sexual offences against a family member. He had post-traumatic stress disorder (PTSD) and had received counselling in the community. Mr Dimmock had last spent time in prison 20 years earlier.

2. Mr Dimmock arrived at Hewell with a suicide and self-harm warning form from court staff, but prison staff did not consider starting suicide and self-harm prevention procedures (known as ACCT).

3. The following day, Mr Dimmock was admitted to hospital after being found unresponsive in his cell. The cause of Mr Dimmock's collapse is not clear. Prison staff suspected he was suffering the effects of an illicit psychoactive substance (PS), while hospital staff described him as having been admitted following "an overdose". Mr Dimmock initially refused to eat, drink or take his medication and was tearful and expressed suicidal thoughts.

4. On 21 March, prison staff opened ACCT procedures while Mr Dimmock was in hospital. He returned to Hewell on 27 March and continued to be monitored under ACCT until 8 April. He was referred to the prison's mental health and substance misuse teams, began psychological therapy for his PTSD and was prescribed medication for anxiety. Mr Dimmock was very anxious about his court hearing date which was scheduled for June.

5. On 14 May, Mr Dimmock was again admitted to hospital after being found unresponsive in his cell. He returned to Hewell the next day. Staff assumed he had used PS but Mr Dimmock denied this.

6. On 24 June, Mr Dimmock appeared in court and was sentenced to ten years and nine months in prison. In the early hours of the next morning, staff found Mr Dimmock hanged in his cell. Staff radioed a medical emergency code promptly and tried to resuscitate Mr Dimmock. Paramedics arrived at Mr Dimmock's cell at 5.37am and recorded shortly afterwards that he had died.

Findings

Assessment of risk and ACCT management

7. When Mr Dimmock arrived at Hewell, his Person Escort Record (PER) noted that a suicide and self-harm warning form had been completed for him at court. Reception staff should have assessed his risk and considered whether to start ACCT monitoring.

8. Staff appropriately started monitoring Mr Dimmock under ACCT procedures a week later when he was at hospital. However, there were a number of deficiencies.

9. Although he had PTSD and was receiving prescribed medication, no one from the healthcare or the mental health team attended any of his ACCT case reviews.

We found no evidence that the mental health team was aware that Mr Dimmock was subject to ACCT procedures.

10. The ACCT caremap was poor: it failed to identify key risks, particularly Mr Dimmock's concerns about his court hearing and possible sentence, and did not include that Mr Dimmock was under the care of the mental health team and was receiving prescribed medication.

11. We consider that staff stopped ACCT monitoring prematurely. Mr Dimmock continued to tell healthcare staff that he was increasingly anxious about his court hearing, but this was not communicated to prison staff.

12. We consider that support should have been put in place for Mr Dimmock when he returned from court after receiving a long sentence.

Cell-sharing risk

13. Prison staff failed to share important changes in Mr Dimmock's cell-sharing risk with healthcare staff. This was a missed opportunity to support Mr Dimmock's mental health needs and potentially identify his increasing risk of suicide.

Clinical care

14. The clinical reviewer concluded that the healthcare that Mr Dimmock received at Hewell was equivalent to that which he could have expected to receive in the community. However, during Mr Dimmock's reception screen, staff failed to contact his community GP to obtain information about his medical history.

Resuscitation

15. While we understand that staff wanted to save Mr Dimmock's life, rigor mortis was present when he was found, meaning he had been dead for some time. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Healthcare staff should therefore not have tried to resuscitate him.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that:
    - Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.
    - Staff have a clear understanding of their responsibilities and the need to record and share promptly relevant information about possible risk.
    - Prison, healthcare and mental health team staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review and subsequent reviews if the prisoner has serious health concerns.

    - Staff hold multidisciplinary ACCT reviews, with the same case manager and which involve staff who contribute to a prisoner's care.
    - Case managers complete caremaps, identifying all the risks, setting specific and meaningful caremap actions, identifying who is responsible for them, reviewing progress at each review and not closing ACCT procedures until all the risks have been addressed.
- The Governor and Head of Healthcare should ensure that prison and healthcare staff share all information about a prisoner's cell-sharing risk and record it in prison and medical records.
- The Head of Healthcare should ensure that in cases where prisoners are admitted with no known GP and then a registered GP becomes identified some time later, healthcare staff should give consideration as to whether their medical history is requested or not.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance and understand the circumstances when they should not try to resuscitate prisoners in line with European Resuscitation Council Guidelines.

The Investigation Process

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

17. The investigator visited Hewell on 2 July 2019. He obtained copies of relevant extracts from Mr Dimmock's prison and medical records.

18. NHS England commissioned a clinical reviewer to review Mr Dimmock's clinical care at the prison. The investigator and clinical reviewer jointly interviewed 12 members of staff at Hewell during the investigation.

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

20. The Ombudsman's family liaison officer contacted Mr Dimmock's family to explain the investigation and to ask if they had any matters they wanted us to consider. They said that they wanted to know all the events that led to his death, including whether Mr Dimmock had been prescribed medication, whether he had asked to be transferred to another prison because he was being bullied and feared for his safety, and whether he was attending to his personal hygiene needs. We have addressed these issues in this report.

21. Mr Dimmock's family received a copy of the draft report. They raised a number of questions that do not impact on the factual accuracy of this report.

Background Information

HMP Hewell

22. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Care UK provide health services and there is a 20-bed inpatient unit.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Hewell took place in June 2019. Inspectors reported that there had been a marked decline, with safety and purposeful activity assessed as poor at the secure site (where Mr Dimmock lived). Hewell was graded as poor for safety for the third time and the Chief Inspector considered invoking the Urgent Notification (UN) process, requiring the Secretary of State to produce an action plan for improvement within 28 days. However, the Chief Inspector did not do so because Hewell had already been in 'special measures' for a considerable time and the Chief Inspector concluded that it was highly unlikely the UN process would achieve the required improvements.

24. Inspectors found that newly arrived prisoners were sometimes held on escort vehicles which queued outside reception. They noted that most prisoners spent too long in reception and staff did not consistently assess prisoners' cell-sharing risk in private. They found that first night risk assessments were not always completed, which put prisoners at risk during their early days in custody. Inspectors noted that the delivery of induction programmes was often delayed and weak, and management oversight of the process was poor. They found that not all staff working on the unit had received adequate training in first night procedures. Although most prisoners attended an induction, it was often delivered late and did not provide adequate or up-to-date information to newly arrived prisoners.

25. Inspectors identified that PPO recommendations following deaths in custody had not been fully implemented, and oversight of their progress was inadequate.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest published annual report for the year to September 2018, the IMB noted that staffing levels had improved but that many staff were inexperienced. Healthcare staff told the IMB that there were not enough staff to deal with the number of newly arrived prisoners and the prison did not recognise the need for late working.

Previous deaths at HMP Hewell

27. Mr Dimmock was the third prisoner to have taken his life at Hewell in the past two years. In the previous investigations, we made recommendations about cell-sharing risk assessments and resuscitation and we await Hewell's response to these. We have again identified concerns about both these issues in this case.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

29. On 14 March 2019, Mr Richard Dimmock was remanded to HMP Hewell, charged with historic sexual offences (against a family member) and indecent assault. He had last spent time in prison 20 years earlier.

30. Mr Dimmock arrived at Hewell with a Person Escort Record (PER), which noted that a suicide and self-harm warning form had been completed at court, that he used cannabis and that he had Post-Traumatic Stress Disorder (PTSD).

31. Prison staff recorded in reception that it was Mr Dimmock's first time in prison in 20 years, that his mood was low and he was happy to share a cell. A Supervising Officer (SO) gave a statement to confirm that he was in charge of reception duty that day and did not recall Mr Dimmock arriving with a suicide and self-harm warning form.

32. A nurse recorded in Mr Dimmock's medical record that she had completed his initial health screen. She noted that he had no thoughts of suicide or self-harm, no history of substance misuse and was not prescribed any medication. She noted that Mr Dimmock had been upset as the outcome of the court hearing had not been what he had expected. He told her that he had had counselling for PTSD in the community. She referred Mr Dimmock to the mental health team but did not request Mr Dimmock's medical records from his community GP. She did not refer to a suicide and self-harm warning form.

33. Due to his offence, Mr Dimmock agreed to be located on Houseblock 5, the vulnerable prisoners' wing.

34. On the morning of 15 March, an officer completed Mr Dimmock's basic custody screen. Mr Dimmock said that he had PTSD and intended to see the prison GP about his counselling options. He said that he was in contact with his family.

35. That afternoon, staff found Mr Dimmock in his cell, unresponsive but breathing. His cellmate reported that Mr Dimmock had fallen out of his bed onto the floor. Staff immediately radioed a medical emergency code blue (used to indicate that a prisoner is unconscious or having breathing difficulties) and an ambulance was called. A nurse responded to the emergency and examined Mr Dimmock. She noted that his pulse was fast and his oxygen saturation levels were low. She suspected he had taken a psychoactive substance (PS). When the paramedics arrived, they took Mr Dimmock to hospital.

36. Healthcare staff at Hewell telephoned the hospital daily to maintain communication and received updates about Mr Dimmock's condition and care requirements.

37. On 21 March, hospital staff informed the Hewell healthcare team that Mr Dimmock had refused food, fluids and his medication. They asked for Mr Dimmock to be referred to the mental health team at Hewell on his return.

38. Prison staff started suicide and self-harm prevention procedures, known as ACCT, while he was still in hospital. Mr Dimmock told a hospital doctor that he was "not sure" that he wanted to live. He was tearful and said that his father and

sister had both committed suicide in 2016 within eight months of each other. He said that he had not spoken to his other sister, his next of kin, since he had been in custody. He also said that he wanted to see a psychiatrist.

39. Staff recorded in the ACCT immediate action plan that Mr Dimmock's hospital doctor had referred him to a psychiatrist. Prison staff arranged for Mr Dimmock to speak to his sister by telephone. During their conversation, Mr Dimmock was crying and said that he wanted to be "sectioned" (that is, compulsorily detained in a secure psychiatric hospital under the Mental Health Act). He was also upset as his aunt had apparently died the day after he arrived in custody.

40. That day, a Custodial Manager (CM) visited Mr Dimmock in hospital and completed an ACCT assessment. Mr Dimmock told him that he had not intentionally refused to eat but had felt so anxious that he could not "physically" eat. He told him that he was also engaging with hospital staff and treatment, which he had initially refused. The CM noted that Mr Dimmock was in "despair" because he had been charged with historic sexual offences which he denied. Mr Dimmock said that he had lost his home, his family, his sister, his daughter, his dogs and his car. He said that he had PTSD, could not do prison and would "rot away".

41. On 22 March, an officer noted that while she escorted Mr Dimmock around the ward to stretch his legs, she saw a child at the other end of the ward. Given his alleged offences and the restrictions in place on his contact with children, she asked him to return to his bed. Mr Dimmock became irate at this request and stated that his human rights were being breached. He later spoke to his sister on the phone and told her to report the prison to the newspapers.

42. The next day, Mr Dimmock's sister phoned the prison and said that she was upset about her brother. On 24 March, Mr Dimmock's sister visited him in hospital. It was noted that Mr Dimmock began to eat after her visit.

43. On 25 March, a Custodial Manager (CM) chaired the first ACCT review, with a SO present. The CM noted that it was difficult to assess Mr Dimmock while he was in hospital and arranged to review him in a week or on his return to Hewell, whichever was sooner. He noted in the ACCT caremap that Mr Dimmock's main issue had been a lack of contact with his sister but this had been resolved.

44. Mr Dimmock returned to Hewell on 27 March. A senior prison manager and a SO interviewed Mr Dimmock in reception and completed an ACCT review. No-one from the healthcare team attended. Mr Dimmock said that he had no thoughts of suicide or self-harm, and that he was eating and taking his medication. He said that two of his family members had taken their own lives but gave no further information about this. The senior prison manager noted that Mr Dimmock's risk level was low and set hourly observations. Mr Dimmock was returned to Houseblock 5, a standard wing, and shared a cell with another prisoner. His ACCT caremap did not say that he had been prescribed medication.

45. A nurse recorded in Mr Dimmock's medical record that she had not seen Mr Dimmock on his return, but that an officer had given her a bag of prescribed medication and a discharge letter from the hospital. The letter confirmed that Mr Dimmock did not need follow-up treatment at hospital but asked that the prison

GP undertake a chest x-ray in six weeks and follow up on his outstanding toxicology test results. It noted that Mr Dimmock had been admitted to hospital for an "overdose" and said that one of the tests completed showed a "haziness of the chest" which was treated with antibiotics. The nurse noted that the hospital had prescribed Mr Dimmock co-amoxiclav (an antibiotic), paracetamol, docusate and senna (both of which are used to treat constipation).

46. The nurse made an appointment for Mr Dimmock to see the prison GP the next day, but he did not attend. There is no evidence to explain why not. The GP noted that Mr Dimmock's appointment would be re-booked and a chest x-ray arranged.

47. On 31 March, a pharmacist recorded that she had spoken to Mr Dimmock the previous day and asked him why he had not collected his medication. Mr Dimmock said that he was unaware that he had been prescribed any medication. Although she explained why the hospital had prescribed him medication, Mr Dimmock said that he did not need to take it. She sent a note to the GP to tell him this.

48. On 1 April, Mr Dimmock failed to attend his appointment with the nurse.

49. That day, the ACCT case manager chaired an ACCT review. Another SO was present. No one from the healthcare team attended. The case manager noted that the review was an interim one as he had not been told that Mr Dimmock had returned to prison from hospital. Mr Dimmock said that he had no thoughts of suicide or self-harm and was getting on well with his cellmate. He said that he was concerned about his court hearing and that he had been unable to contact his solicitor by phone. Mr Dimmock said that he had not come out of his cell since his return from hospital and that hourly ACCT observations offered him no privacy. The case manager assessed Mr Dimmock's risk level as low and agreed to reduce his ACCT observations to three times a day (morning, afternoon and evening) and every two hours at night.

50. On 2 April, the ACCT case manager chaired another ACCT case review. An officer was present. No one from the healthcare team attended. The case manager noted that Mr Dimmock appeared "vulnerable/scared" and rushed his words when speaking. Mr Dimmock's main concern was that he had been unable to use the PIN phone to contact his legal team. The case manager explained that due to Mr Dimmock's public protection restrictions, the prison security team had to check his external contacts, including telephone numbers, before authorising them for use. He gave Mr Dimmock an application form, and noted his solicitor's details. He took the form immediately to the PIN phone clerk to expedite the process. He noted that staff had also facilitated a phone call earlier that day for Mr Dimmock to contact his legal team but his solicitor had not been available. Mr Dimmock said that he did not want to kill himself as this would leave his daughter with the same questions he had had when his father and sister took their lives. He said that he was not interested in getting a job in prison. Mr Dimmock had stopped taking his prescribed medication but there is no record that this was discussed in the ACCT case review.

51. The ACCT review panel made no changes to Mr Dimmock's risk or observation levels. The ACCT caremap was updated and noted that Mr Dimmock's

application with his PIN number for contacting the legal team had been completed and passed to the PIN office.

52. That day, it was recorded in Mr Dimmock's medical record that he had been added to the waiting list for psychosocial substance misuse support after the suspected PS incident of 15 March.

53. On 4 April, the clinical mental healthcare team manager recorded that wing staff had told her that Mr Dimmock appeared very anxious. Due to his recent hospitalisation for suspected PS use, she decided that the substance misuse team should review Mr Dimmock and refer him for psychological support for his PTSD, if needed. (The substance misuse team and mental health team at Hewell are integrated and managed jointly.)

54. On 5 April, staff called a code blue after Mr Dimmock complained of chest pains, appeared anxious and was fidgety. An ambulance was called and after assessment, the paramedics decided that he did not need to go to hospital. A prison GP also examined Mr Dimmock. Mr Dimmock said that he had not been sleeping well and had heard banging noises at night for the past week. He said that this caused tension with his cellmate, who had denied hearing any noises. Mr Dimmock told the GP that he thought he might be hallucinating. He said that he had been okay until his father and sister died, and that he had been blamed for their deaths. He denied having any thoughts of self-harm and said that he did not take drugs. The GP prescribed a short course of diazepam (for anxiety). He considered prescribing an antidepressant but Mr Dimmock said that he expected to be released from prison in three weeks' time so did not need it. The GP made no entry in the ACCT record to say that he had seen Mr Dimmock.

55. Staff recorded that afternoon that they had issued Mr Dimmock his canteen (items from the prison shop), and that he had earlier asked if he could move to another cell because he was not getting on with his cellmate.

56. On 6 April, Mr Dimmock failed to attend an appointment with the nurse. No reason was recorded.

57. On 8 April, Mr Dimmock was moved to another cell on Houseblock 5. That day, the ACCT case manager chaired an ACCT case review. An officer and a member of the chaplaincy team were present. No one from the healthcare team attended. Mr Dimmock said that his sister was yet to visit him but he had spoken to her on the phone. He said that his recently prescribed medication had helped with his anxiety and he felt calmer, and that he had spoken to his legal team about his hearing and felt positive. He said that his next court hearing date was scheduled for 29 April. He said that he was trying to stay positive for his daughter and although he had occasional thoughts of self-harm, he had not acted on them because he did not want to leave his daughter with the same questions he had had. Mr Dimmock said that he was also getting along with his cellmate. The review panel noted that Mr Dimmock's risk level was low and agreed to stop ACCT monitoring.

58. On 9 April, a nurse completed Mr Dimmock's secondary healthcare screen and a prison GP then reviewed him. Mr Dimmock reported that his mood was low, and that he was tearful, anxious and not sleeping well. Although he had changed

cells, Mr Dimmock said that he still heard banging noises at night. He also saw pictures of his family projected onto his cell walls. He said that he felt like he had palpitations, felt agitated and his stomach was churning. He was looking forward to being released from prison but said that he was struggling to cope. He denied that he had thoughts of self-harm. The GP prescribed propranolol to treat Mr Dimmock's palpitation symptoms and referred him to the mental health team.

59. On 10 April, a substance misuse recovery worker reviewed Mr Dimmock. He told her that he did not use drugs or alcohol and therefore did not wish to engage with the substance misuse service. She noted that she would follow up on Mr Dimmock's decision in 28 days' time. She also noted that she would tell the clinical mental healthcare team manager that Mr Dimmock was in the ACCT post-closure period. The team manager agreed that the recovery worker would be Mr Dimmock's case worker and that she may need to liaise with the chaplaincy team for bereavement support for Mr Dimmock. The recovery worker also intended to contact a clinical psychologist to assess Mr Dimmock's anxiety and see whether he was suitable for an anxiety management programme.

60. On 7 May, the substance misuse recovery worker saw Mr Dimmock for a follow-up appointment and offered substance misuse support again. Mr Dimmock again declined substance misuse support but told her that he heard banging and voices shouting his name, that he had PTSD and anxiety and that he was not eating or sleeping well. She agreed to discuss Mr Dimmock's case at the mental health multi-disciplinary team (MDT) meeting that week to access psychological support.

61. The substance misuse recovery worker spoke to the clinical mental healthcare team manager about Mr Dimmock. On 8 May, she referred Mr Dimmock to an assistant psychologist for an assessment.

62. On 9 May, a nurse from the mental health team and the substance misuse recovery worker reviewed Mr Dimmock, who said that he did not know why he was being sentenced and that the death of his father and sister had greatly affected him. He said that he had nightmares, cold sweats and heard a female voice calling his name. He said that he had been due to start "talking therapies" counselling before he was sent to prison.

63. The mental health nurse noted that Mr Dimmock's symptoms appeared to be a reaction to the trauma or loss of his family members but he did not exhibit any signs of psychosis, thought disorder or paranoia. She agreed that the recovery worker should keep Mr Dimmock on her caseload and would work in partnership with the psychology team. In addition, she asked for a prison key worker to be appointed to help answer Mr Dimmock's questions about his sentence. (The key worker system was in the process of being rolled out at Hewell.) She also suggested that Mr Dimmock should consider seeing a GP for a prescription of antidepressants. The recovery worker noted later that day that an officer had been appointed as Mr Dimmock's key worker.

64. On 14 May, Mr Dimmock did not attend an appointment to see a prison GP. No reason was recorded.

65. At 5.00pm that day, staff called a code blue after they found Mr Dimmock unresponsive, lying on his bed. A prison paramedic responded to the emergency and noted that Mr Dimmock appeared to have no injuries and was breathing but he was grey. She administered naloxone (a drug to treat opioid overdose). Ambulance paramedics arrived and took Mr Dimmock to hospital.

66. Mr Dimmock's prison records indicate that staff had to restrain him at hospital because he tried to elbow and kick a nurse while she was conducting his health observation checks.

67. On 15 May, Mr Dimmock returned to Hewell without a hospital discharge letter. The recovery worker told the investigator that all the staff had assumed that Mr Dimmock had had a reaction after taking PS.

68. On 16 May, the recovery worker saw Mr Dimmock to discuss his recent hospital admission. Mr Dimmock denied that he had taken any illicit substances, including PS, and said he did not know what had happened. He complained that he had had no feelings in his hands and feet since he returned to Hewell. She booked an appointment for Mr Dimmock to see a member of the healthcare team the next day, but he failed to attend.

69. That afternoon, the key worker saw Mr Dimmock for a key worker session and explained his role. He noted afterwards that Mr Dimmock's attitude towards him was "awful". He noted that Mr Dimmock only wanted to talk about the legal aspects of his case and why he was in prison, matters which were not prison-related and which he could not help him with. Mr Dimmock was not happy about this.

70. Mr Dimmock also asked the key worker about the prison's policy on money and cash/spend accounts. Wing staff had apparently already spoken to Mr Dimmock about a request which they had not been able to approve. Mr Dimmock made a similar request to the key worker and was upset that he gave him the same response as wing staff. Mr Dimmock did not want to accept his response, and said that he intended to complain about him. Mr Dimmock ended their key worker session by saying, "Do not bother, you are no help and I feel sorry for the rest of your key workers".

71. On 22 May, a prison GP saw Mr Dimmock after he said that he still had panic attacks. Mr Dimmock told him that the medication he was taking (propranolol) had only marginally helped him and he had had two panic attacks that week. He said that he was also still hallucinating, was not sleeping well and was sensitive to noise. Mr Dimmock denied that the recent code blue incident was because he had taken PS. The GP diagnosed that Mr Dimmock had anxiety and arranged for him to have blood tests to rule out other causes for his night sweats. (The blood tests were negative.) He also asked for healthcare staff to follow up the chest x-ray and hospital toxicology results in line with the hospital discharge instructions after Mr Dimmock's admission into hospital in March. In addition, Mr Dimmock agreed to try mirtazapine, an antidepressant, as well as his already prescribed propranolol.

72. On 23 May, a SO accompanied the key worker at Mr Dimmock's next key worker session. This was in part due to the difficult first key worker session. The SO

noted that Mr Dimmock insisted that he did not need a key worker as they were pointless to him. She noted that he did not want to listen to her and had accused her and the key worker of trying to intimidate him. She told Mr Dimmock that despite his refusal to engage, the key worker would continue to check on his wellbeing on a weekly basis.

73. On 30 May, a prison GP saw Mr Dimmock for his initial psychology appointment. She noted that Mr Dimmock reported difficulties sleeping but admitted that his mirtazapine had helped a little. Mr Dimmock described having daily nightmares that caused him significant distress. In the context of his court appearance on 7 June, she noted that they would focus on providing Mr Dimmock with psycho-education in the form of teaching him a "safe place" exercise and giving him advice on coping with panic. At the end of the consultation, she noted that she would follow up with Mr Dimmock after his court appearance.

74. On 31 May, the key worker met Mr Dimmock for a key worker session and noted that Mr Dimmock's attitude was much better than at their previous meetings and he engaged well. Mr Dimmock said that his main concern was that he had not received his prison canteen despite being charged for it. He said that he had already made applications asking for this to be rectified but had not had a response. The key worker told Mr Dimmock how to rectify the issue. Mr Dimmock also asked for a key for the privacy lock on his cell. The key worker asked wing staff if this was possible, but was told that there was no key for Mr Dimmock's cell. He told Mr Dimmock that he should ask wing staff if he wanted to leave his cell and wanted it to be locked. He noted that, overall, this key worker session was very productive.

75. On 3 June, staff recorded in Mr Dimmock's medical record that he did not attend an appointment for him to be escorted to hospital for an x-ray. No reason was recorded.

76. On 4 June, a member of the substance misuse team visited Mr Dimmock, as he had made an application to become a substance misuse Recovery Champion. This seemed strange because Mr Dimmock had said that he had no history of substance misuse. Mr Dimmock told her that he had significant experience of people close to him having misused illicit substances. She told Mr Dimmock that once the relevant security checks had been completed, he would be given an application form so that he could apply.

77. On 6 June, the key worker met Mr Dimmock for a key worker session. Mr Dimmock explained that although his canteen issue was still outstanding, he had made some progress in addressing the problem. He also wanted to work towards his enhanced IEP status. The key worker explained the criteria for him to achieve this. Mr Dimmock said that he would attend his court hearing the next day.

78. That afternoon, a prison GP reviewed Mr Dimmock who told her that he felt numb about attending court for sentencing. He said that he had regular night terrors and intrusive memories about previous trauma, both of which were caused by the stress of him attending court. He denied having thoughts of suicide but said he felt panicky. The GP focused their session on basic anxiety management. She

noted that she would see Mr Dimmock again in two weeks to determine a longer-term psychological treatment plan.

79. On 7 June, Mr Dimmock refused to attend court and the court rescheduled the hearing to 24 June.

80. On 11 June, an officer noted in Mr Dimmock's prison records and cell-sharing risk assessment that he had increased Mr Dimmock's cell-sharing risk from standard to high. Mr Dimmock said that he had acute stress, anxiety, PTSD and was not sleeping well. He said that he had thoughts of harming others which scared him. Mr Dimmock admitted that he had twice awoken to find his hands wrapped around his cellmate's throat.

81. That day, the key worker recorded that he could not see Mr Dimmock for their key worker session due to an incident in the prison.

82. A prison GP reviewed Mr Dimmock on 20 June. Mr Dimmock said that he felt anxious about his court appearance on 24 June. He did not think he could face it. The GP focused the session on how to cope with anxiety. She noted that she asked Mr Dimmock if he needed support for his court appearance. Mr Dimmock said that he did not think that he would attend and strongly denied the charges against him. He also denied that he had thoughts of self-harm and said that he needed to think about his daughter. She noted that she planned to review Mr Dimmock again after his court appearance.

83. On the evening of 23 June, a pharmacy assistant spoke to Mr Dimmock because he had not been collecting his morning dose of propranolol (although he had collected his evening doses). (The records do not clarify how many morning doses he had missed.) Mr Dimmock told her that he became anxious and only managed to leave his cell to collect his medication in the evening. She noted that she had referred this matter to the prison GP.

84. On this day, Mr Dimmock phoned his sister. They talked about his court case.

24 June

85. Mr Dimmock left Hewell in the morning to attend his court hearing. A reception nurse noted that Mr Dimmock was fit to attend court and had had his medication. Mr Dimmock was sentenced to ten years and nine months in prison.

86. A SO was on duty in the reception area when Mr Dimmock returned to Hewell at around 5.30pm. He reviewed Mr Dimmock's PER and noted that he had received a long sentence. He said he asked Mr Dimmock twice how he felt about his sentence length and if he was okay, but Mr Dimmock did not engage in the conversation. He offered Mr Dimmock the opportunity to talk to someone about what had happened at court that day. A nurse and Listeners (prisoners trained by the Samaritans to offer support to other prisoners) were on duty in the reception area. Mr Dimmock said that he was okay and did not want to speak to anyone. The SO told the investigator that Mr Dimmock did not present to him in any way that he felt would have required him to consider starting ACCT procedures.

87. An officer escorted Mr Dimmock to Houseblock 5. The majority of prisoners had been locked in their cells at around 5.15pm. In his statement, the officer said that Mr Dimmock appeared to be in good spirits and engaged in general conversation. He said that Mr Dimmock showed no signs that his mood was low or that he was distressed. On arrival, he handed Mr Dimmock's care to another officer.

88. CCTV was in operation on Houseblock 5. (The CCTV timings were around seven minutes slow and we have used real time in this report.) The officer locked Mr Dimmock in his cell at 6.39pm. Shortly afterwards, CCTV footage shows a prisoner talking to Mr Dimmock through his cell door observation panel. After Mr Dimmock's death, the prisoner told prison staff that Mr Dimmock had asked him for sugar, which he gave him, and talked to him about his court case. (The prisoner was released from prison soon after Mr Dimmock died, so the PPO investigator was not able to speak to him.)

89. Mr Dimmock pressed his cell bell and asked the officer if he could be unlocked to make a phone call because he had been at court all day. Prison PIN phone records noted that Mr Dimmock phoned his sister at 7.02pm. They talked about his court hearing and his sentence. Mr Dimmock was not happy about his sentence but did not say anything to indicate that he intended to harm himself.

90. After Mr Dimmock completed his phone call, the officer asked him if he needed anything else. Mr Dimmock said that he was fine. He then locked Mr Dimmock in his cell. His completed his duty at 7.30pm.

91. Two officers started their night duty shift at around 8.45pm. Around 9.07pm, Officer A responded to Mr Dimmock's cell bell and spoke to him through his observation panel. Mr Dimmock said that he had been at court all day and therefore had not collected his night time medication. She told Mr Dimmock that she would contact the healthcare team and ask the nurse on night duty whether they were able to issue his medication. Mr Dimmock thanked her for her assistance.

92. Officer A phoned the healthcare team and a nurse told her that they were only allowed to issue medication to new prisoners who had arrived that evening. As Officer B was responsible for Houseblock 5 that evening, she asked him to pass this information to Mr Dimmock when he was doing his roll check.

93. Officer B completed a roll check of Houseblock 5 at around 9.30pm, and told Mr Dimmock that the healthcare team would not be able to issue him his medication that night. He told us that Mr Dimmock appeared content with this response.

25 June

94. At 5.05am, Officer B completed his welfare check and roll check of Houseblock 5. He said that when he looked through Mr Dimmock's cell door observation panel, he saw him hanging by a green bedsheet attached to a cabinet in his cell. He immediately radioed a code blue. Prison records record that this occurred at 5.06am and that the control room immediately called an ambulance.

95. Officer B had not been issued with cell keys and shouted to Officer A, who was on the landing below and who arrived within 30 seconds. He used her cell key

from her sealed pouch, unlocked the cell door and went in. Both officers said that Mr Dimmock showed no signs of life, was grey in colour and that his tongue was protruding from his mouth. Officer B used his anti-ligature knife and cut the ligature from the cabinet. He told the investigator that he had not anticipated Mr Dimmock's weight and Mr Dimmock fell to the floor, hitting his head on the cabinet. Officer A was in shock and was unable to assist him.

96. At this point, the officers heard the wing gates opening and left Mr Dimmock's cell to alert the responding staff to their exact location. Officer B used his radio again and repeated the emergency. He then returned into the cell and cut the ligature from around Mr Dimmock's neck. Mr Dimmock was lying on his back, with his feet towards the door.

97. A Custodial Manager (CM) arrived promptly at 5.07am and found both officers standing outside Mr Dimmock's cell. He noted that they were in shock. Two more officers then arrived. One officer told us that she went into Mr Dimmock's cell with a colleague and started cardiopulmonary resuscitation (CPR). She said that Mr Dimmock's stomach was bloated, his chest was hard and he appeared stiff.

98. A nurse arrived at Mr Dimmock's cell at 5.10am with emergency medical equipment. She examined Mr Dimmock and noted that he showed no signs of life, his chest was congested with fluid, he was cold to touch and hypostasis (blood pooling) was present. She was unable to insert an airway into Mr Dimmock's mouth because of his swollen tongue. She applied a defibrillator, which indicated that Mr Dimmock had no shockable rhythm, and so staff continued CPR until paramedics arrived. All staff who responded to the emergency described Mr Dimmock as cold and grey in colour and said that his body was stiff.

99. After around 20 minutes of continuous CPR, the nurse asked a healthcare assistant to bring additional medical equipment and oxygen to support Mr Dimmock. The healthcare assistant continued to apply oxygen and check Mr Dimmock for vital signs, but detected none. The officers rotated CPR until the paramedics arrived.

100. When paramedics arrived at 5.37am they assessed Mr Dimmock and, at 5.45am, declared that he had died. Ambulance records noted that rigor mortis was present.

101. After Mr Dimmock's death, a note that he had written was found in his cell. The note was addressed to his mother and indicated his intention to take his life.

Contact with Mr Dimmock's next of kin

102. The prison appointed two SOs as family liaison officers. Mr Dimmock had identified his sister as his next of kin. The Governor asked a family liaison officer at HMP Stoke Heath to visit Mr Dimmock's next of kin and notify her of his death. This was because Stoke Heath was much nearer to Mr Dimmock's sister's house which meant that the message would be delivered faster.

103. The Stoke Health family liaison officer visited Mr Dimmock's sister at 10.45am to break the news of his death. A Hewell family liaison officer then contacted Mr

Dimmock's sister that afternoon to offer his condolences and explain the circumstances of Mr Dimmock's death. The prison provided ongoing support and contributed towards the costs of Mr Dimmock's funeral in line with national policy.

Support for prisoners and staff

104. The duty governor debriefed prison staff directly involved when Mr Dimmock was discovered.

105. The prison posted notices informing other prisoners of Mr Dimmock's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm in case they had been adversely affected by Mr Dimmock's death.

Post-mortem report

106. Mr Dimmock's post-mortem examination established that Mr Dimmock died from ligature suspension (hanging). A toxicology report noted the presence of Mr Dimmock's prescribed medications, mirtazapine and propranolol, in low concentrations consistent with therapeutic levels and not indicative of excessive use before his death.

Findings

Assessment of Mr Dimmock's risk of suicide and self-harm on arrival

107. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody list risk factors and potential triggers for suicide and self-harm. Mr Dimmock had a number of risk factors when he arrived at Hewell in March 2019: it was his first time in custody for 20 years, he had been remanded for a serious offence against a family member, he had PTSD, his PER indicated that a suicide and self-harm warning form had been completed at court and he was considered vulnerable.

108. PSI 07/2015 requires that staff appropriately manage newly arrived prisoners who are at risk of suicide and self-harm. It requires that reception staff examine the PER and any other available documentation to assess a prisoner's risk of suicide, self-harm or harm to or from others.

109. Contrary to national instructions, neither prison nor healthcare staff acknowledged, challenged or recorded critical risk information from Mr Dimmock's PER. We cannot say whether or not reception staff considered the PER or suicide and self-harm warning form. There is no reference to these documents in reception records. This is a significant concern as they contained important information which would have helped staff assess his risk. If staff had assessed Mr Dimmock's risk fully when he arrived, we consider that it is likely that they would have started ACCT procedures for him.

Managing Mr Dimmock's risk of suicide and self-harm

110. PSI 64/2011 requires a multidisciplinary approach for ACCT case reviews and says that, where possible, the ACCT assessor and staff from the healthcare team, including the mental health team, should attend the first ACCT review.

111. A week after Mr Dimmock arrived at Hewell, staff started ACCT procedures while he was in hospital. His ACCT assessment noted that he was in "despair" because of his alleged offences, the breakdown of his relationships with his family, his PTSD and his inability to cope in prison.

112. Following his discharge from hospital on 27 March, prison staff completed four ACCT case reviews. We are concerned that, although Mr Dimmock had just spent nearly two weeks in hospital, healthcare staff, including the mental health team, were not involved in any of these reviews and did not contribute at all to the ACCT process. A prison GP saw Mr Dimmock on 5 April when he was subject to ACCT monitoring, and prescribed him diazepam for anxiety. However, this contact was not recorded in the ACCT record and there is no reference to ACCT monitoring in Mr Dimmock's medical record.

113. The PSI requires that ACCT caremaps reflect a prisoner's needs, level of risk and the triggers of their distress. They should aim to address issues identified in the ACCT assessment. They must be tailored to meet individual needs, be time-bound and say who is responsible for completing the action.

114. From his arrival, staff acknowledged that Mr Dimmock had PTSD and anxiety and referred him to the mental health team. Although he was prescribed medication, staff failed to reflect this in Mr Dimmock's caremap, and they did not record what progress had been made to reduce this aspect of his risk. We are concerned that this omission occurred because the healthcare team did not contribute to the ACCT process.

115. In addition, other than an action to establish family contact for Mr Dimmock, none of the issues identified in his ACCT assessment formed part of his caremap and were therefore not addressed. For example, the caremap did not refer to his forthcoming court hearing, even though the ACCT assessment noted his concern about this and his statements that he could not cope with prison. This meant that this concern was never addressed.

116. When the ACCT procedures were stopped on 8 April, Mr Dimmock's risk factors still existed and even increased as his court hearing date approached. On 9 April, for example, a nurse and a doctor noted that his mood was low, and that he was he was tearful, anxious, having palpitations, not sleeping well and struggling to cope, and they referred him to the mental health team. Healthcare staff continued to record that Mr Dimmock's anxiety was increasing as the court hearing approached and the mental health team offered support for his anxiety. Unfortunately, this was not communicated to prison staff.

117. We are concerned that the lack of multi-disciplinary work meant that important information about Mr Dimmock's risk factors was missed, that his risk was not properly assessed and that his ACCT monitoring was ended prematurely. Given his frequently expressed anxiety about his court hearing, we consider that staff should have considered putting support in place for him when the hearing took place. As it was, the officer who saw him in reception after the hearing, had no information to suggest that Mr Dimmock was at heightened risk of suicide.

118. We make the following recommendations:

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

- **Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.**
- **Staff have a clear understanding of their responsibilities and the need to record and share promptly relevant information about possible risk.**
- **Prison, healthcare and mental health team staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review and subsequent reviews if the prisoner has serious health concerns.**
- **Staff hold multidisciplinary ACCT reviews, with the same case manager and which involve staff who contribute to a prisoner's care.**

- **Case managers complete caremaps, identifying all the risks, setting specific and meaningful caremap actions, identifying who is responsible for them, reviewing progress at each review and not closing ACCT procedures until all the risks have been addressed.**

Cell sharing risk

119. PSI 20/2015 on assessing prisoners' cell-sharing risk prevents prisoners who are assessed as posing a heightened risk from sharing a cell. On 11 June, an officer reviewed Mr Dimmock's cell-sharing risk and noted that his risk should increase from standard to high because Mr Dimmock said that he had acute stress, anxiety and PTSD, had had thoughts of harming others and had twice woken up with his hands wrapped around his cellmate's throat. Prison staff did not share this information with healthcare staff. Healthcare staff told the investigator that they would have increased the support they provided Mr Dimmock if they had known. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that prison and healthcare staff share all information about a prisoner's cell-sharing risk and record it in prison and medical records.

Clinical care

120. The clinical reviewer noted that overall, the mental and physical healthcare that Mr Dimmock received was equivalent to that which he could have expected to receive in the community. However, she made a number of recommendations which the Head of Healthcare will need to address.

Continuity of healthcare

121. PSO 3050, on the continuity of healthcare, requires a member of the healthcare team to assess and follow up the immediate medical needs of newly arrived prisoners, including obtaining any information required from their community GP. Healthcare staff did not request Mr Dimmock's medical history from his community GP. A prison GP told us that Mr Dimmock's PTSD diagnosis was not confirmed but that his symptoms were in line with PTSD or acute anxiety. If Mr Dimmock's community medical records had been available, they might have informed a diagnosis. We make the following recommendation:

The Head of Healthcare should ensure that in cases where prisoners are admitted with no known GP and then a registered GP becomes identified some time later, healthcare staff should give consideration as to whether their medical history is requested or not.

Mental health and substance misuse service

122. When Mr Dimmock arrived at Hewell, he was referred to the mental health team because he said that he had PTSD. He was again referred shortly afterwards when he was admitted to hospital. The substance misuse service and mental health team are integrated at Hewell and staff attend the same multi-disciplinary team meetings. Following a suspected PS incident, Mr Dimmock was allocated a substance misuse recovery worker. Although Mr Dimmock refused this support, the team kept him on their caseload due to his ongoing anxiety. A mental health

nurse completed sessions with him to help him manage his acute stress before his court appearance. The prison GP also saw Mr Dimmock and prescribed him medication to reduce his palpitations and an antidepressant for his anxiety. This was good practice.

Resuscitation

123. In September 2016, Professor Sir Bruce Keogh, the National Medical Director at NHS England, wrote to Heads of Healthcare for prisons, introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The European Guidelines were updated in November 2017 but the same principles apply.

124. Staff responded promptly to the medical emergency code blue on 25 June. They described Mr Dimmock as cold, pale and not breathing. The nurse also described signs of rigor mortis and hypostasis (blood pooling), all indicators that he had been dead for some time. However, she decided to continue resuscitation efforts. CPR continued for approximately 44 minutes due to the delay in the ambulance arriving. When paramedics arrived, they pronounced that Mr Dimmock had died. Contrary to the European guidelines and the joint NHS and Prison Service policy on when not to resuscitate, the nurse told the investigator and clinical reviewer that she felt that she was not qualified to pronounce death, which she would have had to do if she had stopped resuscitation attempts.

125. We understand why staff might want to continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance and understand the circumstances when they should not try to resuscitate prisoners in line with European Resuscitation Council Guidelines.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141