

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Jerome Dangar, a prisoner at HMP Dartmoor, on 15 April 2019

**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 Jerome Dangar died on 15 April 2019, of an overdose of prescribed propranolol, at HMP Dartmoor. He was 45 years old. I offer my condolences to Mr Dangar's family and friends.

Mr Dangar was prescribed propranolol for anxiety. Seven weeks before his death, he was found to have hoarded a large quantity of propranolol tablets. I am very concerned that, with the exception of an entry in his medical records, this incident was not recorded or followed up by healthcare or operational staff. As a result, Mr Dangar's risk and suitability to hold medication was not reviewed and he continued to receive weekly supplies of propranolol that he was allowed to keep in his cell.

I am also concerned about the wider issue of recording and sharing information. I am not persuaded that staff at Dartmoor understand the rationale for sharing information with each other to identify factors which could increase risk, or the benefits of using such information to make better-informed decisions and take preventative action.

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**

**July 2020**

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# Summary

## Events

1. Mr Jerome Dangar was remanded to HMP Exeter on 3 November 2018. It was his first time in prison. (He was later convicted of sexual offences and sentenced to 15 months in prison.)
2. Mr Dangar had a history of anxiety and depression and arrived with a suicide and self-harm warning form stating he had had recent suicidal thoughts. Reception staff considered his risk factors, but concluded that he did not need to be managed under suicide and self-harm prevention procedures (known as ACCT).
3. Mr Dangar had been prescribed propranolol for anxiety and sertraline for depression. They were re-prescribed when he arrived at Exeter and three weeks later, he was given permission to keep these medications in his cell.
4. On 16 November, prison staff intercepted a letter from Mr Dangar in which he had written that he did not want to live, and they began suicide and self-harm procedures. The next day, Mr Dangar told a review team that it had been a fleeting thought which he regretted and that he had no intentions to act on it.
5. Further concerns were raised about Mr Dangar's state of mind three times over a three-week period. Each time, Mr Dangar convinced staff that he would not harm himself and had reasons to live.
6. On 11 January 2019, Mr Dangar transferred to HMP Dartmoor. A mental health assessment concluded that he had reactive low mood due to being in prison and being concerned about his elderly parents running his business.
7. On 25 February, a wing officer handed a pharmacy assistant a large quantity of propranolol tablets found during a search of Mr Dangar's cell. The pharmacy assistant recorded the incident in Mr Dangar's medical record. He continued to receive his medication weekly and to keep it in his cell.
8. On 12 April, Mr Dangar received a letter from his solicitor informing him that Staffordshire Police intended to interview him on 16 April. He was reported to be upset by this. A supervising officer discussed the letter with Mr Dangar, who said he did not know what the interview was about. When asked directly if he had considered harming himself, Mr Dangar insisted that he would not. The supervising officer kept an eye on him over the next two days.
9. Just after 8.00am on 15 April, one of Mr Dangar's friends told a prison officer that he could not wake Mr Dangar. The officer went to Mr Dangar's cell and radioed a medical emergency as he was unresponsive. Healthcare staff and paramedics attended. They did not try to resuscitate him as there were signs of rigor mortis, meaning he had been dead for some time. Paramedics confirmed his death at 8.35am.
10. Mr Dangar had received 21 propranolol tablets the day before his death, but only one was found when the police searched his cell. There were also empty blister

packs of medication prescribed several months earlier. The post-mortem report confirmed that Mr Dangar died from an overdose of propranolol.

## Findings

11. Through oversight, Mr Dangar did not receive a secondary health screen at Exeter. Although this had no direct bearing on Mr Dangar's death, it was poor practice. The Head of Healthcare has since introduced two new processes to prevent this happening again. A list of new prisoners who have not received health screens is produced weekly and they are followed up. Also, administrative staff now routinely check whether an appointment has been booked, as part of their administrative actions.
12. Staff at Exeter were responsive each time concerns were raised about Mr Dangar's welfare. They acted quickly to determine whether he was at immediate risk of self-harm or suicide. At Dartmoor, Mr Dangar was well supported and consistently positive about his prospective release in June 2019 and his plans for the future.
13. We are satisfied that staff could not have predicted his actions on the basis of the information available to them. If they had been aware that he had been stockpiling medication and was facing a possible further charge of manslaughter, it is likely that they would have assessed his risk differently.
14. We are very concerned that no action was taken to review Mr Dangar's risk after he was found to be hoarding medication at Dartmoor. Although it was noted in his medical record, the information was not shared with operational staff. In addition, the prison did not have clear guidance at that time on the steps to be taken to review and manage his risk. The Head of Healthcare has since revised the policy to include instructions on dealing with prisoners stockpiling medication. However, the clinical reviewer has identified scope for the policy to be significantly improved and we consider the document should include explicit references to coordination with operational staff.
15. When concerns were raised about Mr Dangar's reaction to his solicitor's letter, there was an immediate effort to explore his mood and the extent to which he had been affected. As on previous occasions when there were fears about his risk, Mr Dangar convincingly insisted that he was all right and there were no objective signs of heightened risk. Staff did not know at the time that Mr Dangar was facing possible further charges of manslaughter which could have resulted in a lengthy prison sentence.
16. The investigation found deficiencies in recording and sharing information about potential risk. We do not criticise staff judgement on whether Mr Dangar required formal and structured support. However, we consider that stockpiling medication and a police investigation into possible further charges were significant risk factors that should have been recorded and shared.
17. We agree with the clinical reviewer that Mr Dangar's healthcare was equivalent to that he could have expected in the community.

## Recommendations

- The Governor and Head of Healthcare should revise the policy on stockpiling medication to ensure that the weaknesses highlighted in the clinical review are addressed and that actions to be taken are specific and timebound.
- The Governor and Head of Healthcare should ensure that:
  - all operational and clinical staff are aware of their roles and responsibilities when prisoners stockpile medication; and
  - staff consider whether the prisoner is at increased risk of suicide or self-harm.
- The Governor should ensure that staff record and act on all information that suggests a prisoner might be at risk of self-harm or suicide.

## The Investigation Process

18. The initial investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
19. The initial investigator obtained copies of relevant extracts from Mr Dangar's prison and medical records.
20. Our investigation was suspended between 17 April and 1 July 2019, while we waited for the cause of death. On 1 July, the investigation was reassigned to another investigator.
21. NHS England commissioned an independent clinical reviewer to review Mr Dangar's clinical care at the prison. The investigator and clinical reviewer interviewed three staff at Dartmoor on 22 August. On the same day, they also interviewed a member of staff at HMP Exeter, by telephone. The investigator conducted another telephone interview on 28 August.
22. The investigator also liaised with Devon and Cornwall Police and obtained information relevant to the investigation.
23. We informed HM Coroner for Exeter and Greater Devon District of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
24. The Ombudsman's family liaison officer contacted Mr Dangar's next of kin to explain the investigation and to ask if there were any matters she wanted to be considered. Mr Dangar's next of kin said that Mr Dangar had been increasingly depressed, but had repeatedly spoken about his release. She had no specific questions for the investigation to consider.
25. Mr Dangar's next of kin received a copy of the initial report. She made no comments.
26. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendation.

# Background Information

## HMP Dartmoor

27. HMP Dartmoor holds up to 640 adult male prisoners. It has six residential wings. Healthcare services are provided by Care UK and mental healthcare is provided by Devon Partnership Trust.

## HM Inspectorate of Prisons

28. The most recent inspection of HMP Dartmoor was in August 2017. Inspectors reported that, overall, the prison was well managed and there was reasonable access to health services. They considered that the suicide and self-harm prevention procedures needed improvement, but the men managed under the process received good care. Peer support arrangements were good. Inspectors noted that recommendations made by the Ombudsman had been acted on and were regularly reviewed.

## Independent Monitoring Board

29. 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 healthcare provision was timely and of good quality. The Healthcare Board was well-run and managers had responded to problems such as long waiting lists, by increasing service provision, or making service changes.
30. Safer Custody meetings were held regularly to monitor safety issues. They were well-attended and included prisoner representatives.

## Previous deaths at HMP Dartmoor

31. Mr Dangar was the sixth prisoner to die at Dartmoor since April 2017. Of the previous deaths, four were from natural causes and one was self-inflicted. There have been two further deaths, apparently from natural causes. There were no similarities between Mr Dangar's death and those previously investigated.

## Assessment, Care in Custody and Teamwork (ACCT)

32. 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.
33. As part of the process, a caremap (a 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

# Key Events

## Remand to HMP Exeter

34. On 3 November 2018, Mr Jerome Dangar was convicted of sexual offences and remanded to HMP Exeter. It was his first time in prison. The Person Escort Record for the journey recorded depression and anxiety as a risk and included a suicide and self-harm warning form, noting recent suicidal thoughts.
35. At an initial health screen with a nurse, Mr Dangar engaged well but appeared nervous. They discussed the suicide and self-harm warning form. Mr Dangar said that it was a long time since he had felt suicidal and he was taking antidepressants. He felt the medication had kept him stable. She concluded that Mr Dangar was fit and well, except for longstanding hip pain. She assessed him as unsuitable to keep his medication “in possession” in his cell.
36. A prison GP later reviewed Mr Dangar’s records and re-prescribed his medication - propranolol (for anxiety) and sertraline (an antidepressant).
37. An officer who conducted Mr Dangar’s first night interview, noted the self-harm warning form. After considering risks and triggers, she felt that Mr Dangar did not need the support of ACCT.
38. Mr Dangar went through the induction process and appeared to settle. He was not considered to be vulnerable. On 6 November, a prison GP reviewed his community medical records and prescriptions and concluded he should continue the existing dosage.
39. On 12 November, Mr Dangar had a meeting with his resettlement case manager, He told her that he had no debts and planned to return to work at his business, which had accommodation. He mentioned his medication for depression and anxiety, but said that he felt good at that time.
40. Due to the nature of his offences, Mr Dangar’s mail was monitored. On 16 November, one of the operational staff read a letter addressed to Mr Dangar’s partner, written the previous day, in which he said he did not want to live. An officer began ACCT procedures. During his assessment interview, Mr Dangar said he had thought about hanging himself, but did not have the ‘bottle’ do it and his cellmate was supportive. He also said that he did not particularly want to be dead, but he had such thoughts at night when he had more time to think about it. He missed his partner and parents and wanted to get out of prison to rebuild his life. He said his job in the workshop was better than being in his cell.
41. On 17 November, the ACCT case manager held the first ACCT review. Mr Dangar said that he had made the comments in the letter without thinking, as he was feeling low on that day and, afterwards, felt ‘silly’ for doing it. Although he sometimes had thoughts of self-harm, he had no intentions to act on them. He spoke about how he kept himself busy and said he had good relationships with other prisoners. The case review team, which included a mental health nurse, reassured him that it was normal to struggle in prison and reminded him of the various avenues of support. Mr Dangar spoke positively about his release and

returning to his partner and his job. The ACCT was closed (and a post-closure review was held the following week).

42. After a further medication risk assessment on 23 November, a nurse agreed to Mr Dangar keeping his medication in his cell, to be dispensed weekly, rather than monthly.
43. On 27 November, a supervising officer (SO) spoke to Mr Dangar about intelligence received that he had made a comment about killing himself if his court appearance was adjourned (it had been adjourned that day). Mr Dangar said it had been a 'spur of the moment' comment made without thinking, due to frustration and uncertainty. The SO noted that Mr Dangar seemed to be in good spirits and that he was looking forward to going back to his family and work when he was released. He said he felt comfortable talking to wing staff and took courses to keep himself busy and stop him from overthinking.
44. Mr Dangar had an appointment with a doctor on 5 December, due to shoulder pain. He said that taking one propranolol tablet a day was not helping his anxiety, as it was out of his system by lunchtime and he was shaky. The doctor increased the dose of propranolol to the standard dosage of three per day to help control his anxiety, and referred him for physiotherapy for his shoulder. (Mr Dangar did not attend the physiotherapy appointment arranged for 10 December.)
45. On 12 December, a SO had another conversation with Mr Dangar, after his solicitor informed the prison of concerns that he might harm himself. Mr Dangar said he felt stressed as things were not going his way and denied that he felt suicidal.
46. On 17 December, after a videolink conference, Mr Dangar's probation officer contacted the prison's duty governor to raise concerns that Mr Dangar might self-harm. A SO spoke to Mr Dangar, who laughed and said that he had made no comments about self-harm or feeling suicidal, he had simply answered a question about how many times he had been managed under ACCT.
47. An officer was assigned as Mr Dangar's keyworker. At a meeting on 24 December, Mr Dangar said that everything was alright and he did not need any help at that time.
48. On 7 January 2019, Mr Dangar was sentenced to 15 months imprisonment.

### **Transfer to HMP Dartmoor**

49. Mr Dangar transferred to HMP Dartmoor on 11 January. At his reception health screen, a nurse noted Mr Dangar's history of anxiety and depression and referred him to the mental health team. A medication risk assessment concluded that he could continue to keep his medication in his cell.
50. On 17 January, a nurse carried out a mental health triage assessment. The nurse noted that Mr Dangar was calm, with good eye contact and no thoughts of self-harm or suicide. Mr Dangar said he was surprised that he had been referred to the mental health team. He said that his mood was good, except for difficulty getting to sleep and worrying about his elderly parents running a large and

demanding business while he was in prison. However, he expected to be released in June 2019, or before. He thought that the antidepressants had been very effective. The nurse concluded that Mr Dangar had reactive low mood due to his circumstances, but the medication had helped and he had adjusted to his situation.

51. A healthcare assistant carried out a secondary health screen on 18 January. Mr Dangar continued to receive his medication weekly.
52. On 28 January, a nurse and a mental health nurse, held a Mental Health Triage Reflection/Outcome meeting, where they reviewed the nurse's assessment. (Although described as a multidisciplinary meeting, only the two mental health nurses were present.) They discharged Mr Dangar from the mental health team caseload and placed him on Step 1 of the Stepped Care Model, which meant that he would be monitored by the primary care team.
53. Over the next few weeks, Mr Dangar had several meetings with his offender supervisor, and his assigned keyworker. His main concerns were trying to get a job or applying for education courses to relieve his boredom, maintaining contact with his family and applying for Home Detention Curfew (HDC) so that he could be released in February (rather than conditional release in June 2019). Although eligible for HDC, Mr Dangar was considered unsuitable due to the nature of his offence.
54. On 25 February, a wing officer handed a pharmacy assistant 171 propranolol tablets that had been found after a search of Mr Dangar's cell. Although he was allowed to keep the medication in his cell, there were many more tablets than expected if he had been taking them as prescribed. She destroyed the tablets and noted "partial non-compliance" in Mr Dangar's medical record. Other than this entry, there was no record of the cell search or the stockpile of tablets. Mr Dangar continued to be allowed to keep his medication in his cell, propranolol continued to be dispensed to him weekly and further prescriptions were issued on 5 March and 1 April.
55. In March, Mr Dangar continued his education courses and had a job. He expected to be released in June and gave consent for his offender manager to discuss his release plans with his next of kin.
56. On 4 April, an intelligence report stated that a cell search would be conducted on Mr Dangar's cell before "lock up" on 15 April, relating to pornography/indecent material and that there was an ongoing investigation. (Mr Dangar's offender supervisor later explained to the investigator that this was connected to an outstanding criminal investigation, discussed later in this report.)
57. Mr Dangar had reported recurrent hip pain since February. On 8 April, a locum GP re-prescribed a higher dose of naproxen, an anti-inflammatory painkiller, and omeprazole, to protect the stomach.
58. On 12 April, two prisoners asked a SO to talk to Mr Dangar as he appeared to be a little down. Mr Dangar told the SO that he was confused as he had received a letter from his solicitor notifying him that Staffordshire Police wanted to interview him at a local police station on 16 April. He asked the SO about the process.

The SO explained that he would be taken to the police station and return to the prison the same day. Mr Dangar said that he thought it would be more involved than that. He showed the SO the letter, which did not indicate the nature of the investigation, and when the SO asked if he knew what it was about, Mr Dangar replied, "Not a clue, gov."

59. The SO asked Mr Dangar how he felt about the interview and he replied that it was fine, as he did not know what they wanted. He then asked if he had ever considered harming himself, to which Mr Dangar replied, "No way, that's not something I'd ever do." The SO advised him to ring his cell bell, night or day, to speak to staff if he felt in crisis. He also offered to speak to him again over the weekend and reminded him of the other avenues of support, such as the Listener scheme, Samaritans, or chaplaincy. The SO reported back to Mr Dangar's friends, who thanked him. He saw Mr Dangar socialising with his friends throughout the weekend.
60. On 13 April, Mr Dangar wrote a letter to his next of kin, to be sent via the prisoner email facility. He mentioned that Staffordshire Police wanted to interview him, but said he was totally innocent and hoping that they would just be closing the case. He said that he was feeling low, but wrote positively about his achievements in his courses and achieving 'enhanced' status under the Incentives and Earned Privileges scheme. He also wrote about plans after his release and asked his parents to send in photographs.

#### Events on 14/15 April

61. At around 4.45pm on 14 April, an officer locked Mr Dangar in his cell.
62. Between 5.30 and 5.57am on 15 April, an Operational Support Grade (OSG) counted and checked the prisoners on the wing. She checked each cell and all seemed to be normal.
63. Just after 8.00am, an officer was unlocking prisoners for work and education. One of Mr Dangar's friends told the officer he could not wake Mr Dangar. The officer went to the cell and saw Mr Dangar on his bed with his head in a raised position facing the television (which was off), with his right arm and wrist hanging out. He shouted to the other staff on the wing to help him and radioed a code blue medical emergency at 8.17am. (A code blue indicates that a prisoner is unconscious, or has difficulty breathing.) The control room called an ambulance.
64. A SO arrived, shortly followed by two custodial managers (CMs). The SO fetched the defibrillator and when he returned, the officer left to give details to the ambulance service. A CM shook Mr Dangar and they noticed his whole body was stiff.
65. The emergency response nurse went to the cell. Mr Dangar was lying on his right side, with significant mottling of the skin, and fixed and dilated pupils. On examination, he was not breathing, there was no pulse, or heart sounds and his left arm was stiff and hard to move. On the advice of the ambulance call handler, she attached the defibrillator, which found no shockable rhythm. A nurse arrived and both nurses agreed not to start cardiopulmonary resuscitation (CPR).

66. The paramedics arrived at 8.32am. They noted signs of rigor mortis and agreed with the decision not to perform CPR. The paramedics confirmed Mr Dangar's death at 8.35am.
67. Mr Dangar had received 21 propranolol tablets on 14 April. When the police searched his cell after his death, they only found one tablet, so 20 were unaccounted for. There were also empty blister packs of medication that had been prescribed in March and several months before.

### **Contact with Mr Dangar's family**

68. A prison chaplain was assigned as the family liaison officer (FLO). Within an hour of Mr Dangar's death, the FLO and the deputy governor went to his business premises in Cornwall to inform his partner, who had been listed as his next of kin. Staff working there told them that Mr Dangar's partner had left in January, with no forwarding address. They decided to inform his other next of kin, who were in the premises. They offered condolences and support and explained the procedures to be followed. Afterwards, they telephoned Mr Dangar's partner, who said that she did not want to act as next of kin. Nevertheless, they gave her their contact details and offered support.
69. The FLO kept in touch with Mr Dangar's family and arranged for his father and a friend to visit the prison. Mr Dangar's funeral was held on 15 May. In line with national policy, the prison offered a contribution towards the funeral expenses, which his family declined.

### **Support for prisoners and staff**

70. A prison manager and a SO debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
71. The prison posted notices informing other staff and prisoners of Mr Dangar's death and offering support.

### **Post-mortem report**

72. A post-mortem examination confirmed that the cause of Mr Dangar's death was propranolol toxicity. The post-mortem report indicated that:

"The concentration of propranolol in blood was extremely high, within the range noted in adults whose deaths were attributed to propranolol toxicity (4-29 mg/L)<sup>1</sup>. The effects of propranolol in overdose may include nausea, vomiting, low blood pressure, congestive heart failure, bronchospasm, seizures and death."
73. The pathologist found no natural disease, or injury to cause or contribute to death. No other drugs, including synthetic cannabinoids, or alcohol were detected in Mr Dangar's blood or urine.

# Findings

## Management of Mr Dangar's risk of suicide and self-harm

### *Concerns about Mr Dangar at Exeter*

74. Mr Dangar arrived at Exeter with a self-harm warning form noting that he had expressed suicidal thoughts. Reception staff assessed his risk, but had no concerns at that time. Thirteen days later, prison staff began ACCT procedures in response to thoughts of suicide Mr Dangar had written in a letter. The ACCT was closed the next day when Mr Dangar convinced staff it had just been a fleeting thought.
75. Concerns about Mr Dangar's risk were raised on three further occasions, by prison and probation staff, as well as his solicitor. When asked, Mr Dangar repeatedly denied that he intended to harm himself and his behaviour and demeanour appeared to be consistent with this.
76. We are satisfied that staff at Exeter took prompt action in response to concerns about Mr Dangar's wellbeing.

### *Supervision at HMP Dartmoor*

77. As a high-risk offender, Mr Dangar had frequent meetings with his offender supervisor. On average, they met fortnightly. He also had regular meetings with his prison keyworker.
78. At interview, his offender supervisor said that Mr Dangar tended to minimise, or downplay his offence and did not seem to understand the seriousness of it. During their sessions, there had been a lot of positive planning for his prospective release in June 2019. He intended to return to his business to relieve the pressure that had been placed on his elderly parents and spoke about plans to expand his business. He had asked for more information about his licence conditions and had consented to his offender manager (probation officer) in the community discussing his release with his mother whenever required. She said that Mr Dangar was stable throughout her contact with him, with no signs of low mood at any time, and no wing staff had raised any concerns about his behaviour or mood.
79. The prison keyworker told the investigator that Mr Dangar planned to look after his next of kin after his release and expressed no other concerns or issues. He appeared genuine and his prison keyworker, had no reason to doubt what he had said. He said that he can normally sense if a prisoner might be vulnerable to self-harm and, although reserved, Mr Dangar never gave the impression that he had such thoughts. He did not seem down when his prison keyworker, last met him. Records show that at their last meeting on 1 April, Mr Dangar's focus was on completing his courses, maintaining contact with his family and getting out of prison.
80. We are satisfied that Mr Dangar was well supported at Dartmoor and that staff could not have predicted his actions on the basis of the information available to them at the time.

### *Stockpiling medication*

81. Prison healthcare staff should assess prisoners to determine whether it is safe for them to keep medication in their cells, taking into account the risk a prisoner poses from not taking the doses as prescribed, over-medicating or trading.
82. At Exeter, Mr Dangar was initially assessed as unsuitable to hold his medication in his cell. After a review three weeks later, he was permitted to do so - with weekly dispensing - and this continued when he moved to Dartmoor. On 25 February, six weeks after his transfer, a cell search revealed that Mr Dangar had been stockpiling propranolol. There is no record of this cell search, or what prompted it, and the pharmacy assistant who received the excess medication on 25 February did not know the officer who had given it to her. Although she recorded the information in Mr Dangar's medical record, she was unaware of any other reporting process, so it was not reported to a clinician. It was also not recorded in Mr Dangar's prison records.
83. Our investigation found that at the time of Mr Dangar's death, the prison did not have a policy or guidance in place on the action to be taken by staff in the event of prisoners stockpiling in-possession medication. This meant that Mr Dangar's risk was not re-assessed after the propranolol tablets were found. As a result, the medication continued to be dispensed to him and he continued to be allowed to keep it in his cell, where he continued to hoard it.
84. Since Mr Dangar's death, the Head of Healthcare has revised and reissued *LOP 16 - Local Operating Policy for Managing Omitted Doses of Medication*. It now includes guidance on the steps to be taken when prisoners are discovered to be hoarding medication. Staff are required to record incidents in the medical record; clinicians have to speak to the individual to find out the reasons; the GP must be informed; and a review of the prisoner's in-possession risk assessment must take place. The healthcare manager has also introduced daily handover meetings between pharmacy and clinical staff at which issues such as stockpiling can be raised.
85. In spite of the improvements, the document appears to be directed only to clinicians, with no reference to communication with operational staff. In Mr Dangar's case, better coordination might have identified concerns sooner. If wing staff had known that Mr Dangar was stockpiling medication, it is likely that they would have considered whether he should be managed under ACCT procedures and they would have had greater concern about his risk to himself.
86. We agree with the clinical reviewer that the policy should be strengthened to include more clarity on when, how and to whom stockpiling incidents should be reported; the timescales for reporting the incident to a clinician and conducting a review of risk; the action to be taken by the clinician; and the need to suspend medication in-possession and remove those already held. We make the following recommendations:

**The Governor and Head of Healthcare should revise the policy on stockpiling medication to ensure that the weaknesses highlighted in the clinical review are addressed and that actions to be taken are specific and timebound.**

**The Governor and Head of Healthcare should ensure that:**

- **all operational and clinical staff are aware of their roles and responsibilities when prisoners stockpile medication; and**
- **staff consider whether the prisoner is at increased risk of suicide or self-harm.**

*Actions taken after concerns were raised on 12 April*

87. PSI 64/2011 lists several risk factors and triggers which might increase a prisoner's risk of suicide or self-harm. Further charges can be one of those factors. Although this might not increase risk in every case, prison staff should be alert to possible changes in risk and take appropriate action. The expectation is that after speaking to a prisoner, staff should use their judgement, in combination with all available evidence, to inform their decision about whether a prisoner poses a risk to himself.
88. There had been an extensive multi-police force investigation into Mr Dangar's alleged involvement in a further offence (manslaughter). After Mr Dangar received the letter from his solicitor, a SO had an in-depth conversation with him. Mr Dangar claimed he did not know anything about the nature of the charges. He gave assurances that he was all right and insisted he had no thoughts of self-harm. The SO reminded him of the support available. On the basis of their conversation and without knowledge of the seriousness of the potential charges, The SO thought that there was no raised risk and that it was unnecessary to open the ACCT procedures. Over the next two days, he noticed that Mr Dangar spent a lot of time with his friends.
89. The offender supervisor told the investigator that she had been part of the multi-agency forum that had planned the police interview and she had been assigned actions in preparation for this. (One of those actions was to liaise with security staff to arrange the cell search planned for 15 April.) Due to the gravity of the alleged offence and sensitivity of the investigation, the plan to interview Mr Dangar was kept between the offender supervisor, and her manager, and other prison staff were not told about it.
90. Assessing risk is not an exact science and is dependent on staff judgement. It seems that Mr Dangar was somewhat disingenuous about what he knew of the police investigation, as the letter referred to a 'further interview' (which suggests that he had already been interviewed about the matter). On this and previous occasions, Mr Dangar seemed to give convincing reasons why he would not contemplate harming himself.
91. We cannot say for certain that the letter prompted Mr Dangar's actions, particularly as he had previously stockpiled propranolol. We are satisfied that the SO acted promptly on the information available to him and could not have foreseen Mr Dangar's actions. He gave appropriate advice and fully considered whether the thoughts and behaviour displayed merited management under the ACCT procedures. If he had been aware that Mr Dangar had stockpiled medication and was facing a possible charge of manslaughter, it is likely that he would have taken a different view of Mr Dangar's risk to himself.

### *Record keeping and sharing information*

92. PSI 64/2011 also highlights the importance of sharing information to enable early intervention and prevention and to promote prisoners' wellbeing. It notes that it is particularly important that information is shared between security departments and healthcare so that appropriate security information is considered by clinical professionals.
93. During Mr Dangar's time at Dartmoor, there were missed opportunities to share relevant information about his welfare. After the cell search in February 2019 which discovered such a substantial amount of stockpiled medication, there were no incident or intelligence reports and no entries were made in either the wing observation book or Mr Dangar's NOMIS prison records. The only record was an entry in Mr Dangar's medical records, which wing staff would not have seen as medical records are confidential.
94. Recording known risks ensures that staff are aware of all the information and helps them make a balanced decision. However, the concerns raised by Mr Dangar's friends and the SO subsequent conversation with him were not recorded. The incident came to light in a statement written two days after Mr Dangar's death. We are not critical of the SO's decision that Mr Dangar did not need structured support and we accept that there was little to suggest that he was at high or imminent risk of suicide. However, we consider that the incident was of sufficient significance to have been documented in Mr Dangar's personal record and the wing observation book, so that other staff were aware of it. We make the following recommendation:

**The Governor should ensure that staff record and act on all information that suggests a prisoner might be at risk of self-harm or suicide.**

### **Clinical care**

#### *Physical and mental healthcare*

95. Mr Dangar had a comprehensive mental health assessment, which concluded that he had reactive depression due to his circumstances and concern about his elderly parents. When he reported physical problems, he received prompt and appropriate care. We agree with the clinical reviewer that, overall, Mr Dangar's care was at least equivalent to that which he could have expected to receive in the community.

#### *Secondary health screen*

96. National Institute for Health and Clinical Excellence (NICE) guidelines and Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, set out the expectation that prisons ensure continuity of care for prisoners. This includes considering relevant clinical information and carrying out a general health assessment, equivalent to a primary care assessment when registering with a new GP in the community.
97. We are concerned that Mr Dangar did not have a secondary health screen at Exeter, particularly as he had a pre-existing mental health condition managed with medication. Although this omission did not have a bearing on Mr Dangar's

death, such health checks are essential to help maintain optimum mental and physical health.

98. The Head of Healthcare explained that this was an oversight by the reception nurse and, at that time, there was no process to identify that Mr Dangar was missing from the list. Since his death, two processes have been implemented to address this and provide a safety net to ensure that men are not overlooked. Healthcare staff run a weekly report of those who have not received a secondary health screen and this is followed up. In addition, the administration team now check that a secondary health screen has been booked, as part of the initial administrative actions. If not, they then book it. We are satisfied that steps have been taken to rectify this gap.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations