

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Dobson, a prisoner at HMP Dovegate, on 24 November 2019

A report by the Prisons and Probation Ombudsman



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Independent Investigation into the death of Mr Michael Dobson, a prisoner at HMP Dovegate, on 24 November 2019, Prisons and Probation Ombudsman, 5 March 2021, licensed under the Open Government Licence.

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 Michael Dobson died in hospital on 24 November 2019 after being found hanging in his cell at HMP Dovegate. He was 35 years old. I offer my condolences to his family and friends.

Mr Dobson had escalating mental health issues, including signs of paranoia. He had a history of self-harm, and self-harmed by cutting twice in the month before his death.

Prison staff appropriately started suicide and self-harm prevention procedures (known as ACCT) after Mr Dobson self-harmed. However, decisions about his level of risk and follow up actions to support him were poor, and the clinical reviewer found that the mental health care Mr Dobson received was of a mixed standard and not equivalent to that he could have expected in the community.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

October 2021

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Summary

Events

1. In 2011, Mr Michael Dobson was sentenced to life imprisonment in a Scottish court, with a minimum term of 16 years. At his request he transferred to the English prison estate in 2012. He spent time in a number of prisons in England before being transferred to HMP Dovegate on 4 June 2018
2. Mr Dobson had a history of substance misuse, mental ill health and self-harm. He was found to be under the influence of psychoactive substances (PS) on several occasions during his time at Dovegate. He received medication for Attention Deficit Hyperactivity Disorder (ADHD), but this was sometimes stopped because staff were concerned about the risk of him taking illicit drugs at the same time.
3. From August 2019, Mr Dobson reported feeling increasingly paranoid and thinking that staff and prisoners were plotting against him. As a result, he received ongoing support from the mental health team. On 9 October, staff noticed that Mr Dobson had been involved in a fight, but he said it was just a misunderstanding and denied he was in debt.
4. On 28 October, staff started prison suicide and self-harm prevention procedure, (known as ACCT) because Mr Dobson had made cuts to his arms. On the same day, Mr Dobson's mother telephoned the prison twice to express concerns about her son's mental health and illicit drug misuse. Mr Dobson told staff that his decline in mental health was triggered by the death of his grandfather and subsequent family issues relating to money left to him by his grandfather.
5. On 31 October, during an ACCT review, Mr Dobson told staff that he was in debt and being threatened by other prisoners. On 2 November, staff found that Mr Dobson had made holes in the light fitting in his cell (which could be used for a ligature) and he handed staff an improvised weapon which he said he had found. On 6 November, he was moved to another wing. ACCT monitoring ended on 12 November as staff thought he was now stable.
6. On 20 November, staff started ACCT monitoring again because Mr Dobson had cut his arms and said that he was low in mood. On 22 November, Mr Dobson's mother contacted Dovegate again to raise concerns about her son's mental health. Staff spoke to Mr Dobson, but he said that he was 'ok' and that he had cut ties with his mother as he thought she had cheated him over his grandfather's Will.
7. At 7.25pm, on 24 November, an officer carrying out an ACCT check found Mr Dobson hanging from the light fitting in his cell. He radioed an emergency medical code and other staff responded. They entered the cell, cut Mr Dobson down and began CPR. Paramedics arrived and took him to hospital, but he did not regain consciousness and died later that evening.

Findings

Management of risk of suicide and self-harm

8. Prison staff appropriately started ACCT procedures when Mr Dobson made cuts to his arms. However, there was a focus on how he presented at the expense of his risk factors for suicide. Decisions about his level of risk and frequency of observations were made without the full consideration of Mr Dobson's circumstances and caremap actions were not followed through.
9. We are concerned that the ACCT reviews did not involve Mr Dobson's key worker or his mental health care coordinator and that, as a result, those present did not have a full understanding of the deterioration in Mr Dobson's mental health or the significance of the breakdown in his relationship with his mother.
10. We are also concerned that information about key worker and mental health sessions was not recorded in Mr Dobson's ongoing ACCT record.

The key worker scheme

11. Although Mr Dobson had regular key worker sessions, he did not see the same officer consistently. In the last month of his life he had four key worker sessions with four different officers. This was a missed opportunity to establish a meaningful relationship with Mr Dobson and to identify concerns and changes in his mood and behaviour.

Clinical care

12. The clinical reviewer found that the substances misuse services Mr Dobson received were of a good standard and equivalent to that he could have expected in the community.
13. However, he found that the mental health care Mr Dobson received was of a mixed standard, and that although there were some examples of good practice, overall the care was not equivalent to that he could have expected in the community.

Emergency response

14. The PCO who found Mr Dobson hanging in his cell, failed to enter the cell immediately and instead he waited for assistance after calling a code blue emergency. He and another PCO did not start CPR immediately after they cut Mr Dobson down.

Recommendations

- The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that:
 - prison and healthcare staff share all information that affects risk, and make appropriate entries in the ACCT ongoing record;

- staff consider all relevant information that affects risk when completing the immediate action plan, and set appropriate levels of observations and caremap objectives; and
- staff review the prisoner's level of risk whenever there is an event or change of circumstances that could impact on risk.
- The Director should ensure that:
 - there is an effective keyworker scheme which provides consistent and meaningful support to prisoners, in line with national policy;
 - key workers record their interactions in the ACCT record; and
 - key workers are able to have input into ACCT reviews.
- The Director should share this report with the COM and discuss the Ombudsman's findings with her.
- The Director and the Head of Healthcare should ensure that, whenever possible, care coordinators from mental health and substance misuse are invited to ACCT reviews to ensure continuity of care.
- The Head of Healthcare should ensure that all staff are aware of the requirements of PSI 64/2011 and the importance making entries in the ACCT record after any intervention with prisoners to ensure continuity of care.
- The Head of Healthcare should ensure that all staff are aware of the requirement to maintain a full, contemporaneous record, documenting all relevant information.
- The Head of Healthcare should share a copy of this report with the mental health nurse and discuss its findings with her.
- The Director should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that the prisoner may be at risk, in line with PSI24/2011.
- The Director should ensure that a copy of this report is shared with PCOs A and B so that they are aware of the Ombudsman's findings.
- The Director should:
 - initiate an investigation into Prisoner A's allegation that the NOO entered Mr Dobson's cell on 1 November and threatened to assault him if he kept asking for a Listener, including interviewing the NOO, the Head of Safer Custody and prisoners in adjacent cells; and
 - write to the Ombudsman to inform her of the outcome of the investigation.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact her. Three prisoners responded.
16. The investigator visited Dovegate on 4 December 2019. She obtained copies of relevant extracts from Mr Dobson's prison and medical records.
17. The investigator interviewed 10 members of staff and 2 prisoners at Dovegate on 4 December 2019 and 11 April 2020, and another prisoner on 2 March 2020.
18. NHS England commissioned a clinical reviewer to review Mr Dobson's clinical care at the prison. He interviewed healthcare staff jointly with the investigator.
19. We informed HM Coroner for Staffordshire South of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
20. The Ombudsman's family liaison officer contacted Mr Dobson's mother and brother to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The family raised concerns about:
 - Mr Dobson's mental health treatment
 - his access to illegal drugs
 - his access to Listeners (prisoners trained by Samaritans to support other prisoners)
 - the frequency with which he was observed after he expressed suicidal thoughts.

We have addressed these questions in this report.

Background Information

HMP Dovegate

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

HM Inspectorate of Prisons

22. The most recent inspection of HMP Dovegate was in September–October 2019. Inspectors reported some notable improvements since their last inspection in 2017.
23. Inspectors found that, despite recent challenges in staffing, mental health practitioners responded promptly to prisoners' needs, and the range of therapeutic options was limited, but growing. A comprehensive and joined-up approach to combating the misuse of drugs was now in place but, despite this, drug availability remained a key concern. Almost all prisoners on an ACCT reported feeling well supported. The standard of ACCT case recording was generally good and a recent deterioration in quality was being addressed, with a safeguarding adult strategy in place. A very high proportion of ACCT case reviews received appropriate input from mental health and other specialist staff and ensured that risks were being assessed appropriately.

Independent Monitoring Board

24. 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 September 2018, the IMB reported that incidents of self-harm had fallen by around 8% during the year.

Previous deaths at HMP Dovegate

25. Mr Dobson was the 12th prisoner to die at Dovegate since November 2017. Of the previous deaths, three were self-inflicted, three were drug-related and five were from natural causes. There have been no subsequent deaths.
26. In a previous investigation into a self-inflicted death at Dovegate in May 2019, we found that decisions about the prisoner's level of risk and the frequency with which he should be observed were poor, and some key information was not properly shared between healthcare and prison staff. We also made a recommendation about the need for staff to enter a cell quickly if there is a risk to life. We have repeated those concerns in this report.

Assessment, Care in Custody and Teamwork

27. ACCT is the Prison Service procedure used to support prisoners at risk of self-harm or suicide. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and

interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

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

Psychoactive Substances (PS)

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

Key worker scheme

30. HMPPS's key worker scheme is intended to be an important means of reducing violence and self-harm in prisons. Under the Offender Management in Custody model each prison officer is the named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations with each prisoner.

Key Events

31. On 10 May 2011, Mr Dobson was sentenced to life in prison at Edinburgh Crown Court for murder. He received a minimum tariff of 16 years. This was not his first time in prison. At Mr Dobson's request, he transferred from the Scottish prison estate to an English prison in October 2012, and he spent time in a number of prisons in England before he was transferred to Dovegate on 4 June 2018.
32. A nurse completed Mr Dobson's health screen when he arrived at Dovegate. She noted he was prescribed medication for ADHD (Attention Deficiency Hyperactivity Disorder) and that he was diagnosed with OCD (Obsessive Compulsive Disorder), personality disorder and asthma. Mr Dobson was referred to the prison's mental health team and substance misuse services for continuation of his previous medication. He was placed on a maintenance dose of methadone for his opiate addiction.
33. A prison GP re-prescribed his ADHD medication, Lisdexamfetamine, on a temporary basis. Mr Dobson was placed on the waiting list for a psychiatric review because Lisdexamfetamine (which is primarily used for children) can only be prescribed to adults by a psychiatrist. A prison GP re-referred him on 27 July 2018, because he was concerned about continuing Mr Dobson's ADHD medication without a psychiatric review. Mr Dobson was added to a mental health nurse's caseload on 27 July.
34. In August, Mr Dobson was managed under suicide and self-harm prevention procedures, known as ACCT, for two short periods after he self-harmed. When the mental health nurse saw him on 23 August, he told her that he was feeling increasingly paranoid, believing prisoners and officers were plotting against him. She recorded that there was no evidence of any psychotic symptoms. After this, Mr Dobson received on-going support from the mental health team and was reviewed and monitored monthly.
35. In September, Mr Dobson was found trying to conceal his medication, raising concerns that he was intending to trade it with other prisoners. In December, Mr Dobson was found under the influence of PS, and a prison GP decided not to renew his ADHD medication because of the risk of combining it with illicit drugs.
36. Later that month, a consultant psychiatrist saw Mr Dobson. He recorded that Mr Dobson was very agitated and distressed that his ADHD medication had been stopped. Mr Dobson said that his sleep was poor and that he was experiencing a significant increase in his ADHD symptoms as a result. The psychiatrist agreed to re-prescribe the ADHD medication, but recorded that he discussed in detail with Mr Dobson the risk of using PS with his mental health medication.
37. After his medication was re-prescribed, Mr Dobson disengaged from the prison's mental health and substance misuse services. Staff were concerned that his PS use was increasing and were worried about its interaction with his medication. The Safer Prescribing Committee recommended that Mr Dobson move to the prison's inpatient healthcare unit to stabilise his medication, but he refused to engage.

2019

38. In February 2019, Mr Dobson was again found trying to conceal his medication. The mental health nurse attempted to review Mr Dobson in March. He refused to see her but agreed to see the psychiatrist to ensure his medication continued to be prescribed. Mr Dobson was discharged from the mental health services, but it was agreed that he would continue to have annual reviews with the consultant psychiatrist for review of his medication.
39. In April, staff recorded that Mr Dobson was upset because his grandfather had died, and he had not been able to go to the funeral.
40. Over the next few months, Mr Dobson had a period of stability. He secured a wing-based job and was reported to take pride in his work. He was placed on the enhanced regime in June. He told staff that he had friends on the wing and felt safe. He was on a methadone reduction programme and he said that he was not using any illicit drugs. He was in regular contact with and received visits from his family. He was seen regularly by his key worker or a substitute but was described as 'reserved'.
41. In July 2019, the Safer Prescribing Committee agreed that Mr Dobson's ADHD medication should be stopped because of his refusal to engage with the mental health team and his on-going use of PS (the latter appears to have been an error). Mr Dobson then asked to be referred to the prison's mental health team. A mental health nurse was appointed as his mental health care coordinator with a view to re-engaging with him, and he was also asked to participate in voluntary drug testing on a weekly basis to make sure that he was not taking illicit drugs.
42. In late July, a nurse refused to dispense Mr Dobson's medication because his records wrongly showed that he had tested positive for illicit drugs. Mr Dobson said that he did not take any illicit drugs and that the last drug test he took in April had been negative. When Mr Dobson returned to his wing, he threatened staff with violence. He said that the main reason he had been behaving well was because he had his prescribed medication. Staff checked Mr Dobson's record and found that his MDT test result had been wrongly recorded. Mr Dobson's medication was reinstated by a consultant psychiatrist shortly afterwards.

Autumn 2019

43. Mr Dobson initially engaged well with the mental health nurse. On 21 September, she recorded that he was expressing paranoid thoughts about prison staff and said that he thought other prisoners were going to attack him. She arranged further sessions to offer support and monitor his mental health.
44. On 9 October, the mental health nurse treated Mr Dobson for injuries to his face. Staff suspected that he had been involved in a fight. Mr Dobson said that he had been 'playfighting' as the result of a 'misunderstanding'. On 17 October, a Prison Custody Officer (PCO) saw Mr Dobson for a key worker session and noted that he had two black eyes and his face was still bruised. Mr Dobson said that the misunderstanding had been sorted out and that there were no further concerns. He assured her that he was not in debt. He said he had cancelled a visit with his mother and rearranged it for the following week.

ACCT: 28 October to 12 November

45. On 28 October, staff opened an ACCT because Mr Dobson had made cuts to his arms. Observations were set at eight per day. Mr Dobson said that he thought his mental health was deteriorating. He spoke to a Listener (other prisoners trained by the Samaritans to provide support). On the same day, Mr Dobson's mother telephoned the prison twice to express concern about Mr Dobson's mental health and illicit drug misuse.
46. A mental health nurse reviewed Mr Dobson the following day. She recorded that he was expressing paranoid ideas about his mother spending the inheritance he had received from his grandfather. He also believed that other prisoners could listen in on his phone calls, and as a result he had ripped the telephone off the wall in his cell. He said that he had self-harmed the previous day to reduce his anxiety and denied any further thoughts of self-harm. The nurse told the investigator that she made an appointment for Mr Dobson to see the psychiatrist in two weeks' time (although there is no record of this appointment).
47. On 31 October, Mr Dobson spoke with his Offender Supervisor about his mental health. He said that his head had "fallen off" and he attributed this to the recent death of his grandfather and subsequent dispute with his mother about the amount of money left to him by his grandfather. He said he no longer trusted his mother and had, therefore, removed her as his next of kin and cancelled her visit.
48. Staff held an ACCT review later that day. A mental health social worker attended from the mental health team. A Custodial Operations Manager (COM) recorded that Mr Dobson said that the 'playfight' on 9 October had in fact been an assault. He said he was under threat because he owed other prisoners £40 which he could not pay and that he was also being threatened by other prisoners to pay a debt for his friend who was in the segregation unit. Staff offered Mr Dobson a wing move which he declined because he "didn't want to look like a grass". Staff asked Mr Dobson about a request he had made for a DNACPR order (meaning that he did not want anyone to resuscitate him if his heart or breathing stopped). He said this was a cry for help and that he did not really want one. He denied any suicidal thoughts. Staff increased Mr Dobson's observations to two per hour.
49. On 1 November, a PCO saw Mr Dobson for a key worker session. He recorded that Mr Dobson said he had had a visit from his family that day which he was happy about, and that he had no safety concerns in the prison.
50. On 2 November, staff reviewed Mr Dobson's ACCT after discovering two holes burnt in the light fitting in his cell (which could be used for a ligature). Mr Dobson said that he did not do it. The COM recorded that Mr Dobson spoke about his paranoia and his belief that his family members were being fleeced for money by other prisoners. Mr Dobson said he was working with the mental health team, but that they offered no real help and simply spoke to him for five minutes and then went away. It was agreed that Mr Dobson's observation levels would remain unchanged.
51. On the same day, Mr Dobson was placed on a disciplinary charge after he handed staff an improvised weapon which he said he had found. He subsequently received a suspended punishment of seven days loss of privileges

and seven days cellular confinement. Mr Dobson also received another suspended punishment of seven days cellular confinement for testing positive for PS.

52. On 4 November, staff downgraded Mr Dobson to the standard regime after finding damage to the fabric of his cell. On 6 November, he was downgraded again to the basic regime after refusing to move to another wing. He was later moved to M wing and upgraded to the standard regime.
53. On 8 November, a mental health nurse saw Mr Dobson for a routine outreach appointment. She told the investigator that Mr Dobson was still paranoid and suspicious.
54. During a key worker session on 9 November, a PCO noted that Mr Dobson said he was not under threat, but that he was concerned about his mental health and the thoughts he had about hurting himself. She reminded Mr Dobson of staff and Listener support.
55. At an ACCT review on 12 November, a mental health worker representing the mental health team, noted that Mr Dobson appeared settled, had good family contact and said he did not have any suicidal thoughts. Mr Dobson asked for the ACCT to be closed, which was agreed.
56. On 16 November, staff from the safer custody team went to see Mr Dobson after he called the reporting line from the telephone in his cell. Mr Dobson said that he was ok now and it was sorted. He refused to say anything more when questioned.
57. The COM completed an ACCT post-closure review on 18 November. She recorded that Mr Dobson said that he had no thoughts of suicide or self-harm. He said had settled on M wing and had other prisoners to turn to for support and a brother outside in the community. She noted that staff were looking at finding him a wing-based job.

20 November onwards: ACCT

58. On 20 November, staff started ACCT monitoring procedures because Mr Dobson had made more cuts to his arms. At an ACCT assessment later that day, Mr Dobson said that he had cut his arms due to frustration at losing his job and that he wanted a transfer back to a Scottish prison. He said that he had no intention of taking his own life as he didn't want to upset his mother.
59. On 21 November, the COM chaired Mr Dobson's ACCT review. The mental health social worker attended as the representative of the mental health team. The COM told the investigator that Mr Dobson presented no differently than when she had previously seen him, and that he engaged with the review. He requested a transfer back to Scotland and wanted to be allocated a job. Staff assessed Mr Dobson's level of risk as low and set observations as one per hour.
60. Actions on his caremap included an appointment to be made for him to see the psychiatrist, bereavement counselling, and for staff to pursue his transfer request to Scotland. The COM recorded that Mr Dobson needed to keep active and that, if they could not find him a job, they would look at finding him voluntary work. She

marked all these actions as 'Completed'. She told the investigator that this was because they had been set in train, even though they not yet been implemented. She said she had no concerns about Mr Dobson because he seemed happy with what they were doing for him and he was planning for the future.

61. The mental health social worker said at interview that he was concerned that Mr Dobson's self-harm had been more serious than on previous occasions and he therefore booked him a review with a mental health nurse the following day. He also planned to take over as Mr Dobson's mental health care coordinator as he knew he did not get on with the nurse. However, the nurse said she already had an appointment with Mr Dobson booked for 28 November and did not think it necessary to see him sooner.
62. On 23 November, Mr Dobson had a keyworker session with a PCO. He recorded that Mr Dobson said he felt a little happier after moving cells. He noted that Mr Dobson was a little reserved and just kept saying he was ok. The PCO also noted that he had previously spoken to Mr Dobson when he went to check on him after his mother rang to say Mr Dobson was not in a good place, and that Mr Dobson had said he had cut all ties with his mother and that she had no right to call the prison. He noted that he had passed this on to Mr Dobson's own key worker.

Events of 24 November

63. Between 12.34pm and 7.00pm on 24 November, Mr Dobson made several short telephone calls, mainly to family members, with some calls either not connecting and Mr Dobson or the recipient hanging up. His last call was made to a friend.
64. At 6.12pm, PCO A can be seen on CCTV at Mr Dobson's cell door checking Mr Dobson as part of his ACCT monitoring. The PCO told the investigator that the observation panel in the cell door was covered by paper. He said he asked Mr Dobson to remove the paper, which he did. He said Mr Dobson said he was "ok" and was using the toilet. Mr Dobson stepped back from the door to allow him to look in. The PCO told the investigator that Mr Dobson showed no signs of distress and that he had no reason to think he was at imminent risk.
65. At 6.58pm, staff escorting a Listener off the wing noticed that Mr Dobson's emergency light had been activated. PCO B responded. When he opened the observation panel of cell door, Mr Dobson asked him to turn his electricity back on as it had gone off. (The electricity in a cell can 'trip' if a prisoner tries to get a light to smoke illicit drugs using exposed wires, but it is not known what cause the problem in Mr Dobson's cell.) He told Mr Dobson this would be sorted when the key could be obtained. He closed the observation panel and walked away to continue his escorting duties.
66. At 7.25pm, PCO A went to check on Mr Dobson as part of his ACCT monitoring. He saw Mr Dobson was hanging from the light fitting in the toilet area with a piece of bedding.
67. At 7.28pm (according to the control room log) PCO A radioed an emergency code blue, indicating a life-threatening situation. He waited for other staff to arrive before entering the cell. PCO B heard the call for assistance and went to

help and they entered the cell together. PCO A held Mr Dobson around his waist to take his weight. PCO B cut the ligature around Mr Dobson's neck and, together with another PCO who had also arrived, they laid Mr Dobson on the floor.

68. PCO A and B can be seen on CCTV leaving the cell. They told the investigator they had checked Mr Dobson for signs of breathing or pulse and found none, and that they were in shock, having never seen this before.
69. More staff responded. PCO A re-entered the cell and started cardiopulmonary resuscitation (CPR). Two nurses responded and brought an emergency medical resuscitation bag. They applied a defibrillator, but no shock was advised. Mr Dobson was still not breathing. Due to the restricted space in the cell, staff carried Mr Dobson out on to the landing and continued with CPR.
70. At 7.35pm, an ambulance arrived at the prison. The paramedics and doctor continued with CPR. At 8.20pm, Mr Dobson was taken to hospital. He did not regain consciousness and died later that evening.
71. After Mr Dobson's death a note was found in his cell, which appeared to have been written just before he took his own life. This said that he wanted to name his brother as his next of kin and that he had taken his own life because he believed his mother and sister had stolen the money his grandfather had left him. He also said that he believed that they were providing drugs, phones, money, clothes, pornography and phone sex to other prisoners at Dovegate, one of whom he named. He said he did not want them to receive any of his property or to attend his funeral.

Contact with Mr Dobson's family

72. At 10.23pm on 24 November, the prison telephoned Mr Dobson's mother, but did not get an answer. The prison contacted Leicester police and asked them to make a home visit to Mr Dobson's mother to inform her of her son's death, and to tell her that the prison would be in contact to arrange a visit.
73. On 25 November, a prison family liaison officer (FLO) contacted Mr Dobson's mother to arrange for a FLO and the safer custody manager to visit her home later that day. However, given the contents of Mr Dobson's final letter, all contact thereafter was made with Mr Dobson's brother.

Support for prisoners and staff

74. After Mr Dobson's death, the duty manager debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and offering support. The staff care team also offered support.
75. The prison posted notices informing other prisoners of Mr Dobson's death, and offering support. Staff reviewed all prisoners assessed as being at risk of self-harm or suicide in case they had been adversely affected by Mr Dobson's death, and Listeners were made available.

Post-mortem report

76. The coroner accepted the cause of Mr Dobson's death as hanging. At the time of writing, we have not received the results of the toxicology tests.

Information received after Mr Dobson's death

77. Prisoner A who worked as a Listener, told the investigator that he knew Mr Dobson well as he worked with him as a mentor. He said that a few months before his death, Mr Dobson started "to go a bit downhill": he was using more drugs, his mental health deteriorated, and he was hearing voices and self-harming. He said that he and other prisoners tried to support Mr Dobson and to assure him that his concerns were not real, but that Mr Dobson would become very distressed and talk about harming himself. He said he reported his concerns about Mr Dobson to mental health staff five or six times and told a mental health nurse he thought Mr Dobson needed to see a psychiatrist. He said she told him Mr Dobson was "on the radar".
78. Prisoner A said that about a month before he died, Mr Dobson was having a bad time and he was called out to see him in the evening on 1 November in his role as a Listener. Mr Dobson was very emotional but after about an hour staff told him that the Night Orderly Officer (NOO) had said he needed to leave, even though Mr Dobson did not want him to go. He said that the following morning, Mr Dobson told him that he had repeatedly pressed his cell bell overnight and asked for a Listener again but had been refused and that the NOO had come into the cell and threatened to 'beat him up' if he kept pressing his bell. He said Mr Dobson said he had been refused a Listener again the following night. He said he had complained about this to the Head of Safer Custody.
79. Prisoner A also said that he went to see Mr Dobson on M wing a few days before his death. He said that Mr Dobson had been upset at being on a wing where he knew no one and that he told the Nurse Prescriber that Mr Dobson needed a referral to mental health. He said that he felt mental health staff had failed Mr Dobson and had not given him the formal support he needed, and that staff on H wing had moved him to M wing because they saw him as a nuisance.
80. Prisoner A was adamant that Mr Dobson had not been in debt and was not being bullied. He said the incident when Mr Dobson had been punched had been a one-off and that Mr Dobson and his attacker had shaken hands afterwards.
81. Another prisoner told the investigator that he had been friends with Mr Dobson on H wing. He said that Mr Dobson had told him and other prisoners that he was hearing voices and felt suicidal and that they had told staff he needed help and should remain on H wing where he had friends who could support him.

Findings

Management of risk of suicide and self-harm

82. Mr Dobson was being managed under ACCT procedures when he hanged himself. We have, therefore, considered whether his risk to himself was appropriately assessed and managed.
83. PSI 64/2011 lists a number of risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. The ACCT document also provides guidance on how to assess the level of risk of suicide and self-harm. It says that risk is high, for example, when the prisoner has frequent suicidal ideas which are not easily dismissed. Risk is raised when suicidal ideas are frequent but generally fleeting, or there are recent suicide attempts. Risk is low when suicidal thoughts are soon dismissed and there is no self-harming behaviour.
84. Mr Dobson had a number of risk factors for suicide and self-harm during the month before his death. These included: previous self-harm, deteriorating mental health (including increasing paranoia), illicit drug use, bullying and debt, unemployment (meaning he spent more time alone in his cell), the death of his grandfather, and the breakdown of his relationship with his mother (which had previously been a protective factor).
85. Prison staff appropriately started ACCT procedures on 28 October after Mr Dobson self-harmed. However, we consider that they failed to explore and address all Mr Dobson's issues including his debt, mental ill health, his recent bereavement and the breakdown of his relationship with his mother. We consider that the ACCT was closed prematurely on 12 November, given that Mr Dobson's issues had not been resolved, he had recently damaged his light fitting in a way that could be used to tie a ligature, was still expressing concerns about his mental health to a key worker on 8 November, was still unemployed and had just been moved to a wing where he knew no one.
86. On 20 November, Mr Dobson made more cuts to his arms. This was only two days after he had told the COM at the ACCT post-closure review that he had no thoughts of suicide or self-harm. Staff appropriately started ACCT monitoring. However, although they created a caremap at the first case review on 21 November, it did not address his recent decision to refuse visits with his mother. We are also concerned that the caremap actions were marked 'Completed' when they were in fact still outstanding. We consider that this was misleading.
87. We are concerned that staff placed too much emphasis on Mr Dobson's assurances that he had no thoughts of suicide or self-harm and that he would speak to staff if he did feel suicidal, even though he had given similar assurances in the past before going on to self-harm. We consider that they did not give enough consideration to his poor mental health and the breakdown in his relationship with his mother when deciding how frequently he should be observed. We are concerned that there is no evidence that the ACCT reviews took account of Mr Dobson's mother's concerns about his mental health, given

that she had hitherto been an important support for him and obviously knew him very well.

88. We are also concerned that some of the prison staff who should have known Mr Dobson best – his key worker and his mental health and substance misuse care coordinators - were not involved in his ACCT reviews and that the reviews did not, therefore, have access to all the information they needed to assess Mr Dobson’s risk to himself. This was particularly the case in relation to Mr Dobson’s paranoia and his relationship with his mother, which should in our view have received more attention in ACCT reviews as key risk factors. We have more to say about this below in the sections on the key worker scheme and mental health care.
89. We make the following recommendations:

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

- **prison and healthcare staff share all information that affects risk, and make appropriate entries in the ACCT ongoing record;**
- **staff consider all relevant information that affects risk when completing the immediate action plan, and set appropriate levels of observations and caremap objectives; and**
- **staff review the prisoner’s level of risk whenever there is an event or change of circumstances that could impact on risk.**

The key worker scheme

90. Mr Dobson’s key worker was not involved in his ACCT reviews. The COM told us that it is was not her practice to involve key workers because it was not possible to timetable ACCT reviews in advance and they had to be fitted in when there was time available.
91. In prisons where the key worker role is working well, key workers can be vital in helping to identify a prisoner’s underlying issues and picking up on changes in a prisoner’s mood and behaviour. However, although Mr Dobson had relatively frequent key worker sessions, he did not see the same officer consistently. During the last month of his life, when he self-harmed twice and was being managed under ACCT, he had four key worker sessions with four different officers. Only the first of these on 25 October was with his designated key worker. (There was a similar lack of consistency in previous months.) We consider that this was very poor practice.
92. Mr Dobson was regularly described to the investigator as someone who did not open up to staff, but it is difficult to see how he could be expected to discuss sensitive matters (such as his mental health and his relationship with his mother) when he had no opportunity to establish a consistent relationship with one person.
93. The lack of consistency also meant that the officers who carried out the key worker sessions did not know what ‘normal’ looked like for Mr Dobson and were not therefore able to pick up on the deterioration in his mental health or to

recognise that the breakdown in his relationship with his mother should have rung alarm bells.

94. We are also concerned that there is no evidence that information from the key worker sessions was taken into account in the ACCT reviews. For example, on 9 November, Mr Dobson told a PCO that he was worried about his mental health and the thoughts he had about hurting himself. This was not referred to when the COM decided to close the ACCT on 12 November.

95. We recommend:

The Director should ensure that:

- **there is an effective keyworker scheme which provides consistent and meaningful support to prisoners, in line with national policy;**
- **key workers record their interactions in the ACCT record; and**
- **key workers are able to have input into ACCT reviews.**

The Director should share this report with the COM and discuss the Ombudsman's findings with her.

Clinical care

96. The clinical reviewer concluded that Mr Dobson's clinical care was of a mixed standard and not fully equivalent to that which he would have received in the wider community.

Substance misuse

97. Mr Dobson had a lengthy history of using illicit drugs, he admitted to using PS illicitly on a regular basis and intermittently engaged with substance misuse services while at Dovegate. The clinical reviewer found evidence of good partnership working by the substance misuse staff and considered that the care Mr Dobson received for his substance misuse was equivalent and of a good standard.

Mental health care

98. The clinical reviewer had concerns about Mr Dobson's mental health care.

99. There were initial delays in mental health services engaging with Mr Dobson when he arrived at Dovegate. He was initially referred appropriately following his reception health screen on 4 June 2018, but he had to be re-referred on two further occasions before he was seen by a mental health nurse on 23 August, and he was not seen by a psychiatrist until December. The clinical reviewer said that the referral should have been expedited given that Mr Dobson was being prescribed a stimulant drug over normal limits for ADHD.

100. Mr Dobson chose not to engage with mental health services once his ADHD medication had been approved. He re-engaged when his ADHD medication was stopped due to illicit drug use in July 2019. The mental health nurse

appropriately established a Care Programme Approach care plan and engaged with a consultant psychiatrist.

101. However, when Mr Dobson's mental state appeared to be deteriorating during October/November 2019 and he self-harmed, the clinical reviewer was concerned that the mental health nurse did not appear to actively attempt to engage in the ACCT process, although she was aware that Mr Dobson was becoming increasingly paranoid. In addition, the nurse did not record her interactions with Mr Dobson in his ACCT record. This meant that, although other members of the mental health team did attend ACCT reviews, the full extent of Mr Dobson's deteriorating mental health was not apparent.
102. In the last month of his life, Mr Dobson told both staff and other prisoners that he did not feel that his review sessions with the mental health nurse were helping with his mental health problems. The mental health social worker said that Mr Dobson and the mental health nurse did not have a good relationship. The clinical reviewer was concerned that, although the nurse assured Mr Dobson on 29 October that he had a follow up appointment with a psychiatrist, there is no evidence that an appointment was ever made. A further concern is that the discussion between the mental health social worker and the nurse on 22 November (about whether her appointment to review Mr Dobson's mental state should be brought forward), was not documented in Mr Dobson's medical record.
103. The clinical reviewer concluded that mental health care Mr Dobson received was of a mixed standard, and that although there were some examples of good practice, overall the care was not equivalent to that he could have expected in the community. We recommend:

The Director and the Head of Healthcare should ensure that, whenever possible, care coordinators from mental health and substance misuse are invited to ACCT reviews to ensure continuity of care.

The Head of Healthcare should ensure that all staff are aware of the requirements of PSI 64/2011 and the importance making entries in the ACCT record after any intervention with prisoners to ensure continuity of care.

The Head of Healthcare should ensure that all staff are aware of the requirement to maintain a full, contemporaneous record, documenting all relevant information.

The Head of Healthcare should share a copy of this report with the mental health nurse and discuss its findings with her.

Emergency Response

104. PSI 24/2011 on management and security at nights says that in normal circumstances, the night orderly officer must give authority to unlock a cell during night state and no cell should be opened unless at least two or three members of staff are present. However, the PSI also says that the preservation of life must take precedence over security, and that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night

orderly officer and an individual member of staff may go into the cell on their own, following an on-the-spot risk assessment.

105. When PCO A found Mr Dobson hanging, he radioed an emergency code blue and waited for assistance. He told the investigator that staff were not allowed to enter a cell on their own in an emergency. We are concerned that the PCO did not understand his responsibilities under PSI 24/2011. Our view is that after he radioed for assistance, he should have considered entering Mr Dobson's cell and trying to cut him down.
106. Once PCOs A and B had established that Mr Dobson was not breathing and had no pulse, they left the cell. We appreciate that this was a shock for them, but they should have begun CPR immediately.
107. We cannot say if these delays affected the outcome for Mr Dobson, but a delay of even a few minutes may make a crucial difference in a medical emergency.
108. We make the following recommendations:

The Director should ensure that, subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that the prisoner may be at risk, in line with PSI24/2011.

The Director should ensure that a copy of this report is shared with PCOs A and B Deeming so that they are aware of the Ombudsman's findings.

Allegation that a member of staff threatened to assault Mr Dobson

109. Prisoner A said that Mr Dobson had told him that the Night Orderly Officer had entered his cell and threatened to assault him if he kept pressing his cell bell and asking to speak to a Listener. The prisoner did not witness this interaction himself, although he said the prisoners in the next-door cell confirmed Mr Dobson's account and that he (Prisoner A) complained to the Head of Safer Custody on Mr Dobson's behalf. We note that Mr Dobson was having paranoid thoughts at the time and thought that staff and prisoners were plotting to attack him, but that does not automatically mean that his account was untrue. We have not been able to confirm or refute this allegation, which would be a very serious one if true. We, therefore, recommend:

The Director should:

- **initiate an investigation into Prisoner A's allegation that the NOO entered Mr Dobson's cell on 1 November and threatened to assault him if he kept asking for a Listener, including interviewing the NOO, the Head of Safer Custody and prisoners in adjacent cells; and**
- **write to the Ombudsman to inform her of the outcome of the investigation.**

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