

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Ashley Dougan, a prisoner at HMP Altcourse, on 3 September 2021**

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100



## 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

**OGL**

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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 Ashley Dougan died in hospital on 3 September after he was found hanging in his cell at HMP Altcourse the previous day. Mr Dougan was 32 years old. I offer my condolences to his family and friends.

Mr Dougan had been in prison several times before and had few risk factors for suicide and self-harm. There was evidence in the time before his death that he was worried about his upcoming sentencing and an officer spent time talking to him about this. Despite the final outcome, I consider that his decision not to begin suicide and self-harm prevention procedures was reasonable at the time.

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 2022**

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# Summary

## Events

1. On 23 June 2021, Mr Ashley Dougan was remanded in custody to HMP Altcourse. He had previously served several prison sentences and had no recorded history of self-harm or mental ill health.
2. Mr Dougan's first two months in prison were uneventful and he was promoted to the highest level of Altcourse's Incentives and Earned Privileges (IEP) scheme to encourage and reward responsible behaviour. On 21 July, he pleaded guilty to his charges.
3. On 24 August, Mr Dougan telephoned his mother and told her that he was struggling to cope in prison and was worried about his upcoming sentencing (which was scheduled for 15 September). In line with prison policy, this call was not monitored by prison staff at the time.
4. On 30 August, Mr Dougan spoke to an officer about his guilty plea and sentencing, saying that he was worrying about this "all the time". The officer suggested that they refer Mr Dougan to the mental health team, which he declined.
5. At around 8.20am on 2 September, Mr Dougan's cellmate alerted staff that he was hanging from a ligature. Prison and healthcare staff attended and performed cardiopulmonary resuscitation. Paramedics took Mr Dougan to hospital, where he died the following evening.

## Findings

6. Mr Dougan had few risk factors for suicide and self-harm. While he evidently struggled with the thought of his upcoming sentencing, we are satisfied that it was reasonable for staff at the time not to start suicide and self-harm prevention procedures.
7. When staff were first alerted to the incident on 2 September, they initially summoned assistance using an inappropriate method. There was only a short delay before the correct emergency radio message was used and we cannot say that this delay would have affected the outcome.

## Recommendations

- The Director should ensure that all prison staff are aware of their responsibilities during medical emergencies, including that they use the appropriate medical code to communicate the nature of the emergency effectively.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact him. He obtained copies of relevant extracts from Mr Dougan's prison and medical records.
9. The investigator interviewed three members of staff at Altcourse in October 2021, and one member of staff in November 2021. NHS England commissioned a clinical reviewer to review Mr Dougan's clinical care at the prison.
10. Mr Dougan's cellmate was released from prison shortly after Mr Dougan's death. We wrote to him at his release address to invite him to speak to us about the events, but he did not respond.
11. We informed HM Coroner for Liverpool of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
12. The Ombudsman's family liaison officer contacted Mr Dougan's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not ask any questions.
13. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies.
14. We also shared the initial report with Mr Dougan's mother. She did not make any comments.

## **Background Information**

### **HMP Altcourse**

15. HMP Altcourse is a local prison in Liverpool which holds up to 1,324 remanded and sentenced men. G4S manages the prison and provides primary healthcare services.

### **HM Inspectorate of Prisons**

16. The most recent inspection of HMP Altcourse was in November 2021. Inspectors reported that there had been eight self-inflicted deaths since their previous inspection (in 2017), which was a significant concern. They found that, despite a decrease in the previous year, rates of self-harm were still higher than at similar prisons. Inspectors reported that some aspects of ACCT case management had ongoing weaknesses. They also reported that relationships between staff and prisoners were a real strength at Altcourse. They found that key work took place more frequently than in similar prisons and was of a better standard.
17. Altcourse was also one of three local prisons subject to a short scrutiny visit in April 2020. The aim of this was to give a snapshot of how the prison was responding to the COVID-19 pandemic. Inspectors reported that self-harm had reduced slightly since the start of COVID-19 restrictions.

### **Independent Monitoring Board**

18. 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 June 2021, the IMB reported that Altcourse “remains a safe prison” and identified low levels of self-harm and violence.

### **Previous deaths at HMP Altcourse**

19. Mr Dougan was the seventeenth prisoner to die at Altcourse since September 2019, and the fourth to take his own life. There are no significant similarities between the circumstances of Mr Dougan’s death and those of the previous self-inflicted deaths.

### **Assessment, Care in Custody and Teamwork**

20. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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 multidisciplinary review meetings involving the prisoner.

## Key Events

21. Mr Ashley Dougan was first sent to prison in 2010 and served several prison sentences afterwards. He had no recorded history of self-harm either in prison or the community and no recorded mental health diagnosis or treatment.
22. On 23 June 2021, Mr Dougan was remanded in custody to HMP Altcourse, charged with possession of a firearm with intent to endanger life. This was his first time in prison for around a year and a half. Court records identified no history or risk of suicide or self-harm. At an induction interview, Mr Dougan said that he had no issues and that there was “no chance” he would harm himself.
23. A prison nurse assessed Mr Dougan. She identified no history or current issues with physical or mental ill health, and Mr Dougan told her that his mental health was “good”. The nurse recorded that Mr Dougan said he was “okay” about being back in prison and had no thoughts or history of suicide or self-harm. He had no prescribed medication.
24. Mr Dougan spent his first two weeks in prison isolating in line with national COVID-19 procedures. He reported no issues or concerns and told staff that he was helping his cellmate who was in prison for the first time.
25. On 14 July, Mr Dougan told a prison nurse that he was in pain due to an historic rib injury sustained before prison. He was prescribed paracetamol.
26. On 21 July, Mr Dougan attended court and pleaded guilty to his charges. He was remanded to Altcourse to await sentencing. (His next scheduled court appearance was 15 September.)
27. On 29 July, an officer conducted a key work session with Mr Dougan. He recorded that Mr Dougan had no current issues and expressed an interest in transferring to HMP Buckley Hall after sentencing. Mr Dougan said that he had good contact with his family by telephone. (Prisoners at Altcourse have telephones in their cells.)
28. On 19 August, staff upgraded Mr Dougan to enhanced status under the prison’s IEP scheme. A Prison Custody Officer recorded that Mr Dougan was polite and helpful.
29. On 24 August, Mr Dougan telephoned his mother. (All prisoners’ telephone calls are recorded. Security staff listen to some calls at random or if there is intelligence about the safety of individuals or the prison. Mr Dougan’s telephone calls were not listened to until after his death.) During the call, Mr Dougan said:

“[My] fucking head’s going, I don’t know what’s going on ... Trying to battle through this but it’s hard ... Gonna be stuck in here, can’t cope with it. It’s horrible ... Not sleeping, feel like shit, drained, head feels like it’s gonna explode ... Gonna end up doing something stupid ... Worrying about what sentence I’m gonna get.”
30. On 26 August, Mr Dougan received two negative entries. On the first occasion, he made a sexually explicit comment about a female officer. On the second occasion, he asked a female officer if she was “on her period”.

31. On 27 August, Mr Dougan telephoned his mother. They discussed his possible sentence. Mr Dougan said that his solicitor had had the “intent to endanger life” charge dropped, and that he was therefore looking at a sentence of around six years rather than the eight years he had been expecting.
32. On 30 August, an officer conducted a key work session. They spoke about Mr Dougan’s recent negative entries and Mr Dougan said that his “head is up his arse due to going guilty on his charges and is thinking about it all the time”. The officer recorded that he asked Mr Dougan if he would like to speak to the mental health team about this, which Mr Dougan declined. Mr Dougan said that he was going to education and hoped to complete his course so that he could start work in the prison.
33. The officer told us that Mr Dougan was a “bouncy and bubbly” man who had lots of friends on the wing and did not cause any trouble. He said that Mr Dougan was a bit down about his potential sentence when they spoke. He said that in his experience, this was not unusual for prisoners whose court date was imminent. The officer told us that Mr Dougan said that he had no other issues in prison or in the community.

## **1-2 September 2021**

34. In his police statement, Mr Dougan’s cellmate said that on the evening of 1 September, he saw a mark around Mr Dougan’s neck. He told Merseyside Police that Mr Dougan said that he had been fiddling with his lanyard and was not aware of a mark. Mr Dougan’s cellmate said that he then spoke to an officer (who he knew by his first name only), as he was concerned for Mr Dougan.
35. An officer with this first name worked on Valentines Green Unit that evening and is likely to be the officer to whom Mr Dougan’s cellmate referred. He no longer works for G4S and we were not therefore able to interview him.
36. Mr Dougan’s cellmate told the police that he woke up at around 4.00am on 2 September and found Mr Dougan with a shoelace tied tightly around his neck. He said that they talked for around an hour and a half before Mr Dougan went to bed. Mr Dougan’s cellmate said that Mr Dougan spoke about the long sentence he expected to receive and that this might be up to 14 years. He said that Mr Dougan was also upset that he would not be able to see his daughter on her upcoming birthday.
37. At around 8.20am, an officer unlocked Mr Dougan’s cell. Mr Dougan’s cellmate told police that this woke him up and that he found Mr Dougan lying on his bed, with a kettle cord tied around his neck. He left the cell and shouted to the officer who had spoken to Mr Dougan on 30 August.
38. The first officer returned to the cell, cut the ligature and placed Mr Dougan on the floor. The other officer arrived at the cell and pressed a ‘first response’ button on his radio, which indicates an emergency that requires other staff to attend immediately. Both officers began cardiopulmonary resuscitation. The control room operator recorded the ‘first response’ at 8.20am.

39. A nurse was working on the unit at the time and went to Mr Dougan's cell. On arrival, she asked the second officer to radio a code blue medical emergency, indicating a life-threatening situation. The control room operator recorded the call at 8.22am and telephoned for an ambulance.
40. The nurse left the cell to fetch an emergency medical bag, returning after a minute. She applied a defibrillator, which advised no shock and to continue chest compressions. At 8.30am, paramedics arrived and took charge of the resuscitation.
41. At 9.12am, paramedics took Mr Dougan from Altcourse to the Aintree University Hospital. He died at 8.20pm on 3 September.

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

42. Shortly after Mr Dougan was taken to hospital, an operational manager tried to telephone his mother, but recorded that her number was engaged. At 9.40am, he spoke to Mr Dougan's brother and informed him of the events. Mr Dougan's family visited him in hospital later that morning and were with him when he died.

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

43. After Mr Dougan's death, an operational manager 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.

### **Post-mortem report**

44. The post-mortem report and cause of death were not available when we issued our report.
45. The inquest verdict recorded Mr Dougan's cause of death as hypoxic ischaemic encephalopathy (a decrease in blood flow to the brain) caused by cardiorespiratory arrest and low hanging.

# Findings

## Identifying the risk of suicide and self-harm

46. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at HMP Altcourse should have recognised Mr Dougan as at risk and started ACCT procedures.
47. Mr Dougan had few risk factors for suicide and self-harm. He had no recorded history of having harmed himself either in prison or in the community and no recorded diagnosis or treatment for mental ill-health. There is no record that he used drugs at Altcourse or that he was in debt to or being bullied by other prisoners. He had completed several prison sentences in the past, seemingly without incident.
48. Around a week before his death, Mr Dougan telephoned his mother and said that he was worried about his upcoming sentencing and that he was struggling to cope with being in prison. This call was not monitored by prison staff at the time. Three days before he died, Mr Dougan told an officer that he was “thinking ... all the time” about his guilty plea and charges and indicated that this had affected his behaviour a few days earlier.
49. PSI 64/2011 identifies that court appearances, especially sentencing, can be a trigger for suicide and self-harm. It states that after speaking to a prisoner (about a potential trigger), staff should use their judgement in combination with all available evidence to inform their decisions about prisoners who pose a risk to themselves.
50. The officer recognised that Mr Dougan was “down” and appropriately spoke to him about a referral to the mental health team (which Mr Dougan declined). He recognised some protective factors, including that Mr Dougan hoped to start work in prison and had regular contact with his family, and identified that Mr Dougan had no history of suicide or self-harm in prison. While hindsight suggests that Mr Dougan’s risk was greater than thought, we are satisfied that it was not unreasonable for the officer to have concluded that he did not need to be monitored under ACCT procedures at the time.

## Events of 1 September

51. Mr Dougan’s cellmate told Merseyside Police that, on the evening of 1 September, he told an officer that he was concerned about Mr Dougan. We have not been able to interview either party about this allegation. Mr Dougan’s cellmate was released shortly after the death and did not respond when we wrote to him, and the officer to whom he referred no longer works for G4S. There was no entry about such a conversation in any of the prison records we saw.
52. We do not therefore know what happened and cannot make a substantive finding. Nevertheless, this serves as a reminder to prison staff that they must record any conversations with prisoners about the risk of suicide and self-harm.

## Emergency response

53. PSI 03/2013 on Medical Emergency Response Codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is radioed, an ambulance must be called immediately. Staff should ensure that there are no delays in calling an ambulance and it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling one.
54. Staff at Altcourse use emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when the prisoner has difficulty breathing or is unconscious.
55. An officer pressed a 'first response' button on his radio rather than making a 'code blue' call. 'First response' is usually used to summon staff quickly to a non-medical emergency, such as a fight. When a prisoner is hanging, 'code blue' should be used as this ensures, firstly, that the control room operator knows to request an ambulance immediately and, secondly, that the response nurse knows to bring an emergency medical bag to the incident.
56. There was only a short delay before the nurse arrived at Mr Dougan's cell and requested a code blue radio message and we cannot say that this would have affected the outcome. Nevertheless, it is important that prison staff understand their roles in a medical emergency as immediate intervention when someone is found hanging might save their life. We make the following recommendation:

**The Director should ensure that all prison staff are aware of their responsibilities during medical emergencies, including that they use the appropriate medical code to communicate the nature of the emergency effectively.**

## Inquest

57. The inquest into Mr Dougan's death concluded on 17 March 2023. The jury concluded that he died of a self-inflicted ligature contributed to by the national lockdown measures, wanting to be moved nearer home and concern over the possible length of sentence.

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